Kookiri ki Taamakimakaurau Trust

Alcohol Position Statement

Key messages

1. To Maaori, alcohol is not only a harmful commodity but a colonial commodity
2. Maaori endure the highest-burden of alcohol-related harm of all New Zealanders – a breach by the Crown of te Tiriti o Waitangi
3. Policies that reduce alcohol availability and affordability, and restrict alcohol marketing, are the most cost-effective strategies for reducing alcohol-related harm. That said, more evidence is needed to understand the impact of these universal policies on Maaori
4. There is a lack of recognition in policy and legislation that the use of maatauranga Maaori is the most effective way for many Maaori to achieve their aspirations and equity
5. We urgently call on the Crown to review the Sale and Supply of Alcohol Act 2012, starting with a cross-government te Tiriti o Waitangi assessment of the causes of alcohol harm, and thereby improve the social determinants of health for Maaori
6. Kookiri ki Taamakimakaurau Trust does not want prohibition – we are anti-harm, not anti-alcohol

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Kookiri ki Taamakimakaurau Trust is a kaupapa Maaori organisation that aims to prevent and eliminate alcohol's unequal and disproportionate impacts on Maaori. We want to do this by breaking the intergenerational cycle of harm that stems from the colonisation of Aotearoa so that Maaori can achieve equity of outcomes and their aspirations. Kookiri ki Taamakimakaurau Trust recognises that Maaori have the knowledge, skills and capacity to control their health and destiny. As such, we want to empower them to change systems, so maatauranga Maaori drives Maaori futures.

A position statement is a brief, evidence-based, high-level statement about a specific issue. This policy document outlines our position on alcohol, and the solutions we believe are necessary to tackle alcohol harm. Each of the strategies below have been identified through current scientific practice and maatauranga Maaori. We add this caveat :

- Some of the critical scientific documents are not strong on protecting and supporting indigenous health and wellbeing to achieve equity and mana Motuhake. For example, there is a lack of evidence on the impact of the universal policies on Maaori regarding the interventions included in World Health Organisation's SAFER initiative (see page 8).
- There is a lack of maatauranga Maaori in policy and legislation regarding the solutions for alcohol harm

Kookiri ki Taamakimakaurau Trust will update this position statement with further maatauranga Maaori after completing the national Maaori health needs assessment. Please see the appendix for the justification and evidence base for these policy positions.

Recommended interventions

Kookiri ki Taamakimakaurau Trust believes that implementing strategies to prevent alcohol-related harm to Maaori across Aotearoa New Zealand is essential to achieve equity and Maaori aspirations. These strategies will improve where Maaori live, learn, work, pray and play, and consequently, outcomes for all New Zealanders. What is good for Maaori is good for non-Maaori. It is clear that the Sale and Supply of Alcohol Act 2012 ('**the Act**') has had little impact on changing the environment that encourages unhealthy drinking, or on minimising alcohol-related harm to Maaori. Accordingly, Kookiri ki Taamakimakaurau Trust supports the following:

Te Tiriti o Waitangi and equity

1. Giving effect to Te Tiriti o Waitangi in legislative and policy responses to alcohol
To include but not limited to:

- A cross-government te Tiriti assessment of the legislative and policy responses to alcohol
- A call to action for urgent and full review of the Sale and Supply of Alcohol Act 2012, with:
    - Insertion of a Te Tiriti o Waitangi clause, embedding te Tiriti and its principles in the Object of the Act, and giving effect to te Tiriti throughout
    - Amendments to sections 4, 105, 131 and 142, and other amended/new sections added to the Act that incorporate some of the recommendations listed below

2. The Crown addresses the determinants of health and social wellbeing as a cross-government priority
To include but not limited to:

- Increasing Maaori incomes
- Reducing the number of Maaori living in poverty
- Eliminating racism and discrimination
- Increasing the use of maatauranga Maaori
- Combating the commercial determinants of health in legislation
    - Excluding all parties with commercial conflicts of interest from policy-making processes

3. Reform the alcohol licensing process
To include but not limited to:

- Putting the strategic leadership of alcohol licensing under the stewardship of the Maaori Health Authority (*this does not mean the MHA would employ the licensing staff*)
- Creating a fourth Maaori agency to exercise mana Motuhake, with two functions:
    - Inquiring into licence applications
    - Exercising veto rights on new or renewal licence applications before they move to a final decision-making body, currently the District Licensing Committee (DLC)
- Ensuring agencies consult with Maaori in their local rohe on applications that are a priority to Maaori, as determined by Maaori
    - Inclusion of Maaori Impact Statements
- Replacing DLCs with permanent commissioners to hear applications in the interests of all New Zealanders
    - Two of the three-panel members will be Maaori
    - Decisions made by consensus, not a majority vote
- Designing a system that fosters close collaboration between the regulatory agencies (Licensing inspectors, Police and Medical Officers of Health) and reduces duplication, preferably within a single agency.
- Increasing monitoring of higher risk licences, namely bottle-shops and taverns in high Maaori population areas, with renewals required annually, not on a three-year cycle
- Prohibiting licenced premises 1.5 km from a sensitive site, with sensitive sites itemised in the Act such as marae, schools, maunga, and churches.

4. **Increase community participation in the licensing process**

To include but not limited to:

- Recognising Maaori status as tangata whenua, Maaori will be given standing for any application they wish to object to regardless of geographical proximity
- Ring-fenced funding for Maaori legal support by Maaori legal teams
- Prohibiting the cross-examination of whaanau as community objectors by alcohol industry lawyers
- Application fees include stipend payments to each whaanau members who attends a DLC hearing as an objector
- Increasing the 15 working day reporting window to 30 working days to allow for increased whaanau engagement
- Improvinge the notification requirements of an alcohol licence application, enabling whaanau to know what is being lodged in their local environment
    - Maaori are included in s 103
    - Mandated notification of all marae in the rohe of the premises
    - Use of digital technology to notify the community, such as that used for transmitting COVID-19 alerts to populations

    - Observing tikanga throughout the entire process, and making te Reo translators available for each hearing

Implementation of evidence-based policies to reduce alcohol harm across the whole population

5. Enable the restriction of the accessibility and availability of alcohol through the Act

To include but not limited to:

- Reducing the default maximum national trading hours, especially the closing hour (i.e. to 9 pm for off licences, 2 am for on licences and 12 pm for club licences) but also opening hours so alcohol outlets are not open when tamariki are walking to school
- Increasing the purchase age from 18 to 20 years
- Revoking the Local Alcohol Policy (LAP) appeals process and mandate LAP development by Territorial Authorities
- Restricting online alcohol sales and aligning the requirements for online alcohol sales with in-person sales, including:
    - Requiring all online alcohol sellers to obtain a section 40 (remote sellers) alcohol licence
    - Prohibiting same day delivery
    - Requiring the buyer and receiver to verify their age (i.e. make this mandatory in legislation)
    - Prohibiting alcohol products to be left unattended at the delivery
    - Requiring that the delivery only occurs within permitted trading hours of the physical premises or for online-only sellers, being the more restrictive of the default national maximum trading hours or local alcohol policy.
- Enabling licence numbers to be lowered in high Maaori population locations by inserting a 'sinking lid' and cap on the number of premises of one per 5 km radius
    - All current licences holders in high Maaori population areas will systematically re-apply for their licence at the same point in time to ensure the 'safer' operators hold the licences

6. Strengthen s.237 of the Act to eliminate commercial marketing, advertising, and sponsorship of alcohol across all media, including on digital platforms

To include but not limited to:

- Adopt the Law Commission recommendations so that no alcohol advertising should be allowed in any media other than advertising that communicates objective product information
    - This includes banning of alcohol sponsorship of sports and other events open to the public.

7. Reduce the affordability of alcohol:

To include but not limited to:

- Increasing the alcohol excise tax by 50%
    - A proportion of which ring-fenced to fund kaupapa Maaori solutions and services
    - Introducing a minimum unit price (MUP) for alcohol

8. Increase drink-driving countermeasures:

To include but not limited to:

- Increase random breath testing to best-practice levels of one test per year per qualified driver
- Lower the adult legal blood alcohol limit to 0.02 g/dL in the Land Transport Act 1989, with 0.05 g/dL constituting a criminal offence.

Other recommended interventions

9. Requirement for appropriate and accessible health services for Māori

Maaori are not hard to reach; the necessary support from those in power is hard to access or not culturally appropriate. We need to make every contact count and provide appropriate support by:

- Developing kaupapa Maaori care pathways and services across the life course.
- Ensuring all health and social care professionals are trained to provide services that do not discriminate by ethnicity and treat all with the same care.
- Routinely providing screening, brief alcohol advice and, where indicated, referral to safe, appropriate and accessible treatment services.

10. Fetal Alcohol Syndrome Disorder (FASD)

To include but not limited to:

- Increase the awareness of FASD, and implement prevention strategies at both population level and for high risk populations
- Increase the knowledge of FASD in Maaori communities and relevance to whanau ora
- Advocate to classify FASD as a standalone disability

11. Further systemic changes to prevent alcohol harm and minimise inequities.

To include but not limited to:

- The Crown to commit to and deliver against the WHO global alcohol action plan 2022 – 2030 (*when implemented*)
- The Crown to develop a whole-systems, multi-faceted, national alcohol strategy that also addresses the negative influence of the alcohol industry
- Implementation of a national policy goal similar to Smokefree 2025
- Implementation of a national data indicators framework and publishing of alcohol sales figures
- Equitable and ring-fenced investment in alcohol harm prevention for Maaori

Background: Alcohol in our communities

Alcohol is not an ordinary commodity. It is an intoxicant (gets you drunk), a carcinogen (causes cancer), toxin (poison), and an addictive drug.[1] The pro-alcohol culture in New Zealand has led to the normalisation of drinking in various settings and has resulted in cultural blindness to the impact of alcohol-related harm.

Alcohol use is a cause of more than 200 acute and chronic health conditions, including injuries, liver disease and cancer,[2] and lifelong disabilities including fetal alcohol spectrum disorder (FASD).[3] In New Zealand, alcohol is estimated to have been responsible for 802 deaths (5.4% of all deaths) and 13,769 years of life lost (YLLs) for people under 80 years of age in 2007. For Maaori, the death rate from alcohol was 2.5 times the rate for non-Māori, and the years of life lost due to alcohol were 2.6 times greater for Māori than non-Maori.[4]

The economic cost to society from alcohol harm is estimated to be $7.85billion per year,[5] significantly higher than the tax revenue from alcohol sales at just over $1billion per year.[6] It is estimated that 3% of New Zealand's Gross Domestic Product (GDP) is spent on alcohol-related harm.[7] This means we all pay for alcohol-related harm, even if we drink or not.

Colonisation and Alcohol

To Maaori, alcohol is not just a harmful commodity but a colonial commodity. Maaori lived for over 400 years without any form of Alcohol in Aotearoa New Zealand, until Europeans introduced it in the late 1700s.[8] Thus, the entirety of the burden of alcohol-related harm for Māori is attributable to extrinsic factors.[9] [10]

Alcohol or waipiro, meaning 'stinking water', is a significant cause of harm to Maaori communities and is a consequence and cause of inequity for our people.[11] The numerous inequities in health and social outcomes caused by alcohol reflect ongoing breaches of Te Tiriti o Waitangi, which are avoidable, unethical and unjust.[12] The disparities between Maaori and non-Maaori are due to colonisation being a key driver in the harm and social injustices.[13][14][15]

The social, economic and physical environments are critical determinants of inequities in drinking and harm for Maaori. They must be addressed for Maaori to achieve, and then exceed, equity of health and social outcomes.[16] We say "exceed" as reaching non-Maaori health status is not our aspiration; we want to be bolder than that. Furthermore, there is evidence that people in lower socio-economic areas experience more harm per drink than those in higher socio-economic areas.[17] Therefore, pro-Tiriti and pro-equity policies are needed so Maaori can achieve their aspirations concerning alcohol and so that New Zealand as a society meets its obligations to te Tiriti o Waitangi.[18]

Alcohol Harm to Maaori

In many ways, it feels like outlining alcohol's harm to Maaori is futile. At a high level, we have known that the harm to Maaori has been disproportionate for decades, but nothing changes. Inequities persist, and Maaori are frustrated with the inaction and the lack of leadership regarding alcohol harm prevention. As a result, alcohol is normalised, affordable, promoted and widely available in Maaori communities,[19] despite being the most harmful drug in our society.[20] Some of the inequities in alcohol harm include:

- Waahine Maaori experience more harm from other people's drinking than other demographic groups.[21]
- Maaori are 2.5 times more likely to die from alcohol than non-Maaori.[22]
- The proportion of cancer due to alcohol is greater in Maaori than non-Maaori, an average of 12.7 years of life is lost from alcohol-attributable cancer for Maaori compared to 10.1 years for non-Maaori.[23]
- The experience of discrimination explains 35% of the relationship between Māori ethnicity and hazardous drinking. [24]

The trends in this harm have been manifesting for generations. It is time that Maaori were allowed control over their health and wellbeing: what is good for Maaori is good for all New Zealanders. Maaori will not fail paakehaa like paakehaa have failed Maaori.

Policy and legislative environment

Kookiri ki Taamakimakaurau Trust's position on alcohol in Maaori communities has been developed in the context of te Tiriti o Waitangi, including but not limited to the national policy and legislation outlined below. Additionally, the United Nations (UN) Declaration on the Rights of Indigenous Peoples,[25] the UN Convention on the Rights of a Child 1990,[26] and the New Zealand Government's wellbeing priorities[27] require strategies that address longstanding inequities in alcohol-related harm between Maaori and non-Maaori. Maaori want their mokopuna to grow up in healthy and supportive environments. Only then can they realise their full potential and break the intergenerational cycle of alcohol harm.

Stage One of the Health Services and Outcomes Kaupapa (WAI2575) 2019

In the findings of WAI2575, Dr Ashley Bloomfield, the Director General of Health, acknowledged that the New Zealand Health and Disability system is institutionally racist and that racism is a determinant of health and wellbeing for Maaori. A critical comment in the report states:

"The Crown's failure to abide by its Treaty obligations and ensure that its agents and the health sector as a whole are doing the same has contributed to the dire state of Maaori health outcomes. It cannot continue to evade its obligations... the health inequities experienced by Maaori'. Some of the findings included:

- The Crown has failed to commit to health equity for Maaori
- There has been consistent underfunding of Maaori health services and interventions
- There is a lack of Maaori health data for monitoring and accountability
- The Crown was aware of said failures and failed to remedy
- There is a lack of Tiriti-consistent Maaori control
- The New Zealand Health and Disability system is not Treaty compliant
- The health system does not recognize tino rangatiratanga or mana Motuhake (selfgovernment)[28]
- There is a lack of partnership in decision-making concerning health design and delivery

New Zealand Health and Disability Health system review 2020

The review of the Health and Disability system has led to the system undergoing a transformation process. The findings dovetailed with that of WAI2575. The key findings relevant to achieving equity for Maaori include:

- Communities need to be more actively engaged in needs assessment, analysis and system planning
- Greater community engagement that places whaanau at the centre of all decision making
- Maaori should be enabled to embrace maatauranga Maaori and fully express their cultural identity
- Improvement in data collection that needs to be at the centre of decision-making
- The system needs to be Tiriti compliant
- Clearer and enforceable mandates and accountability of performance
- Effective and long-term strategic planning is required
- A need to focus on prevention

World Health Organisation SAFER Framework 2018

The World Health Organization (WHO) launched the SAFER Framework in 2018 which outlines five evidence-based strategies to be used by governments reduce the harmful use of alcohol and related health, social and economic consequences.[29] However, Global alcohol Action Plan has not yet been completed.
The five high impact strategies are:

1. **S**trengthen restrictions on alcohol availability
2. **A**dvance and enforce drink driving countermeasures

3. **F**acilitate access to screening, brief interventions and treatment
4. **E**nforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion
5. **R**aise prices on alcohol through excise taxes and pricing policies.

The adoption of population-wide strategies to reduce the harm from alcohol, based on the evidence of effectiveness from international research, was championed by NGOs such as Alcohol Action NZ (5+ solution), and by academics and community groups in New Zealand but ignored by successive governments. At the end of their third term in 2008, the Labour government commissioned a review of alcohol legislation with a view to the drafting a new comprehensive law to reduce harm from alcohol. The review and drafting of the law were completed after a change in government.

Alcohol in our lives: Curbing the harm, Law Commission 2010

The Law Commission undertook a comprehensive review, the findings were published in 2010, of the role of alcohol regulation in New Zealand in light of the liberalising Sale of Liquor Act 1989 where the philosophy was that licences would be '*easier to get, easier to lose.*'Wine sales were allowed in supermarkets from 1989 and beer sales from 1999. The age of lawful purchase was also lowered from 20 to 18 years of age in the Sale of Liquor Amendment Act 1999.[30] [31] The report '*Alcohol in our Lives: Curbing the Harm*'[32] recommended significant changes to the sale and supply of alcohol, including reducing alcohol affordability and availability and restricting advertising and sponsorship. While the Act incorporates many of the licensing and administrative recommendations from the Law Commission report, the Crown did not implement the critical recommendations for population-based policies that reduce harm.

Sale and Supply of Alcohol Act 2012

The Ministry of Justice administers the Sale and Supply of Alcohol Act 2012, which replaced the Sale of Liquor Act 1989 after the Law Commission 2010 report was completed. The intent was to move to a health-based approach to alcohol control was lost with the change of government. Unsurprisingly given the the critical recommendations for population-based policies from the Law Commission 2010 report were not implemented, it is widely accepted that this Act has not met its objective and is ineffective, with various reports recommending changes.[33][34][35][36] Indeed, hazardous drinking rates and inequities between Maaori and non-Maaori are increasing.[37]

The 2030 Agenda for Sustainable Development, United Nations 2015

The United Nations' has developed 17 Sustainable Development Goals (SDGs) that require national and international collaboration to '*end poverty, protect the planet and improve the lives and prospects of everyone, everywhere*.' The goals were adopted in 2015 by all United Nation member states with a 15 year plan to achieve the goals.[38] These asipirations align with Maaori aspirations. Reducing the consumption of alcohol will help achieve, directly and indirectly, several of these goals including goals on ending poverty (SDG 1), good health and wellbeing (SDG 3) which includes a target of one-third reduction in premature deaths from NCDs by 2030, quality education (SDG 4), gender equality (SDG 5), economic growth (SDG 8) and reducing inequalities between and within countries (SDG 10).[39] Arguably responsible consumption (SDG 12) and climate action (SDG 13) also apply due to the impact of alcohol production and transportation on the climate, and the use of wai, Maaori taonga or treasure, that is used to produce a commodity that harms our people.

This position statement also has strategic alignment to:

- WAI 2575 Stage One of the Health Services and Outcomes Kaupapa 2019
- WAI 2575 (WAI 2624) Alcohol Healthcare Claim
- Pae Ora – Healthy Futures 2015
- United Nations Convention on the Rights of a Child 1990
- United Nations Declaration on the Rights of Indigenous People 2007
- World Health Organisation's prevention of non-communicable disease 2017
- New Zealand Government's Wellbeing priorities 2021
- Kaupapa Maaori Tukanga moo te Panoni (Process for Change) 2019[40]

Appendix

Justification for the policy positions

The table below shows Kookiri ki Taamakimakaurau Trust's justification for the recommendations to prevent and eliminate alcohol-related harm. The recommendations are made from a mixture of population-based strategies tested internationally , maatauranga Maaori and Official Information Act (OIA)1982 responses. The justification, where appropriate, gives some suggestions regarding how the recommendation could work in practice.

The recommendations are informed by key documents, including:

- Waitanhi Tribunal health kaupapa report WAI 2575 (stage one) [41]
- Waitanhi Tribunal health kaupapa report WAI 2575 (WAI 2624)[42]
- Health and Disability System Review 2020[43]
- Law Commission's 2010 report *Alcohol in our Lives: curbing the harm*[44]
- World Health Organisation's SAFER initiative initiative[45]
- Alcohol Action NZ's 5+ model[46]
- Alcohol Healthwatch's Evidence-based alcohol policies: building a fairer and healthier future for Aotearoa New Zealand [47]
- Health Coalition Aotearoa's expert alcohol panel priorities
- District Health Board Chief Executives and Chairs Position Statement on the Sale and Supply Alcohol Act 2012

Kookiri ki Taamakimakaurau Trust will update these recommendations in line with new evidence becoming available, particularly the conclusion of the Maaori alcohol health needs assessment. The recommendations do not allow for political appetite, so our alcohol prevention and elimination strategy will be agile to policy windows.

We recognise that there are many recommendations; this is because the issues and solutions for Maaori are deep-rooted and complex, stemming from colonisation and the legacy since. The higher the number of the recommendations implemented, the more influential the response to preventing and eliminating the harm to Maaori.

Recommendation	Justification
Implementation of evidence-based policies to reduce alcohol harm across the whole population	
Enable the restriction of the accessibility and availability of alcohol	
Reducing the default maximum national trading hours, especially the closing hour - to 9 pm for off licences; and - 2 am for on licences and 12 pm club licences.	Reducing the trading hours of alcohol sales reduces the harm, particularly reducing the closing hours. Reducing trading hours is recommend in WAI2624, Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies, the SAFER initiative, Health Coalition Aotearoa's alcohol priorities and the national DHB alcohol position statement.
Increase the purchase age from 18 to 20 years	The longer rangatahi delays drinking, the less harm they are likely to have over their life course. Increasing the age will delay the onset of drinking, and may delay social supply by parents and other adults. Increasing the purchase age is recommend in WAI2624, Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies, the SAFER initiative, Health Coalition Aotearoa's alcohol priorities and the District Health Board Chief Executives and Chairs Position Statement on the Sale and Supply Alcohol Act 2012.
Revoking the Local Alcohol Policy (LAP) appeals process and mandate LAP development by Territorial Authorities	Many LAPs across the motu have been 'watered-down' or delayed by the interests of the alcohol industry, including the very active use of the appeals process. The economic interests of the alcohol industry should not be put before the lives of Maaori. This is recommended in Alcohol Healthwatch's Evidence-based policies and the District Health Board Chief Executives and Chairs Position Statement on the Sale and Supply Alcohol Act 2012.
Restrict online alcohol sales and align the requirements for online alcohol sales with in-person sales.	Prohibiting same day delivery will stop intoxicated people buying alcohol. Compliance with regulations governing other alcohol sales eliminates the loopholes in basic protections being exploited by online delivery.

	Restricting online sales reduces availability of alcohol, which is recommended in WAI2624, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies, the SAFER initiative, Health Coalition Aotearoa's alcohol priorities and the District Health Board Chief Executives and Chairs Position Statement on the Sale and Supply Alcohol Act 2012.
Enabling licence numbers to be lowered in high Maaori population locations by inserting a 'sinking lid' and cap on the number of premises	Many Maaori communities are saturated with licensed premises, so we don't just want to prevent new premises, but also reduce what we already have. As a minimum, we would recommend one off-licence per 5km radius as the harm from a bottle-shop radiates nearly 5 km from source. As stated in WAI 2624, this is also important to reduce the exposure to advertising, availability and amount of cheap booze in high Maaori population areas. The higher the density of outlets, the more alcohol advertising exposure. As shoppers have more choices on where to buy alcohol, premises compete for business by lowering prices and staying open for longer. Reducing the density of licenced premises is recommended in Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies, the SAFER initiative, Health Coalition alcohol priorities and the District Health Board Chief Executives and Chairs Position Statement on the Sale and Supply Alcohol Act 2012.
All current licences holders in high Maaori population areas will systematically reapply for their licence at the same point-in-time to ensure the licences than remain are held by the safer operators	This recommendation is important in conjunction with a cap on licences. We do not want the sinking lid to occur by the first 'cab off the rank' having to close to achieve the cap of licences in a high Maaori population area. This is unfair to the better operators and more importantly, Maaori could be left with the worst operator in a given area. Therefore, all licences premises in Manurewa, for example, would have to reapply for their alcohol licence at the same time. Those that cause the least harm,

	and the community are most comfortable with, would be granted a licence so the density of alcohol licences reaches the cap limit. This step is important as renewals for licenced premises arise on different dates, and it could be that a safer operator is due for a renewal in the next month and the least safe operator in three years time. We recognise this will create a burden on the system in the short-term, but this can be recouped from the fees and will reduce the long-term burden as there will be fewer premises for renewal. We also want to point out that we do not believe there is such a thing as a safe operator, but the risk can be reduced.
Strengthen s.237 of the Act to eliminate commercial marketing, advertising, and sponsorship of alcohol across all media, including on digital platforms	
Adopt stage 3 of the Law Commission recommendations so that no alcohol advertising should be allowed in any media other than advertising that communicates objective product information o including sponsorship of all events, including sports and cultural activities	Cumulative exposure to alohol advertising is a cause of young people starting to drink earlier than they would otherwise and to drink larger amounts. For vulnerable adults (e.g. dependent drinkers or those trying to reduce drinking) advertising has been shown to trigger relapse. We also know that tamariki Maaori are exposed to more alcohol advertising than non-Maaori, meaning they will experience more harm from alcohol than non-Maaori children.[48] Regulating alcohol marketing is a recommended approach in WAI2624, Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies, the SAFER initiative, Health Coalition Aotearoa's alcohol priorities and the District Health Board Chief Executives and Chairs Position Statement on the Sale and Supply Alcohol Act 2012.

Reduce the affordability of alcohol	
Increasing the alcohol excise tax by 50% Proportion ring-fenced for kaupapa Maaori solutions and services	Increasing excise tax is the most tested and cost-effective intervention to reduce alcohol consumption and harm in populations. Therefore it is a recommend approach in WAI2624, the Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies, the SAFER initiative, Health Coalition Aotearoa's alcohol priorities and the District Health Board Chief Executives and Chairs Position Statement on the Sale and Supply Alcohol Act 2012.
Introducing a minimum unit price (MUP) for alcohol	The affordability of alcohol has a strong impact on alcohol use, meaning the cheaper it is the more people consume. The affordability of alcohol in Aotearoa has increased and is more affordable than ever,[49] despite the Law Commission 2010 recommending an increase in alcohol prices to reduce the harm. Minimum Unit Pricing (MUP) makes the cheapest alcohol products less affordable, meaning less alcohol will be consumed. International research suggests that it would not mean less kai on the table, but we encourage similar research on Maaori. Pricing policies are recommended by the Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies and the SAFER initiative.
Increase drink-driving countermeasures:	
Increase random breath testing to best-practice levels of one test per year per qualified driver	Recommended in Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies and the SAFER initiative.
Lower the adult legal blood alcohol limit to 0.02 g/dL in the Land Transport Act 1989, with 0.05 g/dL constituting a criminal offence.	Recommend by Alcohol Action NZ 5+, because of evidence that it reduces harm further, and because it counters the idea that there is a safe level.

Te Tiriti o Waitangi and equity interventions	
Giving effect to Te Tiriti o Waitangi in legislative and policy responses to alcohol	
A cross-government Tiriti assessment of the legislative and policy responses to alcohol	Alcohol harm to Maaori can be prevented and eliminated by more effective legislation and policy from a range of Ministries and associated agencies. It is not solely the responsibility of the Ministry of Health and Justice. For example, the Ministry of Foreign Affairs and Trade, the Ministry of Social Development and the Treasury all have a role in preventing and eliminating alcohol-related harm to Maaori.
Call to action for an urgent and full review of the Sale and Supply of Alcohol Act 2012	It is widely acknowledged that the Act has not achieved its stated object and needs reform, as most recently noted in the national District Health Board (DHB) alcohol position statement. The 2019 Alcohol Regulatory and Licensing Authority annual report noted the following: *"The Authority notes that the number of applications refused for new licences is very low compared to the number of applications being granted. The same can be said for applications for licence renewals and new manager's certificates. The reasons why there are so few refusals may be worthy of some investigation by policy officials to see if this is consistent with what was envisaged at the date of commencement of the Act".* *This is supported by:* - *Analysis from Auckland Regional Public Health Service which showed 99% of applications over a three year period went unopposed.*[50] - An Official Information Act 1982 response from the Ministry of Health, Ref: H202105503, transferred to Public Health Units (PHUs), showed that out of over 31,000 applications nationally from July 2018 to May 2021, 677 or just 2% had a positive outcome such as a licence declined or a negotiated outcome. Reviewing the Act is recommend in WAI 2624, Alcohol Healthwatch's Evidence-based policies, He Ara Oranga - the Government Inquiry into Mental Health and Addiction

	2018,[51] Health Coalition Aotearoa's alcohol priorities and the national DHB alcohol position statement.
Insertion of a Te Tiriti o Waitangi clause, embedding te Tiriti and its principles in the Object of the Act, and giving effect to te Tiriti throughout Amendments to sections 4, 105, 131 and 142, and other amended/new sections added to the Act that incorporate some of the recommendations listed below	The Act does not address the disproportionate impact of alcohol on Maaori, nor does it uphold and honour the Crown's obligations under Te Tiriti o Waitangi. This is clearly articulated in many reports, including WAI 2624. Giving effect to te Tiriti is much more than adding a Tiriti clause and impacts all provisions with the Act, including those required to be added as a consequence of giving effect to te Tiriti in the Act, such as price. By not having a te Tiriti clause, the rights guaranteed by the Tiriti o Waitangi are being denied to Maaori. WAI 2624 states that: "*This claim, therefore, raises constitutional issues, namely the importance and place of the Treaty in the Act (and New Zealand legislation generally), and the Treaty-based right of Māori to participate in matters directly affecting their quality of life, and the Crown's failure to ensure the same*." WAI2624 also states that: "*Because the Act legislatively omits any reference to the Treaty, those empowered under it are legislatively unrestrained by the Treaty – and actively ignore it to the ultimate detriment of Māori.*" In a recent Official Information Act 1982 request from the Ministry of Health, Ref: H202105503, PHUs across Aotearoa were asked how many alcohol licence applications they have investigated in consultation with Maaori as part of their investigations. The complete picture is not yet known, but to date, we know there have been over 31,000 applications from July 2018 until May 2021, and only 87 investigations met their obligations to te Tiriti, or just 0.2%, the majority ot which were in Taamakimakurau. This is unacceptable. Some PHUs noted that consulting with Maaori is not a requirement in the Act. Some direct quotes are shown below:

	1. *"We are unable to consult with Māori and/or the general public about an application."* 2. *"Our current investigation process does not routinely involve consultation with Māori. The sheer number of licences received and the statutory timeframes involved make meaningful engagement problematic."* 3. ***"There is no obligation under the Sale and Supply of Alcohol Act to consult with Māori****."* 4. *"Nil. Regulatory Officers do not consult with the public when reporting on licence applications."* Although the Act does not say PHUs should consult with Maaori, it also does not say they should not either. Until the Act is amended, the default should be required to consult with Maaori as outlined by the New Zealand Public Health and Disability Act 2000.
The Crown addresses the determinants of health and social wellbeing as a cross-government priority	
Increasing Maaori incomes and reducing the number of Maaori living in poverty	These factors are linked to the legacy of colonisation, where Maaori land, treasures, language, and way of life were eroded and stolen by Paakehaa. Maaori incomes are generally lower than non-Maaori, and more Maaori live in poverty than non-Maaori. If incomes were to be raised and Maaori enabled to be lifted out of poverty, then alcohol harm, and other harms, would decrease.[52] [53] Improving these factors is also important to reach the UN's Sustainable Development Goals and the WHO's prevention of non-communicable disease (see page 10.
Eliminating racism and discrimination	Racism was identified as a determinant of health by Dr Ashley Bloomfield in his expert witness testimony for WAI 2575. Maaori experience widespread racism, so it must be eliminated so we can be healthier, achieve our aspirations and live in a fairer society. As noted in the WAI 2624 MoJ claim: (138) *"The alcohol-related prejudice suffered by Māori is beyond calculation, both financially and in terms of the human impact. Nor will that prejudice be removed or ameliorated*

	*quickly as it is likely that it will take generations to address, as the effects are intergenerational and the pathway to resolution **riddled with institutional racism**.*"
Increasing the use of maatauranga Maaori	Indigenous knowledge is just as legitimate as Western knowledge, but we have been institutionalised to believe the Western scientific evidence is better and more reliable through imperialism. But, the west does not know best for Maaori; otherwise, we would not be at the lowest end of most health and social indicators. It is time to give the responsibility of the health and wellbeing of our people back to Maaori, which includes enabling and utilising maatauranga Maaori. This was highlighted clearly in the Health and Disability systems review 2020 and WAI 2575.
Combating the commercial determinants of health in legislation o Excluding all parties with commercial conflicts of interest from policy-making processes	The alcohol industry's profits should not come before the health and wellbeing of Maaori. The alcohol industry 'preys' on Maaori, which is why we see a higher saturation of alcohol premises in high Maaori areas. All companies, organisations and people who gain from the sale of alcohol, must be excluded from the process of alcohol policy-making at local and national levels, due to their absolute conflict of interest. As well as producers, distributors, retailers etc this includes, for example, the advertising industry which derives substantial income from the alcohol sector. The alcohol industry should not be able to influence public policy-making as their legal requirement is to maximise sales for shareholders. To reduce alcohol harm, we need to reduce alcohol consumption, which is directly in conflict with the industries obligation to make a profit by maximising sales. As such, the alcohol industry cannot be trusted as it prevents effective, proportionate and evidence-based policies that fail to protect indigenous people.[54] New Zealand governments are not providing the robust response to the alcohol industry that we see concerning tobacco, despite greater societal harm.[55] This suggests the

	need for a policy response like the Framework Convention on Tobacco Control for alcohol, starting in particular with an equivalency to clause 5.3.[56] At the GAPA 2020 conference in Dublin, the Republic of Ireland's Health Minister stated they had implemented a 'lobbying register'[57] to understand which companies and industries were lobbying politicians to influence public policy. This was credited as part of the strategy the reduced the influence of the alcohol industry by increasing the transparency of such tactics. If a country with a strong alcohol lobby that includes Guinness can do it, New Zealand indeed can replicate. But to be clear, it is exclusion of the industry that is required, or as it is sometimes called, "sequestration".
Reform the alcohol licensing process and increase community participation	
Putting the strategic leadership of alcohol licensing under the stewardship of the Maaori Health Authority (*this does not mean the MHA would employ the licensing staff*)	We believe the Maaori Health Authority should lead the stewardship of alcohol licensing, or as a minimum, in joint partnership with the non-Maaori agency. We would see this as enabling Maaori to exercise mana Motuhake. Maaori have suffered alcohol harm since the 1800s; today, we are 2.5 times more likely to die from alcohol than non-Maaori,[58] and the inequities continue to grow.[59] We see this as a logical move and mana enhancing, particularly as reducing alcohol outlet density is a priority for Maaori.[60] In an Official Information Act 1982 response from the Ministry of Health, Ref: H202105503, PHUs across Aotearoa were asked how many alcohol licence applications they had investigated in consultation with Maaori as part of their inquiries. The whole picture is not yet known, but to date, we know there have been nearly 33,000 applications from July 2018 until May 2021 motu wide, and only 87 were in consultation with Maaori or just 0.02%. This is unacceptable. To ensure obligations to te Tiriti o Waitangi and its principles are met, it is time for Maaori to lead alcohol licensing. What is good for Maaori is good for non-Maaori, so all New Zealanders will prosper under this approach, as currently, Maaori do not.

Creating a fourth Maaori agency to exercise mana Motuhake, with two functions: o Inquiring into licence applications o Exercising veto rights on new or renewal licence applications before they move to a final decision-making body, currently the District Licensing Committee (DLC)	Currently, non-Maaori agencies determine what they oppose, and Maaori do not have the same status in the licensing process. This is a breach of te Tiriti o Waitangi as Maaori do not have mana Motuhake, highlighted as a right and privilege by WAI 2575 and the Health and Disability review 2020. As noted in WAI 2624, the Waitangi Tribunal said, "*a duty to protect the Māori duty to protect [their taonga], and an obligation to strengthen Māori to strengthen themselves*." As also noted in WAI 2624: *according to the Waitangi Tribunal, Māori communities protect and strengthen themselves through the exercise of mana Motuhake*. This is also important as Auckland Regional Public Health Service research shows that success at a DLC is highest when the agencies and public oppose and object together. Out of 16,000+ applications over three years, over 99% of applications were not opposed by the three agencies. Out of the 180 hearings held from the 16,000+ applications when the community objected without agency support, success was only 2%. So for clarity, 2% of the 1% were successful.[61] This is unacceptable to Maaori as non-Maaori agencies reduce the likelihood of success of Maaori communities as objectors. As also noted in WAI2624: (71) The Treaty guaranteed Māori the **right to exercise tino rangatiratanga** in all matters that directly concern them, including their health and wellbeing….. and the right to participate – and the Crown must ensure this occurs." The recommendation is that a fourth Maaori agency will be one agency with two roles: to inquire into a licence the same as a licensing agency and then determine whether

	the application proceeds to the final decision-making body, currently the DLC. If the Maaori agency determines that the community does not want the licence, it will be automatically declined. To enable and achieve mana Motuhake/tino rangatiritanga Maaori must have the overriding decision. Once an application reaches a DLC, it is then their determination if the licence is granted or not. There are precedents for this. Although the alcohol laws have been discriminatory at times since the middle of the 1800s, the Outlying Districts Sale of Spirits Act 1870, amended in 1873, saw a reduction in alcohol harm to Maaori. Under this legislation, Maaori assessors had greater authority over their alcohol environment, including the power to veto any new licenses and the renewal of existing ones.[62] Having veto rights is enabling Māori the **right to exercise tino rangatiratanga** as te Tiriti o Waitangi intended.
Ensuring agencies consult with Maaori in their local rohe on applications that are a priority to Maaori, as determined by Maaori o Inclusion of Maaori Impact Statements	As stated above, in an Official Information Act 1982 response from the Ministry of Health, Ref: H202105503, PHUs consulted with Maaori on 0.02% of the 32,000+ applications received over three years motu wide. This is despite s4 of the New Zealand Public Health and Disability Act 2000[63] saying: *'To recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Maori, Part 3 provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in the delivery of, health and disability services.'* In the same OIA mentioned above, PHUs were asked how many of the 32,000+ applications were made in high Maaori population areas. Only two PHUs had some idea of a number, with the majority stating they did not know or refused to answer under s 18(f). A consultation rate of 0.2% and not knowing where applications were lodged in a given rohe, clearly show that the principles of the Treaty of Waitangi have not been recognised and respected by DHBs and PHUs. This underlines our stance that the Maaori Health Authority should lead the strategic direction of alcohol licensing.

Replacing DLCs with permanent commissioners to hear applications in the interests of all New Zealanders o Two of the three-panel members will be Maaori o Decisions made by consensus, not a majority vote	DLCs across the motu are often said to be variable in the way they apply the criteria within the Act. Permanent commissioners provide an alternative that would enable a level of consistency to alcohol application decision-making and bring a higher standard to the process. To continue enabling mana Motuhake, Maaori must be the majority representation on all decision-making panels, but would still represent the interests of all New Zealanders. What is good for Maaori is good for non-Maaori. As noted in WAI2624: *according to the Waitangi Tribunal, Māori communities protect and strengthen themselves through the exercise of mana Motuhake*. To be tikanga compliant, decisions need to be reached by consensus.
Design a system that enhances collaboration between partners to create one agency to reduce duplication and foster collaborative working	Many licensing teams across the motu have multiple functions and small caseloads where alcohol is not a priority. This means the understanding and application of the Act is variable across Aotearoa. A centralised agency would improve standards and ensure alcohol is a priority in all rohe across the motu. In terms of merging the licensing agnecies, this is common sense. We acknowledge that each agency brings their own perspective, but this can be brought together under one investigation as one team to maximise scarce resources. Currently, three Crown organisations can often submit three similar, if not identical reports, to the DLC on the same application. There are various examples of multidisciplinary teams from multi-agencies working together. The Multi-agency Safeguarding Hub (MASH)[64] in the UK is a good example. In an Official Information Act 1982 response from the Ministry of Health, Ref: H202105503, only two PHUs indicated they had an s 295 (b) Duty to Collaborate plan with the Police and Territorial Authority. This section states the Police, inspectors, and Medical Officers of Health must:

	'work together to develop and implement strategies for the reduction of alcohol-related harm.' We consider this a failing of the agencies within both the Act and to te Tiriti, and could be improved if the agencies were merged and co-located.
Increasing monitoring of higher risk licences, namely bottle-shops and taverns in high Maaori population areas, with renewals required annually, not on a three-year cycle	Currently, whaanau can often have to wait three years for an opportunity to object to a licence that is causing harm in their community after missing the initial opportunity due to the poor notification process. This is too long. This could be a condition that truncates all licences for higher risk applications in high Maaori population areas (short-term) but should become criteria in the Act. A high Maaori population area would be equal or greater than the national average based on the most recent census by Stats NZ. We understand that this will cause an extra burden on scarce resources, so funding should be increased accordingly, preferably through increased fees paid by the economic operator.
Prohibit licenced premises 1.5 km from a sensitive site, with sensitive sites itemised in the Act such as marae, schools, maunga, and churches.	A schedule of sensitive sites should be included in the Act, and we agree with Alcohol Healthwatch that s.106 should be strengthened. Some sensitive sites are taonga to Maaori, which we have mana Motuhake over as per article two of te Tiriti o Waitangi. We consider it a breach when alcohol outlets are opened within sight of our treasures.
Increase community participation in the licensing process	
Recognising Maaori status as tangata whenua, Maaori will be given standing for any application they wish to object	Maaori are tangata Tiriti so have a higher status than the general public as a right and privilege. Therefore, Maaori's standing as having a greater interest than the general

to regardless of geographical proximity	population is already established. Furthermore, Maaori experience the greater burden than the general public, so their interest is greater more generally. As noted in WAI 2624: (43) *Section 102(1) fails and prejudices Māori in several aspects. Firstly, it fails to acknowledge that Māori have a special place in society greater than that of the public generally. Māori are signatories to the Treaty of Waitangi. The general public are not. Under the Act, Māori are not given that recognition or status.* (44) *Section 102(1) fails to take into account that the alcohol related prejudice suffered by Māori - is greater than that of the general public.* (46) *The standing definition actively prejudices Māori:* *a. It makes no reference to Māori, including their whānau, hapū, iwi, marae or organisation of their choosing;* *b. It makes no reference to mana whenua; and* *c. It disregards whakapapa.*
Ring-fenced funding for Maaori legal support by Maaori legal teams	There should be dedicated legal support for Maaori, by Maaori, similar to Community Law. Maaori lawyers would understand and interpret decision in line with te Tiriti more readily than non-Maaori lawyers. This would also help reduce inequity.
Prohibit the ability to cross-examine whaanau as community objectors by alcohol industry lawyers	Whaanau can feel traumatised after attending a DLC and feel attacked by industry lawyers, vowing never to return. Lawyers who are paid experts at dissecting arguments should not be able to intimidate laypeople in this way, especially at a tribunal. Similar

	cross-examination does not occur in other tribunal hearings, such as Resource Management. This approach is also recommended in Alcohol Healthwatch's Evidence-based policies, Health Coalition Aotearoa's alcohol priorities and the national DHB alcohol position statement.
Application fees include stipend payments to each whaanau member who attends a DLC hearing as an objector	The only people not paid to be at a DLC hearing are community objectors, who are most likely the people who can least afford to be there. As such, a stipend of $100 should be paid to each whaanau member attending a hearing as an objector at the applicant's expense by an addition to their fees, in recognition of the whannau's time and loss of wages or annual leave taken. The decision to attend a DLC can often be a choice between the cost to attend or kai on the table. This is not social justice. The licence should not be granted until the stipend has been paid to whaanau or in the case of a renewal, s 280 should be used and the licence suspended until paid.
Increasing the 15 working day reporting window to 30 days to allow for increased whaanau engagement	To be Tiriti compliant, Maaori need the appropriate time to koorero widely with whaanau. 15 working days is not long enough to consult and submit a report, particularly with the current poor notification processes across the motu.
Improve the notification requirements of an alcohol licence application so whaanau know what is being proposed in their local environment	As stated in WAI 2624, whaanau often do not know an application is being lodged or renewed in their rohe as the notice is not visible or placed on vacant premises that nobody takes notice of.
Tikanga is observed throughout the entire process including te Reo translators are available for each hearing	WAI 2624 states the licensing process is not '*tikanga compliant*' and "*the Act ignores Māori and their special status and abrogates their mana, mana whenua, kaitiakitanga and tino rangatiratanga.*" If te Reo translators are not available, whaanau have the right without prejudice to postpone the hearing.

	Opening and closing a hearing with a karakia does not make the process tikanga compliant.
Other recommended interventions	
Requirement for appropriate and accessible health services for Māori	
Ensuring all health and social care professionals are trained to provide services that do not discriminate by ethnicity and treat all with the same care.	Maaori are not hard to reach, the required support from those in power is hard to access. We need to make every contact count and provide appropriate support to whaanau who need it. WAI2624 advocates for increased screening and brief advice, not only to prevent and eliminate harm but also to reduce the disproportionate proportion of Maaori in prison. This also needs to be delivered without discrimination. Also recommend in Law Commission 2010, Alcohol Action NZ 5+, Alcohol Healthwatch's Evidence-based policies 2020 and the SAFER initiative.
Developing kaupapa Maaori care pathways and services across the life course. Routinely providing screening, brief alcohol advice and, where indicated, referral to safe, appropriate and accessible treatment services.	Maaori want to break the intergenerational harm caused by alcohol. This includes more services and solutions that are kaupapa Maaori so we have the options for the world we choose to live in. Too many of the solutions are not in line with Te Ao Maaori and must be addressed as noted in Health and Disability systems review, WAI 2575 and WAI2624.

Fetal Alcohol Syndrome Disorder (FASD)	
- Increase the awareness of FASD, and implement prevention strategies at both population level and for high-risk populations - Increase the knowledge of FASD in Maaori communities and relevance to whanau ora - Advocate to classify FASD as a standalone disability	As noted in WAI2624, rates of fetal alcohol spectrum disorder are estimated to be much higher than average in communities with a prevalence of hazardous drinking. In a 2015 study, an estimated 34% of Māori women consumed alcohol while pregnant, in comparison to 20% of European women. More needs to be done to prevent Maaori children being born with this life long disability, including increasing diagnosis and early intervention.[65] Recommended in WAI 2624, Alcohol Healthwatch's Evidence-based policies and Health Coalition Aotearoa's alcohol priorities.
Further systemic changes required to prevent alcohol harm and minimise inequities	
The Crown to commit and deliver against the WHO global alcohol action plan 2022 – 2030 (when implemented) The Crown to develop a whole-systems, multi-faceted, national alcohol strategy that also addresses the negative influence of the alcohol industry	New Zealand is not only a Member State but a founding member of the WHO. We urge the Crown to apply the same mobilisation to non-communicable disease elimination as it did for its globally-acclaimed response to COVID-19.
Implementation of a national policy goal similar to Smokefree 2025	We have seen the benefit of having a national policy goal such as Smokefree 2025 and the focus and attention that has eventually brought from polticians and policy officials alike. But, goals alone do not bring about change, good policy and regulation of industry does. Alcohol causes more social harm than tobacco, so it is common sense to have a similar approach to alcohol to focus and drive the harm prevention and

	elimination effort as a mechanism to gain community support and in return political appetite for a Framework Convention on Alcohol Control for example.
Implementation of a national data indicators framework and publishing of alcohol sales figures	There is a serious lack of reliable data documenting the nature and extent of alcohol's harm to Maaori beyond high-level statistics. A national data framework that can be broken down by rohe which shows the inequities is needed. This would hold the Crown and associated agencies to account for their performance to reduce inequities. The lack of accountability for performance was cited as a rationale for the health reforms.[66] There is also a lack of reliable data such as the number of licenced premises in Aotearoa, the ARLA database being particularly poor. We would like alcohol sales data from economic operators including supermarkets to be published, as recommended by the Law Commission.
Equitable and ring-fenced investment in alcohol harm prevention for Maaori	In an Official Information Act request, Ref: H202105503, the Ministry of Health reported that the total expenditure of the Vote Health budget for alcohol-related harm prevention services and initiatives for Maaori in 2021/21 was just $287,000, this is despite the Crown gaining over $1 billion in excise tax revenue.[67] This is very disappointing and must urgently be rectified to meet the Crown's Tiriti obligations given that Maaori are 2.5 times more likely to die as a result of alcohol than non-Maaori. This ring-fenced investment could come from the alcohol levy, and/or an increase in the alcohol excise tax.

End.

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