Australian Psychological Society

Submission to Senate Economics References Committee

Inquiry into personal choice and community impacts: Sale and service of alcohol (term b)

Australian Psychological Society

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Senate Economics References Committee
Inquiry into personal choice and community impacts:
Sale and service of alcohol (term b)

The Australian Psychological Society (APS) welcomes this additional opportunity to respond to the Senate Economics References Committee Inquiry into personal choice and community impacts, with specific regards to the Sale and service of alcohol (term b).We also refer the committee to our previous submission to the current Inquiry.

A key goal of the APS is to actively contribute psychological knowledge for the promotion and enhancement of community wellbeing. Psychology in the Public Interest is the section of the APS dedicated to the communication and application of psychological knowledge to enhance community wellbeing and promote equitable and just treatment of all segments of society.

The APS believes that the discipline and profession of Psychology has contributions to offer in striking an evidence-based balance between notions of individual liberty, responsibility, 'personal choice' and 'nanny state' concerns on one hand, the related risks of 'blaming the victim' by expecting people to bear the health care costs of those choices, and of direct or indirect harm to others, versus adopting a whole of community approach to prevention and health promotion.

Individual (personal) choice in the context of public (good) health

To summarise, as stated in our previous submission to the current Inquiry, the APS believes the following need to be carefully considered in determining the right balance between individual personal choice and responsibility and the public good.

- Personal choice does not exist in isolation. Personal choices and associated behaviours are shaped and influenced by a wide range of biological, social, environmental and economic factors (social determinants of health). Given increasing research about the multitude of potential influences on personal choice, measures to restrict or enhance personal choice should be assessed on an issue-by-issue basis and supported by a sound evidence base.

- A distinction should be drawn between those (very few) actions that have consequences for the individual 'chooser' only, and those that might jeopardise the health and wellbeing (and financial security) of others, directly or indirectly (the 'harm principle'). Public health measures that restrict personal choice may be implemented 'for the individual's own good', but should be directed more at those personal choices that can harm others. Such harm might well extend to increased strain on health systems, services and costs from behaviours that

jeopardise individual and community health. Alcohol is one such example where harm inflicted upon others justifies restriction of choice.

- In contrast to purely punitive measures, interventions that limit personal choice as a consequence of previous poor decision-making (such as ignition interlocks for drivers charged with alcohol driving offences that restrict their driving choices but reduce their risk of future alcohol driving offences) may be justified as promoting behaviour change while minimising harm. Such 'health consequence' policies should be based on ethical principles and evaluated on their merit.

- Consideration needs to be made to the impact of laws about personal choice as they relate to children, young people and those with cognitive vulnerability who have limited capacities to make informed decisions to protect themselves or others.

- It is important to highlight the many, often hidden, influences on choice and both expose their influence and develop policy responses that address harmful impacts. For example, the alcohol industry already exerts influence on personal choice by mass advertising, cheaper products and accessibility.

The APS position is that the evidence for preventive measures that restrict choice should be assessed on an issue-by-issue basis, taking into account the following distinctions:

- when a behaviour primarily involves risk of harm to the individual, more than to anyone else, such as cycling without a helmet or overeating (although it can be argued that such behaviours do result in indirect harm to others, via increased strain on health systems, services and costs from behaviours that jeopardise individual and community health)

- when a behaviour involves risk of harm both to the individual and to those around her/him (e.g., gambling, smoking, substance use, non-vaccination)

- when personal choices are made by those who do not have a fully developed capacity to assess the risk of harm to self or others

- when a behaviour primarily involves risk of harm to others (e.g., use of firearms).

Two particular models that may be useful for the committee in their investigation are outlined in Appendix 1. The models provide tools to support decision-making about appropriate measures of intervention.

The sale and service of alcohol, including any impact on crime and the health, enjoyment and finances of drinkers and non-drinkers (b)

The remainder of the submission will address TOR b: the sale and service of alcohol.

Alcohol prevalence and harm

Alcohol use is a widely accepted part of Australian and most other western societies, with alcohol being consumed on a weekly basis by almost half of all people aged 14 years and over, and a daily basis by around 8% (NHMRC, 2015). The NHMRC's most recent report on *Alcohol and Health in Australia* (2015) found that 83% of Australians aged over 14 years had consumed alcohol in the previous 12 months, with only 10% having never consumed at least one standard drink of alcohol. While risky or high levels of alcohol consumption have reduced in the period from 2010-2013, 18.2% of Australians still consumed alcohol at risky or high risk levels according to the 2009 Australian Alcohol Guidelines.

Alcohol is second only to tobacco as a leading preventable cause of death and hospitalisation in Australia, and it has been estimated that alcohol contributed to 3.2% of the burden of disease (Begg et al, 2007), which includes being linked to more than 200 disease and injury conditions (WHO) and 15 deaths and 430 hospitalisations each day in Australia (Gao, Ogeil & Lloyd, 2014).

The harms that are due to the association between substance use and mental health and illness are of special concern. Evidence shows the inordinately high rate of substance use among people with both low and high prevalence mental disorders, to the extent that co-morbidity is the norm (e.g., AIHW, 2007). Of special note, suicide—a leading cause of death in Australia—is strongly related to co-morbid substance use, particularly alcohol use, and mental disorder (Nock et al., 2008). Emerging evidence also points to the risks of exposure to maternal alcohol use or initiation of alcohol use at an early age in childhood or adolescence as linked to neurological and physical changes that are a contributory cause of a number of mental illnesses.

In the case of alcohol, personal choices and community impacts are inextricably linked. Harmful alcohol use is associated with problems beyond those experienced by the individual, and poses considerable risk of harm to the wider Australian community. For example, it is estimated that for every one person who drinks alcohol in large and/or frequent quantities, at least four other people are negatively affected (APS, 2008). Estimates of the economic burden of alcohol misuse range from 15 to 36 billion dollars annually.

Harmful alcohol use can have a major impact on families through neglect, violence, separation, and financial and legal problems. It can affect work colleagues through

absenteeism, loss of productivity, and work accidents, and the wider community through accidents and crime (APS, 2008).

Acknowledging the social gradient in health and recognising the contribution of social determinants to unequal health outcomes, the APS has acknowledged that health and wellbeing are not simply consequences of individual choices and behaviours. With regards to alcohol use and harm, specific groups who are already disadvantaged are particularly vulnerable to alcohol harm and therefore of particular concern. Among others, these include young people, victims of family violence and Indigenous people and communities.

Children, young people and alcohol

There are special vulnerabilities associated with children and young people in relation to alcohol availability and use. Maternal alcohol use during pregnancy is causally related to Foetal Alcohol Syndrome and symptoms (House of Representatives, 2011). Exposure to maternal alcohol consumption during pregnancy or while breast feeding is associated with children developing positive perceptions of alcohol in adulthood (Hannigan et al, 2015). Australian longitudinal studies have shown that maternal alcohol consumption during pregnancy predicts an increased risk of children developing alcohol-related disorders and problems as adults (Alati et al, 2006).

Initiating alcohol use in childhood or adolescence predicts heavier adolescent alcohol use (Mason et al, 2011) and this has been shown to predict alcohol-related disorders and problems in adulthood (McCambridge, McAlaney, & Rowe, 2011). Reducing the availability of alcohol through policies such as raising the legal drinking age have been shown to reduce alcohol use in adolescence leading to reductions in alcohol-related disorders and problems in adulthood (Toumbourou, Kypri, Jones & Hickie, 2014).

The unrestricted availability of alcohol in Australia appears to be harmful to children and young people. Children that live in locations with a high geographic density of alcohol sales outlets are more likely to use alcohol in childhood or adolescence (Rowland et al, 2014). This effect is partly explained by parents living in locations with a high density of alcohol outlets being less willing or able to set rules forbidding adolescent alcohol use and being more likely to supply adolescent alcohol use (McMorris et al, 2011: Rowland et al, 2014). Underage youth are more able to illegally purchase alcohol from retailers trading in locations with high alcohol sales densities (Rowland et al, 2015).

Adolescence is a life-stage of special interest for understanding substance use because it is during this period that first substance use usually occurs. It is also a period of risk taking, experimentation and testing boundaries, and the experimental use of alcohol and other drugs can be part of this developmental process (Parker,

Aldridge, & Measham, 1998). It is also a period when many mental health problems first emerge, often accompanied by harmful alcohol and other drug use.

According to the most recent Australian National Drug Strategy Household Survey (NDSHS), 3.4 per cent of 12-17 year olds and 32.7 per cent of 18-24 year olds drink weekly (AIHW, 2014). As brain development continues throughout adolescence, young people are particularly vulnerable to the adverse health effects of alcohol consumption as outlined above.

Young people's capacity to judge risk is also still developing and significantly increases the likelihood of sustaining an injury or inflicting harm when under the influence of alcohol. Early alcohol use in adolescence tends to be associated with developmental trajectories of escalating alcohol use into adulthood (Toumbourou, et al., 2014).

Given the potential for alcohol to do long-term damage to their physical and psychosocial development, adolescents must be supported through education and early intervention programs to make informed, responsible choices about alcohol consumption. However such initiatives must be reinforced by government through concrete regulatory measures, as outlined below, which minimise the health and safety risks of alcohol consumption to young people and mitigate the harms to others caused by the drinker.

Alcohol and family violence

Family violence and other forms of violence are examples of where individual choices around alcohol directly contribute to harmful outcomes for other people and communities, and have particular impacts for women and children. Alcohol is involved in up to 65 per cent of family violence incidents reported to police and up to 47 per cent of child abuse cases in Australia. Alcohol was also consumed by the perpetrator in more than a third of intimate partner homicides (Laslett et al, 2015).

Alcohol can play a role in family violence when it interacts with the main drivers of violence against women, namely adherence to rigid gender roles, stereotypes and expectations, and the excusing, promoting or justifying violence as a legitimate means of solving disputes. Consuming alcohol at an early age and excessive use of alcohol both appear to be component causes that predict adult violence (Krug et al, 2002; McCambridge, McAlaney, & Rowe, 2011) and the likelihood of family violence (Costa et al, in press). Interventions that reduce and treat excessive alcohol use have been found to reduce population levels of family violence (Kilmer, Nicosia, Heaton, & Midgette, 2013).

The Australian Parliament has recently recognised the role of alcohol in family violence in the Senate Report of the Inquiry into Domestic Violence in Australia. Responses that integrate alcohol prevention and treatment programs with family

violence services, taking account of the rights and safety of the primary victims need to be urgently prioritised to prevent violence and harm.

Aboriginal and Torres Strait Islander communities

Indigenous Australians experience health and social problems resulting from alcohol use at a rate disproportionate to non-Indigenous Australians, with estimates that the burden of disease associated with alcohol use by Indigenous Australians is almost double that of the general Australian population (Wilson et al, 2010).It is worth noting however, that most research shows that the percentage of abstainers among the Indigenous population is higher than among the non-Indigenous population. Indigenous Australians are acutely aware of the costs of alcohol and have been actively involved in responding to alcohol misuse in their communities.

The APS acknowledges that substance use must always be understood within its social and cultural context. This is particularly relevant for Aboriginal and Torres Strait Islander peoples, who tend to be underemployed and marginalised within Australian society—both highly significant predictors of vulnerability to alcohol and other drug use (Spooner & Hetherington, 2005). The cultural stress, grief, trauma, separation, disadvantage, and physical illness that are disproportionately experienced by Aboriginal and Torres Strait Islander peoples also contribute to their high prevalence of substance use problems which in turn can exacerbate risks of serious psychological distress:

> … it is clear that Indigenous people who do use/abuse alcohol are exposed to a range of risk factors to health and SEWB not experienced by other Australians, including: police custody, alcoholic poisoning, addiction, withdrawal states, liver disease, hospitalisation and preventable mortality. In addition, as noted previously, alcohol use appeared to be associated with mental health issues and violence, which increased the risk of either hospitalisation or incarceration and resultant psychological distress.
> (Kelly, Dudgeon, Gee, & Glaskin, 2009, p. 21)

Restrictions on the supply of alcohol (such as restrictions on the sale of low-cost high-alcohol-content beverages such as cask wine; restrictions on hours of trading; and bans on the consumption of alcohol in particular public locations) have most commonly been applied in areas with high proportions of Indigenous Australians as well as Indigenous people in many remote areas declaring their communities 'dry'. As discussed by Wilson et al, (2010), these strategies have resulted in some reduction in consumption among drinkers, delay in uptake of alcohol use among young people and reductions in alcohol-related harms. However for interventions to be effective they should: have the support of and be controlled by local communities; be designed specifically for the needs of a particular community and sub-groups within the community; be culturally sensitive and appropriate; have

adequate resourcing and support; provide aftercare; and, cater for complex presentations. The important role of social and structural determinants in the alcohol-related harms experienced by Indigenous Australians needs to be addressed, including the ongoing impact of colonisation, racism and child removal.

Preventing and reducing alcohol related harm

There is a very high level of evidence that alcohol is a product that poses a high level of risk to individuals and the community, causing a wide range of health and social problems and costs to the Australian people, including substantial psychological harm in areas such as mental health and reduced human potential.

Despite the expectation that 'education' will change people's behaviour, evidence shows that changing people's attitudes or knowledge about a health-related topic does not necessarily translate into behaviour change (Wallace & Staiger, 1998). In particular, simply presenting information or relying on scare and fear messages has been shown to be ineffective.

There is an important role therefore, for balancing personal freedoms with the public interest to ensure that regulatory measures are proportionate to the harm posed by the issue. Alcohol availability needs to be more strongly regulated to prevent harm. The APS believes that governments have a responsibility to regulate to protect citizens from taking action or participating in behaviours that places themselves and others at risk of preventable harm, particularly when the risk of harm is elevated or when the individual may not fully comprehend the risk entailed. This is particularly the case with substances such as alcohol, due to the effect of intoxication, which accentuates the risk of all actions and behaviours undertaken in that state.

In promoting awareness of and positive attitudes towards alcohol consumption, the largely self-regulated alcohol marketing industry exercises considerable influence over the choice of non-drinkers, particularly adolescents, to become drinkers. Young people are directly and excessively exposed to alcohol advertising via television commercials, magazine and newspaper advertising, billboards and posters, product placement, social media and more. Research has shown that alcohol marketing leads to: underage young people beginning to consume alcohol; regular young drinkers becoming prone to binge drinking; and established young drinkers consuming alcohol at potentially harmful levels (RACP, 2015). Given their particular vulnerability, policies designed to mitigate the accessibility and appeal of alcohol to young people are required, and advertising and promotions aimed at encouraging them to consume alcohol must be better regulated. There is a need to strengthen regulations that currently enable alcohol advertising during live sport broadcasts on weekends and public holidays, in addition to the product placement of alcohol logos on uniforms, playing fields and stadiums under sponsorship agreements (this would

mean reducing the exemption to the Commercial Television Code of Practice that allows alcohol to be advertised during broadcasts of live sport).

Given the direct link between alcohol prices, level of consumption and consequential harm, policies that increase the price of alcohol via taxation are one of the most effective policy interventions to reduce the level of alcohol-related harm, particularly the harmful consumption among young people. Along with the Royal Australasian College of Physicians (2015), the APS supports the recommendation of nine separate government reviews that the Wine Equalisation Tax (WET) be replaced by a volumetric tax on wine, and the WET rebate be abolished.

There is good evidence that alcohol-related harm can be reduced by limiting the availability of alcohol by measures such as: reducing the hours that alcohol is sold (Menéndez, Weatherburn, Kypri & Fitzgerald, 2015); increasing the purchase age (Toumbourou et al, 2014); and monitoring and enforcing regulations restricting the sale and supply of alcohol (Rammohan et al, 2011). Evaluations of cost-effectiveness (Vos et al, 2010) have shown that the problems and costs related to alcohol in Australia can be substantially reduced by limiting the marketing and sale of alcohol through four policy changes:

- increasing the alcohol tax to 30%
- raising the alcohol volumetric tax to 10% above the current excise on spirits
- implementing advertising bans
- raising the minimum legal drinking age to 21.

Recommendations

The APS recommends that:

1. *the Senate Committee recognises the considerable social, economic, financial, health, mental health and personal harm caused by alcohol, and the role of government to create conditions which make healthy, safe choices possible and protect its citizens from alcohol related harm*

2. *the Australian Government recognise that alcohol is not an ordinary product, but one that causes significant harms and cost to the community, and therefore that governments have a right and responsibility to restrict the availability and access of alcohol. Evidence-based practices should be implemented to limit the availability of alcohol based on cost-effectiveness in reducing the impact of alcohol on the Australian community*

3. *the Australian Government ensure effective regulation of advertising and promotion for alcohol, particularly minimising the exposure of children and young people. Of particular urgency is the need to remove the exemption to the Commercial Television Code of Practice that allows alcohol to be*

advertised during broadcasts of live sport, in order to reduce the advertising of alcohol to children and young people

4. *the Australian Government recognise that alcohol taxation, when used to increase the price of alcohol, is one of the most effective policy interventions to reduce the level of alcohol related harm, particularly the harmful consumption among young people. In particular, the APS supports an approach to alcohol taxation that is volumetric, with tax increasing for products with higher alcohol volumes*

5. *the Australian Government acknowledge the role of alcohol in family violence and develop responses that integrate alcohol prevention and treatment programs with family violence services, taking account of the rights and safety of the primary victims*

6. *the Australian Government work collaboratively with Aboriginal and Torres Strait Islander communities to address alcohol related harm. Interventions should be supported by local communities and designed for their needs, be culturally sensitive and have adequate resourcing. The social and structural determinants of alcohol-related harm experienced by Indigenous Australians need to be addressed.*

Conclusion

Individual choices around alcohol often have harmful community impacts. With health costs associated with the misuse of alcohol estimated to be up 36 million dollars, there is a clear case for further government intervention to reduce harm. Current policy does not enable a large number of individuals the freedom to make healthy choices, as they are victims (either directly or indirectly) of alcohol-related violence and harm. Moreover, it could be argued that the entire Australian community is the target of aggressive, expensive and sophisticated marketing that is designed to diminish their ability to make healthy and socially constructive personal choices.

Policy and regulation around the sale and service of alcohol is therefore one area where governments have a right and responsibility to develop policy and legislative responses that protect individuals and communities from alcohol-related harm. This will involve a level of restriction for some individuals, but mean more choices for others (for example victims of family violence where alcohol is a factor). Public policy, regulation and preventive health measures must be designed to foster an environment in which the Australian public can make responsible choices about their health, and are appropriately supported and encouraged to do so (RACP, 2015).

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Appendix 1

The Nuffield Council on Bioethics Stewardship Model

The Nuffield Council on Bioethics stewardship model of public health (2007) seeks to clarify ethical boundaries for public health interventions. It recommends that public health programs: not attempt to coerce adults to lead healthy lives; minimise introduction of interventions without consent; and minimise interventions that are unduly intrusive and in conflict with personal values. The stewardship model proposes an 'intervention ladder', to encourage thinking about the different ways in which public health policies can influence people's choices. The rungs range from 'no intervention', to 'eliminating choice' altogether, as follows:

- Eliminate choice – e.g. compulsory isolation of patients with infectious diseases
- Restrict choice – e.g. removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants
- Guide choice through disincentives – e.g. through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces
- Guide choices through incentives – e.g. offering tax breaks for the purchase of bicycles that are used as a means of travelling to work
- Guide choices through changing the default policy – e.g. in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an available option)
- Enable choice – e.g. by offering participation in a National Health Service (NHS) stop-smoking program, building cycle lanes or providing free fruit in schools
- Provide information – e.g. campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day
- Do nothing or simply monitor the current situation.

The stewardship model of public health emphasises the state's responsibility to address the needs of both individuals and the population, but is careful to articulate what the practical limits of this responsibility might be and how such limits might be identified. The options higher up the ladder are more intrusive and therefore require more justification.

The 'Optimal defaults' Model

Brownell and Frieden (2009) use an 'optimal defaults' model in which public policies can determine what the optimal default positions are, yet the choice remains with the individual to opt out. The model describes conditions that promote beneficial or healthy choices as the optimal default option. Rather than focusing on changing

people's behaviour one person at a time, good public policy makes positive changes in the environments that support particular behaviour patterns. For large scale effectiveness, this sort of intervention is much more successful. Practising more healthful behaviour becomes the optimal default – that is, choosing a more healthful behaviour becomes easier, if not automatic.

Brownell and Frieden cite organ donation as an example of where personal choice could be guided to better support desirable outcomes for the community. An optimal default could be created whereby people are automatically signed up for organ donation at the time of getting their driver's licence. If people do not want to donate their organs, they need to ask to opt out. In countries where optimal defaults have been used, the sign-up for organ donation has changed from 10 per cent to 98 per cent. In Australia, where we are merely encouraged to opt in, the rate is less than 15 per cent. Brownell pointed out that no public education campaign could ever hope to achieve such a massive swing in collective behaviour.

Thus, the optimal defaults model (which is similar to the Guide choices through changing the default policy rung of the Nuffield Foundation ladder above) is another policy measure which could be used effectively to influence personal choices for whole-of-community gain.