Rodney Holmes Policy Submissions

A submission to the inquiry into the health impacts of alcohol and other drugs in Australia

December 2024

About RHPS

Rodney Holmes Policy Submissions is a Brisbane-based service that crafts credible and persuasive NGO policy submissions, for lodging to inquiries, reviews and consultations, that contribute to successful social policy outcomes.

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Disclaimer

The views expressed in this submission are those of its author, Rodney Holmes, and do not necessarily represent the positions of any of my clients or employers.

A note about language

In this submission I use non-stigmatising language to describe people who use alcohol and other drugs (AOD) and people experiencing AOD harms, including AOD dependence, as recommended in AOD language guides.

The use of language about AOD is also influenced by my own personal lived experience of alcohol dependence. I recognise that people with lived experience of AOD use and harms, including AOD dependence, may self-identify using whatever language they feel comfortable with. (This does not justify the use of such self-identifying language in government, media, research or industry communications.)

A note about '*individual responsibility*'

This submission advocates for a broadening of policy focus from the dominant population-based approach, to include a targeted, individual-focus on people at highest risk of AOD harms, including people experiencing AOD dependence. It is critical to note this does not endorse the stigmatisation of these people by the alcohol industry and some politicians, using neoliberal '*individual responsibility*' framing intended to avoid evidence-based regulation.

The evidence and arguments for increasing the focus on people experiencing the greatest harms from AOD, including AOD dependence, cannot be cherry-picked away from the broader context, which includes the commercial determinants of health. These commercial determinants include the fundamental conflict-of-interest between profit-motivated harmful industries and their political influence on health policy.

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Executive summary

> *"Addiction remains one of the least understood and discussed public health issues"*[1]

This inquiry provides an important opportunity to hear both from people with lived experience of alcohol and other drugs (AOD) and from people with AOD policy expertise. I have both. I have experienced alcohol dependence and recovery and have worked in alcohol policy for years. I am uniquely positioned to draw on both in responding to this inquiry.

Australians should be able to enjoy health, safety and wellbeing. Yet, despite what alcohol companies might claim, harms from alcohol in Australia are significant and continue to increase. Alcohol costs 4,700 lives[2] and $67 billion[3] a year in Australia, which is currently experiencing the highest rates of alcohol-induced deaths in over 20 years.[4]

Why is alcohol still causing so much harm, when the population is using it less overall?

- *Why are people with lived experience of alcohol harms rarely directly involved in alcohol policy and program development? (See section **1. Valuing lived experience**.)*
- *Why do politicians and media centre alcohol use in Australian culture, while stigmatising alcohol harms to support punitive policies? (See section **2.** **Culture of alcohol**.)*
- *Why do we use one-size-fits-all measures designed for the general population, intending to reduce alcohol harms for people experiencing dependence with impaired decision-making agency? (See section **3. Psychology of alcohol**.)*
- *Why do we focus almost exclusively on the different levels of alcohol use for understanding and responding to alcohol dependence, when the determinants and the diagnostic criteria, are psycho-social? (See section **4. Frameworks compared**.)*

The inquiry terms of reference focus mainly on AOD treatment service delivery. This submission reflects on the lived and professional experience of someone on both sides of AOD service delivery. It also addresses systems and frameworks used to understand and develop responses to AOD harms. The scope of this submission is primarily *alcohol* use and harms, especially alcohol dependence, to reflect my personal and professional experience and knowledge. However, where appropriate, I will also address broader AOD use and harms.

How can we best reduce alcohol harms for people experiencing alcohol dependence? What can governments do differently to better prevent significant harm from alcohol?

- *Is it time to abandon contested models of alcohol use distribution that support deliberately deprioritising people with alcohol dependence who experience some of the greatest alcohol harms? (See section **5. Reductionist models**.)*
- *Why should alcohol companies (that donate millions to major political parties) get to influence alcohol laws and regulate their own saturated marketing of their harmful products? (See section **6. Neoliberal conflicts of interest**.)*
- *Why do voluntary, abstinence-based approaches trigger such antagonism from some AOD professionals and researchers? (See section **7.** **Alcoholics Anonymous**.)*
- *Why don't Australian governments properly fund AOD and mental health treatment services, despite a demonstrated return on investment? How can we better co-ordinate targeted policies and programs alongside population-level alcohol policies and programs? (See section **8. Universal + targeted**.)*

Policymakers and decision-makers need to value, accept, understand, prioritise and support people experiencing AOD use and AOD harms. This will prevent those AOD harms from being normalised, glorified, glamorised, stigmatised, marginalised and criminalised.

I thank the Standing Committee on Health, Aged Care and Sport for the opportunity to make this submission to the '*Inquiry into the health impacts of alcohol and other drugs in Australia*'.

Recommendations

Rodney Holmes Policy Submissions recommends:

1. Valuing lived experience - more than just illustrating & inspiring

Recommendation 1. Develop AOD lived experience frameworks in all jurisdictions.

Recommendation 2. Establish a network of AOD lived experience advisory groups across Australia, with the engaged participation of appropriately supported and compensated lived experience advocates, providing them with access to influence AOD policies and programs.

2. The culture of alcohol – normalise, glorify, glamorise, stigmatise & criminalise

Recommendation 3. Implement de-stigmatising language requirements for government, industry, research and media to prevent glamorising alcohol harms and to prevent stigmatising people experiencing alcohol dependence.

Recommendation 4. Discontinue alcohol policies and programs targeting people experiencing alcohol dependence that are coercive and criminalising.

3. The psychology of alcohol – mental health & alcohol dependence

Recommendation 5. Implement harm reduction policy and program measures specifically addressing alcohol dependence, that consider its psycho-social domains.

4. Frameworks compared - guidelines, diagnostic tools & policies

Recommendation 6. Commission ongoing data collection, (eg. AIHW National Drug Strategy Household Survey), that incorporates broader measures than just levels of alcohol use or AUDIT-C data, eg. full AUDIT with psycho-social domains.

Recommendation 7. Expand the National alcohol guidelines beyond levels of use for adults, children and people who are pregnant or breastfeeding, by incorporating an evidence-based recommendation for people experiencing alcohol dependence and other mental ill-health.

5. Reductionist models underpin alcohol policies & marginalise dependence

Recommendation 8. Commission research to build alternate psycho-social models of alcohol use and harms beyond an exclusive focus on levels of use, to replace contested, reductionist models that have diverted policy attention away from people at the highest risk of harms.

6. Neoliberal conflicts of interest, policy interference & 'individual responsibility'

Recommendation 9. Prohibit political donations and lobbying from harmful industries, including alcohol companies.

Recommendation 10. Establish comprehensive and effective conflict of interest policies to prevent policy interference by alcohol companies.

7. Alcoholics Anonymous (AA) – misunderstood & misrepresented

Recommendation 11. Publish accurate information about AA, its principles and practices, (including research evidence of its success), to facilitate best practice research, policymaking, program design and co-ordination, (including referral pathways) for alcohol dependence.

8. Targeted & universal responses - resourced, co-ordinated & prioritised

Recommendation 12. Ensure adequate funding (secure and indexed), co-ordination and governance for AOD and mental health sectors. Ensure people have equitable access to culturally responsive, trauma-informed and non-stigmatising treatment and support.

Recommendation 13. Implement alcohol policies and programs with a mix of both universal, population-based and targeted, individual approaches.

1. Valuing lived experience - more than just illustrating & inspiring

Why are people with lived experience of alcohol harms rarely directly involved in alcohol policy and program development?

Rodney Holmes' lived experience

My life experiences provide unique perspectives to understand alcohol harms and responses:

1. Lived experience of alcohol dependence and recovery

Experiencing alcohol dependence and recovery has been a significant, life-threatening and life-changing process. I experienced physical, mental, social, relational, work and financial harms. My story represents only my own experience. However, active participation in a peer-based organisation for many years exposed me to the stories of many hundreds of other people. This allowed me to observe the similarities and common themes. It also gives me an intuitive sense about alcohol policy and its impact on people with lived experience of alcohol dependence.

2. Professional experience in AOD support

I worked professionally for some years in social services, including helping support the recovery of people from alcohol dependence. This gave me further insights into people's individual journeys, some effective pathways and unique organisational models of peer-based recovery.

3. Professional experience in alcohol policy

My postgraduate studies in public policy, and my professional policy experience, (including working with AOD peak bodies), provided formal frameworks about the diverse, evidence-based responses to AOD use and harms. I have developed over 50 policy submissions for various organisations to inquiries, reviews and consultations, including on alcohol policy. My lived experience interacted with various conceptual frameworks used in alcohol policy that helped structure my curiosity and research.

My lived experience story of alcohol dependence & recovery

Purpose. I am very grateful that I have not had the need to use alcohol for almost 25 years. I share my story of alcohol dependence for a few reasons:

1. for identification for people who may know someone struggling with dependence,
2. to help reduce the stigma and shame associated with dependence,
3. to challenge the portrayal in marketing, media and politics, that alcohol must somehow be central to every part of Australian life: normalising, glamorising or stigmatising it.
4. to *inform* research, policies and programs, not just to *illustrate* or *inspire*.

Background. I didn't fit some stereotypes of alcohol dependence, as I didn't use alcohol until my mid-20s. But I did end up using alcohol excessively and compulsively for many years. I began drinking in the late 1980s, and gradually increased my use with home brewed beer, wine club deliveries and many solo work trips interstate and overseas in the 1990s.

Geographical isolation. My inability to stop drinking, led me to deny and hide my dependence, and move interstate from Sydney to Brisbane to escape the scrutiny of family and friends. The very things I needed to be well, that is: *connection with people* and the ability to *think clearly* – were both seriously damaged and distorted by my alcohol dependence.

Progression. I graduated from beer to wine to spirits, increasing the quantity, frequency and consequences. My alcohol dependence became a terrifying and exhausting nightmare, deeply damaging to all aspects of my life: my family, my work and my mental and physical health. I had

significant relationship and financial problems. I experienced anxiety and depression. I was often physically unwell with searing gut pain, heart palpitations, memory blackouts, disturbed sleep and auditory hallucinations.

If you do something that hurts and harms, then you stop - but not with addiction. If you're sick, you simply go to the doctor - but not with addiction. The illness keeps making you sicker and also prevents you from seeking the help you need to get well.

Mental obsession. The physical unwellness, emotional shame and mental anguish led to extreme desperation. Dependence was an overwhelming, powerful obsession locking out other considerations. If I wasn't drinking, I was thinking about drinking. If I wasn't drunk, I was miserable. Eventually, alcohol became the most important thing in my life. No matter what else was going on, the thought of where and when I would get my next drink was always top of my mind. Trying to juggle life responsibilities alongside my alcohol obsession was overwhelming.

Wide ranging harms. I often went against my own values – my behaviour was unacceptable to me and others. My own self-criticism was usually worse than anything anyone else could say to me. I was barely able to hide my drinking from my family. Thankfully, I did not become physically violent with people but was so with furniture on occasions. I couldn't do anything sober. I was a so-called 'functioning alcoholic' – still somehow working and part of a family. But my world had narrowed significantly to drinking, earning money to drink, and trying to hold on to my family, believing I would simply die without them.

Futile attempts to control or quit. I finally acknowledged to my wife that I was an alcoholic – but without a clue about what to do about it, except keep drinking. I tried many times to quit or cut back on my own, but was never able to keep it up, despite trying many suggestions about times of day / week, or never alone / never at home. I would try giving promises, car keys and credit cards to my wife, but nothing ever worked.

I had no capacity to respond positively to any public health messaging.

Baffling. I was totally baffled by my reaction to this substance. Why did I obsessively go back, again and again, to something I knew was so damaging to me and others? Although I knew the stereotype of 'alcoholics', the increasing shame and isolation meant that I did not know anyone else personally who used alcohol the way I did. Alcohol didn't even make me feel good anymore! It did the opposite of what the alcohol ads promised. I drank to feel good but felt bad; I drank to relax but got the shakes; I drank to remove inhibition and became isolated; I drank to gain confidence but got anxious; I drank for inspiration but became brain fogged.

Downward spiral. I experienced the vicious spiral of using alcohol to relax, only to have it make me more anxious. The worse I felt, the more I would drink, which made me feel even worse. My first thought every morning was a drink, and first action when experiencing a bad hangover was the '*hair of the dog*' 'medicine' to treat the problem with the very thing that had caused it. I continued to have an overwhelming urge to use it, despite feeling no relief from it anymore.

Rock bottom. I had a blood test which showed my liver was seriously affected by my drinking, but was simply put on anti-depressants, which required abstinence to work, which I couldn't achieve. I wasn't safe to travel by myself and had to have my family accompany me on business trips. I finally experienced a '*rock bottom*' in a hotel room in Canberra, on a work trip in 2000. During that week, I knew for certain, that if I kept drinking that I would die, but I also knew, just as certainly, that it was completely impossible for me to stop drinking. I was totally isolated and was suicidal. I was convinced that I had lost both my family and my business.

Rehab and relief. I was finally able to seek help, and I ended up in a Sydney rehab in mid-2000. I was introduced to clinical treatment and peer-based support. *Firstly*, I experienced an enormous relief in realising that this was a 'thing', it wasn't just defective me. There is a mental

health condition called 'Alcohol Use Disorder', which is not just about how much you drink – but the affect it has on you. I was a sick person needing to get well, not a bad person needing to become good. And *second*ly, I realised I was not alone. I discovered there were plenty of people just like me who experienced the harms and overwhelming contradictions of alcohol dependence. I had some hope, but not confidence, and decided to give it a try.

Recovery and sense of community. I found enormous diversity among the people in recovery and made many new friends. I identified strongly with hearing other people's stories, and it convinced me that recovery was possible. I was too scared not to do the suggestions that others had followed, so when I returned to Brisbane, I quickly committed to actively following a peer-based recovery program.

Everything changed. Recovering from dependence led to big changes in my life, as I continued to access both therapy and peer support. Despite all the damage it had done, alcohol had been my best friend (as well as my worst enemy), so there was a period of mourning the absence of alcohol, despite the relief. Some damage continued after I got sober. I experienced both divorce and bankruptcy in early sobriety. After living on the disability pension for a year, I worked in social services, did postgraduate study, which led to working in policy for the past 8 years.

Things got better. While dependence caused some permanent harms, recovery has also brought ongoing benefits. Life is not without struggles and challenges, but it always has a way forward with some strengths, wisdom and optimism that may never have been there without having gone through dependence and recovery. Recovery allowed me to rebuild relationships and develop personally, especially with my daughters, who now have their own families, and my partner of 14 years who has never seen me drink.

What it's like now. Most of the time I'm pretty content, and I don't ever think alcohol can solve a problem. "*Nothing is so bad, that alcohol can't make it worse*". I continue to access mental health support as needed. Other people's drinking doesn't usually bother me. We often have alcohol in the house for my partner and visitors. I am grateful every day that alcohol dependence didn't kill me as it did others I've known.

Lived experience frameworks & advisory groups

Lived, or living, experience of AOD use and harms has been an important and effective part of responding to, and recovering from AOD harms, ever since the original AOD 'peer-workforce' in Alcoholics Anonymous (AA). (See Section 7. Alcoholics Anonymous).

Valuing, accepting, understanding, prioritising and supporting people with lived experience of AOD use and harms can help prevent AOD harms. Our AOD lived experience is an essential part of the expert evidence for informing and contributing directly to policy and program development. Our intuitive, authentic insights can contribute key questioning and reality sense-testing for policy ideas, approaches and measures.

Lived experience is especially vital in evaluating theoretical models developed by scholars.

These contributions can directly benefit the likely effectiveness of alcohol policy outcomes. Lived experience should be genuinely involved and accommodated early in the design and development of programs and policies, in line with the public participation spectrum, (inform, consult, involve, collaborate and empower).[5]

However, until now, the lived experience of people who have experienced AOD use and AOD harms has been regularly used to illustrate or promote policies and programs that they often had no influence over.[6] People with lived experience of alcohol harms are also regularly stigmatised by industry and some politicians in their neoliberal '*individual responsibility*' narratives, (see Section 6).

Lived experience is necessarily diverse, unique and individualistic. Lived experience advocates may contribute in one or more of three ways:[7]

1. **Self-advocacy** – expressing their own interests, needs and rights: "*I speak for myself*"
2. **Individual advocacy** – walking beside an individual while supporting them to be well informed and their responses heard and listened to: "*I support you to speak for yourself*"
3. **Systemic advocacy** – representing and advocating for the interests of a group for improvements in policies and programs: "*I speak for members of my peer group*"

Lived experience advocacy includes participation in lived experience advisory groups that exist for various issues including domestic, family and sexual violence (DFSV), mental health, disability and poverty. Besides elevating the voices of people with lived experience, these groups can provide opportunities to directly contribute to new policy and program approaches.

One example of this is the Queensland Lived Experience (Peer) Workforce Leadership Group (LEWLG), which is a group of strategic-level senior Lived Experience professionals, working in Hospital and Health Service mental health and AOD services across Queensland. The LEWLG was established in 2005 at a Statewide level to facilitate opportunities for collaboration and support across the workforce, especially for smaller, solo, and rural and remote teams.[8]

There are National and State frameworks for mental health lived experience which are primarily for lived experience (peer) workforces. However, the National Framework, and most of the States, exclude AOD lived experience (peer) workforces. This is due to a lack of funding and pervasive stigma creating barriers to the development of the AOD experience workforce.[9] Only the WA framework specifically includes AOD lived experience (peer) workforces.[10]

Recommendation 1. Develop AOD lived experience frameworks in all jurisdictions.

Recommendation 2. Establish a network of AOD lived experience advisory groups across Australia, with the engaged participation of appropriately supported and compensated lived experience advocates, providing them with access to influence AOD policies and programs.

2. The culture of alcohol – normalise, glorify, glamorise, stigmatise & criminalise

Why do politicians and media centre alcohol use in Australian culture, while stigmatising alcohol harms to support punitive policies?

Increasing alcohol harms

The Australian population is using less alcohol overall, with the proportion of those reporting no past year use steadily increasing since 2001 (18% vs. 23%). There are also declines in the number of people who use alcohol daily (6.5% to 5.9%), weekly (37.3% to 35.8%), and an increase in those who use alcohol less than weekly (34.5% to 35.8%).[11]

However, the harms from alcohol continue to increase in Australia. 4,700 people a year die in Australia from alcohol-attributable causes,[12] and Australia has recently been experiencing the highest rates of alcohol-induced deaths in over 20 years.[13] Alcohol is an addictive substance related to multiple mental health conditions, including alcohol dependence. Alcohol is the most common drug of concern in AOD treatment, (comprising 43% of treatment episodes),[14] and causing 53% of all AOD hospitalisations.[15]

Alcohol contributes significantly to Australia's healthcare and non-healthcare economic costs, costing $67 billion a year.[16] Overall health burden of disease attributable to alcohol as measured by disability-adjusted life years (DALYs) was 238,262 DALYs in 2024, or 4.1%.[17]

The health impacts of alcohol include hospitalisation and deaths from injury and other acute and chronic diseases, like cancer and mental ill-health. Alcohol is a carcinogen, causing at least seven types of cancer, including mouth, throat, oesophagus, liver, breast and bowel cancer.[18] Alcohol also causes alcohol-related brain injury and Fetal Alcohol Spectrum Disorder (FASD). FASD is a lifelong disability describing a range of neuro-developmental impairments that impact on the brain and body of individuals prenatally exposed to alcohol.[19]

Alcohol-related harms go beyond physical and mental health. They also include social harms and harms to others (injuries, violence, risky behaviour, relationship and work problems).

Centring alcohol in Australian life

Alcohol is deeply enmeshed in Australian culture, playing a seemingly unavoidable, central role in social life, apparently essential to connecting, celebrating and unwinding. High-risk alcohol use, often encouraged and praised, is particularly tied to masculine norms, where it is seen as key to mateship and character. This widespread acceptance has made Australian culture dependent on alcohol as a defining feature of the country's identity.

Alcohol saturates nearly every social and online occasion, from celebrations and sporting events to casual gatherings and work functions. Alcohol is a staple, expected and present at most events, whether parties, weddings or funerals, leaving few opportunities for entertainment or socialising without it. You don't even have to leave your home to be bombarded with alcohol ads or online drinking games.

Any criticism of alcohol use is often dismissed as strict, moralistic and puritanical, with those opposing it being labelled as '*wowsers*'. This stereotype, perpetuated through media has made it difficult for people to challenge the widespread availability of alcohol without facing social stigma. As a result, Australians are generally uncomfortable with those who choose not to use alcohol, viewing it as a rejection of social norms, despite claiming that alcohol use is a personal choice - when it is more of a cultural expectation than a genuine freedom.[20]

Alcohol & politics

Politics and alcohol are so closely entwined that we now have well-established alcohol-related political customs and processes. These include pub-based political campaigning and election events, 'politics in the pub', the 'pub test' and alcohol industry political donations.

Alcohol-based political campaigning

Politicians play a key role in perpetuating Australia's drinking culture, with the longstanding stigma of '*wowserism*' deterring critical discussion of alcohol or its regulation. Debates on alcohol policy are often prefaced by politicians repeating industry slogans to '*drink responsibly*' to avoid being accused of being overly restrictive or promoting a '*nanny state*'. In recent years, pubs have shifted from being venues of political activism to stages for political theatrics, with politicians using them as settings to appear more relatable during election campaigns.[21]

Leading politicians embrace alcohol as part of their public persona, often skolling a beer for the cameras at various events, symbolising their connection with voters. These moments reflect the use of alcohol-related theatre to engage with the public and bolster their political image.

The '*pub test*' and '*politics in the pub*'

The 'pub test' is an Australian concept suggesting that complex ideas or policies should be understandable to the 'ordinary person', similar to the legal idea of a '*reasonable person*'. While it has been a longstanding tradition, critics argue it is an ineffective and exclusionary tool for public engagement. Some point out that pubs have not historically been inclusive spaces, making the pub test a poor measure for involving non-experts in important discussions. While

politicians frequently invoke the pub test, it may not accurately reflect public opinion or contribute to meaningful debate.[22]

Historically, hotels were venues of political activism and strategising. They are also being used to host what seems to be intended as 'community-based' political conversations, known as '*politics in the pub',* often involving politicians. Once again this may actually be more exclusionary to the many who do not drink or who do not feel comfortable in a pub setting.[23]

Alcohol harms in parliament

Recent alcohol politics have focused on the drinking culture in Canberra, particularly in Parliament, where a 'boozy workplace' environment has persisted without proper restrictions. Parliament and other workplaces need to be more inclusive, considering women, people from diverse backgrounds, and those who abstain or prefer not to be around intoxicated colleagues. The issue gained significant attention after the 2021 Jenkins review, which identified the drinking culture as a safety concern.[24] The review called for better regulation of alcohol use in Parliament, leading to a draft code of conduct currently being finalised. While the new policy will promote 'responsible' alcohol use, it won't impose enforceable rules.

Political responses to alcohol and gendered violence

In September 2024, the Prime Minister chaired a National Cabinet meeting focused on accelerating change under the National Plan to Reduce Violence against Women, with one of the key areas being the impact of alcohol. State and Territory First Ministers agreed to review alcohol laws and their effects on family and domestic violence victims, with the aim of identifying best practices, implementing reforms, and reporting back on progress.[25]

In December 2024, South Australia was the first jurisdiction to act on this commitment,[26] implementing the '*Rapid Review of Prevention Approaches to End Gender-Based Violence'* recommendations.[27] These included having clear primary objectives to prevent gendered violence and restricting alcohol sales and delivery timeframes.

AOD, stigma & the media

Commercial media have even less restraint than politicians when it comes to stigmatising alcohol harms. Stigma, misunderstanding and fear about AOD use are often the basis of hostile AOD representation in media narratives. This can lead to the community rejecting those struggling with AOD dependence and social services may resist offering supportive services to those who would have benefited greatly from them. Ironically, these attitudes prolong the issues faced by people using AOD, creating barriers to treatment access. The media is perpetuating the thing it claims to be against - unhealthy individuals using AOD in self-destructive ways.[28]

Media representations of alcohol-related issues tend to align more closely with the interests of the alcohol industry than with scientific public health recommendations. The media largely downplays negative consequences of alcohol, normalising high-risk alcohol use, and providing limited coverage of public health measures.[29] This frames people experiencing alcohol dependence with admiration (normalise / glamorise), or ridicule and public shaming (stigmatise / criminalise), monetising their health issues. There are several AOD language guides that can be applied to government, industry, research and media, to help prevent this stigmatisation.[30,31]

Punitive approaches that criminalise AOD use & harms

Paradox of prohibition vs. regulation

Political action on reducing alcohol harms is challenging enough when the powerful stigma of alcohol harms is just too attractive to politicians wanting to capitalise on it, (also motivated by alcohol company political donations). It is further complicated by requiring enough nuance to

avoid ineffective extremes to achieve effective responses. These extremes are complete prohibition (leading to unregulated criminal market) on the one hand, and complete deregulation of a commercial market, (recklessly exploiting alcohol harms for profit without restrictions), on the other. This nuanced balance is known as the '*Prohibition Paradox*'.[32]

For example, the Brisbane Lord Mayor recently conflated regulation with criminalisation, saying "*it was ironic the Greens supported decriminalisation of hard drugs but were against one celebratory drink*".[33]

Criminalising AOD policies and programs

The counter-productive war on drugs has cast a long criminalising shadow over responses to AOD harms – broadening and deepening the harms from AOD. Australia spends twice as much on AOD law enforcement than on prevention, treatment and harm reduction combined.[34]

> *"The War on Drugs is a global genocide. Far from reducing drug-related harms, criminalisation instead makes every aspect of the trade exponentially more dangerous, with toxic and unregulated supply leading to ever-growing rates of fatal poisonings, state and extrajudicial killings, underground violence, and mass incarceration."*[35]

Yet the harms from the criminalisation of AOD are not limited just to illicit drugs. Alcohol is one of the most popular, legal drugs, yet its use and harms are also often criminalised. Examples of punitive criminalisation of alcohol harms, especially alcohol dependence, include:

- Criminalising people with Fetal Alcohol Spectrum Disorder (FASD), leading to the over-representation of people with FASD detained in the criminal justice system,[36]
- framing people accessing social security as committing 'welfare-fuelled violence', forcing them onto the Cashless Debit Card that restricts access to alcohol,[37]
- automating the criminalisation and net-widening of alcohol dependence using electronic monitoring with trans-dermal alcohol testing, and[38]
- banned drinker registers (BDR) identifying and stigmatising people experiencing alcohol dependence, as an ineffective punitive, rather than a health-based, response.[39]

The use of stigmatising narratives by media, backed by the alcohol industry, creates an incentive for politicians to use alcohol harm stigma for political advantage. The false '*tough on crime'* narrative pushed by outrage-clickbait media at elections drive politicians towards punitive alcohol policies. This has been especially evident in the recent 2024 Northern Territory and Queensland elections.[40]

Recommendation 3. Implement de-stigmatising language requirements for government, industry, research and media to prevent glamorising alcohol harms and to prevent stigmatising people experiencing alcohol dependence.

Recommendation 4. Discontinue alcohol policies and programs targeting people experiencing alcohol dependence that are coercive and criminalising.

3. The psychology of alcohol – mental health & alcohol dependence

Why do we use one-size-fits-all measures designed for the general population, intending to reduce alcohol harms for people experiencing dependence with impaired decision-making agency?

Alcohol is not just a toxic, carcinogenic substance causing physical harms, including harms to others, it is also addictive, with significant mental health harmful impacts. Yet addiction,

including alcohol dependence, remains one of the least understood and discussed public health issues.[41]

Definitions of alcohol dependence

The latest data from the National Drug Strategy Household Survey indicates that almost one in ten Australians (9.2%) who use alcohol, may be experiencing an alcohol dependence issue.[42]

Alcohol dependence, also known as alcohol use disorder (AUD), is a mental ill-health condition, described in the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Unfortunately, it is quite common in alcohol research and policy, to conflate alcohol dependence simply with high levels of alcohol use, ignoring the psychology of alcohol dependence. This has significant implications for understanding and developing effective responses to alcohol dependence.

The mental health condition of alcohol dependence is similar to, and different from, other alcohol and mental health issues in various ways. The social and psychological aspects of AUD, such as tolerance, withdrawal, cravings, memory, impulse control, and risk-taking, contribute to an understanding of the relationship between alcohol and mental health.

The criteria for alcohol dependence have evolved somewhat over the decades. The previous 1994 version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) contained two categories of 'Alcohol Abuse' and 'Alcohol Dependence'. The current 2013 Diagnostic and Statistical Manual of Mental Disorders (DSM–5) merged these two categories into one of '*Alcohol Use Disorder'*, retaining most of the diagnostic criteria from the previous two:

DSM–5 (2013) Diagnostic Criteria for Alcohol Use Disorder (p. 490-491)[43]

Alcohol use disorder (AUD) is a problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within 12 months:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following: a. a need for markedly increased amounts of alcohol to achieve intoxication or desired effect b. a markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following: a. the characteristic withdrawal syndrome for alcohol b. alcohol is taken to relieve or avoid withdrawal symptoms.

Turning Point's '*Rethink Addiction'* provides a broad definition of addiction / dependence:

*"**What is Addiction?** Addiction is one of the most misunderstood health conditions.*[44]

- *Addiction is a chronic health condition that occurs when someone is unable to stop consuming a drug or activity, even if it is causing physical or psychological harm, or affecting their life.*
- *Addiction is a major contributor to the burden of disease in Australia, and a leading preventable cause of injury, illness and death.*
- *Addiction does not discriminate – it affects young and older Australians from all communities, yet it remains one of the least understood and discussed public health issues*

- *Overcoming addiction is not simply about having good intentions or greater willpower, and such stigmatising views stop people reaching out for help.*
- *Nobody chooses to become addicted. There are biological, environmental, and life experience-related vulnerabilities that predispose people to addiction. Isolation, pain and trauma are the leading causes.*
- *Addiction can be successfully managed with the right treatment and support. People who get help can achieve recovery, prevent relapse and experience an improved quality of life.*
- *People living with addiction often face a range of other health and social challenges, yet they are required to navigate a fragmented system to find the right type of treatment and support. We need to make getting help much easier."*

People understand intoxication: if you use a certain amount of alcohol, you become temporarily physically and mentally impaired, which risks injuries, vehicle crashes, drownings and poisonings, resulting in disability, chronic pain, trauma and death. Once explained, people can comprehend the various chronic diseases that alcohol causes such cirrhosis, heart disease, cancer, FASD, dementia. There are many primary prevention programs such as public awareness campaigns and public health policies, to reduce the risk of these illnesses.

Yet somehow, perhaps partly because of the complex and sometimes paradoxical psychological basis of alcohol dependence, it seems quite baffling to many – including those of us with personal lived experience of it. Some paradoxes associated with alcohol include the '*prohibition paradox'* and the '*harm paradox'*. Alcohol dependence has received very little specific policy attention beyond being exploited and stigmatised by alcohol companies and some politicians, and its treatment services being chronically underfunded.

The greatest alcohol harms - misunderstood & ignored

The greatest alcohol-related harms occur to people experiencing alcohol dependence.

People experiencing alcohol dependence are at risk of experiencing the same alcohol-related harms as people without dependence, plus significant additional (physical, psychological and social) harms of alcohol dependence.[45] Alcohol dependence is responsible for the greatest burden of disease within the alcohol category of health impacts.[46] Yet despite the significantly higher levels of harms associated with alcohol dependence, it remains the most misunderstood types of alcohol harm.

Responses to these significant harms are also deliberately minimised and marginalised due to unrealistic, reductionist models of the relationship between alcohol use and alcohol harms, (see *the 'Prevention Paradox'* in Section 5). These disputed models position most people, (who are not experiencing alcohol dependence or high-risk use of alcohol), as carrying the greater *collective* burden of alcohol harm, and therefore requiring the priority attention.

Yet, as discussed in Section 8, population-based public health messaging is not as effective at reducing harms for people using alcohol at high-risk levels.[47] The messaging works for people who use alcohol at low-risk levels who consequently use even less, but with smaller change in individual harms, while people using alcohol at high-risk levels are less responsive to messaging and high rates of alcohol harm continue. Alcohol policy and programs must be a mix of measures aimed at the population and at individuals (see Section 8).[48]

Psycho-social symptoms & impaired agency

Current alcohol policy and program measures are primarily population focused. This includes both structural policy measures (price, promotion and availability) and public education campaigns (providing people with information to influence them to make healthier choices about alcohol use). This approach is an effective way to reduce alcohol harms for people who do not experience alcohol dependence or other mental ill-health.

However, this exclusive population-focus does not seem to acknowledge or make allowances for the role of impaired agency with alcohol dependence. As a result, people experiencing the greatest harms from alcohol dependence are largely missed by both public health messaging, and alcohol policy settings. Several of the dependence diagnostic domains, (see Section 4), describe psycho-social symptoms that impair people's decision-making capacity and make it challenging for them to respond positively to public health messaging. As a result, individuals experiencing the greatest alcohol harms lie largely outside the reach of 'choice-based' policy.[49]

In addition to this policy gap, there are challenges in navigating service systems. Navigating fragmented AOD service systems can be challenging for anyone. However, people experiencing alcohol dependence have to face these challenges with impaired decision-making, (like people navigating mental health service systems). This leads to a significant gap between people meeting the criteria for dependence, and people accessing AOD treatment, (see Section 8).[50]

Recommendation 5. Implement harm reduction policy and program measures specifically addressing alcohol dependence, that consider its psycho-social domains.

4. Frameworks compared - guidelines, diagnostic tools & policies

Why do we focus almost exclusively on the different levels of alcohol use for understanding and responding to alcohol dependence, when the determinants and the diagnostic criteria, are psycho-social?

As discussed in the previous section, alcohol dependence is complex and paradoxical. This is due to its causes and symptoms being a combination of inter-acting psycho-social factors.

Physical & psycho-social domains

The diagnostic guidelines, screening and assessment tools used by AOD professionals in supporting people experiencing alcohol dependence span a range of psycho-social domains:

1. Volume (dose) and frequency of alcohol use (most common & often exclusive measure)
2. Direct physical impact (cancer, diabetes, liver, injuries)
3. Physical dependence symptoms (tolerance, withdrawal, cravings, memory)
4. Psychological dependence (impulse control: inability to reduce / stop)
5. Behavioural change (risk-taking, unable to do normal tasks)
6. Social / relational (concerns, financial, legal, work / study problems)
7. Emotional impact (guilt, shame, remorse, envy, resentment, anger)

The specific elements of each framework, guidelines, and tools within these domains, are shown in the comparison table below.

Comparing alcohol dependence frameworks

Alcohol guidelines, assessment tools and diagnostic criteria, each have a somewhat different (if overlapping) scope and purpose. The guidelines usually have a population-focus, whereas assessment tools and diagnostic criteria have an individual-focus. Only the AUD screening and diagnostic tools, (full AUDIT and ASSIST tools and DSM-5 diagnostic criteria), focus primarily on alcohol dependence. However, all these frameworks aim to reduce alcohol harm, draw on the same evidence base, and should not be counter-productive to each other.

The '*Australian Guidelines for the Treatment of Alcohol Problems'* acknowledges some of these similarities and differences: *"there are two major approaches to diagnosis, ICD and DSM, that offer both areas of agreement and of difference."*[51]

Comparing the focus of NHMRC, AUDIT, ASSIST, DSM & AA

	1. Use volume / frequency	2. Direct physical impact	3. Physical dependence symptoms	4. Psychological dependence	5. Behavioural change	6. Social / relational	7. Emotional impact
NHMRC National Guidelines[52]	Yes, 3 guidelines	(Inferred)	None	None	None	None	None
AUDIT-C tool (3 questions)[53]	Yes, 3 questions	(Inferred)	None	None	None	None	None
AUDIT tool (10 questions)[54]	Yes, 3 questions	Yes, 1 question	Yes, 2 questions	Yes, 1 question	Yes, 1 question	Yes, 1 question	Yes, 1 question
ASSIST-Lite tool (3 questions)[55]	Yes, 1 question	None	None	Yes, 1 question	None	Yes, 1 question	None
ASSIST tool (7 relevant questions)[56]	Yes, 2 questions	Yes, 0.5 question	Yes, 1 question	Yes, 1 question	Yes, 1 question	Yes, 1.5 question	None
DSM-IV 1994 Abuse / Dependence (11 criteria)[57]	None	None	Yes, 3 questions	Yes, 3 questions	Yes, 4 questions	Yes, 1 question	None
DSM-5 2013 Alcohol Use Disorder (11 criteria)[58]	None	None	Yes, 4 questions	Yes, 3 questions	Yes, 4 questions	None	None
Is **AA** for You? (12 questions)[59]	None	Yes, 0.5 question	Yes, 2 questions	Yes, 5 questions	Yes, 1 question	Yes, 1.5 questions	Yes, 2 questions

National alcohol guidelines

The National Health and Medical Research Council (NHMRC) acknowledges that alcohol effects are '*different for each person*'[60], however, the '*Australian Guidelines to reduce health risks from drinking alcohol*'[61] are standardised, population-level recommendations. The guidelines provide a recommended number (volume / frequency) of standard drinks, based on population-level evidence, differentiated by gender, age and pregnancy only, but not by dependence. This omits any consideration of the above psycho-social symptoms, and it omits explicitly promoting abstinence, (other than for pregnancy and breastfeeding).

Screening & assessment

One validated assessment tool for alcohol dependence is the 10-question 'Alcohol Use Disorders Identification Test' (AUDIT) developed by the World Health Organisation (WHO). A common screening version of this tool used in clinical practice and academic research is the AUDIT-C,[62] which has 3 Questions (the first three of the ten AUDIT questions), all exclusively about *volume and frequency* of alcohol use. Whilst AUDIT-C is believed to be an indicator of alcohol dependence,[63] there are disagreements about its accuracy[64]. The effectiveness of many program interventions is evaluated using AUDIT-C. The Treatment Guidelines recommend that the AUDIT instrument is the most effective screening tool available and is recommended for primary care and hospital populations. [65]

The full 10-question AUDIT tool (and the ASSIST tool) better reflects and overlaps with other Diagnostic Criteria than the shorter AUDIT-C. These criteria include the 11 symptoms listed in the DSM–5 for Alcohol Use Disorder (AUD), and with the 12 Questions in "Is AA for You?". The

NHMRC Guidelines and the AUDIT-C, which focus exclusively on level of alcohol use, contrast starkly with the DSM-5 and AA questions which have no criteria for levels of alcohol use.

The International Classification of Diseases (ICD-11) adapted its coding to accommodate the diversity of alcohol-related illness, and to differentiate between disorders and risk factors. There are numerous physical and psychological illnesses that list alcohol as a direct contributor. The ICD has included indirect physical harm such as self-injuries but doesn't classify any other social or behavioural impacts such as financial, legal, employment or relationship problems.

Exclusive focus on levels of alcohol use

The risk of alcohol harm is associated with a spectrum of alcohol use; from abstinence to 'moderate' (low risk), to 'excessive' (high risk / problematic) to 'dependent'. For many decades there has been an almost exclusive focus on the *level* of alcohol use (volume and frequency), in alcohol policy and advocacy. Public health policy talks about reducing '*levels'* of alcohol use to reduce risks of alcohol harm. Most population-level, public health policy responses focus on this reduction primarily through three of the five WHO SAFER '*high-impact, evidence-based, cost-effective interventions'*: price, promotion and availability.

This focus is based on the evidence that increased levels of alcohol use do increase the risk of harms, and that reducing use reduces risk harms. [66] It is also based on contested models proposing that different levels of alcohol use across populations, (low-risk, high-risk and dependent), rise and fall uniformly with different per-capita levels of use (see Section 5).[67]

The relationship between determinants and harm is not linear, and the causal direction is unclear.[68] Harms may result from long-term or acute use, and different groups are at risk of different patterns and types of harms.[69] Alcohol dependence may perpetuate high-risk alcohol use, or high-risk alcohol use may contribute to the development of alcohol dependence, (but they are not synonymous).[70]

Most people who use alcohol at high-risk levels do not meet the criteria for alcohol dependence,[71] and there is little evidence that people experiencing alcohol dependence can be characterised by specific levels of average daily alcohol use.[72] (Hence the absence of levels of use in the AUD criteria in the DSM-5 and "*Is AA for You?".)* This anomaly has significant alcohol policy implications, as high levels of use have been used as a proxy for alcohol dependence in research, policy development and public health campaigns for decades.

Recommendation 6. Commission ongoing data collection, (eg. AIHW National Drug Strategy Household Survey), that incorporates broader measures than just levels of alcohol use or AUDIT-C data, eg. full AUDIT with psycho-social domains.

Recommendation 7. Expand the National alcohol guidelines beyond levels of use for adults, children and people who are pregnant or breastfeeding, by incorporating an evidence-based recommendation for people experiencing alcohol dependence and other mental ill-health.

5. Reductionist models underpin alcohol policies & marginalise dependence

Is it time to abandon contested models of alcohol use distribution that support deliberately deprioritising people with alcohol dependence who experience some of the greatest alcohol harms?

Over many decades there have been numerous attempts to quantitatively model alcohol use and alcohol harms, including alcohol dependence. This research aims to help develop better alcohol policies including alcohol taxation policies, to reduce the harm from alcohol.

Quantitative econometric modelling relies on the behaviour of markets, and on consumers presumed to have '*rational choice'*. Most of these attempts are inevitably reductionist models that use proxy values to over-simplify qualitative causes and consequences.

Three of the most influential econometric alcohol models are the Ledermann and Skog '*Collectivity' or* '*Total Consumption'* distribution model, Kreitman's '*Prevention Paradox'* and the Becker and Murphy '*Rational Addiction Theory'*. These were primarily developed in the 1980s and have come to achieve prominent and ongoing acceptance and influence yet have also been disputed by the multiple studies cited below.

Ledermann & Skog's '*collectivity' or* '*total consumption'* model

A theory from 1985 by Norwegian sociologist Ole-Jorgen Skog,[73] known as the '*Collectivity of drinking cultures*' (or '*Total Consumption Model'*) has underpinned alcohol-related public health policies ever since. Skog's model of collectivity followed the work of another researcher, Sully Ledermann,[74] who observed in the 1950s a baffling pattern of population-level liver cirrhosis that corelated with per capita alcohol use, even though many in a general population never used alcohol at such levels to develop cirrhosis.

Ledermann and Skog proposed that as per capita levels of alcohol use rose, all different types of drinking levels (moderate, heavy or dependent) also rose uniformly in concert, maintaining their distribution across the spectrum. This up-ended the previous policy focus on only people with dependence, and set the foundation for our now, almost exclusive, policy focus on population-levels of alcohol use and harms.

Up until the 1970s, researchers and policymakers had focused most of their efforts on people with high-risk use or alcohol dependence. Ledermann and Skog's work began a shift of focus to population-levels of alcohol use, presuming that by reducing the per-capita use, this would also reduce the level of use (and harm) for people with high-risk use or alcohol dependence. (This presumed a direction of causation between population-level alcohol use and alcohol dependence, which has not been determined by research evidence.)[75]

Scholars have begun to question the effectiveness of this universal, population-level model.[76] A 2020 study by Raninen and Livingston, questions the decades-long acceptance and influence of the collectivity population-level model on multiple grounds, demonstrating that the model:

- is too vague to be useful,
- had inadequate data (especially empirical) to properly test it when proposed,
- shows a disconnect between level of use and level of harm, and
- experienced an uncritical persistence in following the model despite the above.[77]

There may also be a problem with the proposed causal foundation of Skog's model, which was that social networks were the mechanism for developing a collectivity of 'drinking culture'. This seems to ignore the fact that people experiencing dependence often also experience significant social isolation as both a cause and consequence.[78] This would, at best, confound if not directly act against social networks having significant influence.

Raninen and Livingston's paper suggests researchers and policymakers are long overdue to re-examine and re-evaluate the Skog model of collectivity and to develop alternatives. This would seem to have some significant implications for alcohol harm reduction policy measures (eg. price, promotion, availability) as they target population-level initiatives almost exclusively.

Kreitman's 'prevention paradox'

Another theoretical model contributing to deprioritising alcohol dependence is the '*Prevention Paradox'* developed by Norman Kreitman in 1986. This suggests that, collectively the greatest alcohol harms are experienced by the majority of the population who experience less harms

each, rather than the people who use alcohol the most, (ie. the 'top 10%' of people in Australia who use 54% of the total alcohol used).[79]

It may seem obvious that most of the population would collectively experience most of the harms. However, this is intended to suggest that the minority experiencing the greater harms (individually) do not experience such great harms, that they outweigh the burden collectively experienced by the majority. This gives rise to the unusual assertion that most harms are experienced by the *'bottom 90%'*! A potential benefit of using this model is analysing the distribution of population-based harms burden to prioritise response resources. This allocation would be based on achieving a greater societal gain through a small reduction in alcohol harms within a larger group of people with low-risk alcohol use and less serious harms.

However, it also leads to deliberately deprioritising the reduction of harms among the smaller, (yet still significant), number of people experiencing more serious harms, including alcohol dependence. Such an approach is reductionist and deliberately ignores the significant, *disproportionate* levels of harms among people experiencing alcohol dependence. It disrespects the individual experience of people suffering the most significant alcohol harms.

The scientific literature on the Prevention Paradox is also limited, the number of empirical studies is small, and the findings are not consistent. Studies of the prevention paradox are methodologically limited by failing to measure the frequency and severity of alcohol-related harms, potential under-reporting or non-participation by people with high-risk alcohol use, and the use of short reference periods for alcohol use while harms reflect lifetime experiences.[80]

Another problem with it is that most episodes of harm experienced by the large number of people with lower use of alcohol overall, are from when they engage in occasional binge drinking, making their alcohol use patterns 'spikey'. This is problematic because it means the Prevention Paradox fails to clarify that the harm is primarily experienced by those among the low-risk drinkers with occasional episodes of high-risk use, (who are a significant subset of this group).[81] If alcohol use is measured on either the day of highest use, or the day of highest alcohol-related harm then the Preventive Paradox disappears.[82]

Significantly, in Australia, at a population level, despite reductions in alcohol use, we still see a rise in alcohol harms.[83] Most alcohol is used by a smaller proportion of people at high-risk levels, while people using alcohol at low-risk levels are reducing use, which does not impact as significantly on the risk of harms.[84] This suggests the Prevention Paradox is invalid, yet its application has diverted policy attention away from people at the highest risk of harms.

Becker & Murphy's 'rational addiction theory'

In the 1980s, Gary Becker developed an econometric model of alcohol dependence known as the '*rational addiction theory*'.[85] Becker's theory is a reductionist model,[86] which assumes that reducing alcohol use is just as 'addictive' as increasing the use of alcohol, based purely on price elasticity, with no consideration of the direction of the changed use, up or down, with the same drivers and the same magnitude.

The '*rational addiction theory'* assumes 'rational' behaviour by people using alcohol at high-risk levels, including those experiencing psychological conditions like dependence. This model ignores the psycho-social symptoms of alcohol use disorder listed in the DSM5, such as continued alcohol use despite persistent physical, social, financial or psychological problems exacerbated by alcohol use.

The '*rational addiction theory'* has been further developed by Michael Grossman.[87] The model assumes '*forward-looking behaviour'* by people using alcohol at high-risk levels, including by people experiencing alcohol dependence, (with symptoms that include being unable to consider the consequences of their behaviour).

Many studies have critiqued the model:

- It does not satisfactorily explain the complex instability,[88]
- there is much evidence that its assumptions are unrealistic,[89]
- not useful as an explanation of real-world addictive behaviour and its ability to assess the effects of addictions, and[90]
- the poorly constructed mathematical model is based on a lack of transparency about inaccurate assumptions selectively justified by ad-hoc stories.[91]

The consequence of the ongoing acceptance of the flawed '*Rational Addiction'* theory is that it continues to be used to substantiate current policies such as alcohol taxation.[92]

Despite each of these attempts at reductionist models of alcohol use and harms, we still know little of the reasons why the distributions of risks for harmful outcomes look as they do. There is no accepted formal model of alcohol use to which alcohol harms can be reliably related.[93]

Recommendation 8. Commission research to build alternate psycho-social models of alcohol use and harms beyond an exclusive focus on levels of use, to replace contested, reductionist models that have diverted policy attention away from people at the highest risk of harms.

6. Neoliberal conflicts of interest, policy interference & '*individual responsibility'*

Why should alcohol companies (that donate millions to major political parties) get to influence alcohol laws and regulate their own saturated marketing of their harmful products?

Commercial determinants & industry conflicts of interest

Alcohol is not just a toxic, addictive carcinogenic substance, it is also a highly profitable, $1.5 trillion a year, commodity.[94] Commercial determinants of health are private sector activities that affect people's health. Alcohol industry activities operate as key commercial determinants of AOD health. Their actions contribute to high-risk alcohol use, resulting in a range of health and social harms to individuals, families and communities.[95]

The production and marketing of alcoholic products are globally dominated by a small number of large firms. This oligopolistic market structure enables alcohol companies to achieve high profit margins, with profits supporting substantial marketing and political lobbying budgets whose reach is extensive. Global corporate entities in the alcohol industry promote and practice principles of the dominant political ideology of *neoliberalism* to sustain and extend their dominance. These principles include open competitive markets, reduced government regulation and taxation, unchecked growth, corporate power, commodification, narrative control and individual responsibilisation.[96]

This powerful group of multinational alcohol corporations exerts significant political influence over governments, collectively opposing any policies that might limit their reach. Through well-funded industry lobby groups and think tanks, they push for ineffective measures that prioritise the continued increase in alcohol use by leveraging marketing, lobbying, pricing and increasing supply. These corporations represent the greatest barrier to reducing alcohol-related harms.[97]

There are high levels of alcohol industry penetration into all governments. All jurisdictions report the presence of transnational alcohol corporations, and most report government officials or politicians having held alcohol industry roles. There are multiple examples of government

partnerships or agreements with the alcohol industry, and government incentives for the industry. In contrast, government safeguards against alcohol industry influence are limited.[98]

The recent report of the '*Rapid Review of Prevention Approaches to End Gender-Based Violence'*[99] notes that a failure to consider domestic, family and sexual violence in alcohol policy has allowed unprecedented growth in alcohol availability, both in the density of liquor outlets and online delivery hours of operation. The National Cabinet meeting in September 2024 addressed the role that harmful industries play in exacerbating violence.[100] Addressing commercial determinants of gendered violence includes preventing the policy influence of the alcohol industry and making them accountable for the harms their products cause.

Alcohol companies and their lobby groups seek to prevent effective regulation of alcohol marketing and availability. Political donations enable alcohol lobbyists to build long-term relationships with politicians and influence short-term decision making in their favour.[101] Companies that profit from gambling and alcoholic products and their lobby groups paid more than $2 million, (that we know of, excluding dark money donations),[102] to major political parties in the last federal election year.[103] The latest disclosures in February 2024 bring alcohol-related payments to political parties to a total of $16.3 million over the last decade.[104]

Neoliberal stigmatised 'individual responsibility'

A key principle of neoliberalism, that the alcohol industry regularly employs, is *individual responsibilisation*.[105] This is most commonly done by using the strategically ambiguous term '*drink responsibly*'.[106] This term allows for multiple interpretations, rarely referencing government drinking guidelines, and does not to lead to positive behaviour change.[107] Alcohol-related stigma is often associated with the belief that individuals are responsible for their own behaviour and alcohol use, and therefore do not deserve sympathy.[108]

Focussing on individual responsibility contributes to the deregulation of markets, including the alcohol industry. The alcohol industry has long tried to shift the narrative by focussing on blaming and shaming individuals with high-risk levels of alcohol use, (despite them being their most profitable customers).[109] Neoliberal individual responsibilisation pretends to offer individual consumer choice. However, it places the blame of structural issues that have social and commercial determinants, (like AOD harms) on individuals who are excluded from power to influence the systemic determinants.

The primary focus of public health AOD harm reduction has shifted significantly, since the 1980s, away from targeted, individual approaches to universal, population-level approaches, (see Section 8. Universal + targeted). This shift has, in part, been intended to avoid industry '*individual responsibility'* stigmatisation.[110,111]

However, this has also led to some marginalisation and de-prioritisation of people with high-risk AOD use and AOD dependence, within AOD policymaking. Some writers have misrepresented the industry '*individual responsibility'* framing as being associated with AOD treatment, and unhelpfully polarising AOD harm reduction as an 'all-or-nothing' choice between individual treatment and population-based approaches.[112,113] This overlooks the fact that the alcohol industry is using '*individual responsibility'* to avoid accountability and resist regulation, not to improve AUD treatment outcomes.

Another neoliberal principle relevant to alcohol use and harms, is a belief in the necessity of inequality. Neoliberal capitalism deliberately causes socio-economic inequality.[114] There is evidence that alcohol harms are greater for poorer than for richer people, and considerably greater in poorer than in richer societies.[115] This is even though they generally use less alcohol than the more affluent groups. This phenomenon is known as the '*alcohol harm paradox*'.[116]

Recommendation 9. Prohibit political donations and lobbying from harmful industries, including alcohol companies.

Recommendation 10. Establish comprehensive and effective conflict of interest policies to prevent policy interference by alcohol companies.

7. Alcoholics Anonymous (AA) – misunderstood & misrepresented

Why do voluntary, abstinence-based approaches trigger such antagonism from some AOD professionals and researchers?

AA in its own words

The oldest and most widely used alcohol dependence peer support program is Alcoholics Anonymous (AA). AA was founded in the United States in 1935 and has since grown to encompass over 125,000 groups worldwide, with approximately 2.1 million members in over 180 countries.[117] AA is an informal, peer-based society of people in recovery from alcohol dependency. In Australia, there are about 20,000 members, who meet in AA groups at 2,000 AA meetings each week around Australia.[118]

> *"AA is a fellowship of people who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self- supporting through our own contributions. AA is not allied with any sect, denomination, politics, organisation or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety".* (AA Preamble)

AA meetings range in size from a handful to a hundred or more in larger communities. An AA meeting may take one of several forms, but at any meeting people speak about what using alcohol did to their life, what actions they took to help themselves; and how they are living their lives now. The AA program, known as The Twelve Steps, provides a framework for self-examination and a pathway to recovery, free of alcohol.

Accessible, voluntary, democratic, non-professional, non-affiliated & self-identifying

Accessible, free, informal, voluntary & inclusive

- AA is free - there are no fees for membership; it is self-supporting through voluntary member contributions, AA does not charge for its services.
- AA does not accept contributions from non-AA sources.
- AA is informal and voluntary.
- AA is inclusive - you are an AA member if you say so.

Genuine democratic governance

- AA has no central authority controlling groups or members.
- AA offices do not issue directives.
- AA is non-hierarchical, with regularly rotating peer-based leadership
- AA has distributed and participative decision-making, with a right of appeal and substantial unanimity.

Non-professional & non-affiliated

- AA is non-professional. It has no clinics, doctors, counsellors or psychologists. All members are themselves in recovery from alcohol dependence.
- AA is not affiliated with any outside entity. AA does not endorse, finance, or lend the AA name to any facility or outside enterprise.

Self-identification

- AA does not diagnose anyone or tell anyone that they should stop using alcohol.
- AA says that only people themselves can decide whether to give AA a try.
- AA provides some questions which can help people decide for themselves.

AA research & success rates

Studying AA has sometimes been difficult due its principles of anonymity, confidentiality, non-affiliation, and having no opinions on outside issues. Defining success can be also fraught. Some equate it with a lack of relapse, despite many (including AA) normalising relapse as a common experience in recovery from dependence. Another challenge is that AA is abstinence-based, which is often not the goal of other AOD programs. Each of these issues can create challenges for comparing 'success' with other programs and can result in incorrect claims that AA has low efficacy rates.[119]

Regardless, there have been increasingly rigorous examinations of the effectiveness of AA using high quality experimental designs. These studies examined the various mechanisms through which AA benefits individuals with alcohol dependence. These include a systematic review of random control trials of AA and 12-Step Facilitation (TSF) interventions, (which has the goal of getting people engaged in 12 step programs). AA / TSF were found to deliver better outcomes for continuous abstinence and remission and reduced healthcare costs. Implementing one of these proven manualized AA/TSF interventions is likely to enhance outcomes for individuals with alcohol dependence.[120]

Guidelines for the Treatment of Alcohol Problems, Department of Health (2021)[121]

"Over the past 50 years, hundreds of studies have examined the effectiveness of AA. In recent years, there have been several randomised and quasi-randomised controlled trials examining AA attendance and drinking outcomes. This has enabled researchers to undertake a systematic review on the effectiveness of AA as well as assertive referral interventions into AA. There is sufficient evidence to indicate:

- AA and TSF interventions are superior to other well-established treatments (eg. CBT) when the outcome is abstinence, and at least as effective as these other well-established treatments for other outcomes (eg. reduced drinking intensity and alcohol-related consequences)
- members who engage more fully with the AA program tend to benefit more than those who simply attend meetings; there is a clear association between the level of involvement in AA and better patient outcomes
- AA attendance is effective as part of an extended care plan, resulting in improved abstinence rates and greater treatment retention
- patients who attend AA alongside or following treatment show better long-term outcomes than those who attend either treatment or AA alone.

Participation in AA is an effective strategy for maintaining abstinence from alcohol (and improving other alcohol related outcomes), as a standalone or adjunctive approach to formal treatment."

Criticism: abstinence, religion, agency, disease model, stigma, coercion & currency

Whilst AA has received much praise over the decades, there has also been criticism. Some professionals have warned against AA as if it was dangerous, or competing with, rather than complimenting, other AOD treatment approaches. This can involve misrepresenting AA about abstinence, religion, agency, disease model, stigma, coercion and currency.[122,123,124]

Abstinence

Abstinence seems to get a bad rap from some AOD researchers and AOD professionals. This can be despite the same professionals acknowledging there are some alcohol impacts that have no zero-risk level of alcohol use (eg. cancer, FASD). They also acknowledge that some people may need to abstain due to their 'relationship with alcohol', where controlled use is difficult if not impossible.

AA is abstinence-based, asserting there is no safe level of alcohol for people experiencing alcohol dependence, and *suggesting* that they voluntarily abstain. AA also views alcohol dependence as a lifelong illness. However, while AA is an abstinence-based program, the goal is never simply physical abstinence. The AA program suggests that abstinence is just the beginning, and people should be able to enjoy life sober, without constantly struggling with feeling the need to have to drink.

Tensions between abstinence-based and harm reduction approaches have continued for decades. However, each 'side' of the debate may not have needed to be so exclusive, as each approach seems to work for many. Voluntary abstinence is a form of harm reduction, and the AA text '*The Big Book'* encourages people to try controlled drinking to help them decide whether they self-identify as being alcohol dependent.[125]

Religion

AA is not a religious organisation, nor is it affiliated with any religious body, or offer any religious services. It welcomes members of all religions, agnostics and atheists alike. However, AA does have religious origins and is self-described as a spiritual program of recovery. Despite the religious foundation of AA, a significant break with the previous Temperance Movements, was for AA to position alcohol dependence, as an illness, not a moral failing.

Also, despite the religious background of AA, the founders made a concerted effort to design it to be accessible for people of any belief or non-belief. This included using the language of '*choosing a god of your own understanding'*. Many AA members will suggest that AA is spiritual, not religious. However, that distinction is not always easy to demonstrate. AA does have undeniable religious elements, such as talking about god, a spiritual awakening, and prayer and meditation.

Some research evidence shows that while the AA program suggests that a spiritual awakening is an essential step to achieve recovery from dependence, this may only be true for a minority of participants with high level of dependence severity. (AA itself makes no such distinction.) The research suggests that AA's beneficial effects may be predominantly through social, cognitive, and emotional mechanisms.[126]

Disease and agency

Best practice AOD treatment uses non-judgmental approaches, making a diagnosis only when beneficial for treatment. This is done to support people's agency and to avoid 'medicalising' or 'problematising' their experience of AOD use and harms. The 'disease' model of dependence is a common conception, but has been criticised for problematising or stigmatising dependence, potentially creating a barrier to help-seeking.

AA did not invent the concept of alcohol dependence being an illness, which was developed during the 19th century, but it did adopt it as part of its program. AA defined alcohol dependence as a progressive illness that cannot be cured but can be arrested and is the combination of a physical sensitivity to alcohol and a mental obsession with using alcohol. The DSM later also identified alcohol dependence as a psychiatric illness, which also originally used the term alcoholism, but later changed to 'alcohol use disorder' (AUD).[127]

Some writers acknowledge that the disease model was a great improvement on the previous moralistic framing of dependence, which caused blame-related stigma. AA does use the 'labels' of '*alcoholism'* and '*alcoholic'* with the intention of helping people understand that what they experience is an illness, not a moral failing. This illness, although incurable, is treatable, and people can learn to live happy, sober lives without alcohol.

AA's Step 1 in the 12-step program, "*We admitted we were powerless over alcohol*", is said to be disempowering of people's agency. However, the powerlessness in Step 1, is only about using alcohol. It not about a person having no agency to take action to recover from dependence. It is how AA defines alcohol dependence, and how it helps people to decide for themselves whether AA can help them. People are invited to self-identify as having lost the power of choice over alcohol. (AA, after all, is considered a '*self-help'* program.)

Stigma

Alcohol dependence is a stigmatised condition, so that the alcohol problem, a diagnosis of this disorder, and the terms used to describe the disorder, (not just alcoholism and addiction), are all stigmatised entities. This means that avoiding stigmatised labels is challenging. In general, the language guides recommend a person-centred approach, using non-stigmatising, person-centred language.[128] While critics challenge labels as stigmatising, they overlook the fact that many people find empowerment and relief in identifying AUD as a condition, aligning with approaches like AA that emphasise recovery without blame.

AA retains the terms '*alcoholism'* and '*alcoholics'* which are now considered stigmatising. This was ironically originally intended by AA to de-stigmatise people experiencing alcohol dependence, by fostering solidarity among AA members, and reclaiming the words for common use. Importantly, noting that AA doesn't label people, it encourages people to consider whether they voluntarily self-identify with the 'label'.

Coercion

Some criticism of AA is based on a misconception that abstinence in AA is a mandatory requirement and that the AA program compels or coerces people into compliance. Yet AA has always been an entirely voluntary program. The language of the 12 steps is deliberately framed in the past tense saying, "*Here are the steps we took, which are suggested as a program of recovery",* inviting, not coercing, people to follow the program.

- No AA member can compel another to do anything; nobody can be punished or expelled
- AA does not solicit members
- AA does not keep attendance records or case histories
- AA does not follow up or try to control its members.
- You're a member of a group if you choose to be. You can come and go as you please.

Some AOD treatment facilities may impose mandatory abstinence, but AA doesn't.

Currency

AA is almost 90 years old, having been established in 1935 by co-founders Bill Wilson (a stockbroker) and Dr Bob Smith (a surgeon), who both had lived experience of alcohol

dependence. The AA program was developed by borrowing concepts, and getting input from, the fields of medicine, psychiatry and religion.

The two issues regarding currency are language used in the AA literature, and the recovery concepts being scientifically up to date. The AA 12-step model of recovery is largely unchanged since its inception. The AA text "The Big Book of Alcohols Anonymous" is also largely unchanged through four editions from 1939 until 2001, except for the updating of different stories in the Appendix.

Some of the language in this older AA literature is dated, gendered and sexist, whilst newer publications are more broadly inclusive and representative of the diversity in AA now. A significant recent development in 2024 is that AA has published a "*Plain Language Big Book*", updating much of the gendered and sexist language, for example, replacing the Chapter "*For Wives*" with "*For Partners*".

In regard to AA keeping up to date with the latest scientific developments, AA has stated that it would listen to and reflect the latest developments in any relevant scientific field, and always to co-operate with anyone working in the AOD field.

Occasionally AA is wrongly criticised for being out of date with scientific developments about genetic causes of dependences, when AA expresses no view about causes of dependence. Other times AA is criticised for its disease model (see above), when the DSM-5 criteria also presume a disease concept. AA has also been vindicated by research evidence in having no view about levels of alcohol use defining dependence,[129] (which neither does the DSM-5).

Recommendation 11. Publish accurate information about AA, its principles and practices, (including research evidence of its success), to facilitate best practice research, policymaking, program design and co-ordination, (including referral pathways) for alcohol dependence.

8. Targeted & universal responses - resourced, co-ordinated & prioritised

Why don't Australian governments properly fund AOD and mental health treatment services, despite a demonstrated return on investment? How can we better co-ordinate targeted policies and programs alongside population-level alcohol policies and programs?

Australia's response to AOD use and harms lacks resourcing, co-ordination and a balanced prioritisation.

Resourcing treatment & prevention

There is significant disproportionate amount of funding spent by Governments on the 'supply reduction' strategy of AOD criminalisation, compared with the under-resourced prevention treatment and harm reduction. While an estimated $5.45 billion was spent in 2021/22 on AOD-related responses, two-thirds of this went to law enforcement, ($3.50 billion, 64%). This left just $2 billion for prevention ($364 million, 7%), treatment ($1.49 billion, 27%), and harm reduction ($90 million, 2%).

This inequity impedes the effectiveness of AOD policy, and there is an urgent need to increase funding for health-based interventions. The $5.45 billion is 0.63% of government expenditure, which is a decrease from 0.8% in 2009/10, and is a real reduction in proactive spending on AOD harm reduction by Australian governments.[130]

This under-resourcing means there is extensive unmet AOD treatment demand in Australia. In NSW, for example, comparing the number of people receiving treatment against the estimates of the number of people in need of treatment, leaves 101,773 people in need and seeking AOD treatment missing out in 2022, (including 50,000 people experiencing alcohol dependence). This 101,773 people comprise the following for each drug type:[131,132]

NSW	Diagnosed Need	Demand (Seeking)	Received Treatment	Treatment Gap	% Treated	% Untreated
Alcohol	169,483	67,793	17,831	49,962	26%	74%
Cannabis	49,467	19,787	7,744	12,043	39%	61%
Methamphetamine	41,798	31,348	9,498	21,850	30%	70%
Opioids	50,315	45,284	27,367	17,917	60%	40%
Total	**311,063**	**164,212**	**62,439**	**101,773**	**38%**	**62%**

The evidence is also clear about the cost effectiveness of AOD harm reduction. For every $1 invested in AOD treatment, $5.40 is returned in benefit to the community. For every $1 invested in harm reduction programs, such as Needle and Syringe Programs, $27 is returned in community benefit.[133]

Co-ordinating AOD & mental health services

Navigating the fragmented AOD service system is challenging. It has complex funding structures and lacks adequate co-ordination with the mental health sector. This creates barriers for help-seeking, as there is significant co-morbidity (dual diagnosis) AOD harms including dependence and mental ill-health. We need to make finding the right type of treatment and support much easier. There is a need to better understand effective treatment interventions targeting co-morbidity in alcohol use and mental illness, including education, psycho-social, peer-based, community-based, and pharmacological approaches. We need to research and evaluate any potential integration of the two service systems without just merging them, obliterating necessary differences.

Balanced prioritisation: targeted & universal approaches

Two of the most influential, yet contested, alcohol policy models, the Total Consumption model and the Prevention Paradox, (see Section 5. Reductionist models), suggest policies and programs should prioritise population-based approaches. This is at the expense of targeting people using alcohol at high-risk levels, including people experiencing alcohol dependence.

This suggested approach is despite most of the alcohol being used by a smaller proportion of people using alcohol at high-risk levels, while people who use alcohol at low-risk levels are already reducing their use, which does not impact significantly on the population-level risk of harms. Focussing exclusively on population interventions and outcomes, means neglecting the individuals with lived experience of high-level alcohol harms.[134] Further, the population-based approaches are not as effective at reducing harms for people using alcohol at high-risk levels:

> *"Public health messaging is more effective for people who use alcohol at low-risk levels who consequently use even less, but with minimal change in harms. Conversely, people using alcohol at high-risk levels appear less responsive and high rates of alcohol harm continue."*[135]

Alcohol policy should be a mix of measures aimed at population groups and at individuals.[136] It is critical to not shift funding away from AOD treatment, when the evidence shows there is significant unmet demand for AOD treatment, (see Resourcing above). Both prevention and individual treatment are needed. Addressing social and commercial determinants can help prevent, but not treat, alcohol dependence.

There is even the suggestion that policy measures targeted at people experiencing high-risk alcohol use and harms are more politically acceptable, and therefore more feasible, than population-based measures.[137] However, this political pragmatism risks stigmatising AOD harms, which is sometimes used for political advantage in seeking to criminalise AOD use and harms. Any such prioritisation of targeted, individual approaches must necessarily be without stigmatising or blaming people.

Could a continuum model better address harms than categorical?

An alternate approach which might balance the extremes of population-only or targeted-only is a 'continuum' model. This is intended to represent the complex, heterogeneous nature of alcohol use and harms, which presents challenges to understanding, treating or preventing alcohol harms including dependence. Proponents of a continuum model suggest that attempts to represent the complex phenomenon of alcohol dependence, (including the use of AUD criteria), have limitations. These include representing the broad spectrum of alcohol use and harms and the many pathways to prevention, treatment, and recovery.[138]

A continuum model departs from the dominant categorical model, which applies a threshold to determine 'use disorder', 'harmful use' or 'dependence' according to the severity of alcohol harms experienced by an individual, and the number of symptom criteria met. However, a continuum-based models raises key challenges for the conceptualisation of alcohol use harms, not least how such a model can be applied within treatment and clinical practice to challenge existing decision-making thresholds and paradigms.[139] Ignoring the way people in face-to-face situations make their decisions risks a situation where researchers and practitioners work in different ways, lessening communication between them. Researchers working in this space must be mindful of the practical limitations that those on the front-lines face.[140]

Every swing of the pendulum, back and forth, between universal and targeted approaches, over the past 100 plus years, brought new insights, learning, progress and some improved outcomes for people experiencing harms from alcohol. However, with each polarisation to an extreme, (or the alternate suggestion that there are no useful distinctions), we also lose something in our understanding and response to alcohol harms. With harms continuing to increase, we must continue to respond to the AOD harms experienced by individual people, plus put in place the structural, population-based measures seeking to prevent these harms happening in the first place. We have always needed to do both.

Recommendation 12. Ensure adequate funding (secure and indexed), co-ordination and governance for AOD and mental health sectors. Ensure people have equitable access to culturally responsive, trauma-informed and non-stigmatising treatment and support.

Recommendation 13. Implement alcohol policies and programs with a mix of both universal, population-based and targeted, individual approaches.

Conclusion

This submission has discussed some of the questions, paradoxes and challenges of AOD use and harms, especially alcohol use and harms, including alcohol dependence.

It has adopted a lived experience perspective, exploring the culture and psychology of alcohol, the frameworks and models used to understand alcohol use and harms, and examined some responses like AA, and universal and targeted approaches.

It has identified significant barriers, limitations, misrepresentations, contradictions, conflicts of interest and gaps in understanding alcohol use and harms. It has also suggested changes to lived experience engagement, to the understanding and representation of alcohol use and

harms, and to the policy and program responses. These changes include valuing, accepting, understanding, prioritising and supporting people experiencing AOD use and harms.

This submission makes specific recommendations that Australian Governments can implement to prevent AOD harms from being normalised, glorified, glamorised, stigmatised, marginalised and criminalised. This can allow Australians to experience better health, safety and wellbeing.

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