To Liquor Project Co-ordinator
Law Commission
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SUBMISSION TO THE LAW COMMISSION REVIEW AND

RESPONSE TO ISSUES PAPER - ALCOHOL IN OUR LIVES

OUR DETAILS

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PART ONE - INTRODUCTION

Alcohol Healthwatch is an independent charitable trust that works to reduce alcohol-related harm. We are contracted by the Ministry of Health to provide a range of services regionally and nationally, including provision of research-based information on policy and practice, as well as co-ordination and public health expertise for inter-agency and community groups who work on alcohol issues.

Alcohol Healthwatch is excited by the opportunity to reflect on the effectiveness of New Zealand's laws and policies on alcohol, and propose positive change to achieve sustained harm reduction.

This reflection draws on 20 years experience that has taken the form of:

a) Providing public health information and advice on policy, practice and planning to reduce alcohol-related harm at national and local levels

b) Co-ordinating community action, coalitions and networks on alcohol harm reduction

c) Raising awareness and building knowledge and skills on the issues and evidence-based interventions to reduce alcohol-related harm

d) Building a solid evidence and information base, and

e) Supporting research and evaluation

Alcohol Healthwatch commends the work of the Law Commission to-date in reviewing the role of alcohol in our society. The Commission's Issues Paper – *Alcohol in Our Lives* is comprehensive and easy to read. The Commission and its President Sir Geoffrey Palmer have made themselves accessible to the community and this has been greatly valued.

The Law Commission has done an excellent job of capturing the key aspects of alcohol-related harm according to the available evidence in its Issues Paper. Therefore we have tried not to repeat these in this submission, other than to affirm key points, rather we will emphasis alcohol's significance as a public health issue and add any other evidence where possible.

For any queries regarding this submission please don't hesitate to contact us and for further information visit our new website www.ahw.org.nz. This includes comprehensive briefing papers on key policy issues, fact sheets and other useful information.

We wish the Law Commission well in their final report to Parliament.

A) The Global response to alcohol-related harm

"*Prevention makes sense clinically, economically, and socially*"[i].

We note that New Zealand is not the only country endeavouring to address significant burden associated with alcohol use. Alcohol contributes to 4% of the Global Burden of Disease. However, in economically developed countries this burden grows to 18.5%. Hazardous alcohol use is estimated to cause 31.5% of all deaths in 15-29 year old men in the developed world[ii].

There is growing recognition worldwide that the alcohol-related harm burden is under-estimated, and yet alcohol is one of the most protected substances of abuse when it comes to pecuniary vested interests. This 'hands off' response, that largely leaves behavior change up to the consumer and the influence of this to vested interest groups, is insufficient and ineffective at reducing the global alcohol burden of disease. This is especially true of self-regulation and industry promoting education campaigns. *"Campaigns and health education messages funded by the alcohol industry seem to have a negative effect, serving to advance both the industry's sales and public relations interests[iii].*

It is up to Governments worldwide to step up to their responsibility to protect their people from the risks presented by this drug, this freely available but no ordinary commodity. The World Health Organisation is moving to strengthen its member states efforts to reduce the burden of alcohol-related harm with its development of a Global Alcohol Strategy. New Zealand as a member state has an obligation as a global citizen.

We see the Law Commission Review as an opportunity for New Zealand to reflect on the role alcohol plays in our lives and whether this is serving our best interests. It also calls on us as a nation to demonstrate leadership, as has occurred for other areas of health and social development. This is particularly relevant given our role and influence in the Pacific region.

In reflection, it is important to acknowledge the size and influence of the global liquor industry. In particular we must acknowledge the impact of their enormous aggressive marketing capacity and the pro-alcohol messages that are delivered with no genuine regard to the harm burden; the role of their so called "social aspect organizations" which serve to blur the boundaries of health promotion and independent research, and serve to foster their image as great benefactors; and the extraordinary influence they have on the uptake of effective harm-reduction policies and interventions.

As an example of this last point we quote from liquor industry giant Diageo's Corporate Citizenship Report 2005. *"In Australia, we worked with key government and industry stakeholders to prevent a potential tax increase on RTDs that would have impacted local production of Diageo brands, such as Bunderburg Rum."*

It is of utmost importance that we show the necessary courage and fortitude to rise above these influences as we look ahead with ambition to the future health and well-being of this nation.

B) New Zealand's alcohol history

Alcohol and its associated harm are notoriously dispersed throughout New Zealand's history. Unknown to pre-European Maori society, alcohol (waipiro) had a profoundly negative effect on Maori society as part of colonization.

In the early 19th Century New Zealand developed the dubious reputation as 'the hell hole of the Pacific' due to drunken lawlessness. Law and taxes were introduced to help tame this out of control frontier behavior. Attempts at civilising society through liquor prohibition in the early 20th century were less than ideal, as have been attempts to 'civilise' drinking through liberalisation of sale and supply in the later half of last century.

Some liken the drunkenness, violence, graffiti, broken glass, blood, urine and vomit seen in any downtown area on a Friday or Saturday night, as an indicator that present day New Zealand has regressed to the 19th Century 'hell hole'. While this may be somewhat overstating the situation, what cannot be ignored is that more than a Century and half later, it is children and adolescents and their future potential that are being harmed by the current environment and attitudes the most.

It is worthy to note from *"Alcohol in Our Lives"* that the 1945 Royal Commission identified very similar concerns to those expressed today, and that young, women and Māori were regarded as requiring special protection from the state. Yet have we offered this protection? NO we haven't. Not only have we failed to reduce harmful drinking already well established among men, we have facilitated young people, Māori and women to develop similar patterns of harmful drinking, and other groups such as Pacific populations to join the list of those who experience inequitable health outcomes from alcohol.

C) Alcohol in New Zealand today

Alcohol in Our Lives provides a comprehensive summary of alcohol in New Zealand today. It describes the size and scope of the industry, how we are drinking, the risks and benefits of alcohol consumption.

In the 21st Century neither extreme prohibition nor extreme liberalization are ideal. However, finding a workable and effective balance between is now necessary. We acknowledge that this is not an easy task, and the result will not likely meet the approval of all in our society.

Political and public support is needed to institute effective policy measures. Some politicians fear public or industry backlash, and are sensitive to rhetoric, such as nanny state, political correctness, anti-trade etc, which can lead to a lack of commitment to evidence-based measures and result in watered down regulation.

On the other hand as pointed out by the Deputy Regional Director of the World Health Organisation Regional Office for Europe Dr Nata Menabde, *"Fortunately, behaviour is an important determinant of attitudes and support*

for alcohol policies tends to increase after they are implemented and harmful alcohol consumption decreases."[iv]

Implementing evidence based changes to alcohol regulation to improve public health and safety outcomes, will require political fortitude. Our experience of the past two decades is that evidence is often demanded but rarely acted upon.

Harmful drinking and alcohol-related harm has become commonplace to the extent that society has adapted to accept this as inevitable and normal. Adaptation of young people has been so profound their drinking activities form part of their identity, and drunken behaviour part of the 'legend' and his and her-stories. However, we believe the Law Commission will hear that a large proportion of the general public of New Zealand have had enough, are expressing their concern, and are mobilising to demand legislative change to create safer, healthier communities.

The law as it relates to the sale and supply of liquor has been the primary mechanism through which a responsible framework is set in New Zealand. The last major review of alcohol-related laws resulted in the Sale of Liquor Act 1989. We believe there is overwhelming evidence to demonstrate that current legislative and policy controls on alcohol, as established by this Act, do not achieve their stated objectives and in many cases serve to facilitate harm.

Despite the object of this Act being to …*contribute to the reduction of liquor abuse…*, this law has facilitated the following changes directly linked with increasing harmful outcomes:

1. Proliferation of licensed premises (more than doubled)
2. Sales of beer, wine and mead through supermarket/grocery outlets
3. Greater competition leading to lower priced alcohol and heavy discounting
4. Longer opening hours and seven day trading
5. Lowered minimum purchase age
6. Local community input into licensing decisions disabled
7. High exposure to alcohol advertising by young people
8. An upward trend in per-capita consumption over the last decade.

The results of these changes support harmful drinking patterns across society. The outcomes of which are well captured in *Alcohol in Our Lives.* In economic terms these outcomes result in $5.3 billion dollars a year in health and social costs[v]. In human terms the cost is immeasurable. While about 1000 New Zealand lives are lost, many in their younger years, each of these lives represent a tragedy for the family/whanau and wider community and lost potential for society.

This burden is not shared evenly. Children, young people, Māori, Pacific Peoples are among those that experience a disproportionate burden of harm.

Alcohol in Our Lives provides ample evidence to demonstrate that harm to young people and how the liberalized alcohol environment has impact on their health and well-being. These include increased admissions to emergency departments, increased alcohol-related road crashes, early drinking and heavier drinking.

The Youth 2007 survey confirms that 61% of young people under 18 years are drinking, 34% are binge-drinking[vi]. Harm among young people has increased since the minimum purchase age was lowered from 20 years to 18 years in 1989. There is evidence of increase admissions to emergency departments, increase in alcohol-related crashes and increase in alcohol-related poisonings. In addition the age of onset of drinking has lowered.

Outlet density is linked with harmful drinking and outcomes for tertiary students[vii].

There has been a significant increase in the prevalence of drinking among Māori. There is now no significant difference in prevalence between Māori and non-Māori. The prevalence of heavier drinking per occasion is higher among Maori than non-Māori[viii].

We are also facing increasing consumption trends. Lack of controls on the types and strengths of beverages produced and marketed has resulted in consumption being largely driven up by a single beverage category that is spirit-based drinks, also referred to as ready-to-drinks (RTDs) or alcopops. These colourful sweet drinks are designed to mask the taste of alcohol and appeal to children and adolescents, in particular young women - a specific target of the alcohol producers. For example, Independent Distillers Australia (IDA) says it is targeting women drinkers with six new products, stating in the media, *"We studied the market and identified the areas where the female consumer of today has been forgotten. In response to what we learned, we will be leading the market by introducing Australia's first beer and cider tailored specifically for women as well as adding a more sophisticated twist to our Vodka ready-to-drink category."* [ix]

The recently released life expectancy tables (Statistics New Zealand 2008) show that while life expectancy for every other group improved, young women aged 15-19 years, with an increasing death rate, experience a lowered life expectancy. The primary cause of death of people in this age group being those closely associated with alcohol use that is accidents, violence and poisoning.

We assert that the law as it stands is acting counter to its object and resulting in increased harm rather than reduced harm.

PART TWO: SPECIFIC RESPONSES TO ISSUES PAPER – *Alcohol in Our Lives*

We support a significant proportion of the Commission's favoured options. However, there are some areas where we believe the Commission have fallen short in its assessment of the risks, and therefore the most effective options to address these.

What follows is Alcohol Healtwatch's response to the Law Commission's questions and range of options.

We have responded to questions 1 – 6 and then move to responding to the range of options to avoid duplication.

A: QUESTIONS 1-6

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

Yes.

The level of alcohol-related harm in New Zealand is unacceptable and warrants a new approach, one that offers greater protection and promotion of public health and community safety.

Children and young people are particularly vulnerable to the primary and secondary effects of alcohol-related harm and have a right to protection under the law.

We believe that the perspective of children has been largely overlooked in the assessment of harm and risks of alcohol consumption. This could be explained, but not justified by the poor collation of information in this regard. What is alcohol's role in child abuse, neglect and childhood injury? What influence does our promotion-filled, adult-focused liquor environment have on our children? How does our adult role modeling affect our children? What do walls and mountains of liquor displays in our supermarkets say to our children? What does alcohol consumption at children's birthday parties say to our children? Considering the answers to these questions might enable us to more readily accept laws that modifying the environment and our adult drinking behaviours to ensure the health and well-being of our children and future generations.

As well as children and young people, women, Māori, Pacific peoples, tertiary students and those experiencing higher levels of socio-economic deprivation all experience a disproportionate and preventable burden of harm, and also have the right to greater protection under the law.

New Zealand's approach to-date on alcohol policy has been piece meal and commercially driven rather than being aimed at achieving measurable reductions in alcohol-related harm.

Overall the result is an environment that promotes alcohol use and supports harmful patterns of drinking to be developed and sustained.

What is needed now is a principled and enabling approach to new legislation and public policy in relation to alcohol:

Enabling legislation and policy such as Smokefree Environments Act

- Enabling of effective controls on availability, access and supply, advertising, price, blood alcohol levels
- Enabling alignment with and consistency with our national and international obligations such as the Treaty of Waitangi, United Nations Convention on the Rights of the Child
- Enabling of communities to fully engage in alcohol and licensing decisions
- Enabling the application of prevention and protection principles.

Principals to guide legislative change

The harm from alcohol far outweighs any perceived benefit to society yet there are enormous inconsistencies in the way in which that harm is perceived and addressed. As pointed out by Professor Sellman from the Christchurch School of Medicine, during his speaking tour around New Zealand communities, if alcohol was a new drug on the market it would qualify as a dangerous 'Class B' substance, alongside the methamphetamine, 'P'.

Compared to alcohol, the response to 'P' has been high profile and swift. Yet as pointed out in a NZ Doctor article - Putting 'P in perspective[x] – less than 10 percent of 13 to 65 year olds have ever tried amphetamines and despite media report only a small minority of 'P' addicts become violent.

In contrast, the majority of police and court work is alcohol-related. Judges in the District Court report[xi] (Youth Court Newsletter, October 2009) that at least 80 percent of defendants coming before the criminal courts have alcohol or other drug (AOD) dependency or abuse issues connected with their offending with an estimated 80 percent of those cases the drug involved is alcohol.

Current National Drug Policy provides for a harm minimisation approach. This approach needs a stronger emphasis towards policy that prevents harm and protects the health and well-being of the population, especially those experiencing greater risk/disproportionate harm.

Reviewing our laws and developing our capacity and capability to reduce alcohol-related harm, both through legislative and other means, requires a principled approach. Alcohol Healthwatch fully endorses the following principles developed by the World Health Organisation (WHO), and included in the current *Working Document for Developing a Draft Global Strategy to Reduce Harmful Use of Alcohol*. As a WHO member state, it would be pertinent for New Zealand to develop it's response in line with the following...

WHO DRAFT GLOBAL ALCOHOL STRATEGY - GUIDING PRINCIPLES

The protection and preservation of the health of the population by preventing and reducing harmful use of alcohol are a public health priority. The following principles are proposed to underpin the development and implementation of policies at all levels to prevent and reduce harmful use of alcohol. The principles reflect the multifaceted determinants of alcohol-related harm and the complexity of implementing effective interventions.

(1) Public policies and interventions to prevent and reduce alcohol-related harm should be based on clear public health goals, and be formulated by public health entities.

(2) Policies and interventions should be based on the best available evidence, equitable, and supported by sustainable implementation mechanisms.

(3) A precautionary approach that gives priority to public health should be applied in the face of uncertainty or competing interests.

(4) Specific consideration should be given to populations at particular risk from harmful use of alcohol, including the effects of harmful drinking by others, in the development and implementation of policies to prevent and reduce harmful use of alcohol.

(5) Policies and interventions should be sensitive to different national, religious and cultural contexts, and to trends in prevalence and patterns of drinking.

(6) All involved parties have the responsibility to act in ways that do not undermine implemented public policies and interventions to prevent and reduce harmful use of alcohol.

(7) Children, young people and people who choose not to drink alcohol should be supported in their non-drinking behaviour and not experience pressure to drink alcohol.

(8) Effective prevention, treatment and care services should be available, accessible and affordable for those affected by harmful use of alcohol.

(9) Stigmatization of, and discrimination against, groups and individuals affected by harmful use of alcohol should be avoided and actively discouraged in order to improve help-seeking behaviour and the provision of needed services

We support the Law Commission's proposal for a new Act. We agree with the Commission's objectives for such an Act as they are given in the issue paper "Alcohol in Our Lives" that is *to establish a system for the sale, supply and consumption of liquor for the benefit of the community as a whole, and in*

particular to minimise crime and disorder, promote protect and improve public health etc.

However, the above object does not relate to the marketing of alcohol, nor does it contain any specific wording requiring the reduction of alcohol-related harm.

A new law must specify intent to reduce alcohol-related harm and control of exposure to alcohol marketing and promotion.

Alcohol-related harm is a complex problem that demands an integrated approach within a legal framework. We believe there would be benefit in bringing other alcohol-related legislation under such an Act or enabling the object of this new Act to take precedence over others.

We are aware that issues such as alcohol advertising, warning labels and blood alcohol concentration for driving sit outside of the current Sale of Liquor Act. We believe that if all alcohol legislation is together under one Act (or linked to this Act) it would ensure a common purpose is served.

Alcohol must be treated as a drug in law, and not as a food. The active ingredient in alcoholic beverages is a toxin to the body. It does not provide nutrients, and in fact can act to delete the body of essential nutrients. In addition many alcoholic beverages contain high levels of calories. Alcohol is considered teratogenic and carcinogenic. We and others on both sides of the Tasman, have been advocating for nearly two decades for alcohol to carry warning labels through the food standards regulations to no avail. Food regulations are simply inadequate to deal with a product that carries such high levels of inherent risk to health.

The current use of the conscience vote on alcohol matters in Parliament presents challenges for decision-making in line with the evidence base. We are aware of the first paper by the Law Commission from this review that covers this issue in detail.

It must be ensured that our laws and other public policies, work together to achieve common purpose for the greater public good.

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

Yes.

This is best summed up by a quote from the October 2009 edition of "Court in the Act" The newsletter of the Youth Court of New Zealand "…*The Youth Court deals with offenders aged 14-16 years. The very large number of those young people whose offending has alcohol consumption as an underlying cause reflects the now normalised behaviour of 'binge-drinking'.*

Young people in the Youth Court have little idea that their drinking is even problematic because their drinking is the same as all those around them. Serious dependency does not stand out in this crowd and often goes untreated until very well established…"

Early onset of drinking is a significant risk factor in determining the likelihood of drinking hazardously into adulthood.

3. Do you think the risks associated with heavy drinking are well known?

No.

If not, what more could be done to make people aware of them?

Knowledge about the wide range of risks of heavy drinking is variable. Heavy drinking and associated risks are often minimized as little more than the exuberant high jinks of youth or perceived to be - and promoted by the industry to be - limited to a 'small percentage of abusers' who can't control their behaviour.

The short-term risks associated with heavy drinking are self evident, and as such are relatively well known to both the heavy drinker and those affected by their drinking. Consequences such as injury, hangover, violence etc are easy to link with the drinking. However, what is deeply concerning is that these drinkers continue to drink in high-risk ways, thus over-riding their common sense and better judgement, and repeatedly putting themselves and others at risk.

The longer term risks associated with heavy drinking are less well known and understood.

It would seem that knowledge about the risks plays a smaller part in drinker's decision-making. Other factors such as the appeal and social aspects of drinking, social norms that tolerate binge-drinking, peer pressure, liberal trading hours, price and promotions, and the effect of intoxication are stronger influences.

In the case of young people knowledge and awareness must be considered in relation to brain development. Brain development is not complete until 20 years or older in most people, meaning important functions such as planning and reasoning are not fully developed. This not only makes the brain more sensitive to damage from alcohol and other drugs it also means that having information is unlikely to be enough to motivate moderation.

Some of our current policies give very mixed messages to drinkers and the general public, for example our current blood alcohol level for adult drivers (80mg/100mg) for driving allows for substantial amounts of alcohol to be consumed while remaining under the "legal" limit. A lower limit, with

rigorous enforcement and promotion of the limit would be more consistent with improving awareness of risks associated with alcohol.

If heavy drinkers are to be motivated to moderate their drinking they will need a supportive environment and encouragement to do so.

Introducing a comprehensive national programme of early and brief intervention would also help to address this. This programme must be integrated across sectors so that opportunities to pick up problem drinking earlier are available and taken. Once established such programmes will offer cost effectiveness through reducing the demand on health and social services over time. They will also enhance the quality of life and opportunities for the individuals who are supported to reduce their alcohol intake through these programmes.

Findings from New Zealand studies have shown that the use of electronic brief interventions in university campus settings have been shown to be effective at reducing hazardous drinking by students[xii] [xiii].

Also see comment regarding warning labels below. These will also be useful in communicating the short-term and acute harms as well as the cumulative life time harms.

4. Do you think the cumulative lifetime risks associated with drinking are well known?

No.

If not, what more could be done to make more people aware of them?

The longer term effects and risks of even moderate drinking, such as those associated with cancer, mental illness, heart disease are not well known. The risks associated with drinking during pregnancy are better known however, knowledge about the risks of even small amounts and risk throughout the pregnancy are less understood.

Results from the 2007/2008 New Zealand Alcohol and Drug Use Survey show that 28.7% of women who had been pregnant in the last three years had consumed alcohol while pregnant.
The survey also found that 68% of women who had been pregnant in the past three years had been advised not to drink alcohol when pregnant[xiv].

It is important that drinkers have access to accurate information about the product and the short and long-term risks associated with its use. We note that alcohol is currently not required to carry nutritional information or warnings.

The use of graphic warning labels on cigarette containers and point of sale are an integral part of strategic response to tobacco control and are shown to be effective in communicating information and motivating behavioural change such as quitting. They also reduce the appeal of the product.

In addition to providing the public with a clear indication that alcohol is 'no ordinary commodity' information conveyed via the product would help to facilitate discussion by healthcare professionals, families and communities.

Introducing a rotating set of bold and graphic warnings on alcohol containers, at point of sale and accompanying any permitted advertising would be a useful strategy to include in a comprehensive approach to reducing alcohol-related harm.

We are also very concerned about the inculcation of pro-drinking attitudes through the aggressive proliferation of liquor industry marketing. The evidence is now overwhelming that this increases the uptake of alcohol consumption by children and adolescents and encourages heavier drinking.

Aggressive and sophisticated marketing techniques ensure that alcohol advertising and promotion pervades every aspect of society. It festoons the backs of buses, bill-boards, beanies and jerseys provided to junior sports teams, surrounds the sports fields and events, its at the cinema, music and cultural events, a comes direct to via text messages, emails, social networking sites etc.

We can expect a "battle of the beers" in 2011 when the Heineken World Cup takes on the Steinlager All-Blacks.

According to a new meta-analysis of studies, The Science Group of the European Alcohol and Health Forum have concluded that, *"… alcohol marketing increases the likelihood that adolescents will start to use alcohol and to drink more if they are already using alcohol."*[xv]

We recommend the banning of alcohol advertising and sponsorship in all media and the promotion of liquor at point of sale. In particular we wish to see the end of "life style" advertising which portrays alcohol consumption in positive ways and makes it difficult to convey the risks associated with drinking.

Banning alcohol advertising will also support delaying the onset of drinking by young people which is linked with both short and long-term negative health and social outcomes.

5. Is the management of intoxicated people an acceptable use of a large part of the New Zealand Police resources?

No.

If not, what are the alternatives?

Alcohol-related harm consumes far too many resources of the Police and other emergency services. Alcohol is an avoidable aggravator of violent and sexual offending and injury.

There needs to be better compliance by licensed premises to the laws requiring them not to allow intoxicated patrons on to the premise, not to serve to intoxication and removing intoxicated patrons. The Hospitality industry is quick to apportion blame for public drunkenness to off-licence purchase and consumption, or 'pre-loading', prior to entry of on-licence premises. While there is no doubt this occurs and is an added problem, there is a legal requirement for a licensed premise to not serve liquor to an intoxicated person.

A recent Christchurch City Council survey revealed that patrons consume the equivalent of 10 beers or 1.3 bottles of wine before heading to the city on a Saturday night.

A survey conducted in Auckland in 2005 assessing the breath alcohol content of young drinkers leaving on-licensed premises found that nearly 75% of survey participants aged 18 or 19 years and 42% of 20-24 years old participants were over their respective legal limits for driving. Between 34-40% of participants were assessed as moderately intoxicated and 8% as extremely intoxicated. Almost half intended to go to another bar.

The question for the hospitality industry therefore, is why are they allowing intoxicated patrons into their clubs and bars in the first place?

Even though dealing with alcohol-related crime and disorder consumes far too much police time and resources, increased monitoring and enforcement resources are required to ensure compliance with the law. Stronger penalties should apply to these offences, and premises with two offences should lose their licence.

Any increased cost of monitoring should be met through the licensing fee system commensurate with a health impact and risk level assessment. A significant "late trading fee" could be introduced for any premises that are granted extended licensing hours.

International research gives clear guidance as to what are the most cost-effective strategies to address the levels of harm experienced. Addressing the underlying factors and risks of harmful drinking associated with the risk environment is the only sustainable way to reduce the burden on front line services. A prevention focus is required.

6. Is the balance in the current law between individual responsibility and providing an environment that is conducive to moderate drinking the correct one?

No.

If not, what changes could be made?

There are a number of imbalances at work in the current environment:

- Imbalance between the burden of harm attributable to alcohol and the legislative and other policy means used to address this
- Imbalance between the interests of public health and safety and commercial interests
- Imbalance between interventions that address the individual's drinking behaviours and those that address the environmental factors.

International evidence supports policies and interventions that target the whole population and address the environmental factors over those that attempt to change the behaviour of the individual drinker. Yet the response in New Zealand has largely been weighted towards the least effective options while freeing up the sale and supply environment.

Self-regulation is shown to be ineffective. Industry bodies promote the least effective policy options and have lobbied successfully to prevent the introduction of more effective approaches.

We question whether it is appropriate that a law is *conducive to moderate* drinking. There is no safe level for drinking for all people all of the time. All drinking carries with it a risk. We acknowledge that many people can and do enjoy alcohol at relatively low risk levels. However, the purpose of law must be to protect, and therefore the law must support those interests are best met by no exposure to alcohol, and those who choose not to drink. Here we highlight the rights and needs of the unborn children, children and young people, and those suffering from addiction or mental health disorders. We also highlight situations where no alcohol is the best option; such as the supervision of children, in the work place, driving a motor vehicle or operating other machinery, on or near water or other natural settings that present risks.

We note that serving sizes of alcohol have crept up over time. We believe that for many drinkers "a drink" is in fact 2-3 standard servings and that this shocks many when this is pointed out to them.

Modern science also puts forward significant challenges to the long held beliefs that alcohol offers health benefits such as protection against cardio-vascular disease. Despite the fact that alcohol use increases the risk of over 60 negative health consequences, these purported benefits feature in our policy documents and remain part of popular understandings.

It is no longer valid or acceptable to factor such benefits into law and policy making, nor is it acceptable to leave New Zealand drinkers uninformed about the risks they are taking by consuming alcohol.

A Whanau Ora assessment of new law and policy for its potential to promote and protect the health of Māori is needed.

Health and social objectives must take priority in alcohol legislation and commercial interests must be secondary.

PART TWO B: OPTIONS for CHANGE

SUPPLY CONTROL

Purchase/drinking age options

Alcohol Healthwatch supports:

- The reinstatement of the legal minimum purchase age to 20 years
- The requirement of mandatory age verification for the sale of alcohol

In the event that the purchase age remain at 18 years or the split age option is introduced the following options must apply

- Making it an offence for any/every person other than a legal parent or guardian who supplies liquor to a person under legal purchase age
- That there be a legal requirement for supervision of consumption of alcohol supplied to those under the legal purchase age by the parent/legal guardian.

Comment

We have discussed the option of a split purchase age – that is leaving the minimum purchase age at on-licences at 18 and increase the minimum purchase age at off-licences to 20 years. We are not aware of any evidence to support the effectiveness of this option. We understand that it may present a compromise to those opposed to returning the purchase age to 20 years in belief that this isn't feasible. However, we see this as a compromise of the health and well-being of our young, and as such unacceptable.

Licensed premise are linked with increased risk of violent offending such as assaults. The split age option could encourage greater patronage of licensed premises by those 18 and 19 years. Therefore there could be increased risk of alcohol-related violence in and around licensed premises. An investigation into the potential risks of the split age option must be undertaken if that is to be considered.

The early onset of drinking is a key risk factor in developing harmful drinking patterns, and evidence points to increased drinking by young people and a lower age of onset of drinking since the age was lowered.

We remain open minded about introducing a minimum drinking age in New Zealand. On one hand it could help to promote the message that drinking by young people is highly risky, and support those parents who are attempting to delay drinking by their children. On the other it could increase the tendency to blame the problem on young people and hold them accountable for problems created by the environment and adult role-modeling around them. If a minimum drinking age were to be introduced the main weight of the law should fall on the supplier. We don't need to criminalise more young

people, rather we need to build a supportive environment for them to develop and reach their potential.

To make a drinking age feasible and in fact to improve our drinking culture what is needed are viable alternatives to drinking. Creating and promoting social opportunities, especially for young people must be part of the mix. We see the role of health promotion and community action as being key to facilitating this.

We see the issue of gaining consent as problematic from an enforcement perspective. We believe that a law related to social supply should be clear and enforceable. The above options make it clear what is best for young people. They will also encourage parents to follow the best advice available, which is to delay the onset of drinking for as long as possible, and when supplying moderate that supply and supervise.

Licence options

Alcohol Healthwatch supports:

- Having two basic licences – **on** and **off** with conditions added to reflect the requirements of a Local Alcohol Plan and/or licencing agency criteria
- Removing existing exemptions
- Increasing and allowing for graduated licensing fees to reflect the risks associated with granting of a particular licence
- Clarifying the requirements of managers and temporary managers
- Requiring national standards for the education/training and increasing the age of managers and door staff.

Comment

We propose a two licence type option – that being on-licence and off-licence, with conditions added to reflect the nature of business and ensure that any risks of harm at mitigated as far as possible.

There are clear distinctions between these two types of licence premises enabling the Law to be simplified from the current four types, and allowing for a greater number of standard conditions to be applied. We believe this would encourage consistency across the country.

Liquor Licensing Authority (LLA) options

Alcohol Healthwatch supports:

Retaining the Licensing Authority but give it enhanced powers and functions such as ability to monitor and report on trends, award costs, impose fines,

quality control of DLA output and compliance as suggested by the Law Commission.

District Licensing Agency (DLA) options

Alcohol Healthwatch supports:

Enhancing the powers and functions of the District Licensing Authority such as; requiring higher levels of performance and reporting, ability for Local Authority to keep fines from any prosecutions, providing for mandatory training, setting of licensing fees to allow effective functioning of DLA, ensuring independence from local authority, specifying membership as suggested by the Law Commission.

Comment
Ensuring the independence of the DLA is essential. Decisions on liquor matters should be determined by law, and through robust social impacts assessments and local planning.

Training for DLAs will need to be delivered by recognised providers and to national standards.

When based in a new legal framework that better serves public good both the LLA and DLA will have great potential to reduce alcohol-related harm and support safer and healthier communities.

Licence criteria and objections options

AHW supports:
All of following options for change.

- Change the law to allow licensing decision-maker to refuse licences on wider grounds than at present, e.g. social impact, lessening of community amenity, quiet or good order

- Allow the licensing decision-maker to impose any condition it considers appropriate to reduce alcohol-related harm

- Widen the category of people who can object to a liquor licence application

- Authorise Medical Officers of Health to report on all types of licences and licence renewals

- Define and strengthen the criteria for suitability of licence applicants

- Improve the effectiveness and efficiency of the process for notifying the public of licence applications.

Comment
In "Alcohol in Our Lives" (pages 126 and 222) reference is made to the need for Local Alcohol Polices. However, the Commission does not make specific options for these.

In addition to the above we support having a requirement in law for all local authorities to develop and adopt a policy/plan on alcohol, including a policy on controlling the number, density and location of licensed premises, with involvement from the Medical Officer of Health and other relevant stakeholders. Such a local alcohol policy/plan would be developed in full consultation with community, and identify specific mechanisms for community engagement in the licensing process

A Social/Health Impact Assessment should be carried out by the local authority in partnership with Medical Officers of Health to inform this policy and to identify harm reduction performance measures of the plan.

Hours options

Alcohol Healthwatch supports:

- Nationwide standard trading hours
- Restrict the opening hours of all off-licences to 10am – 10pm
- Restrict on-licence premises from selling alcohol after a specified time e.g. 12midnight or 1am, allowing extended hours to 2 or 3am subject to the premise having a risk management plan in place (to satisfaction of Liquor Licensing Authority), and pays the costs associated with implementing this plan.

Comment
Trading hours are directly linked with harm outcomes - therefore the fewer the hours of trading the less harm.

We are also aware that as yet unpublished research from Manukau City that links higher density of outlets with longer trading hours.

National trading hours will be a useful measure to offer greater protection for communities who are being impacted on by other factors such as socio-economic deprivation.

Local Alcohol Plans may allow for further restrictions on trading hours, but it must be ensure that they are not able to extend trading hours beyond those provided for nationally.

Prohibited days options

Alcohol Healthwatch supports: No change –continued ban on trading on currently prohibited days.

Types of off-licence premises/options

Alcohol Healthwatch supports:

- Confine off-licence sales to dedicated liquor stores only
- If sales continue to be permitted in supermarkets and grocery outlets that these be confined to a dedicated area and checkouts.

Comment
Both larger retail outlets, such as Supermarkets and large chain stores, and smaller grocery stores present issues in relation to alcohol-related harm.

Supermarkets and large chain stores, due to their sheer volume of sales, aggressive pricing/discounting strategies and powerful marketing strategies play a dominant and influential role in the off-licence liquor retail environment.

Examples have been observed where supermarket chains have been actively attempting to circumvent the Sale of Liquor Act to include spirits and spirit-based drinks in their range of products. Discount retailer The Warehouse has also achieved a liquor license through the "store within a store" concept. (We note that they have since withdrawn from the liquor retail market). We believe these tactics demonstrate that industry interests pursue commercial gain above all else, and do not hold public health and well-being in high regard.

Supermarkets generally show better compliance with the Sale of Liquor Act in relation to sales to minors, most having more rigorous age verification polices and practices in place.

If Supermarkets continue to sell liquor we recommend that separate areas and checkouts are required. This would help to reduce exposure of alcohol promotion/marketing to young people and help to de-normalise drinking. Failing this, placing limits on the floor area, size and placement of displays within Supermarkets will be necessary.

Smaller grocery outlets on the other hand perform less well in relation to sales to minors in Control Purchase Operations and Pseudo-Patron surveys. They also contribute to the issue of outlet density.

We would prefer off-licence sales being confined to dedicated liquor stores only.

Off-licence product options

Alcohol Healthwatch supports:

- Prohibit the sale of all alcohol products currently able to be sold by supermarkets and grocery stores

- Provide a regulatory power to prohibit the sale of liquor products that have been linked to increased harm.

Comment
See above discussion regarding supermarkets and groceries.

Having a regulatory power, able to prohibit certain products is an important back stop to prevent and reduce harm. Ready-to-drinks for example are shown to be related to heavier drinking. They also commonly include additives such as caffeine and taurine. Our knowledge about the effects of such mixes are limited however, it is concerning that such additives can mask the effects of intoxication allowing on-going drinking when significant amounts have already been consumed.

If supermarkets and grocery stores retain the right to sell alcohol then it must be ensure that the current limits on products range i.e. beer, wine and mead must be maintained.

Product labeling and serving sizes

Alcohol Healthwatch supports:

- Require health warning labels on alcohol products
- Require nutritional information and ingredients to be listed on alcohol products
- Require health warnings on any permitted alcohol advertising/sponsorship.

Comment:
While evidence does not currently support the use of warning labels on alcohol we believe it is an unrealistic to demand that an information based measure change social behaviour. The purpose of information is to inform. The precursor to behaviour change is awareness.

Also, as pointed out in the World Health Organisation Regional Office for Europe paper (2009), *"Although warning labels have little impact on behavior, they are important in helping to establish a social understanding that alcohol is a special and hazardous commodity."*[xvi]

As previously discussed graphic warning labels have been a key tool in the international efforts to reduce the burden of tobacco.

Licence renewal options

Alcohol Healthwatch supports:

- Leaving the current licence renewal process as it is, i.e. one year licence then three-yearly renewals
- We also support enabling a review of licence following a complaint from the public or statutory body.

Licensing Trust options

Alcohol Healthwatch supports: No change.

Monopolies can be effective harm prevention tools, particularly if they have a specific objective to reduce harm. In a new legal framework Licensing Trusts could have enhanced potential to reduce harm.

DEMAND REDUCTION

Excise tax options

Alcohol Healthwatch supports:

- A significant overall tax increase be applied to help deter risky drinking and better reflect the cost to society of addressing alcohol-related harm

- A greater proportion of the revenue generated from alcohol excise taxation be allocated to a specified budget for evidence-based, co-ordinated harm prevention strategies, law enforcement, research and treatment

- The current alcohol excise system be changed to one based on the actual alcohol content in beverages (volumetric), to remove current anomalies and encourage production of lower priced beverages

- A regulatory power to impose specific taxes on products associated with increased levels of harm e.g. RTDs/Alcopops should other measures above not address this.

Comment

Alcohol Healthwatch commends the Law Commission for recognizing and responding to the excise tax as a means to reduce harm. Taxation is one of the most cost-effective tools we have to achieve alcohol-harm reduction and one that is not well utilised currently in New Zealand.

Increases in price are shown to effectively reduce drinking by the young, reduce the amount of alcohol consumed per occasion and stop or slow drinkers from progressing from moderate to heavy, heavy to heavier drinking. All alcohol-related harms can be reduced by utilizing pricing strategies. They also have no impact on non-drinkers and lower impact on the moderate drinker.

In introducing a volumetric system it must be ensured that any production cost benefits, such as those for spirits are managed to ensure that the retail price does reflect the alcohol volume.

Pricing options

Alcohol Healthwatch supports:

- Regulate the price by introducing a minimum price per unit of alcohol
- Prohibit giveaways and prizes of alcohol and promotions that create any incentive to buy/consume alcohol
- Require the Licensing Authority to take into account past retail practice in licensing decisions and require liquor licensees to supply data
- Prohibit advertisements containing the price of alcoholic beverages

Comment

According to models developed by the University of Sheffield, setting a minimum price per standard drink substantially reduces alcohol-related harm[xvii] . A minimum price of 90 cents would reduce drinking levels by approximately 7 percent significantly reducing hospital admissions, alcohol related crime and criminal damage. Drinkers affected the most by the price increases modeled are the chronic harmful drinkers, while hazardous drinkers are affected less, and moderate drinkers are hardly affected. This contradicts the view of the alcohol industry which maintains heavy drinkers do not respond to price increases. It also exposes their argument that it is unfair to "penalize" moderate drinkers. The study also models the impact of bans on discounting alcohol in packaged liquor (off- premises) venues such as bottle shops liquor barns, supermarkets. A ban on discounts would reduce overall alcohol consumption by 3% with reductions in crime (especially among young people) and improvements in health conditions. A combination of the discount with a minimum price would increase the gains.

Advertising options

Alcohol Healthwatch supports:

- Banning all advertising of alcohol in all media
- Banning all alcohol industry sponsorship

- And requiring prominent and specific warning statements to accompany any permitted alcohol advertising.

Comments

The Law Commission has not adequately responded to the impact of alcohol advertising in its Issues Paper. While industry interests argue that the current self-regulatory regime works well, the question is what is it working well to achieve? Or whose interests does it serve?

The current system is largely based on content matters and does not adequately respond to the issue of exposure. The complaints-based system ensures that exposure to offending material continues until the complaint is addressed.

Perhaps the following quotes from young people will help to reveal the true picture.

"I was just like yes Smirnoff Blue, Smirnoff Blue, I'm going to get so wasted tonight. I was in the taxi and I was like passing it back to see if anyone wanted it, and everyone was no screw that shit, and I had it straight. I was just like going, oh you guys are just pussies." (Ed, 17 years).

"At the Lion Red fishing contest… you see like slaughtered people, absolutely trolleyed and it's just awesome." (Mark, 15 years).

"This is not helping me in the future but... there's nothing else to do and I'm just.. I really want to have a good time for now, I don't really care about the consequences until they come…" (Emily, 15 years).

These quotes come from youth participating in a study undertaken by Tim McCreanor and others from Whariki Research Group, Massey University 2006[xviii]. They make it clear that alcohol marketing is not just about branding – it is about identity, about intoxication, and about it's about recruiting young drinkers.

We believe that it is socially irresponsible to allow marketing of a drug that causes significant and unacceptable levels of harm to individuals and society. We do not believe it is possible to effectively protect young people from the influence of alcohol advertising/marketing other than through banning it.

Failing a ban on all alcohol advertising and sponsorship we suggest that the French model (Loi Evin) offers an alternate. This must be managed by an independent health authority.

We also support the establishment of an alternative source of funding for alcohol sponsorship from alcohol excise tax.

Promotions options

Alcohol Healthwatch supports:

- Banning all promotion of alcohol.

Comments

While it is available for sale, given the level of harm associated with the consumption of alcohol, a consistent harm prevention approach would restrict all alcohol promotion.

The new code for Naming, Labelling, Packaging and Promotion of Liquor considers the following to be promotion – *materials and activities generated by the producer, distributor or retailer, for example: user generated content on websites and emails, sponsorship, media releases, branded merchandise, competitions, word of mouth marketing, advergaming, product displays and sampling.*

PROBLEM LIMITATION

Enforcement and penalties options

Alcohol Healthwatch supports:

- Increase in penalties for breach of licence conditions including making it easier to lose licence
- Provide the police with the power to close a bar immediately
- Provide the police and inspectors with the ability to request an urgent hearing with the Licensing Authority if there are serious concerns or breaches of the Act
- Provide for infringement notices for minor or technical breaches of Act or conditions of licence
- Provide medical officers of health with the same powers of entry as licensing inspectors
- Remove the requirement for licensing inspectors to identify themselves when entering premises
- Make it an infringement offence to present fake evidence of age documents
- Empower licensees to confiscate fake evidence of age documents and hand to Police.

Comment

We believe the above options will support better monitoring and enforcement of the current Act and will provide useful guides to inclusion in a new Act should that be the determined way forward.

We also believe there is great potential in building the capacity and capability of Maori and Pacific Wardens. They play a vital role in communities across the country and provide a huge support to the NZ Police and other statutory agencies in managing alcohol issues.

Evidence does not support the effectiveness of Alcohol Accords (voluntary codes of bar practice)[xix].

However, we are aware that Alcohol Accords have been used to achieve better compliance with the law, and potentially could enable premises to better meet requirements of stricter licence conditions, such as those suggested earlier in relation to extended trading hours, through pooling/sharing resources.

If they do have a role to play in the future licensing regime it would seem essential to recognise them, to clearly specify the conditions of their membership and function and to give further consideration of excluding them from the provisions of the Commerce Act (1986).

Alcohol in public places options

Alcohol Healthwatch supports:

- Making it an offence to drink in a public place.

Comment

Many of New Zealand's public places present increased risk of harm, particularly in relation to roads (road crash), beaches, coastline, lakes and rivers (falls and drowning), events, gatherings in streets, school grounds, parks and reserves, (violence, injuries from broken glass). Drinking in public also serves to present a model to young people that drinking is a necessary part of everyday life.

Communities could identify particular exemptions to such a restriction through their Local Alcohol Plan. They may for example chose to free up certain public spaces for particular events/activities subject to risk management conditions being met.

The current approach to liquor bans seems variable and inconsistent across the country. They can also push drinking into other areas of the community.

We recognise that some New Zealanders would currently consider a total ban on drinking in a public place unacceptable. As a minimum we support:

- Continue the status quo, where liquor bans are dealt with by way of local authority bylaws, and

- 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, and

- Provide a power for the police/Licensing Authority to ban specified persons from entering or remaining in an area or on specified premises within an area, and

- 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 alcohol, that shall be sufficient proof that the beverage in fact contains alcohol for the purposes of seizure and destruction of the alcohol, and

- Empower persons other than the police (for example, persons employed by local authorities) to transfer intoxicated persons home or elsewhere for safety reasons.

Comment
While we support the intent of reintroducing the offence of being drunk in a public place we have concerns about its effectiveness, enforcement, and consider the term "drunk" to be subjective and potentially discriminatory. We would urge the Commission to be guided by enforcement agencies on this issue.

Perhaps "intoxicated" could replace "drunk", subject to this being clearly defined.

Transport options

Alcohol Healthwatch supports:
A zero tolerance approach to drinking and driving.
As a minimum we support

- A 0.05 blood alcohol limit for drivers 20 years and over, and zero for drivers under age of 20 and those on a learners and restricted licence
- Ban the possession of alcoholic beverages in an open container in a moving or stationary motor vehicle
- Introduce alcohol ignition locking devices for all or some convicted drink drivers accompanied by an appropriate treatment programme to address underlying issues
- Introduction of a legal blood alcohol limit for a person in charge of a pleasure craft e.g. yacht.

To ensure the effectiveness and maximum impact of this change it must be accompanied by continued rigorous enforcement, community road safety programmes and public advertising of the risks of drink-driving and the law relating to it.

Treatment options

Alcohol Healthwatch supports:

- Increased treatment opportunities for heavy drinkers and dependent drinkers
- 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
- 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
- Develop the workforce capacity and capability to ensure assessment, referral and brief interventions can be delivered by appropriate professionals across a range of health and social sectors. Funding to be drawn from excise tax increase
- Identification of treatment and intervention gaps and the development of a optimal level plan to address these and resource the implementation of this plan
- Increase Maori specific treatment services and interventions
- Increase treatment and interventions responsive to high risk population groups
- Funding of primary care providers to deliver screening, brief and early interventions and referral to specialist treatment
- Develop use of electronic screening and brief interventions in a range of settings
- Develop and implement a framework for integrated treatment delivery that is family/whanau focused with community intervention support
- Better monitoring of the prevalence of alcohol use disorders and the delivery of screening, brief interventions, and referrals in primary care and emergency departments.
- Early intervention options are available at secondary schools in order to pick up problem drinking earlier.

Comments

Treatment must not be seen as separate to other harm prevention efforts, rather as an essential part of a continuum. We must seek to provide alternative pathways to healing, ones that may sit outside of our traditional medical and treatment systems, and draw on community and cultural values.

We must also aim to reduce the burden on and need for treatment services through other preventive action.

As discussed, electronic brief interventions are effective in reducing harmful drinking. We strongly emphasise the need for these to be introduced nationally and sustainably funded.

Treatment depends upon the ability to identify and diagnose a problem. Fetal Alcohol Spectrum Disorder this is an obvious unmet need in this regard in New Zealand.

Through our co-ordination of the national network – Fetal Alcohol Network New Zealand (FANNZ) we receive many calls of desperate parents and caregivers of affected children and adults who are unable to gain access to appropriate services.

PART C: SUMMARY AND KEY RECOMMENDATIONS

Summary

We assert that the law as it stands is acting counter to its object and resulting in increased alcohol-related harm rather than reduced harm.

What is needed now is principled and enabling approach to new legislation and public policy in relation to alcohol:

In taking a principled approach to new law and future planning, there is an imperative to recognise the relationship between the Crown and Māori, and bring to bear the principles of the Treaty of Waitangi.

A Whanau Ora assessment of new law and policy for its potential to promote and protect the health of Māori is supported.

A new law must specify its intent to reduce alcohol-related harm, and an object to control of exposure to alcohol marketing and promotion.

We highlight the need to recognise the rights of children to safety and protection.

An evidence-based approach to reducing alcohol-related harm involves identifying and applying the optimal mix of policies and strategies. This will include policies and interventions that target the population as a whole and focus on changing the drinking environment, and those that target vulnerable high risk drinkers or settings.

Industry self-regulation does not feature in an evidence-based approach.

It is no longer valid or acceptable to factor health benefits into law and policy making, nor is it acceptable to leave New Zealand drinkers uninformed about the risks they are taking by consuming alcohol.

Health and social objectives must take priority in alcohol legislation and commercial interests must be secondary.

New Zealand must utilise the full scope of law to support a change to our harmful drinking culture. It must be acknowledged that due to the normalisation of alcohol many people will need to be persuaded and motivated towards accepting a more restrictive environment and modifying their drinking behaviours.

We must also demonstrate leadership in the Pacific region.

Community action and mobilization strategies to reduce alcohol-related harm are effective interventions, and currently under-utilised and under-funded in New Zealand. These would be complementary strategies to those enabled by

law, and help communities to understand the law and engage in it to maximize their safety and well-being.

Educative approaches are better utilized in building support for, uptake of and compliance with effective policies and interventions.

It must be ensured that our laws and other public policies, work together to achieve common purpose for the greater public good.

We urge the Law Commission to accept the challenge and confidently present to Parliament an evidence-based response to the issue of alcohol-related harm, and in doing so help to set a new blue print for a healthier, safer and more prosperous New Zealand.

Key Recommendations

We recommend that:

- A new law is created to regulate the sale, supply, consumption and marketing of alcohol.
- That this new Act is under-pinned by a set of principles that reflect the rights of children to protection and the relationship between the Crown and Māori, and protect and promote the health, safety and well-being of New Zealanders through reducing alcohol-related harm.

And the following evidence-based options are enacted:

- Return the Minimum Purchase Age to 20 years from all licensed premises.
- Restrict the number, location and density of liquor outlets and the hours they are allowed to trade nationally.
- Require local councils to undertake a comprehensive social/health impact assessment of alcohol and develop a Local Alcohol Plan to reduce the negative consequences in full community consultation.
- Otherwise improve community input into liquor licensing and alcohol matters through better public notification, wider grounds to object to licence applications and to complain.
- Increase price of alcohol through increased taxation, and introduce a minimum price per unit of alcohol.
- Ban all alcohol advertising, sponsorship and promotion in all New Zealand media and establish an alternative source of funding for alcohol sponsorship from alcohol excise tax.
- Lower the Blood Alcohol Concentration for driving to at least 50ml/100mg for adult drivers on full license, and zero for all drivers under the age of 20 years and those on learners and restricted licences.
- Require all alcohol to carry bold graphic warning labels and nutritional information.
- Improve treatment options and make access to treatment easier, in particular ensure that screening, brief and early interventions are widely available nationwide.

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