



The Honourable Members of the House of Representatives  
Standing Committee on Health, Aged Care and Sport  
Parliament House  
Canberra, ACT 2600

**SUBJECT: RESPONSE TO THE INQUIRY INTO THE HEALTH IMPACTS OF ALCOHOL  
AND OTHER DRUG USE IN AUSTRALIA**

Dear Committee Chair

Thank you for the opportunity to participate in a hearing of the inquiry on 30 October 2024, and for the opportunity to submit further evidence to the Committee.

During the hearing, our delegation noted the desire of the Committee to learn more about 'what works', how Drug ARM has applied that in our programs and services, and what lessons can be taken and applied across the country.

Following the hearing, our delegation undertook further research and consultation with our services team and have provided more detailed and direct answers to questions about evaluating the efficacy of models, suggested models of care, and the lessons learned from our outreach services.

As mentioned in our initial submission, we also have expanded further on regulatory and legal measures that can be taken to address the drug that has the most impact on Australians – alcohol.

Finally, we make 16 key recommendations, outlining steps that can be taken to address alcohol and other drug impacts in Australia.

This letter and enclosed information forms our final written submission to the inquiry. However, if there is any further information we can provide on any of the points raised, please do not hesitate to get in touch.

We look forward to working with all members of the Committee to have a positive influence in addressing the harmful impacts of alcohol and other drugs in Australia.

Yours sincerely

**Dr Dennis Young AM**  
Chief Advocate



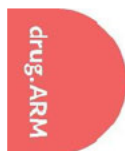
## Alcohol and other drugs in Australia

The impacts of alcohol and other drugs in Australia are primarily a public health issue, which need to be addressed in a systematic and organised way. Our health systems must be oriented to address the patterns and burden of disease of substance use, specific to the needs of Australians.

When we look at the prevalence of alcohol and other drug use in this country, and the patterns surrounding its use and impacts, we see the following trends:

- The harms of alcohol and other drugs are unequally distributed across the population (i.e. concentrated in young males, socioeconomic disadvantage)
- Risky alcohol and other drug use commences in late childhood or early adolescence, increases throughout adolescence and peaks in late adolescence or early adulthood, before declining (similar to the well-established age/crime curve phenomenon in criminology<sup>1</sup>)
- Patterns of alcohol and other drug use suggest Australia is very high by world standards in alcohol consumption and use of illicit drugs
- Community attitudes and beliefs contribute to ineffective and limited resources (stigma held by health professionals affects interest in developing diagnostic and treatment skills needed)
- While there are committed service providers, support for these programs and providers is limited and there is a concern that in many geographic areas there may be, effectively, a complete absence of services (it is impossible to know the unmet needs, however there is some suggestion that between 180,000 and 553,000 Australians need yet can't access alcohol and other drug services<sup>2</sup>)
- Cultural acceptance and normalisation of alcohol consumption has led to high levels of alcohol availability and consequently harm
- The increased use of digital media to advertise/promote alcohol to young persons
- Few restrictions on the sale of alcohol to minors/and or intoxicated persons via online sales

Any strategies to address the impacts of alcohol and other drug use in Australia must consider the context, and be prepared to address the harms, supply and demand simultaneously.



## Effective public health approaches

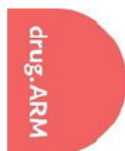
An effective public health approach cannot be isolated from an understanding and consideration of the underlying social determinants that drive the strength and health of the community and its individuals. A social determinants approach, i.e. addressing issues of housing, education, economics, transport, employment, justice, recreation, nutrition, social status and power; is integral to Public Health. To accomplish this effectively, public health should be considered across its five domains:

- **Biomedical** (Activities are aimed at the prevention and early detection of disease, relying on use of medical technology/interventions)
- **Education** (Constructed opportunities for learning involving some form of communication designed to improve health literacy and facilitate knowledge)
- **Behavioural** (Education programs/interventions based on particular behavioural change theories that attempt to encourage individuals to change attitudes, acquire skills and knowledge to perform desired behaviours)
- **Empowerment** (Process through which people gain greater control over decisions and actions affecting their health or where communities act collectively to gain greater influence and control over the determinants of health and the quality of life)
- **Social change** (Interventions that address the social determinants focusing on policy, legislation and/or social or environmental structures.)

Just as the principles of modern medicine can no longer consider individual body organs in isolation to each other, but seek to address the individual as a whole person, a Public Health/Health Promotion approach cannot address a particular health issue in isolation to the complex web of social, cultural, political, historical threads that entangle our communities. A Public Health strategy should seek to incorporate as best it can, aspects of these five domains.

In practice, this suggests that a two-pronged approach must be taken to effectively address alcohol and other drug impacts in Australia. That is, the adequate provision of on the ground services that can meet immediate needs consistently running parallel with governments and institutions working together to solve and address the broader social determinants of health.





## Evaluating efficacy

There is a good body of convincing evidence in Australia and overseas for public health policy measures to address population-wide alcohol and other drug trends. For example, Australia can be proud of its world leading approach in addressing tobacco harms, with rates falling significantly over the past 20 years. There are a series of measures that governments can implement relatively simply and at low cost to replicate this success. Examples of these are outlined under the heading ***Regulation and Legislation.***

The evidence base for specific models of care or community interventions to address substance use is not as well established, notwithstanding significant community interest in understanding what works. There are many alcohol and other drug agencies and services across Australia, operating evidence-informed services struggling to develop an evidence base for their programs. One obvious element of this, that has been spoken to in many of the submissions to this inquiry, are funding and operational challenges (see Queensland Network of Alcohol & other Drug Agencies submission – Section 3). Additionally, there are difficulties in measuring and evaluating programs. Central to this is ascertaining success indicators, or outcomes. The available literature focuses largely on abstinence as a success indicator, and the measurement tools employed are not sensitive enough to document efficacy differences between models.

Best practice alcohol and other drug services in Australia operate from a person-centred, harm reduction framework. On the ground that may result in a service addressing one area of harm reduction – for example needle and syringe programs addressing spread of infectious disease – or psychosocial interventions that work to a broad range of individually-led goals – perhaps employment, better mental health, or a reduction in substance use. The real challenge lies in how you measure successful treatment for alcohol and other drug management when the immediate needs and goals of people receiving treatment vary so greatly, and each model may work to a different component of alcohol and other drug harm. Within the national standards for which government funded alcohol and other drug services must comply, a whole range of potential outcomes are possible. As such, there is a sense that comparing different models in Australia would be like comparing ‘apples with oranges’. Moreover, there is little integration of services across the spectrum of providers. Little is known about continuity of care, follow up of clients after treatment, and the short- and long-term outcomes of treatment. Data sets that can be collected by organisations are often too small to be scientifically significant, and funding challenges restrict organisation’s abilities to develop, acquire and maintain systems in place to align to national standards.



Drug ARM cautions against potential risks with hastily applying outcomes-based measures to alcohol and other drug programs. Substance use disorders are complex, chronic health issues and there is concern that including restrictive measures may put pressure on agencies to exclude clients with complex presentations so as not to jeopardise outcomes, and therefore funding for “less complex” clients seeking support.

### Models of care – ‘what works’

Within available resourcing, quality alcohol and other drug agencies such as Drug ARM draw on existing evidence in the literature to inform our models of care. Below we share models that we draw upon which have been shown to have small to moderate promising effects in addressing substance use, while also addressing the immediate and urgent needs of individuals.

#### Models that offer options for longer term engagement

**Source:** Beaulieu, M., Tremblay, J., Baudry, C., Pearson, J., & Bertrand, K. (2021). A systematic review and meta-analysis of the efficacy of the long-term treatment and support of substance use disorders. *Social Science & Medicine*, 285, 114289. <https://doi.org/10.1016/j.socscimed.2021.114289>

Substance use disorders (SUD) are chronic conditions, with relapse rates in the first year varying between 40% and 60%<sup>345</sup>. Understanding the optimal length of treatment is therefore fundamental for providing services to people with persistent SUD. In a meta-analysis based on a systematic literature review, Beaulieu et al measured the efficacy of substance use disorder treatments and supports lasting 18 months or more compared to treatments of shorter duration. The results of their study suggest that people who receive longer term treatment or support had a 23.9% greater chance of abstaining or consuming moderately than did people who received a shorter standard treatment. This aligns with studies for other physical chronic diseases for which there are no time restrictions on treatment, where continued progress is expected for as long as services remain available<sup>67</sup>.

#### **In practice: Creating Options**

Drug ARM’s Creating Options psychosocial interventions program incorporates longer term engagement strategies into its model. People with persistent SUD are able to access up to 12 months of psychosocial and case management support from a qualified and experienced Clinical Worker.



Given the high dropout rates associated with people accessing SUD treatment, a significant focus is put on retaining clients in this program which is achieved by increasing accessibility through offering in-home, in-community and telehealth options. In Drug ARMs limited dataset, there is early evidence to confirm the value of longer treatment episodes.

Challenges of this program include attracting a retaining high-quality team of clinicians, a lower appointment capacity per clinician due to travel requirements, and subsequently higher waiting times than less comprehensive programs.

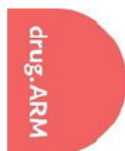
### **Models that address co-occurring substance use and mental health disorders**

**Source:** Cleary, M., Hunt, G. E., Matheson, S., & Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illness and substance misuse: systematic review. *Journal of advanced nursing*, 65(2), 238-258.  
<https://doi.org/10.1111/j.1365-2648.2008.04879.x>

**Source:** Mehta, K., Hoadley, A., Ray, L. A., Kiluk, B. D., Carroll, K. M., & Magill, M. (2021). Cognitive-behavioral interventions targeting alcohol or other drug use and co-occurring mental health disorders: a meta-analysis. *Alcohol and Alcoholism*, 56(5), 535-544. <https://doi.org/10.1093/alcalc/agab016>

Substance use and mental health comorbidity is estimated between 30% and 45% for individuals with alcohol and other drug dependence<sup>89</sup>. Dual diagnosis for people with severe mental illness is common, and has many adverse consequences. There is often an issue of falling through the gaps, as clinicians may lack the skills to deal with one of the presenting issues. As Dumaine noted, treating adults with these co-occurring conditions has sometimes been labelled 'mission impossible'<sup>10</sup>. Evidence for the effectiveness of interventions is inconsistent, though there are some interventions that may be more effective for the reduction of substance use, at least in the short term. In their systematic review of 54 studies, Cleary et al found that motivational interviewing in psychiatric settings can assist in the reduction of substance use; long term residential treatment may be effective, and contingency management may be a promising strategy. Mehta et al, in their meta-analysis of 15 clinical trials examining the efficacy of an integrated cognitive-behavioural intervention (CBI) delivered to individuals with a co-occurring substance use disorder and mental health condition found a small and variable effect for integrated CBI compared with single disorder intervention. In all of the above studies, individuals with comorbidities were found to have better outcomes when clinicians can address both substance use and mental health conditions.





### In practice: Creating Options

Drug ARM's Creating Options psychosocial interventions program has a specialist focus on treating comorbidities with clinicians trained in dual diagnosis interventions for substance use disorders and mental health conditions. Drug ARM is often referred clients that the state-run alcohol, tobacco and other drugs service deems too complex – who would otherwise fall through the gaps. Clinicians employ psychosocial interventions such as motivational interviewing techniques, and cognitive behavioural therapies. In Drug ARM's limited dataset there is early evidence to confirm that working with both conditions concurrently results in higher self-reported wellbeing and reduced substance use. Drug ARM has trialled contingency management for participation in programs (offering gift cards for attending sessions) from one site in Central Queensland, however not enough data is available to make any conclusive statements regarding its effectiveness. Ideally, if able to secure funding, Drug ARM would be eager to roll out contingency management in all Creating Options locations to further test its effectiveness.

### Models that offer group psychotherapy

**Source:** Coco, G. L., Melchiori, F., Oieni, V., Infurna, M. R., Strauss, B., Schwartz, D., ... & Gullo, S. (2019). Group treatment for substance use disorder in adults: A systematic review and meta-analysis of randomized-controlled trials. *Journal of substance abuse treatment*, 99, 104-116. <https://doi.org/10.1016/j.jsat.2019.01.016>

Group therapy is a common treatment for substance use issues due to its widespread clinical acceptance, the influence of mutual support groups such as Alcoholics Anonymous and other twelve step programs, and an increased focus on cost containment. In a meta-analysis of thirty-three randomised controlled trials, Lo Coco et al compared the efficacy of group psychotherapy to no treatment control groups, individual psychotherapy, medication, self-help groups, and other active treatments providing no specific psychotherapeutic techniques for people with substance use disorders. The analysis found that there were significant small short-term effects of group psychotherapy on abstinence compared to no treatment, individual therapy, and other treatments. There were also significant moderately sized effects for mental state compared to no treatment. This is promising but cautious interpretation is warranted given the limitations of available data.

### In practice: Day Program

Drug ARM's Day Program involves a combination of therapeutic groups and



individual case management. This program often attracts people who are seeking the more frequent and comprehensive support than weekly sessions (3 days per week), as well as individuals seeking work or family friendly hours. In Drug ARM's limited dataset there is early evidence to suggest increased daily functioning capacity during and immediately after treatment. Other benefits of day programs are their relative cost of care in comparison to other comprehensive group programs such as residential treatment.

### Lessons from 35 years of Street Outreach Services

Drug ARM's Street Outreach services have been operating in Australia since 1989. The services play an essential role in offering immediate aid, facilitating long-term support, and fostering trust with individuals experience harm through homelessness, substance use issues and mental health concerns. The aim of the program is to ultimately enhance their quality of life through connections and pathways toward stability. The key lessons learned have been as follows:

#### The benefits of access to immediate and urgent support

Mobile outreach services bring critical resources to people in distress, allowing for direct and immediate assistance and helping to stabilise individuals who may otherwise be isolated from support and feeling disconnected from society. Our staff and volunteers provide compassionate, person-centred care that can reduce feelings of isolation which is important for building mental wellbeing and self-worth.

#### Building trust is vital for reducing barriers to engagement

Mobile outreach services also serve as a bridge to more sustained support through building trust and rapport. This trust and rapport is built by consistent, face to face interactions week on week with people who may be hesitant to engage with formal services. The relationship forms a solid foundation from which to connect individuals to additional services that they may need over the long term and provides a pathway to broader support systems and structured programs.

#### Helping people understand what is available to them

Often, we will meet people who have never had to access social services. Our outreach teams are able to assess situations directly and provide a personalised response, acting as a conduit to available services such as housing programs, shelters, and other social services. Navigating these complex systems can be completely overwhelming or inaccessible without this face to face support.





## Regulation and legislation

Alcohol is consistently ranked as the most harmful substance in Australia<sup>11</sup>. Given the persistent and pervasive harms caused by alcohol, policies to reduce harms from alcohol should be a priority. Adopting the following legislation and regulation would be a critical step to reducing alcohol's health, social and economic burden on Australians.

### Alcohol and cancer

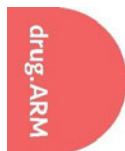
The number of Australians diagnosed with alcohol-related cancers is growing each year. Moderate alcohol consumption is directly linked to various cancers, including those affecting the oral cavity, throat, liver, and breast, contributing to nearly 6,000 lives lost annually and over 144,000 hospitalizations across Australia<sup>1213</sup>. It accounts for over 200 disease and injury conditions, costing Australia an estimated \$66.8 billion annually and comprising 4.5% of the total burden of disease<sup>141516</sup>. Alarmingly, 4% of all new cancers in Australia are attributed to alcohol<sup>17</sup>.

Despite the irrefutable causal link between alcohol use and cancer, awareness remains low among Australians<sup>18</sup>. There is a pressing need for robust public education similar to anti-smoking campaigns, which have effectively reduced smoking rates. Research has also shown the effectiveness of adding cancer warning levels to alcohol products, increasing awareness of the causal link with cancer and other diseases<sup>19</sup>.

### Cheap alcohol products

Cheap alcohol products are disproportionately responsible for alcohol-related harms in Australian communities, despite making up only a small fraction of the market. These products are often targeted at the most vulnerable to alcohol-related harms — individuals who consume alcohol at dangerously high volumes. Research demonstrates that just 20% of Australians are responsible for consuming 75% of all alcohol sold in the country, highlighting the need for interventions targeting harmful drinking patterns.

Current alcohol taxation in Australia varies greatly across different types of alcohol and their methods of delivery. While most taxes are volumetric within each category, they are not consistent across categories. Beer, for example, is taxed much less than spirits, and beer on tap is taxed at a fraction of the rate of packaged beer. Wine is taxed differently, using an 'ad valorem' approach based on its assessed dollar value, resulting in cheap wine often being taxed at disproportionately low rates.



The recommendation for a volumetric tax has been under consideration since the Henry Tax Review in 2010, which highlighted the need for reform, especially criticising the Wine Equalisation Tax (WET) and the disparity between taxes on beer and cheap wine. Despite recommendations from the National Alcohol Strategy 2019-2026 and numerous government reviews, reform has yet to occur.

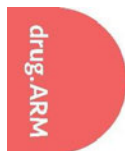
The cheapest alcoholic beverage available in Australia, cask wine, has a mean price per standard drink of just \$0.55, with some products priced as low as \$0.24 per standard drink. Introducing a minimum unit price of at least \$1.30 per standard drink could significantly reduce alcohol consumption nationwide, by an average of 1.5 standard drinks per week per person.<sup>20</sup> This sets a floor price below which cheap alcohol cannot be sold, typically at a level lower than what moderate drinkers pay for beer, wine, or spirits but high enough to reduce access to the cheapest and most harmful alcohol products. Evidence shows that for most Australians, a minimum price would not impact their alcohol purchases. However, it can encourage heavy drinkers to reduce their consumption and, in some cases, seek help. The Northern Territory experience further demonstrates that MUP, alongside other reforms, leads to meaningful reductions in alcohol harms including reductions in alcohol-related ambulance callouts, emergency department visits, assaults, arrests, road crashes, and child protection cases.<sup>21</sup> These broad community benefits underline the value of setting a properly indexed MUP across Australia.

### Online sales and delivery reform

Each state and territory across Australia has unique laws governing the control of alcohol, typically referred to as Liquor Acts and Regulations. These laws cover aspects such as liquor licensing, community involvement, and alcohol service. In recent decades, significant shifts have occurred in how alcohol is marketed, sold, and consumed, but the laws have not evolved accordingly.

We are now facing a scenario where existing restrictions on alcohol availability, originally designed with traditional brick-and-mortar stores in mind, no longer align with the digital age. In today's world, smartphones have essentially become virtual bottle shops and advertising platforms. This legal framework has not adapted to address rapid online alcohol delivery, which has become the fastest-growing segment in alcohol retail. Combined with digital marketing technologies that enable continuous, targeted advertising, this creates a seamless environment where a single click can lead to the immediate delivery of large quantities of alcohol to a consumer's doorstep.

The current laws are guided by dual objectives: fostering industry growth while reducing harm. This duality often leads to conflicts, where community perspectives may be overlooked and individuals may face excessive penalties for alcohol-related harm.



## Alcohol marketing

Alcohol marketing in Australia is through a fragmented system of regulation by both the Australian Government and state and territory bodies. Primarily, this regulation is enforced through state and territory liquor licensing laws, while federal oversight is limited to health and nutrition claims through the Food Standards Australia New Zealand (FSANZ) Act 1991.

Instead of comprehensive federal rules, alcohol marketing is predominantly evaluated through the industry-created Alcohol Beverages Advertising Code (ABAC), managed by the ABAC Scheme Limited. This scheme is financed and governed by alcohol industry groups, including the Brewers Association of Australia, Spirits & Cocktails Australia, and Australian Grape & Wine.

In practice, this patchwork system results in alcohol marketing that is minimally regulated in Australia, with key issues such as:

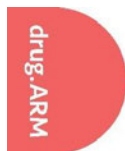
- A primary focus on content rather than quantity or exposure, often leaving room for interpretation. Limited regulations exist for some media, like television and licensed venues, but other spaces, including online, remain less controlled.
- A lack of proactive monitoring and enforcement, with community-driven complaints taking significant time to resolve.
- Self-regulation by entities with vested commercial interests, whose profit motives may inherently conflict with effective marketing restrictions.

Consequently, Australians are exposed to pervasive alcohol marketing. The rise of data-driven digital marketing further worsens the problem, allowing targeted ads to reach children and vulnerable individuals online. Young people's exposure to alcohol marketing has been linked to earlier initiation of drinking and increased likelihood of high-risk alcohol use later in life. Additionally, marketing can amplify positive perceptions of alcohol, trigger cravings in at-risk individuals or those with alcohol use disorders, and evoke a desire to drink among those in recovery.

Comprehensive federal regulation is suggested as the most effective way to limit community exposure to alcohol marketing. Such a regulatory framework, implemented by the Australian Government, must meet these key conditions:

- Be grounded in legislation with mandatory compliance,
- Be developed, administered, and enforced independently from commercial interests,
- Feature effective systems for deterring and penalising harmful marketing practices,
- Include proactive monitoring of harmful marketing activities.





Legislation that comprehensively aims to limit alcohol marketing will best protect children and young people, as well as others at high risk of harm. Children and youth are often exposed to marketing in shared environments with adults, making limited-scope policies ineffective. Moreover, people at risk of or recovering from alcohol use disorders continue to be vulnerable to exposure without robust protections in place.

### Industry influence

Addressing the impacts of alcohol and other drugs in this country must involve curbing the policy influence of the alcohol industry and holding them accountable for the harm caused by their products.

Alcohol companies and their lobbying groups often work to obstruct effective regulation concerning alcohol marketing and availability. Research indicates that political donations allow alcohol lobbyists to cultivate long-term relationships with politicians and shape short-term policy decisions in their favour<sup>22</sup>.

In the most recent federal election year, companies and lobby groups profiting from alcohol and gambling contributed over \$2 million to major political parties, including significant amounts from organisations pushing for reduced alcohol taxation<sup>23</sup>. As of February 2024, disclosures show that total alcohol-related contributions to political parties have amounted to \$16.3 million over the past decade<sup>24</sup>.



## Recommendations

It is our hope that Federal, State and Local Governments across Australia can come together to address alcohol and other drug use by adopting the following recommendations:

### Service Provision

1. Fund a range of models of care along the continuum of support needs – including but not limited to group programs, psychosocial treatments, and dual-diagnosis programs
2. Fund different providers to ensure diversity of services offered to individuals, offering them a choice in the care they receive
3. Fund organisations adequately to deliver programs aligned with best practice, and build in resourcing for providers to effectively assess their models
4. Fund independent research to evaluate services in an Australian context
5. Adopt 3+2 year service agreements to address funding instability
6. Include annual indexation linked to CPI and employment awards in service agreements to address funding erosion
7. Undertake service planning across regions and government levels to ensure consistency of service availability across recommissioning periods
8. Work across all levels of government with the community to solve and address the broader social determinants of health

### Regulation and Legislation

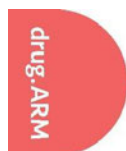
1. Introduce a Minimum Unit Price (MUP) for alcohol in each state and territory, that is properly indexed to inflation.
2. Launch a comprehensive community education campaign highlighting the direct link between moderate alcohol consumption and cancer.
3. Require warning labels on alcohol products that clearly outline the risks associated with alcohol consumption, including the link to cancer.
4. Continue to index the excise on beer and spirits.
5. Replace the Wine Equalisation Tax (WET) and with a volumetric tax rate.
6. Develop and implement a regulatory framework with a legislative basis that effectively reduces community exposure to alcohol marketing.
7. Implement a regulatory framework with a legislative basis that effectively reduces harms from online sales and delivery of alcohol.
8. Exclude alcohol companies and their lobby groups from the development of laws policies or programs related to alcohol harm reduction.
9. Prohibit political donations from alcohol companies and their lobby groups.



## References

- <sup>1</sup> Sweeten, G., Piquero, A. and Steinberg, L. (2013). Age and the explanation of crime, revisited. *Journal of Youth and Adolescence*, 42(6), pp.921-938.
- <sup>2</sup> Ritter, A., Chalmers, J., & Gomez, M. (2019). Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model. *Journal of studies on alcohol and drugs. Supplement*, Sup 18(18), 42–50.  
<https://doi.org/10.15288/jsads.2019.s18.42>
- <sup>3</sup> Brecht, M. L., & Herbeck, D. (2014). Time to relapse following treatment for methamphetamine use: a long-term perspective on patterns and predictors. *Drug and alcohol dependence*, 139, 18-25.
- <sup>4</sup> Finney, J. W., & Moos, R. H. (1992). The long-term course of treated alcoholism: II. Predictors and correlates of 10-year functioning and mortality. *Journal of studies on alcohol*, 53(2), 142-153.
- <sup>5</sup> Schellekens, A. F. A., De Jong, C. A. J., Buitelaar, J. K., & Verkes, R. J. (2015). Co-morbid anxiety disorders predict early relapse after inpatient alcohol treatment. *European Psychiatry*, 30(1), 128-136.
- <sup>6</sup> McLellan, A. T. (2003). The outcomes movement in addiction treatment: Comments and cautions. In J. L. Sorensen, R. A. Rawson, J. Guydish, & J. E. Zweben (Eds.), *Drug abuse treatment through collaboration: Practice and research partnerships that work* (pp. 157–179). American Psychological Association. <https://doi.org/10.1037/10491-010>
- <sup>7</sup> McLellan, A. T., McKay, J. R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. *Addiction*, 100(4), 447-458.
- <sup>8</sup> Farrell, M., Howes, S., Taylor, C., Lewis, G., Jenkins, R., Bebbington, P., ... & Meltzer, H. (1998). Substance misuse and psychiatric comorbidity: an overview of the OPCS National Psychiatric Morbidity Survey. *Addictive behaviors*, 23(6), 909-918.
- <sup>9</sup> Worley, M. J., Trim, R. S., Tate, S. R., Hall, J. E., & Brown, S. A. (2010). Service utilization during and after outpatient treatment for comorbid substance use disorder and depression. *Journal of Substance Abuse Treatment*, 39(2), 124-131.
- <sup>10</sup> Dumaine, M. L. (2003). Meta-analysis of interventions with co-occurring disorders of severe mental illness and substance abuse: implications for social work practice. *Research on Social Work Practice*, 13(2), 142-165.
- <sup>11</sup> Bonomo, Y., Norman, A., Biondo, S., Bruno, R., Daglish, M., Dawe, S., ... & Castle, D. (2019). The Australian drug harms ranking study. *Journal of Psychopharmacology*, 33(7), 759-768.





- 
- <sup>12</sup> International Agency for Research on Cancer. IARC monographs on the evaluation of carcinogenic risks to humans volume 100E. Personal habits and indoor combustion. 2012. <https://publications.iarc.fr/Book-And-Report-Series/Iarc-Monographs-On-The-identification-Of-Carcinogenic-Hazards-To-Humans/Personal-Habits-And-Indoor-Combustions-2012> (accessed Nov 9, 2020).
- <sup>13</sup> Lensvelt E, Gilmore W, Liang W, Sherk A, T. C. Estimated alcohol-attributable deaths and hospitalisations in Australia 2004 to 2015. Perth: National Drug Research Institute, Curtin University, 2018
- <sup>14</sup> Rehm J, Gmel GE, Gmel G, et al. The relationship between different dimensions of alcohol use and the burden of disease—An update. *Addiction*. 2017;112(6):968-1001.
- <sup>15</sup> Ibid Whetton S, Tait RJ, Gilmore W, et al
- <sup>16</sup> Australian Institute of Health and Welfare. Australian Burden of Disease Study. Impact and causes of illness and death in Australia 2018. Canberra: AIHW, 2021
- <sup>17</sup> Whetton S, Tait RJ, Gilmore W, et al. Examining the social and economic costs of alcohol use in Australia: 2017/18. Perth, WA: National Drug Research Institute, Curtin University, 2021.
- <sup>18</sup> Alcohol change Australia Public opinion on alcohol in Australia - knowledge, attitude and support for change November 2023
- <sup>19</sup> Zhao J, Stockwell T, Vallance K, Hobin E. The effects of alcohol warning labels on population alcohol consumption: an interrupted time series analysis of alcohol sales in Yukon, Canada. *J Stud Alcohol Drugs* 2020; 81: 225–37.
- <sup>20</sup> CEDAAR (2022) Investigating the introduction of the alcohol minimum unit price in the Northern Territory [https://health.nt.gov.au/\\_\\_data/assets/pdf\\_file/0007/818278/investigating-introduction-of-alcohol-minimum-unit-price-final-report.pdf](https://health.nt.gov.au/__data/assets/pdf_file/0007/818278/investigating-introduction-of-alcohol-minimum-unit-price-final-report.pdf)
- <sup>21</sup><sup>212121</sup> Jiang H, Livingston M, Room R, et al (2020) Modelling the effects of alcohol pricing policies on alcohol consumption in subpopulations in Australia <https://onlinelibrary.wiley.com/doi/10.1111/add.14898>
- <sup>22</sup> Kypri K, McCambridge J, Robertson N, et al (2019) 'If someone donates \$1000, they support you. If they donate \$100 000, they have bought you'. Mixed methods study of tobacco, alcohol and gambling industry donations to Australian political parties. *Drug Alcohol Rev*. 2019 Mar;38(3):226-233. <https://pubmed.ncbi.nlm.nih.gov/30474155/>
- <sup>23</sup> FARE (2023) Gambling and alcohol lobby plough \$2.165 million into political parties, up 40% from previous year <https://fare.org.au/gambling-and-alcohol-lobby-plough-2-165-million-into-political-parties-up-40-from-previous-year/>
- <sup>24</sup> FARE (2024) Alcohol lobby ploughs \$1.3m into political parties <https://fare.org.au/alcohol-lobby-ploughs-1-3m-into-political-parties>