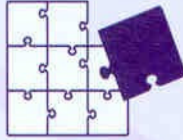

Healthy Christchurch

Submission to The Law Commission's Issues Paper on the Reform of New Zealand's Liquor Laws

October 2009

Introduction

The Healthy Christchurch submission has been adapted from the submission developed by the Canterbury District Health Board.

We welcome the opportunity to provide our views on the Law Commission's Issues Paper on the Reform of New Zealand's Liquor Laws

Healthy Christchurch, modeled on a World Health Organisation initiative called Healthy Cities[1], was developed as a mechanism for organisations who become signatories to the Healthy Christchurch Charter to work together to promote, protect and improve the health and well-being of the people of Christchurch. Healthy Christchurch was launched in February 2002 after extensive consultation; many significant projects have been carried out since then.

Currently nearly 200 organisations have signed the Healthy Christchurch Charter and agreed to work together to promote, protect and improve the health and wellbeing of the people of Christchurch.

Alcohol has become a major threat to health in New Zealand, as in many Western countries. The Alcohol Use in New Zealand Survey show that 81.2% of New Zealanders aged 12-65 had consumed alcohol in the last 12 months and that of these 2 in 5 drinkers reported that they felt the effects of alcohol after drinking the night before. Rates are higher for males than females and for Maori than non-Maori (New Zealand Ministry of Health, 2007).

Evidence

Alcohol-related harm includes the immediate effects of intoxication such as increased risks of injury, violence, and death, and the long-term effects of alcohol on health (including increased risks of some cancers, liver disease and its impact on mental health). People who misuse alcohol also place the health of others at risk, through impaired judgement which can lead to dangerous driving and violence. Because of this, minimising the harm caused by alcohol and illicit and other drug use to individuals and the community is one of the objectives of the New Zealand Health Strategy (New Zealand Ministry of Health, 2000).

The World Health Organisation's International Agency for Research on Cancer recently classified alcoholic beverages as "carcinogenic to humans." They have determined that alcohol directly contributes to over 60 different disorders and a range of injuries. This places alcohol in the same hazard category as tobacco, asbestos and formaldehyde (International Agency for Research on Cancer, 2007).

Experts have suggested that if alcohol were to be categorised on the same risk basis as illicit drugs it would receive a Class B classification. This places it in the same category as opium and ecstasy, and higher than cannabis (Nutt, 2007; Sellman, 2009).

Further to this about 1000 New Zealanders die from alcohol related causes every year with approximately half the deaths due to accidents and about quarter due to alcohol related cancers. Many hundreds of New Zealanders will be hospitalised through alcohol related road

[1] A "Healthy City" is defined by the World Health Organisation as one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

accidents and conditions including alcohol disorders, gross intoxication, alcohol poisoning and cuts and fractures. Many will be either the perpetrators or victims of violent and drunken behaviour (Connor, 2005).

It has been shown that increases in the density of alcohol outlets and bars are related to increased violence in cities (Gruenewald, 2006; Livingstone, 2008) with every six outlets being associated with an increase in assaults resulting in at least one extra overnight stay in hospital (Gruenewald, 2006). In New Zealand, the density of alcohol outlets is strongly related to teenage drinking (Huckle, 2008) and university student drinking (Kypri, 2008). Outlet density is also associated with drinking levels and with alcohol-related harm. These associations for university student drinking remain after controlling for demographic variables and pre-university drinking patterns, and are therefore unlikely to be due to self-selection (Kypri, 2008).

Of patients attending the Auckland emergency department for the treatment of injuries, 35% reported having consumed alcohol prior to injury. Of those whose injuries were the result of violence, 82% reported that "in their opinion" the other person was intoxicated, and 78% reported that they themselves had been drinking (Humprey, 2003). Following the lowering of the minimum legal drinking age in 1999, a retrospective observational study of presentations to the Auckland Hospital emergency department found that the number of intoxicated 18 and 19 year olds presenting to the emergency department increased in the year after the law change (Everitt, 2002). This was a statistically significant increase in the proportion of presentations in this age-group (RR 1.51, 95% CI 1.11 – 2.03); whereas there was no evidence of an increase in the proportion of presentations for those aged over 19 years (RR 0.97, 95% CI 0.89 – 1.06).

In Christchurch, alcohol was involved in 14% of all motor vehicle crashes in urban areas and 20% of all motor vehicle crashes in rural areas in 2002 (Christchurch City Council, 2004). Of frequent attendees at Christchurch Hospital emergency department, 26% had a diagnosis of alcohol or substance abuse (Kennedy, 2004).

An editorial by two leading New Zealand injury prevention researchers entitled "Politics can be deadly" presents a strong argument that the combination of New Zealand's low driver licensing age and low alcohol purchase age is a lethal combination. New Zealand's motor vehicle crash death rate for 15-24 year olds was 22.4 per 100,000 in 2003; the third highest rate of the 30 countries contributing to the Road Traffic and Accident Database (Langley, 2006).

A review of the global economic burden of alcohol found that alcohol contributes to between 1.3% and 3.3% of total health costs, 6.4% to 14.4% of total public order and safety costs, 0.3% to 1.4% of GDP for criminal damage costs, 1.0% to 1.7% of GDP for drink-driving costs, and 2.7% to 10.9% of GDP for workplace costs; these costs were in the range of $210 to $665 billion in 2002 (Baumberg, 2006). Interventions such as roadside breath testing, advertising bans, reduced hours of sale at retail outlets, and brief physician advice for hazardous drinkers have favourable cost-effectiveness ratios (Chisholm, 2004; Mundt, 2006).

Alcohol causes considerable harm to society. Some of this harm results in costs to the health sector, but much of the harm results in costs to other sectors including businesses and local government (Slack, 2009)
More research is needed around the impacts of alcohol on the community and the effect of alcohol misuse on people other than the drinker. Alcohol related harm affecting those other

than the users includes high levels of domestic violence leading to the violent deaths of children and partners and the resulting social impact on communities and interference with quality of life due to noise, wilful damage and anti social behaviour on the streets. As a consequence of this lack of research we may fail to account for the alcohol related harm to others created by episodic drinking of alcohol in homes and neighbourhoods.

Key approaches to address alcohol that have been found effective include: (Alcohol Advisory Council of New Zealand, 2004)

- denormalizing alcohol use by changing the "drinking culture",
- de-emphasizing alcohol's role in social events, and,
- harm reduction activities such as reducing outlet density have been found to be effective in young populations.

These approaches include intersectoral planning and urban design to address such issues as legislation and regulation, density of alcohol outlets and bars, alcohol bans, monitoring and enforcement, labelling, and workplace policies (Ministry of Health 2008).

There has been a significant emphasis on education as a way to change behaviour. The World Health Organization (WHO) has stated that while information and education programmes have a role in providing information, reframing alcohol-related problems and increasing attention to alcohol on the political and public agendas, they do not reduce alcohol-related harm (World Health Organization, 2009).

Treatment options are an important part of a comprehensive approach to addressing alcohol. There is significant evidence to support treatment's contribution to harm reduction and its cost effectiveness. For every dollar spent on treatment there is a $4 to $7 reduction in costs associated with alcohol related crime. Addiction treatment outcomes include positive effects on measures including health status, criminal behaviour, family functioning, mental health and employment (National Committee for Addiction Treatment, 2008).

In conclusion, population based approaches such as increasing the price of alcohol, reducing accessibility and enforcing licensing laws reduce hazardous drinking. They have their most marked effect on young people and heavy drinkers. These measures have little impact on the moderate drinker, except to reduce their risk of harm from the drinking of others.

Processes

The Commission is to be commended for the comprehensiveness of the report and for the excellent analysis of the issues.

The Champions of Healthy Christchurch have agreed to add their collective voice to the many concerns being raised about the issue of alcohol misuse in our city and related harm, and more importantly, to the solutions. Healthy Christchurch is a network of nearly 200 organisations who undertake to work together to promote, protect and improve the health and wellbeing of the people of Christchurch.

Thank you for the opportunity to contribute to this consultation.

Recommendations & Preferred Options

1.0 Object of the Act (section 4)

Healthy Christchurch endorses the Law Commissions view that the Object of a Sale of Liquor Act needs to be more precise.

Rather than the statement "the reduction of liquor abuse", the objects should include:

- Minimise crime and disorder
- Promote public safety
- Protect families and children from harm
- Encourage a responsible attitude to alcohol
- Ensure the liquor industry operates responsibly

In addition, a statement to the effect that "alcohol is not an ordinary commodity, but rather a mind altering drug" should be included in the wording of the object of the Act.

Range of Options

2.0 Purchase/Drinking Age Options

Preference:

(b) Restore the minimum purchase age to at least 20 years OR if this is not possible:

(c) Create a split purchase age – that is leave the minimum purchase age at on-licences at 18 and increase the minimum purchase age at off-licences to 20 years.

Comment:
A higher legislated age to access alcohol is the most responsible option. This option better accounts for potential harm to young drinkers in the context of risks associated with their physiological (particularly relating to brain development), cognitive, and social maturity and is supported by international evidence, providing that the minimum age is enforced (World Health Organization, 2009). This will support a change in the drinking culture, and a purchase age of (at least) 20 years would also potentially impact New Zealanders' perception of what is an appropriate age to initiate or introduce young people to alcohol in private settings.

However, if this is not feasible then at a minimum, option (c), should be considered as it represents a practical interim solution. Imposing a purchase age of 20 in on-licenses risks displacing 18 and 19 year olds from controlled to uncontrolled drinking environments. A strategic approach is required that aims to curb or reduce the supply by others to people under 18 who are largely compelled to congregate in uncontrolled settings when they drink alcohol.

Many 18 year old purchasers of alcohol from off-licenses do supply to their under 18 'network'. Many of these 18 year olds are still at school. Secondary schools are the natural 'hub' for secondary student networks that extend across and down through the school population (13 -19 years).

Conversely, the social networks of most 20 year olds do not usually extend through secondary school populations, rather through workplaces, tertiary settings, and friends no longer at school, and often extend upward to people in their early 20s.

Increasing off-licensed supply to those 20 and over is sensible and workable and is likely to have a direct and immediate impact on the access to alcohol by those under the age of 18 and still at school.

Maintaining the purchase age at 18 in on-licensed settings
In a well controlled on-licensed environment, where licensees, and their staff comply with the Sale of Liquor Act, 18 and 19-year-old patrons (and others) are less likely to suffer or generate harm than in uncontrolled or unsupervised settings. However, the effectiveness of the present "Reasonable system of control…" in on-licensed settings depends on the commitment of the licensees to ensure compliance with the Act.

3.0 Individual and Parental Responsibility for Young People's Drinking Options

Preference:

Combine (b) & (d) with variation

Make it an offence for an adult to supply liquor to a young person other than the adult's child or ward.

Make it a legal requirement for parents or legal guardians supplying liquor to their child or ward to supervise the consumption of that liquor.

Note: should the split age option be selected, the definition of "young person" will need to coincide with these options

Comment:
ALAC Youth Drinking Surveys indicate that the majority of minors access alcohol through social sources, either their parents or friends. This proposed change would clearly place the onus of supervision and responsibility on parents who supply their minor children.

4.0 Licence Options

Preference:

(b), (c) with variation & (d) with variation, (e) & (f)

(c) allow the issuing authority to set whatever conditions it sees fit to reflect the nature of the business, its locality and environment.

(d) review the licence fees to better reflect the costs that processing and monitoring of any particular licence, is likely to generate

In respect of (f) - allow for the conditions of a licence to require more than one holder of a General Manager's Certificate but retaining only one "Duty Manager" per licence. This will ensure that in the event of any breach of condition of legislation, the Duty Manager is responsible.

Comment:
The ability for the issuing authority to impose whatever conditions it sees fit, focussed on reducing the likelihood of alcohol related harm associated with any particular premise is key. The ability to assign a particular point on a graduated fee scale to a premise based on a risk

matrix would ensure that premises carry their appropriate burden towards the costs of the licensing system and towards the social costs of alcohol related harm.

5.0 Liquor Licensing Authority Options

Preference:

(d) Licensing Inspectors should either be employed by the Liquor Licensing Authority or by a national body independent of TLA's e.g.: Gambling Inspectors employed by Internal Affairs.

Comment:
Currently, especially in the smaller District Council areas, Licensing Inspectors are often part-time or contract workers whose sole focus is not liquor licensing and who have limited knowledge and expertise. Additionally, many inspectors complain of the challenge to their independence at both a political and bureaucratic level. Licensing Inspectors employed at a national or regional level similar to Gambling Inspectors provide independence and consolidate the necessary expertise.

6.0 District Licensing Agency Options

Preference:

(b) Abolish DLAs and incorporate their functions and powers in a central body.

Comment:
The large number of DLAs and their differing approaches mean that achieving consistency in the implementation of the Act is hugely challenging. TLAs should be compelled to have a properly consulted Liquor Policy for their areas and given the automatic status of "a person with more interest than the public generally" when it comes to licence matters within their boundaries. TLAs should initially consider the social impact of licences within their boundaries and submit this assessment to the licence issuing authority (presumably the LLA).

As discussed under LLA Options, this would be supported by having Licensing Inspectors independent of TLAs.

7.0 Licence Criteria and Objections Options

Preference:

(b) Change the law to allow the licensing decision-maker to refuse licences on wider grounds than at present, for example, on grounds that:

- 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 matters such as the site of the proposed premises, the density and type of other premises in the area, and the health and social characteristics of the local population;
- granting the licence would be inconsistent with the object of the Act;
- the amenity, quiet or good order of the locality would be lessened by the granting of the licence.
- the licence would be inconsistent with the relevant local alcohol policy.

(c) Allow the licensing decision-maker to impose any licence condition it considers appropriate for the purpose of reducing alcohol-related harm.

(d) Widen the category of persons who can object to a licence application.
(e) Specifically authorise medical officers of health to report on all types of licences and licence renewals.
(f) Better define and strengthen the criteria for suitability of licence applicants.
(g) Improve the effectiveness and efficiency of the process for notifying the public of licence applications.

Comment:
The role of the Medical Officer of Health, (as with District Licensing Agencies) is inconsistent throughout New Zealand. Different District Health Boards/Public Health Units apply differing levels of resourcing and methods in supporting Medical Officers of Health in this process.

Locally, Canterbury DHB licensing officers work in collaboration with partners to assess all license applications. Having the Medical Officer of Health's representatives involved has provided an opportunity to consider potentially harmful situations and plan to mitigate these.

8.0 Hours Options

i) Off-licence hours

Preference:

(b) Restrict the opening hours of all off-licences, for example from 8 am to 10 pm, on a nationwide basis.

Comment:
The interplay between alcohol availability, access, price and problems extends to hours of availability of alcohol from off-licenses. Twenty-four hour alcohol availability from supermarkets and convenience stores facilitates 'spontaneous' pre-loading by drinkers. For example, the following is a typical scenario in Canterbury:

At midnight a group of male students intending to visit the city's bars chooses to first get two hour's worth of cheaper pre-loading in at a private, uncontrolled setting. They drive to a nearby supermarket and buy a 6 pack of beer each for $10. By consuming 6 beers each over two hours at home they've each saved around $30 (compared to on-licensed prices). At 2am they set off for the city. Each person has consumed in excess of 6 units of alcohol in that one occasion which constitutes harmful or binge drinking. When they arrive in town, they'll drink more if admitted to a bar. Failing that, there are several 24 hour licensed convenience stores in the city – a convenient contingency to ensure unfettered alcohol supply.

A mixture of low alcohol prices and long hours of availability conspires to create an incentive for increased consumption generally, while reducing the proportion of alcohol consumed under appropriate licensed supervision.

We strongly support the report's suggested option to restrict off licence hours unilaterally to ensure no access between 10 pm and 8 am. This coupled with a mechanism to increase price, targets environmental determinants of drinker behaviour.

ii) On-licence hours

Preference:

(c) Restrict on-licence premises from selling alcohol after a specified time, for example 2 am, on a nationwide basis.
And:
(d) The same as (c), but provide for a standing extension to serve alcohol until 4 am if the premises operates a one-way door policy whereby patrons can remain on the premises, but patrons cannot enter the premises after a specified time, for example from 1 am, as a condition of its licence. (WHO – limiting open hours reduces harm)

9.0 Prohibited Days Options

Preference:
(b) Maintain the status quo, but specify the hour at which the prohibition begins, for example, 2 am.

Comment:
Prohibited days appear to have minimal effect on public health although there is some evidence of a reduction in the early morning alcohol related Emergency department peak on the day following a prohibited day. Currently some DLAs allow trading by way of Special Licence into the early hours at the start of a prohibited day. There is a need to create nationwide consistency and to include "entertainment style" licences which in many cases trade little differently to many tavern style premises.

10.0 Types of Off-Licence Premises Options

Preference:
(c) Specify and further restrict the type of premises in respect of which off-licences may be granted (for example, restrict supermarket sales; better define what constitutes a grocery store).

Comment:
We could not support any further liberalisation of the current off licence provisions. It is clear that the 1989 Act allowing supermarkets to sell wine and the subsequent amendments ten years later allowing the sale of beer have forever changed the face of the alcohol retail trade. With alcohol sales in supermarkets now estimated to have topped $1 billion a year the general acceptance by the consumer of the availability of alcohol through supermarkets appears too entrenched to contemplate the restriction back to dedicated liquor stores. There has been a shift from consumption that was demand driven and constrained by regulation, to a saturated market where consumption is being increased by supplier initiatives.

What must be addressed is the further liberalisation that has allowed the proliferation of 'convenience stores' selling alcohol. By representing themselves as a scaled down version of a supermarket these stores presently avail themselves of the extended trading hours (up to 24 hours) granted to "grocery" style off licence premise. Clarification is required as to how to verify what constitutes a bona fide small grocery store as opposed to an ambitious dairy.

Research has shown that 'pre loading' or 'front loading' has become accepted practice by younger drinkers due to the discrepancy between off licence and on licence pricing of alcohol. What is also apparent is due to the availability of alcohol through the 24 hour convenience stores the practice of 'post loading' is also prevalent. Drinkers that have already consumed a considerable amount of alcohol and would usually be headed home have access to a convenient supply allowing for further spontaneous drinking.

This 24 hour drinking regime is allowing for a further increase in the likelihood of alcohol related harm to the population that we serve.

11.0 Off-Licence Product Options

Preference:

(d) Provide a regulatory power to prohibit the sale of undesirable liquor products based on expert recommendations to the Minister.
(e) Allow the licensing decision-maker to restrict the type of alcohol products able to be sold as a condition of the licence.

Comment:
We do not support any move to allow for all off licence premises to sell all alcohol products. As stated in the Law Commission Report, the sales of beer and wine through supermarkets is already more that $1 billion a year. A large proportion of alcohol is sold by just half a dozen major retailers dominated by the two main supermarket chains.

The purchasing power of the supermarket chains is a key factor in the development of a highly competitive liquor retail market. Supermarkets have discounted wine and beer to a greater degree than traditional bottle stores and use loss leading on alcohol in a bid to increase market share. The Law Commission's paper states the impact of deregulation is that, taken overall, alcohol has become more affordable since 1989.

The concern is that with greater buying power, there is the opportunity for increased competition in the RTD, spirit or 'alco-pop' market to lead to heavily discounted spirit based drinks. Spirits have always carried a higher concern as to the level of alcohol related harm due to the higher alcohol content.

It is clear that this commercial initiative will not contribute to any reduction of liquor abuse and in all likelihood is liable to markedly increase the levels of harm to younger drinkers.

The practice of supermarkets treating alcohol as just another commodity to sell must be addressed.

We support providing a regulatory power to prohibit the sale of undesirable products. Given the constantly changing retail market with new products being developed and introduced, the law must remain flexible enough to deal with any products that provide serious health concerns.

There is also merit in allowing the licensing bodies to be able to restrict the type of alcohol products available through licence conditions. This would allow more flexibility to deal with individual licensees based on the type of premise, matters of compliance and the customer base that they serve.

12.0 Options on Product Labelling and Serving Sizes

Preference:

(b) Provide a regulatory power to restrict the alcohol content and size of packaged alcoholic beverages.

Comment:
These limitations are useful tools to both reduce harm and to provide clear messages.

13.0 Licence Renewal Options

Preference:

(c) Create a "permanent" licence for licensees who have shown there are no issues with their performance in adhering to the regulatory regime, and where no change in licence conditions is sought. The licence would be reviewed if there was a complaint from the public or at the instigation of the police, a licensing inspector or a medical officer of health.

Comment:
Currently, the requirement to "enquire into and report" on all premises at least every 3 years often diverts limited resources from concentrating on premises of real risk. This needs to be combined with licence fees based on risk. Creating a fee structure based on alcohol units sold does not place those selling low volumes at a disadvantage. With GST, this regime should be far more rigorous than the pre 1989 system.

14.0 Excise Tax Options

Preference:

(b) Increase the current levels of excise tax on alcohol
(c) Reduce tax on low-alcohol products; and
(d) Pledge some or all of the excise tax collected from alcohol for expenses and costs associated with alcohol related harm, for example, treatment.

Comment:
It is not clear that adjusting alcohol excise tax alone will significantly influence retail prices of 'draw-card' items such as cheap packaged beer. There are now many anecdotes in NZ referring to the pressure applied to manufactures by major alcohol retailers to 'absorb' the effect of excise increases in order to preserve attractive retail price points and margins, particularly in packaged beer product.

Wielding 'buying power' is intrinsic to major retail and grocery, as is their practice of competing aggressively for foot traffic using heavily reduced popular consumer products. This is to be expected given major retailers' commercial imperative. The issue for the legislators is who, if not business, will clarify the distinction between ordinary commodities and alcohol? Who will moderate between acceptable retail practices, and retail practices that promote social mischief?

Setting (and periodically reviewing) a minimum unit retail price for alcohol is a more effective measure to reduce demand.

15.0 Pricing Options

Preference:

(b) Regulate the pricing of alcohol by introducing a minimum price per unit of alcohol.

Comment:
Alcohol in Our Lives reflects the Law Commission's sound grasp of the complex interplay between alcohol availability, access, price and problems.

Limiting price (as one prominent variable of availability) will offer immediate relief from some associated problems.

Imposing a minimum unit price could help reduce both cumulative harm linked to regular and prolonged 'lifetime' alcohol consumption, as well as the more immediate harms caused by excessive per-occasion alcohol consumption, particularly in uncontrolled drinking settings.

Minimum unit pricing and levels of consumption
Price effects consumption. Discretionary income is limited for most drinkers, particularly the high (alcohol harm) risk demographic from eighteen to late twenties. With respect to alcohol purchasing decisions, many in this age segment seek out cheap alcohol in order to make their limited dollars go further. For an individual drinker, a strategically set minimum retail price for alcohol (by unit) would limit the total units of alcohol available to be consumed based on the relationship between limited price and limited spend. For example:

> "Dillon is 21 and allocates $40 of his income each week to spend on beer from an off-licence. He's not brand driven. He can usually find a dozen packs of 330 ml for around $10, or the equivalent in another size. The avalanche of junk mail aids in his quest.
>
> For his $40, Dillon regularly buys 48x330 ml of beer. Because he can't afford any more, this is his limit until next payday. The beer is 4% alc/vol meaning that Dillon will consume approx 52 units of alcohol that week (330 ml @4% = 1.1 units).
>
> One day the price goes up. Dillon is unaware that a minimum retail unit price is imposed on all alcohol (calculated at $1.20 per unit of pure alcohol). No matter where he looks he can't buy beer for under $15.85 per dozen (other than light beer).
>
> Still limited to his $40 weekly spend, Dillon goes ahead and purchases 30x330ml (4% alc/vol), which is now the most beer he can buy for $40. This week he consumes 33 units of alcohol instead of his usual 52 units, but, he does not drink as many on each occasion, thus stretching them over the week.
>
> Dillon continues to search for cheap beer. He's considered switching to RTDs, but it seems they've also gone up in price. He's noticed a few new beer products on the market that are under $12 per dozen, but they're all around 3.5%. He will think about this.
>
> In this scenario, everyone wins - Dillon's long-term health outlook improves, the retailer's margin increases, and GST revenues are potentially enhanced."

Minimum unit price and pre-loading
By introducing minimum unit pricing at a retail level, the widening price differential (per unit of alcohol) between on-licenses and off-licences could be reduced. Any intervention that reduces the incentive for drinkers to pre-load at home or other private settings before embarking for late-night licensed venues is worthwhile.

A disproportionately wide price differential has been created by the availability of very cheap alcohol from off-licenses. There is now a strong financial (and emerging social) incentive for drinkers to pre-load before 'going out' to bars. Liberal access to very cheap liquor from off-licenses, particularly from supermarkets, creates a disincentive to drink in controlled on-licensed settings, and has changed the way bar patrons plan their evening.

Drinkers still seek the entertainment and social experience offered by city bars. The costs associated with providing these venues and entertainment is significant and determines a necessary price differential between off and on prices.

This widening price gap created by very cheap alcohol from off-licenses contributes significantly to increased public disorder and offending. Christchurch's bar and door staff presently encounter waves of patrons arriving late(r) at night. Often, these patrons are too well primed (pre-loaded) to be comfortably or legally admitted to any controlled licensed environment. In many cases the responsible intervention by staff results in conflict and disorder, with no goods or services exchanged.

Pre-loading causes drinkers heading to city bars to arrive much later at night than one might expect, and with higher levels of intoxication than typical patrons. This puts enormous pressure on bars and staff, stretches limited police resources, and tests city infrastructure.

16.0 Advertising Options

We support Alcohol Action New Zealand's submission to reduce marketing and advertising by:

- Providing regulatory power to require licensed premises to offer standard measures of wine beer and spirits
- Require health warning labels on alcohol products
- Introduce a "loi Evan" system of advertising restriction, that is no alcohol promotion is permitted on television, cinema, or through sponsorship of cultural or sporting events. Marketing of alcohol at youth is expressly prohibited. The limited advertising that is permitted in print media, on billboards, and on radio broadcasts must be limited to messages that provide information directly related to the product rather than selling values.

17.0 Enforcement and Penalties Options

<u>Preference:</u>

(b) Increase the penalties for breach of licence conditions, including making it easier for a licensee to lose a licence.

(c) Provide the police with the power to close a bar immediately to prevent further breaches of the Act or for serious public safety concerns based on behaviour in the licensed premises or in the immediate vicinity.

(d) Provide the police and licensing inspectors with the ability to request an urgent hearing with the Licensing Authority if there are serious concerns or repeated breaches of the Act to expedite the Licensing Authority's consideration of the matter.

(e) Provide for infringement notices to be issued for any technical or minor breach of the Act or a licence condition.

(f) Provide a legal definition of intoxication for the purposes of enforcement in any new legislation.

(g) Provide medical officers of health with the same powers of entry as licensing inspectors.
(h) Remove the requirement for licensing inspectors to identify themselves when entering licensed premises.
(i) Provide a statutory process for the development and recognition of alcohol accords for the purpose of minimising alcohol-related harm, and exclude these accords from the provisions of the Commerce Act 1986.
(j) Make it an infringement offence to present fake evidence of age documents to a licensee.
(k) Empower licensees to confiscate fake evidence of age documents, including driver licences, and hand these in to the Police.

NOTE – Re (f) – the current case law definition is set and workable

Comment:
There is a clear need for Police and Licensing Inspectors to be given powers to detail with wide ranging issues in licensed premises.

Breaches of Licence conditions should be subject to infringement notices issued by both Police and Inspectors. Police also require the ability to demand immediate closure until offences are remedied, e.g., the lack of a Duty Manager and unauthorised sales. These powers should be in addition to the current powers of closure relating to disorder.

The Liquor Licensing Authority (LLA) needs to be better resourced to allow for urgent hearings of enforcement applications in respect to serious concerns or repeated breaches of the Act or licence conditions.

There is not a need for a legal definition of "intoxication"; rather, case law and proof requirements of the LLA will best meet the objectives of the Act. The same definition needs to be used in respect to the proposed "in a public place" offence rather than "drunk" in a public place – consistent messaging is important to avoid confusion in the community.
The current requirement for Licensing Inspectors to identify themselves on entering premises removes the ability for Inspectors to observe the operation of premises in a "natural state", to test food availability and other compliance matters. There should be a requirement for Inspectors to carry appropriate identification.
If proposals regarding minimum unit pricing, hours of trade and advertising and promotional restrictions are enacted, then the need for alcohol accords will be, in the main, negated. If thee provisions are not enacted, it is imperative that the concept of alcohol accords, aimed at reducing alcohol related harm, be exempted from the conflicting with the provisions of the Commerce Act. Police, Licensing Inspectors and Medical Officers of Health and their representatives should be protected from Commerce Act provisions when proposing, discussing or supporting initiatives aimed at reducing alcohol related harm through hours of trade, pricing, advertising and promotion. Consideration of the removal of alcohol from the Commerce Act acknowledges that it is not an ordinary commodity.

18.0 Alcohol in Public Places Options

Preference:

(a) Continue the status quo, where liquor bans are dealt with by way of local authority bylaws.

(b) Provide the Police with a power to issue an infringement offence for breach of a liquor ban, with a reserve power of arrest for the purposes of safety of persons.
(d) Reintroduce the offence of being drunk in a public place.
(f) Provide a power for them police/Licensing Authority to ban specific persons from entering or remaining in an area or on specified premises with an area.
(g) Provide that where the Police have reasonable cause to suspect that a beverage contains alcohol, and have taken steps to ascertain that the beverage contains

Comment:
(d) Public Drunkenness
Licensed premises already operate under legal imperatives to prevent and exclude drunkenness on their premises. We strongly support the (re)introduction of making drunkenness in a public place an infringement offence for individuals. When applied by police (with discretion), this could act as a general public deterrent in the same manner as other infringement offenses such as speeding. It would also equip police with a facility to prevent more serious alcohol related (convictable) offending by drunken individuals.

Police could apply the same assessment procedure that has been formalised and matched to fit the present high standard required by the Liquor Licensing Authority to prove intoxication which, in its escalated form, is drunkenness.

NZ needs a strong cultural signal that being drunk, particularly in public, is not something to which lawmakers lend tacit support, or are prepared to overlook because it's considered 'normal'. Stigmatising drunkenness in public supports other proposed reforms aimed to reduce alcohol related harm stemming from licensed premises.

Potentially, the administration of this infringement system would provide an opportunity to capture data from 'repeat' offenders in order to identify and channel them into appropriate assessments or treatment services.

Liquor Bans –Liquor in Public Places
The current liquor ban situation allows local solutions for local issues as long as the agencies work together. Making it an offence to drink alcohol in a public place would impact approximately 80% of the community who do not cause issues by having small amounts of alcohol in public places e.g., at picnics, etc.

Making it an offence between certain hours e.g., 10 pm and 7 am may be more appropriate; however, this does not deal with all of the issues. As a result, each local authority must have the flexibility to address local situations, i.e. Sumner Liquor ban used to deal with disorderly youth groups congregating on the Esplanade on Sunday afternoons.

We therefore support the status quo but with the introduction of infringement notices for breaches and the evidential aspects provided by paragraph g).

19.0 Transport Options

Preference:

(c) Lower the blood alcohol limit from 80 milligrams of alcohol per 100 millilitres of blood to 50 milligrams of alcohol per 100 millilitres for those over 20 years, and lower the blood alcohol limit to zero for those under 20 years.
(d) Ban the possession of alcoholic beverages in an open container in a moving or stationary motor vehicle
(f) Introduce a legal blood alcohol limit for a person in charge of a pleasure craft, for example, a yacht.

Comment:
The proposal to change Transport Act will address the issue of alcohol use by those driving motorized vehicles.

20.0 Treatment Options

Preference:

(b) Provide centres for temporary supervision for individuals who are not charged with an offence but pose a significant concern to their own or others' safety or health.
(c) Require the need for alcohol and other drug assessment and treatment to be taken into account during sentencing in cases where alcohol and other drugs may have contributed to the offending.
(d) Develop the workforce to ensure assessment, referral and brief interventions can be delivered by appropriate professionals across sectors (for example, primary care, mental health, emergency departments, justice, corrections, education, Work and Income, ACC).
(e) Investigate the range of alcohol-specific treatment interventions provided, with a view to determining gap areas (for example, alcohol detoxification and nationally consistent drink driving group interventions) with the potential to increase funding via the alcohol levy managed through the Alcohol Advisory Council of New Zealand (ALAC).
(f) Fund primary care providers to deliver screening, brief interventions and referral to specialist treatment.
(g) Investigate the feasibility of using electronic screening and brief interventions in a range of settings.
(h) Monitor the prevalence of alcohol use disorders, and the delivery of screening, brief interventions, and referrals in primary care and emergency departments.

Comment:
Specialist Services
We support the Commission's call for increased funding of alcohol treatment services. CDHB Alcohol and Drug service in Canterbury operates a waiting list for initial assessments which aim to keep under two weeks but which is typically four weeks or more. While this waiting time might not seem long relative to some other areas of health care it is of critical importance in the area of addiction. It is a hallmark of addiction that people with alcohol dependence will often feel ambivalent about engaging in treatment, due to thinking variously that it is unnecessary, too hard, or too late to change. Longer waiting times led to greatly increased rates of non-attendance at assessment appointments and so opportunities to intervene are lost.

Once service users have been assessed they are provided with ongoing treatment (by CDHB) or referred on to other services. There is a shortage of programmes to refer service users to and as a consequence some treatment needs are not fully met.

In addition to providing assessment and treatment for Canterbury residents, the CDHB also provides a six-bed regional South Island withdrawal management and stabilisation unit - Kennedy. While there is high demand for this service there are insufficient places in treatment programmes to which potential service users are then able to go. Greater provision of residential and day programme services would thus increase demand for Kennedy beds.

Alcohol treatment does not require expensive equipment or materials. What is required is trained skilled staff working in well managed services. The addiction workforce has gone through a process of professionalization over the past ten to twenty years. The sector has well trained and committed staff but to adequately meet the treatment needs of New Zealand, more are required.

Early Intervention
Beside those suffering from moderate to severe alcohol dependence requiring treatment, we are aware that an even larger population of problem drinkers exist: those drinking at hazardous levels, experiencing alcohol-related problems and meeting criteria for mild alcohol dependence. Clearly there is the need for a wide range of health and social service providers to have the skills and the willingness to intervene when and where these problem drinkers present. Primary care in particular is an area with great potential for effective early interventions. The development of this area will require adequate resourcing.

This submission was endorsed by the following Healthy Christchurch Signatory organisations:
Environment Canterbury
Canterbury District Health Board
Pegasus Health
University of Otago, Christchurch
Partnership Health
Delta Community Support Trust
Knox Presbyterian Church
Association of Blind Citizens
START
Sustainable Otautahi Christchurch
Accident Compensation Commission
Sport Canterbury
Christchurch Resettlement Services
CPIT – Applied Sciences and Allied Health
Depression Support Network
CWEA Co-ordinator for the CWEA Executive
He Waka Tapu Limited
Bryndwr Churches Community Support Society
Jackie Fitzsimmons Consultancy

References

Alcohol Advisory Council of New Zealand. (2004). *Alcohol Use and Tertiary Students in Aotearoa – New Zealand*. Wellington: Alcohol Advisory Council of New Zealand.

Baumberg, B. (2006). The global economic burden of alcohol: a review. *Drug and Alcohol Review, 25*, 537-551.

Chisholm, D., Rehm, J., Van Ommeren, M., Monteiro, M.,. (2004). Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *Journal of Studies on Alcohol and Drugs, 65*, 782-793.

Christchurch City Council. (2004). *Christchurch Road Safety Strategy*. Retrieved. from http://www.ccc.govt.nz/Publications/RoadSafetyStrategy/RoadSafetyStrategy04Speed.pdf

Connor, J., Broad, J., Jackson, R.,. (2005). *The Burden of Death, Disease and Disability due to Alcohol in New Zealand.* Wellington: ALAC.

Everitt, R., Jones, P.,. (2002). Changing the minimum legal drinking age - its effect on a central city emergency department. *New Zealand Medical Journal, 115*, 9-10.

Gruenewald, P. J., Remer, L.,. (2006). Changes in outlet densities affect violence rates. *Alcoholism-Clinical and Experimental Research, 30*(7), 1184-1193.

Huckle, T., Huakau, J.,Sweetsur, P.,Huisman, O.,Cassell, S.,. (2008). Density of alcohol outlests and teenage drinking: living in an alcogenic environment is associated with higher consumption in a metropolitan setting. *Addictions, 103*, 1614-1621.

Humprey, G., Casswell, S.,Han, D.Y.,. (2003). Alcohol and injury among attendees at a New Zealand emergency department. *New Zealand Medical Journal, 116*(1168), 1-10.

International Agency for Research on Cancer. (2007). *Consumption of Alcoholic Beverages*.

Kennedy, D., Ardagh, D. (2004). Frequent attenders at Christchurch Hospital's emergency department: a 4-year study of attendance patterns. *New Zealand Medical Journal, 117*(1193), 1-8.

Kypri, K., Bell, L.M., Hay, G. Baxter, J.,. (2008). Alcohol outlet density and university student drinking: A national study. *Addictions, 103*(7), 1131-1138.

Langley, J., Kypri, K.,. (2006). Politics can be deadly. *Injury Prevention, 12*, 69-70.

Livingstone, M. (2008). A longitudinal analysis of alcohol outlet density and assault. *Alcoholism-Clinical and Experimental Research, 32*(6), 1074-1079.

Mundt, M. (2006). Analyzing the costs and benefits of brief intervention. *Alcohol Research and Health, 1*, 34-36.

National Committee for Addiction Treatment. (2008). *Investing in addiction treatment: A Resource for funders, planners, purchasers and policy makers*. Christchurch New Zealand.

New Zealand Ministry of Health. (2000). *The New Zealand Health Strategy*. Retrieved. from http://www.moh.govt.nz/moh.nsf/pagesmh/2285/$File/newzealandhealthstrategy.pdf.

New Zealand Ministry of Health. (2007). *Alcohol Use in New Zealand: Analysis of the 2004 New Zealand Health Behaviours Survey – Alcohol Use*. Wellington: Ministry of Health.

Nutt, D., King, L., Salisbury, W., Blakemore, C.,. (2007). Development of a National Scale to Assess the Harm of Drug of Potential Misuse. *Lancet, 369*, 1047-1053.

Sellman, J., Robinson, G., Beasley, R.,. (2009). Should Ethanol Be Scheduled as a Drug of High Risk to Public Health? *Journal of Pyschopharmacology, 23*, 94-100.

Slack, A., Nana, G. Webster, M., Stokes, F., Wu, J.,. (2009). *Costs of Harmful Alcohol and Other Drug Use*.

World Health Organization. (2009). *Evidence for the effectiveness and cost–effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: WHO Regional Office for Europe.