Auckland Regional Public Health Service

Rātonga Hauora ā Iwi o Tamaki Makaurau

Working with the people of Auckland, Waitemata and Counties Manukau

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Submission on the Draft Auckland Council Local Alcohol Policy

1. Thank you for the opportunity for the Auckland Regional Public Health Service (ARPHS) to provide a submission on the Draft Local Alcohol Policy.

2. The following submission represents the views of the Auckland Regional Public Health Service and does not necessarily reflect the views of the three District Health Boards it serves. However, this submission has been formally endorsed by the Emergency Department Clinical Directors for hospitals in Auckland, Waitemata, Counties Manukau, and Waikato. Please refer to Appendix 1 for this endorsement and further information on ARPHS.

3. ARPHS understands that all submissions will be available under the Local Government Official Information and Meetings Act 1987, except if grounds set out under the Act apply.

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Executive summary

1. ARPHS supports the overall intention of the draft Local Alcohol Policy (LAP) as a means to reduce alcohol related harms. Alcohol is a major source of a wide variety of harms to health. Alcohol is associated with over 200 diseases and is also associated with other harms including vehicle accidents, domestic violence and assault.

2. Alcohol is widely consumed in New Zealand, and often in a hazardous manner. Consequently alcohol is associated with between 600 and 1000 deaths each year in New Zealand. This has major social and economic costs. Alcohol is also strongly associated with health inequalities, particularly for young people and Māori and Pacific people.

3. Due to the major harms associated with alcohol consumption we strongly endorse greater restrictions on alcohol availability throughout the draft LAP. Our recommendations are based on policy measures that have been shown to work in reducing alcohol related harms. Our organisation also commissioned a survey that was designed to ensure that public opinion was captured, and has also been used to guide these recommendations. Public opinion strongly supports more restrictive provisions for alcohol licensing.

4. Our key recommendations for the Auckland Council Local Alcohol Policy to reduce alcohol related harms in the region are:

Broad Areas

- We support the priority overlays, but recommend greater restrictions.
- Specifically, we recommend that the entire city centre, Broad Area A, be reclassified as a Priority Overlay Area in recognition of the high levels of alcohol-related disorder throughout the area and to prevent displacement of alcohol-related harm.

Density

- We recommend greater restrictions on the density and number of licensed premises.
- Specifically, we recommend a freeze or sinking lid policy for on and off-licenses in Broad Area A, neighbourhood centres and all Priority Overlay Areas for the six-year duration of the LAP.

Proximity

- We recommend an exclusion zone near sensitive sites (including schools), to limit the proximity of alcohol retailing premises to vulnerable members of society.

Trading Hours

- We recommend further restricting trading hours for licensed premises, and strongly support consistent trading hours across the Auckland region to prevent migratory drinking and any associated harms.
- Specifically, we are strongly opposed to extensions of trading hours for 'best practice', or other, operators.
- For on-licensed premises, we support restricted trading hours of 10am – 1am for the whole Auckland region.
- For off-licensed premises, we support restricted trading hours of 10am – 9pm for all premises, including supermarkets.
- If consistent trading hours are not implemented, we advocate the use of a one-way door policy.

Discretionary Conditions

- We support discretionary conditions, but note that these are not an adequate substitute for the more effective means of reducing alcohol related harms summarised above.

Environmental Cumulative Impact Assessments

- We support the use of environmental cumulative impact assessments (ECIAs), but note the importance of Council ownership that is separate from the alcohol industry. This helps avoid any conflict of interest caused between the objective of the EICA, to reduce alcohol-related harm, and the industry's economic imperative.
- We note that the ECIA is not adequate to appropriately protect vulnerable populations.

Integrated Dispersal Plans

- ARPHS supports the use of integrated dispersal plans to reduce the potential for alcohol related harm by ensuring safe and efficient travel options for patrons of alcohol retailing premises.

Evaluation

- In order to monitor the ongoing effectiveness of the measures to reduce alcohol related harm in the LAP, we recommend ongoing evaluation.

Consistency with the Unitary Plan

- ARPHS recommends that the LAP and proposed Unitary Plan are consistent. The Unitary Plan proposes growth in many areas of Auckland and a greater mix of housing types. Policy should aim to reduce alcohol related harm in these future areas to ensure the effectiveness of the LAP.
- ARPHS believes that more restrictive policy limiting the availability of alcohol is needed to reduce alcohol related harms and effectively meet health-related targets in the Auckland Plan, as well as achieving the Mayoral vision of a highly liveable city.

Introduction

5. Alcohol related harm is of major importance to public health in the Auckland region. Thank you for the opportunity to submit on the Auckland Council Draft Local Alcohol Policy. We would also like to thank Council for the opportunities provided to the Medical Officer of Health (MOH) to contribute to this process.

6. We note that under section 78(4) of the Sale and Supply of Alcohol Act 2012 (SSOAA), LAPs must be created in consultation with the Medical Officer of Health.

   "The authority must not produce a draft policy without having consulted the Police, inspectors, and Medical Officers of Health"[1].

   As such, this submission forms part of our statutory role in the development of Auckland's LAP.

7. There is a substantial scientific knowledge base for policy makers on the effectiveness and cost effectiveness of policy interventions that reduce alcohol related harm[2]. Our policy submission is based on this scientific evidence of proven measures to reduce harm, as well as public health ethics[3], and research on community opinion regarding the LAP.

8. Reducing alcohol related harms is an important part of improving health outcomes in Auckland. We note that the Auckland Plan strategic targets provide the guiding imperative for all of Council's other policies and plans. We have outlined ways in which Council can meet many of these targets, by reducing alcohol related harms through the LAP, in Appendix 5 of this document.

Alcohol use in New Zealand

9. While all alcohol consumption is potentially harmful, heavy drinking, both regular and irregular, presents the greatest risk for negative health outcomes related to alcohol[4]. Heavy drinking remains a predominant feature of New Zealand's drinking culture. Almost one-half (44%) of all alcohol consumed by adults is consumed in heavy drinking (binge drinking) episodes[5].

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[1] Sale and Supply of Alcohol Act s78(4) (2012). New Zealand Statutes. Retrieved from: http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3951542.html

[2] World Health Organization (2007). WHO Expert Committee on Problems related to alcohol consumption. Second Report. WHO Technical Report Series 944. Accessed from: http://www.who.int/substance_abuse/expert_committee_alcohol_trs944.pdf?ua=1

[3] Reducing alcohol related harms to health have been specifically identified as an area in which (central and local) governments have an important ethical duty to intervene. Please refer to the Nuffield Institute of Bioethics: http://www.nuffieldbioethics.org/news/government-and-industry-not-doing-enough-our-health

[4] Connor. J. (2013) 'The Health Impacts of the way we drink in New Zealand', Alcohol NZ: Health and Social Impacts of Alcohol. Health Promotion Agency. Wellington.

[5] Law Commission. 2009. Alcohol in our lives: An issues paper on the reform of New Zealand's liquor laws. Issues Paper 15.

Health impacts of alcohol

10. The consumption of alcohol is a major personal and public health issue in New Zealand. The harmful use of alcohol is considered to be one of the main risk factors for poor health globally[6]. Alcohol is ranked among the top five preventable causes of morbidity and mortality worldwide[7].

11. Alcohol is a contributing cause of more than 200 illnesses, as defined by the World Health Organization (WHO) International Classification of Diseases[8].

12. In New Zealand, alcohol is responsible for 600 to 1000 deaths per year[9],[10] (additionally, many more New Zealander's live with disability due to alcohol).

13. Alcohol is classified as a class one carcinogen[11],[12]. The primary carcinogen in alcoholic beverages is ethanol[13].

14. Alcohol consumption is linked with a wide number of cancers[14] including the following:
    - Mouth
    - Oesophagus / stomach
    - Colo-rectum
    - Liver
    - Female breast.

15. The 2014 World Cancer Report (WCR)[15] has recently stated that there is no 'safe limit' for alcohol consumption[16].

Alcohol related harms

16. As well as the direct harm to health from alcohol consumption, alcohol also harms health in other ways including alcohol related injuries, assaults, violence, road accidents and other crime.

17. The New Zealand Police report that alcohol is a major contributor to crime statistics. Alcohol is associated with:
    - 50% of all serious violent crime[17]
    - 20% of sexual offending[18]
    - 33% of all family violence[19]
    - 33% of all police apprehensions[20].

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[6] World Health Organization (2010). The Global Strategy to reduce the harmful use of Alcohol. Geneva, Switzerland. Page 5.
[7] World Health Organization (2009). 'Global Health Risks'. 'Mortality and burden of disease attributable to selected major risks'. Accessed from: http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf
[8] World Health Organization (2010). *International Classification of Diseases.* Malta. Accessed from: http://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf
[9] Slack, A., Nana, G., Webster, M., Stokes, F., & Wu, J. (2009). *Costs of harmful alcohol and other drug use.* (BERL Economics report). 134.
[10] Connor. J. (2013) 'The Health Impacts of the Way we drink in New Zealand', Alcohol NZ: Health and Social Impacts of Alcohol. Health Promotion Agency. Wellington.
[11] IARC ***Group 1 carcinogen****: The agent (alcohol) is carcinogenic to humans. The exposure circumstance entails exposures that are carcinogenic to humans.* This category is used when there is *sufficient evidence* of carcinogenicity in humans.
[12] Alcohol was first identified as a carcinogen by the IARC Working Group in 1988. International Agency for research on Cancer (1988). Alcohol drinking (IARC Monographs on the Evaluation of the Carcinogenic Risk to Humans). Lyon: World Health Organization. 13-20.
[13] Lachenmeier DW, Przbylski MC, & Rehm J. (2012). Comparative risk assessment of carcinogens in alcoholic beverages using the margin of exposure approach. *International Journal of Cancer.* 131(6), E995-E1003.
[14] IARC Working Group(1987). 'Alcohol drinking'. Lyon, 13-20 October 1987. *IARC Monogr Eval Carcinog Risks Hum.* 44:1-378.
[15] The World Cancer Report (WCR) is issued by the International Agency for Research on Cancer (IARC). The WHO is IARC's parent organization.
[16] Rehm J, Shield K. (2014) Alcohol consumption. In: Stewart BW, Wild CB, eds. World Cancer Report 2014. Lyon, France: International Agency for Research on Cancer.
[17] NZ Police Commissioner, Howard. B. (2010). 'Alcohol causes violence'. Media release. 24 March 2010. Accessed from: http://www.police.govt.nz/news/commissioners-blog/alcohol-causes-violence
[18] Ibid.
[19] Ibid.
[20] NZ Police 2010.

18. The Ministry of Transport have reported that 26% of drivers involved in fatal crashes were recorded as having had alcohol[21].

19. The ADHB adult emergency department (ED) at Auckland hospital finds that approximately 30 - 50% of overnight attendances, especially during weekends, are related to alcohol use[22]. Auckland hospital ED estimates that this amounts to an annual cost of $NZ 1.38 million[23],[24].

20. Globally around 20% of hospitalisations are associated with alcohol use[25]. In the 2005/2006 year, gross hospital related costs for alcohol related admissions in New Zealand were estimated at NZD$126 million[26]. Overall, alcohol related harms impose a major burden on the health system in Auckland.

21. As outlined earlier in this submission, all levels of alcohol consumption are a risk to health, and the risk increases with increasing consumption. Further details on harms related to alcohol can be found in Appendix 8 of this document.

Alcohol and health inequalities

22. Alcohol is a major contributor to health inequalities. Reducing alcohol related harm is an important factor in improving health inequalities[27]. Other details on how alcohol related harm disproportionately affects the most disadvantaged can be found in Appendix 6 of this document. We have also outlined in Appendix 7 of this document some of the many requirements for the SSOAA (2012) including consideration both of minimising alcohol related harms and the health of the residents in the local area.

23. Reducing alcohol related harms to health have been specifically identified as an area in which both central and local governments have an important ethical duty to intervene[28]. We also note that reducing health inequalities are part of Auckland Council's key strategic targets under the Auckland Plan[29].

Economic costs

24. The estimated economic cost of alcohol related harm in New Zealand was estimated at NZD$4.9 billion in one year alone (2005/06)[30].

25. The World Health Organization also identified that:

> *'The mortality and prolonged disability associated with NCDs have a sizeable economic impact on households, industries and societies, both via the* ***consumption of health services and via losses in income, productivity and capital formation****'*[31].

26. Alcohol related harm and disease contribute significantly to the overall non-communicable disease (NCD) burden in Auckland. NCDs, including those associated with alcohol, pose a

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[21] Ministry of Transport. 2006-2008 data.
[22] Dr Anil Nair, Clinical Director, Adult Emergency Department, Auckland Hospital. 4th February 2014. Local Alcohol Policy Recommendations: oral presentation to Auckland Councillors. Auckland Regional Public Health Service.
[23] Ibid.
[24] This estimate is similar to that found in other Australian hospitals. Descallar, J., Muscatello, D. J., Weatherburn, D., Chu, M. and Moffatt, S. (2012), The association between the incidence of emergency department attendances for alcohol problems and assault incidents attended by police in New South Wales, Australia, 2003–2008: a time–series analysis. *Addiction*, 107: 549–556.
[25] WHO (2009). Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. Copenhagen, Denmark: WHO Regional Office for Europe.
[26] Slack, A., Nana, G., Webster, M., Stokes, F., & Wu, J. (2009). Costs of harmful alcohol and other drug use. BERL Economics. Page 120.
[27] Loring. B. (2014). Alcohol and inequities. Guidance for addressing inequities in alcohol related harm. World Health Organization (WHO).
[28] Nuffield Institute of Bioethics: http://www.nuffieldbioethics.org/news/government-and-industry-not-doing-enough-our-health
[29] Please refer to Appendix 5 of this document for our summary of areas in which Council can improve health outcomes in line to better reach its Auckland plan targets through changes to the draft LAP document.
[30] Slack, A., Nana, G., Webster, M., Stokes, F., & Wu, J. (2009). Costs of harmful alcohol and other drug use. BERL Economics, 40.
[31] World Health Organization and World Economic Forum (2011). 'From burden to 'best buys': Reducing the Economic Impact of Non-Communicable Diseases in Low and Middle-Income Countries'. Accessed from: http://www3.weforum.org/docs/WEF_WHO_HE_ReducingNonCommunicableDiseases_2011.pdf

significant burden on economies and businesses. This was highlighted in a global survey of business leaders from around the world carried out by the World Economic Forum, where chronic disease was identified as one of the leading threats to global economic growth[32]. Conversely, economic growth in health harming industries such as global alcohol production, fast food and tobacco, are leading causes of global disease burdens[33]

Need for separation of alcohol industry from local government policy process

27. We urge Council to prioritise public health and community wellbeing ahead of the economic interests of the alcohol industry in its policy decisions on the LAP under the SSOAA (2012).

28. The stated objective of the SSOAA (2012) is to minimise alcohol related harms[34], rather than to minimise economic impacts on the alcohol industry.

29. The Global Alcohol Policy Alliance[35] issued a statement of concern opposing the role of alcohol producers in the development of alcohol related public policy. This stated that:

    'Unhealthy commodities industries such as the global alcohol producers should have no role in the formation of national and international public health policies[36].

30. Similarly, we wish to emphasise the need for evidence based restrictions in order to reduce alcohol related harm, rather than relying on the ineffectual and *laissez faire* policy instruments generally favoured by alcohol industry interests[37].

31. We urge Council to keep in mind that local alcohol policies are designed to enable community input into liquor licensing decisions and are the main legislative tool to reduce the availability of alcohol and associated alcohol related harm.

Purpose of LAPs under the Sale and Supply of Alcohol Act

32. The key principles of the Act include the need to minimise alcohol related harms. Alcohol related harms outlined in the Objects of the Act 4(2) include[38]:

    "(2) For the purposes of subsection (1), the harm caused by the excessive or inappropriate consumption of alcohol includes —

    (a) any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by the excessive or inappropriate consumption of alcohol; and

    (b) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by any crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in paragraph (a)."

33. We note that local alcohol policies were developed under the Sale and Supply of Alcohol Act (SSOAA 2012) to better cater to community concerns regarding the over-provision of alcohol retailing outlets in their local areas.

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[32] World Economic Forum (2010). Global Risks 2009: A Global Risk Network Report.

[33] World Health Organization and World Economic Forum (2011). 'From burden to 'best buys': Reducing the Economic Impact of Non-Communicable Diseases in Low and Middle-Income Countries'. Accessed from: http://www3.weforum.org/docs/WEF_WHO_HE_ReducingNonCommunicableDiseases_2011.pdf

[34] Section 4 'Objective'of the Sale and Supply of Alcohol Act (SSOAA) 2012. Accessed from http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339340.html

[35] More than 500 public health professionals, health scientists and NGO representatives from 60 countries signed this joint Statement of Concern about the activities of the global alcohol producers.

[36] Global Alcohol Policy Alliance (2013). Statement of Concern: The International Public health Community responds to global alcohol producers' attempts to implement WHO global strategy on alcohol. Accessed from: http://corporationsandhealth.org/2013/02/13/public-health-response-to-global-alcohol-producers-attempts-to-implement-who-global-strategy-on-alcohol/

[37] Ibid.

[38] Section 4 'Objective'of the Sale and Supply of Alcohol Act (SSOAA) 2012. Accessed from http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339340.html

34. The government has stated that one of the key benefits of the Sale and Supply of Alcohol Act is the greater provision for communities to influence the conditions surrounding alcohol availability in their local areas[39].

35. Therefore, we emphasise the need for the draft LAP to give strong weighting to community opinion regarding policy measures around the sale and supply of alcohol within the LAP.

Public opinion – Local Alcohol policy – ARPHS survey

36. As part of the process for preparing for the LAP, ARPHS commissioned a study of public opinion on local alcohol policies in the Auckland region in January 2014[40]. There were 800 randomly selected CATI (computer-assisted telephone interviewing) interviews undertaken with adults in the Auckland Council region.

37. Overall, the survey found that the majority of public opinion is in favour of more restrictions than are currently in force regarding the availability and supply of alcohol. The key findings of this survey can be found in Appendix 2 of this document. As per the SSOAA, we urge Council to pay special credence to the voice of community opinion in formulating the final Local Alcohol Policy.

38. In Appendix 9 of this document we have also illustrated the extremely high level of harm to wider society resulting from alcohol related harm. As such, we strongly emphasise that alcohol use should not only be considered as an individual choice. As a whole society must bear the burden of its harms, we strongly suggest that policies to regulate the sale and supply of alcohol should also reflect the wishes of the entire community.

Key findings

39. Overall, there was majority support for more restrictive alcohol policies in the Auckland region than those currently proposed in the draft LAP.

40. We note that the overall support for greater restrictions on the supply of alcohol in the Auckland region is also reflected in other surveys, such as the one undertaken by the Health Sponsorship Council in Appendix 3 of this submission.

ARPHS' SPECIFIC COMMENTS ON DRAFT LAP

LOCATION- BROAD AREAS

ARPHS recommendations on this issue

41. ARPHS is supportive of the three defined areas proposed in the LAP; broad area A in the city centre, broad area B being the rest of Auckland, and the priority overlay. ARPHS is pleased to see that the priority overlay covers some areas across Auckland that are currently experiencing a high level of alcohol-related harm[41].

[39] Collins., J., (2013). 'Communities to have more say on alcohol licenses'. 18 June 2013. Media Release. Beehive.govt.nz Accessed from: http://www.beehive.govt.nz/release/communities-have-more-say-alcohol-licenses

[40] Wyllie, A. (2014).'Public support for alcohol policies in the Auckland Council Region'. Report prepared for Auckland Regional Public Health Service. Wylie and Associates. Accessed from: http://www.arphs.govt.nz/Portals/0/Health%20Information/Alcohol/Public%20Support%20for%20Alcohol%20Policies.pdf

[41] Page 3. NZ Police (2014). Final draft of New Zealand Police submission for the Auckland Council Local Alcohol Policy.

42. We support the areas that have been proposed and agree that these areas require additional restrictions in order to successfully reduce local alcohol related harms.

43. ARPHS recommends a freeze on both on and off-licenses for six years in broad area A, neighbourhood centres and the priority overlay areas (the length of the policy).

44. In broad area B, the priority overlay is proposed in 20 areas. We are particularly concerned with areas in the southern initiative region and we are pleased to see that these areas have been identified as a priority. In broad area B, the Priority overlay contains priority streets, and covers areas within 250 metres of these streets. We support this approach. We also support further restrictions in neighbourhood centres.

45. ARPHS, however, believes that further assessment is required around the impact that the priority overlay areas will have in neighbouring centres and we have concerns around displacement. The proposed priority overlay covers priority streets in broad area A (city centre). We are unsure as to the effectiveness of having a very small number of priority streets in the CBD and feel that this is highly likely to lead to displacement. The entire city centre is an area of concern to ARPHS, as the whole area has high levels of alcohol-related disorder[42].

46. ARPHS proposes that the entire city centre area (broad area A) be classified as a priority overlay area.

47. ARPHS has strong concerns regarding the inflexibility of the draft LAP. More flexibility is required to take into account demographic, economic and land use changes over time. The dynamics of areas are likely to change within the six year period of the policy, and this risk is magnified without a proper forecast risk assessment of the impact of the proposed policy at neighbourhood levels. Additionally, there must be a process in place in order to add or remove areas to the priority overlay when required.

48. On account of this, ARPHS recommends annual reviews by Council of the priority overlay areas in order to ensure that they are appropriate and are reducing alcohol related harm without causing displacement. In addition, it is crucial that the impacts of the policies the draft LAP proposes are understood and appropriate mitigation is factored into the LAP itself.

DENSITY

Research findings:

Association between density of on-license premises and alcohol harms

49. There is strong evidence linking the numbers and density of licensed premises and alcohol related harms [43],[44],[45],[46]. This association is especially pronounced in younger people[47].

50. International research has linked increasing numbers of licensed alcohol retailing premises to increased assaults, drink driving, domestic violence, homicide, suicide and child abuse[48]. Research in Newcastle, Australia, has linked higher numbers of licensed alcohol retailing

[42] Page 3. NZ Police (2014). Final draft of New Zealand Police submission for the Auckland Council Local Alcohol Policy.
[43] Livingston, M., (2008). Alcohol Density and Assault: A spatial analysis. *Addiction.* 103, 619-628.
[44] Livingston, M. (2012). Implications of outlet density, type and concentration on alcohol consumption & harm. Seminar presentation, Centre for Addiction and Mental Health, Toronto, April 25, 2012.
[45] Stockwell, T., Zhao, J., MacDonald, S., Vallance, K., Gruenewald, P., Ponicki, W., Holder, H.,& Treno, A. (2011). Impact on alcohol-related mortality of a rapid rise in the density of private liquor outlets in British Columbia: A local area multi-level analysis. *Addiction*, 106(4), 768 – 776.
[46] Ibid.
[47] Livingston, M., (2008). Alcohol Density and Assault: A spatial analysis. *Addiction.* 103, 619-628.
[48] Michael Livingston (2011), 'Alcohol Outlet Density and Domestic Violence'. A Longitudinal Analysis of Alcohol Outlet Density and Domestic Violence'. *Addiction.* 2011 May,106 (5):919-25. 2011 Feb 14.

premises to higher levels of assault, domestic violence, chronic harms and high risk drinking amongst young people[49].

51. This is also consistent with New Zealand research which also links higher numbers of licensed premises with higher rates of alcohol related criminal offending[50].

52. A New Zealand based 2013 study found that[51]:
Licensed club density and other on-license density are significantly positively related to many of the categories of police events.
    - Bar and nightclub density has the largest effects, and are significantly positively associated with all categories of police events and with motor vehicle accidents.
    - Supermarket and grocery store density generally has statistically significant and positive effects on increased police events, but are also significantly negatively related to motor vehicle accidents.

Effectiveness of controls on alcohol density and alcohol related harms:

53. Density controls are strongly advocated in New Zealand and International literature as an effective measure to reduce alcohol related harms[52],[53],[54].

54. Restricting access to retailed alcohol is also identified by the WHO and the World Economic Forum as one of the most cost effective measures to reduce alcohol related harms[55].

Community survey – density and alcohol related harms

55. There was strong community support for no further increase in on-licenses in the CBD or in local communities.
    - 'Not increase any other on-licenses in the CBD' (between 72% and 83%). There was significantly less support for 'retain the status quo' (between 52% and 64%)'.
    - 'Not increase the number of on-licenses in local communities' (between 66% and 89%). There was significantly less support for 'retain the status quo' (between 56% and 60%).

ARPHS recommendations on this issue

On-licenses

56. ARPHS is very concerned that no density controls have been proposed for on-licenses within the draft LAP and that the environmental cumulative impact assessment (ECIA) is currently the only proposed tool to potentially reduce the number of on-licenses throughout the region.

57. ARPHS recommends the use of a freeze or sinking lid in broad area A, neighbourhood areas and all priority overlay areas for a six year period.

Off-licenses

Density of off–licenses in Auckland

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[49] Livingston, M., (2008). Alcohol Density and Assault: A spatial analysis. *Addiction*. 103, 619-628.
[50] Cameron, M., Cochrane, W., Gordon, C., Livingston, M., (2013). 'The Locally-Specific Impacts of Alcohol Outlet Density in the North Island, New Zealand'. Research report commissioned by the Health Promotion Agency of New Zealand. University of Waikato.
[51] Cameron, M., Cochrane, W., Gordon, C., Livingston, M., (2013). 'The Locally-Specific Impacts of Alcohol Outlet Density in the North Island, New Zealand'. Research report commissioned by the Health Promotion Agency of New Zealand. University of Waikato.
[52] Livingston, M., (2008). Alcohol Density and Assault: A spatial analysis. *Addiction*. 103, 619-628.
[53] Livingston, M. (2012). Implications of outlet density, type and concentration on alcohol consumption & harm. Seminar presentation, Centre for Addiction and Mental Health, Toronto, April 25, 2012.
[54] Stockwell, T., Zhao, J., MacDonald, S., Vallance, K., Gruenewald, P., Ponicki, W., Holder, H.,& Treno, A. (2011). Impact on alcohol-related mortality of a rapid rise in the density of private liquor outlets in British Columbia: A local area multi-level analysis. *Addiction*, 106(4), 768 – 776.
[55] World Health Organization and World Economic Forum (2011). 'From Burden to "Best Buys"" Reducing the Economic impact of Non-Communicable Diseases in Low- and Middle- Income Countries". Geneva, Switzerland. Page 7.

58. ARPHS has found that the density of alcohol retailing premises in the CBD of the Auckland region is very high. Figure 1 below illustrates a high number of off-license premises are within 10 minutes walking distance of many residential addresses in the CBD area.

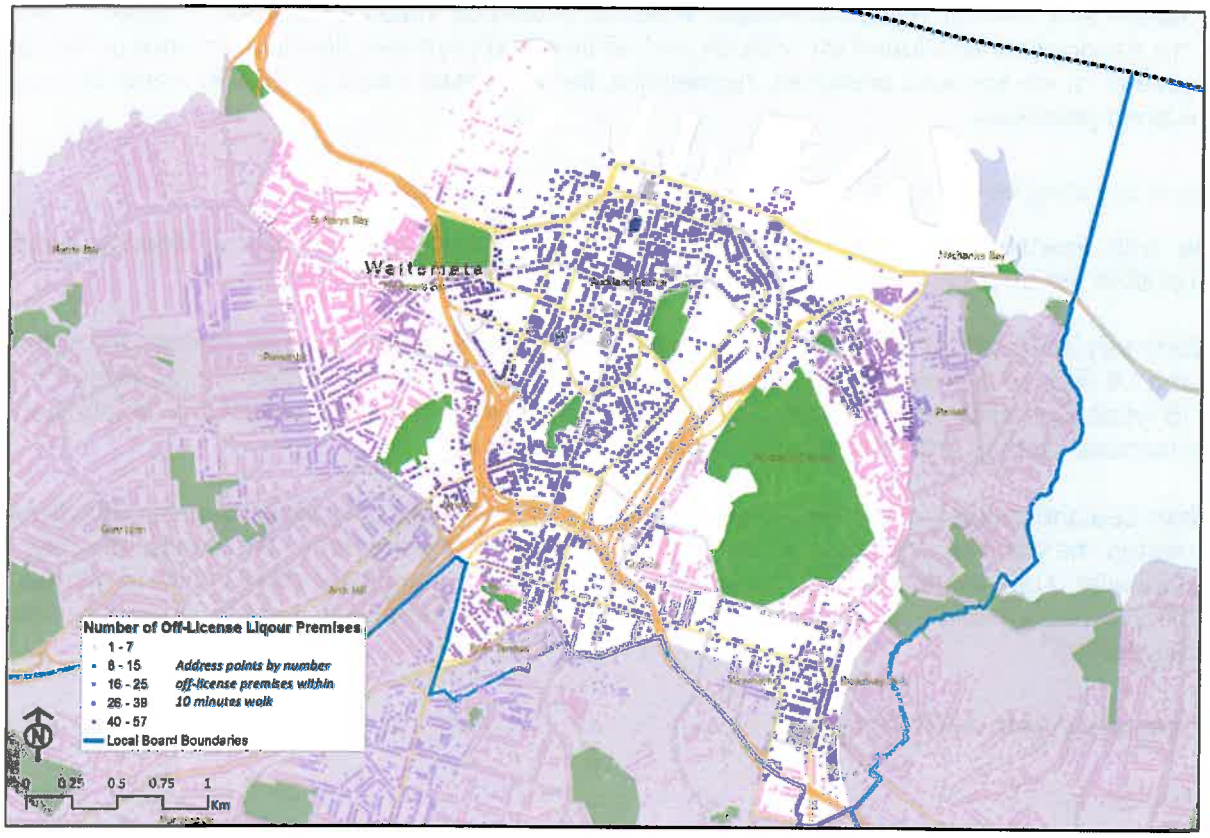

Figure 1. GIS map of showing the walking distances of off-licensed premises in the CBD, Auckland[56].

Research findings

Off-licenses and alcohol related harms

59. Off-licenses (including bottle stores and supermarkets) are strongly linked to increased alcohol related harms. A recent study undertaken by Otago University found that, of the alcohol related admissions to Christchurch Hospital Emergency Department, over 80% of alcohol affected patients had consumed alcohol from an off-license premise[57].

60. We note recent research from Palmerston North[58] highlighting the role of off-licenses in youth alcohol consumption. Of survey respondents, 77% stated that they 'pre-loaded' from off-licensed premises[59] before going on to on-licensed premises. Of the surveyed group, 47% reported having a negative experience[60] on a typical weekend (involving pre-loading)[61].

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[56] King, R. (2014). Number of Off-license liquor premises in CBD. (Map). Auckland Regional Public Health Service. Personal Communication 11/7/2014.

[57] Alcohol related admissions comprised 30% of the ED department admissions for the study period. More than 80% of the alcohol affected group had been 'binge drinking'. Source: http://www.otago.ac.nz/news/news/otago063639.html

[58] UMR Research (2013). 'Pre-loading of alcohol and associated harm in Palmerston North. A quantitative and qualitative study of the general public'. http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf

[59] The off license preloading for this group was mainly from liquor stores (79%) or supermarkets (35%). From: UMR Research (2013). 'Pre-loading of alcohol and associated harm in Palmerston North. A quantitative and qualitative study of the general public'. http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf

[60] The most common negative experiences were 'doing something they later regretted' (36%), 'partner / relationship negatively affected by drinking' (30%), and 'injuring or hurting themselves or someone else while drunk' (24%). Many negative experiences recorded higher incidence across pre-loaders with 42% claiming to have done 'something they later regretted while drunk'. From: UMR Research (2013). 'Pre-loading of alcohol and associated harm in Palmerston North. A quantitative and qualitative study of the general public'. http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf

[61] UMR Research (2013). 'Pre-loading of alcohol and associated harm in Palmerston North. A quantitative and qualitative study of the general public'. http://www.pnsab.co.nz/images/custom/pre-loading_of_alcohol_and_associated_harm_in_palmerston_north__umr_research.pdf

Off-license density and alcohol related harms

61. The availability of alcohol is linked to many negative health indicators for children, including child abuse. A longitudinal study found a relationship between the density of alcohol retailing outlets and alcohol related domestic violence, including violence towards children[62]. While this association was found for both on and off-licensed premises, the effects were particularly severe for off-licensed premises, highlighting the increased need for density controls on off-license premises.

Effectiveness of reducing off-licenses

62. As with licensed premises, research indicates that policies to reduce off-license density controls are strongly associated with reductions in alcohol related harms.

63. Summary analyses of studies show a clear association between reduced density (of both on and off-license premises) and reduced alcohol consumption and alcohol related harms[63]. An 18 year Canadian study found a significant association between reductions in off-license premises' density and reductions in alcohol consumption[64].

64. New Zealand studies also show a strong association between off-license density and alcohol related harms, for instance a 2013 study found that increasing off-license density, in particular, supermarket and grocery store density, has a significant relationship to increased alcohol related crime, and police events (although it is negatively related to motor vehicle accidents)[65].

Community attitudes from ARPHS survey

Off-license density

65. There was extremely strong community support for no further increases in the number of off-licenses. There was, however, different opinions regarding the types of off licenses.
    - 'Not increase the number of off-licenses' (between 91% and 95% did not want increases for the different types of off-license).
    - 'Retain the status quo for supermarkets selling alcohol' (63%), 'large chain liquor stores' (52%) and 'wine stores/ small bottle stores' (52%).
    - There was no majority option for grocery stores selling alcohol, with 49% wanting 'less', 45% 'the same', 4% 'more' and 1% undecided.

ARPHS recommendations on this issue

66. We support the temporary freeze on off-licenses in broad area A, neighbourhood areas and the priority overlay areas. We strongly recommend a freeze for six years (the length of the policy) rather than 24 months. However, the concept of a rebuttable presumption against the issue of a new license after the 24 month period and the requirement of an ECIA after this time are worthwhile if the six year period is not approved.

67. ARPHS recommends strong density controls on off-license premises in order to effectively reduce alcohol related harms.

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[62] Michael Livingston (2011), 'Alcohol Outlet Density and Domestic Violence'. A Longitudinal Analysis of Alcohol Outlet Density and Domestic Violence'. *Addiction.* 2011 May,106 (5):919-25. 2011 Feb 14.

[63] C., A., Campbell, R., A., Hahn, R., Elder, R., Brewer, S., Chattopadhyay, J.,Fielding, T., S., Naimi, T., Toomey, B., Lawrence, J., Cook Middleton. Task Force on Community Preventive Services (2009). 'The Effectiveness of Limiting Alcohol Outlet Density as a Means of Reducing Excessive Alcohol Consumption and Alcohol-Related Harms.' *American Journal of Preventative Medicine.* Volume 37, Issue 6, December 2009, Pages 556–569

[64] J.,F., Hoadley, B.,C., Fuchs, H.,D., Holder (1984) 'The effect of alcohol beverage restrictions on consumption: a 25-year longitudinal analysis.' *American Journal of Drug and Alcohol Abuse*, 10 (3) (1984), pp. 375–401.

[65] Cameron, M., Cochrane, W., Gordon, C., Livingston, M., (2013). 'The Locally-Specific Impacts of Alcohol Outlet Density in the North Island, New Zealand'. Research report commissioned by the Health Promotion Agency of New Zealand. University of Waikato.

68. We would like to see the introduction of a freeze or sinking lid policy for broad area A, neighbourhood areas and the priority overlay in order to effectively reduce the number of off-licenses in these areas.

LOCATION: PROXIMITY

Research findings

69. We note that the World Health Organization has stated that reducing zoning and liquor outlet density near schools and youth venues has been identified as a key strategy[66] for reducing alcohol related harm for young people, particularly those in disadvantaged groups.

70. Proximity to sensitive sites such as schools poses several issues in relation to alcohol related harms. This includes increased exposure to alcohol advertising including signage to vulnerable populations including young people. Signage and advertising of alcohol is strongly associated with increased drinking in younger people[67], as well as earlier initiation of drinking[68],[69].

71. Internationally, policy restrictions on alcohol retailing premises near sensitive sites have been undertaken to reduce alcohol related harms. For example, local Council's in Poland have designated sites (such as schools, churches, sports facilities and bus/train stations) that must not have alcohol outlets within a minimum distance. Controls on alcohol retailing premises near sensitive sites (e.g. schools, hospitals, churches/places of worship) have also been established in New York, Paris, England and Wales[70].

Community attitudes from ARPHS survey

Buffer zones near schools

72. With the exception of supermarkets (57% thought they should be allowed), most people did not want off-licenses near schools and likewise for 'taverns and large bars' and 'small neighbourhood bars'. Thirty-five percent of participants surveyed did not want off-licenses of any type near schools.

ARPHS recommendations on this issue

73. We acknowledge that proximity to sensitive sites will be taken into account during the ECIA process. ARPHS, however, wants to see the inclusion of buffer zones around schools as a policy tool in its own right.

74. We support the definition of sensitive sites that has been proposed (ECEs, schools including primary and secondary, and addiction treatment facilities) but believe that further sites could also be added to this, including rest homes.

75. ARPHS recommends that off-licenses that will be located anywhere near schools are closed between the hours of 3pm and 4pm on days that schools are in operation. If buffer zones are not approved ARPHS recommends a robust notification process whereby all residents near sensitive sites are actively notified of any license applications.

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[66] The WHO report stated a key strategy as being to: 'Introduce zoning restrictions to reduce disproportionate density of alcohol outlets in low-income or other areas with a high burden of alcohol-related harm, and reduce alcohol outlets near schools and youth venues'. *Source:* Loring. B. (2014). Alcohol and inequities. Guidance for addressing inequities in alcohol related harm. World Health Organization (WHO). Page 29.

[67] Smith, L. A., & Foxcroft, D. R. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: Systematic review of prospective cohort studies. *BMC Public Health*, 9(51).

[68] Anderson, P., De Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44(3), 229-243.

[69] Gordon, R., Harris, F., Marie Mackintosh, A., & Moodie, C. (2011). Assessing the cumulative impact of alcohol marketing on young people's drinking: Cross-sectional data findings. *Addiction Research and Theory*, 19(1), 66-75.

[70] Matthews. S. (2010). 'To compare regulatory and planning models which reduce crime in the night time economy'. Churchill fellowship report. Winston Churchill Memorial Trust: Australia.

MAXIMUM TRADING HOURS AND ONE-WAY DOOR POLICY

Maximum trading hours – on-licenses

Research findings

Trading hours

76. Research identifies the trading hours of alcohol outlets as a key factor influencing the physical availability of alcohol, and a key policy mechanism with which to regulate alcohol supply and consumption[71],[72].

77. Trading hours, especially later trading hours, are strongly associated with increased consumption and alcohol related harms[73].

> "There is strong and reasonably consistent evidence from a number of countries that changes to hours or days of trade have significant impacts on the volume of alcohol consumed and on the rates of alcohol-related problems. When hours and days of sale are increased, consumption and harm increase and vice versa[74]."

Evidence - alcohol harm associated with increased trading hours

78. Evaluations of extended trading hours in other countries have consistently reported increases in alcohol-related harms and the temporal displacement of harms[75]. In Ireland, an increase in trading hours resulted in increases in binge drinking, accident and emergency attendances, reports of disorder, vandalism and offences[76].

Evidence of benefits of restricting trading hours on reducing alcohol related harms

79. Several large summary reviews[77],[78] have also found that restricting trading hours, especially later trading hours are associated with reductions in alcohol related harms. Similarly a 2007 study of restrictions on on-premise trading hours in Brazil found a significant decrease in the number of homicides[79].

80. Earlier opening hours are similarly related to increased alcohol related harms, as drinkers tend to drink for longer and consume more when licensed premises open earlier[80].

81. We note that figures recently released from the New Zealand Police indicate that following the February 2014 introduction of reduced closing hours from the Sale and Supply of Alcohol Act, there was an 11% reduction in reported serious assaults, public violence and disorder[81].

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[71] Palk, G., Davey, J. and Freeman, J. (2007). Policing alcohol-related incidents: A study of time and prevalence. *Policing*, 30, 82-92.
[72] Stockwell, T. (2013).'International policies to reduce alcohol consumption and related harms'. In: Miller, P., Blume, A., Kavanagh, D., Kampman, K., Bates, M., Larimer, M., Petry, N., De Witte, P. and Ball, S. (eds.) Interventions for addiction: comprehensive addictive behaviours and disorders. San Diego: Elsevier.
[73] Chikritzhs, T., Catalano, P., Pascal, R., & Henrickson, N. (2007). Predicting alcohol-related harms from licensed outlet density: a feasibility study. Accessed from: http://www.nabca.org/assets/Docs/predicting-alcohorelated-harms.pdf
[74] Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Osterberg, E., Rehm, J., Room, R. and Rossow, I. (2010). Alcohol, no ordinary commodity: research and public policy, Oxford, Oxford University Press.
[75] Hahn, R. A., Kuzara, J. L., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., Naimi, T. S., Toomey, T., Middleton, J. C. and Lawrence, B. (2010). Effectiveness of policies restricting hours of alcohol sales in preventing excessive alcohol consumption and related harms. American *Journal of Preventive Medicine*, 39, 590-604.
[76] Plant, E. J. and Plant, M. (2005). A "leap in the dark?" Lessons for the United Kingdom from past extensions of bar opening hours. *International Journal of Drug Policy*, 16, 363-368.
[77] Hahn, R. A., Kuzara, J. L., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., Naimi, T. S., Toomey, T., Middleton, J. C. and Lawrence, B. (2010). Effectiveness of policies restricting hours of alcohol sales in preventing excessive alcohol consumption and related harms. *American Journal of Preventive Medicine*, 39, 590-604.
[78] Rossow, I. and Norström, T. (2012). The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities. *Addiction*, 107, 530-537.
[79] Duailibi, S., Ponicki, W., Grube, J., Pinsky, I., Laranjeira, R. and Raw, M. (2007). The effect of restricting opening hours on alcohol-related violence. *American Journal of Public Health*, 97, 2276-2280.
[80] Smith., D.I. (1986). Comparison of Patrons of Hotels with Early Opening and Standard Hours. *International Journal of the Addictions.* 21 (2). 155-163.

82. Consistency in trading times reduces the risk of 'migratory drinking[82]' where drinkers move to other alcohol retailing venues. This is associated with a range of likely alcohol related harms including drink driving and car crashes.

Community opinions from ARPHS survey

Preferred closing time for CBD on-licenses

83. Maximum of 2am closing time for on-licenses in the CBD (61% did not want it any later), 1am for larger centres (60%) and midnight for the rest of Auckland (52%).

Preferred on-license closing time (if all of Auckland was the same)

84. If all parts of Auckland were to have the same closing time for bars and restaurants, public opinion favoured 1 am, with 56% preferring this option or earlier.

ARPHS recommendations on this issue

85. We applaud the Council's decision to further restrict the standard maximum trading hours for all of Auckland.

86. We recommend, however, that the trading hours are reduced further due to clear evidence showing the impact of reduced hours on lowering levels of harm.

Need for consistency in trading hours

87. **ARPHS proposes maximum hours from 10am – 1am closing for the entire Auckland region.** ARPHS believes that having consistent trading hours for the region will prevent displacement issues.

88. ARPHS is strongly opposed to the concept of trial extensions of hours for best practice operators. Extensions up to two hours over the maximum standard hours will have a significant impact on alcohol-related harms in these areas.

One-way door policy

Research findings

89. We note that the evidence in support of one-way door policies is to some extent mixed. However, on the basis of the evidence available, we support one-way door policies as a measure to reduce alcohol related harms, *in lieu* of our preferred option of earlier and consistent closing times.

90. In New South Wales, instating a policy of 1am lockouts and 3am closing times resulted in a statistically significant 37% reduction in alcohol-related assaults, with an 11% decrease in the proportion of assaults occurring after 3am[83],[84]. There is also some evidence that indicates positive benefits of 'one-way door' policies in New Zealand. A trial of a 'one-way door' policy in Dunedin was associated with reduced alcohol related violence[85].

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[81] Tolley, A. (2014). Changes to Alcohol Laws have an immediate effect'. Media Release. Accessed from: https://www.national.org.nz/news/news/media-releases/detail/2014/04/23/changes-to-alcohol-laws-have-immediate-effect

[82] Tompson., W., (2013).'Migratory drinking: Cops calling time on CBD drinkers". *New Zealand Herald.* Monday 23 September 2013. Accessed from: http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11128563

[83] Jones, C., Kypri, K., Moffatt, S., Borzycki, C. and Price, B. (2009). the impact of restricted alcohol availability on alcohol-related violence in Newcastle. NSW. Crime and Justice Bulletin. NSW Bureau of Crime Statistics and Research.

[84] Kypri, K., Jones, C., Mcelduff, P. and Barker, D. (2011). Effects of restricting pub closing times on night-time assaults in an Australian city. *Addiction*, 106, 303-310.

[85] N.Z. Police (2009). Policing Fact Sheet: Licensed premises trading hours. Prepared by: Organisational Performance Group. Police National Headquarters: Wellington.

ARPHS community attitudes survey

91. The community attitudes survey indicated that the majority of respondents supported the 'one-way door policy', e.g. a 'lock out rule' for places closing later, which does not allow new people to enter a drinking location after the time at which on-licenses close in the rest of Auckland (66%).

ARPHS recommendations on this issue

92. As stated earlier, we emphasise that consistent trading hours are strongly our first preference. However if Council continues to propose staggered trading hours for the Auckland region we recommend inclusion of a mandatory one-way door policy in the City Centre two hours prior to closing in order to reduce the harms from migratory drinking

Maximum trading hours – off-licenses

Research findings

93. Summary reports have indicated that reducing trading hours for off-licenses is a key strategy for reducing alcohol related harms[86]. A 1998 study[87] of restrictions on off-license trading hours in a small town in Western Australia identified corresponding reductions in alcohol consumption, criminal charges, alcohol-related hospital presentations and incidents of domestic violence. Reducing the opening hours of off licenses is also important in reducing alcohol consumption. A Swedish study found that the introduction of morning opening hours for alcohol retailing premises was linked to increased alcohol consumption[88].

ARPHS community attitudes survey

Maximum trading hours – off-licenses

94. We note that the majority of community support was for consistent and more restrictive trading hours for off-licenses. This included the following:
    - Having the same hours for all off-licenses (68% support).
    - Off-licenses stopping sales no later than 10pm (between 73% and 78% support depending on off-license type).
    - Off-licenses beginning sales no earlier than 10am (between 60% and 68% support).

ARPHS recommendations on this issue

95. ARPHS recommends a maximum closing time of 9pm for all off-licenses. We do not support an opening time of 9am.

96. We would like to see maximum trading hours of **10am - 9pm** for all premises, with no exceptions for supermarkets. The 10am opening time is particularly important for off-licenses in close proximity to institutions attended by vulnerable members of society, such as schools and rest homes.

DISCRETIONARY CONDITIONS

97. Host responsibility plays an important part in reducing alcohol related harms. We note that host responsibilities, including preventing, identifying and managing intoxicated and aggressive

[86] Hahn, R. A., Kuzara, J. L., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., Naimi, T. S., Toomey, T., Middleton, J. C. and Lawrence, B. (2010). Effectiveness of policies restricting hours of alcohol sales in preventing excessive alcohol consumption and related harms. *American Journal of Preventive Medicine*, 39, 590-604.

[87] Douglas, M. (1998). Restriction of the hours of sale of alcohol in a small community: A beneficial impact. *Australian and New Zealand Journal of Public Health*, 22, 714-719.

[88] Norström, T., Skog, O.J. (2005). Saturday opening of alcohol retail shops in Sweden: an experiment in two phases. *Addiction*, 100: 767–776.

drinkers, is included amongst the suite of measures recommended in the WHO global strategy to reduce the harmful use of alcohol[89].

98. However, host responsibility should not be seen as an adequate substitute for other effective policy instruments to reduce alcohol harm, such as reducing alcohol retailing premises and closing hours.

ARPHS recommendations on this issue

99. We are supportive of discretionary conditions varying with different license types. We also support some discretionary conditions being a requirement and more being required on a case-by-case basis.

100. We are particularly supportive of the requirement for all on and off-licenses to maintain a register of alcohol-related incidents.

101. ARPHS is also very supportive of certified managers being required to be on site for club licenses at busy times.

102. We support the introduction of mandatory host responsibility policies and training and restrictions on drinks prior to closing and that these should be mandatory for all relevant licenses.

ENVIRONMENTAL AND CUMULATIVE IMPACT ASSESSMENTS (ECIA)

ARPHS recommendations on this issue

103. ARPHS acknowledge the importance of the ECIA as a policy tool. We are encouraged by the ECIA process being a requirement for a number of new on and off-license applications, particularly those that are determined to be high risk. We support ECIAs including matters of environmental risks, cumulative impacts and individual risks.

104. ARPHS recommends that the use of ECIAs be extended further to be mandatory for all license applications.

105. Importantly, ECIAs must be the responsibility of Council or an independent organisation. In addition, they must be conducted by those with the appropriate qualifications and experience in conducting environmental and health risk assessments.

106. While alcohol retailing premises can and should be asked to provide evidence of harm, assessment of this potential harm should be undertaken by an independent body, free from industry influence. Independent assessment of alcohol impact is essential in order to reduce the risk of potential conflicts of interest and bias in the reporting of likely alcohol related harms.

107. We acknowledge that proximity to sensitive sites will be taken into account during the ECIA process. ARPHS, however, wants to see the inclusion of buffer zones around schools as a policy tool in its own right. As mentioned previously, we note that the ECIA alone is not adequate to protect sensitive sites such as schools. We do not want our communities to be forced to squander their resources on endless re-litigation through the DLC process in order to protect their schools and their children from proximity to alcohol outlets. It seems particularly unfair and wasteful when taking into account the fact that poorer communities must fight this battle more often and more vigorously given the greater density of liquor outlets in poorer areas, while having fewer resources to engage in this battle.

[89] World Health Organization (2010). Global Strategy on the Harmful use of Alcohol. Page 17.

ADDITIONAL COMMENTS

Integrated dispersal plans

Research findings

108. Evidence has indicated that inadequate transportation options for patrons leaving alcohol retailing venues is linked with increased alcohol related harms[90]. Alcohol related harms are associated with the congregation of intoxicated people on the streets after venues close, and is linked to crime, for example, fights breaking out in overcrowded taxi ranks and bus queues[91].

109. We note that internationally 'integrated dispersal plans' are used as another means of reducing alcohol related harms[92]. Dispersal plans include ensuring that lighting, cleaning and transportation systems are coordinated in order to ensure that people are able to travel safely home at night.

ARPHS recommendations on this issue

110. We suggest that Auckland Council consider the use of integrated dispersal plans and ensure that the Local Alcohol Policy closing times are aligned with the provision of safe public transportation systems.

111. We also note that as part of Auckland's continuing growth and development, the provision of safe transportation options needs to be considered for growth areas in order to protect against potential alcohol related harm in the future.

Unitary plan and 'mixed use'

112. We note that the currently proposed Unitary plan will allow for a much greater variety of housing, and increased density in Auckland, particularly in the inner city and metropolitan areas of Auckland. This will increase population density in these areas, and will include an increasingly aged population. The well-being and safety of these residents from alcohol related harm also needs to be considered with regards to the liveability of Auckland, and particularly the CBD area.

ARPHS recommendations on this issue

113. We recommend that the LAP be tailored to consider the reduction of alcohol related harms in growth areas as defined by the Unitary plan (e.g. new subdivisions and areas with zoning changes under the Unitary plan).

Ongoing evaluation of effectiveness of Local Alcohol Policy

ARPHS recommendations on this issue

114. Ongoing evaluation of the Local Alcohol Policy is essential in order to gauge its effectiveness. ARPHS recommends robust evaluation procedures and an annual review of the Local Alcohol Policy.

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[90] Civic Trust (2004). Town and city centres and the evening and late night economies. Accessed from: http://www.civictrust.org.uk/evening/survey.shtml

[91] ODPM (Office of the Deputy Prime Minister) (2004). Good practice in managing the evening and late night economy: a literature review from an environmental perspective. HMSO, London.

[92] Matthews. S. (2010). 'To compare regulatory and planning models which reduce crime in the night time economy'. Churchill fellowship report. Winston Churchill Memorial Trust: Australia. Page 4. Accessed from: http://www.churchilltrust.com.au/media/fellows/2009_Matthews_Suzanne.pdf.

A 'Liveable city' – for all

115. ARPHS notes that the liveable city is a key vision for Auckland Council. We applaud this vision. We also note that the argument has been raised (mainly by the alcohol industry in New Zealand) that more restrictive provisions on alcohol consumption will have a negative impact on Auckland's tourism and night life[93],[94].

116. We contest this point on the basis that more restrictive alcohol policies increase health and well-being, personal safety, and are deemed desirable by the majority of our community. We also note that a wide variety of non-alcohol-related and health promoting forms of entertainment and social activities exist as alternatives to alcohol related entertainment[95].

Results of ARPHS community attitudes survey

117. The ARPHS survey found that there was a clear preference for more non-alcohol focused entertainment in the Auckland CBD.

118. More specifically, in the CBD, 62% of Aucklanders wanted more 'places providing shows and other entertainment, where the main focus is not on drinking'.

119. Many respondents stated that a reduction in bars and taverns would make them *more* likely to visit the CBD for shopping and to visit cafes and restaurants.

Alcohol related harms and liveability

120. Further comments on the global liveability surveys can be seen in Appendix 4 of this document.

Reaching Auckland Plan targets through improved LAP policies

121. ARPHS also notes that evidence based policies to restrict alcohol use will be a key means of reaching the targets of improving health outcomes that have been outlined in Auckland Council's Auckland Plan. These are outlined in more detail in Appendix 4 of this document.

122. We note that all council policies and plans (including the Local Alcohol Policy) must give effect to the targets outlined in the Auckland Plan. To this effect we recommend that the LAP follow a more restrictive stance on the provision of alcohol in order to reach these aims.

ARPHS recommendations on these issues

123. We recommend that Council supports its vision of Auckland as an aspirationally liveable city, and reaches its Auckland plan targets, by introducing more restrictive alcohol policies in the LAP to reduce alcohol related harm.

Conclusion

124. Thank you for the opportunity to comment on Council's draft Local Alcohol Policy. We urge Council to adopt our evidence based and publically endorsed recommendations on the LAP to substantially improve the health, safety and well-being of Aucklanders through reducing alcohol related harms in the Auckland region.

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[93] 'Save our Nightlife' campaign. Facebook. Accessed from: https://www.facebook.com/pages/Auckland-Save-our-Night-Life/652386628174056

[94] Hospitality New Zealand: the voice of hospitality. (2014). 'Regional News and Industry Updates'. 'Auckland save our nightlife – public submissions open 16 June' Accessed from: http://www.hospitalitynz.org.nz/Media.html?cid=7892

[95] Cultural activities, sports, artistic pursuits, social engagement, healthy food related activities are all forms of entertainment that can exist independently of alcohol consumption, both during the day and at night.

Appendix 1 – Endorsement of ARPHS submission on draft LAP

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

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Date: 15th July 2014

ENDORSEMENT OF ARPHS SUBMISSION ON THE DRAFT LOCAL ALCOHOL POLICY

The submission is endorsed by the Emergency departments (ED) in the Auckland region and is also supported by the Clinical Director of Waikato Hospital.

The Auckland Local Alcohol Policy (LAP) provides a unique opportunity to reduce alcohol related harm in the Auckland population. It is important that the LAP addresses the concerns of health professionals who see first-hand the significant harm alcohol causes to our society.

There is a significant increase in the number of alcohol related attendances to EDs, particularly presenting after midnight. This places significant demand on the resources in the EDs and diverts care from other emergencies.

There is strong evidence that shows a restriction in the hours of sale of alcohol, or reduction in density of alcohol retail premises, results in a reduction in volume of alcohol consumed and on the rates of alcohol related presentations to Hospitals. The LAP should therefore have provisions to reduce the accessibility and availability of alcohol.

We would like to recommend the following changes to the LAP

1. A reduction in the trading hours of off-licence premises from 10am to 9pm.
2. A reduction in the hours of trading of all on licenses from 9am to 1am.
3. A reduction in the number of on license and off-licence outlets serving alcohol.

Dr Anil Nair
Clinical Director, ED, Auckland Hospital

On behalf of
Dr Willem Landman, Clinical Director , ED, North Shore Hospital ; Dr Vanessa Thornton, Clinical Director, ED , Middlemore Hospital ;Dr John Bonning, Clinical Director, ED, Waikato Hospital

Auckland Regional Public Health Service

Auckland Regional Public Health Service (ARPHS) provides public health services for the three district health boards (DHBs) in the Auckland region (Auckland, Counties Manukau and Waitemata District Health Boards), with the primary governance mechanism for the Service resting with Auckland District Health Board.

ARPHS has a statutory obligation under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of people and communities in the Auckland region. The Medical Officer of Health has an enforcement and regulatory role under the Health Act 1956 and other legislative designations to protect the health of the community.

ARPHS' primary role is to improve population health. It actively seeks to influence any initiatives or proposals that may affect population health in the Auckland region to maximise their positive impact and minimise possible negative effects on population health.

The Auckland region faces a number of public health challenges through changing demographics, increasingly diverse communities, increasing incidence of lifestyle-related health conditions such as obesity and type 2 diabetes, outstanding infrastructure needs, the balancing of transport needs, and the reconciliation of urban design and urban intensification issues.

Appendix 2 – ARPHS survey on community attitudes towards alcohol restrictions

The following tables highlight some of the community survey results from our survey of community attitudes relating to local alcohol policies.

TIME BARS AND RESTAURANTS SHOULD CLOSE IF SAME TIME FOR ALL OF AUCKLAND

TIME BARS AND RESTAURANTS SHOULD CLOSE IF SAME TIME FOR ALL OF AUCKLAND	Total Sample (n=800) %	Those preferring different closing times (n=419) %	Those preferring same closing time for all of Auckland (n=381) %
Before 10 pm	2	1	4
10 pm	7	5	9
11 pm	7	5	9
Midnight	22	21	23
1 am in the morning	18	20	15
2 am	18	18	17
3 am	11	14	8
4 am	2	3	1
5 am	1	1	1
6 am	1	1	1
7 am	0	0	0
After 7 am	0	0	0
Not close at all/ open 24 hours	2	2	2
Same as now	2	1	2
Don't know	6	5	4
Refused	1	1	0
Total 1am or earlier	**56**	**52**	**61**

PREFERRED NUMBER OF OFF-LICENCES

PREFERRED NUMBER OF OFF-LICENCES	More %	The same %	Less %	Don't know/ Refused %	Total wanting no increase %
Supermarkets selling alcohol	8	63	28	1	91
Large chain liquor stores	5	52	42	1	94
Wine stores and small bottle stores	7	52	39	1	92
Grocery stores selling alcohol	4	45	49	1	95

Base: Total sample (n=800)

PREFERRED NUMBER OF ON-LICENCES IN LOCAL COMMUNITY

PREFERRED NUMBER OF ON-LICENCES IN LOCAL COMMUNITY	More	The same	Less	Don't know/ Refused	Total wanting no increase
	%	%	%	%	%
Taverns and large bars	10	60	29	1	89
Small neighbourhood bars	17	56	26	1	82
Licensed cafes and restaurants	33	57	9	1	66

Base: Total sample (n=800)

PREFERRED NUMBER OF ON-LICENCES IN CBD

PREFERRED NUMBER OF ON-LICENCES IN CBD	More	The same	Less	Don't know/ Refused	Total wanting no increase
	%	%	%	%	%
Taverns and large bars	11	57	25	6	83
Small neighbourhood bars	14	59	22	5	81
Licensed cafes and restaurants	25	64	9	3	72
Night clubs	12	52	26	9	79
Places providing shows and other entertainment, where the main focus is not on drinking	62	29	6	3	35

Base: Total sample (n=800)

Appendix 3 – Health Sponsorship Council survey of public support for restrictions on Alcohol in New Zealand

Health Sponsorship Council of New Zealand survey results

The following table highlights the strong desire for greater restrictions on the availability of alcohol in New Zealand[96]. This survey similarly highlights majority support for reducing the availability of alcohol.

Policy measure	**Agree or strongly agree**	**Neutral**	**Total unopposed**
Reducing the hours that alcohol can be sold	66%	18%	84%
Restriction on alcohol advertising or promotion seen or heard by young people	82%	14%	96%
Banning all alcohol advertising or promotion	50%	27%	77%
	Too many	**About right**	**Too few**
Number of liquor outlets	65%	33%	22%

Figure 2: Health Sponsorship Council survey of public support for greater restrictions on alcohol in New Zealand, 2010[97].

[96] Peck,R. (2011). 2010 Health and Lifestyles Survey: Alcohol related attitudes. Wellington: Health Sponsorship Council.
[97] Ibid.

Appendix 4 – Liveability (through reducing alcohol related harm)

'Liveability' is a core feature of the Auckland Council's vision of the 'World's most liveable city'. ARPHS strongly supports this aim. We wish to support this aim by advocating for effective and evidence based measures to reduce alcohol related harm, as a means of ensuring that Auckland becomes a healthier, safer and more liveable city, for all Aucklanders.

Many of the core features of global liveability surveys relate to factors that can be improved through effective controls on alcohol related harm.

Table 5-2 Top issues of concern raised by IPSOS Mind and Mood participants, 2011–13

Key concerns	Sydney (per cent)	Other Australian major cities (per cent)	Regional New South Wales (per cent)
Health care	44	49	56
Crime	34	31	34
Cost of living	33	32	30
Transport	33	26	21
Housing	30	22	21

Source: Ipsos Australia 2013

Figure 3: IPOS Mind and Mood Survey[98].

The Australian 'Mind and Mood' liveability report on Australian cities[99] highlights a number of areas related to liveability that are linked to alcohol related health and safety outcomes. This survey highlighted that the top two concerns for residents in Australia were:

- Health care system
- Crime.

Both of these measures, are, as outlined earlier in our submission, affected by alcohol related harm.

Health care system:
In terms of the health care system in the Auckland region, the major impacts of alcohol related harm place a major strain on the health system in the Auckland region.

Crime/personal safety:
Personal safety and crime as we have also outlined earlier in this submission, crime is particularly closely related to alcohol use, with 50% of all serious violent crime[100] and 33% of all police apprehensions in NZ associated with alcohol[101].

More traditional liveability indices tend to be developed with more focus on the needs of industry. These traditional indices, however, also focus on personal safety and crime. For example:

- *Mercer Quality of Living Survey*[102]. Top features of liveability include: 'Lack of crime'.
- *Monocle's most liveable cities Index*. Top features of liveability: 'Personal safety/crime'
- *Economist's Intelligence Unit Liveability index:* Top features of liveability: 'Low personal risk'.

We note that the Melbourne has a policy on ensuring a liveable city[103] which highlights the need for ensuring time for recuperation for city residents. Restricting alcohol licencing times are a key feature of ensuring time for recuperation for inner city residents, in order to better ensure a good quality of life.

[98] State of Australian Cities (2013) 'Liveability'. State of Australian Cities. IPOS 'Mind and Mood Survey'. Page 271. Accessed from: http://www.infrastructure.gov.au/infrastructure/pab/soac/files/2013_09_INFRA1782_MCU_SOAC_CHAPTER_5_WEB_FA.pdf
[99] Ibid.
[100] NZ Police Commissioner, Howard. B. (2010). 'Alcohol causes violence'. Media release. 24 March 2010. Accessed from: http://www.police.govt.nz/news/commissioners-blog/alcohol-causes-violence
[101] NZ Police 2010.
[102] http://www.imercer.com/products/2014/quality-of-living.aspx

Appendix 5 – Auckland Plan targets and ARPHS recommendations on LAP

We note that the Auckland Plan provides the overarching strategic framework for all of council's policies and plans, which includes Auckland Council's Local alcohol policy.

We also note that all Council policies and plans are intended to give support to these strategic objectives.

Given the extreme harm to health and personal safety caused by alcohol related harm, the strong need for stricter regulatory controls, and the strategic aims of the Auckland plan to improve the overall health and wellbeing of Aucklanders, we see options to improve health outcomes through changes to the LAP.

These support the Auckland plan targets in the following areas:

Topic Area	Health outcomes; Auckland Plan targets	ARPHS LAP recommendations that contribute to these objectives
Auckland's people	➢ There will be no gaps in life expectancy between European, Māori, Pacific and Asian ethnicities by 2040.	Enacting controls on alcohol availability in order to minimise alcohol related harm, and reduce health inequalities – particularly in Southern Initiative areas.
	➢ Decrease the number of child hospitalisations due to injury by 20% by 2025.	Reduce availability and supply of alcohol through evidence based recommendations in submission
	➢ Ensure that the incidence of trauma from road crashes caused by alcohol, speeding or lack of restraints will be in line with nationally set targets by 2020.	• Reducing availability of alcohol. Ensuring consistent standards for closing times across the city in order to reduce migratory drinking. • Aligning LAP with availability of public transportation options. • Reducing opportunities for binge drinking.
	➢ By 2020 the number of breaches of the Domestic violence Act (1995) will have stabilised and by 2040 will have fallen by 40%.	Reduce availability and supply of alcohol through evidence based recommendations in submission
	➢ Increase residents perceptions of safety in their neighbourhood from 68% in 2010 to 80% by 2030.	Reduce availability and supply of alcohol through evidence based recommendations in submission.
	➢ Reduce the rate of total criminal offences per 10,000 population from 939 in 2010 to 800 in 2040.	Reduce availability and supply of alcohol through evidence based recommendations in submission
Transport	➢ Reduce road crash fatalities and serious injuries from 506 (2010) to no more than 410 in 2040.	• Reducing availability of alcohol. Ensuring consistent standards for closing times across the city in order to reduce migratory drinking. • Aligning LAP with availability of public transportation options. • Reducing opportunities for binge drinking.

[103] City of Melbourne (2010) City of Melbourne's Policy for the 24 Hour City: A Framework for Action, accessible through:http://www.melbourne.vic.gov.au/CommunityServices/CommunitySafety/Documents/24%20Hour%20City%20Policy.pdf

Appendix 6. Alcohol related harms and their relationship to Health Inequalities

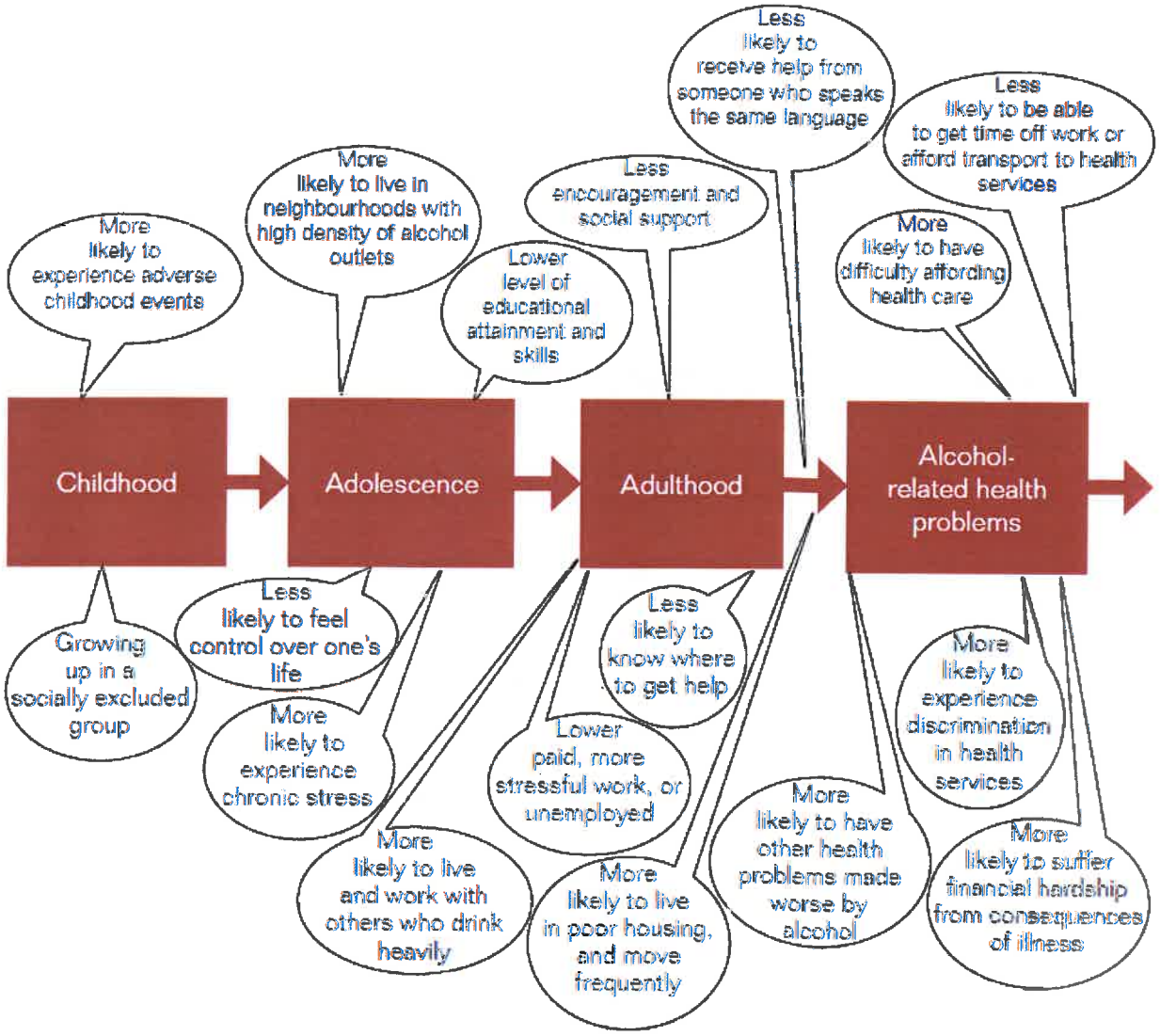

Figure 4: How inequalities in alcohol related harm compound over a life course[104].

[104] Loring. B. (2014). Alcohol and inequities. Guidance for addressing inequities in alcohol related harm. World Health Organization (WHO). Page 11.

Appendix 7. Sale and Supply of Alcohol Act (SSOAA) Purposes of the Act and local alcohol policies

The SSOAA

We seek here to outline several key features of the Act that relate to the conditions under which LAP should be created. This includes the requirement that under the SSOAA 2012, LAPs should aim to minimise alcohol related harms. Under the SSOAA, LAPs must also give regard to a number of issues including the nature and severity of current alcohol related harms, and the overall health indicators of residents within an area.

4 Object
(1) The object of this Act is that—
(a) the sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and
(b) the harm caused by the excessive or inappropriate consumption of alcohol should be minimised.
(2) For the purposes of subsection (1), the harm caused by the excessive or inappropriate consumption of alcohol includes—

(a) any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by the excessive or inappropriate consumption of alcohol; and
(b) any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by any crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in paragraph (a).

"78 Territorial authorities must produce draft policy

- (1) A territorial authority that wishes to have a local alcohol policy must produce a draft policy.
  (2) When producing a draft policy, a territorial authority must have regard to—
  - (a) the objectives and policies of its district plan; and
  - (b) the number of licenses of each kind held for premises in its district, and the location and opening hours of each of the premises; and
  - (c) any areas in which bylaws prohibiting alcohol in public places are in force; and
  - (d) the demography of the district's residents; and
  - (e) the demography of people who visit the district as tourists or holidaymakers; and
  - (f) the overall health indicators of the district's residents; and
  - (g) the nature and severity of the alcohol-related problems arising in the district.

  (3) For the purposes of subsection (2), a district's residents include people who have holiday homes there.
  (4) The authority must not produce a draft policy without having consulted the Police, inspectors, and Medical Officers of Health, each of whom must, if asked by the authority to do so, make reasonable efforts to give the authority any information they hold relating to any of the matters stated in subsection (2)(c) to (g)."

Appendix 8 – Summary of Alcohol related harms

Alcohol is responsible for 600 to 1000 deaths in New Zealand per year[105],[106] (additionally many more New Zealander's live with disability due to alcohol). In 2007, 802 deaths of New Zealanders under 80 years of age were attributable to alcohol consumption[107]. Of these 43% were attributable to injuries, 30% were due to cancer and 27% were due to other chronic conditions[108].

Alcohol is also classified as a class one carcinogen[109]. Alcoholic beverages contain at least 15 different carcinogens including; acetaldehyde, acrylamide, aflatoxins, arsenic, benzene, cadmium, ethanol, ethyl carbamate, formaldehyde, and lead[110]. The primary carcinogen in alcoholic beverages is ethanol[111].

Alcohol is also classed as a neurotoxin[112]. Heavy alcohol consumption is linked to brain damage. Some of these include black outs, memory impairment, alcohol related psychosis and damage to the developing brain in the new born child[113].

Alcohol related harms

The New Zealand police report that alcohol is a major contributor to crime statistics. Alcohol related harm is associated with:

- 50% of all serious violent crime[114]
- 33% of all violence[115]
- 20% of sexual offending[116]
- 33% of all family violence[117]
- 33% of all police apprehensions[118].

The Ministry of Transport have reported that 26% of drivers involved in fatal crashes were recorded as having had alcohol[119].

Globally around 20% of hospitalisations are associated with alcohol use[120].

The ADHB Adult emergency department (ED) at Auckland hospital receives a significant amount of patients due to the direct or indirect effects of alcohol. This is primarily because of its location close to the CBD and its position as the regional trauma centre. About 30 - 50% of overnight attendances especially on weekends are related to alcohol use. The ED department also tends to have peaks in presentations over public holidays and major social events in the CBD and its surrounds[121]. Please note that the official

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[105] Slack, A., Nana, G., Webster, M., Stokes, F., & Wu, J. (2009). Costs of harmful alcohol and other drug use. BERL Economics, 40.
[106] Connor. J. (2013) 'The Health Impacts of the Way we drink in New Zealand', Alcohol NZ: Health and Social Impacts of Alcohol. Health Promotion Agency. Wellington.
[107] Ibid.
[108] Ibid.
[109] IARC ***Group 1 carcinogen:*** *The agent (alcohol) is carcinogenic to humans. The exposure circumstance entails exposures that are carcinogenic to humans.* This category is used when there is *sufficient evidence* of carcinogenicity in humans.
[110] Lachenmeier DW, Przbylski MC, Rehm J. Comparative risk assessment of carcinogens in alcoholic beverages using the margin of exposure approach. Int J Cancer. 2012;131:E995-E1003.
[111] Ibid.
[112] The United States Department of Human and Health Sciences (2000).The 10th special report to the U.S. Congress on Alcohol and Health. 'The neurotoxicity of alcohol'. Accessed from: http://pubs.niaaa.nih.gov/publications/10report/chap02e.pdf
[113] Examples include fetal alcohol syndrome, the most preventable type of developmental brain damage.
[114] NZ Police Commissioner, Howard. B. (2010). 'Alcohol causes violence'. Media release. 24 March 2010. Accessed from: http://www.police.govt.nz/news/commissioners-blog/alcohol-causes-violence
[115] Ibid
[116] Ibid
[117] Ibid.
[118] NZ Police 2010.
[119] Ministry of Transport. 2006-2008 data.
[120] WHO. Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. Copenhagen, Denmark: WHO Regional Office for Europe; 2009.
[121] Dr Anil Nair, Clinical Director, Adult Emergency Department, Auckland Hospital. 4th February 2014. Local Alcohol Policy Recommendations: oral presentation to Auckland Councillors. Auckland Regional Public Health Service.

figures however tend to underestimate the impact of alcohol as attendances to ED of less than 3 hours are not coded.

Young people

Amongst youth aged 16-17 years, eight in ten (79.6%) people aged 16–17 years had consumed alcohol in the past year[122]. Of these many young people experienced harm due to their own drinking, for example 15.0% had experienced injuries related to drinking[123].

Alcohol related inequalities

Figure 5 below indicates the strong association between alcohol use and the social gradient, with the most deprived group at three times greater risk of alcohol dependence compared with the most affluent group.

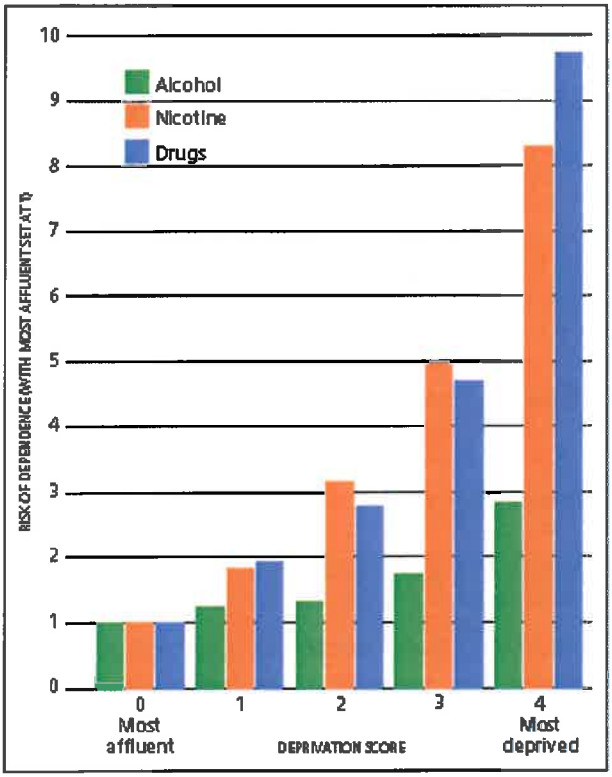

Figure 5: Socioeconomic deprivation and risk of dependence on alcohol, nicotine and other drugs[124].

[122] Ministry of Health (2007). 'Alcohol use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey'. Page xxii http://www.health.govt.nz/publication/alcohol-use-new-zealand-key-results-2007-08-new-zealand-alcohol-and-drug-use-survey

[123] Ibid.

[124] Wilkinson, R., 'The Solid Facts: Social Determinants of Health' World Health Organization. Accessed from: http://www.euro.who.int/en/publications/abstracts/social-determinants-of-health.-the-solid-facts

Appendix 9. Social and personal harms of alcohol related to other drugs

Alcohol is a drug with higher impacts to other people than any other recreationally used drug. The following study assessing drug harms to users and others, ranked alcohol as the most socially harmful drug.[125] While other recreationally used drugs are also extremely harmful to human health and society, we would like to emphasise that the severity of harms related to alcohol are borne by the whole society, rather than just an individual choice, and therefore, policy recommendations should reflect the wishes of the entire community.

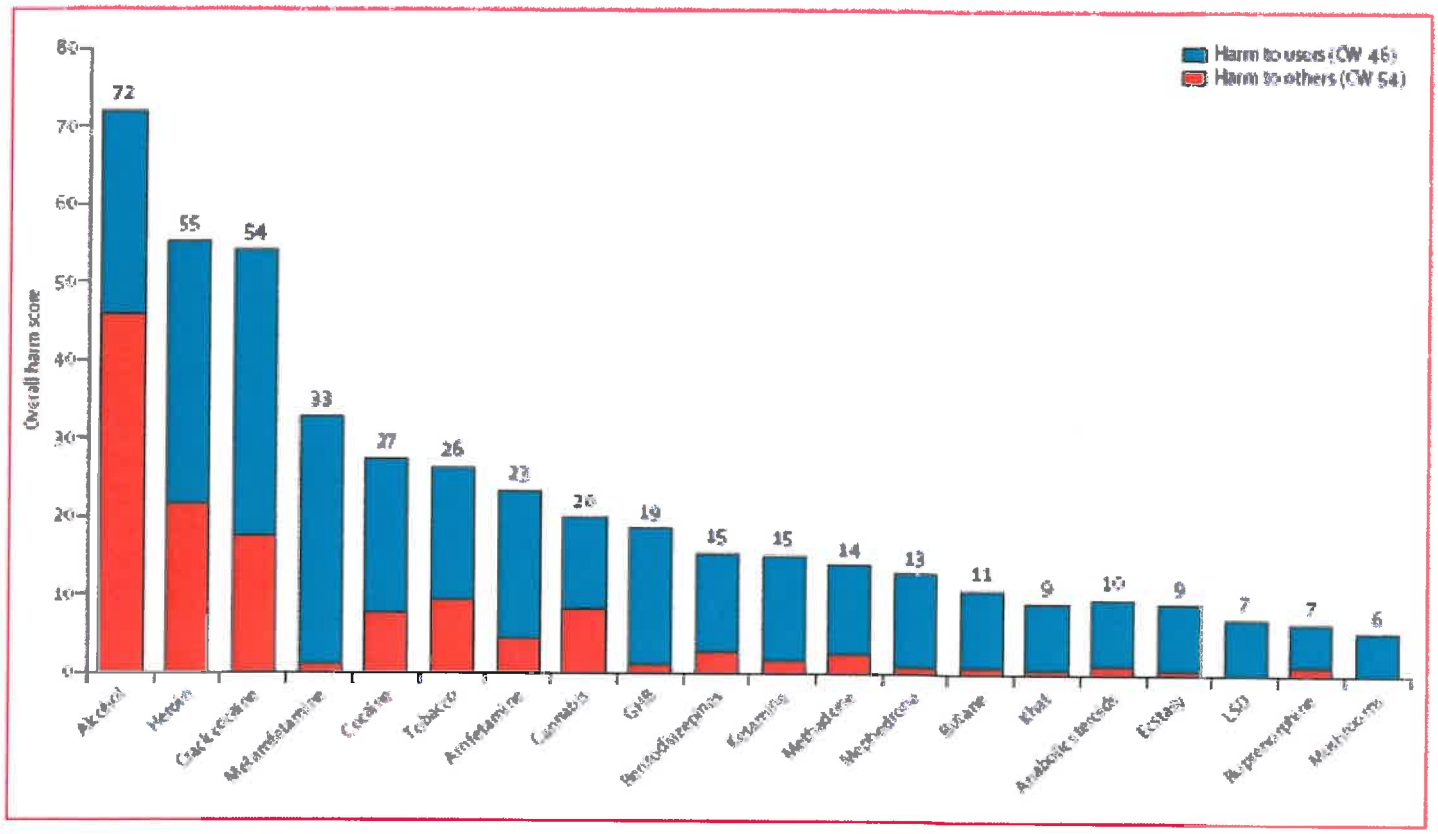

Figure 6. Overall harms of alcohol compared with other drugs[126].

Note: Drugs are ordered in this graph based on their overall harm scores, showing the separate contributions to the overall scores of harms to users and harms to others. The weights after normalisation (0-100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for the criteria to others, 54). CW=cumulative weights. GHB=y hydroxybutyric acid. LSD=lysergic acid diethylamide[127].

[125] Nutt, D, King, L, & Phillips, L. (2010) Drug harms in the UK: a Multicriteria Decision Analysis, *Lancet*, 378, 1558-65.
[126] Ibid.
[127] Ibid.