Waikato
DISTRICT COUNCIL

# Local Alcohol Policy Report

## *Development of a local alcohol policy*

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# 1. Introduction

## 1.1 Purpose

In 2013 Waikato District Council resolved to develop a Local Alcohol Policy (LAP) for the Waikato district. Under section 78 of the Act Council must produce a draft LAP for public consultation prior to adopting the final LAP. The purpose of this report is to provide the information to support the development of a LAP and outline the alcohol-related issues to be addressed through the development of a LAP.

## 1.2 Scope

The scope and structure of the report largely aligns with the information requirements for developing a local alcohol policy, as set out in section 78 of the Act. These include:

- the objectives and policies of the Waikato District Plan; and
- the number of licences of each kind held for premises in its district, and the location and opening hours of each of the premises; and
- any areas in which bylaws prohibiting alcohol in public places are in force; and
- the demography of the district's residents; and
- the demography of people who visit the district as tourists or holidaymakers; and
- the overall health indicators of the district's residents; and
- the nature and severity of the alcohol-related problems arising in the district.

This report does not assess the merits of different policy levers or mechanisms for addressing each issue. It is ultimately the role of Council's elected members to make decisions on the shape and form of any LAP. In the development of the LAP Council will engage in community consultation and meet all other statutory requirements as part of the policy development process.

# 2. Background legislation

## 2.1 Contents of local alcohol policies

Section 77(1) of the Sale and Supply of Alcohol Act ("the Act") states that a local alcohol policy may include policies on any or all of the following matters relating to licensing (and no others):

a) *location of licensed premises by reference to broad areas;*
b) *location of licensed premises by reference to proximity to premises of a particular kind or kinds;*
c) *location of licensed premises by reference to proximity to facilities of a particular kind or kinds;*
d) *whether further licences (or licences of a particular kind or kinds) should be issued for premises in the district concerned, or any stated part of the district;*
e) *maximum trading hours;*
f) *the issue of licences, or licences of a particular kind or kinds, subject to discretionary conditions;*
g) *one-way door restrictions.*

Section 77(2) of the Act makes it clear that a policy on the following aspects may apply to special licences, or premises for which a special licence is held or has been applied for:

- maximum trading hours
- discretionary conditions, and
- one-way door restrictions.

## 2.2 Definitions and interpretation

**'Discretionary conditions'** are not defined in the Act and therefore section 77(1)(f) is broad in scope.

In essence as long as the discretionary conditions are related to licensing (per section 77(1)) and are reasonable in light of the objects in the Act (see section 3 of this paper below) then they can be included in the local alcohol policy for the licensing committee or licensing authority to have regard to when considering licence applications or renewals.

Notwithstanding the above, the Act provides some direction on potential discretionary conditions in sections 110 (on-licences and club licences), 116 (off-licences) and 147 (special licences).

Section 117 provides that the DLC or ARLA may issue any licence subject to any reasonable conditions not inconsistent with the Act.

**'Facilities'** is not defined in the Act. As such this section of the Act introduces the possibility of limits on the location of licensed premises by reference to their proximity to education facilities such as early childhood centres, kindergartens, schools or tertiary education establishments, places of worship, sports facilities, community centres or any other facilities as defined by Council.

**'One-way door restriction'** is defined in section 5 of the Act as follows:
*One-way door restriction, in relation to a licence, is a requirement that, during the hours of the restriction, –*

a) *no person is to be admitted (or re-admitted) into the premises unless he or she is an exempt person; and*
b) *no person who has been admitted (or re-admitted) into the premises while the restriction applies to the licence is to be sold or supplied with alcohol.*

## 2.3 Trading hours

Section 43(1) of the Act states:

*"The default maximum national trading hours—*
a) *are the hours between 8am on any day and 4am on the next day for the sale and supply of alcohol for consumption on premises for which an on-licence or a club licence is held:*
b) *are the hours between 7am and 11pm for the sale and supply of alcohol on premises for which an off-licence is held".*

Section 45 of the Act states that, where a local alcohol policy is in force, the maximum trading hours for a licensed premises are the more restrictive of:

- the relevant maximum hours per the local alcohol policy, or
- any maximum hours specified as a specific condition of the licence.

The impact of section 45 is that where a local alcohol policy sets maximum trading hours the District Licensing Committee has no discretion to set case-by-case hours beyond those maximum hours.

Note though that a local alcohol policy could set localised maximum trading hours that are more permissive than the default national trading hours.

# 3. Alcohol related harm

## 3.1 Consumption behaviour

There are two important dimensions to consider in relation to alcohol consumption: the quantity of, and frequency with which, alcohol is consumed (Law Commission, 2009). How much people drink in a single occasion, especially when drinking to intoxication, influences the risk of immediate harms such as accident, acute health trauma or injury, whereas the overall volume consumed (i.e. how often and how much someone drinks) determines the cumulative effects, particularly from a health perspective (Law Commission, 2009; Babor et al., 2010).

## 3.2 General patterns of consumption

The World Health Organisation (WHO) estimates that annual consumption in New Zealand equates to 12 litres of pure alcohol per head of the drinking population (aged 15 years and over) (WHO, 2011)3. This compares with Australia (11.9), Canada (12.6), France (14.0), Germany (13.4), Ireland (19.3), Netherlands (13.8), Norway (8.7), Sweden (12.5), Switzerland (13.4), United Kingdom (15.6), and United States of America (14.4) (WHO, 2011).

Notwithstanding the different approaches to measuring consumption, the cumulative findings of this research indicate that about half of drinkers under 25 years, and about 25 percent of all adult drinkers, drink large quantities when they drink (Law Commission, 2009). Accordingly, heavy, 'episodic' drinking is one of the key themes documented in the literature (Law Commission, 2009).

## 3.3 Age, gender and ethnic differences in consumption patterns

The literature also focuses on age, gender and ethnic-based differences in consumption patterns. Research shows that these, as well as other individual factors such as socio-economic status and personality-type can influence consumption behaviour (Law Commission, 2009).

Generally, younger people tend to drink higher volumes of alcohol, with less frequency, while older people tend to drink lower volumes but at a greater frequency (Law Commission, 2009).

A survey reported by ALAC (2005), showed that of all young people aged 12 to 17 years:

- 48 percent were non-drinkers
- 21 percent were "supervised drinkers" (i.e. drink fortnightly or less often, typically at home with their families)
- 16 percent were "social binge drinkers" (i.e. drink at least once every two weeks and binge with their friends mainly during weekends and holidays)
- 16 percent (typically male) were "uncontrolled binge drinkers" (i.e. drink more regularly than social binge drinkers, for the main intention of getting drunk).

For many young people, getting drunk is pre-meditated (McEwan et al., 2011) and commonly involves "pre-loading" (Law Commission, 2009). Pre-loading involves drinking in private venues, where consumption is not regulated (e.g. at home, in a car) before visiting licensed premises. Licensed premises are then enjoyed for their entertainment value (e.g. dancing, meeting people), but not necessarily to buy drinks (Law Commission, 2009; McEwan et al., 2011). There is evidence to suggest that the price differential between on-licences and off-licences is contributing to the prevalence of 'pre-loading' (Law Commission, 2009).

In terms of gender differences, men are more likely to be drinkers than women are, however, the literature is increasingly concerned with changing consumption patterns among women. Many studies have observed increased consumption among women, especially young women (Law Commission, 2009). The Ministry of Health (2008) for example, analysed consumption patterns over time (1996/97 compared to 2007/08) and found that there has been a change in the age of uptake, whereby younger people, especially young females, started drinking at a younger age than in previous generations, and moreover were drinking larger amounts.

Research shows that Maori are significantly less likely to be drinkers than non-Maori, and that those Maori who do drink, do so less frequently than non-Maori. However, Maori are more likely to drink large volumes of alcohol when they do drink (Law Commission, 2009; Bramley et al., 2003). Consumption behaviour among Pacific drinkers seems to follow a similar pattern to Maori (Huakau et al., 2005).

### 3.4 Socio-economic status

Socio-economic status is also a determinant of drinking behaviour (independent to differences based on age, gender or ethnicity). Drinkers among lower socio-economic groups tend to drink more on a typical occasion (Law Commission, 2009). By comparison, drinkers among higher socio-economic groups tend to drink more frequently (Law Commission, 2009).

### 3.5 Alcohol-related issues

The excessive consumption of alcohol can cause harm directly to drinkers themselves, to people around drinkers, and to wider society, which has to cope with the consequences. Research shows that alcohol-related issues are widespread and varied, and contribute significantly to a range of costs including injury and death, other medical problems, crime (including property damage, violence and assaults), traffic accidents, absenteeism, unemployment, public disorder and treatment costs (Babor et al., 2010; Matheson, 2005; ALAC, 2008; Anderson and Baumberg, 2006). In its 2009 issues paper, the Law Commission stated:

*"The misuse of alcohol does not result in one single problem, but a whole set of problems, some of which affect the health and wellbeing of the individual drinker, some of which impact on those with whom the drinker comes in contact, and some of which impact on the community at large" (p. 7).*

Babor et al. (2010) categorise these various alcohol-related harms into two broad classes:

- issues affecting illness, injury and poor health
- social problems.

### 3.6 Alcohol and health generally

Drinking responsibly is key to reducing alcohol-related health impacts. Alcohol used in moderation, has been associated with reduced rates of certain illnesses for some groups. However, within the health sector, alcohol is seen as a major contributor to preventable diseases, injury and accident.

When alcohol is misused the resulting harms can be considerable. These harms include physical and mental health problems, injuries and death while under the influence of alcohol (including on the roads), drowning, violence (including family violence), unplanned pregnancies and foetal abnormalities (Ministry of Health, 2009).

Alcohol is medically classified as a group one carcinogen (along with tobacco and asbestos) and contributes directly to over 60 different disorders and diseases (Ministry of Health, 2009).

### 3.7 Alcohol and emergency departments in the Waikato

*Number of presentations*

Patients admitted to Waikato Hospital, including those who attend the Emergency Department (ED) for more than 3 hours, have their notes reviewed by clinical coders. The clinical coders analyse the notes and translate them into health classification codes. A code for alcohol involvement in an admission is not possible unless there is specific mention that alcohol was a contributing factor. This can create a problem with health data because it may not be known by hospital staff that alcohol was the cause of a hospitalisation.

An example of this is represented by cases where the patient is an injured third party in an event such as a motor vehicle crash. The role of alcohol in the incident is unknown, unlikely to be known and, furthermore, is irrelevant to treatment. Hence the resultant coding values may be perfectly correct from a clinical/treatment point of view but for statistical purposes they cumulatively understate the incidence and significance of causal factors such as acute and chronic alcohol use.

It should be noted that there is difficulty in providing accurate alcohol specific health data for the Waikato district because specific hospitalisation data could not be collected from Waikato Hospital ED. This is because they do not flag if a presentation is alcohol related in the patient notes.

Waikato District Health Board Population Health (Population Health) has however compared ED data from Wellington, Christchurch and Hamilton which shows that there is a surge of ED presentations from young people over weekends where alcohol was involved

with the ED presentation. Data provided from Wellington and Christchurch EDs show that in these hospitals over 60% of injuries which present between midnight and 6 am on a Saturday and Sunday involve alcohol. It is worth noting that presentations in which the alcohol status is not known are grouped with those in which alcohol is not involved. The true percentage of alcohol related presentations may therefore be greater. Using comparative data Population Health concluded that alcohol has significant impact on the Waikato ED, particularly over the weekend. This could pose a risk to ED staff and other patients in the department, and also limits the resources available to other ED and hospital departments and the Waikato District Health Board as a whole. The data also demonstrates that alcohol is involved in approximately 10% of all injuries which present to EDs; again these injuries are particularly prevalent in younger age groups.

### 3.8 Perceptions of alcohol related harm

The literature also documents the differences between actual alcohol-related harms and the way that people perceive and understand them. Alcohol's role as a social lubricant or relaxant are commonly cited as explanations for people's drinking patterns. For many, alcohol is "associated with sociability, enjoyment and for some, even a sense of cultural and national identity" (Law Commission, 2009, p.43) and this can influence the way people perceive alcohol-related harm.

### 3.8 Alcohol-related crime nationally

*Violent offending*

Research shows a strong correlation between the misuse of alcohol and violent offending (Babor et al., 2009). In New Zealand, the Police are concerned that despite an overall decrease in recorded crime, the number of recorded violence offences has increased (New Zealand Police, 2009).

Many of these violence offences involve alcohol. In 2009, the Police undertook a National Alcohol Assessment, which found the following:

- During the 2007/08 fiscal year, at least 33 percent of violence offences in New Zealand were committed when the alleged offender was identified as having consumed alcohol prior to the offending.
- From 2005/06 to 2007/08, the proportion of alleged offenders where alcohol was recorded as present in a family violence incident (where violence was recorded as the most serious offence) was between 33 and 34 percent.
- Approximately half (49.5 percent) of recorded homicides involved either a suspect or victim being under the influence of alcohol at the time of the incident.

The Police also found that Saturday and Sunday have the highest numbers of recorded violence offences over the ten-year period to 2007/08. On average 37 percent of all recorded violence offences were recorded on those days. Higher numbers were also recorded for Fridays (15 percent) compared to other weekdays (11 – 13 percent).

In terms of the time that offences occur, in the 2007/08 fiscal year, the largest number of violence offences were recorded between:

- 9pm Friday and 3am Saturday
- 6pm Saturday and 3am Sunday.

The Police report that these peaks in violence-related offences correspond closely with trends in alcohol-related apprehensions (NZ Police, 2009).

*Police enforcement*

Under the current law, it is not an offence to be drunk or intoxicated in a public place. However, section 36 of the Policing Act 2003 gives Police the power to intervene when someone is found in public place intoxicated to the point where they are a risk either to themselves or others. The Police may either place the person in custody or drive them home (recorded as "drunk home" or "drunk custody" events). These events are not recorded as offences, as the person is not arrested.

The Law Commission (2009) raised concerns about the extent of Police time and resources spent fulfilling this custodial role.

## 4. Addressing alcohol-related issues

### 4.1 Harm reduction

Alcohol policy in Australia and New Zealand has tended to focus on reducing 'problem' drinking and alcohol-related harm, targeting interventions to high-risk populations and settings (ALAC, 2008; 2005; Stewart, 1997). This can be contrasted with the approach many governments have adopted in relation to tobacco policy, where the overall prevalence of tobacco use is targeted at a population level (Stewart, 1997).

Some commentators argue that alcohol's contribution to health and social costs warrants a policy approach aimed at reducing average alcohol consumption, with a view to reducing harm (e.g. Babor et al., 2003). However, given the widespread cultural acceptability of drinking in New Zealand, as well as the role of the alcohol industry in contributing to the economy, a harm reduction approach is seen as more politically acceptable (Stewart, 1997).

It is also seen as more appropriate because the relationship between per capita consumption and harms is modified by a number of factors, including the social norms around patterns of drinking and factors about the drinking environment (ALAC, 2008; Babor et al., 2003). In addition, the distribution of drinking within populations is generally uneven, with heavy drinkers consuming a disproportionate share of the total consumption and causing a disproportionate share of problems (Babor et al., 2003).

### 4.2 Policy mechanisms

A number of comprehensive reviews of alcohol policies have been undertaken in recent years, most notably by the New Zealand Law Commission. The Commission concluded that a comprehensive approach to reducing alcohol-related harm is required and recommended changes in relation to:

- supply control (e.g. liquor licensing matters)
- demand reduction (e.g. price and advertising promotion)
- problem limitation (e.g. enforcement issues).

Further detail is provided below, with particular focus on supply controls. However, demand reduction and some problem limitation initiatives fall outside the scope of a LAP. Some of the problem limitation measures could be incorporated into discretionary conditions within the LAP.

### 4.3 Supply controls

'Supply based' policies seek to reduce alcohol consumption by restricting the physical availability of alcohol to consumers, for instance by restricting the hours of trading or the location and density of alcohol outlets (Babor et al., 2010; Matheson, 2005). Such approaches argue that reducing the supply of alcohol will increase the cost and inconvenience of accessing alcohol, which will in turn reduce alcohol consumption and alcohol-related harm (Babor et al., 2003; Ragnarsdóttir et al., 2002; Livingston et al., 2007).

The weight of evidence supports this theory and suggests that supply controls can be effective in helping reduce alcohol-related problems (Sewel, 2002; Babor et al., 2010; Anderson and Baumberg 2006). This is clearly illustrated in cases when bans or restrictions were introduced, lifted and then re-introduced (Babor et al., 2010).

*Minimum purchase age*

In New Zealand, the minimum purchase age for alcohol is set by central government (i.e. it is outside Council's control). Alcohol purchased at an on-licence must be consumed at the place of purchase (e.g. restaurants, bars, taverns); whereas off-licences are licensed to sell alcohol for consumption elsewhere (e.g. bottle stores, or supermarkets). The purchase age remains at 18 years. From 18 December 2013 a person can only supply alcohol to a person under the age of 18 years if:

- they are the parent or guardian of the minor; OR
- they have express consent from the parent or guardian; OR
- the young person is married, in a civil union or living with a de facto partner.

Anyone who supplies alcohol to a person under the age of 18 years must do so responsibly, for example by supplying food and non-alcoholic drinks and arranging safe transport. The penalty for failing to do so is a fine of up to $2,000.

*Reducing opening hours*

There is much debate over policy relating to opening hours. The recent policy direction in New Zealand and internationally has been to increase the licensed hours and days of trading (Babor et al., 2010; Casswell and Maxwell, 2005). However, studies have tended to find that large increases in opening times (particularly night hours) are associated with an increase in alcohol sales and related harms (Chisholm et al., 2003), while large reductions in trading hours tend to result in a number of benefits for communities. It is less clear how smaller changes in opening hours influence alcohol related harms (Trolldal, 2005; Chikritzhs and Stockwell, 2002).

Babor et al. (2010) report clear patterns of increased rates of alcohol-related problems with increased trading hours, in the form of higher assault frequencies, alcohol-impaired driving, other injuries, and increased Police work. In places where restrictions were introduced, problems such as violent offending were reduced.

Although some studies fail to support these conclusions, Babor et al. (2010) argue that the weight of evidence suggests that policies restricting the hours of opening have the potential to reduce alcohol related harm. In restricting licence hours, however, policy makers should be mindful of the risks associated with migratory drinking patterns, whereby patrons move between areas with different closing times.

*Regulating licence density*

Alcohol-related harm is often linked to the availability of alcohol, based on the assumption that easier access to alcohol leads to higher consumption and hence to negative outcomes (Babor et al. 2010). This may arise when clustering leads to shorter travel distances to outlets, price competition or longer opening hours, particularly amongst off-licences and in poorer areas (Cameron et al., 2010). Similarly, clusters of on-licences can become entertainment precincts in the minds of patrons, collectively attracting more people and problems than each venue would in isolation (ALAC, 2008; Livingston et al., 2007).

Anderson and Baumberg (2006), Babor et al. (2010), and Cameron et al. (2010) report outlet density studies employing a variety of methodologies (including long-term time series analyses, panel analyses, cross-sectional analyses and short-term natural experiments involving temporary closures). These studies suggest that patterns have been found between outlet density and alcohol-related harms, particularly violence, but also including outcomes as varied as child maltreatment, car crashes, pedestrian injuries, and sexually transmitted infections (STIs).

In some studies, however, alcohol-related harms did not appear to be related to outlet density. For example, there is research suggesting that in areas where outlet density is reduced, people may be prepared to travel outside their local area to purchase alcohol (Anderson and Baumberg, 2006).

An extensive review by Cameron et al. (2009), which includes New Zealand research, showed similarly mixed results regarding outlet density and harms. They suggest the differences between studies may reflect differences in local context and confounding variables, such as volume of alcohol sales and socio-economic level (Cameron et al. 2009). Their review also contains a content analysis of coverage of alcohol issues in the popular press. They conclude that media reports presented a strongly negative view of alcohol, and that these may be affecting the public's views of outlet density unduly.

Opponents argue that restricting outlet density is anti-competitive and gives an unfair advantage to certain retailers (Livingston et al., 2007; Donnelly et al., 2006). Others consider that there are advantages to the clustering of licensed premises, such as containing alcohol-related problems in a confined area and the ability to target resources, such as Police and public transport (Babor et al. 2003). There are also substantial commercial benefits for establishments in being located within entertainment precincts.

However, the additional harms associated with clustered premises can increase the costs of enforcement and can create neighbourhood problems with noise, public disorder and vandalism, and increase young people's exposure to advertising. This is particularly problematic in the case of unintentional clustering where there are not appropriate buffers for residents or sufficient enforcement resources (Livingston et al., 2007).

## 4.4 Demand reduction

Demand reduction strategies are the domain of central government rather than local government and tend to focus on:

- pricing and taxation
- advertising and marketing

## 4.5 Problem limitation

Problem limitation measures focus on reducing the incidence of alcohol misuse and the level of alcohol-related harm (Law Commission, 2009). Key approaches include:

- host responsibility
- licensing enforcement
- liquor bans
- education.

*Host responsibility (managing the drinking context)*

Good evidence for the effectiveness of interventions such as host responsibility is provided by the STAD (Stockholm Prevents Alcohol and Drug Problems) alcohol and drug prevention programme in Sweden, which ran for 10 years (Babor et al., 2010). Refusals to serve drunk people in project areas (550 licensed premises) demonstrated a drop in violent crime compared to rates in control areas (270 licensed premises).

A similar project in Surfers Paradise demonstrated marked decreases in violent crime over a two-year period, but this outcome was not sustained over a longer period.

The Rhode Island Community Alcohol Abuse/Injury Prevention Project found declines in injuries, assaults and motor vehicle accidents in areas served by participating liquor outlets (both on-licence and off-licence) compared with outlets in control areas. However, these gains were not maintained over time (Babor et al., 2010).

*Importance of enforcement*

Further investigation is required of the lack of long term success of programmes aimed at modifying the drinking context. One factor suggested by Babor et al. (2010) to account for the lack of sustained positive outcomes might lie in the levels of policing and enforcement. In the STAD project, policing remained vigorous throughout. In the others, there were indications that levels of enforcement were not maintained (Babor et al., 2010). A study on random breath testing in Australia concluded that people have to believe that there is a high risk of getting caught before they modify their behaviour (Homel, 1988).

New Zealand studies provide further support for the role of enforcement in achieving positive outcomes. Sim et al. (2005) found no sustained gains outside the time period of enhanced policing. Informal investigations using pseudo-patrons in the Waitakere City Council area also showed that in the period outside of concerted campaigns for effective implementation, many sales people lapsed into providing minors with alcohol without conducting the required age checks.

Another key domain of enforcement is in controlling drink-driving (Babor et al., 2010). Approaches including sobriety checkpoints, random breath testing, lower legal limits of blood alcohol concentration, "zero-tolerance" rules for young drivers, administrative licence suspension, and graduated licensing for young drivers all contribute to positive outcomes. Babor et al. (2010) conclude that overall "enhanced enforcement of laws and regulations by Police, liquor licensing, municipal authorities and others has been shown to be a powerful approach to reducing harms in the commercial drinking environment".

*Education*

ALAC argues that the main underlying driver of excessive drinking in New Zealand is a culture that tolerates and supports drinking, binge drinking in particular (ALAC, 2005). ALAC concludes that, whilst all other types of intervention are useful, changing the drinking culture is fundamental to achieving lower rates of alcohol-related harms. ALAC provides evidence in favour of this approach in relation to reduced tolerance of the public to drink-driving (ALAC, 2005; Cagney, 2006).

However Babor et al. (2010), Caswell et al. (2005) and Giesbrecht (2011) conclude that overall, compared to other intervention strategies, education is least effective in achieving behavioural changes. They argue that strategies based on pricing, raising the minimum legal drinking age, lowering the legal blood-alcohol limit for driving, restrictions on hours of trading and on the density of liquor outlets are likely to be the most effective, and enforcement of these is essential.

## 5. Role of local alcohol policy in decision-making

A matter that should be considered when providing direction on the policy is the extent to which the policy could "lock in" decisions regarding circumstances that Councillors cannot foresee when preparing the policy.

### 5.1 The legislation

Section 105 of the Act sets out the 'criteria for issue of licences'. It states, among other things, that:

"*(1) In deciding whether to issue a licence, the licensing authority or the licensing committee concerned must have regard to the following matters:*
*c) any relevant local alcohol policy*"

Similarly section 131 of the Act sets out the 'criteria for renewal'. It states, among other things, that:

"*(1) In deciding whether to renew a licence, the licensing authority or the licensing committee concerned must have regard to the following matters:*
*a) the matters set out in paragraphs (a) to (g), (j) and (k) of section 105(1)*"

### 5.2 The meaning of "must have regard to"

The Act is new and there is as no case law on interpretation of the meaning of "must have regard to". In considering this issue, the clearest and most illustrative parallel in case law concerns section 104 of the Resource Management Act 1991 ("RMA") which contains similar provisions when considering an application for a resource consent.

Case law from the RMA is clear that the directive "must have regard to" is not to be elevated to mean "must give effect to". Rather it is a requirement to give genuine attention and thought to the matters required to be considered, but they must not necessarily be accepted. Any or all of the matters may be rejected or given whatever weight the decision maker considers appropriate.

### 5.3 Implications for the local alcohol policy

In short, if the case law relating to the RMA was applied to the local alcohol policy provisions in the Sale and Supply of Alcohol Act then the DLC and ARLA need to "give genuine attention and thought" to the matters set out in the local alcohol policy, "but they must not necessarily be accepted". The specified matters must be considered but any or all of them may be rejected or given whatever weight the decision-maker considers appropriate.

In other words the local alcohol policy becomes a reference document for the DLC or ARLA to be consulted and considered. It does not become a document that binds their decisions.

Therefore, both the DLC and ARLA retain flexibility in their decision-making and can be guided by, but are not constrained by, the local alcohol policy.

It is noted that an exception to this is where provisions of the LAP are given statutory effect. This is the case with maximum trading hours where section 45 of the Act specifies that the maximum trading hours permitted are those specified in a LAP or any more restrictive hours specified as a condition of a licence. The DLC and ARLA cannot permit more permissive hours than those specified in the LAP.

## 6. Potential challenges to local alcohol policy provisions

Section 81 of the Act provides the right of appeal to decisions made by the councils in the development of a local alcohol policy. The scope of such appeals is defined in section 81(4) which states:

"The only ground on which an element of the provisional policy can be appealed against is that it is unreasonable in the light of the object of this Act."

Section 4 defines the object of the Act as follows:

"(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, disorderly behaviour, illness, or injury of a kind described in paragraph (a)."*

Given the narrow avenue for appeals, the object of the Act is critical to all decision-making during the development of a local alcohol policy.

## 7. Kinds of licence

Under the Act there are four kinds of licence: on-licences, off-licences, club licences, and special licences (section 13).

While there are four kinds of licence to consider, there are a number of sub-sets within each kind that elected members may wish to consider separately. These are set out in the following subsections of this paper.

### 7.1 Off-licences

Section 32 of the Act identifies the kinds of premises for which off-licences may be issued. The list identified in section 32 can be summarised as follows:

a) off-licence sales from all or part of a hotel or tavern
b) bottle stores and other retail premises where 85% of sales are of alcohol, such as specialist wine stores
c) remote sellers (mail-order or internet sales outlets)
d) places which manufacture alcohol, such as a winery or brewery
e) supermarkets (being over 1,000m$^2$), and grocery stores.

In addition to the above list, section 34 of the Act allows for an off-licence to be issued for premises not listed above if the sale of alcohol in premises listed under items (b), (d), (e), and (f) above would not be economic. This is effectively the 'rural clause' where an isolated premises not meeting the above definitions may be able to obtain an off-licence.

Finally, section 35 of the Act also permits an off-licence to be granted to a shop not in the above list if it is not a food shop but "alcohol would be an appropriate complement to goods of the kind sold (or to be sold) in the shop".

<u>Places that cannot be granted an off-licence</u>

Section 36 of the Act specifically excludes certain premises from being able to obtain an off licence. In full, section 36 states:

*The licensing authority or licensing committee concerned must not direct that an off-licence should be issued for any premises if (in its opinion)—*

*(a) the principal business carried on there is—*

*(i) the sale of automotive fuels; or*

*(ii) the repair and servicing of motor vehicles and the sale of automotive fuels; or*

*(b) they are a shop of the kind commonly thought of as a dairy; or*

*(c) they are a shop of the kind commonly thought of as a convenience store; or*

*(d) they are a conveyance; or*

*(e) they are situated (wholly or partially) within a shop; or*

*(f) the public can reach them directly from a shop, or directly from premises where the principal business carried on is a business of a kind described in paragraph (a).*

Note that section 36 overrides section 34 such that, even in areas where a 'normal' off licence would be uneconomic it is still not legal for a dairy, convenience store, or petrol station to hold an off-licence.

Difference between a grocery store and a dairy or convenience store

The Act attempts to draw a clear distinction between grocery stores, which can obtain an off licence, and dairies or convenience stores which cannot.

Section 33 provides the 2012 Act's definition of a grocery store as being premises where:

(i) a range of food products and other household items is sold; but

(ii) the principal business carried on is or will be the sale of food products.

For the purposes of this definition 'food products' does not include alcohol, confectionery, ready-to-eat food, snack food, or drink (other than milk) in containers smaller than one litre.

The Sale and Supply of Alcohol Regulations 2013 provide a methodology for determining the principal business utilising certified accounts.
Section 33 of the Act also makes it clear that the decision as to whether a particular premises is or is not a grocery store will be made by the licensing authority or licensing committee based on the specific facts of that case.

Auctioneers' off-licence

Section 20 of the Act allows that an auctioneer can obtain a specially endorsed off-licence to enable the sale of alcohol by auction in the course of his or her business.

Remote seller's off-licence

Section 18 of the Act allows that a person can obtain a specially endorsed off-licence to enable the sale of alcohol from the premises the licence is issued for and deliver it somewhere. They cannot sell alcohol on the premises as a normal off-licence allows. Section 49 of the Act exempts remote sales from any maximum trading hours restriction.

### 7.2 On-licences

As with off-licences there are a variety of different types of on-licence. The Act refers separately to, and in places includes different provisions for, the following types of on-licences:

- hotels
- taverns
- restaurants
- BYO restaurants
- conveyances (defined as an aircraft, coach, ferry, hovercraft, ship, train or other vehicle used to transport people), and
- airport bars.

In addition to the above, section 16 of the Act addresses caterers' on-licences which allow the holder to deliver alcohol from the premises for which the licence is held and "sell it on any other premises for consumption there by people attending a reception, function, or other social gathering promoted by a person or association of people other than the holder".

### 7.3 Club licences

Sections 21 and 60 of the Act provide that the holder of a club licence may sell alcohol for consumption on the premises to anyone who is:

- a member of the club, or
- on the premises at the invitation of, and accompanied by, a member of the club, or
- a member of some other club which has reciprocal visiting rights for members.

An off-licence may be issued in conjunction with a club licence (but not a sports club), but only for alcohol served to the people listed above.

### 7.4 Special licences

Section 22 of the Act defines two types of special licence: on-site special licences, and offsite special licences. Section 22 makes it clear that all special licences are for the purposes of events. On-site special licences can extend the normal licensed hours of an on-licensed or club licensed premises.

Off-site special licences allow the holder to sell alcohol at an event but for consumption elsewhere. In addition, the holder can supply alcohol, free of charge, as a sample for consumption on the premises for which an off-site special licence is granted.

## 8. Impact on existing venues and potential new venues

Section 133(1) of the Act states:

*"In considering whether to renew a licence, the licensing authority or licensing committee concerned must not take into account any inconsistency between a relevant local alcohol policy and—*

*a) the renewal of the licence; or*

*b) the consequences of its renewal."*

This means that existing premises for which a licence is to be renewed will not be affected by new provisions in a local alcohol policy regarding:

- the number or density of outlets, or
- the proximity of outlets to other facilities.

However, where there is a change of ownership of an existing premises, then the new owner will need to apply for a licence. This is considered to be a new licence rather than a renewal and as such will need to comply with any local alcohol policy provisions relating to the number of outlets and proximity and density. Consideration must therefore be given to the status of existing premises and the effect of the LAP on these.

Section 133(2) of the Act states:

*"The licensing authority or licensing committee concerned may impose particular conditions on any licence it renews if—*

- *there is any relevant local alcohol policy; and*
- *it considers that the renewal of the licence, or the consequences of the renewal of the licence, without those conditions imposed on it would be inconsistent with the policy."*

This means that existing premises for which a licence is to be renewed are likely to be affected by new provisions in a local alcohol policy regarding:

- hours of operation
- discretionary conditions
- one-way door restrictions

('Likely' as the legislative reference is "may" not "must" leaving a degree of flexibility for the licensing authority or licensing committee.)

Where there is a change of ownership of an existing premises, then the new owner will need to apply for a licence. This is considered to be a new licence rather than a renewal and is covered by section 109 of the Act which mirrors section 133(2) almost identically:

*"The licensing authority or licensing committee concerned may issue a licence subject to particular conditions if—*

*a) there is any relevant local alcohol policy; and*

*b) in its opinion, the issuing of the licence, or the consequences of the issuing of the licence, without those conditions would be inconsistent with the policy."*

Again this means that new licence applications are likely to be affected by new provisions in a local alcohol policy regarding hours of operation (being a condition of a licence). The parallel phrasing of sections 109 and 133(2) suggest that Parliament expected new and existing businesses to be treated equally with regard to conditions of licence such as trading hours.

However, given that both sections use the word "may" rather than "must" there is discretion for the District Licensing Committee or the licensing authority.

# 9. Matters that council must have regard to under section 78 of the Act

## 9.1 Objectives and policies of the district plan

Council has a district plan with two different sections covering the traditional Waikato district area (Waikato Section) and the former Franklin district area (Franklin Section). The

District Plan rules recognise the adverse environmental effects that often accompany licensed premises and the patrons using them. Premises involved in the sale of liquor have the potential to create adverse effects that conflict with the amenity of the neighbouring areas when they are open to the public late at night and located in close proximity to residential areas. For this reason, rules pertaining to the sale of liquor place restrictions on hours of operation and the location of the premises in relation to residential properties.

The key provisions of the District Plan as they relate to the sale of alcohol are as follows:

Waikato Section

### Chapter 11: Social, Cultural and Economic Wellbeing

| OBJECTIVES | POLICIES |
|---|---|
| 11.2.1<br>Towns, villages, neighbourhoods and localities have social coherence and a sense of place. | 11.2.6<br>Activities should avoid breaking up community and neighbourhood coherence, having particular regard to the cumulative effects of activities. |
| 11.2.7<br>Valued social and cultural characteristics of communities are retained. | 11.2.8<br>Activities should meet the needs of individuals and groups and be sensitive to the existing social and cultural characteristics of communities. |

### Chapter 13: Amenity Values

| OBJECTIVES | POLICIES |
|---|---|
| 13.2.1<br>Adverse effects of activities on amenity values are managed so that the qualities and character of the surrounding environment are not unreasonably compromised. | 13.2.2<br>Adverse effects associated with lighting, litter, electromagnetic radiation, vermin, traffic, spray drift, and noise should be contained within the site where they are generated.<br>13.2.4<br>Adverse effects that cannot be contained on the site where they are generated must be remedied or mitigated. |

| 13.2.6<br>Amenity values of localities are maintained and enhanced. | 13.2.7<br>Scale, intensity, timing and duration of effects of activities should be managed to be compatible with the amenity and character of the locality.<br>13.2.8<br>Activities with similar effects or a similar expectation of amenity should be located together.<br>13.2.9<br>Activities sensitive to noise, dust, smoke, odour, spray drift, lighting, litter, electromagnetic radiation, vermin or traffic should locate in areas where local amenity values are not already compromised by those effects.<br>13.2.10<br>Activities with dissimilar effects or a dissimilar expectation of amenity should be separated where possible.<br>13.2.11<br>The district should be divided into zones for the purposes of resource management. |
|---|---|

Franklin Section

Objective 19.4.1 – To permit a wide range of activities to occur within the district's established urban, commercial and urban industrial areas provided performance standards are achieved, and only allow business activities out of these area where any adverse effects can be appropriately and effectively addressed.

Policy 19.4.1.5 - That the development of sites for business and other activities be such as will ensure a standard of access, parking, loading, building development, and amenity that will safeguard:

- The safe and convenient use of adjacent properties;
- The intended character of the particular area as set out in Parts 37A and 40A
- The pleasantness of adjacent properties, particularly those not zoned business
- Pedestrian safety and convenience, particularly in defined business centres.

Policy 19.4.1.9 – That sensitive activities in or near the Business Zone, Tuakau Industrial Zone and the Tuakau Industrial Services Zone be expected to tolerate reasonable levels of effects typically experienced in Business areas. Sensitive activities likely to be affected by lawfully established air discharges from other activities in the Business Zone will be warned of the potential adverse effects of locating near such activities.

## 9.2 Number, location and hours of licences in the district

### 9.2.1 Number and location of licences

As at 23 September 2014 there were 141 permanent licences in force in the district, comprising 50 on-licences, 40 off-licences and 51 club licences. The number of licensed premises is slightly less since some premises hold more than one licence - eg hotels and taverns generally hold an on-licence and an off-licence. As at 23 September 2014 Council had also received 66 special licence applications in 2014. A breakdown of the types of premises in the main towns is given in Table 1.

**Table 1 - Alcohol Licences in Waikato District**

| | Ngaruawahia Town | Huntly Town | Raglan Town | Te Kauwhata Town | Tuakau Town | Rural | Totals |
|---|---|---|---|---|---|---|---|
| **On Licences** | | | | | | | |
| Hotel/Tavern | 2 | 2 | 3 | 1 | 2 | 8 | 18 |
| Cafe/Restaurant | | 4 | 8 | 1 | 2 | 9 | 24 |
| Function/Event Centre | | | | | 1 | 5 | 6 |
| Accommodation | | | 1 | | | 1 | 2 |
| Other | | | 1 | | | | 1 |
| | | | | | | | **50** |
| **Off Licences** | | | | | | | |
| Hotel/Tavern | 2 | | 2 | 1 | 1 | 6 | 12 |
| Standalone Bottle Store | 2 | 3 | 1 | | 1 | 1 | 8 |
| Supermarket | 1 | 1 | | | | | 2 |
| Grocery Store | 1 | 2 | 2 | 1 | 2 | 2 | 10 |
| Winery | | | | | | 1 | 1 |
| Club | | 1 | 1 | | 1 | 1 | 4 |
| Other | | 1 | | | 1 | 1 | 3 |
| | | | | | | | **40** |
| **Club Licences** | | | | | | | |
| Sports/Social Cub | 6 | 8 | 3 | 4 | 3 | 21 | 45 |
| Chartered Club | 1 | 2 | 1 | | 1 | 1 | 6 |
| | | | | | | | **51** |
| | | | | | | | |
| **Totals** | **15** | **24** | **22** | **8** | **15** | **58** | **141** |

### 9.2.2 Number and location of licences relative to population

Figure 1 below shows the number of licences relative to population for several towns within the Waikato region and indicates areas having the highest number of alcohol outlets per person. Raglan features in the top 10 (sixth) while other included towns of Ngaruawahia and Huntly do not feature highly.

**Figure 1 - Waikato region licences relative to population**
(Source: Waikato Times, 17 May 2013)

### 9.2.3 Hours of operation of licensed premises

Hours for which premises have been licensed have been set on a case by case basis in accordance with the type of premises and guided by alcohol policies developed by the council. These previous policies have no statutory effect but have been used to guide expectations. Council currently has two policies covering the traditional Waikato district and the former Franklin district areas, summarised in Table 2. Note that some licences have been issued with hours outside those indicated, including for example one or two hotels or taverns with closing times up to 3am instead of 1am and grocery stores or supermarkets with opening hours before 9am.

It should also be noted that in practice some licensees may not operate the full hours they are licensed for. This gives them a degree of flexibility in the operation of their business to meet the needs of customers. For example cafes or restaurants may have been granted hours from 7.00am but not usually open until 9.00am or later. The earlier hours allow them the flexibility to cater for special occasions, for example champagne breakfasts.

**Table 2: Current guideline policy hours**

| | Original Waikato District | Ex Franklin District |
|---|---|---|
| Hotels and taverns | 7.00am – 1.00am | 10.00am – 1.00am Sun - Thurs<br>10.00am – 3.00am Fri & Sat |
| Cafes & restaurants | 7.00am – 1.00am | 10.00am – 12.00 midnight |
| Function centres | 7.00am – 1.00am | 10.00am – 1.00am |
| Supermarkets, grocery stores | 9.00am – 11.00pm | 10.00am – 10.00pm |
| Off Licences in taverns/hotels | 9.00am – 11.00pm<br>(across the bar same as on licence hours) | Same as on licence up to one hour before closing |
| Club Licences (eg RSA, Workingmens, Cosmopolitan) | 7.00am – 1.00am | 10.00am – 1.00am Sun - Thurs<br>10.00am – 3.00am Fri & Sat |
| Sports clubs | Vary depending on the purposes and operation of the club but no later than 1.00am | Considered on a case by case basis related to hours and days when the club is engaged in its principal activity |
| Special licences | Vary depending on the proposed event but generally restricted to 1.00am | 1.00am Sun – Thurs<br>3.00am Fri, Sat & public holidays |

## 9.3 Alcohol control bylaw areas

### 9.3.1 Overview

Alcohol control bylaws prohibit people from possessing or consuming alcohol in specified public places. They do not apply to private property or licensed premises. The power to make bylaws for alcohol control purposes comes from section 147 of the Local Government Act 2002. The current provisions under section 147 came into force on 18 December 2013, with the Local Government (Alcohol Reform) Amendment Act 2012 introducing new provisions relating to alcohol control bylaws as part of the government's overall alcohol reform measures. The new provisions extend the definition of a public place to cover more areas used by the public than previously provided for. They also introduced criteria for making or continuing bylaws under new Section 147A, such that Council must be satisfied that the bylaw can be justified as a reasonable limitation on people's rights and freedoms, that there is evidence that the area to which the bylaw is intended to apply has experienced a high level of crime or disorder that can be shown to have been caused or

made worse by alcohol consumption in the area, and that the bylaw is appropriate and proportionate in the light of the crime and disorder.

It is also noted that when reviewing an existing bylaw, Council must be satisfied that the level of crime or disorder experienced before the bylaw was made is likely to return if the bylaw does not continue.

### 9.3.2 Current Alcohol Control Bylaws

Council currently has two alcohol control bylaws in force - the Waikato District Council Public Places Liquor Control Bylaw 2009 in respect of the traditional Waikato district area and the Franklin District Council Liquor Control Bylaw 2008 in respect of the area of the district in the former Franklin district.

The Waikato district bylaw provides for a 24 hour prohibition of alcohol in public places in the main township areas of Raglan, Ngaruawahia, Taupiri, Huntly, Te Kauwhata, and Meremere. It also applies to all council controlled cemeteries. Between 23 December to 6 January it also provides for an expanded area surrounding Raglan. There is also a ban between 10pm and 10am in all council controlled recreation reserves and parks.

The Franklin district bylaw provides for a ban in the Tuakau CBD and various reserves between 7pm to 7am daily. There is a 24 hour, 7 day per week ban at Sunset Beach.

The current bylaws are due to be reviewed in 2015.

### 9.3.3 Key Issues

The types of issues typically associated with drinking in public places include vandalism, litter, negative effects on business, noise, violence and disorder. Consumption of alcohol in public places is also widely considered to be a factor that influences people's perceptions of safety. However, liquor bans can also create problems of displacement, whereby drinkers move to areas with fewer restrictions. Moreover, the actual effectiveness of liquor bans depends heavily on the ability of the Police to enforce them.

*Enforcement*

Whilst numbers of recorded breaches provide an indication of the prevalence of public drinking, it is important to note that differences in enforcement and the ability for Police to use their discretion significantly limits the reliability of this data for measuring the effect of liquor bans, at least as an independent measure. As the enforcement of liquor bans is one of many policing activities, the level of enforcement will be influenced by a variety of factors such as other operational demands. The public also play a role by alerting the Police to areas where there are persistent breaches.

*Discretion*

As outlined above, the Police exercise discretion in enforcing liquor bans. Warnings are generally issued when people comply (such as being asked to tip out their liquor and leave the area). The test for more serious action is whether there is likelihood of violence, aggression or disorder, as shown by the person's demeanour. Repeat offences also result in more serious action. This indicates that the quantitative data showing the number of

recorded breaches represents only a small portion of the total number of actual breaches occurring across the district.

*Recorded Breaches*

Police data provided record breaches as follows:

| Year | Area | Number of breaches |
|---|---|---|
| 2007/2008 | Raglan | 3 |
| 2008/2009 | Raglan | 1 |
| 2009/2010 | Huntly | 2 |
| | Ngaruawahia | 2 |
| | Raglan | 1 |
| 2010/2011 | Ngaruawahia | 3 |
| | Raglan | 7 |
| 2011/2012 | Huntly | 1 |
| | Ngaruawahia | 4 |

### 9.4 Demography of the district's residents

This section summarises the demography of both the Waikato district's residents and of the people who visit the district as tourists or holidaymakers

#### 9.4.1 Population

The population of Waikato district from the 2013 census is 63381 representing 1.5% of New Zealand's population. Statistics New Zealand indicate that the population has increased by 5769 people or 10.1% since the 2006 census. Individual area populations and increase since the 2006 census are detailed in Figure 2 below.

**Figure 2 - Waikato district population**

| Town/area | Population (2013 census) | Percentage change since 2006 census |
|---|---|---|
| Ngaruawahia | 5127 | <1% |
| Huntly West | 2835 | -3.2% |
| Huntly East | 4119 | +5.4% |
| Raglan | 2736 | +3.6% |
| Te Kauwhata | 1473 | +23.4% |
| Tuakau | 4182 | +19.5% |
| Pokeno | 1782 | +4.4% |
| Maramarua | 1011 | +6.3% |
| Gordonton | 1137 | +19.6% |

### 9.4.2 Sex and Age

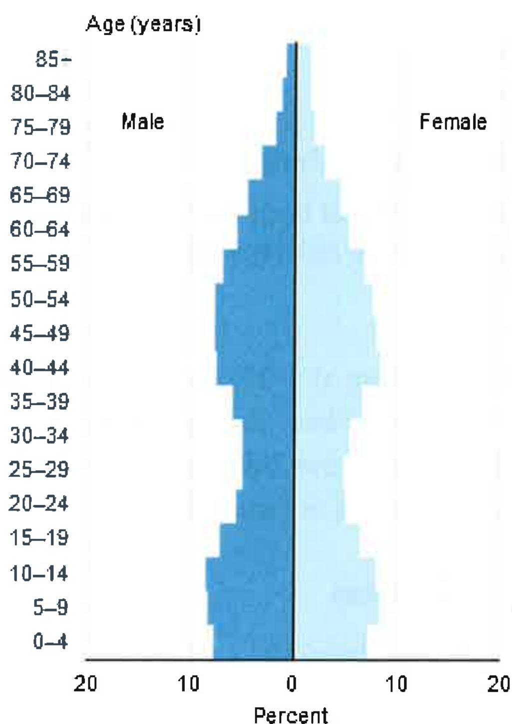
Statistics New Zealand report that:

- The median age (half are younger, and half older, than this age) is 38.2 years for people in Waikato District. For New Zealand as a whole, the median age is 38.0 years.
- 11.8 percent of people in Waikato District are aged 65 years and over, compared with 14.3 percent of the total New Zealand population.
- 24.0 percent of people are aged under 15 years in Waikato District, compared with20.4 percent for all of New Zealand.

The age ranges and sex profile is shown in Figure 3 below.

Due to the additions of the former Franklin district area in 2010 it is difficult to assess trends between census'.

**Figure 3 - Age and Sex Waikato District (2013 Census)**




Source: Statistics New Zealand

### 9.4.3 Ethnicity

The majority of residents in Waikato district identify as belonging to the European ethnic group (79.1%) with 24.2% identifying as belonging to the Maori ethnic group (some people identify as belonging to more than one ethnic group). The proportion of people of Maori ethnicity is considerably higher than the national average of approximately 15%.

Figure 4 below from Statistics New Zealand gives a breakdown of the ethnic groups in the Waikato district.

**Figure 4 - Ethnic groups in Waikato District and New Zealand**
2013 Census

| Ethnic group[1] | Waikato District (percent) | New Zealand (percent) |
|---|---|---|
| European | 79.1 | 74.0 |
| Māori | 24.2 | 14.9 |
| Pacific peoples | 3.5 | 7.4 |
| Asian | 3.8 | 11.8 |
| Middle Eastern, Latin American, African | 0.4 | 1.2 |
| Other ethnicity | | |
| New Zealander | 1.7 | 1.6 |
| Other ethnicity nec | 0.0 | 0.0 |
| Total other ethnicity | 1.8 | 1.7 |

1. Includes all people who stated each ethnic group, whether as their only ethnic group or as one of several. Where a person reported more than one ethnic group, they have been counted in each applicable group. As a result percentages do not add up to 100.
Note: nec = not elsewhere classified.
**Source:** Statistics New Zealand

### 9.4.4 Deprivation

Socio-economic status is also a determinant of drinking behaviour (independent to differences based on age, gender or ethnicity). Drinkers among lower socio-economic groups tend to drink more on a typical occasion (Law Commission, 2009). By comparison, drinkers among higher socio-economic groups tend to drink more frequently (Law Commission, 2009).

Research indicates that the location of both on and off licence premises can impact on the amount of harm that is caused by alcohol. A deprivation value of 10 indicates that the meshblock/area is in the most deprived 10% of areas in New Zealand. A meshblock is evaluated against a set of criteria which determine where its deprivation index. These include income, home ownership, qualifications, living space, and access to communications and transport.

The location of alcohol outlets can be assessed against deprivation information for that area.

This may be able to give information on what parts of society have the greatest access to alcohol. A large proportion of off-licence alcohol outlets in the district are in areas with a deprivation score of 7 or higher, with the greatest concentration of off-licences in areas where social deprivation is rated 9-10. This would suggest that the most vulnerable members of society have the greatest access to alcohol from off-licences. It is noted that the main centres of Huntly, Ngaruawahia, Raglan and Tuakau all have a deprivation index of either 9 or 10. Te Kauwhata has a deprivation index of 7.

## 9.5 Demography of the district's tourists and holidaymakers

### 9.5.1 Overview

Visitor expenditure in the Waikato district is estimated to have increased from $86 million in 2009 to $96 million dollars in 2013. The majority of this is from domestic visitors from Auckland and the wider Waikato region with approximately $29 million of expenditure in 2013 from visitors from Auckland and $39 million from visitors from around the Waikato region.

The Waikato district has iSite information centres located in Huntly and Raglan. Visitor information from these centres shows visitor growth from 82600 in 2012 to just under 90000 in 2013. Figure 5 below shows the origins of visitors utilising the iSite centres.

The number of free independent travellers, typically those hiring campervans and caravans as well as friends and family, visiting the Waikato is increasing.

**Figure 5 - iSite Visitors**

| iSite Visitors (1 July - 30 June) | Huntly | | Raglan | |
|---|---|---|---|---|
| **Country of Origin** | **2012 - 2013** | **2011 - 2012** | **2012 - 2013** | **2011 - 2012** |
| Asia | 16132 | 11050 | 802 | 557 |
| USA/Canada | 12015 | 11922 | 1678 | 696 |
| UK/Europe | 14022 | 16558 | 4683 | 3510 |
| Australia | 13351 | 11179 | 687 | 539 |
| New Zealand | 7954 | 6085 | 8723 | 10423 |
| Other | 8900 | 8990 | 960 | 1084 |
| **Totals** | **72374** | **65784** | **17533** | **16809** |

### 9.5.2 Impacts for sale and supply of alcohol

Raglan and its beaches are a major visitor and holiday attraction, particularly over the summer months where the population can more than double. The impact of this requires consideration in respect of the economic opportunities to service the expectations of visitors in respect of entertainment venues, restaurants and ability to purchase alcohol for consumption at their accommodation.

## 9.6 Overall health indicators of the district's residents

### 9.6.1 Health Indicators - Waikato DHB Future Focus

The Waikato DHB covers the traditional Waikato district area but excludes that area of the district coming from the former Franklin district which is covered by the Auckland Regional Public Health Service.

The Waikato DHB Future Focus report provides a comparison of key findings for each territorial authority in the WDHB region. This shows that in the area of the district covered, Waikato district has higher average incidences of chronic medical conditions that affect the population relative to other districts. For Waikato district the overall population has:

- Rate of mortality
- Rate of avoidable mortality
- Rates of mortality 0 - 14 years
- Rates of mortality 15 - 24 years
- Percentage of people living in multi-family households
- Percentage of overcrowding
- Rates of bronchiolitis (inflammation of the airways) hospitalisations in under one year
- Percentage of mortality due to diabetes mellitus

The Maori population has above average rates of:

- asthma hospitalisation
- pneumonia hospitalisation
- decayed missing and filled teeth at age 5 years
- rates of COPD (lung disease) hospitalisation

### 9.6.2 Life Expectancy

Life expectancy at birth indicates the total number of years a person could expect to live, based on the mortality rates of the population at each age in a given year or period. The breakdown of life expectancy information is provided by territorial authority level below against the national and regional data. The information shows the Waikato district life expectancy is below the national and regional average for males and slightly below the averages for females in the latest figures shown.

| | 2005 - 2007 | |
|---|---|---|
| | **Males** | **Females** |
| **Waikato district** | 75.6 | 80.7 |
| **Waikato region** | 77.2 | 81.8 |
| **New Zealand** | 78.0 | 82.2 |

## 9.7 Nature and severity of alcohol-related problems

Information relating to the nature and severity of Waikato district's alcohol-related problems was sought from the NZ police. A data pack was received in 2013 that provided limited information and did not include information for the former Franklin district. For a number of reasons the Police cannot estimate the true level of alcohol related offending in any community.

### 9.7.1 Sale of Alcohol

The sale of alcohol is now regulated under the Sale and Supply of Alcohol Act 2012 which came fully into force on 18 December 2013. The data on offences provided by the police relates to the previous Sale of Liquor Act 1989 (SOLA).

Offences under the SOLA can be sanctioned through the district courts or the Liquor Licensing Authority (LLA), now the Alcohol Regulatory and Licensing Authority (ARLA).
A specific group of offence codes are used by the Police to record breaches of the SOLA. Offences address the following matters:

- breaches in operating hours
- alcohol and minors
- specific licensee or manager obligations
- unlicensed sale of alcohol.

Between 2007 - 2012 five Sale of Liquor Act offences were recorded, four in Huntly and one in Raglan. Four of these were in 2007 - 2008 and one in 2011 - 2012.

Records of infringement notices issued for alcohol related offences are shown below.

| | 2007 - 2008 | 2008 - 2009 | 2009 - 2010 | 2010-2011 | 2011-2012 |
|---|---|---|---|---|---|
| **Huntly** | | | | | |
| Person under 18 drank liquor in a public place | 5 | 1 | 1 | | 1 |
| Person under 18 had liquor in a public place | 3 | | | | 1 |
| | | | | | |
| **Ngaruawahia** | | | | | |
| Person under 18 in supervised area in licensed premises | 1 | | | | |
| Person under 18 drank liquor in a public place | 3 | | | | |
| Person under 18 had liquor in a public place | 2 | | 1 | | 1 |
| | | | | | |
| **Raglan** | | | | | |
| Person under 18 drank liquor in a public place | 1 | | | | |
| Person under 18 had liquor in a public place | 3 | | 2 | 2 | |
| | | | | | |
| **Totals** | **18** | **1** | **4** | **2** | **3** |

## 10. Contents of Policy - Background Information and Opinions

This report presents a summary of evidence and opinions on six specific elements of licensing policy that may become part of a local alcohol policy:

- location and density of outlets
- proximity of outlets to other licensed premises
- proximity of outlets to other facilities
- trading hours
- one-way door restrictions, and
- discretionary conditions.

Background information is drawn from the Law Commission's report 'Alcohol in our lives: curbing the harm'. A full copy of the Law Commission's report can be obtained at http://lawcom.govt.nz/project/review-regulatory-framework-sale-and-supply-liquor?quicktabs_23=report

### 10.1 Consultation

Section78(4) of the Act requires a local authority to consult with the Police, Medical Officer of Health and the licensing inspectors before producing a draft policy. Comment was sought from these agencies. The Police have not provided specific written comment but their views through verbal conversations are reported below.

The Medical Officer of Health and licensing inspectors have provided written responses detailing their opinions, attached as Appendices Aand B respectively. The Waikato District Health Board 'Population Health' unit is working under delegation from the Medical Officer of Health. It is noted that Auckland Regional Public Health Services were also contacted for comment in respect of the former Franklin district area but advised that they discussed the matter with the Waikato DHB and agreed that it would be most practical for Council to liaise with the Waikato DHB with regard to that area.

Community engagement

- As part of the pre-engagement process a community survey was undertaken in July 2013. A limited response of only 56 responses was received. A summary of the results is included as Appendix C.
- Further public meetings were held in August 2014 where feedback was received from those attending on specific questions. A summary is included as Appendix D.

One submission from Tuakau indicated they felt that the number of respondents to the survey was "way too small to represent 64,000 people's opinion to use for law change seeing 50% of those votes would be people with financial interest for their own gain".

Other Stakeholders

Hospitality New Zealand has provided a research document "Alcohol policy in New Zealand communities - A review of research and trends" together with specific comment on issues that a LAP can address. These are attached as Appendix E.

## 11. Location, Number and density of outlets: background evidence and opinions

### 11.1 Law Commission's Alcohol in our lives: curbing the harm, 2010

The Law Commission includes extensive analysis relating to the availability of alcohol in Chapter 6 of its report.

The Law Commission considered the association between alcohol outlet numbers and density and three variables: alcohol consumption; alcohol-related harm; and community degradation.

Key messages in the Law Commission's report include:

- Research suggests a discernible relationship between a high concentration of outlet numbers and alcohol consumption at a neighbourhood level. (para 6.9)
- Several international studies have also pointed to an association between outlet density and local levels of alcohol consumption. (para 6.10)
- A significant New Zealand study found a statistical link between binge drinking and the number of outlets. It reported "a 4% increase in binge drinking associated with each extra off-licence within 1km of home". (para 6.12)
- Not all surveys are as conclusive, with the authors concluding that the risk posed by clustering of outlets will vary from one community to another. (para 6.13)
- International alcohol researchers have concluded that "there is a substantial body of evidence linking gradual changes in outlet density to alcohol-related problems, particularly violence." (para 6.18)
- The same New Zealand survey as noted above found statistically significant associations between outlet density and alcohol related harm for all outlet types examined. Of these, the association was strongest for club-licences and off-licences. (para 6.21)
- A study in Manukau found an association between the number of on- and off-licences and total police events. Every one extra off-licence per 10,000 population is associated with 59 extra police events, while every one extra on-licence per 10,000 population is associated with an additional 42 police events. (para 6.25)
- Reducing outlet density is likely to reduce rather than merely displace much of the offending and anti-social behaviours that are associated with outlet clustering. (para 6.34)
- "... the occurrence and accumulation of secondary harms associated with high outlet density can contribute to the degradation of community wellbeing." (para 6.39)

The Law Commission's conclusion is stated in paragraph 6.40.

"The conclusion that can be drawn from the above discussion is that the risks posed by outlet density will vary from neighbourhood to neighbourhood. For some areas, a concentration of outlets may be associated with increased consumption, particularly amongst younger people, higher levels of harmful drinking as evidenced by more alcohol related crime or anti-social behaviours, or a variety of secondary harms that can undermine community wellbeing. Equally, high outlet density in other areas may have little or no effect in terms of these three outcomes. While the research is certainly not unanimous, the body

of studies indicating that outlet density can be problematic for some communities is substantial."

## 11.2 Police opinion

While the police have not provided specific comment, verbal conversations indicate that they consider off-licence premises should not be located in industrial areas, similar to their stance in respect of the Psychoactive Substances Policy. They consider that there is a risk of greater levels of damage to neighbouring properties and attraction to boy racer and associated persons and groups if off-licences are established in these areas.

The police consider that licensed premises should be located in retail precincts and that there should be restrictions on proximity to sensitive community areas such as schools, such as restricting licensed premises from access streets to schools and community centres.

Police generally support a cap on the number of premises (density) based on population, geographic location, demographics, and the type of licensed premises.

## 11.3 Medical Officer of Health opinion

The Medical Officer of Health referenced a number of studies and then concluded as follows:

"Evidence suggests that there is a strong link between the availability of alcohol and alcohol related harm. Most studies consider *availability theory* when examining the relationship between alcohol outlet density and alcohol related harm, e.g. greater availability of alcohol leads to greater consumption of alcohol which leads to negative social outcomes. Studies have generally found that in areas where there is greater availability of alcohol through a high density of outlets, there is a higher level of alcohol consumption. This often leads to higher levels of alcohol harm, antisocial behaviour and alcohol related offences."

"Managing, capping and reducing alcohol outlet densities is likely to have a positive effect in reducing alcohol-related harm. Studies have indicated that higher density of alcohol outlets (resulting in greater availability) may lead to increased consumption of alcohol and associated harms. There is also evidence that a large proportion of off-licence stores in the Waikato District Council and the greater Waikato District Health Board are in areas of high deprivation, where harms to vulnerable members of the community may be even higher."

"It is clear from the data provided in section 4 above that a large number of off licences are located in areas of high deprivation. This is likely to lead to a greater level of harm for people living in these areas than for those located in areas of low deprivation."

The Medical Officer of Health then provided the following recommendations:

- Population Health advocates for council to adopt risk rating procedures, as described in section 5 above, that take into account the health risks associated with greater availability of alcohol within lower socio-economic areas. A greater availability of alcohol leads to greater levels of consumption, which in turn is likely to lead to a greater amount of alcohol related harm, both acute and chronic. Population Health strongly advocates for this to be a key consideration in granting and controlling alcohol licensing under the Local Alcohol Policy.

- Population Health does not expect a licence to be declined solely on the basis that it is within an area of high deprivation. However, the potential risks that are associated with this should be addressed to ensure they are mitigated to a reasonable degree.
- Population Health advocates for Waikato District Council to cap the number of alcohol licences granted at its current level. This will, over time, reduce the number of alcohol licences in high deprivation areas and decrease harm caused by them".

### 11.4 Inspectors' opinion

Inspectors consider that the only restriction on location of licensed premise should be that they are located in areas permitted by the Resource Management Act, which is the default requirement of the Act. In urban areas it is expected that this be in commercially zoned areas.

The question of the number and types of premises needs to be considered carefully so as not to preclude the introduction of premises that have no detrimental effect. In on-licensed premises alcohol is more expensive and consumption is controlled. Cafes and restaurants are rarely indicated in cases of alcohol abuse or disorder.

The increase in tavern type premises is of more concern as the emphasis of these premises is the consumption of alcohol as opposed to food. There is also likely to be higher levels of noise emitted and more scope for the amenity and good order of the locality to be reduced.

Off licences are of greater concern in that they sell alcohol that is cheaper and in the case of stand- alone off licences sell alcohol that is more appealing to the young (eg RTDs).

The Inspectors note that there must be evidence to support any cap that may be placed on the issue of any further licences. They note that the density of off-licences in Huntly, Ngaruawahia and Raglan is high and suggest that Council could consider restricting the number of standalone bottle stores in these areas. The case is less clear in Te Kauwhata and Tuakau.

The Inspectors do not consider that restricting other types of off-licence or any other kinds of licence is warranted.

### 11.5 Community Opinion

The results from the survey and public meetings indicate that:

- The large majority across the district did not think there were too many on-licences or club licences in their area.
- On average a small majority across the district thought there were too many off-licences in the district.
- A large majority in Huntly and Ngaruawahia thought there were too many off-licences in their towns.
- A smaller majority in Raglan thought there are too many off-licences in their town.
- A majority in Te Kauwhata and Tuakau did not think there were too many off-licences in their town.
- Most concern was expressed in respect of bottle stores, followed by grocery stores.

One submission from Tuakau urges Council "to have the courage to make tough decisions to restrict the harm that alcohol and gambling has on our communities" although does not specifically state what decisions are sought.

One submission from Huntly notes that "I am totally against any liquor/gaming/gambling licences in Huntly and surrounds" and "I know that a dry area would never happen :) ! So therefore I would support any move that would restrict licences and decrease the number of licences. I personal think that the supermarket and two other liquor stores plus onsite licences would be more than adequate to service the needs of the community."

### 11.6 Other stakeholder opinion

Hospitality NZ (Appendix E) submit that limiting the issue of further licences, particularly on-licences, would be detrimental to tourism, economy, growth and development of the region and the development of the on-premises industry itself. They submit that if Council chooses to apply any density controls to types of on-licence they should not apply to existing premises.

The industry in general has also made it clear that they do not support restricting or capping the number of licensed premises, including off-licences.

## 12 Proximity to premises of a particular kind: background evidence and opinions

### 12.1 Law Commission's Alcohol in our lives: curbing the harm, 2010

The Law Commission did not specifically address the issue of the proximity of alcohol outlets to particular types of premises or other licensed premises apart from the commentary on density of outlets.

### 12.2 Police opinion

Police have not indicated any preference for a separation between licensed premises.

### 12.3 Medical Officer of Health opinion

The Medical Officer of Health did not specifically refer to proximity restrictions between licensed premises, focusing on the visual impact especially where it is visible to children or underage young people. The relevant elements of the Medical Officers of Health response are repeated below.

"There is increasing evidence of the visual impact of alcohol outlets, especially to young people. As the number of off licences has grown, so has the visual impact of marketing.

The proliferation of licensed premises and the impact of these on the communities in which they have appeared was one of the drivers for the present Act. While the impact of liquor premises is obviously multi faceted and includes implications for health, as well as crime and disorder, an inescapable issue which is high on the public agenda is the visual impact.

It is useful to break this into two considerations:

The "eyesore" issue

Many liquor store frontages have been dominated by signage giving the names of alcoholic products and the prices or 'specials' relating to them. The standard of sign writing has sometimes been such that there has been little to distinguish this in quality from graffiti. Like graffiti this sign writing impacts the aesthetic values of the community (Image 1).

While some liquor stores have taken this issue to an extreme, the issue is not specific to liquor stores. Other councils (e.g. Auckland) have passed bylaws to limit this shop front advertising, but bylaw enforcement has been resource difficult. In the case of licensed premises, compliance with visual impact restrictions can be a condition of the licence. The onus to ensure compliance then falls to the licensee as a suitability issue.

Visual impact restrictions are envisaged to include a percentage figure of the shop front area that can be signage. It is important that the restriction is compatible with, but not necessarily the same as, what may be imposed by a future bylaw. For example, if a licensed premises was permitted a maximum of 25% of the shop front area for alcohol related signage, this would be compatible with a by law that specified a maximum of 40% for all signage. Auckland currently stipulates 50% for all signage. Measurement of the actual percentage is achieved either by measuring the actual area of signage or by placing a grid pattern over the image of the shop front (Image 2, Ngaruawahia Cheep Liquor).

Product promotion signage

Liquor stores are generally located in high public use areas with significant foot traffic, which includes children. The impact of brand depiction on levels of brand recognition, alignment and preference among young people has resulted in regulation limiting brand depiction in the media to certain times of the day. In the case of tobacco, regulation has placed a ban on all brand marketing at points of sale accessible to young people. However brand depiction of alcohol on shop fronts continues to be visible to all age groups at all times of the day (Images 3 and 4).

The Medical Officers of Health then provided the following recommendations:

- Population Health advocates for the acknowledgement of the visual impact of off-licence premises (as defined in Section 17 of the Sale and Supply of Alcohol Act2012) within the Local Alcohol Policy as a discretionary condition. There is a connection between exposure to alcohol marketing and consumption, particularly in young people.
- Population Health advocates that the Local Alcohol Policy provide for restrictions on the visual impact of off licences as part of the licensing conditions, and along with additional restrictions on hours of operation, place more stringent visual impact limitations for those near schools. Restrictions would include a maximum area of advertising as a proportion of the shop front area and a restriction or ban on product marketing where it is visible or accessible to children or underage young people.

### 12.4 Inspectors' opinion

Inspectors have noted that in general they consider adequate provision for considering proximity is made within the default criteria of the Act when assessing a licence application.

They also suggest a separation of one kilometere between a proposed bottle store, supermarket or grocery store from any existing bottle store, supermarket or grocery store.

They do not consider there is any basis for a separation requirement for cafes, restaurants, hotels or taverns in a commercial zone, remotes sellers or other complementary sales off-licences.

### 12.5 Community opinion

Comment was not specifically sought on any separation between licensed premises at the public meetings.

The survey asked if there should be a minimum separation between off-licence premises. Responses indicated that 60% consider a separation should be imposed with most considering a separation of 1 km or more appropriate.

### 12.6 Other stakeholder opinion

Hospitality New Zealand (Appendix E) do not support any restrictions in relation to proximity between on-licence premises and that there is no evidence to support any restrictions. They submit that if Council chooses to apply any proximity controls to types of on-licence they should not apply to existing premises.

## 13. Proximity to other facilities: background evidence and opinions

### 13.1 Law Commission's Alcohol in our lives: curbing the harm, 2010

The Law Commission did not specifically address the issue of the proximity of alcohol outlets to other facilities including education facilities.

They did include a section on 'Alcohol's impact on children' (para 3.76 to 3.96) though most of that section deals with secondary impacts on children of other people's drinking. The Law Commission also recognised the importance of reducing accessibility issues for school-aged persons:
"... it is more appropriate for licensed premises to open after schools have started in the morning. This means the opportunities for young people to gain access to alcohol before school starts are reduced." (para 9.44)

### 13.2 Police opinion

Police would generally like to see restrictions on location of premises around sports grounds, community centres, churches early childhood centres and schools etc. Police have concerns about advertising exposure and the normalization of alcohol in young people. This would include access corridors to these facilities.

### 13.3 Medical Officer of Health opinion

The response from the Medical Officers of Health did not specifically reference the proximity of alcohol outlets to places of worship and other facilities.

### 13.4 Inspectors' opinion

Inspectors have noted that the only type of premises they consider it may be appropriate to prescribe a general separation distance from a "sensitive site" is in respect of standalone bottle stores and any premises that may operate in the manner of a tavern. They consider that 100 metres is an appropriate distance.

The do not consider it appropriate to consider any separation requirement for premises where sale of alcohol is not the primary focus of the business.

### 13.5 Community opinion

- A large majority of respondents across the district consider that all licensed premises should have a separation requirement from a "sensitive site" including schools, early childhood centres, places of worship and community halls.
- The most popular distances for places which sell alcohol to be located away from the facilities noted above was greater than 100m at the public meetings and greater than 500 metres from survey respondents.

### 13.6 Other stakeholder opinion

Hospitality NZ (Appendix E) do not agree that any restriction in relation to proximity is appropriate or that there is sufficient evidence to support any such restrictions. They expressed particular concern that there is little or no regulation around the establishment of "deemed sensitive sites" and that these can literally pop up almost anywhere at any time. They also submit that if Council chooses to apply any proximity controls they should not apply to existing premises.

Major off-licence retailers promote themselves as responsible retailers of alcohol and as such do not believe they should be restricted from opening close to particular facilities and premises.

Supermarket and grocery stores chains believe that if Council was to introduce locality based restrictions in the LAP, supermarkets and grocery store licences should be distinguished from other specialist liquor stores.

## 14. Hours of operation: background evidence and opinions

### 14.1 Law Commission's Alcohol in our lives: curbing the harm, 2010

The Law Commission includes extensive analysis relating to the availability of alcohol in Chapter 9 of its report.

Key messages in the Law Commission's report include:

- "In addition to density of outlets, the hours in which alcohol may be sold is also a factor affecting the availability of alcohol and, therefore, the level of alcohol-related harm." (para 9.24)
- Pre-1989 assumptions that unrestricted opening hours would not increase harm have been found to be wrong. (paras 9.27 and 9.28)
- Quoting a 2007 World Health Organisation report: "In general, reducing the hours or days of sale of alcohol beverages results in fewer alcohol-related problems, including homicides and assaults." (para 9.30)
- Various international studies have noted that changes to hours of sale have been associated with changes in alcohol-related harm. (para 9.31)
- "This international research indicates there is a relationship between hours of sale of alcohol and alcohol-related harm, by showing both an increase in harm when hours are increased and a decrease in harm when hours are reduced. This signifies that limiting trading hours for the sale of alcohol is a key policy lever for reducing alcohol related harm." (para 9.36)

The Law Commission's recommendations were as follows:
- Maximum hours for off-licences should be 9am to 10pm.
- Maximum hours for on-licences should be 9am to 4am (with one-way door restrictions from 2am – one-way door restrictions are covered in section 11 of this paper).

Note that when turning the Law Commission's Alcohol in our lives report into the Sale and Supply of Alcohol Act, Parliament established standard maximum hours which are more liberal than those recommended by the Law Commission (Section 43):
- Off-licences – 7am to 11pm
- On-licences and club licences – 8am to 4am

### 14.2 Police opinion

Police take the general view of "Longer hours, greater availability, greater harm"

Generally the Police are comfortable with the norm for on-licences of 8.00 am to 1.00 am.

The Police consider that Off-licence hours should be 10.00 am to 9.00 pm for all off licences including supermarkets, grocery stores and club off-licences.

Police consider that a special licence for a non-licensed venue should be limited to no more than the hours for a normal on-licence. For a special license for licensed venues, hours should be no longer then 1 hour beyond normal hours of trade.

### 14.3 Medical Officer of Health opinion

The relevant elements of the Medical Officers of Health response are repeated below.

Studies are quoted which link increased trading hours for licensed premises with increased harm.

"Population Health views opening hours as a key component to addressing some of the more harmful types of alcohol consumption within Waikato District. It is important to acknowledge the harm that extended opening hours can bring, and address these as part of the Local Alcohol Policy."

The opening hours advocated below strike a balance between the potential health impacts on communities of alcohol availability and the needs of the hospitality and alcohol industry. Extended opening hours ensures alcohol is available to more people for longer periods of time. Late closings are likely to benefit people who are already under the influence of alcohol. However, long opening hours for neighbourhood off licences invite crime and poor health outcomes for those living in the community. This is especially problematic for those in areas of high deprivation, which have the greatest number of off licences in Waikato District.

The Medical Officer of Health recommends the following opening hours:

| | **Opening time** | **Closing time** |
|---|---|---|
| Off licence | 9:00 am | 9:00 pm |
| On licence (urban Sunday-Thursday) | 10:00 am | 10:00 pm |
| On licence (urban Friday-Saturday) | 10:00 am | 1:00 am |

"Population Health would further **advocate** for no exceptions or exemptions to these hours, including in cases of supermarkets."

### 14.4 Inspectors' opinion

The Inspectors note that the historical closing time of on licence and club licence premises has been restricted to 1.00 am with some premises having been granted up to 3.00 am closing. They note that very few issues arise in respect of the operation of licensed premises in the district.

They also note the provisions of the Sale and Supply of Alcohol (Fees) Regulations 2013 which set fees based on risk of the premises. Weightings for hours of operation of premises do not apply until after 2am after which it is recognised that greater alcohol related issues arise.

The Inspectors note that guests in hotels should be able to be provided alcohol at any time to provide for minibars.

The Inspectors also note that RSAs should be able to open as early as 5am on Anzac Day to provide for Anza commemorations. This is a common provision in other LAPs.

The Inspectors note a variance of opinion in respect of the latest closing time in urban areas for hotels, taverns and function centres with some advocating 2.00 am during weekends as being reasonable while others prefer restricting times to 1.00 am due to noise issues and lack of police resources in the early hours in places such as Raglan. Subject to this proviso the Inspectors have indicated they consider the following hours appropriate for on-licences and club licences:

Restaurants 8.00 am - 1.00 am

| | |
|---|---|
| Function Centres | 8.00 am - 1.00 am (Urban commercial zone areas Sunday - Thursday)<br>8.00 am - 2.00 am (Urban commercial zone areas Friday & Saturday)*<br>8.00 am - 1.00 am (All other areas) |
| Caterer's On-Licence | 8.00 am - 1.00 am |
| Taverns | 9.00 am - 1.00 am (Urban commercial zone areas Sunday - Thursday)<br>9.00 am - 2.00 am (Urban commercial zone areas Friday & Saturday)*<br>9.00 am - 1.00 am (All other areas) |
| Hotels | 9.00 am - 1.00 am (Urban commercial zone areas Sunday - Thursday)<br>9.00 am - 2.00 am (Urban commercial zone areas Friday & Saturday)*<br>9.00 am - 1.00 am (All other areas)<br>At any time on any day to a person residing on the premises |
| Other on-licences | 8.00 am - 1.00 am |
| Sports/Social Clubs | 9.00 am - 1.00 am |
| Chartered Clubs | 9.00 am - 1.00 am (Urban commercial zone areas Sunday - Thursday)<br>9.00 am - 2.00 am (Urban commercial zone areas Friday & Saturday)*<br>9.00 am - 1.00 am (All other areas)<br>RSAs from 5.00 am on Anzac Day |

* Not supported by all Inspectors

For outdoor dining areas in a public area it is considered that hours should be restricted to 11.00 pm.

In respect of off-licences the Inspectors note that closing times have historically been set at 11.00 pm although across the bar sales have been permitted in hotels and taverns until the closing time of the on-licence. The Inspectors do not support this later provision for across the bar sales.

The Inspectors again note the provisions of the Sale and Supply of Alcohol (Fees) Regulations 2013 that set fees based on risk of the premises. Weightings for hours of operation of premises do not apply until after 10.00 pm after which it is recognised that greater alcohol related issues arise.

The Inspectors note that "in hotels and premises where alcohol is the principal focus of the business such as bottle stores it is considered that the appropriate earliest opening time is 9.00 am. In grocery stores, supermarkets and other premises where alcohol is complementary or ancillary to the main business it is considered that 7.00 am is an appropriate opening time to allow complementary sale with the main products sold."
The Inspectors have identified they consider the following hours appropriate for off-licences:

| | |
|---|---|
| Bottle Stores | 9.00 am - 10.00 pm |
| Hotel/Taverns | 9.00 am - 10.00 pm |

| | |
|---|---|
| Grocery Stores/Supermarkets | 7.00 am - 10.00 pm |
| Club Off-Licences | 9.00 am - 10.00 pm |
| Other Off-Licences | 7.00 am - 10.00 pm |

The Inspectors do not consider that the LAP should specify maximum trading hours for special licences due to the range of situations that may arise requiring a licence. Rather they consider that the DLC set hours on a case by case basis. They do recommend that guideline hours are indicated between 7.00 am and 1.00 am.

### 14.5 Community survey responses

At the public meetings attendees were presented some potential hours and asked to indicate whether they thought these were about right, or should be more or less restrictive.

The hours presented were:

| | |
|---|---|
| Hotels and Taverns | 9.00 am – 1.00 am Sunday to Thursday<br>9.00 am – 2.00 am Friday and Saturday |
| Cafes/Restaurants | 7.00 am to 1.00 am |
| Bottle Stores | 9.00 am to 10.00 pm |
| Grocery stores and supermarkets | 7.00 am to 10.00 pm |
| Clubs | 9.00 am to 1.00 am |

Hotels and Taverns (9.00am – 1am, Sunday – Thursday; 9.00am - 2.00am Friday & Saturday)

- Across the district 50% of people thought the proposed hours were appropriate while 45% thought they should be more restrictive.
- In Raglan and Ngaruawahia opinion was evenly divided with 50% considering the hours appropriate while 50% thought they should be more restrictive.
- In Huntly 42% thought the hours were appropriate while 58% thought they should be more restrictive.
- In Te Kauwhata 52% thought the hours were appropriate while 48% thought they should be more restrictive.
- In Tuakau 52% thought the hours appropriate while 29% thought they should be more restrictive and 19% thought they should be more permissive.

Cafes/Restaurants (7.00am – 1.00am)

- Across the district 57% of people thought the proposed hours appropriate while 39% thought they should be more restrictive and 4% thought they should be more permissive.
- In Raglan 64% of people thought the proposed hours appropriate while 36% thought they should be more restrictive.
- In Ngaruawahia 43% considered the hours appropriate while 43% thought they should be more restrictive and 14% thought they should be more permissive.
- In Huntly 70% thought the hours were appropriate while 30% thought they should be more restrictive.
- In Te Kauwhata 53% thought the hours were appropriate while 47% thought they should be more restrictive.
- In Tuakau 53% thought the hours appropriate while 37% thought they should be more restrictive and 11% thought they should be more permissive.

Bottle stores (9.00am – 10.00pm)

- Across the district 38% of people thought the proposed hours appropriate while 59% thought they should be more restrictive and 4% thought they should be more permissive.
- In Raglan 36% of people thought the proposed hours appropriate while 64% thought they should be more restrictive.
- In Ngaruawahia 13% considered the hours appropriate while 75% thought they should be more restrictive and 13% thought they should be more permissive.
- In Huntly 44% thought the hours were appropriate while 56% thought they should be more restrictive.
- In Te Kauwhata 38% thought the hours were appropriate while 62% thought they should be more restrictive.
- In Tuakau 43% thought the hours appropriate while 48% thought they should be more restrictive and 10% thought they should be more permissive.

Grocery stores/Supermarkets (7.00am – 10.00pm)

- Across the district 18% of people thought the proposed hours appropriate while 82% thought they should be more restrictive and 2% thought they should be more permissive.
- In Raglan 29% of people thought the proposed hours appropriate while 71% thought they should be more restrictive.
- In Ngaruawahia 22% considered the hours appropriate while 67% thought they should be more restrictive and 11% thought they should be more permissive.
- In Huntly 0% thought the hours were appropriate while 100% thought they should be more restrictive.
- In Te Kauwhata 13% thought the hours were appropriate while 87% thought they should be more restrictive.
- In Tuakau 19% thought the hours appropriate while 76% thought they should be more restrictive and 5% thought they should be more permissive.

Clubs (7.00am – 1.00am)

- Across the district 53% of people thought the proposed hours appropriate while 43% thought they should be more restrictive and 3% thought they should be more permissive.
- In Raglan 50% of people thought the proposed hours appropriate while 50% thought they should be more restrictive.
- In Ngaruawahia 64% considered the hours appropriate while 36% thought they should be more restrictive.
- In Huntly 75% thought the hours were appropriate while 25% thought they should be more restrictive.
- In Te Kauwhata 29% thought the hours were appropriate while 71% thought they should be more restrictive.
- In Tuakau 63% thought the hours appropriate while 26% thought they should be more restrictive and 11% thought they should be more permissive.

The survey carried people's thoughts on the licence hours in the previous guidelines

In the original Waikato district:

- 51% thought the hours for hotels and taverns were about right, 8% thought they were too restrictive, 29% too lenient and 12% didn't know
- 60% thought the hours for cafes and restaurants were about right, 4% thought they were too restrictive, 30% too lenient and 6% didn't know
- 50% thought the hours for off licences were about right, 9% thought they were too restrictive, 30-38% too lenient and 4-11% didn't know
- 52% thought the hours for clubs such as RSA, Cosmopolitan and Workingmens clubs were about right, 6% thought they were too restrictive, 31% too lenient and 11% didn't know
- 64% thought the hours for sports clubs were about right, 2% thought they were too restrictive, 23% too lenient and 11% didn't know
- 66% thought the hours for special licences were about right, 11% thought they were too restrictive, 13% too lenient and 10% didn't know

In the former Franklin district:

- 29% thought the hours for hotels and taverns were about right, 11% thought they were too restrictive, 42% too lenient and 18% didn't know
- 64% thought the hours for cafes and restaurants were about right, 11% thought they were too restrictive, 8% too lenient and 17% didn't know
- 45% thought the hours for off licences were about right, 23% thought they were too restrictive for supermarkets and grocery stores, 6% thought they were too restrictive for tavern/hotel off-licences, 22% too lenient and approximately 16% didn't know
- 38% thought the hours for clubs such as RSA, Cosmopolitan and Workingmens clubs were about right, 3% thought they were too restrictive, 41% too lenient and 18% didn't know
- 53% thought the hours for sports clubs were about right, 3% thought they were too restrictive, 23% too lenient and 21% didn't know

The survey asked respondents what hours they thought should apply to premises.

- 14% favoured bottle stores opening at 9am, 27% at 10am, 25% at 11am with the remainder at varying other times or didn't know.
- 22% favoured bottle stores closing at 9pm, 31% at 10pm, 24% at 11pm with the remainder at varying other times or didn't know.
- 19% favoured grocery stores and supermarkets opening at 7am, 11% at 8am, 20% at 9am, 17% at 10am with the remainder at varying other times or didn't know.
- 32% favoured grocery stores and supermarkets closing at 9pm, 27% at 10pm, 18% at 11pm with the remainder at varying other times or didn't know.
- 15% favoured cafe/restaurants opening at 7am, 10% at 8am, 19% at 9am, 19% at 10am, 21% at 11am with the remainder at varying other times or didn't know.
- 14% favoured cafe/restaurants closing at 11pm, 27% at midnight, 39% at 1am with the remainder at varying other times or didn't know.
- 18% favoured hotels and taverns opening at 9am, 31% at 10am, 22% at 11am with the remainder at varying other times or didn't know.
- 12% favoured hotels and taverns closing at midnight, 51% at 1am, 10% at 2am with the remainder at varying other times or didn't know.

- 10% favoured clubs such as RSA, Cosmopolitan and Workingmens clubs opening at 9am, 36% at 10am, 28% at 11am with the remainder at varying other times or didn't know.
- 18% favoured clubs such as RSA, Cosmopolitan and Workingmens clubs closing at midnight, 47% at 1am, 8% at 2am with the remainder at varying other times or didn't know.
- 14% favoured sports clubs opening at 9am, 27% at 10am, 29% at 11am with the remainder at varying other times or didn't know.
- 10% favoured sports clubs closing at 11pm, 18% at midnight, 41% at 1am with the remainder at varying other times or didn't know.

The survey also asked if people favoured allowing pubs a later closing time during the weekend. 47% favoured allowing a later closing time during the weekend while 53% were opposed. Of those in favour 52% favoured a 2am closing, 22% 3am and 26% indicated various other times.

Overall, apart from bottle stores, grocery stores and supermarkets, it appears that the majority are comfortable with the hours proposed at the public meetings. There is a very clear indication that the community does not see a distinction between bottle stores and grocery stores/supermarkets in respect of sale of alcohol and that they should have similar hours.

The Te Kauwhata community alone has significant concerns over the hours for club licences.

### 14.6 Other stakeholder opinion

Hospitality NZ "strongly believe that the LAP should retain the current status quo for on-licensed premises hours for all parts of Waikato District Council area".

They support some consistency across licences in relation to broad areas but have concerns over blanket or fixed closing times over very large areas, areas with numerous licences, or too-small areas, suggesting that this can lead to the very behaviour that communities seek to avoid.

They consider that efforts should be focussed on those people outside of the controlled, regulated and monitored environments of on-licensed premises and who are instead pre-loading an consuming alcohol in uncontrolled environments.

Hospitality NZ submit that where on-licensed premises also hold an off-licence, the off-licence should have the same closing time as the on-licence for over the counter sales.

Hospitality NZ also submit that supermarket off-licences should not be considered separately to other off-licences, suggesting that supermarkets have exacerbated problems of pre-loading and side-loading by selling alcohol at excessively cheap prices, often far cheaper than Hospitality NZ members can buy wholesale direct from manufacturers.

Supermarket chains consider that there is a need to align off-licence hours with existing supermarket business hours or potential hours, suggesting that to impose shorter hours on alcohol sales would create undue costs in respect of new systems and training potentially leading to increases in grocery prices that they would seek to avoid.

They also note the inconvenience to customers expectations to receive a full supermarket service at all times potentially leading to customers shopping elsewhere, inconveniencing the customer an also impacting negatively on the business.

"The Tourism Industry Association (TIA) is...concerned is about the impact certain aspects of the new Sale and Supply of Alcohol Act 2012 will have on hotels and how they operative. The amount of alcohol served in a hotel outside the default hours is minimal, however it does happen and hotels pride themselves on being able to offer a full guest service i.e. if a guest rings Room service at 6.00am requesting a champagne breakfast to be delivered to their room at 7.00am a hotel would like to be able to do this. Under the new Act a hotel would not be able to provide this service until 8.00am".

There is an argument that the sale and supply of alcohol in the mini-bar happens at the time of check-in, however Section 46(1) of the Act is quite specific in its wording:

*The holder of a licence must ensure that no alcohol is sold or supplied on the premises outside the permitted trading hours.*

In a worst case scenario it hotels could not guarantee they could continue to operate legally with minibars in guest rooms they may choose to remove them completely. This may have implications for a hotel's Qualmark star rating.

Hotels would need to apply for a Special Licence to serve alcohol outside the default hours. Champagne breakfasts for conference groups and the requirement to apply for a Special Licence if the breakfast falls outside the default licensing hours is onerous...providing a champagne breakfast is often a last minute decision by a conference organiser and a hotel is unlikely to be able to secure a Special Licence within a 24 hour period.

We understand that these concerns could easily be addressed in the Local Alcohol Policy...for example within your LAP allowing hotels the provision to provide alcohol to lodgers 24 hour a day 7 days a week would solve the minibar issue very well".

## 15. One-way door restrictions: background evidence and opinions

### 15.1 Law Commission's Alcohol in our lives: curbing the harm, 2010

The Law Commission includes analysis relating to one-way door restrictions in paragraphs 9.54 to 9.62 of its report.

Key messages in the Law Commission's report include:

- One-way door restrictions have advantages over uniform closing times, largely because departures from licensed premised will be staggered between the commencement of the one-way door restriction and the ultimate closing time. This reduces the risk of alcohol-related harm in entertainment precincts. (para 9.54)
- Studies of one-way door restrictions in Christchurch, Queensland and Victoria have identified a reduction in some elements of alcohol-related harm. (paras 9.57 to 9.61)
- The Law Commission recommended mandatory one-way door restrictions from 2am for all on-licences and club licences (based on a 4am maximum closing time).

### 15.2 Police opinion

Police support a one way door policy 1 hour before closing for tavern style and club licences where the principal nature of the business is the consumption of alcohol. This would assist the issue of persons migrating between premises after already consuming alcohol, particularly those that may have been excluded from one premises late at night, going to the next premise and continuing to drink and therefore be at greater risk of alcohol related harm.

### 15.3 Medical Officer of Health opinion

The Medical Officer of Health notes:

"A one way door policy prevents the entry of new customers to a licensed premise beyond a set time of day, while allowing those already within the premise to remain inside. Such a policy is a tool for councils (and premises) to use as part of the Local Alcohol Policy. It may be useful as a means of controlling where people drink alcohol and for how long. It also has the ability to reduce the large rush of people leaving bars and clubs within the CBD at one time. From a health perspective, it may therefore be a useful tool to contain alcohol related harm incidents.

Population Health supports the adoption of a one way door policy, and advocates for this to be in place from 1:00am within Waikato District. However, if opening hours suggested in Section 10.3 are adopted, a one way door policy would not be required in the district.

### 15.4 Inspectors' opinion

They note that care must be exercised in deciding whether or not to define such a restriction in a LAP and if doing so the circumstances should be clearly specified. They note that the DLC can already impose a one way door restriction if necessary and this could be more restrictive than a restriction specified in the LAP.

Inspectors note a difference in opinion as to an appropriate time and application for one way door restrictions to apply if one is to be imposed. Some prefer midnight for on-licence and special licences while others prefer 1.00am if the maximum trading hours permit licences beyond this time. Some also consider that any blanket restriction should only apply to specific on-licences and not to special licences where a case by case approach to the individual circumstances can be applied by the DLC.

### 15.5 Community opinion

The public meetings did not specifically address one-way door restrictions.

The survey considered one-way door restrictions with responses indicating that 68% favoured a one way door policy, 19% were not in favour and 13% didn't know.

### 15.6 Other stakeholder opinion

Hospitality NZ are opposed to any one-way door policy. They consider that there is a lack of evidence to support a one-way door policy being included in the LAP. They quote Australian studies that showing certain types of crime increase when a "lock-out' system was implemented with alcohol related hospital emergency presentations on Friday and Saturday nights in Melbourne increasing and continuing during the lock-out period. They also note that their own experience is that people not allowed into bars are likely to drink in public places, move to where there are no restrictions or party at home.

## 16. Discretionary conditions: background evidence and opinions

### 16.1 Law Commission's Alcohol in our lives: curbing the harm, 2010

The Law Commission includes analysis relating to general licence conditions in paragraphs 9.6 to 9.23 of its report.

Key messages in the Law Commission's report include:

- There is merit in allowing licensing bodies to impose any reasonable condition on a licence (in contrast to the Sale of Liquor Act 1989 which permitted only a specific list of conditions). (para 9.7)
- Jurisdictions in the UK and Australia have much wider powers to impose discretionary (or mandatory) conditions on licences. (paras 9.12 to 9.16)

- Studies of one-way door restrictions in Christchurch, Queensland and Victoria have identified a reduction in some elements of alcohol-related harm. (paras 9.57 to 9.61)

The Law Commission made the following recommendations regarding mandatory and discretionary conditions.

"R24 Mandatory statutory conditions places on on-licence and club premises should include:

- the provision of food for consumption on the premises;
- the sale and supply of low-alcohol beverages and soft drinks;
- the provision of free drinking water; and
- the provision of assistance with, or information about, alternative forms of transport.

"R25 Discretionary conditions to be imposed on on-licence and club premises depending on the circumstances should include (in addition to specified existing conditions):

- the provision of CCTV cameras, including requirements for their location and number;
- the provision of seating;
- no serving in glass containers at specified times;
- the number of door staff required;
- no shots or particular types of drinks to be served after specified times;
- a limit on drink sizes after specified times;
- a limit on the number of drinks per customer;
- restrictions on permitted drinking vessels;
- no alcohol service for a specified time before the closing of a licensed premises;
- conditions relating to management, for example, with a requirement for multiple managers at large establishments;
- the provision of transport for patrons.

"R26 For off-licences there should be a mandatory condition for specialist alcohol retailers to be designated as a supervised area, and a discretionary power to impose conditions relating to lighting and security measures (in addition to specified existing conditions).

"R27 For supermarkets, there should be a mandatory condition for a single area restriction.

"R28 The licensing decision-makers should be able to impose any reasonable condition designed to minimise harm on all licences."

### Legislative response

Bullet points 1, 2 and 3 under R24 (food, low-alcohol and soft drinks, transport information) are specifically addressed for on-licences and clubs under the Act[7].

Bullet point 3 under R24 (drinking water) is also covered as a mandatory condition under the Act for all licence types[8].

R27 (single area restriction) is specifically addressed as a mandatory condition for supermarkets and grocery stores under section 112 of the Act.

The remaining recommendations from the Law Commission may be matters that elected members may wish to consider as discretionary conditions.

## 16.2 Police opinion

The Police views on discretionary conditions generally cover three themes.

- Menu of conditions
- Recommend preparation of a 'menu of conditions' to be considered when issuing special licences. Examples suggested include:
  - Maximum serves per sale
  - Minimum pricing of drinks
  - Size and type and alcohol percentage of drinks sold
- Police, inspectors and other partners to work together to establish the list.
- List may also be relevant to other licence types.

Types of activity

- Appropriateness of 'entertainment style' licences questioned.

Licence-to-occupy areas

- Clarity on use of licence-to-occupy areas requested, particularly with regard to seated versus standing drinking.
- Also note the difficult relationship between one-way door restrictions and the licence-to-occupy areas.
- Recommend that where a licence-to-occupy area is in operation, a one-way door restriction should start two hours before closing and the licence-to-occupy area should be cleared one hour before closing.

## 16.3 Medical Officer of Health opinion

The relevant elements of the Medical Officers of Health response are summarised below.

Sections 51 (non-alcoholic drinks to be available), 52 (low-alcohol drinks to be available), 53 (food to be available), and 54 (help with and information about transport to be available).

Section 110(2)(c) for on-licences and clubs; section 116(2)(c) for off-licences; section 147(3)(b) for special licences.

"Population Health advocates that all applicants for a licence or renewal of a licence to sell or supply alcohol be required to identify the risks that are associated with their sale or supply and develop a plan to minimise or eliminate those risks. This would take the form of an *alcohol (risk) management plan* and should be a discretionary condition of the licence.

Alcohol management plans have superseded Host Responsibility Policies as a fundamental tool for licensees and managers of licensed premises to identify alcohol risks relating to their premises. In addition these plans identify and implement practical steps to minimise that harm. They have been used to extremely good effect across the gambit of licensed premises from Ruapehu Alpine Lifts to the Auckland Casino, from the Oakune Mardigras to rugby clubs. In fact every rugby and rugby league club form Taumarunui to Otorohanga has written and implemented their own detailed alcohol management plan.

The principle of health and safety planning as a requirement of all businesses is already well established in law, but this does not encompass the considerable risks, to customers and the public associated with the sale and supply of alcohol.

It falls within the responsibilities of those who sell or supply alcohol, to identify the risks that are associated with this and to have a plan to minimise these risks. A requirement for an alcohol management plan is entirely consistent with the object of the Act and is a proven tool in reducing alcohol harm associated with licensed premises.

It is also important that those running off licensed premises identify and understand the harm and risks of harm associated with their business and have a plan to address those risks".

Population Health advocates for the acknowledgement of the visual impact of off licence premises (as defined in Section 17 of the Sale and Supply of Alcohol Act 2012) within the Local Alcohol Policy as a discretionary condition. There is a connection between exposure to alcohol marketing and consumption, particularly in young people.

Population Health advocates that the Local Alcohol Policy provide for restrictions on the visual impact of off licences as part of the licensing conditions, and along with additional restrictions on hours of operation, place more stringent visual impact limitations for those near schools. Restrictions would include a maximum area of advertising as a proportion of the shop front area and a restriction or ban on product marketing where it is visible or accessible to children or underage young people".

### 16.4 Inspectors' opinion

The Inspectors note that because discretionary conditions may already be applied to licences by the DLC, defining them in the LAP appears to serve little purpose. As they are discretionary the only purpose can be to identify types of conditions that may be appropriate. This is already the nature of the role of the DLC and any potential conditions are likely to be identified and recommended by the reporting agencies.

The Inspectors do note some types of discretionary conditions that could be included as guidance including requiring clubs to have a manager on duty at specified days and times. Inspectors consider that all chartered clubs that operate in the manner of a tavern should have a condition requiring a manager to be on duty at all times the licence is being operated. Similarly sports clubs with hours to 1.00am should be required to have a manager on duty when operating the licence at times when the licence hours permit trade to 1.00am.

They also note that conditions could provide for restrictions on outside entertainment after 11.00pm, but this would be on a case by case basis and considered during the licensing process.

The Inspectors consider that the following matters could be detailed as potential discretionary conditions as appropriate to the circumstances:

Off licence

- Stand alone off licences to be designated supervised (mandatory)
- The amount of the frontage of an off licence that can be covered in signage restricted
- Restriction on the number and size of sandwich boards outside premises

On Licence/Club Licence

- Licensed to occupy areas such as footpaths to be seated only
- Provision of security cameras
- Manager required to be on duty in clubs

Special Licence

- Containers alcohol served in ie glass/cans/plastic cups
- Maximum number of drinks per serve
- Pricing of drinks
- Security staff
- Alcohol management plan for large scale events

### 16.5 Community opinion

The public meetings did not specifically address discretionary conditions.

The survey considered discretionary conditions but limited feedback was received.

### 16.6 Other stakeholders

Hospitality NZ note that many licence holders pay themselves less than the minimum hourly wage and that some often proposed discretionary conditions would come at a significant cost to operators an is an unnecessary burden to be placed on good operators who are already operating responsible tightly controlled an monitored premises. They believe that any discretionary conditions should be focussed only when needed and only in relation to premises which are evidenced to need any. This should be assessed on a case by case basis.

They note that the DLC already has the ability to issue licences subject to discretionary condition and consequently do not think anything further needs to be included in a LAP.

Hospitality NZ submit that if Council are to include discretionary conditions in the LAP, the conditions be focussed on those outlets responsible for the other 76% of alcohol sold (off-licences and club licences).

Hospitality NZ submit that all club licences should have a mandatory condition that a fully certificated manager is on duty at all times in the same way that on-licences are required to have.

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## 18. Attachments

### 18.1 Appendix A – Medical Officer of Health Consultation

### 18.2 Appendix B – Licensing Inspectors Consultation

### 18.3 Appendix C – Community Consultation Survey

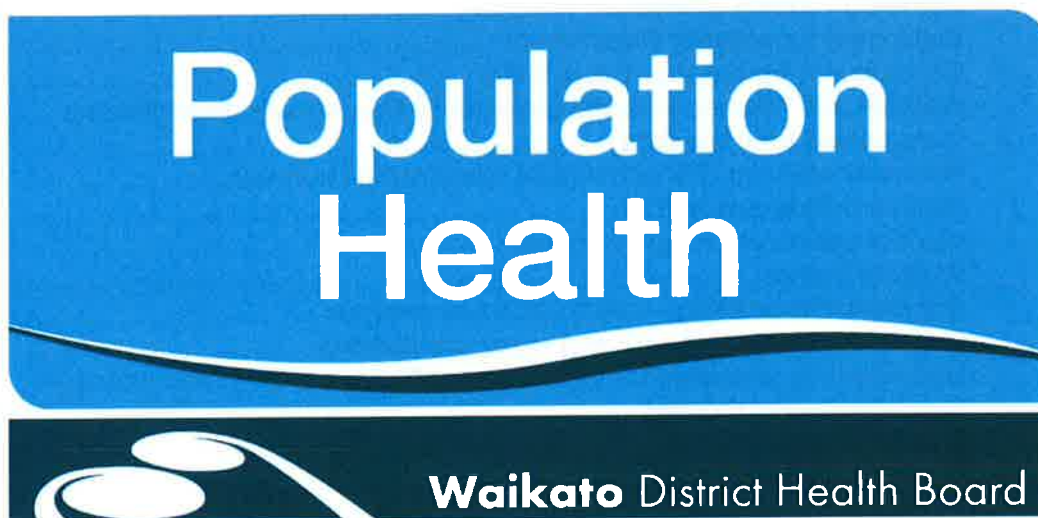
### 18.4 Appendix D – Community Consultation Public Meeting Summary

### 18.5 Appendix E – Stakeholder Submission – Hospitality New Zealand

## Appendix A – Medical Officer of Health Consultation

# Waikato District Council
# Local Alcohol Policy

# Alcohol and health information pack




Population Health, Waikato District Health Board (DHB)
September 2013

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## Forward by John Bonning, Clinical Director, Waikato Emergency Department

Emergency Departments (ED) are the first port of call for acute presentations to hospital. We receive patients from the youngest newborn to the very old, and see a huge range of illnesses and injuries every week - from a child with meningitis or an elderly patient with a broken hip to motor vehicle crashes resulting in multiple injuries. ED staff have to be ready to receive, triage and treat these patients, and also collaborate with other hospital departments regarding admission, investigation or outpatient follow up.

Waikato Hospital's Emergency Department is the third busiest ED in the country. There are regularly more than 200 patient presentations per day and the majority arrive outside of 'business hours'. Our staff have to be highly organised and our processes structured, whilst still maintaining the level of flexibility necessary to appropriately respond to whatever comes through the door 24/7.

The burden of alcohol on ED presentations is substantial. The busiest time for EDs across New Zealand is after hours – evenings, overnight and on the weekends, when we often have to respond to patients who have injured themselves, been in fights and sometimes have consumed so much alcohol that they are unconscious and at risk of death without our care.

Drunken patients and their intoxicated associates are generally labour intensive and can prove very difficult to manage. Staff are at risk of verbal or physical abuse, other patients and their relatives are subjected to noise and disruption, and our department may be subject to drunken patients vomiting or making a mess in the department. Commonly security staff or the police have to be called to control patients or associates who are intoxicated and a danger to themselves or others. Other (non-intoxicated) patients frequently complain about the disruption that intoxicated patients cause during their treatment.

Another impact of alcohol that is not accurately measured is those non-intoxicated patients who are assaulted or involved in car crashes with intoxicated third parties.

It is important to note that patients with problems related to alcohol consumption take time to look after, denying resources from other patients with medical emergencies and tying up staff and beds. This contributes to difficulties reaching Ministry of Health targets and good patient care. They represent significant costs for the Waikato District Health Board (DHB) and for providers such as the Accident Compensation Corporation (ACC). Alcohol related injury and illness is a type of self-inflicted injury that can be avoided by using alcohol in moderation.

New Zealand's legal blood alcohol level for drivers is too high and society have a message that is ok to drink one or more drinks an hour and still stay under our too high limit. This sends the wrong message, that driving drunk is ok, and also contributes significantly to the impact on road trauma.

The majority of weekend ED presentations relating to alcohol consumption involve young people. This is of concern, as their drinking habits leave them at risk of becoming alcohol dependent, of injuring themselves to a degree that causes long term disability, or of harassment or physical abuse. Our department, along with many others in the hospital, is also involved in providing care for those impacted by the

longer term affects of alcohol misuse, for example people with alcohol related liver disease.

The Sale and Supply of Alcohol Act (2012) is an opportunity for local governments to address some of the issues relating to alcohol abuse in our community. There is strong evidence which shows that reducing access to alcohol in the community results in fewer alcohol related injuries and presentations to hospital. This would allow our department to function more effectively and allocate our time and resources more efficiently. I encourage the council to utilise its powers to address alcohol harm, and reduce its burden on the Emergency Department and wider health care system.

Yours sincerely,

Dr John Bonning,
Clinical Director, Emergency Department.
Waikato District Health Board

# 1 Introduction

Population Health has a significant interest in how alcohol impacts on the health and wellbeing of communities. Population Health is involved in a number of different fields, from health promotion through to regulatory work.

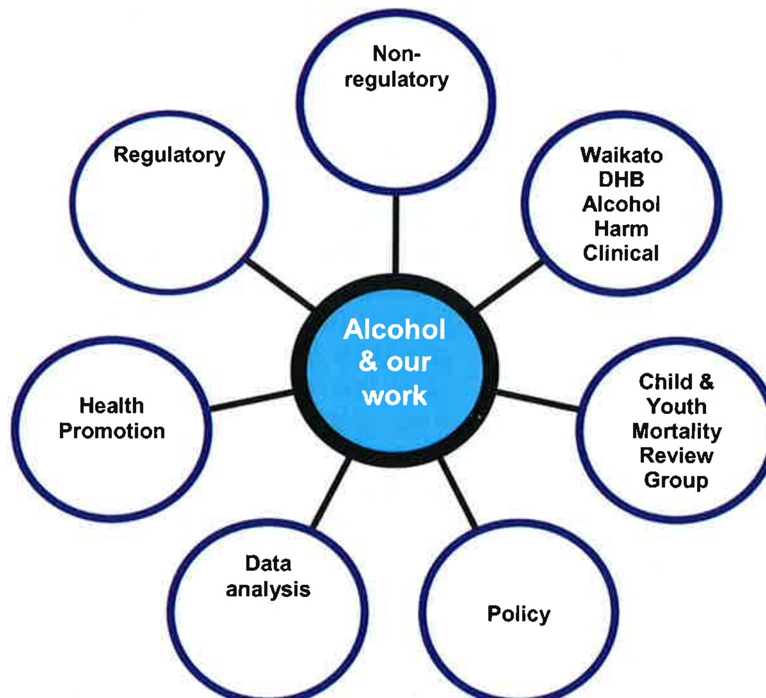



**Figure 1: Population Health's alcohol related work.**

This document provides information on the associated harms of alcohol consumption from a health perspective. Local data has been used where available. Sections 3 and 4 provide information on how alcohol impacts on health and health systems. Sections 5 and 6 review how information such as the location and density of alcohol outlets affects consumption which can lead to harm, and how this may be mitigated through risk rating. Section 7 provides Population Health's assessment of the data and how this may be incorporated in the draft Local Alcohol Policy for Waikato District Council.

Population Health acknowledges the work undertaken by Council to this point and looks forward to continuing to work towards a strong and effective Local Alcohol Policy.

# 2 Alcohol use and associated harms (literature review)

Alcohol use is associated with a wide range of physical, mental and social harms. Its consumption can affect many organs in the human body and is linked to more than 60 disease conditions and 2.5 million deaths globally per annum. This accounts for nearly 4% of all deaths, which is greater than the number caused by HIV/AIDS or tuberculosis[1]. In New Zealand about 1000 people die each year secondary to alcohol use[2]. Over half of alcohol related deaths involve injury, a quarter is due to cancer and the final quarter is related to chronic disease. The link between alcohol and health is dependant both on the volume of alcoholic units consumed and the pattern of consumption, with binge drinking being particularly dangerous[3]. Alcohol has the potential to harm individuals acutely by means of intoxication, alcohol poisoning or accidental harm while drunk, and chronically by means of long term damage to organ systems.

Although alcohol use and abuse can be associated with such a myriad of problems, quantifying the extent to which alcohol contributes to an outcome is difficult. This is because alcohol is often not the sole contributing factor. For example, alcohol is associated with oral cancer, but a person who drinks is also more likely to smoke, which is also associated with oral cancer. The alcohol may therefore not be the only causal factor in an outcome, and determining the extent of its role is prone to confounding issues.

A further problem in determining the burden associated with alcohol use relates to people who are harmed by other people's drinking. This can happen even before a person is born if a prospective mother consumes alcohol. Alcohol use also plays a part in many assaults, crimes, domestic violence cases and road traffic accidents. Determining the burden associated with these health issues is challenging. Although alcohol has been a contributing factor in the events, one cannot always be certain that if no drinking had taken place, the events would not have happened.

## 2.1 Who drinks alcohol?

The reaches of alcohol in our society are of concern and affect every socioeconomic group, and both males and females. Harm associated with alcohol use is unequally distributed among lower socioeconomic groups and ethnic minorities internationally[4]. Eighty five percent of New Zealand adults have drunk alcohol in the previous year, with over 60% having drunk more than recommended levels. Nearly 20% of adults are considered to have a potentially hazardous drinking pattern, and 30% of women have consumed alcohol while pregnant. Young people are also drinking dangerously,

with over 70% of secondary school students having drunk alcohol, and 46% of student drinkers consuming over five units the last time they drank[5]. Māori tend to drink less frequently than non-Māori, however consume more units of alcohol when they do drink[5]. This pattern is also evident among Pacific people, and may be a reflection of socioeconomic status as well as ethnicity.[5]

## 2.2 Acute alcohol effects

Alcohol is classed as a sedative and hypnotic drug. In low doses it acts as a stimulant (which is why many people drink). However in larger doses alcohol leads to drowsiness, depression and in severe cases coma and respiratory suppression[5]. Even in low doses, consumption of alcohol increases the probability of certain injuries and illnesses. Alcohol increases self-confidence, while at the same time decreases fine motor skills and balance. This can lead to an individual attempting a physical activity which is beyond their ability, resulting in a fall or crash and physical injury. Other acute alcohol effects include a shortened attention span, and impaired judgement. Implications of this could include distraction while driving leading to a crash or an individual making a poor judgement while drunk - for example getting into a car with a drunk driver, or overreacting to a perceived slight which results in an altercation. As alcohol intake increases, an individual suffers impaired memory, delayed reaction time and difficulty balancing. Nausea, vomiting and impaired senses can also become a problem. The end result is a person who is not able to react normally, makes poor judgments and has poor balance and coordination. This leaves the individual at risk of injuring themselves and potentially those around them[5].

If an individual makes it to bed without injury, when severely intoxicated they are at risk of vomiting in their sleep and aspirating their vomit. If a person sleeps when drunk, a disturbed and poor quality sleep will be had[6], and the next day they are likely to suffer a hangover which results in poor reactions, attention and motor skills – and an ongoing increased risk of injury. Productivity in the workplace is also decreased[5].

Many people associate the acute effects of alcohol with a good night out. Indeed alcohol is often seen as a requirement for social participation and enjoyment. New Zealander's like to drink, with 88% of men and 83% of women consuming alcohol on a regular basis[7]. Alcohol related harm is also taken somewhat for granted and there is a degree of tolerance to it which is not extended to other drugs. Lack of immediate longer term problems following a drinking session (in the absence of an injury) means that habits of regular drinking can be formed in young people which continue into adulthood. For many people, alcohol consumption will never cause any serious harm. For others addiction or dependence will develop, which can have social effects, e.g. marriage breakups. For many more longer term alcohol consumption will lead to one of the many health problems associated with sustained alcohol intake, a few of which are discussed in the following sections.

## 2.3 Chronic alcohol effects

### 2.3.1 Chronic liver disease

Consumption of alcohol can lead to a fatty liver, hepatitis and cirrhosis. It can also cause pancreatitis. Alcohol is considered to be the leading cause of liver cirrhosis in developed countries[1]. The first stage of alcohol related liver disease is a fatty liver, a build up of fat cells. Almost all heavy drinkers will have a degree of fatty liver disease. This does not normally cause any symptoms, and if a person stops drinking, it usually reverses itself. If heavy drinking continues it can progress to alcoholic hepatitis, an inflammation of the liver. Mild hepatitis should settle if alcohol is avoided, and causes problems such as weight loss, nausea and vomiting. Liver function tests (a blood test) may also be abnormal. More severe hepatitis can cause symptoms of abdominal pain, fevers and jaundice. It can lead to liver failure. Cirrhosis of the liver occurs following hepatitis. It is scarring of the liver tissue, which reduces the livers ability to function normally. Ten to twenty percent of heavy drinkers get cirrhosis which is not reversible. Complications of cirrhosis include bleeding abnormalities, build up of fluid in the abdomen, bleeding from veins in the stomach and progression to liver cancer or liver failure requiring transplant[8].

### 2.3.2 Cancer

Alcohol consumption is associated with malignancies at 27 anatomical sites[9], including cancer of the mouth, oesophagus, stomach, liver and colorectum. It is also associated with female breast cancer. Daily consumption of alcohol raises the likelihood of cancer by two to three times, and if the individual also smokes this risk is even greater[8]. Alcohol is considered a group one carcinogen – meaning that the association between alcohol and cancer is proven.

### 2.3.3 Cardiovascular disease

Research and media attention have been given to the potentially protective effect that low level alcohol consumption can have on the cardiovascular system. A recent meta-analysis concluded that one to two standard drinks a day may reduce the risk of death from coronary heart disease[10]. This protective effect is lost (and harm can be caused) if alcohol is consumed in greater volumes, or if an individual regularly drinks a small amount with occasional days of higher consumption[11]. A myriad of other cardiovascular diseases are adversely affected by alcohol consumption, including hypertension, heart failure and cardiac arrhythmias.

### 2.3.4 Mental health and neurological disorders

Alcohol can reduce stress and tension in low dose, and indeed this is one of its attractions to many. In higher doses however, it can create rather than relieve stress, and can make people sad, aggressive or prone to mood swings. Alcohol is commonly consumed by people before they self-harm or attempt suicide[12]. Alcohol use can lead to dependence, with withdrawal symptoms (including delirium tremens) in people who suddenly abstain, and difficulties maintaining a job or social relationships in people who are addicted.

Alcohol dependent individuals have been shown to have a two to three fold increased risk of depressive disorders[11]. Alcohol use is not only a cause of depression, but it

also worsens symptoms in depressed people, demonstrated by an improvement of symptoms with abstinence and worsening of symptoms with increased consumption. Alcohol use is also linked to poorer control of psychiatric conditions such as anxiety and schizophrenia and neurological conditions such as epilepsy. Chronic alcohol abuse can lead to peripheral neuropathy (loss of feeling in hands and feet) and damage to areas of the brain which are responsible for speech generation, vision, memory and balance (Wernicke-Korsakoff syndrome). Low levels of alcohol consumption have also been shown to increase the risk of stroke, particularly in males[1].

### 2.3.5 Fetal alcohol spectrum disorder and pregnancy

Alcohol consumption during pregnancy can have negative health effects for both the mother and the developing foetus. Alcohol passes freely to the foetus across the placenta, and can lead to miscarriage or spontaneous abortion, still birth, low birth weight and Fetal Alcohol Spectrum Disorder (FASD). FASD is characterised by physical, behavioural and cognitive abnormalities[13]. In addition to dysmorphic facial features, children with FASD suffer prenatal and/or postnatal growth retardation, and structural brain abnormalities which can lead to behavioural problems, a low IQ and learning difficulties. Consequences are life long, and are not always evident at birth[14].

The volume of alcohol consumption which is required to cause these problems is unclear due to multiple confounding factors, although damage to the foetus is more likely if the mother consumes large amounts of alcohol in one sitting, or consumes alcohol regularly throughout pregnancy. Drinking alcohol during the first trimester can be particularly dangerous. The Ministry of Health (MoH) acknowledges that there is no known "safe" level of alcohol use at any stage of pregnancy[15]. The MoH and the Alcohol Advisory Council of New Zealand (ALAC) therefore recommend that alcohol is not consumed while pregnant or when planning a pregnancy. Following this advice could be difficult however if a pregnancy is unplanned, if a woman does not know she is pregnant for some weeks following conception, or if she feels compelled by societal norms to drink alcohol at social events.

A study in Canada estimated that health care costs related to fetal alcohol syndrome were $6.7 million in 2008/09, and considers this to be an underestimate[16].

### 2.3.6 Sexually transmitted diseases and fertility

Alcohol consumption has been shown to be associated with the spread of sexually transmitted diseases in both men and women[17]. Being drunk, lowers ones sexual inhibitions making one more likely to engage in sexual activity, and to engage in risky sexual activity, e.g. having unprotected sex or having sex with strangers. Women also have the risk of unplanned pregnancies.

Long term heavy alcohol use can lead to impotence, loss of sex drive, wasting of testicles and reduced fertility in men as it affects testosterone levels. In women, alcohol use can cause reduced fertility, heavy irregular periods or amenorrhea[5]. Chronic infections with sexually transmitted diseases such as chlamydia or gonorrhoea can also affect fertility.

## 2.4 Burden of disease

In 2004, 4.6% of the global burden of disease and injury was attributable to alcohol[11]. Nearly 4% of all global deaths were attributable to alcohol – 6.3% for men and 1.1% for women. Despite being lower, mortality in women is rising as the number of women who drink and the volumes and frequency that they drink is also increasing. Mortality rates were higher in younger age groups. Burden of disease and mortality rates are highest in countries which have the greatest per head alcohol consumption (the former Soviet Union and Europe) and outcomes are worse for those who are poorest in society[2].

Alcohol is therefore considered a major risk factor for the burden of disease. The global effect of alcohol on burden of disease (in 2004) is about the same as smoking was in 2000[11] however, consumption of alcohol is continuing to trend upwards.

In New Zealand, a study in Auckland found that alcohol was consumed in the six hours prior to injury in 35% of injured people who presented to an emergency department[18]. This is high in comparison to international studies which report that 10-18% of injury presentations to EDs involved alcohol. In all studies youths and males are over-represented. Furthermore, violence was the cause of 17% of injury cases, and alcohol was involved (victim and/or perpetrator) in 79% of these cases.

## 2.5 Cost burden of alcohol

Quantifying the costs relating to alcohol use on society, or even one section of it, is highly complex. Alcohol misuse has costs to many areas of government and health provision including law enforcement, Child, Youth and Family Services (CYFS), St John, and the health care system – both primary and secondary care. As discussed alcohol may often play a part in any given problem or disease, but determining its attributable fraction is complex.

That said, there is no denying that social costs of alcohol are significant. A 2009 study undertaken by Business and Economic Research Limited (BERL) estimated that alcohol use cost New Zealand society $4.9 billion in 2005/6[19] and up to 50% of these costs were avoidable. A recent study by BERL reports that alcohol related injuries and illnesses cost Canterbury healthcare $63 million in 2011, and this is a conservative estimate. These healthcare costs are also rising rapidly; in 2006 Canterbury costs in relation to alcohol were estimated to be $38.8million. [20]

Costs to the health care system from alcohol use are not merely limited to particular conditions, but also have knock on effects. The time and resources involved with looking after an intoxicated person in ED for example denies the health system funds for other services, such as elective surgery. These represent opportunity costs. In today's economic climate of restricting funding in all areas of health care combined with achieving government set health targets reigning in costs associated with alcohol could free up funds for use elsewhere.

Given the diversion of health resources to managing alcohol injury and illness, more effective laws on alcohol have the potential to be, in the view of the Waikato District Health Board, a key government measure to aid achieving health targets in other areas. This opportunity has been devolved, in part, to local authorities via the provisions of the act regarding local alcohol policies.

## 2.6 Alcohol outlet density and opening hours

Evidence suggests that there is a strong link between the availability of alcohol and alcohol related harm. Most studies consider *availability theory* when examining the relationship between alcohol outlet density and alcohol related harm, e.g. greater availability of alcohol leads to greater consumption of alcohol which leads to negative social outcomes[21]. Studies have generally found that in areas where there is greater availability of alcohol through a high density of outlets, there is a higher level of alcohol consumption. This often leads to higher levels of alcohol harm, antisocial behaviour and alcohol related offences.

There are several studies that link opening hours to consumption and alcohol related harm. Studies from several countries concluded that extensions in opening hours for alcohol stores resulted in increased alcohol related injuries, chiefly vehicle related injuries and assaults. Other studies where 24 hour licences have been granted have showed no increase in alcohol related harm, but a shift forward in time as to when they happen. Studies looking at the effect of a reduction in opening hours have shown a significant decrease in crime and alcohol related harm. Local data from the Police following a reduction in opening hours in Timaru showed a reduction in violent offending, not just a change in eth time these occurred[22]. The studies don't indicate a significant change to chronic alcohol conditions.

## 2.7 Visual impact of alcohol marketing

Whilst there are many factors that may contribute to an individual's decision to consume alcohol, the impact of marketing is considerable. Marketing plays a significant role in the normalisation of alcohol as part of everyday life. At a community level, this is seen most clearly through the visual impact of off-licence stores, where advertising features heavily on the outside of the building. There is increasing evidence that alcohol advertising can impact on an individual's decision to take up drinking, or to increase consumption if they are already drinking[22]. Studies in the United States have shown that young people in areas with higher levels of expenditure on alcohol advertising drank more than areas of lower spending[22].

Studies into the effects of long term exposure have also shown a change in beliefs towards alcohol and increased self reported consumption. Alcohol advertising has been linked with identity formation in young people, which may have an impact on decisions to drink. Research has suggested that the effects of marketing on beliefs about alcohol counteract possible effect from health promotion messages[22].

# 3 Hospitalisation data

The following information is offered relating to alcohol's role in hospitalisation data within New Zealand.

## 3.1 Admission coding at Waikato Hospital

Patients admitted to Waikato Hospital, including those who attend ED for more than three hours, have their notes reviewed by clinical coders. The clinical coders analyse the notes and translate them into health classification codes. The coded information can then be used by the DHB to determine funding, monitor hospital performance, help guide policy decisions, produce health statistics, or research the epidemiology of diseases in the Waikato region.

The clinical coders work to a strict set of guidelines and are not allowed to create any diagnoses or diagnostic codes which are not explicitly made by medical practitioners. A code for alcohol involvement in an admission is not possible unless there is specific mention that alcohol was a contributing factor. For example, if a very high blood alcohol level is recorded in the notes, or if a doctor writes that a patient consumes four bottles of wine a day, this does not allow a coder to use an alcohol related diagnostic code. It is only if the attending doctor writes a diagnosis such as "alcohol induced hepatitis" or "alcohol related presentation x" that an alcohol related code can be used.

Population Health sought a list of admissions which were coded as alcohol related from Waikato DHB, however, due to the above reasons the results were highly likely to be an underestimate, and we believe did not represent an accurate picture of the effects of alcohol on the DHB.

In Wellington and Christchurch Hospital's the recording of data is different. These hospitals specifically ask in the EDs electronic clinical record if:

(a) alcohol was consumed by the patient in the hours prior to admission
(b) the patient presentation was the result of someone else's alcohol consumption, e.g. an alcohol related assault or a car crash involving a drunk driver.

It is therefore straightforward for coders to know if alcohol was involved in the ED presentation and code appropriately. It should be noted that while the data collected with this method is very useful in terms of identifying the burden of alcohol on acute presentations (e.g. presentations which are at least in part attributable to alcohol consumption), it still fails to identify the myriad of chronic conditions in which alcohol is a risk factor or can be caused by alcohol misuse. An example of this is oral cancer, which is linked to alcohol abuse, but also has other risk factors, e.g. smoking. There is no accurate means of determining the number of oral cancers in the DHB which are caused by alcohol.

The data from Wellington and Christchurch Hospitals in this section focuses on alcohol involvement in acute presentations to the respective emergency departments. It is believed that the trends from both Wellington and Christchurch ED are applicable to Hamilton ED. Although the population demographic of the three cities varies, the EDs are the largest in the respective DHB regions and the three hospitals are located in New Zealand's second, third, and fourth largest cities. It is

not expected therefore that drinking culture will be significantly different from each other in these cities.

**The causal uncertainty problem**

**The difficulty in providing accurate data on alcohol as a causal factor in health services admission or discharge analysis.**

This is a national as well as a regional problem with health data and its origins lie in the dangers of making clinical/treatment judgements or decisions on the basis of what is possible, likely or probable as opposed to what is known to be the case.

Not only would doing so be unsound from a clinical point of view, it would also undermine the patient's entitlements and rights.

An example of the causal uncertainty problem in relation to alcohol is represented by cases in which the patient is an injured third party in an event such as a motor vehicle crash. The role of alcohol in the incident is unknown, is unlikely to be known to health services and, furthermore, is irrelevant to treatment.

Hence the resultant coding values may be perfectly correct from a clinical/treatment point of view but for statistical or epidemiological purposes they are worse than useless in that they cumulatively understate the incidence and significance of causal factors such as acute and chronic alcohol use.

**How do analysts get around the causal uncertainty problem?**

Understanding the causal uncertainty problem enables legitimate researchers and analysts to back-fill data gaps with projections based on reputable research, correlated data sets, and legitimate studies of comparable environments

**What are the dangers of causal uncertainty problem?**

The real danger of the causal uncertainty problem is that analysts or researchers will use compromised health data to influence public policy either

1) without realising that there is a problem with it or
2) without understanding the extent of the problem or
3) in order to use the distorted data to downplay the significance of health risks relating to specific products.

Typically, this third manifestation of the problem takes the rhetorical form of legitimate scientific debate, while not adhering to the actual principles of that debate, one of which is the use of valid data. Typically also, this has been associated with industry advocates or lobby groups. A frequently quoted example of this has been "research" associated with the tobacco industry but other examples include industries involved in the manufacture and supply of alcohol.

## 3.2 Wellington Emergency Department

The available data from Wellington ED includes acute presentation of injuries which involved alcohol from 2010 and 2011. There is a variation in percentage of ED injury presentations which involve alcohol in the admission throughout the year (Table 1) and throughout the week (Table 2). Over the year, alcohol is involved in 10.9% of injury related admissions. Alcohol plays a greater role in ED injury presentations in the summer months than winter months, February had the highest percentage of alcohol related admissions (15%) and June had the lowest percentage of alcohol related admissions (8.6%). Certain days of the week are also related to increased alcohol related presentations to ED, with the weekend being particularly busy.

**Table 1: Number and percentage of admissions related to alcohol in months from January 2010 to December 2011. The highest month (February 2010), lowest month (June 2010), and total for the year (2010) are given. Source: Wellington City Hospital ED.**

| | Admissions | | |
|---|---|---|---|
| | Alcohol related | Total presentations | Percentage alcohol related |
| February | 148 | 983 | 15.1% |
| June | 79 | 924 | 8.5% |
| Year total | 1252 | 11,499 | 10.9% |

**Table 2: Alcohol related admissions by day of the week 2010/2011. Source: Wellington City Hospital ED.**

| Day | Percentage of alcohol related admissions |
|---|---|
| Monday | 7.1% |
| Tuesday | 6.0% |
| Wednesday | 6.5% |
| Thursday | 10.8% |
| Friday | 11.8% |
| Saturday | 23.5% |
| Sunday | 34.3% |

Table 3 shows the age breakdown of injury presentations which were alcohol related in 2010 and 2011. The highest percentage of injuries for both males and females is in the 18-24 age groups. For all age groups, alcohol is involved in 12.3% of male injuries, and in 8.1% of injuries in females.

**Table 3: Age of patient with an injury presentation by alcohol involvement in 2010-2011. Source: Wellington City Hospital ED.**

| | | Alcohol involved | | Alcohol not involved or alcohol status not known | | Total | |
|---|---|---|---|---|---|---|---|
| | | Number | % | Number | % | Number | % |
| Male | Under 18 years | 105 | 3.2 | 3,148 | 96.8 | 3,253 | 100 |
| | 18 - 24 years | 695 | 23.3 | 2,283 | 76.7 | 2,978 | 100 |
| | 25 - 44 years | 551 | 14.2 | 3,341 | 85.8 | 3,892 | 100 |
| | 45 - 64 years | 197 | 10.4 | 1,691 | 89.6 | 1,888 | 100 |
| | 65 years and over | 52 | 5.0 | 989 | 95.0 | 1,041 | 100 |
| | Total | 1,600 | 12.3 | 11,452 | 87.7 | 13,052 | 100 |
| Female | Under 18 years | 49 | 2.3 | 2,093 | 97.7 | 2,142 | 100 |
| | 18 - 24 years | 325 | 20.5 | 1,262 | 79.5 | 1,587 | 100 |
| | 25 - 44 years | 257 | 11.0 | 2,082 | 89.0 | 2,339 | 100 |
| | 45 - 64 years | 85 | 5.8 | 1,378 | 94.2 | 1,463 | 100 |
| | 65 years and over | 40 | 2.2 | 1,797 | 97.8 | 1,837 | 100 |
| | Total | 756 | 8.1 | 8,612 | 91.9 | 9,368 | 100 |

Alcohol related presentations with injury are given by time of day in Table 4. Injuries in which alcohol is involved are particularly prevalent in the early hours of the morning, and the busiest time is over the weekend. Over 60% of injuries which present between midnight and 6 am on a Saturday and Sunday night involve alcohol. It is worth noting that presentations in which the alcohol status is not known are grouped with those in which alcohol is not involved. The true percentage of alcohol related presentations may therefore be greater.

**Table 4: Alcohol related presentations with injury by time of day. Source: Wellington City Hospital ED.**

| | | Alcohol involved | | Alcohol not involved or alcohol status not known | |
|---|---|---|---|---|---|
| | | Number | % | Number | % |
| Sunday | Midnight - 6:00 | 422 | 62.6 | 252 | 37.4 |
| | 6:01 - 18:00 | 243 | 10.6 | 2,046 | 89.4 |
| | 18:01 - 22:00 | 62 | 9.1 | 620 | 90.9 |
| | 22:01 - Midnight | 25 | 17.1 | 121 | 82.9 |
| Monday | Midnight - 6:00 | 39 | 23.5 | 127 | 76.5 |
| | 6:01 - 18:00 | 108 | 5.2 | 1,951 | 94.8 |
| | 18:01 - 22:00 | 30 | 4.4 | 658 | 95.6 |
| | 22:01 - Midnight | 17 | 10.3 | 148 | 89.7 |
| Tuesday | Midnight - 6:00 | 26 | 17.2 | 125 | 82.8 |
| | 6:01 - 18:00 | 57 | 3.0 | 1,849 | 97.0 |
| | 18:01 - 22:00 | 32 | 4.4 | 700 | 95.6 |
| | 22:01 - Midnight | 24 | 12.8 | 163 | 87.2 |
| Wednesday | Midnight - 6:00 | 43 | 22.4 | 149 | 77.6 |
| | 6:01 - 18:00 | 63 | 3.5 | 1,749 | 96.5 |
| | 18:01 - 22:00 | 34 | 4.5 | 720 | 95.5 |
| | 22:01 - Midnight | 23 | 12.5 | 161 | 87.5 |
| Thursday | Midnight - 6:00 | 112 | 40.4 | 165 | 59.6 |
| | 6:01 - 18:00 | 71 | 3.8 | 1,805 | 96.2 |
| | 18:01 - 22:00 | 40 | 5.1 | 737 | 94.9 |
| | 22:01 - Midnight | 31 | 17.7 | 144 | 82.3 |
| Friday | Midnight - 6:00 | 89 | 37.6 | 148 | 62.4 |
| | 6:01 - 18:00 | 82 | 4.7 | 1,662 | 95.3 |
| | 18:01 - 22:00 | 47 | 7.6 | 570 | 92.4 |
| | 22:01 - Midnight | 67 | 30.7 | 151 | 69.3 |
| Saturday | Midnight - 6:00 | 263 | 58.1 | 190 | 41.9 |
| | 6:01 - 18:00 | 161 | 6.9 | 2,181 | 93.1 |
| | 18:01 - 22:00 | 66 | 9.9 | 604 | 90.1 |
| | 22:01 - Midnight | 79 | 32.0 | 168 | 68.0 |

## 3.3 Christchurch Emergency Department

Christchurch ED summarised data on all alcohol related acute admissions from July 2012 to February 2013.

Figure 2 shows the number of presentations in which alcohol is involved. The busiest period of the week is the weekend. Presentations which involve alcohol are again most common in the early hours of the morning, as seen in
Figure 3.

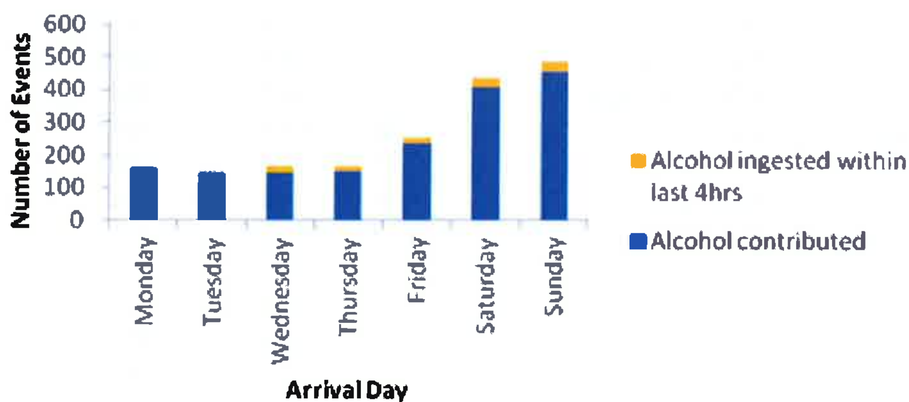



**Figure 2: Total number of alcohol related events by day from July 2012 to February 2013. Source: Christchurch Hospital ED.**

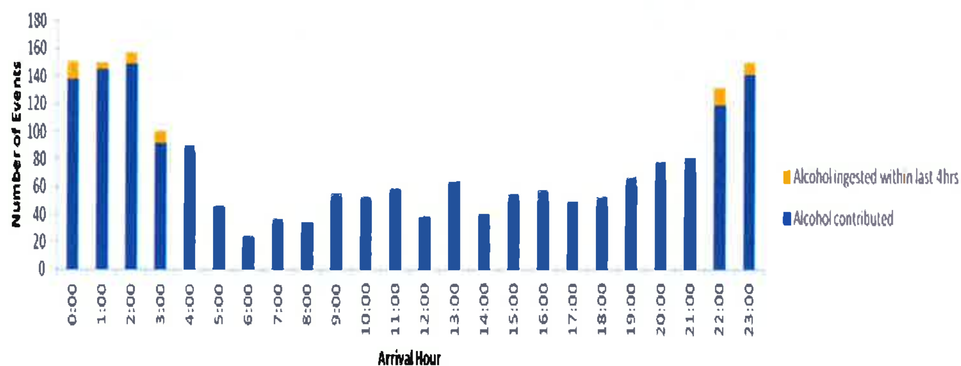



**Figure 3: Total number of alcohol related presentations by hour of day from July 2012 to February 2013. Source: Christchurch Hospital ED.**

Of all Christchurch ED presentations, alcohol is a factor in approximately 4% (Figure 4). It is involved in 9% of injury related presentations (ACC on the graph), and 1% of non-injury presentations (non-ACC on the graph). Coding of alcohol involvement in Christchurch presentations is very strict and dependent on the attending doctor correctly filling out the electronic record. For this reason there may be an undercount, but the numbers should not be an overestimate.

This data offers corroborating evidence with the Wellington data, where it was also seen that alcohol related presentations tended to be at the weekend in the early hours of the morning.

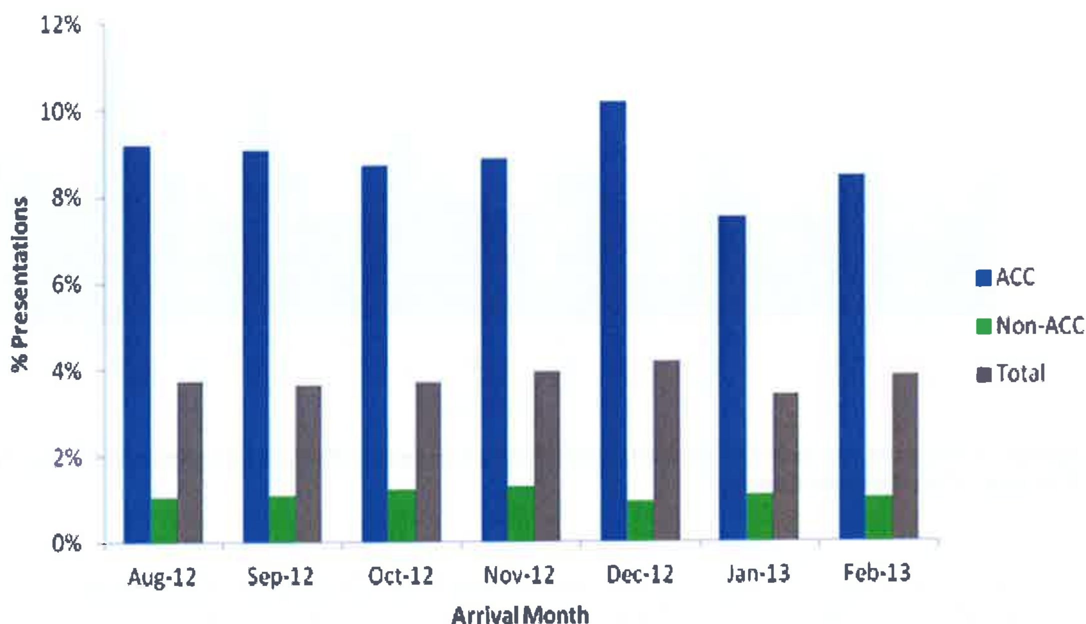



**Figure 4: Percentage of alcohol involvement in presentations to Christchurch ED for the period July 2012 to February 2013.**

## 3.4 Waikato and Thames Hospital Emergency Department presentations

Currently, Waikato Hospital ED does not flag if a presentation is alcohol related in the patient notes. The problems associated with coding of alcohol data (see previous section) mean that it is not possible to obtain accurate data on the number of ED presentations which are alcohol related in Waikato Hospital.

To compare Waikato ED with Christchurch ED and Wellington ED, it is possible to look at the number of presentations to ED and when they occur. Figure 5 shows the percentage of the total Waikato ED presentations for the three year period 2010 to 2012 each hour of the day for the 15-24 age group and Figure shows the same data for all age groups. Of interest is the period between 11 pm and 3 am each day, where the proportion of presentations of 15-24 year olds peaks. On Monday to Wednesday, the 15-24 age group made up approximately 20% of ED presentations each hour from 11 pm to 3 am. On Thursday night, the 15-24 age group accounted for 25% of ED presentations each hour between midnight and 3 am. On a Saturday and Sunday night between the hours of midnight and 3 am, up to 30% of ED presentations were in the 15-24 age group (Figure 5), 10% higher than the rest of the week.

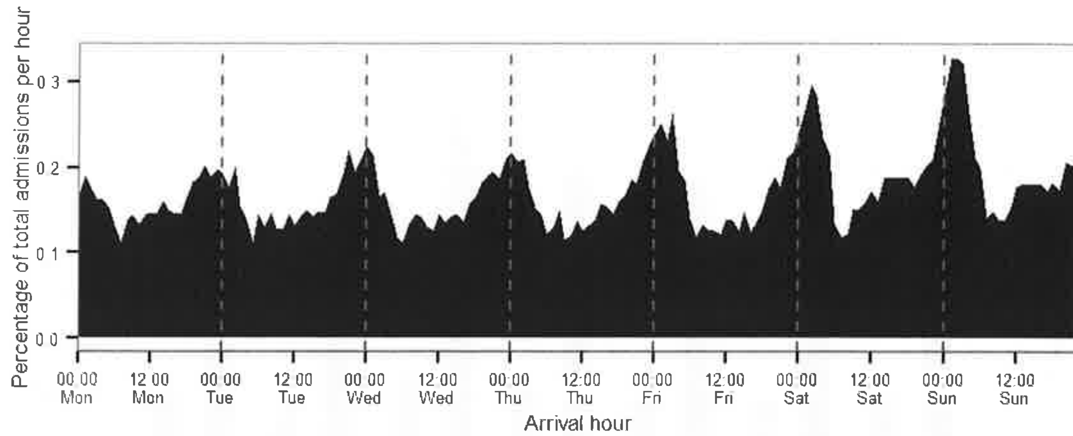



**Figure 5: Percentage of total ED presentations during the period 2010-2012 by hour of the day for 15-24 year olds, Waikato Hospital.**

Compared to other age groups, it is noticeable that 15-24 year olds make up the majority of ED presentations between 11 pm and 3 am, particularly on a Saturday and Sunday (Figure 6). A peak in presentations is perhaps expected during the evening period because 15-24 year olds are likely to be a more active in the evening compared those aged 65 and over, who make up the majority of presentations each hour during the day (Figure 6).

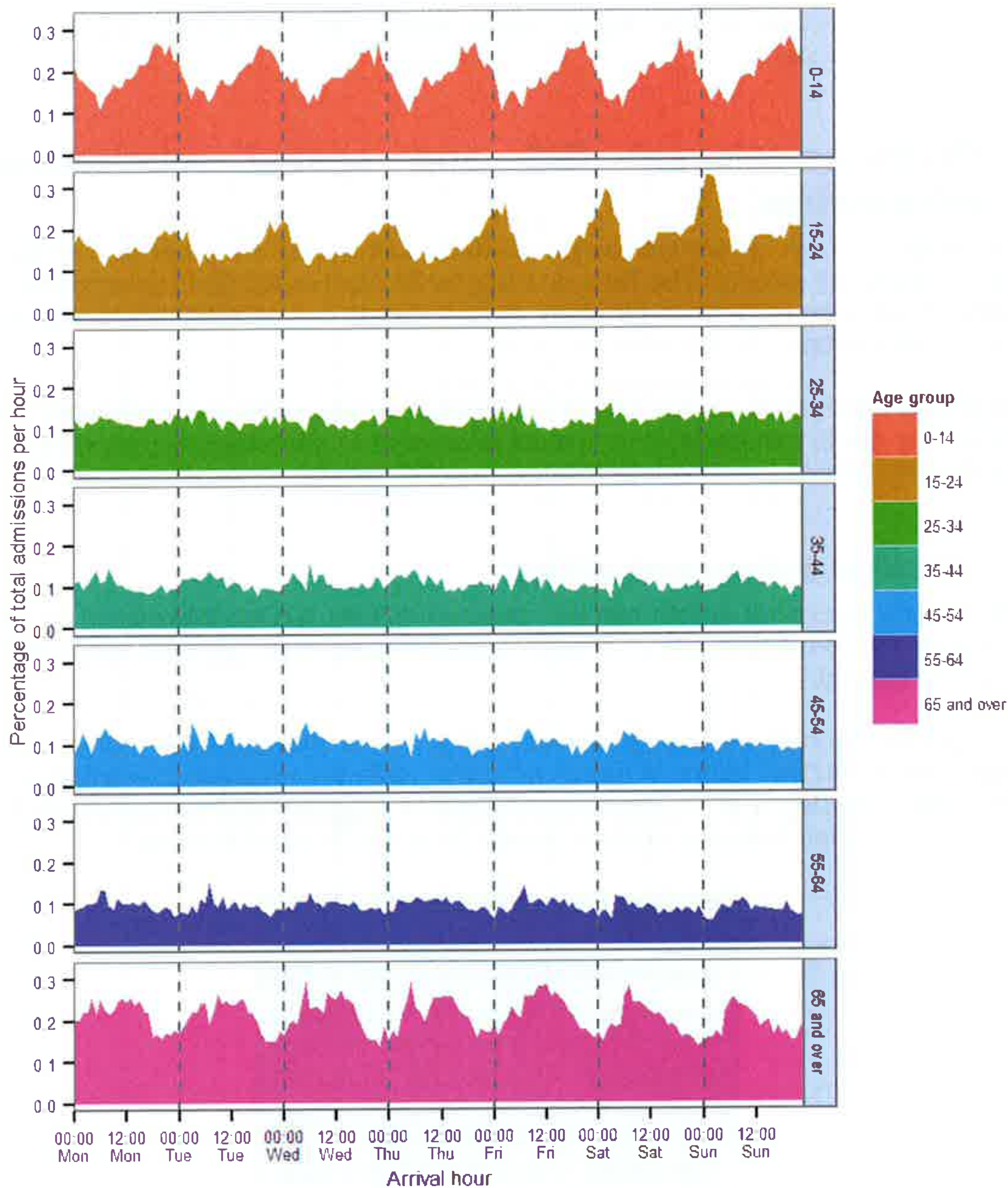



**Figure 6: Percentage of total ED presentations at Waikato Hospital each hour of the day by age group for the period 2010-2012.**

## 3.5 Conclusions from the data

As discussed, there is no means of accurately determining the burden of alcohol harm on Waikato ED. The data we do have however shows that there is a surge of ED presentations from young people over the weekend. Data provided from Wellington and Christchurch EDs also have this surge, and in these hospitals alcohol is a factor in up to 60% of the presentations. There is no reason to believe that the presentations to Waikato ED will be significantly different to those in Wellington or Christchurch. This allows us to conclude that alcohol has significant impact on Waikato ED, particularly over the weekend. This could pose a risk to ED staff and other patients in the department, and also limits the resources available to other ED and hospital departments and the DHB as a whole.

This data has also demonstrated that alcohol is involved in approximately 10% of all injuries presentations to ED. Again, these injuries are particularly prevalent in younger age groups.

# 4 Premises-relevant GIS and spatial relationship information

The location of both on and off licence premises can impact on the amount of harm that is caused by alcohol. The Sale and Supply of Alcohol Act 2012 (and the Act it replaced) place no restrictions on where alcohol outlets can be established, and how many there can be.

Presenting information on the location of alcohol outlets within the community and where they are in relation to other factors is of value in appraising any aspects of a Local Alcohol Policy that may look to address outlet density.

## 4.1 Alcohol outlets and NZDep

The location of alcohol outlets can be assessed against NZDep information for that area. This may be able to give information on what parts of society have the greatest access to alcohol.

A large proportion of off licence alcohol outlets in the Waikato DHB region are in areas with an NZDep score of seven or higher, with the greatest concentration in areas where NZDep is 9-10 (Figure 9). This would suggest that the most vulnerable members of society have the greatest access to alcohol from off licences.

**NZDep**

The NZDep2006 scale of deprivation from 1 to 10 divides New Zealand into tenths of the distribution of the first principal component scores. For example, a value of 10 indicates that the meshblock is in the most deprived 10 percent of areas in New Zealand, according to the NZDep2006 scores. A meshblock is evaluated against a set of criteria which determine where on the NZDep index it falls. These include income, home ownership, qualifications, living space, and access to communication and transport.

## 4.2 Alcohol outlets on a regional basis

The location of alcohol outlets with a regional perspective can give a clearer understanding of what parts of the Waikato DHB region have the greatest number of outlets. Clearly, as the main population centre of the region, Hamilton city has a significantly higher number of alcohol outlets than other Territorial Authorities within the region (Figure 8). Thames-Coromandel has the second highest number and has, by a considerable amount, the highest number of alcohol outlets per head of population when all Territorial Authorities in the region are compared (Figure 7 11). When considering the location of off-licences, these can be mapped against the locations of school, which will impact on how much they are visible to students. Figures 9 and 10 consider this within the Waikato DHB region.

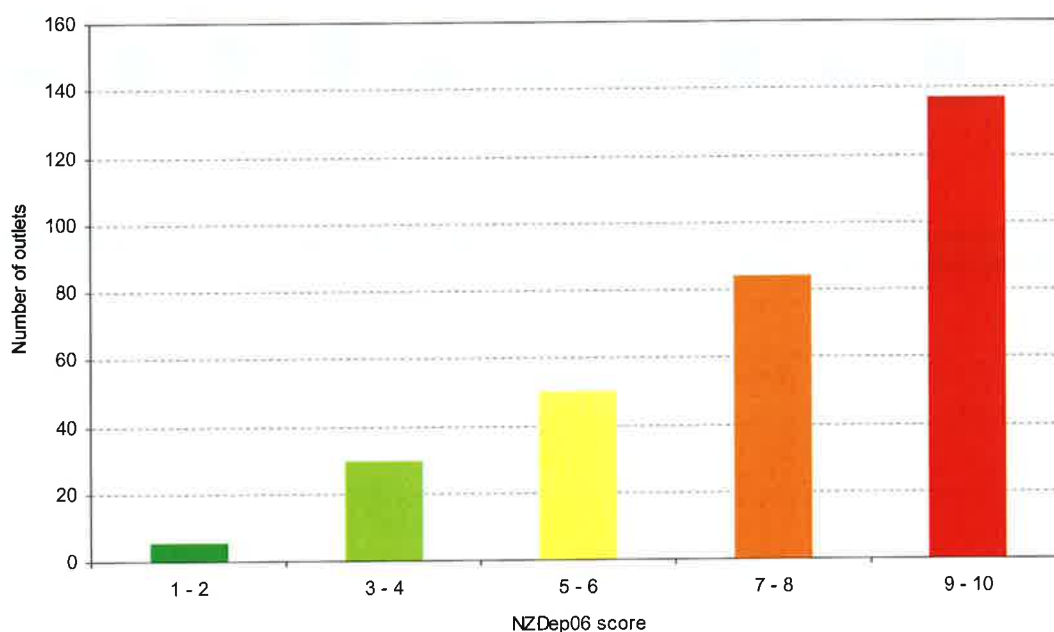



**Figure 7: Number of off-licence liquor outlets in Waikato DHB region by NZDep06 score.**

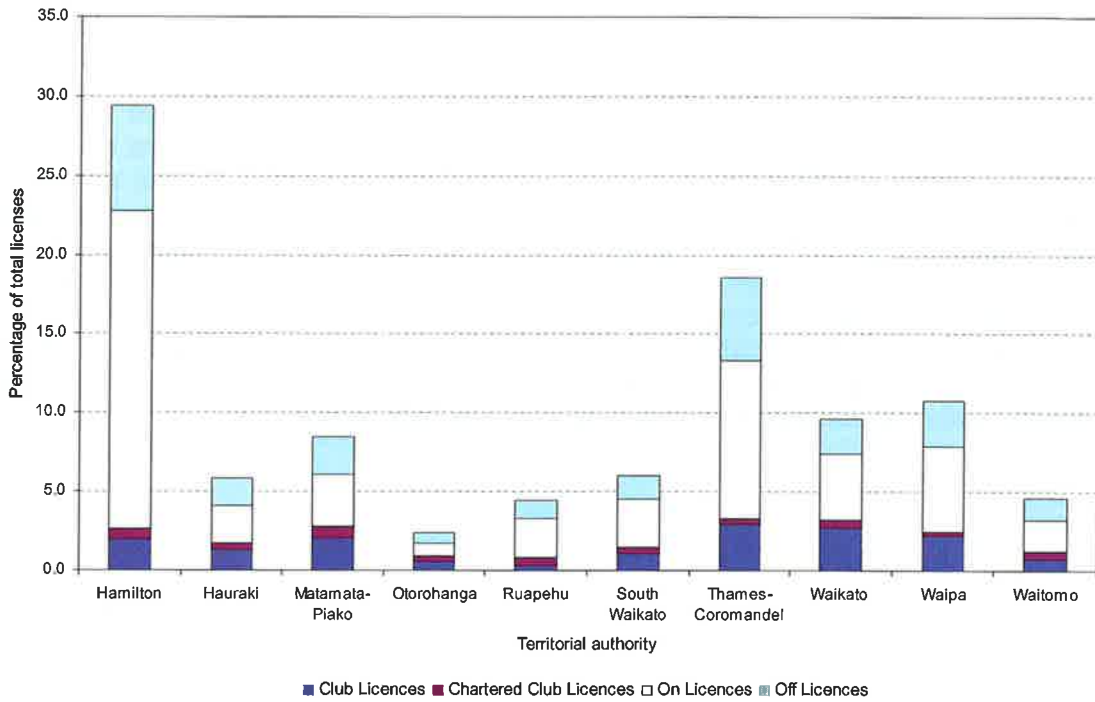



**Figure 6: Percentage of total licensed premises in Waikato DHB region by licence type for each Territorial Authority, April 2012.**

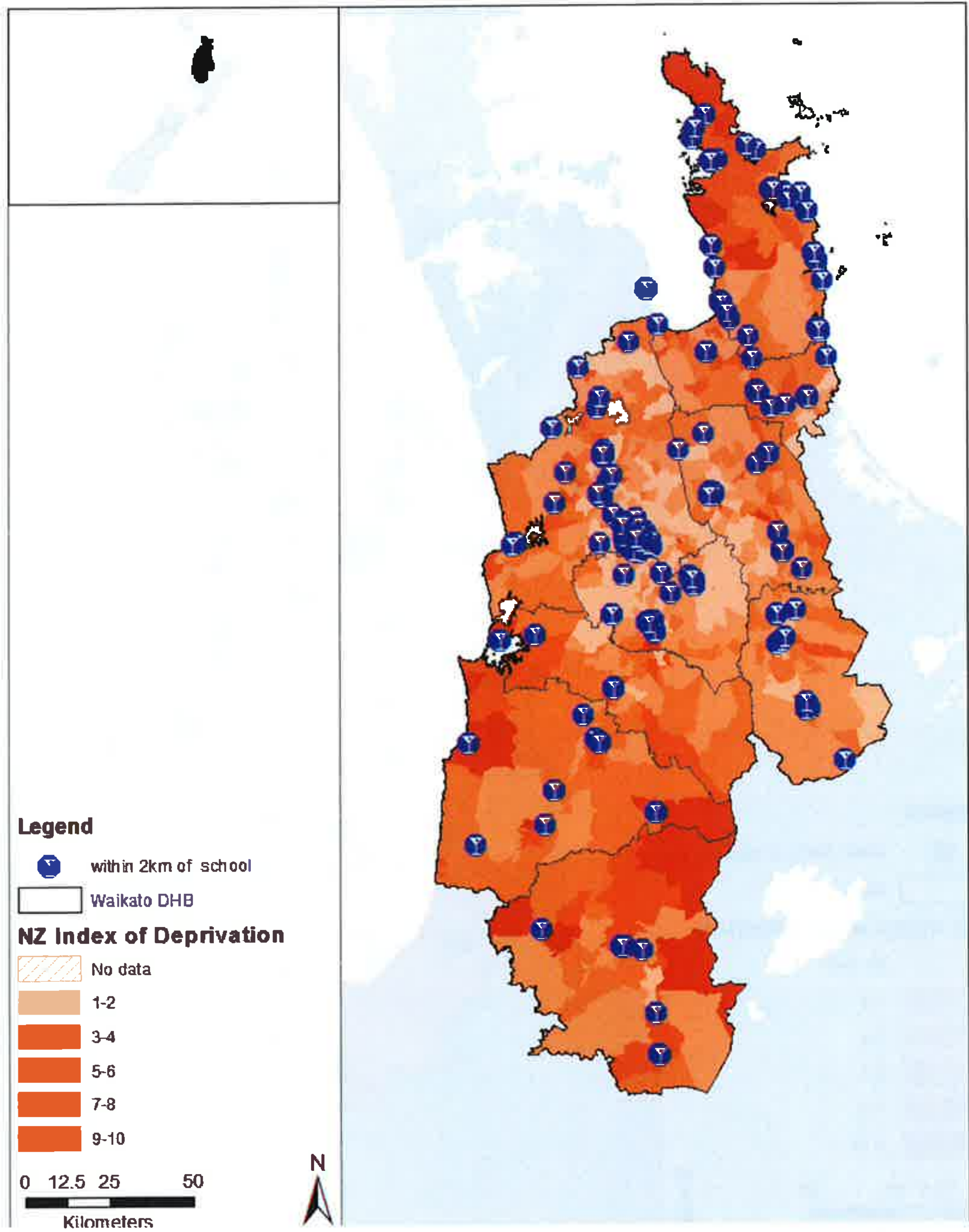



**Figure 9: Off licence alcohol outlets within 2 km of a school, Waikato DHB region.**

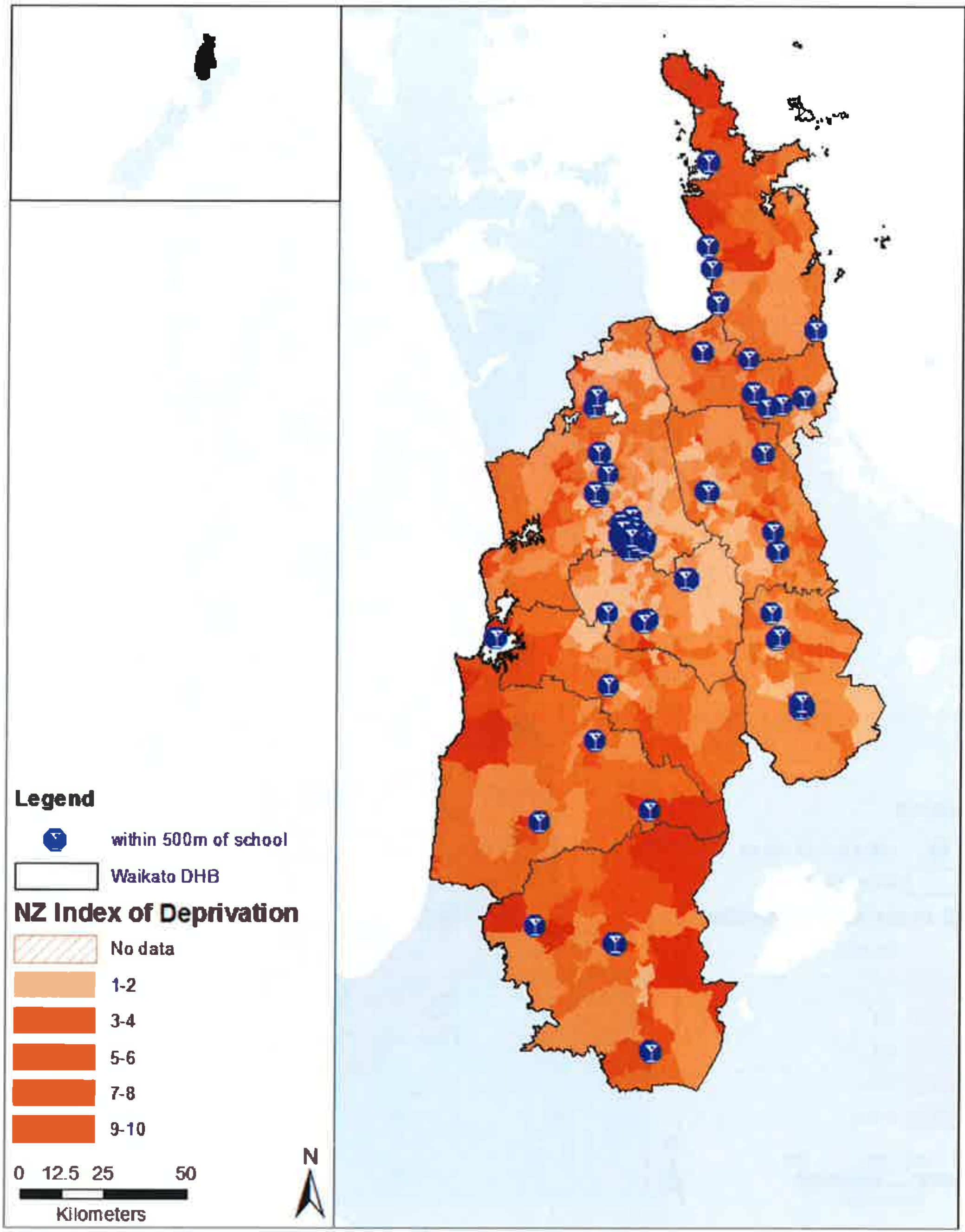



**Figure 10: Off licence alcohol outlets within 500m of a school, Waikato DHB region.**

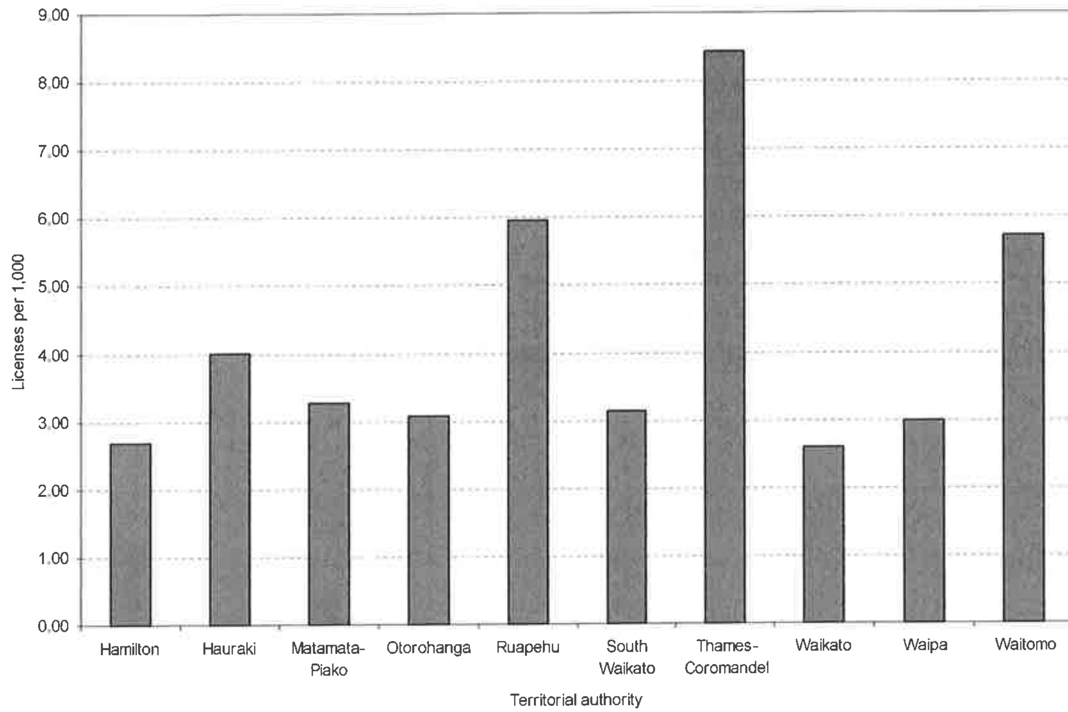



**Figure 7: Total licences per 1000 people by TA in Waikato DHB region. Note: 'population usually resident' from Census 2006 was used for denominator values and only includes the part of Ruapehu Waikato DHB covers.**

## 4.3 Waikato district

Waikato district has four main towns and many smaller townships and communities, each with their own identity and issues relating to alcohol. There may be a degree of migration between these towns, and also to neighbouring districts. Waikato district is a key transition point between the Auckland and Hamilton cities. This may have an influence on the development of the local alcohol policy. As with the Waikato DHB region as a whole, Waikato District has a large proportion of off licence alcohol outlets in areas with an NZDep score of seven or higher, with the greatest concentration in areas where NZDep is 9-10 (Figure 12).

The concentration of alcohol outlets within the towns of Ngaruawhia and Huntly in relationship to schools is also shown (Figures 13, 14, 15).

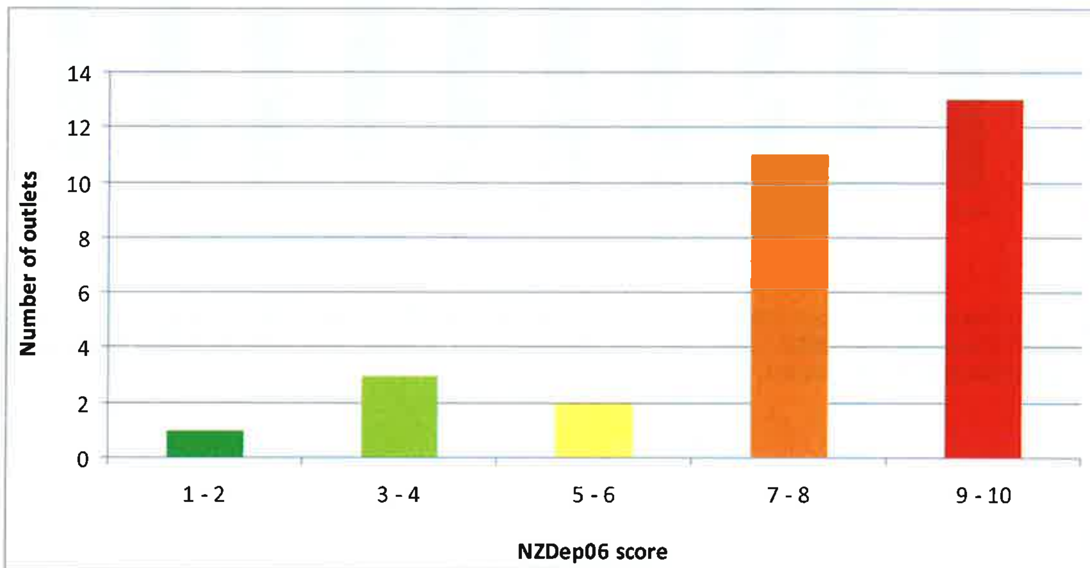
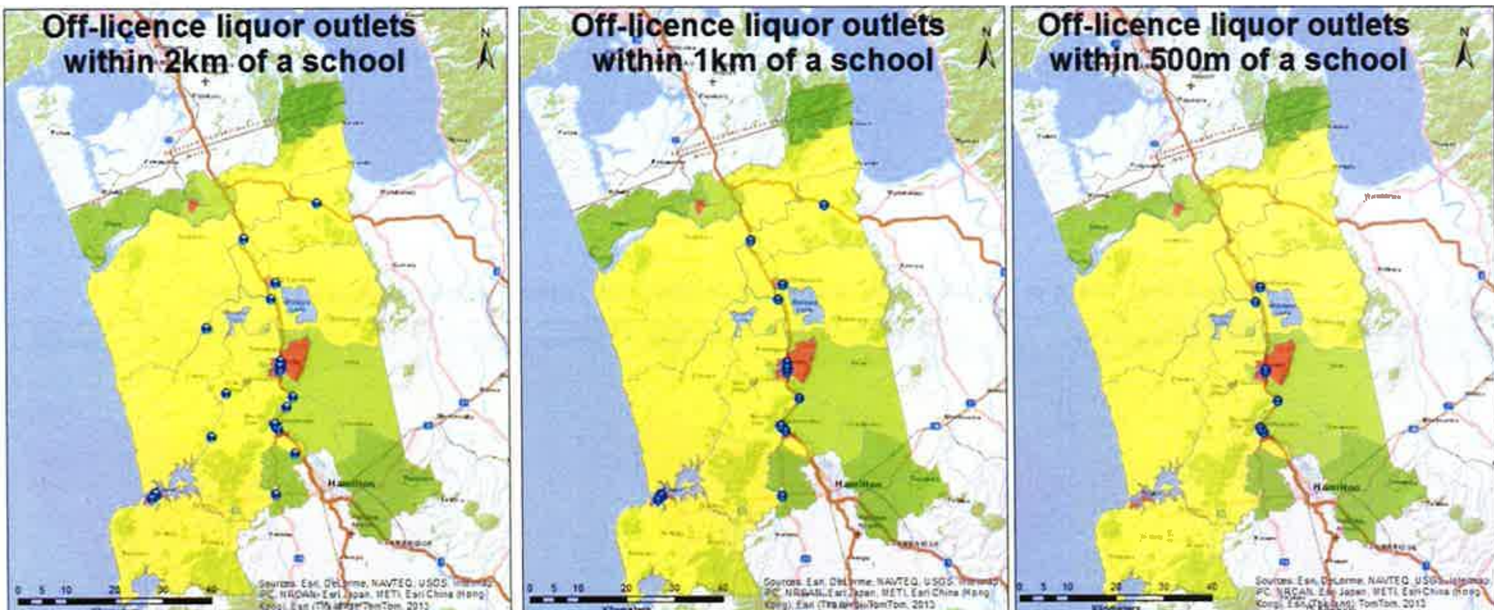



**Figure 12: Number of off-licence liquor outlets in Waikato DHB region by NZDep06 score.**

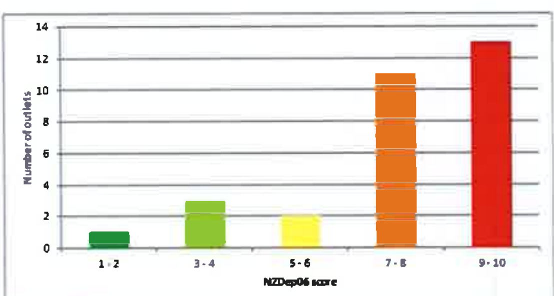



**Legend**

- Off-licence premise

**NZDep06 score by quintile**

- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 8
- 9 - 10




All off-licence liquor outlets within the Waikato District Council boundary (that are within the Waikato District Health Board region) were address geocoded. There were 30 off-licence liquor outlets discovered. Of these 30 all are located within 2km of a school, 83% (25) are within 1km of a school and 47% (14) are within 500m of a school.

These maps show the distribution of these off-licence liquor outlets in relation to NZ deprivation index quintiles (StatsNZ, 2006 Census)

**Figure 83: Off licence liquor outlet proximity to schools in Waikato district, at 500m, 1km and 2km.**

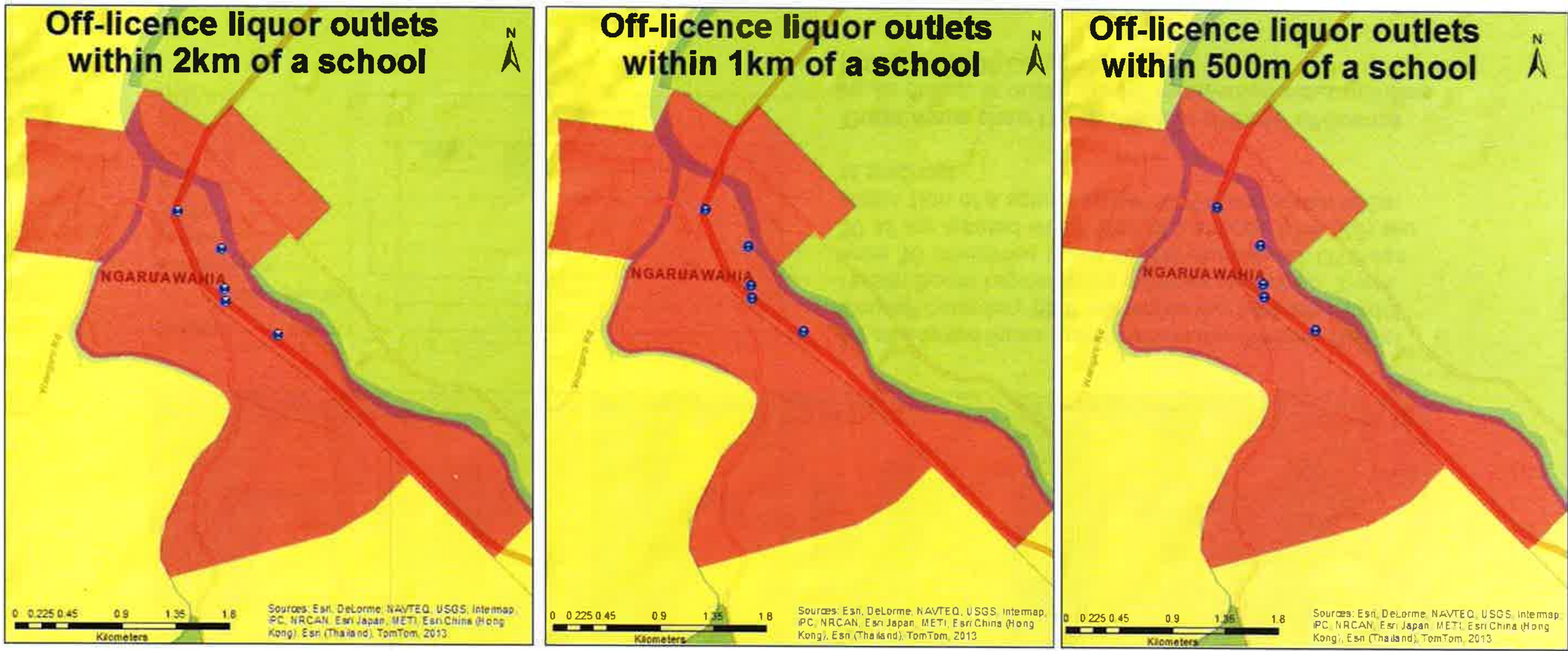



**Figure 14: Off licence liquor outlet proximity to schools in Ngaruawhaia, at 500m, 1km and 2km.**

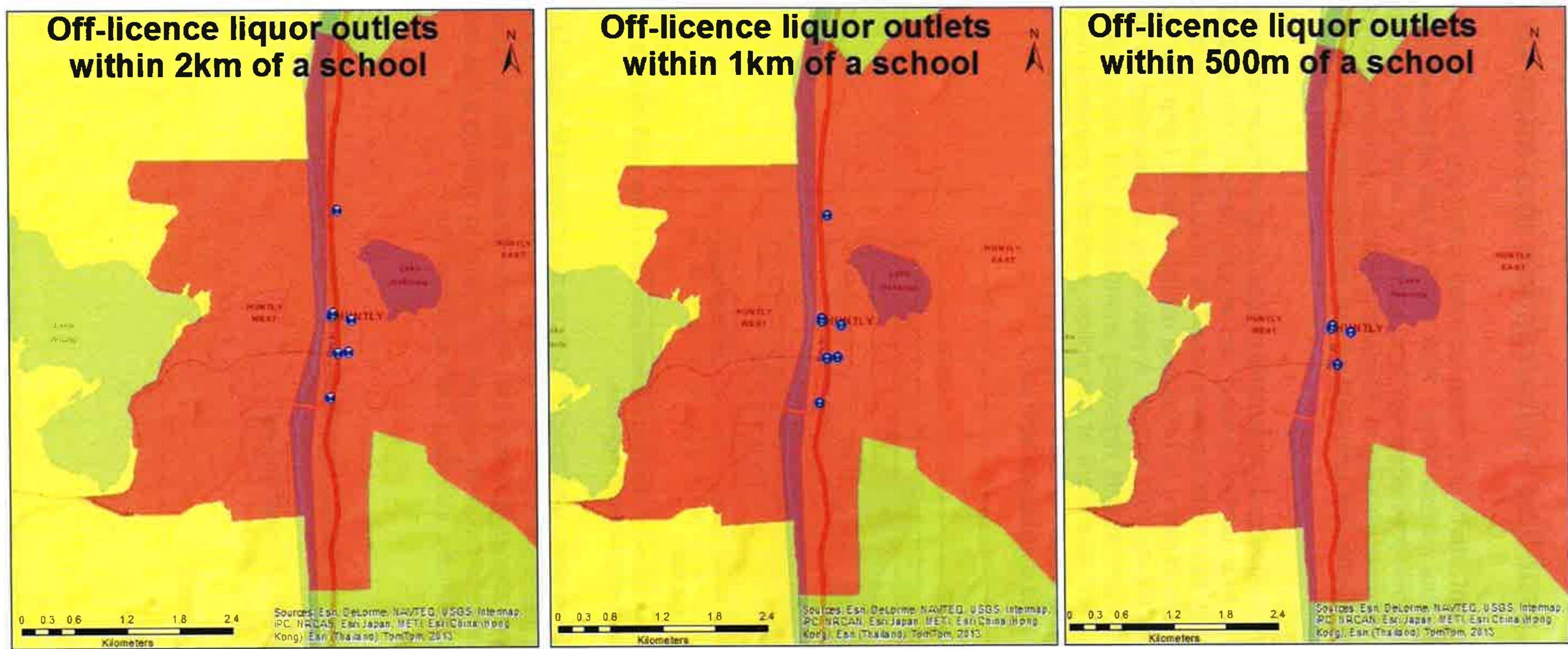



Figure 15: Off licence liquor outlet proximity to schools in Huntly, at 500m, 1km and 2km.

# 5 Premises risk profiling – information and analysis

*Risk profiling* is a method of identifying those licensed premises that have the greatest risk of causing alcohol related harm. Risk profiling has traditionally been performed by the police for their *graduated response model,* in which they prioritise their monitoring and enforcement relating to licensed premises depending on the assessed risk. Population Health has also utilised risk profiling with respect to on licences and club licences.

Risk profiling is performed by utilising a computerised data programme to risk weight licensed premises according to a number of fixed and variable factors. For example, principle purpose or proximity to a state highway would be fixed risk factors whereas the strategies the licensee put in place to remediate alcohol related harm risk, such as transport options, would be variable factors. A risk rating is calculated for each premise, which can support judgements regarding prioritisation and deployment to risk. Figure 16 is an effective equivalent of the police *graduated response model.* This risk distribution can be used to identify risk rating thresholds to determine whether a particular premise is considered high risk.

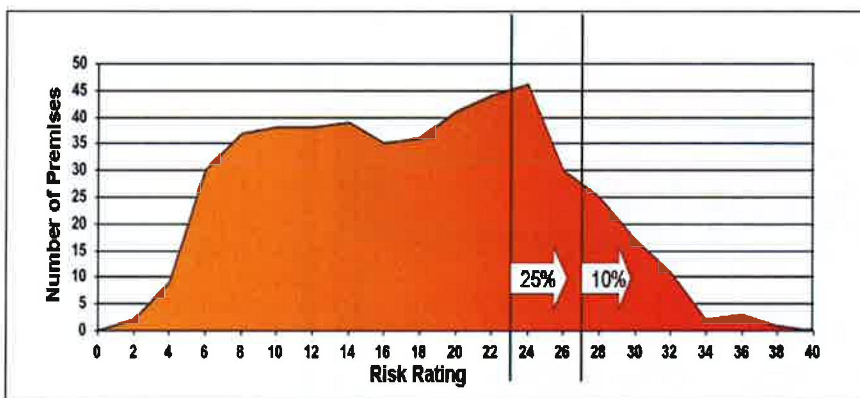



**Figure 16: Risk distribution for on licensed and club licensed premises in the Waikato DHB region. Note: 25% and 10% thresholds indicate high risk.**

Many risks for off licensed premises and special licences are different to those for on licences, but are none the less significant. Risk profiling could therefore be useful to identify the off licences and special licences that have the greatest risk of causing alcohol related harm. A range of risk factors could be utilised to develop a risk rating for off licences and special licences, including (but not limited to):

**Off licences**

- type of premise
- premise location (density issues, high deprivation area, proximity to schools)
- lay out of premises
- shop front (break down of visual impact)
- past performance of licensee

**Special licences (public event)**

- type of event
- location/venue
- duration of event
- target market
- size of event
- experience and past performance of organiser and licensee

# 6 Population Health analysis and recommendations

Section 78 of the Sale and Supply of Alcohol Act 2012 (the Act) requires Territorial Authorities to both request information from and consult with Medical Officers of Health on the contents of the draft Local Alcohol Policy. Therefore, Population Health offers the following analysis of the information provided, together with recommendations for the content of Waikato District Council's Local Alcohol Policy.

The evidence presented indicates that alcohol can play a significant role in creating harm in communities. Population Health **advocates** for Waikato District Council to take a strong and effective stand on these issues through the adoption of a Local Alcohol Policy to ensure alcohol harm is controlled and minimised. Population Health accepts that alcohol consumption is a part of life for many, and that many people consume alcohol in a way that does not have negative impacts on communities. Population Health would like to reiterate to council that the key aim and purpose of Local Alcohol Policies is to reduce alcohol related harm.

## 6.1 Underpinning principles for Local Alcohol Policies and shared principles between local authorities

### 6.1.1 Underpinning principles

Population Health would like to note the following principles that underpin provisions of the Act regarding Local Alcohol Policies.

1. Local Alcohol Policies should be consistent with the object of the Act which refers to safety, responsibility and the minimisation of harm.

2. It falls within the responsibilities of those who sell or supply alcohol, to identify the risks that are associated with this and to have a plan to minimise these risks.

3. The review of alcohol legislation was prompted and driven, to a significant degree, by community concerns about harms associated with alcohol. This is reflected in Section 4 of the Act, which relates to the object of the Act. Through the provisions of the Act relating to Local Alcohol Policies, parliament has acknowledged that TAs are better able to recognise the needs of individual communities and has provided a framework for TAs to respond to those needs. This places the onus on TAs to regulate beyond what was seen as appropriate for central government rather than default to the "broad brush" provisions set down in the Act itself.

### 6.1.2 Shared principles

Population Health does not advocate for joint Local Alcohol Policies between TAs, as joint policies are associated with several risks. These risks include delays and costs to all participating TAs generated by any appeal, and potential difficulties in changing aspects of the policy (e.g. to take into account changing communities or demographics).

Population Health does, however, strongly support shared principles between TAs with respect to Local Alcohol Policies, as these will improve the efficacy of the Local Alcohol Policies in terms of the object of the Act as described in Section 4 of the Act.

Examples of shared principles

1. Off licence hours are consistent between TAs and are linked to strategies to reduce harm, including intoxicated late night decisions to purchase alcohol or to migrate across boundaries for alcohol.

2. Consistent and co-ordinated approach to one way door policies to minimise migration between premises or TAs.

3. Cross boundary consistency toward conditions for off licence visual impact issues, to ensure fairness.

4. Cross boundary consistency toward requirements for signage, to achieve consistent standards and maximise customer recognition and familiarity with rules and expectations.

5. Cross boundary consistency toward special licence criteria, to ensure fairness (especially where the applications relate to existing licensed premises).

6. Cross boundary consistency relating to off licence premise density and proximity criteria, to avoid some TAs developing a concentration of off licences.

Population Health does not advocate for these to be explicitly stated within the LAP, but strongly advocates for territorial authorities to actively engage with one another

## 6.2 Opening hours

Population Health views opening hours as a key component to addressing some of the more harmful types of alcohol consumption within Waikato District. It is important to acknowledge the harm that extended opening hours can bring, and address these as part of the Local Alcohol Policy.

### 6.2.1 Proposal

Population Health **advocates** for the following opening hours for Waikato District:

| | Opening time | Closing time |
|---|---|---|
| Off licence | 9:00 am | 9:00 pm |
| On licence (urban Sunday-Thursday) | 10:00 am | 10:00 pm |
| On licence (urban Friday-Saturday) | 10:00 am | 1:00 am |

Population Health would further **advocate** for no exceptions or exemptions to these hours, including in cases of supermarkets.

### 6.2.2 Rationale

The opening hours advocated above strike a balance between the potential health impacts on communities of alcohol availability and the needs of the hospitality and alcohol industry. Extended opening hours ensures alcohol is available to more people for longer periods of time. Late closings are likely to benefit people who are already under the influence of alcohol. However, long opening hours for neighbourhood off licences invite crime and poor health outcomes for those living in

the community. This is especially problematic for those in areas of high deprivation, which have the greatest number of off licences in Waikato District (Figure 12).

## 6.3 One way door policy

A one way door policy prevents the entry of new customers to a licensed premise beyond a set time of day, while allowing those already within the premise to remain inside. Such a policy is a tool for councils (and premises) to use as part of the Local Alcohol Policy. It may be useful as a means of controlling where people drink alcohol and for how long. It also has the ability to reduce the large rush of people leaving bars and clubs within the CBD at one time. From a health perspective, it may therefore be a useful tool to contain alcohol related harm incidents.

### 6.3.1 Proposal

Population Health **supports** the adoption of a one way door policy, and **advocates** for this to be in place from 1:00am within Waikato District. However, if opening hours suggested in Section 6.2.1 are adopted, a one way door policy would not be required in the district.

### 6.3.2 Rationale

A one way door policy helps enable a steadier and slower number of patrons leaving bars as opposed to the current situation which may see a large number of people leaving bars at the same time as they close. A one way door policy may reduce safety concerns (less inebriated people in one place leading to lower chances of alcohol related violence) and policing issues. If used in conjunction with opening hours suggested in 6.2.1, a one way door policy would not be required, and on licences would therefore not incur costs associated with additional security staff to police the policy.

## 6.4 Alcohol outlet density

It is clear from the data provided in section 4 above that a large number of off licences are located in areas of high deprivation. This is likely to lead to a greater level of harm for people living in these areas than for those located in areas of low deprivation.

### 6.4.1 Proposal

Population Health **advocates** for council to adopt risk rating procedures, as described in section 5 above, that take into account the health risks associated with greater availability of alcohol within lower socio-economic areas. A greater availability of alcohol leads to greater levels of consumption, which in turn is likely to lead to a greater amount of alcohol related harm, both acute and chronic. Population Health strongly advocates for this to be a key consideration in granting and controlling alcohol licensing under the Local Alcohol Policy.

Population Health does not expect a licence to be declined solely on the basis that it is within an area of high deprivation. However, the potential risks that are associated with this should be addressed to ensure they are mitigated to a reasonable degree.

Population Health **advocates** for Waikato District Council to cap the number of alcohol licences granted at its current level. This will, over time, reduce the number of alcohol licences the district and decrease harm caused by them.

### 6.4.2 Rationale

Managing, capping and reducing alcohol outlet densities is likely to have a positive effect in reducing alcohol-related harm. Studies have indicated that higher density of alcohol outlets (resulting in greater availability) may lead to increased consumption of alcohol and associated harms. There is also evidence that a large proportion of off-licence stores in the Waikato District Council and the greater Waikato DHB region are in areas of high deprivation, where harms to vulnerable members of the community may be even higher.

## 6.5 Alcohol Management Plans provided for in the Local Alcohol Policy as condition of licences

Alcohol management plans have superseded Host Responsibility Policies as a fundamental tool for licensees and managers of licensed premises to identify alcohol risks relating to their premises. In addition these plans identify and implement practical steps to minimise that harm. They have been used to extremely good effect across the gambit of licensed premises from Ruapehu Alpine Lifts to the Auckland Casino, from the Oakune Mardigras to rugby clubs. In fact every rugby and rugby league club from Taumarunui to Otorohanga has written and implemented their own detailed alcohol management plan.

### 6.5.1 Proposal

Population Health **advocates** that all applicants for a licence or renewal of a licence to sell or supply alcohol be required to identify the risks that are associated with their sale or supply and develop a plan to minimise or eliminate those risks. This would take the form of an *alcohol (risk) management plan* and should be a discretionary condition of the licence.

### 6.5.2 Rationale

The principle of health and safety planning as a requirement of all businesses is already well established in law, but this does not encompass the considerable risks, to customers and the public associated with the sale and supply of alcohol.

It falls within the responsibilities of those who sell or supply alcohol, to identify the risks that are associated with this and to have a plan to minimise these risks. A requirement for an alcohol management plan is entirely consistent with the object of the Act and is a proven tool in reducing alcohol harm associated with licensed premises.

It is also important that those running off licensed premises identify and understand the harm and risks of harm associated with their business and have a plan to address those risks.

## 6.6 Visual impact of off licence outlets

There is increasing evidence of the visual impact of alcohol outlets, especially to young people. As the number of off licences have grown, so has the visual impact of marketing.

### 6.6.1 Proposal

Population Health **advocates** for the acknowledgement of the visual impact of off licence premises (as defined in Section 17 of the Sale and Supply of Alcohol Act 2012) within the Local Alcohol Policy as a discretionary condition. There is a connection between exposure to alcohol marketing and consumption, particularly in young people.

Population Health **advocates** that the Local Alcohol Policy provide for restrictions on the visual impact of off licences as part of the licensing conditions, and along with additional restrictions on hours of operation, place more stringent visual impact limitations for those near schools. Restrictions would include a maximum area of advertising as a proportion of the shop front area and a restriction or ban on product marketing where it is visible or accessible to children or underage young people.

### 6.6.2 Rationale

The proliferation of licensed premises and the impact of these on the communities in which they have appeared was one of the drivers for the present Act.

While the impact of liquor premises is obviously multi faceted and includes implications for health, as well as crime and disorder, an inescapable issue which is high on the public agenda is the visual impact.

It is useful to break this into two considerations.

***The "eyesore" issue***

Many liquor store frontages have been dominated by signage giving the names of alcoholic products and the prices or 'specials' relating to them. The standard of sign writing has sometimes been such that there has been little to distinguish this in quality from graffiti. Like graffiti this sign writing impacts the aesthetic values of the community (Image 1).

While some liquor stores have taken this issue to an extreme, the issue is not specific to liquor stores. Other councils (e.g. Auckland) have passed bylaws to limit this shop front advertising, but bylaw enforcement has been resource difficult. In the case of licensed premises, compliance with visual impact restrictions can be a condition of the licence. The onus to ensure compliance then falls to the licensee as a suitability issue.

Visual impact restrictions are envisaged to include a percentage figure of the shop front area that can be signage. It is important that the restriction is compatible with, but not necessarily the same as, what may be imposed by a future bylaw. For example, if a licensed premises was permitted a maximum of 25% of the shop front area for alcohol related signage, this would be compatible with a by law that specified a maximum of 40% for all signage. Auckland currently stipulates 50% for all signage. Measurement of the actual percentage is achieved either by measuring the actual area of signage or by placing a grid pattern over the image of the shop front (Image 2, Ngaruawahia Cheep Liquor)

***Product promotion signage***

Liquor stores are generally located in high public use areas with significant foot traffic, which includes children. The impact of brand depiction on levels of brand recognition, alignment and preference among young people has resulted in regulation limiting brand depiction in the media to certain times of the day. In the case of tobacco, regulation has placed a ban on all brand marketing at points of sale

accessible to young people. However brand depiction of alcohol on shop fronts continues to be visible to all age groups at all times of the day (Images 3 and 4).

Major Ready to Drink (RTD) brand signage dominates the shop front of many liquor stores. There is a pattern of "tidying up" liquor stores by replacement of price signage with expensive and compelling brand signage (Images 5 and 6).

Store fronts with a lower visual impact display product and/or price-only advertising, rather than brand advertising (Images 7 and 8).

Lower still is the impact of product and/or price-only advertising in which alcohol is not given prominence over other products (Image 9).

**Table 5: Summary of Population Health recommendations on Waikato District Council Local Alcohol Policy.**

| LAP issue | Population Health recommendation |
|---|---|
| Off licence opening hours | 9:00 am – 9:00 pm |
| On licence opening hours | 10:00 am – 10:00 pm (Sun-Thurs)<br>10:00 am – 1:00 am (Fri-Sat) |
| One way door policy | In place from 1:00 am, or, if opening hours as suggested above are adopted, not required. |
| Alcohol outlet density | • Cap number of licences at current level. New licences granted only in areas of lower deprivation.<br>• Incorporate location as part of risk rating procedure. |
| Alcohol management plans | Alcohol risk management plans required as a conditions of licence. |
| Visual impact of off licence | Place restrictions on the amount of advertising permissible on the outside of off licence premises. |

**Image 1**

**Bottlemart Hamilton East, February 2012. Example of graffiti-like signage. Photo: Population Health.**

**Image 2** (Using a grid to assess visual impact)

**Cheep Liquor, Ngaruawahia 2011. Example of high percentage price signage on front of shop. The grid pattern is used to determine the percentage coverage of the shop front. Photo: Population Health.**

**Image 3**

**Bryant Liquor Centre, Sandwich Road, February 2013. Example of product promotion signage. Photo: Population Health.**

## Image 4

**Super Liquor Taumarunui. Example of price promotion signage. Photo: Population Health, February 2012.**

**Image 5**

**Black Bull Liquor, Melville, February 2012. Example of RTD advertising on shop frontage. Photo: Population Health.**

**Image 6**

**Black Bull Liquor, Melville, May 2013. Example of "tidied up" RTD signage. Photo: Population Health.**

## Image 7

**Hillcrest Super Liquor, February 2012. Example of price only, lower visual impact signage.Photo: Population Health.**

## Image 8

**Taumarunui Liquorland, May 2013. Example of price only, lower visual impact signage, but strong colour scheme. Photo: Population Health, February 2012.**

**Image 9**

**Claudelands Food Centre, May 2013. Example of price only, low visual impact signage. Photo: Population Health.**

**Image 10**

Dinsdale is an example of a high concentration of off licences.
**Clockwise from top left:**
**Dinsdale Liquorland, February 2012. Photo: Population Health.**
**Kiwi Liquor, Dinsdale, May 2013. Photo: Population Health.**
**Countdown, Dinsdale, February 2012. Photo: Population Health.**
**Dinsdale Super Liquor, May 2013. Photo: Population Health.**

Three of the off licences in image 10 are located within 100m of each other. All three bottle stores could be described as having a high visual impact, as described above. The external impact of the supermarket is limited but it is worth noting the prominent location and promotion of alcohol inside this store (accessible to children). The overall effect and concentration of alcohol outlets within a community contributes to the visual impact of alcohol, as well as the individual outlets.

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