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Liquor Project Coordinator
Law Commission
Level 19
171 Featherston Street
Wellington 6011

Dear Liquor Project Coordinator

The following submission is made on behalf of the New Zealand College of Public Health Medicine (NZCPHM). The NZCPHM is the professional body in New Zealand made up of doctors with specific expertise and interest in the practice of Public Health Medicine.

Public health medicine is defined as the branch of medicine concerned with the epidemiological analysis of medicine concerned with the health and health care of populations and population groups. It involves the assessment of health and health care needs, the development of policy and strategy, the promotion of health, the control and prevention of disease, and the organisation of services.

The NZCPHM membership includes 177 fully qualified specialists and 30 registrars who are doctors training in the specialty.

This submission is presented in four parts:

Part One: Summary of priority recommendations
Part Two: Overview and background to NZCPHM views
Part Three: Detailed analysis and evidence to support these views
Part Four: Summary table of all recommendations.

The NZCPHM has worked closely with New Zealand branch of the Royal Australasian College of Physicians (RACP) in developing this submission. The NZCPHM acknowledges the particular expertise of the RACP in the areas of cumulative health impacts of alcohol and treatment as part of problem limitation. The NZCPHM strength lies in the harm reduction related to supply control and demand limitation.

The NZCPHM is available to provide any further assistance the Law Commission would like in respect to this submission and the review.

Yours sincerely

Dr William Rainger FNZCPHM
President

NZCPHM Submission to Law Commission Review: Alcohol in our lives

Part One: Summary of Priority Recommendations

1. Increase age of purchase to 20 years for all licenced premises to reduce harm to youth.
2. Strengthen the regulation for marketing of alcohol, including advertising, promotion and sponsorship through an independent body.
3. Improve the licensing regime for sale and supply of alcohol overall, focussing on opening hours and range and density of outlets, including health and community input via Medical Officer of Health and community consultation in all licensing decisions.
4. Make Local Alcohol Policies/Plans mandatory with minimum range and level of provisions included in regulation.
5. Increase price of alcoholic beverages through increased excise tax, graduated tax regimes and pricing regimes.
6. Decrease the blood alcohol concentration (BAC) to 0.05 and to zero for learner drivers and drivers less than 20 years of age.
7. Include drink driving counter measures in overall policy framework.
8. Increase availability of treatment especially brief interventions for risky behaviour and treatment programmes for criminal offenders through Courts, Corrections and Probation systems.

Part Two: Overview / background to NZCPHM views

Alcohol is the only major dependence producing psychoactive substance causing substantial health harms which is widely used world-wide and at present is not covered by one or another international treaty. Alcohol has intoxicating, toxic and dependence-producing properties that may result in a wide range of harms including: intentional and unintentional injuries (from intoxication); mental and physical disorders of most bodily systems (from toxicity); and individual and societal harms (from intoxication, toxicity and dependence).

NZCPHM congratulates the Law Commission on the extensive in-depth report 'Alcohol in our lives: an issues paper on the reform of New Zealand's liquor laws' (referred to as the Report in this submission). The Report canvasses a wide range of issues well beyond a narrow legal focus, which allows the potential legal and policy frameworks to be considered in a broad context. NZCPHM considers that the response to the problem that alcohol creates for individuals and society must be tackled on many fronts as set out in the Report.

There is growing global consensus on the policy options that are effective in reducing the harm due to alcohol. These are:

- Regulating availability, including hours of sale and outlet density regulation,
- Raising the purchase age,
- Reducing demand by increasing the price of alcohol through taxation and other pricing mechanisms,
- Implementing drink driving counter measures,
- To effectively regulate alcohol marketing including advertising, promotion and sponsorship, and monitor and enforce the regulation through a statutory agency, and
- To ensure treatment is available for those in need.

Policy options that are either shown not to be effective or their value is not proven include regulation of the drinking context (e.g. host responsibility) unless well enforced, and educational approaches including bottle labelling. Community action that includes media advocacy may be useful in reframing the solution to key stakeholders and attracting the attention of decision makers.

Policy needs to be based on research and other evidence so that policy makers are on a firm footing to counter commercial interests. Policy interventions need to be backed by national and global information systems for monitoring and surveillance. And, since the alcohol industry is global, a move towards a global framework for policy interventions is suggested by the World Health Organisation. [1]

[1] World Health Organization, *WHO Expert Committee on Problems related to Alcohol Consumption*, in *WHO Technical Report Series*. 2007, World Health Organisation: Geneva.

The Terms of Reference for the Law Commission Review include:

> "… presenting to government for it's consideration, a revised policy framework covering principles that should regulate the sale, supply and consumption of alcohol, having regard to present and future needs."

Alcohol is no ordinary commodity. Treating it as such will perpetuate and intensify the harms it does. It is an intoxicating, toxic, psychoactive and dependence producing drug. That is why there are already some regulations around its use, and there is an opportunity now to strengthen this regulation to further limit its potential for harm.

Yet alcohol is widely accepted in society and the harms it can do are poorly known or understood by the general public. Any policy framework must balance the widespread acceptance of alcohol as an ordinary commodity, its proven capacity for harm and society's willingness to accept change. NZCPHM members have observed community action against alcohol supply in several communities which could indicate that the community is starting to want to see the harms from alcohol reduced.

The alcohol industry is a huge global and national industry that manufactures, distributes, markets and sells its product through many avenues. When alcohol is treated as an ordinary commodity, public health considerations are subordinated to the logic of the free market and free trade.[2] Trade rules may constrain health or social policy within a trading system that prioritises commercial goals above health.

The industry gives a passing acknowledgment that its product can do harm by sponsoring some selected 'harm prevention' activities and promoting the concept of 'corporate social responsibility'. It also markets its product as if it were an ordinary commercial commodity through advertising, promotions, and sponsorship, some of which is aimed at youth.

It is pertinent to consider the parallels between alcohol and tobacco as public health issues. It could be seen that alcohol is in the position now that tobacco was 50 years ago. Then tobacco was freely marketed, with the Department of Health recommending moderation – six to eight cigarettes a day – and warning against chain smoking as it induces tiredness. The tobacco industry was seen to be 'on-side' with government in voluntarily removing positive health messages from cigarette packets when the negative health impacts became more obvious. There was a tax on tobacco that produced revenue for the government. Cigarettes were produced here in New Zealand so there were similar GDP and employment considerations as for alcohol.[3] [4]

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[2] World Health Organization, *WHO Expert Committee on Problems related to Alcohol Consumption*, in *WHO Technical Report Series*. 2007, World Health Organisation: Geneva. p.42

[3] Thomson, G. and N. Wilson, *Resource Document: A Brief History of Tobacco Control in New Zealand*. 1997, Australasian Faculty of Public Health Medicine (NZ): Wellington.

[4] Trainor, S. *Tobacco control in New Zealand. A history.* Cancer Control Council of New Zealand www.cancercontrolcouncil.govt.nz/files/tobacco_control.pdf

New Zealand has moved from moral based laws on tobacco, with little policy backing, to research based control efforts over the last 50 years. Government action has been assisted by having a specialist tobacco control group in the Ministry of Health, use of expert scientific advice, selection of policy options likely to get approval, use of government and non government agencies and the media to inform and influence the public, persuading politicians and involving Ministers. Progress has been hampered by the size and wealth of the tobacco industry, tobacco marketing and the relative lack of political concern with disease prevention. This has been countered by good research information, action at Ministry of Health level and having some supportive politicians as 'champions'. The work is ongoing.

Tobacco control measures tried include taxes, age restrictions, smoke-free places, marketing controls, available treatment options, health education and promotion (Health Sponsorship Council) and insurance incentives. All are relevant to alcohol. Measures yet to be tried include tied taxes, tar and nicotine limitations, point of sale restrictions and litigation for cost recovery. These are all relevant to alcohol, with point of sale restrictions on the table presently.

In 50 years we will look back on the decisions made now about alcohol. The opportunity for positive change has never been greater and we have a model to follow. Reducing the harms due to alcohol, like tobacco, requires a long term sustained effort, both leading and supporting the community to generate culture change around the place alcohol takes in New Zealand society.

This submission takes a broad public health approach in responding to the review document, including consideration of the need for cross sectoral responsibility for developing and implementing a successful policy framework. Success in tackling the harms done by alcohol depends on an agreed, multi-faceted, multi-agency, well coordinated approach. NZCPHM considers that a new policy framework can positively change future social conditions by acting boldly now on the currently identified need to reduce the harm that alcohol inflicts on individuals and society.

Part Three: Detailed supporting information for NZCPHM position

Harms due to alcohol

Q1. Does the level of alcohol-related harm we are experiencing justify a new approach to the law?

NZCPHM **supports** the view that a complete new Act is required to make the law clear, coherent, simple and accessible. The caveat on this is that drafting a new Act will not slow down the process of law reform.

Action on policy and legal frameworks needs to proceed as soon as possible, as there appears to be community support for change. The Terms of Reference for the review include formulating a revised policy framework covering the principles that regulate liquor, which could be well articulated in a new Act.

Q2. Do you agree that getting drunk is considered acceptable drinking behaviour in New Zealand?

NZCPHM considers that New Zealanders have a high tolerance for drunkenness, drunken behaviour, and the consequences of this. It is a matter of national pride to be able to drink to excess and be able to 'hold our liquor'. The effects of alcohol are used as an excuse for many social 'misdemeanours'. Heavy drinking per occasion is a feature of the drinking culture in all ages, and young people pick up behaviours from the adults around them.

Q3. Do you think the risks associated with heavy drinking are well known? If not, what more could be done to make people aware of them?

NZCPHM considers that the risks of heavy drinking are probably not very well known. There are short and long term impacts of heavy drinking. The long-term impacts are addressed below. The short term effects of intoxication include poisoning, death, injury, crime, antisocial behaviour, road traffic offences, family violence, drowning, mood changes, suicide, aggression and so on. Some are well known, such as drink driving, others not so well known. Experience with tobacco shows that short term impacts are more likely to engender behaviour change than the long term impacts. This should be taken into account when devising strategies for reducing alcohol related harm. Note that knowledge does not necessarily correlate with behaviour change. Young people tend to consider that harm will not fall to them, that they are 'bullet-proof'.

The generic **solution** involves a change in community tolerance of drunkenness through a multi-faceted population based strategy to raise awareness. The law is one vehicle for this. There are other vehicles such as integrating issues around alcohol into the school curriculum alongside other life skills. An integrated health promotion approach includes: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting the health and social sectors as set out in the Ottawa Charter for Health Promotion is applicable to harm reduction for alcohol[5].

[5] World Health Organization, Ottawa Charter for Health Promotion. 1986, WHO: Ottawa.

Q4. Do you think the cumulative lifetime risks associated with drinking are well known? If not, what more could be done to make more people aware of them?

NZCPHM considers that the long term impacts of alcohol consumption are definitely not well known. The long term health effects need to be clearly articulated by the Ministry of Health and other responsible government agencies, and solutions to the drinking problem articulated. For alcohol, the cumulative long term impacts include that of injury, crime and antisocial behaviour, impacts on relationships, income, employment and education, as well as risk of diseases such as cancer, heart disease, gastrointestinal, endocrine dysfunction, psychiatric disorders, neurological conditions, bleeding disorders, vitamin deficiency, and importantly foetal alcohol spectrum disorder due to drinking in pregnancy.

NZCPHM acknowledges the expertise of the RACP on this question and supports the detailed submission by the RACP on this question. Note there is emerging evidence that the positive health benefits attributable to moderate alcohol consumption have been overstated.[6] [7]

Q5. Is the management of intoxicated people an acceptable use of a large part of the New Zealand Police resources? If not, what are the alternatives?

Management of drunkenness is a multi-faceted problem. Police deal with this on the streets and at police stations. Emergency departments frequently deal with this. It depends whether the Police see protecting individuals from themselves as part of their business in the community. Until public drunkenness reduces, someone has to deal with intoxicated people and the Police are well placed to do this. There could be more support from the health sector at Police stations.

Other comments on this section

NZ Liquor industry contribution to GDP & employment

Alcohol cannot be manufactured and supplied according to the same rules as other commercial products.[8] The tobacco industry contributes to GDP and employment, but that is not a reason to encourage people to smoke. Neither can the commercial benefits of alcohol use be put ahead of its impacts on health, wellbeing and civil society. The commercial benefits of the alcohol industry are far outweighed by the costs of the harm due to alcohol.

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[6] Connor J. The life and times of the J-shaped curve.Alcohol & Alcoholism 2006;41(6):583-4.

[7] National Health Committee, Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care: Appendix 4 - Evidence for the effectiveness of brief intervention in primary care. 1999, National Health Committee: Wellington.

[8] Babor, T. (2003). Alcohol :no ordinary commodity : research and public policy. Oxford, Oxford University Press

Coordinated approach to the alcohol issue

A parallel can be drawn between the tobacco story and the alcohol story. In the 1950's the Ministry of Health was setting guidelines of not more than six to eight cigarettes a day, and not to chain smoke because it induces tiredness. New Zealand is at a similar place with alcohol now, suggesting safe drinking patterns. There is an opportunity to take a long term strategic view of regulation of alcohol and consider how far New Zealand is willing to go at this point in time. The law can lead community opinion as well as following it, taking New Zealand in the right direction to minimise harm caused by alcohol use.[9]

Object of the law

Q6. Is the balance in the current law between individual responsibility and providing an environment that is conducive to moderate drinking the correct one? If not, what changes could be made?

NZCPHM considers that the current law is individually focussed and a future legal framework needs to focus more on promoting a safer drinking environment. Supply control needs to take into consideration the community views, outlet density, and health impact assessment of liquor outlets. This can effectively be done though **mandating Local Alcohol Plans** and having **Medical Officer of Health input** into all licensing decisions. Demand reduction can take the population perspective by changing price structure, and further restricting alcohol marketing, including advertising, promotions and sponsorship. The tobacco story is useful to look at here. Cigarettes are no longer widely marketed but alcohol is marketed extensively.

NZCPHM considers that the list of principles as set out on page 219 of the Report covers the main social harms and aspects of responsibility by both the alcohol industry and consumer that could, if well implemented, generate positive societal cultural change in regard to alcohol. The object of the law should include specific reference to the health of the population, for example 'to reduce alcohol related health harms to individuals and communities'. Culture change requires a broad approach and the law is one important mechanism to generate change.

Supply Control

Licensing

Q7. Do you agree with the current system of four types of liquor licence?

NZCPHM **supports** maintaining four licence types currently in use as they reflect the main settings in which alcohol is purchased, supplied and consumed. NZCPHM **strongly supports** removing exemptions for licences in chartered clubs, canteens, parliament, defence establishments, fire fighters facilities and so on, as any supply of alcohol requires a degree of rigour in preventing harm from its use. The licence system clearly indicates who is both responsible and liable for management and moderation of that consumption.

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[9] Thomson, G. and N. Wilson, Resource Document: A Brief History of Tobacco Control in New Zealand. 1997, Australasian Faculty of Public Health Medicine (NZ): Wellington.

NZCPHM **supports** a change in the licence fee to better reflect the costs that granting of a particular licence is likely to generate and the risk posed to the local community by the licence. Special licences may be for one off events where the likelihood of harm may be high without a licence and considerably lessened with a licence. Clubs may have a small membership and limited opening hours with a similarly small risk of harm being generated from the supply of alcohol.

NZCPHM **supports** increasing the education, age and training requirements for managers and door staff working in licenced premises and having sufficient managerial staff on duty to effectively manage premises taking size into consideration.

Note that the law is only as good as its implementation. Granting of liquor licences is just the first part of an effective regulatory system. The system must be monitored and penalties imposed must be sufficient to act as a deterrent. Licencees need to be educated so that they not only know the rules but understand the rationale for them and therefore be willing to comply with the rules. This combines health promotion, health education and regulatory aspects to alcohol harm reduction.

Q8. Should the criteria for licences change and, if so, what should the changes be?

NZCPHM **supports** both widening the grounds for objecting to a liquor licence application and making the grounds nationally consistent. Currently the criteria for objecting to a liquor licence is limited to applicant suitability, hours of operation, designated and restricted areas, methods to comply with the SOLA and the nature of the business.

Liquor licences are currently easy to gain and difficult to lose. Widening the criteria on which a liquor licence can be opposed would move towards licences being hard to get and easy to lose. There are currently no population-based criteria upon which to oppose licences such as social impact, outlet density and overall impact on the locality. The decision maker should be able to take into consideration:

- if the overall social impact of the licence is likely to be detrimental to the well-being of the local or broader community, taking into account the site, density and health and social characteristics of the local population,
- if granting a licence would be inconsistent with the object of the Act,
- if the amenity, quiet or good order of the locality would be lessened, and
- if the licence would be inconsistent with the Local Alcohol Policy.

Note Local Alcohol Policies will only be effective if they are mandatory, which NZCPHM **strongly supports.**

NZCPHM further **supports**:

- specifically authorising a Medical Officer of Health to report on all types of licences and licence renewals,
- widening the category of person who can object to a licence application,
- strengthening the criteria for suitability of licence applicants,
- allowing the licensing authority to impose any appropriate licence condition to reduce alcohol-related harm, and

- improving the process for notifying the public of licence applications and **recommends** extending the public notification period to 20 days and using internet and direct mail notifications. This will improve the effectiveness of the process for notifying the public of licence applications.

In regard to suitability of licence applicants, NZCPHM **recommends** a change in the licensing process, whereby it is mandatory for the licencee and bar manager of the premise to cooperate and be present during the liquor licensing process i.e. not allow 'absentee licencee' applications and licencees.

As stated in Q7, regulations are only as good as their implementation. This applies particularly to the host responsibility provisions of alcohol licences and the provision of food as well as alcohol. The evidence of effectiveness of host responsibility provisions is not extensive, and this is an area where further research would be useful, especially if provisions are tightened in any review of the Act.

Q9. Do you think the Liquor Licensing Authority should be retained as the regulator?

NZCPHM **supports** retaining the Liquor Licensing Authority (LLA) as the specialist regulator and **does not support** the transfer of authority to District Court or a specialist Licensing Commission, as long as the powers and functions of the LLA are increased to:

- Monitor and report on trends and adjust aspects of sale policy like promotions,
- Award costs,
- Impose fines on licencees, managers and staff of licenced premises for breaches of any of the provisions of the Act,
- Enhance the flow of data from inspectors, police, District Licensing Agencies (DLA), Medical Officers of Health and licencees,
- Implement quality control of DLA output and compliance, and
- Increase the powers of Police to authorise immediate closures of premises, breaching the condition of the Sale of Liquor Act or their liquor licence.

Fellows of the NZCPHM have noted that the regulatory processes differ between regions and that there is differing levels of collaboration amongst stakeholders (district inspectors, police, DLA's, public health and licencees). NZCPHM considers that the LLA could take a role in developing national policy guidelines that establish effective practice regionally and allow the system to be responsive to the needs of local communities.

Additional comment - District Licensing Agency options

NZCPHM **supports** restructuring and enhancement of the DLAs, specifically by:

- requiring higher levels of performance and reporting from DLAs,
- Making DLAs independent of Council to prevent conflicts of interest, particularly around business opportunities relating to alcohol,
- Providing for mandatory training of inspectors, and
- Allowing local authorities to keep fines from prosecutions to apply to harm reduction measures.

NZCPHM **does not support** each DLA setting its own fee. Fees should be within the limits set by the Local Alcohol Plan but in line with the guidelines set nationally. This prevents licencees choosing areas with low fees over those with higher fees at the expense of the local community. NZCPHM therefore **recommends** a national graduated fee structure for licences, possibly with some degree of local discretion via the Local Alcohol Policy.

Q10. Do you think local views should be taken into account in respect of licences in that area?

NZCPHM considers that national criteria for licences are important in setting the overall structure of the liquor licensing system. Local views are also important in setting the local environment. NZCPHM **recommends** that local views are taken into consideration in all licensing decisions, but that any criteria set locally are generally more restrictive than those set at national level. Local Alcohol Policies/Plans will be an important mechanism for local community input into licensing decisions.

There have been several examples where communities have demonstrated their objection to liquor licence applications, but the present licensing regime does not allow for local views to be considered in any depth. An example given by a Wellington Medical Officer of Health is the opposition to the licence application for a bottle store in Mungavin Avenue, Cannons Creek, Porirua East in December 2008. Opposition to the licence was voiced by the community, with more than 100 people protesting outside the LLA hearing [10]. The proposed site of the store, existing density of outlets, public health impact, and intense community opposition were not of themselves sufficient grounds on which to refuse the application. The non-appearance of the applicant at the hearing, however, made it possible for the LLA to refuse the application.

Additional comment - Local Alcohol Policies/Plans

Local Alcohol Policies/Plans underpin several of the responses and recommendations of the NZCPHM. NZCPHM **strongly recommends** that Local Alcohol Policies/Plans are made **mandatory** for all local authorities and that minimum provisions are set out in legislation. The establishment of these plans will introduce a degree of rigour into the licensing process and make it possible to address significant issues identified as problematic by the local community.

NZCPHM **recommends** the inclusion of minimum standards into Local Alcohol Policies**.** These standards, (obtained from reviewed evidence of effectiveness in community alcohol harm reduction), would ensure a degree of consistency and effectiveness across local authority boundaries and introduce rigour into the licensing process. A minimum standard requirement would not prevent local authorities from adopting statutory requirements beyond those stipulated. Small local authorities could group together to get a regionally coherent plan.

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[10] Kainuku, A. Liquor licence application meets stiff opposition. City Life Porirua 2008 [cited; Available from: http://www.poriruacity.com/multimedia/pdf/2008_09_18/09.pdf.

Medical Officers of Health (members of NZCPHM) submitted to the Law and Order Select Committee hearing on the Sale and Supply of Liquor Enforcement Bill in April 2009 and suggested the following minimum requirements to be included in Local Alcohol Plans:

- Number, location and density of alcohol outlets,
- Hours of operation of alcohol outlets,
- Host responsibility expectations,
- Establishment of interagency local alcohol forums that include the alcohol industry,
- Methods the DLA will use to monitor and enforce compliance with the plan and the legislation,
- Alcohol harm reduction strategy,
- Encouraging links with consistent approaches across neighbouring local authorities,
- Linkage to local Long Term Community Outcomes and LTCCPs, and
- Other rules around the availability and sale of alcohol.

NZCPHM in addition considers the following are necessary to be included in Local Alcohol Plans:

- Relationship of alcohol outlets to other community facilities including schools,
- A social and health impact assessment for the locality on which to base further social impacts of any individual licence application, and
- A regular review period for the plans.

Local Authorities must consult their communities on Local Alcohol Policies in a meaningful way so that local views are taken into consideration in establishing and reviewing their plans.

Hours

Q11. Do you think the hours that restaurants, bars, and clubs can be open should be restricted? If so, what should the hours be?

There is a wealth of international literature on the relationship between access to alcohol, excessive consumption and abuse of alcohol. NZCPHM **supports** a restriction on availability at on-licenced premises by limiting hours that alcohol can be sold. NZCPHM supports a change in legislation stating the latest time that restaurants, bars and clubs can be open, be restricted to 1.00am.[11] [12] Premises may apply for a standing extension of hours, until 4.00am with the condition of a one-way door policy, whereby patrons can remain on the premise but new patrons cannot enter the premise after 1.00am. The one-way door policy allows for a staggered time for patrons to leave licenced premises. Note these are maximum hours. The licensing authority can prescribe more restricted hours at its discretion in line with Local Alcohol Plans.

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[11] Kirkwood, L. and P. Parsonage, *Evaluation of the Christchurch city one-way door intervention. Final report*. 2008, Alcohol Advisory Council of New Zealand and the Accident Compensation Corporation

[12] Palk, G.R., J.D. Davey, and J.E. Freeman, *Perspectives on the effectiveness of the late night liquor trading lockout legislative provision*, in *Proceedings Stockholm Criminology Symposium*. 2008: Stockholm, Sweden.

NZCPHM **recommends** that the time that on-licenced premises can open be changed from 7am to at 9am. There has been little discussion of the opening times for on-licences, but having a minimum of five hours when alcohol cannot be consumed on licenced premises would not appear to create inconvenience for the vast majority of the community.

Regulating the availability of alcohol from on-licenced premises controls the immediate drinking environment and potentially reduces the immediate harms from alcohol consumption. Much has been done to promote host responsibility in this environment, although there is room to improve the impact of this and the drinking environment at on-licenced premises. However the proportion of alcohol purchased from off-licenced premises is increasing and this is increasingly contributing to alcohol related harm.

Q12. Do you think the hours that off-licence premises (including supermarkets and liquor stores) can sell alcohol should be restricted? If so, what should the hours be?

NZCPHM **considers** that limiting the availability of alcohol from off-licences is an important strategy to reduce harm from alcohol. Limiting the hours that alcohol can be purchased from off-licenced premises is one way of achieving this. Other approaches are commented on in Q14 (age of purchase) and Q18 (groceries and supermarkets selling alcohol and density of outlets) and Q19, 20, 21 (tax/pricing of alcohol).

The easy accessibility of alcoholic beverages from off-licences, as well as the price differential between on and off licences, are drivers of youth in particular 'pre-loading' with relatively cheap alcohol before going to on-licenced venues for their night out and at the end of the night purchase more alcohol on route home, to 'post load'.

NZCPHM **supports** a change to New Zealand legislation stipulating maximum opening hours for off-licences be 8.00am until 10.00pm, therefore creating consistency in each region, nationwide.

It is relevant to consider the purpose of an off-licence, which is to supply alcohol for consumption at times and at a place other than when and where it is purchased. This contrasts to an on-licenced premise, which has a purpose of selling alcohol for immediate consumption in a social setting (even if the sociability is marginal). Hence it is possible to arrange one's life to purchase alcohol well ahead of the planned time of consumption. Restricting off-licence sales can contribute to changing the drinking culture by reducing the current extensive availability of alcohol.

Limiting the hours that off-licences can sell alcohol has the potential to limit excessive drinking. If the off-licence is closed, once the alcohol that has been purchased has been consumed, patrons must wait until the next day to buy more.

Q13. Should we continue to have specific days on which alcohol cannot be sold?

Prohibiting the sale of alcohol on three and a half days a year will not significantly affect the extent of the harms due to alcohol. These provisions are in line with the restrictions on other retailers. NZCPHM **supports** that the provisions remain the same as for shop trading and allow any change to be made through that legal channel. The hour that prohibition begins and ends needs to be clarified.

Age

Q14. At what age should a person be able to purchase alcohol in New Zealand?

NZCPHM acknowledges the contentious nature of the debate on the purchase age for young people. Increasing the purchase age is an important strategy to prevent harm to young people. The harm to young people comes from both the harmful effect of alcohol on the developing brain and the harm from the behaviours as a consequence of intoxication. NZCPHM **recognises** the arguments on both sides of the purchase age debate, but considers that the evidence for harm-reduction with an increased purchase age is both convincing and of paramount importance, particularly in the off-licence situation.

NZCPHM therefore **recommends** the age to purchase alcohol at off-licenced premises be the same as the age to purchase at on-licenced premises, and that age be 20 years. NZCPHM further **recommends** making age verification mandatory for all sales of alcohol.

The easy accessibility of alcoholic beverages from off-licences, as well as the price differential between on and off licences, are drivers of youth in particular 'pre-loading' with relatively cheap alcohol before going to on-licenced venues for their night out. NZCPHM **considers** that limiting the availability of alcohol from off-licences is an important strategy to reduce harm from alcohol. Increasing the purchase age is an important strategy to prevent harm to young people.

The current level of harm to young people from alcohol is unacceptable and can be modified. A purchase age of 18 years inevitably allows greater availability of alcohol to 16 to 17 year olds and younger teenagers as 18 year olds will buy and supply to younger friends, particularly school friends.

Evidence for the harm associated with early initiation of drinking alcohol is clear. Of particular note is the research from the Dunedin Longitudinal Study which highlights the longer-term health effects of early initiation (Odgers 2008).[13]

[13] Odgers, C.L., et al., Is it important to prevent early exposure to drugs and alcohol among adolescents? Psychological Science, 2008. 19(10): p. 1037-44.

A disproportionate burden of harm is borne by young people.[14] As noted by Kypri (2003)[15] this has particular implications for Māori health, considering the young age structure of the Māori population. If alcohol policies remain unchanged, the ethnic health inequalities in morbidity attributable to alcohol will likely increase in years to come. The recent Alcohol and Drug Use Survey (Ministry of Health 2009) highlights the already large disparities, with Māori, and particularly Māori women, being more likely to have experienced harmful effects (including being assaulted or effects on their finances) from their own or someone else's alcohol use.

Allied to the discussion of purchase age is that of a legal drinking age. NZCPHM **does not support** the introduction of a legal drinking age.[16] NZCPHM considers that the measures outlined elsewhere will restrict access to alcohol for young people, and that shifting the onus onto the young person may have detrimental effects. The drunkenness provisions are sufficient to enforce regulation to counter the harms done by heavy drinking by the young when considered as a small component of a broad approach as suggested by NZCPHM in this submission.

Q15. At what age should a person be able to drink at a pub, club, bar or restaurant?

NZCPHM **recommends** the age to purchase alcohol at on-licenced premises be the same as the age to purchase at off-licence premises, and that age be 20 years.

NZCPHM **recognises** that the amount of alcohol consumed at on-licenced venues is limited for young people by its relatively high price. The harm is also reduced by the host responsibility clauses of licence conditions, drinking in an 'observed' environment. NZCPHM is not aware of any evidence to support a differential purchase age between on and off licenced premises and therefore **recommends** that the purchase age for both on and off licences be 20 years.

Refer to detail in Q14 above.

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[14] Ministry of Health, Alcohol Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey. 2009, Ministry of Health: Wellington.

[15] Kypri, K., Maori/non-Maori alcohol consumption profiles: implications for reducing health inequalities.[comment]. New Zealand Medical Journal, 2003. 116(1184): p. U643.

[16] Kypri, K. and J. Langley (2006). "Splitting the alcohol purchase age: gambling with youth health." Drug & Alcohol Review **25**(4): 293-5.

Individual and parental responsibility

Q16. Should it be an offence for anyone other than a parent or guardian to supply alcohol to someone under the purchase age?

NZCPHM **supports** the introduction of legislation that encourages individual and parental responsibility to prevent harm to young people from alcohol. NZCPHM **recommends** it be made an offence for an adult to supply liquor to a young person other than that adult's child or ward. This provides a clear definition of who is able to supply. It removes any difficultly of the interpretation of consent presented in the alternative option.

NZCPHM recognises that it will be difficult to monitor who supplies alcohol to young people. This will only come to the attention of the authorities if harms ensue from the consumption of alcohol.

Types of products

Q17. Do you think there are any alcohol products that should be banned?

NZCPHM **does not support** a ban on any specific alcohol product. NZCPHM **supports** the view that consideration be given to developing a process that could be used to regulate some products if these products are deemed a risk to health.

NZCPHM **recommends** that a Minister (preferably the Minister of Health), on expert advice from a group like the Expert Advisory Committee on Drugs, have powers to ban certain alcoholic beverages for health reasons. Currently products very high in alcohol content that risk rapid and fatal intoxication, and products attractive to the young that introduce them to alcohol, should be considered under this provision. Such Ministerial discretion would allow new formulations of alcoholic products to be assessed as they come to the market.

The current targeting of young people by the Ready To Drink (RTD) formulations is of particular concern as it introduces young people to alcohol at an early age. An Australian study found that RTDs were the most common drink consumed by young people, the most popular drink among 12 to 14 year olds and were very popular with young women. The popularity of RTDs decreased with increasing age.[17] RTDs are consumed in large quantities as young people underestimate their alcoholic content and this leads to intoxication particularly of young women.[18] [19] The consequences of this include unsafe sex, damage to unborn babies, brain developmental damage, injury, and so on. It will be important to consider the wider implications of alcohol as a drug when considering restricting any formulation of the drug.

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[17] Ministerial Committee on Drugs (MCDP). Presented 2 September 2008. Policy Paper. *Ready-To-Drink Beverages*.

[18] Australian General Practice Network (AGPN). May 2009. Submission to the Senate Community Affairs Committee: *Inquiry into ready-to-drink alcohol beverages.*

[19] Roxon N & Swan W. 15 April 2009. Government to re-introduce alcopops measure [*media release*]. Canberra: Minister for Health & Ageing.

Q18. Do you think the rules about supermarkets and grocery stores selling liquor should continue as now?

NZCPHM considers the ideal long term position to be that off-licence sales of alcoholic beverages would be restricted to liquor stores dedicated to the sale of alcohol, and sale of alcohol not be associated with sale of food and grocery items. Alcohol being presented alongside food and grocery items has 'normalised' alcohol as an every day commodity and taken away from identifying it as a potentially harmful drug. Supermarkets have driven the ready availability and accessibility of alcohol by extended trading hours and heavy price discounting.

Two key issues around off-licence sales of alcohol from supermarkets and grocery stores are the density of outlets and the price competition between outlets to generate sales.[20] Price competition can be dealt with under pricing and marketing regulation (Q18, Q20, Q21 and Q22). The density issue can be addressed by a mandatory comprehensive local alcohol plan that must be considered in all licensing decisions. Any decision to grant a licence would be based on health and social impacts of that outlet rather than the type of liquor outlet.[21] In all cases the views of the community would be taken into account, and the density of outlets potentially reduced. Reducing outlet density has been shown to reduce the harm from alcohol.

NZCPHM recognises the body of international and New Zealand research demonstrating correlations between density of outlets and various types of alcohol-related harm, which has been discussed in the issues paper.

On balance, NZCPHM currently **recommends** that both supermarkets and grocery stores are permitted to sell alcohol but that the density of outlets is reduced by implementing a local alcohol plan that has outlet density as a consideration in granting licences. NZCPHM further **recommends** that dairies are phased out of the list of licenced premises allowed to sell alcohol on the grounds previously enacted.

NZCPHM **recommends** supermarkets and grocery stores only be allowed to display alcohol products and advertising materials and associated promotions in one designated area of the store.

NZCPHM **does not support** extending the range of liquor outlets or extending the range of products sold in supermarkets or rural grocery stores. Alcoholic beverage sales should be restricted to beer and wine. Spirits and spirit based products should be excluded from supermarkets.

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[20] Livingston, M., T. Chikritzhs, et al. (2007). "Changing the density of alcohol outlets to reduce alcohol-related problems." Drug & Alcohol Review **26**(5): 557-66.

[21] Huckle, T., J. Huakau, et al. (2008). "Density of alcohol outlets and teenage drinking: living in an alcogenic environment is associated with higher consumption in a metropolitan setting." Addiction **103**(10): 1614-21.

3.4 Demand reduction

Tax/price

Q19. Do you think the availability of cheap alcohol is contributing to alcohol-related harm?

NZCPHM considers that the availability of cheap alcohol encourages purchasing large amounts of alcohol from off-licenced premises and so consumption is in an unsupervised environment.[22]

Studies have concluded that alcohol purchase and consumption is sensitive to price thus validating policies that seek to use price controls to reduce alcohol consumption.[23]

Q20. Does the difference in price between alcohol bought from retailers such as supermarkets and liquor stores and alcohol bought in a bar or restaurant influence where you drink?

There are large disparities between the current price of alcohol at on and off-licenced premises. Young people in particular buy alcohol from off-licences and 'pre-load' with alcohol before going to licenced premises to 'enjoy' their night out. Young people are price sensitive and a recent study found that the majority of youth consumed alcohol from an off-licenced premise.

Q21. Do you think there is a case for increasing tax or setting a minimum price for alcohol in order to help reduce the amount of alcohol consumed by young people and heavy drinkers?

Evidence suggests that alcohol-related harm falls disproportionately on youth. Youth are particularly price sensitive as they have limited disposable income. Mechanisms to increase the price of alcohol and to reduce the price differential between on and off-licenced premises is likely to decrease consumption and have a harm reduction effect on young people in the long term. The effect of any manipulation of price should be monitored so that its impact can be researched.[24] On the basis of this, NZCPHM:

- **recommends** an increase in tax on alcohol tax and a graduated volumetric excise tax system that removes the current bands and simply states more tax the greater concentration of alcohol in the product, with tax rates being regularly reviewed and increases tied at least to Consumer Price Index.
- **does not support** reduced tax on low alcohol products as a graduated tax system would allow this to happen.

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[22] Wagenaar,A.C., Salois, M.J. & Komro, K.A. (2009). Effects of beverage alcohol price and tax levels on drinking: A metaanalysis from 112 studies. *Addiction,* 104(2), pp 179-190

[23] Ministry of Health. 2007. *Alcohol Use in New Zealand: Analysis of the 2004 New Zealand Health Behaviours Survey – Alcohol Use.* Wellington: Ministry of Health.

[24] Anderson P, de Bruijn A, Angus K , Gordon R & Hastings G. Impact of alcohol advertising and media exposure on adolescent use; a systematic review of longitudinal studies. *Alcohol Alcohol.* 2009;44: 229-43

- **supports** regulating the price of alcohol by introducing a minimum price regime and restricting the discounting of alcoholic beverages.
- **supports** an increase in the ALAC levy to be applied to harm reduction initiatives and applying the revenue generated from an increase in tax to treatment services and further harm reduction initiatives.
- **recommends** the use of all excise tax for prevention and treatment to reduce alcohol related harm.
- **supports** the inclusion of the following pricing options:
  - Prohibit the sale of alcohol as a loss leader,
  - Restrict the discounting of alcohol products,
  - Require the Licensing Authority to take into account past retail practice (including pricing and promotions behaviour) in licensing decisions and require liquor licencees to supply the necessary data,
  - Prohibit advertisements containing the price of alcoholic beverages, and
  - Prohibit off-licence price promotions that create an economic incentive for consumers to buy larger amounts.

Advertising

Q22. Should the way alcohol is marketed (including advertising, promotions, and sponsorship) have greater restrictions? If so, what restrictions are appropriate?

Links between alcohol advertising and/or media exposure to alcohol and increased alcohol consumption have been clearly established. This is of particular concern for adolescents, where a recent systematic review of longitudinal studies has shown consistent effects on promoting earlier initiation drinking and heavier drinking amongst those who already drink.[25] Three New Zealand studies from the Dunedin birth cohort were included in the review. Early initiation of drinking and heavy drinking in adolescence both have established links to a range of acute harms, as well s long-term outcomes.

Recently there has been increasingly robust evidence published about the effects of alcohol in the media on drinking.[26] The recent British Medical Association Board of Science review of the effect of alcohol marketing on young people concluded that the vast advertising and promotion activity of alcohol companies has a powerful effect on young peoples drinking and cumulatively on social norms. It describes UK alcohol promotion as 'subject to completely inadequate controls' and recommended that the UK government should 'move away from partnership with the alcohol industry' and 'implement and rigorously enforce a comprehensive ban on all alcohol marketing communications'.

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[25] Anderson P, de Bruijn A, Angus K , Gordon R & Hastings G. Impact of alcohol advertising and media exposure on adolescent use; a systematic review of longitudinal studies. *Alcohol Alcohol.* 2009;44: 229-43

[26] British Medical Association (2009). *Under the influence: The Damaging Effect of Alcohol Marketing on Young People.* British Medical Association, London

NZCPHM also **considers** that the ideal end point for marketing of alcohol is that no marketing of any sort is allowed. The progressively severe regimes around tobacco marketing over many years demonstrate how long it may take to reach this objective. NZCPHM recognises that the community is not yet at a place where this would be an acceptable option, but changes to the current self-regulatory model are recommended.

New Zealanders are exposed to high levels of alcohol advertising and other promotions, including heavy discounting by supermarkets and sponsorship of the All Blacks. Therefore there is an opportunity for substantial health gain by limiting alcohol marketing.[27]

NZCPHM considers that the current self-regulatory model run essentially by the industry operates as it is designed to run quite well, but that it is the **wrong model** for the current complex environment. It is a complaints-based system that encourages advertisers to go to the limit of what is permissible, considers each advertisement on a one off basis and does not consider overall density or exposure to advertising. Promotion, packaging and sponsorship are excluded, although the industry considers these as all part of the marketing strategy. Any penalties are only invoked if there is a complaint made about an individual advertisement and that complaint is upheld. The penalties are minor and insufficient as a deterrent for persistent offenders.

NZCPHM **recommends** that the system be radically changed. NZCPHM **supports** the establishment of a legal framework and statutory body to regulate and control all forms of liquor marketing and **recommends** this include advertising, packaging, promotions, point of sale displays, retail positioning and sponsorship and makes provision to regulate newer forms of marketing through electronic media and other media as these come along. NZCPHM **supports** severely limiting broadcast advertising on television and radio.

3.5 Problem limitation

Treatment

Q23. Do you think there is a need for greater emphasis on treatment for people using alcohol in a risky manner?

The NZCPHM recognizes the expertise of the RACP and College of Psychiatrists in the area of treatment of alcohol disorders, and supports the submissions made by these Colleges on this section.

While the main focus of NZCPHM is prevention and reducing the harm alcohol causes, we acknowledge that there is still a strong need to improve current resources for treatment. Brief interventions for risky drinking behaviour have been shown to be an effective measure and cross the boundary of population health and treatment services. NZCPHM **supports** the view that increased funding across a range of sectors for treatment is required to place a greater emphasis on treatment.

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[27] British Medical Association (2009) Under the influence. The damaging effect of alcohol marketing on young people. London: BMA

Since the harms and cost of harm fall under the jurisdiction of many government departments, NZCPHM recommends that funding be drawn from these departments centrally to allow integrated treatment packages to be delivered by the health sector. The departments would include Courts, Corrections, Police, Occupational Safety, ACC, Work and Income as well as Health. Treatment options need to be included in the policy framework alongside the sale, supply and consumption of liquor. Treatments funded to include risky behaviour situations as well as treatment for alcoholics.

Brief interventions have proved successful in settings overseas for alcohol related problems and introducing these into primary care and Emergency Department situations is supported as a treatment initiative. Guidelines for brief interventions, as for smoking, are required.

National Committee for Addiction Treatment reports that 5% of all drinkers suffer from alcohol dependence, but fewer than 0.5% of all drinkers receive treatment. Furthermore, a large proportion of those who suffer from alcohol dependence are part of New Zealand's more socio economically disadvantaged groups. There is significant evidence to show that treatment works to manage the sustained effects of alcohol use, and just about any treatment is better than no treatment at all.

There are financial and social benefits to be gained through investing in treatment as it is estimated that for every dollar spent on interventions at least four dollars are saved in health care, accidents, and crime. This figure becomes more significant when it is considered that 83% of prisoners in New Zealand have had a substance misuse disorder at some time in their lives (NCAT).[28]

Penalties

Q24. Should there be increased penalties for serious breaches of the liquor laws?

NZCPHM s**upports** increased penalties for serious breaches of licence conditions, including making it easier for a licencee and a manager to lose their licence.

NZCPHM **recommends** a graduated and clear cut penalty process such as: any first offence invokes a written warning (with or without temporary suspension or fine); any second offence invokes temporary suspension of licence and manager's certificate together with a fine; and the third offence invokes cancellation of licence and manager's certificate.

NZCPHM **supports** an increase in responsiveness of the licensing authority including the ability to hold urgent hearings. If the system is improved to be more time-responsive this provision would be used infrequently.

Q25. Should there be greater use of infringement offences for minor breaches of the liquor law?

As stated earlier, the law is only of use if it is well enforced in a timely manner. NZCPHM **supports** the Police having the power to issue infringement notices for all minor offences. This will reduce the time the LLA spends dealing with first and second time minor offences.

[28] http://www.ncat.org.nz/factsheet.html

NZCPHM also **recommends** that District Licensing Authority officers also have the power to issue infringement notices.

NZCPHM **recommends** that the third infringement notice for any minor offence results in escalation to being treated as a serious offence. The process of issuing infringement notices must be robust enough to be used as evidence in a future licensing authority hearing.

NZCPHM **supports** Medical Officers of Health having the same powers of entry as licensing inspectors but **does not support** them having powers to issue infringement notices.

Q26. Should the Police have greater powers to close down bars where there are breaches of law occurring?

NZCPHM **supports** the view that the Police should be able to shut down bars immediately to prevent serious breaches of the Act or on the basis of public safety concerns. The law already allows for this in certain circumstances. Both increasing the powers, and applying the existing powers more effectively, that are required.

Liquor in public places

Q27. Should liquor bans be retained?

NZCPHM **acknowledges** the need to regulate drinking in public places. However, regulation of supply should be part of a **comprehensive local alcohol plan** developed by the Local Authority in consultation with the community. Liquor control Bylaws can inadvertently have the effect of moving the problem of excessive drinking form one locality to another.

NZCPHM **recommends** a modified continuation of a liquor ban system that includes making the bans consistent with the local alcohol plan for the area, and having local authorities work together with neighbouring authorities so that actions in one area do not impact adversely on neighbouring areas.

It is useful to ask why it is necessary to be allowed to drink in public places, and what problems arise from this practice. It allows social gatherings to include alcohol use, but also allows young people to pre-load on cheap liquor before entering on-licenced premises. It encourages drunkenness in public places, which was the initiating issue for liquor bans.

If lessons are to be learnt from tobacco, when children see or know others are smoking, they are at increased risk of smoking and of continuing to smoke, because of the example and normalisation of smoking. There appears to be a dose-response effect, so the more there is smoking around them, the more youth are at risk of smoking. The risk is partly because perceived smoking prevalence indicates to children the social norms for smoking.

Q28. If so, can the liquor ban provisions on notification be improved?

NZCPHM **considers** that if liquor bans are to be effective and meaningfully address the harms from intoxication then the processes around their implementation must be improved. Further evaluation of liquor bans would be useful.

Q29. Do you think an offence of drinking in a public place, rather than the liquor ban system, is preferable?

NZCPHM **does not support** a change in legislation stating it is an infringement offence to consume alcohol in a public place. The provisions allowing for liquor bans (Q27) and the offence of being drunk, disorderly or incapable in a public place (Q30) together are considered sufficient to reduce the public nuisance aspects of alcohol intoxication that will also have an effect on the overall alcohol harms.

Q30. Do you think it should be an infringement offence to be drunk in a public place?

NZCPHM **supports** a change in legislation to make being drunk, disorderly or incapable in a public place an infringement offence. This would allow the Police to issue infringement notices as part of their current management of the drunk, disorderly or incapable people and removes the current risk of a young person receiving a criminal conviction for drunkenness by being arrested for disorderly behaviour. Provision for arrest for other more serious offences, like assault, would need to remain, with alcohol an aggravating factor.

Further comments on this section

Transport options

NZCPHM **recommends:** lowering the BAC limit to 0.05; zero BAC for learner drivers and drivers under 20 years; addressing recidivism through Zero BAC and a move to alcohol interlocks; infringement penalties for BAC between 0.05 and 0.079 for random checks only; promoting the use of alcohol interlocks; and public information about the impact of alcohol on driving.[29]

NZCPHM **recommends** that drink driving countermeasures be included in the policy framework for reducing harm due to alcohol, even though its implementation is through the Ministry of Transport. Integrated alcohol policy is likely to be more effective than a series of isolated measures, and will encourage coordinated action.

Product labelling and serving sizes

NZCPHM **acknowledges** the role of the Australia New Zealand Food Standards Code (ANZFSC) and the work that is underway concerning health advisory labels for alcohol products. NZCPHM would **support** health warnings and nutritional information on alcoholic beverages and anticipates there will be an opportunity for input into the deliberations on the ANZFSC.

There is evidence that warning labels are successful in raising awareness and increasing knowledge but limited evidence that they help change alcohol use. To be successful in changing alcohol behaviours their use should be accompanied by changes in the purchase age, an increase in excise tax and minimum pricing options.

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[29] Ministry of Transport (2009). *Safer Journeys – have your say on our next road safety strategy.* Ministry of Transport

Alcohol is a legal drug being legally sold to consumers. As such consumers are entitled to basic information to enable them to consume the product safely. The information should focus on intoxication and drinking in unsafe contexts, such as pregnancy, driving, operating machinery and drug combination. The labelling should be aimed at maximising impact and awareness.

Part Four: Summary table of NZCPHM recommendations

The harm done by alcohol and the objects of the law	
Consultation question	**NZCPHM position**
Harm done by alcohol	
1. Does the level of alcohol-related harm we are experiencing justify a new approach to the law?	***NZCPHM** supports **the view that a complete new Act is required to make the law clear, coherent, simple and accessible, as long as this does not slow down the process of law reform.***
2. Do you agree that getting drunk is considered acceptable drinking behaviour in New Zealand?	NZCPHM considers that New Zealanders have a high tolerance for drunkenness, drunken behaviour, and the consequences of this. It is a matter of national pride to be able to drink to excess and be able to 'hold our liquor'. The effects of alcohol are used as an excuse for many social 'misdemeanours'. Heavy drinking per occasion is a feature of the drinking culture in all ages, and young people pick up behaviours from the adults around them.
3. Do you think the risks associated with heavy drinking are well known? If not, what more could be done to make people aware of them?	NZCPHM considers that the risks associated with heavy drinking are probably not well known. There are short and long term impacts of heavy drinking. The short term effects of intoxication include poisoning, death, injury, crime, antisocial behaviour, road traffic offences, family violence, drowning, mood changes, suicide, aggression and so on. Some are well known, such as drink driving, others not so well known.
5. Is the management of intoxicated people an acceptable use of a large part of the New Zealand Police resources? If not, what are the alternatives?	Management of drunkenness is a multifaceted problem. Emergency departments frequently deal with drunk patients. As well as dealing with intoxicated people, the Police deal with associated problems such as assault, sexual abuse, domestic violence, property damage, theft, drink driving and so on. Until public drunkenness reduces, someone has to deal with intoxicated people and the Police are well placed to do this. NZCPHM acknowledges that more support from the health sector at Police stations would be beneficial to Police and the intoxicated persons.

5. Is the management of intoxicated people an acceptable use of a large part of the New Zealand Police resources? If not, what are the alternatives?	Management of drunkenness is a multifaceted problem and is not an acceptable use of large amounts of Police resources. Police deal with this on the streets and at police stations. Emergency departments frequently deal with drunk patients. As well as dealing with intoxicated people, the Police deal with associated problems such as assault, sexual abuse, domestic violence, property damage, theft, drink driving and so on. Until public drunkenness reduces, someone has to deal with intoxicated people and the Police are well placed to do this. NZCPHM acknowledges that more support from the health sector at Police stations would be beneficial to Police and the intoxicated persons.
Objects of the law	
6. Is the balance in the current law between individual responsibility and providing an environment that is conducive to moderate drinking the correct one? If not, what changes could be made?	NZCPHM considers that the current law is individually focussed and a future legal framework needs to focus more on promoting a safer drinking environment.

Supply Controls	
Consultation Questions	**NZCPHM position**
Licensing	
7. Do you agree with the current system of four types of liquor licence?	NZCPHM **supports** maintaining the current system of four licence types (on-licences, off-licences, club licences and special licences) as they reflect the main settings in which alcohol is purchased and consumed, and **strongly supports** moving exemptions for licences in chartered clubs, police canteens, parliament, defence establishments, fire fighters facilities and so on. NZCPHM **supports** a change in the licence fee to better reflect the costs that granting of a particular licence is likely to generate and graduating the fee structure to better reflect the risk posed to the local community by the licence.

	NZCPHM **supports** increasing the education, age and training requirements for managers and door staff working in licenced premises and having sufficient managerial staff on duty to effectively manage premises taking size into consideration e.g. requiring multiple managers to be on duty.
8. Should the criteria for licences change and, if so, what should the changes be?	NZCPHM **supports** widening the grounds upon which a liquor licence can be opposed. This would move towards licences being hard to get and easy to lose, whereas the converse is currently the case. There are currently no population-based criteria upon which to oppose licences such as social impact, outlet density and overall impact on the locality. In regard to suitability of licence applicants, NZCPHM **recommends** a change in the licensing process, whereby it is mandatory for the licencee and bar manager of the premise to cooperate and be present during the liquor licensing process i.e. not allow 'absentee licencee' applications and licencees.
9. Do you think the Liquor Licensing Authority should be retained as the regulator?	NZCPHM **supports** retaining the LLA as the specialist regulator and **does not supports** the transfer of authority to District Court or a specialist Licensing Commission, as long as the powers and functions of the LLA are increased as set out on P235 of the Report. NZCPHM **supports** restructuring and enhancement of the District Licensing Authorities NZCPHM **does not support** each DLA setting its own fee. NZCPHM **recommend** a national graduated fee structure for licences, possibly with some degree of local discretion via the Local Alcohol Policy. NZCPHM further **recommends** an increase in the powers of the Police to authorise immediate closure of premises breaching the conditions of the Act of their liquor licences.
10. Do you think local views should be taken into account in respect of licences in that area?	NZCPHM **recommends** that local views are taken into consideration in all licensing decisions. Local Alcohol Policies/Plans will be an important mechanism for this. NZCPHM **strongly recommends** that Local Alcohol Policies/Plans are made **mandatory** and that minimum provisions are set out in the Act.

Hours	
11. Do you think the hours that restaurants, bars, and clubs can be open should be restricted? If so, what should the hours be?	NZCPHM **supports** a change to legislation stating maximum hours that restaurants, bars and clubs can be open, be restricted to 1.00am. Premises may apply for a standing extension of hours, until 4.00am with the condition of a one-way door policy, whereby patrons can remain on the premise but new patrons cannot enter the premise after 1.00am. Note these are maximum hours. The licensing authority can prescribe more restricted hours at its discretion in line with Local Alcohol Plans. NZCPHM **recommends** that the time that on-licenced premises can start serving alcohol be changed from 7am to 9am.
12. Do you think the hours that off-licence premises (including supermarkets and liquor stores) can sell alcohol should be restricted? If so, what should the hours be?	NZCPHM **supports** the view that the maximum opening hours for off-licences be 8am to 10pm. Note these are maximum hours. The licensing authority can prescribe more restricted hours.
13. Should we continue to have specific days on which alcohol cannot be sold?	NZCPHM **supports** that the provisions remain the same as for shop trading and allow any change to be made through that legal channel. The hour that prohibition begins and ends needs to be clarified.
Age	
14. At what age should a person be able to purchase alcohol in New Zealand?	NZCPHM **recommends** the age to purchase alcohol at off-licenced premises be the same as the age to purchase at on-licenced premises, and that age be 20 years. NZCPHM **supports** making age verification mandatory for all sales of alcohol. NZCPHM **does not support** the introduction of a legal drinking age.
15. At what age should a person be able to drink at a pub, club, bar or restaurant?	NZCPHM recommends the age to purchase alcohol at on-licensed premises be the same as the age to purchase at off-license premises, and that age be 20 years. NZCPHM supports making age verification mandatory for all sales of alcohol.

Individual and parental responsibility	
16. Should it be an offence for anyone other than a parent or guardian to supply alcohol to someone under the purchase age?	NZCPHM **recommends** the introduction of legislation to make it an offence for anyone other than a parent or guardian to supply alcohol to a young person under the legal purchase age. NZCPHM **do not supports** any other adult supplying alcohol to a young person with the consent of a parent or guardian, as this is open to variable interpretation.
Types of products	
17. Do you think there are any alcohol products that should be banned?	NZCPHM **does not support** a ban on any specific alcohol product. NZCPHM **supports** the view that consideration be given to developing a process that could be used to regulate some products if these products are deemed a risk to health. NZCPHM **recommends** that a Minister (preferably the Health Minister), on expert advice from a group like the Expert Advisory Committee on Drugs, have powers to ban certain alcoholic beverages for health reasons.
18. Do you think the rules about supermarkets and grocery stores selling liquor should continue as now?	NZCPHM considers the ideal long term position to be that off-licence sales of alcoholic beverages would be restricted to liquor stores dedicated to the sale of alcohol, and sale of alcohol not be associated with sale of food and grocery items. On balance, NZCPHM currently recommends that both supermarkets and grocery stores are permitted to sell alcohol but that the density of outlets is reduced by implementing a local alcohol plan that has outlet density as a consideration in granting licences. NZCPHM further recommend that dairies are phased out of the list of licenced premises allowed to sell alcohol on the grounds previously enacted. NZCPHM do not support extending the range of liquor outlets or extending the range of products sold in supermarkets or rural grocery stores. Alcoholic beverage sales should be restricted to beer and wine. Spirits and spirits based products should be excluded from supermarkets.

Demand Reduction	
Consultation question	**NZCPHM position**
Tax/price	
19. Do you think the availability of cheap alcohol is contributing to alcohol-related harm?	**Yes**. Availability of cheap alcohol encourages purchasing large amounts of alcohol from off-licenced premises and so consumption in an unsupervised environment.
20. Does the difference in price between alcohol bought from retailers such as supermarkets and liquor stores and alcohol bought in a bar or restaurant influence where you drink?	**Yes.** Young people in particular buy alcohol from off-licences and 'pre-load' with alcohol before going to licenced premises to 'enjoy' their night.
21. Do you think there is a case for increasing tax or setting a minimum price for alcohol in order to help reduce the amount of alcohol consumed by young people and heavy drinkers?	Yes. NZCPHM recommends an increase in tax on alcohol tax and a graduated volumetric excise tax system that removes the current bands and simply states more tax the greater concentration of alcohol in the product, with tax rates being regularly reviewed and increases tied at least to Consumer Price Index. NZCPHM do not support reduced tax on low alcohol products as a graduated tax system would allow this to happen. NZCPHM supports regulating the price of alcohol by introducing a minimum price regime and restricting the discounting of alcoholic beverages. NZCPHM supports an increase in the ALAC levy to be applied to harm reduction initiatives and applying the revenue generated from an increase in tax to treatment services and further harm reduction initiatives.
Advertising	
22. Should the way alcohol is marketed (including advertising, promotions, and sponsorship) have greater restrictions?	NZCPHM **considers** that the ideal end point for marketing of alcohol is that no marketing of any sort is allowed. The progressively severe regimes around tobacco marketing over many years demonstrate how long it may take to reach this objective. NZCPHM recognises that the community is not yet at a place where this would be an acceptable option, but changes to the current self-regulatory model are recommended.

If so, what restrictions are appropriate?	NZCPHM **recommends** that the system be radically changed. NZCPHM **supports** the establishment of a legal framework and statutory body to regulate and control all forms of liquor marketing and **recommend** this include advertising, promotions and sponsorship and makes provision for newer forms of marketing through electronic media and other media to be included. NZCPHM **supports** severely limiting broadcast advertising on television and radio.

Problem Limitation	
Consultation questions	**NZCPHM position**
Treatment	
23. Do you think there is a need for greater emphasis on treatment for people using alcohol in a risky manner?	NZCPHM **support** the Law Commission's view that increased funding across a range of sectors for treatment is required to place a greater emphasis on treatment. Since the harms and cost of harm fall under the jurisdiction of many government departments, NZCPHM recommends that funding be drawn from these departments centrally to allow integrated treatment packages to be delivered by the health sector.
Penalties	
24. Should there be increased penalties for serious breaches of the liquor laws?	Yes. NZCPHM s**upports** increased penalties for serious breaches of licence conditions, including making it easier for a licencee and a manager to lose their licence. NZCPHM **recommend** a graduated and clear cut penalty process. NZCPHM **support** an increase in responsiveness of the licensing authority including the ability to hold urgent hearings.
25. Should there be greater use of infringement offences for minor breaches of the liquor law?	**Yes.** NZCPHM **supports** the Police having the power to issue infringement notices for all minor offences. NZCPHM **recommend** that DLA officers also have the power to issue infringement notices. NZCPHM **recommend** that the third infringement notice for any minor offence results in escalation to being treated as a serious offence.

	NZCPHM **supports** Medical Officers of Health having the same powers of entry as licensing inspectors but **does not support** them having powers to issue infringement notices.
26. Should the Police have greater powers to close down bars where there are breaches of law occurring?	Yes. NZCPHM supports the view that the Police should be able to shut down bars immediately to prevent serious breaches of the Act or on the basis of public safety concerns.
Liquor in public places	
27. Should liquor bans be retained?	***NZCPHM*** *acknowledges* ***the need to regulate drinking in public places. However, regulation of supply should be part of a*** *comprehensive local alcohol plan* ***developed by the Territorial Local Authority in consultation with the community.*** NZCPHM **recommends** a modified continuation of a liquor ban system that includes making the bans consistent with the local alcohol plan for the area, and having local authorities work together with neighbouring authorities so that actions in one area do not impact adversely on neighbouring areas.
28. If so, can the liquor ban provisions on notification be improved?	NZCPHM **consider** that, If liquor bans are to be effective and meaningfully address the harms from intoxication then the processes around their implementation must be improved.
29. Do you think an offence of drinking in a public place, rather than the liquor ban system, is preferable?	NZCPHM **does not support** a change in legislation to stating it is an infringement offence to consume alcohol, in a public place.
30. Do you think it should be an infringement offence to be drunk in a public place?	NZCPHM **supports** a change in legislation stating it is an infringement offence to consume alcohol in a public place.

Other: Transport options	NZCPHM **recommends:** lowering the BAC limit to 0.05; zero BAC for drivers certain drivers; addressing recidivism through Zero BAC and a move to alcohol interlocks; infringement penalties for BAC between 0.05 and 0.079 for random checks only; promoting the use of alcohol interlocks; and public information about the impact of alcohol on driving. NZCPHM **recommends** that drink-driving countermeasures be included in the policy framework for reducing harm due to alcohol, even though its implementation is through the Ministry of Transport. Integrated alcohol policy is likely to be more effective than a series of isolated measures, and will encourage coordinated action.
Other: Product labelling and serving sizes	NZCPHM **acknowledges** the role of the Australia New Zealand Food Standards Code and the work that is underway concerning health advisory labels for alcohol products. NZCPHM would **support** health warnings and nutritional information on alcoholic beverages and anticipates there will be an opportunity for input into the deliberations on the ANZFSC. NZCPHM **supports** improved training, education and character requirements for licencees, managers and other staff (see Q7 above). NZCPHM **proposes** that standard serving sizes for beverages, to allow consumers to clearly know how much alcohol they are consuming, be suggested as a voluntary measure by industry. Training for staff could include the harm reduction benefits of standard serve sizes.