FARE submission to the Victorian Royal Commission into Family Violence





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About the Foundation for Alcohol Research and Education

The Foundation for Alcohol Research and Education (FARE) is an independent, not-for-profit organisation working to stop the harm caused by alcohol.

Alcohol harm in Australia is significant. More than 5,500 lives are lost every year and more than 157,000 people are hospitalised making alcohol one of our nation's greatest preventative health challenges.

For over a decade, FARE has been working with communities, governments, health professionals and police across the country to stop alcohol harms by supporting world-leading research, raising public awareness and advocating for changes to alcohol policy.

In that time FARE has helped more than 750 communities and organisations, and backed over 1,400 projects around Australia.

FARE is guided by the World Health Organization's *Global Strategy to Reduce the Harmful Use of Alcohol*[1] for stopping alcohol harms through population-based strategies, problem directed policies, and direct interventions.

If you would like to contribute to FARE's important work, call us on (02) 6122 8600 or email info@fare.org.au.

[1] World Health Organization (2010). *Global strategy to reduce the harmful use of alcohol.* Geneva: World Health Organization.

Contents

When a strike at government liquor stores in Norway reduced the availability of alcohol by ten to 15 per cent, the rate of "home quarrels" dealt with by the police dropped by about one-quarter.

Norway (1978)

Horverak, Ø. (1983). The 1978 strike at the Norwegian wine and spirits monopoly. *British Journal of Addiction*.

Fitzroy Valley introduced restrictions which limited the types of alcohol and the times when alcohol could be sold. An evaluation found that these measures contributed to reduced rates and severity of intimate partner violence and better care of children.

Fitzroy Valley, Western Australia (2007)

Kinnane, et al. (2010). *Fitzroy Valley alcohol restriction report: An evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a two year period*. University of Notre Dame for the Drug and Alcohol Office of Western Australia.

The State of South Dakota 24/7 Sobriety Program requires people arrested or convicted for repeat drink-driving offences to take two alcohol breath tests a day or wear a continuous alcohol monitoring bracelet. An evaluation found a nine per cent reduction in intimate partner violence arrests after the implementation of the program.

South Dakota, USA (2005 to present)

Kilmer, et al. (2012). 'Efficacy of Frequent Monitoring with Swift, Certain, and Modest Sanctions for Violations: Insights from South Dakota 24/7 Sobriety Project', *American Journal of Public Health*.

Summary

The Foundation for Alcohol Research and Education (FARE) welcomes the opportunity to provide a submission to the *Royal Commission into Family Violence* (Royal Commission).

Family violence is an abhorrent violation of human rights, and alcohol is a significant contributor to family violence in Victoria. It is encouraging to see that family and intimate partner violence is rightfully a prominent issue on government agendas across Australia.

Last year, the *Australian Senate Finance and Public Administration Committee* held an *Inquiry into Domestic Violence in Australia*. The Committee is due to release their Inquiry report on 18 June 2015.[1] Last year the Queensland Government also established a Special Taskforce to review intimate partner and family violence in Queensland. The Taskforce released its final report, *Not now, not ever,* on 28 February 2015.[2]

In responding to the Terms of Reference for the Royal Commission, this submission draws on the literature of what is known about alcohol-related family violence. This includes evidence on the relationship between alcohol and family violence and the actions that can be taken to reduce alcohol-related family violence.

In Victoria, alcohol is at least partially implicated in up to 46 per cent (or 27,849) of incidents of reported family violence incidents.[3] Victorians need action by the State Government to prevent and reduce alcohol-related family violence and address harmful opinions that excuse alcohol-related family violence and reinforce gender inequalities.

Implementing alcohol availability controls and other policies that reduce alcohol-related violence are vital to preventing and reducing the severity of family violence and associated harms. Doing so is one way of making an immediate and positive impact on the incidence of family violence, while enhancing the safety and wellbeing of children affected by family violence.

In this submission FARE makes 17 recommendations to the Royal Commission on how the Victorian Government should work to reduce the incidence of alcohol-related family violence. This submission discusses these recommended reforms under five key areas:

1. Regulate the availability and promotion of alcohol in Victoria.
2. Develop and fund comprehensive models of care for victims of alcohol-related family violence.
3. Develop and fund programs targeted at perpetrators.
4. Educate young Victorians on alcohol and family violence.
5. Systematically collect data on alcohol-related family violence and undertake evaluations of existing programs.

This submission concludes with a list of experts and relevant research in the field of alcohol and family violence. The Royal Commission should consider the research referred to in this submission in preparing its recommendations. Further, the Royal Commission should also consider asking the experts on alcohol and family violence referred to in this submission to appear before the Inquiry.

Recommendations

The Royal Commission should recommend that the Victorian Government:

1. Amend the *Liquor Control Reform Act 1998* (the Act) to:
    a) Introduce tighter controls on the density of liquor licences in Victoria, including:
        i) Elevating harm minimisation as the only primary object of the Act.
        ii) Ensuring that approval processes for new on and off-licence premises consider existing levels of alcohol-related harms and community views.
        iii) Interventions that limit or reduce the density of liquor licences in areas with significant levels of alcohol-related harms through the introduction of saturation zones and licence buy-backs.
    b) Introducing the following restrictions to the hours that alcohol is available for sale for both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle shops):
        i) Introduce a closing time of no later than 3am for on-licence venues (with a 1am lockout).
        ii) Maintain the freeze on granting new licences for trading after 1am in the local government areas of Melbourne, Port Phillip, Stonnington and Yarra.
        iii) Limit off-licence trading hours to between 10am and 10pm.
        iv) The removal of all 24 hour liquor licences.
2. Amend the *Liquor Control Reform Act 1998* (the Act) by:
        a. Applying liquor promotion controls for on- and off-licence premises with equal weight.
        b. Banning alcohol promotions from appearing on shopper dockets.
        c. Restricting price-based promotions, such as bulk purchase discounts, and other promotional activities and practices which encourage the consumption of alcohol in risky volumes.
        d. Prohibiting alcohol promotions and advertisements from appearing on public property.
3. Build on the existing Common Risk Assessment Framework to develop a comprehensive, integrated Model of Care for alcohol-related family violence.
4. Provide adequate and ongoing funding to alcohol and other drug services and family violence services to meet demand.
5. Improve the Referral Protocol and Code of Practice to recognise and appropriately respond to the role of alcohol in family violence for victims and perpetrators.
6. Pilot a project for perpetrators that require people arrested or convicted for alcohol-related offences to take two alcohol breath tests a day or wear a continuous alcohol monitoring bracelet with “swift, certain and modest sanctions” for people who are found to consume alcohol.
7. Fund intensive programs targeted at perpetrators and ensure these programs are evaluated to inform future practice.

8. Support better integration between perpetrators and alcohol and other drug (AOD) services where appropriate.
9. Provide support for families of people accessing AOD or perpetrator programs to ensure their safety.
10. Ensure that school-based education campaigns on respectful relationships acknowledge the role of alcohol in family violence.
11. Provide adequate, ongoing funding to programs that educate school students on alcohol and respectful relationships.
12. Formally evaluate school-based education campaigns on alcohol and respectful relationships to assess their effectiveness in changing negative attitudes and behaviours.
13. Improve data collection on family violence and the involvement of alcohol, and publically report on this data to inform policy and research.
14. Ensure that plans and programs for family violence are appropriately evaluated so that they can inform future practice.
15. Enhance the Victorian Commission for Gambling and Liquor Regulation (VCGLR) and VicHealth's liquor licence map further by including incidence of alcohol-related harms data, including family violence, on the map to better inform decision-making by VCGLR on future liquor licence applications.
16. Include measures, statistics and data on alcohol-related family violence in the *Family Violence Index*.
17. The Royal Commission should consider the research referred to in this submission in preparing its policy responses; further, the Royal Commission should consider asking the experts on alcohol and family violence referred to in this submission to appear before the Inquiry.

Alcohol and family violence: Understanding the significance

Alcohol is a significant contributor to family violence in Victoria

Alcohol is associated with both the likelihood of family violence occurring and the severity of harms that result from this violence.[4] Alcohol consumption of both the perpetrator and the victim is a factor that contributes to physical violence.[5] This association has been recognised by the World Health Organization (WHO) and the Council of Australian Governments.[6,7]

WHO has gathered a body of evidence on the relationship between alcohol use and intimate partner violence and concluded that:[8]

- Alcohol use and intimate partner violence may both be linked to the same underlying factors (such as low socio-economic status or impulsive personality).
- Heavy alcohol use may cause or exacerbate relationship stress which increases the risk of conflict.
- Alcohol use affects cognitive and physical function, resulting in perpetrators of intimate partner violence using a violent resolution to relationship conflicts, rather than a non-violent resolution.
- Excessive drinking by at least one partner can aggravate existing relationship stressors such as financial problems, thus increasing the probability of violence.
- Alcohol use is often used by perpetrators as a justification to violence, or excuse for the violence.
- Experiencing intimate partner violence can result in increased alcohol consumption by the victim as a coping mechanism.
- Intergenerational effects may occur, with children who are witnesses to their parents' violence being more likely to have problematic drinking later in life.

WHO has also examined the relationship between alcohol and child maltreatment, concluding that:

- Alcohol effects physical and cognitive function which reduces self-control and increases the propensity to act violently, including towards children.
- Harmful alcohol use can impair responsible behaviour and decrease the amount of time and money that can be spent on a child.
- Harmful parental alcohol use is associated with other factors that increase the risk of child maltreatment such as mental health issues and antisocial personality characteristics.
- Experiencing child maltreatment is associated with problematic alcohol use later in life, to cope or self-medicate. Globally, having a history of child sexual abuse accounts for four to five per cent of alcohol misuse in men and seven to eight per cent of alcohol misuse in women.
- Child maltreatment associated with alcohol misuse is not confined to any one socio-economic group or cultural identity.[9]

In Victoria, alcohol is at least partially implicated in up to 46 per cent of reported family violence incidents (27,849 incidents). Between July 2012 and June 2013 there were 60,055 incidents of family violence reported to Victoria Police, of which:

- 14,015 incidents (representing 23.1 per cent of all family violence incidents) were reported as having definite involvement of alcohol.
- 13,834 incidents (representing 23 per cent of all family violence incidents) were reported as having possible involvement of alcohol.[10]

Regrettably, the number of family violence incidents with definite alcohol involvement has increased by 85 per cent between 2003-04 (when the corresponding figure was 7,567) and 2012-13. This increase was also found when controlling for changes in population, with a 59 per cent increase from 153.4 definite alcohol-related family incidents per 100,000 people to 244.2 per 100,000 over the same time period.

Family violence is not a gender neutral issue. Women are more than three times more likely than men to experience intimate partner violence.[11] Gender inequality and the attitudes that are supportive of it are consistently associated with violence against women. Violence against women is one avenue for men to assert their dominance over women.[12]

The impacts of family violence on women are numerous and devastating. These negative impacts include injury, physical health disorders, psychosomatic disorders, poor mental health, suicidal ideation and the development of habits that are harmful to health such as alcohol misuse.[13] VicHealth found that intimate partner violence within relationships was responsible for more preventable ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking.[14]

In Victoria, a carer's alcohol use was involved in one third (33 per cent) of all substantiated child protection cases between 2001 and 2005 (see Table 1).[15] Data reported in *The hidden harm: Alcohol's impact on children and families* (2015) examined the seriousness and level of intervention required for child protection cases that involved alcohol in Victoria between 2001 and 2005. *The hidden harm* found that child protection cases between 2001 and 2005 which received further and more serious interventions were more likely to involve alcohol:

- Alcohol was involved in 25 per cent (2,717) of substantiated investigations which did not require further intervention.
- Alcohol was involved in 34 per cent (6,523) of cases of interventions where the most serious act was a protective intervention.
- Alcohol was involved in 42 per cent (3,531) of cases which required an order from the Children's Court.[16]

The range and magnitude of alcohol's harm to others (2010) estimated the cost of alcohol-related child maltreatment in Australia to be $675 million. This estimate includes the costs of child protection services, out-of-home care services, intensive family support services and morbidity costs. When the intangible or indirect costs are included, this figure is likely to be much higher.[17]

Table 1: The involvement of alcohol in child maltreatment is significant.

	Child abandoned	Parents deceased or incapacitated	Physical harm	Sexual harm	Emotional harm	Neglect	Total
Alcohol involved (n)	245	245	2,554	385	6,661	2,681	12,771
Alcohol involved (%)	38	55	27	12	39	35	33

Data source: Laslett, AM,. Mugavin, J. Jiang. H., Manton, E., Callinan, S., MacLean, S., and Room R. (2015). *The hidden harm: Alcohol's impact on children and families*. Canberra: Centre for Alcohol Policy Research and the Foundation for Alcohol Research and Education.

Implementing alcohol availability controls and other policies that serve to reduce alcohol-related violence is vital to preventing and reducing the severity of family violence and associated harms. Doing so is one way of making an immediate and positive impact on the incidence of family violence while enhancing the safety and wellbeing of children affected by family violence.

The Victorian Government's response to alcohol-related family violence

Victorian Governments have for some time recognised the role of alcohol in family violence in its strategies, education programs and community engagement concerning family violence. Victorian Government strategies that recognise alcohol as a contributing factor in family violence include:

- *Victoria's vulnerable children: Our shared responsibility. Strategy 2013-2022*
- *Victoria's action plan to address violence against women & children 2012-2015*
- *Reducing the alcohol and drug toll: Victoria's plan 2013-2017*
- *Policing alcohol harm in Victoria*
- *Strong culture, strong peoples, strong families: Towards a safer future for Indigenous families and communities 10 year plan*
- *Victorian homelessness action plan 2011–2015*

Despite this recognition, responses and solutions addressing alcohol's contribution to family violence have not been sufficiently addressed in Government policies and programs to date. WHO has identified action on alcohol misuse as one of several strategies to reduce violence against women.[18] Government action has not adequately addressed this need, and when policies do exist they often do not focus on prevention. Strategies that aim to reduce alcohol-related violence will enhance the safety and wellbeing of children and women affected by alcohol-related family violence.

According to FARE's *Annual alcohol poll 2015*, over a quarter of Victorians (28 per cent) have experienced alcohol-related violence.[19] One in three (34 per cent) Victorians view alcohol as the drug that causes the most harm to Australians. Most Victorians think that that alcohol-related problems will remain the same or get worse in next five to ten years (70 per cent), and that more needs to be done to reduce alcohol-related harms (74 per cent). More than half believe that governments are not doing enough to address alcohol-related harms (54 per cent), and that the alcohol industry makes political donations to influence policy (55 per cent).

More needs to be done by the Victorian Government to:

- Translate recognition of alcohol's contribution to family violence into actions that reduce alcohol-related family violence in the state.
- Directly report on progress against alcohol-related family violence outcomes served by these initiatives and their strategies.
- Ensure that these various strategies and initiatives are interrelated and coordinated to avoid victims of abuse falling through 'gaps' between service delivery agencies.

Policy responses

Implementing strategies that aim to reduce alcohol-related violence are vital to preventing and reducing the severity of family violence. The policy responses in this submission focus on five areas of reform to the Victorian Government's policies and programs which address alcohol's contribution to family violence. These are:

1. Regulate the availability and promotion of alcohol in Victoria.
2. Develop and fund comprehensive models of care for victims of alcohol-related family violence.
3. Develop and fund programs targeted at perpetrators.
4. Educate young Victorians on alcohol and family violence.
5. Systematically collect data on alcohol-related family violence and undertake evaluations of existing programs.

Each of these policy responses are elaborated upon in the sections below.

1. Regulate the availability and promotion of alcohol in Victoria

Responds to:

> Term of reference 1.a. 'The prevention of family violence'.

> Term of reference 2: 'Investigate the means of having systematic responses to family violence...'

The Victorian Government's jurisdiction over alcohol availability and promotion is outlined in the *Liquor Control Reform Act 1998* (the Act). The Victorian Commission for Gambling and Liquor Regulation (VCGLR) is the independent statutory authority which regulates Victoria's gambling and liquor industries. The regulatory remit of VCGLR includes the availability and promotion of liquor. The availability of liquor is regulated through the approval of liquor licences (as stipulated under section 44, 47 and 48 of the Act) and liquor outlet trading hours (as defined in section 3(1) of the Act). The promotion of liquor is regulated through enforcement of section 115A of the Act and its accompanying guidelines for intervening in cases where inappropriate alcohol promotions are conducted by licensees.[20]

Under the Act, the Objects include contributing to minimising the harms that may result from alcohol, as well as furthering the commercial development of the liquor, licensed hospitality and live music industries. The implication is that harm minimisation and commercial development are considered equally.

Availability

In Victoria, alcohol is more available than ever in both the quantity and spatial density of liquor outlets, and the trading hours in which liquor is sold from licensed outlets.[21] Recently, supermarkets in Victoria such as ALDI and Costco have been able to sell alcohol in stores.[22]

Victoria is the "liquor outlet density capital of Australia" as the jurisdiction in Australia with the greatest number of liquor outlets.[23] In 2012-13 there were 19,978 active liquor licences in Victoria. This has increased by 21 per cent over ten years.[24]

As defined in section 3(1) of the Act, the standard trading hours for licensed premises in Victoria for general licences, on-premise licences, and restaurants and café licences are 7am to 11pm from Monday to Saturday and 10am to 11pm on Sunday. The standard trading hours for packaged liquor licences in Victoria are 9am to 11pm from Monday to Saturday and 10am to 11pm on Sunday. Under section 11A, licencees may apply for a late night licence, which allows approved licensed premises to trade from 1am up to 7am or for 24 hour periods. As at August 2014, 952 liquor licences were approved for late night (on-premises) trading; of which 52 per cent were approved to trade to 3am.[25] Currently, there is a moratorium on applications for liquor licences to trade past 1am. This moratorium applies to the local government authorities of Melbourne, Port Phillip, Stonnington and Yarra and is due to expire on 1 July 2015.[26]

To coincide with the unprecedented levels of alcohol's availability in Victoria, the incidence and rates of alcohol-related harms have also increased over time in Victoria. Five indicators of alcohol-related harms in Victoria demonstrate this increase:

- Alcohol involvement in family incidents increased by 85 per cent between 2003-04 and 2012-13 to 14,015 incidents. In that same period, the trend per 100,000 population increased by 59 per cent.
- Alcohol treatment episodes increased by 28 per cent between 2003-04 and 2012-13 to 21,460 episodes. In that same period, the trend per 100,000 population increased by ten per cent.
- Alcohol-related ambulance attendances increased by 146 per cent between 2003 and 2011 to 8,349 attendances. In that same period, the trend per 100,000 population increased by 112 per cent.
- Alcohol-related hospital admissions increased by 53 per cent between 2002-03 and 2010-11 to 29,694 admissions. In that same period, the trend per 100,000 population increased by 33 per cent.
- Alcohol-related assaults increased by 30 per cent between 2002-03 and 2010-11 to 6,768 assaults. In that same period, the trend per 100,000 population increased by 13 per cent.[27]

Research evidence, including Australian research and case studies, has consistently found that increased trading hours leads to increased harms.[28,29,30] Increased outlet density (both hotel, on- and off- licence types) also contributes to increased alcohol harms,[31,32] including family violence[33,34] and child maltreatment.[35]

The association between trading hours and general assaults is significant. Newcastle, NSW introduced a 3am closing time and 1am lockout (later amended to 3.30am and 1.30am) for all on-licensed premises in 2008 which resulted in a 37 per cent reduction in night-time alcohol-related assaults,[36] with no evidence of geographic displacement.[37] These positive effects were sustained, with an evaluation five years later finding on average a 21 per cent decrease in alcohol-related assaults per hour.[38]

In Sydney, NSW, restrictions on alcohol availability were modelled on the example set by the Newcastle restrictions. In January 2014, the State Government introduced 3am cessation of alcohol service; a 1.30am lockout; and a freeze on new liquor licences and approvals for existing licences in the Sydney central business district (CBD) and Kings Cross area. There was also 10pm close imposed for off-licence alcohol across NSW. An evaluation found that between January and December 2014 following the reforms, the incidence of assaults was significantly reduced in both Kings Cross (down 32 per cent) and Sydney CBD (down 26 per cent).[39] The study also found that there was a 40 per cent

reduction in the incidence of assaults in a sub-section of the restricted areas. The impacts of the state-wide 10pm close for off-licence outlets is yet to be evaluated.

The effects of trading hours on family violence has been evidenced internationally and in Australia. In 1978, where a strike at government liquor stores in Norway reduced the availability of alcohol by ten to 15 per cent, the rate of "home quarrels" dealt with by the police dropped by about one-quarter.[40] In Australia, alcohol restrictions have been introduced in some communities which have experienced demonstrable harms from alcohol. Fitzroy Valley in Western Australia introduced restrictions in 2007 which limited the types of alcohol and the times when alcohol could be sold. An evaluation found that these measures contributed to reduced rates and severity of intimate partner violence and better care of children.[41]

The association between alcohol outlet density and family violence is also significant. A study of the effects of changes in the number of off-licence alcohol outlets in neighbourhoods in the Melbourne region between 1996 and 2005 found that adding a new outlet in a postcode increased the family violence rate in police statistics by an average of 28.6 per cent.[42]

A study released in May 2015 examining associations between alcohol sold through off-premise outlets (liquor stores) in Australia and the incidence of traumatic injury in surrounding areas further demonstrates this link. The study found that a ten per cent increase in chain outlet density (such as Dan Murphy's and BWS) is associated with a 35.3 per cent increase in intentional injuries (assaults, stabbing and shooting) and a 22 per cent increase in unintentional injuries (such as falls, crushes, or being struck by an object).[43]

A study in Sydney, New South Wales (NSW), investigated the relationship between liquor licence concentrations and assault rates in local government areas (LGAs). The study found that the concentration of hotels, on-premises, and clubs were predictive of intimate partner violence rates in LGAs. The study also found that "the concentration of hotel licences in an LGA, particularly at higher density levels, was strongly predictive of both intimate partner and non-intimate partner assault rates".[44]

Research published in *Using geocoded liquor licensing data in Victoria* in 2011 found that people living in disadvantaged areas in and around Melbourne had access to twice as many bottle shops as those in the wealthiest areas. For rural and regional Victoria, there were six times as many packaged liquor outlets and four times as many pubs and clubs per person.[45] Given the interrelationship between alcohol misuse, family violence and socio-economic disadvantage, this is concerning.

WHO has highlighted that neighbourhoods which have higher densities of alcohol outlets (both on and off-licences) also have greater child maltreatment problems. These neighbourhoods are also more socially disadvantaged with fewer resources available to support families. This situation can lead to increased stress for families and restrict development of social networks that can prevent child maltreatment.[46]

Understanding that the concentration of alcohol outlets is higher in disadvantaged communities is important when determining appropriate policy options. A review by Michael Livingston in 2012 suggested that the increased access to alcohol in disadvantaged communities may help explain some of the socio-economic disparities in health outcomes. The review also suggested that it might be harder for disadvantaged communities to influence planning and zoning decisions, thereby hindering their ability to prevent the continuing proliferation of outlets.[47]

In Victoria, community members are able to object to a liquor licence in cases where the licence applicant is required to display a public notice. The burden of proof is on community objectors to

appropriately demonstrate that the proposed licence would have a negative impact on themselves as well as the amenity of their area.[48] However, community objectors do not necessarily have the capabilities (in terms of time, financial costs, and research capacity) that are required to meet the burden of proof. These barriers to effective engagement and input may be elevated for disadvantaged communities.

Policy proposals

Decreasing the availability of alcohol in communities reduces and sustains the reduction in alcohol harms over time. This effect can extend to reductions in the incidence of family violence and child maltreatment. Governments can reduce the availability of alcohol through tighter outlet density controls and interventions, and reduced trading hours for all licence types.

Tighter outlet density controls and interventions

To address outlet density, saturation policies need to be introduced. In England and Wales, regulatory bodies have introduced policies such as saturation zones where limitations are imposed on the introduction of new licences in areas that already have a high density of existing licences. Operational saturation zones in the United Kingdom have been determined based on existing outlet density, crime data and family violence statistics.[49,50] Buy-backs could also be initiated in areas where there are deemed to be too many outlets. Supermarkets should also be prohibited from selling alcohol within their stores, to avoid increasing outlet density, and to avoid normalising and facilitating the sale of alcohol that will be largely consumed at home.

To support the harm minimisation Object, an assessment framework must be developed and implemented for liquor licensing decisions. This framework should take into account and prioritise the potential impact on community safety and wellbeing. This is particularly important for disadvantaged communities who are often powerless to stem the proliferation of outlets in their area, and who experience disproportionate levels of health and social harms including family violence.

It is also vital to encourage community participation in decisions around licensing matters, in order to balance representations made by the licence applicants. This can be achieved by reducing the burden of proof for objectors and by enhancing access to information and resources for objectors. Understanding that the concentration of alcohol outlets is higher in disadvantaged communities is important when determining appropriate policy options, especially because people in these communities may face additional challenges when objecting to liquor licences.

Trading hours

The trading hours of alcohol in Victoria must be reduced in order to decrease alcohol harms. Communities and local governments that have introduced restrictions to address the trading hours of alcohol in their area have benefited from significant reductions in general assaults as well as family violence. The positive impacts were immediate and often sustained over time.

To reduce trading hours, policies such as those implemented in Newcastle and Sydney should be implemented in Victoria. This includes limiting off-licence trading hours to between 10am and 10pm, a closing time of no later than 3am for on-licence venues (with a 1am lockout) and banning all 24 hour licences. The current freeze on granting new licences for post-1am trading in the LGAs of Melbourne, Port Phillip, Stonnington and Yarra must be maintained to support these measures.

Recommendations

The Royal Commission should recommend that the Victorian Government:

1. Amend the *Liquor Control Reform Act 1998* to:

    a) Introduce tighter controls on the density of liquor licences in Victoria, including:

        i) Elevating harm minimisation as the only primary object of the Act.

        ii) Ensuring that approval processes for new on and off-licence premises consider existing levels of alcohol-related harms and community views.

        iii) Interventions that limit or reduce the density of liquor licences in areas with significant levels of alcohol-related harms through the introduction of saturation zones and licence buy-backs.

    b) Introducing the following restrictions to the hours that alcohol is available for sale for both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle shops):

        i) Introduce a closing time of no later than 3am for on-licence venues (with a 1am lockout).

        ii) Maintain the freeze on granting new licences for trading after 1am in the LGAs of Melbourne, Port Phillip, Stonnington and Yarra.

        iii) Limit off-licence trading hours to between 10am and 10pm.

        iv) The removal of all 24 hour liquor licences.

Promotion of alcohol

The promotion of alcohol by licensees in Victoria is regulated by the *Guidelines for responsible liquor advertising and promotions* (Liquor Promotion Guidelines).[51] Alcohol promotions by licensed premises take the form of:

- signs, banners, flyers, posters
- newspaper or internet advertisements
- websites and social media site (such as Facebook or Twitter), including comments on a licensee's social media site or website made by third parties, and advertisements and promotions made by promoters engaged by the licensee
- text messages (SMS).[52]

VCGLR has the power to ban inappropriate advertising or promotions.[53] Such action may also result in the VCGLR seeking to vary, suspend or cancel a liquor licence. If a venue does not comply with a banning notice, they are committing a criminal offence and can face penalties over $17,000.[54] The Liquor Promotion Guidelines are based on 16 Principles which guide decisions around the appropriateness of a liquor promotion.[55] These principles focus on:

- Excessive consumption of liquor and antisocial behaviour (Principles 1, 2, 3 and 4): Promotions which are prohibited include those which encourage or reward the purchase of, or drinking of, large amounts of liquor in a single session or transaction.

- Discounting promotions (Principles 5, 6 and 7): Promotions which are prohibited include those which involve extreme discounts (for instance, $1 shots of spirits) or excessive periods of free drinks (such as $50 entry and free drinks all night).
- Promotions which objectify or degrade any person or section of the community (Principles 8, 9 and 11): Promotions which are prohibited include those which target women by offering free or reduced price alcohol combined with incentives to dress provocatively or remove their clothing.
- Association with risky behaviours (Principle 10): Promotions which are prohibited include those which use images or messages associating the consumption of liquor with risky or dangerous activities (including sky diving, motor racing, drink driving, speed boating).
- Illegal activities (Principles 12 and 13): Promotions which are prohibited include those which link the consumption of liquor to drink driving or to breaking the law.
- Underage drinking (Principles 14 and 15) and the likelihood of placing any group at risk of harm (Principle 16): Promotions which are prohibited include those which use characters, imagery, designs, motifs, interactive games, merchandise or media that are likely to appeal to minors.[56]

Alcohol is heavily promoted across Australia in the public domain, on the internet and at the point of sale (POS) for liquor products. In the Guidelines, liquor promotions are not prohibited from being advertised on public property (including public transport), nor in public spaces where children may be exposed to the advertising materials (such as schools and public sporting facilities). POS marketing is an area of liquor promotion and advertising which VCGLR has the remit to regulate for the public benefit. POS refers to promotional materials that are found within or on the exterior of a licensed store or venue at the point where an alcohol purchase will be made (for instance, happy hours, free gifts with purchase, prominent signage, competitions, price discounts for bulk purchases, and sale prices).

The excessive promotion of alcohol and the use of price-based promotions encourages consumers to increase their consumption of alcohol. Low alcohol prices result in higher consumption. This includes heavier drinking, occasional drinking and underage drinking.[57]

POS promotions have been found to encourage the purchase of increased volumes of alcohol[58] and are likely to affect overall consumption patterns of underage, harmful, and regular drinkers.[59] POS marketing is being increasingly used, to the point that it has been coined as “ubiquitous” and “aggressive”.[60] From January to April 2009, liquor outlets in Sydney alone hosted an average of 30 POS promotions per outlet.[61]

Alcohol promotions influence the age at which young people begin drinking alcohol, as well as their levels of consumption.[62] The prolific nature of POS marketing is concerning. It results in young people (including minors) being regularly exposed to advertisements and promotions that depict alcohol consumption as a fun, social and inexpensive activity.[63]

VCGLR takes a passive approach to the identification of inappropriate alcohol promotions conducted by licensed venues. It relies on public complainants to draw VCGLR’s attention to the inappropriate promotional conduct of licensed venues in Victoria. The existing Liquor Promotion Guidelines are also weak in their application to both on- and off-licence premises, their restriction of price-based promotions, and their restriction of alcohol promotions on public property (such as trains, trams, buses and public transport shelters).

Policy proposals

The Victorian Government has acknowledged in *Victoria's action plan to address violence against women & children 2012-2015* that alcohol is a contributing factor to the incidence of family violence and other harms. The Victorian Government has also declared its interest in alcohol harm prevention, as outlined in *Reducing the alcohol and drug toll: Victoria's plan 2013-2017* and *Policing alcohol harm in Victoria*.

In light of this recognition of alcohol harms and the need to prevent them from occurring, the Victorian Government should do more to restrict liquor promotions in the state.

The Government's interests in alcohol harm prevention would be well served by policies that:

- apply liquor promotion controls for on- and off-licence premises with equal weight
- ban alcohol promotions from appearing on shopper dockets
- restrict price-based promotions
- divest government revenues away from alcohol advertising channels.

Applying liquor promotion controls for on- and off-licence premises with equal weight

The Liquor Promotion Guidelines focus on activities which take place at on-licence premises. This is despite the fact that most Australians consume alcohol in a domestic setting[64], with 80 per cent of all alcohol purchased from off-licence venues. The current Liquor Promotion Guidelines fail to appropriately regulate promotions within the contemporary advertising market. To ensure that harmful liquor promotions serve to prevent alcohol harms across the community, liquor promotion controls should be applied with equal weight for on- and off-licence premises.

Restricting price-based promotions

Price-based promotions which result in alcohol being made available for as little as 29 cents a standard drink are also not effectively regulated for both on- and off-licence premises under the current promotion policy. This is problematic because lower prices are associated with increased consumption and harms. To prevent alcohol harms, including family violence, price-based promotions, such as bulk purchase discounts, and other promotional activities and practices which encourage consumption of alcohol in risky volumes should be restricted. Consultation with the community and public health experts should occur to ensure harm minimisation is held as the key objective in the Liquor Promotion Guidelines.

Banning alcohol promotions from appearing on shopper dockets

Shopper dockets are coupons or vouchers for free or discounted alcohol printed at the bottom of supermarket shopping receipts. Following a six month investigation into shopper dockets by the NSW Office of Liquor, Gaming and Racing in 2013, the agency found that shopper dockets were "likely to encourage the misuse and abuse of liquor".[65] Victoria should heed the lessons learned by its counterparts in NSW, and ban alcohol promotions from appearing on shopper dockets.

Divesting government revenues away from alcohol advertising channels

The Victorian Government needs to align its policies on the promotion of liquor with its strategies that concern alcohol harms and family violence. The Government should not profit from or facilitate the promotion or advertising of alcohol companies and retailers. To do that, the Government should prohibit alcohol promotions and advertisements from appearing on public property. Prohibiting liquor

advertisements from being displayed on public property would reduce the presence of alcohol advertising that perpetuates sexist attitudes and behaviours towards women. This would also reduce the exposure of children to liquor promotions.

Recommendations

The Royal Commission should recommend that the Victorian Government:

2. Amend the *Liquor Control Reform Act 1998* by:

    a. Applying liquor promotion controls for on- and off-licence premises with equal weight.

    b. Banning alcohol promotions from appearing on shopper dockets.

    c. Restricting price-based promotions, such as bulk purchase discounts, and other promotional activities and practices which encourage the consumption of alcohol in risky volumes.

    d. Prohibiting alcohol promotions and advertisements from appearing on public property.

2. Develop and fund comprehensive models of care for victims of alcohol-related family violence

Responds to:

> Term of reference 1.b. 'Early intervention to identify and protect those at risk of family violence and prevent the escalation of violence'.

> Term of reference 1.c. 'Support for victims of family violence and measures to address the impacts on victims, particularly women and children'.

> Term of reference 3: 'Investigate how government agencies and community organisations can better integrate and coordinate their efforts'.

Alcohol and family violence

Alcohol is associated with both the likelihood of family violence occurring and the severity of harms that result from this violence.[66] Alcohol is at least partially implicated in up to 46 per cent (or 27,849) of incidents of reported family violence incidents in Victoria.[67] Alcohol consumption of both the perpetrator and the victim is a factor that contributes to physical violence.[68]

It is important to understand the complex association between victimisation and alcohol problems. Alcohol is often used as a form of self-medication, to cope with the abuse itself and associated effects such as isolation, lack of support and feelings of self-blame or shame.[69] The risk of being a victim of intimate partner violence increases with increasing levels of alcohol consumption.[70] Victims who are intoxicated are more likely to be blamed for the violence than victims who are sober.[71] Both family violence and problems with alcohol disproportionately affect Aboriginal and Torres Strait Islander communities, with both likely to stem from the same underlying issues of continued social disadvantage[72] and intergenerational grief and loss.[73]

Problematic alcohol use by a victim of family violence can pose barriers to them seeking help. Problematic alcohol use tends to exclude women from family violence support services and refuges, and can increase the likelihood of a woman losing custody of her children.[74] Other issues that prevent women from seeking support or disclosing family violence include fear of a lack of access to support services,[75] especially in rural and remote communities; and issues of anonymity within the community and kinship groups.[76]

There are a range of risk factors that increase the likelihood of child maltreatment. These risk factors include the parent's own history of child maltreatment, parental mental health issues and use of alcohol and other drugs (AOD), and relationship risk factors.[77,78] Being a victim of, or witness to, family violence has serious emotional, psychological, social, behavioural and developmental consequences for children.[79] These problems from child maltreatment may precipitate life experiences and conditions that create a cycle of violence from one generation to another.[80]

Parents' consumption of alcohol can impede their capacity to take care of their children.[81] Alcohol use by parents and carers is generally considered problematic when it is at levels that impair the judgement or alter the mood of parents, placing the child at risk of abuse or neglect.[82] If both parents are experiencing problems with alcohol, the risk of maltreatment is higher.[83]

Children can also be affected by alcohol exposure before birth. There is strong evidence internationally[84,85,86]and emerging evidence from Australia[87] that children with Fetal Alcohol Spectrum Disorders (FASD) are disproportionately represented in the child protection system. Children born

with FASD most often come from heavy drinking families. Three quarters (75 per cent) of children in a USA study with FASD have a biological father who was a heavy drinker and have extended families with heavy alcohol consumption.[88] Where issues with alcohol do occur they are often associated with other problems that families are likely to be experiencing, such as poverty, violence, housing and employment issues.[89]

Victoria's response to family violence

Victoria has developed a range of progressive and innovative platforms for addressing family violence in the state. As noted by the peak body in the state for family violence services, Domestic Violence Victoria (DV Victoria): "Victoria has been at the forefront of innovation in family violence reform over the past decade which has positioned Victoria as a world leader in not only responding to family violence, but early initiatives in preventing violence before it occurs".[90] Victoria's family violence reforms are commendable for their benefit to Victorians, for their influence in Western Australian and NSW family violence reforms, and for their contributions to the development of the *National plan to reduce violence against women and their children 2010–2022*.

Since the release of *Victoria's action plan to address violence against women & children 2012-2015* (Action Plan), the government has sought to improve system reporting on family violence and responses to the needs of family violence victims. To that end, the Government developed the Common Risk Assessment Framework and the Family Violence Referral Protocol. In addition, Victoria Police developed its *Code of practice for the investigation of family violence* (the Code of Practice). Other family violence training programs funded by the Victorian Government include:

- *Working with culturally and linguistically diverse (CALD) Communities*, which educates practitioners on preventing family violence in ways that work for different community contexts.[91]
- *Reducing violence against women and their children community of practice*, which helps practitioners who implement projects to prevent violence against women and their children share information and knowledge.[92]
- *Strengthening hospital responses to family violence*, which is a pilot project aligned with CRAF to support hospital personnel to identify and respond to family violence experienced by hospital patients.[93] This pilot project is due to be finalised in mid 2015.

In 2013-14, the Victorian Government made a $90 million investment in initiatives that serve its Action Plan.[94]

Common Risk Assessment Framework (CRAF)

CRAF was developed to better identify and respond to family violence.[95] The focus of CRAF is on supporting women and children who are victims of family violence. CRAF serves those professionals who may encounter and work with people who experience family violence.

This includes (but is not limited to) professionals from the following sectors:

- alcohol and other drugs (AOD)
- child FIRST and family services
- women family violence specific services
- housing and homelessness services

- Indigenous services.[96]

CRAF helps these professionals to "make appropriate referrals if family violence is detected or suspected".[97] An evaluation of CRAF found that people in the sector were highly engaged with the Framework, with demonstrated significant changes to practices as a result of the training. The evaluation found that most participants were asking questions about family violence (72 per cent), incorporating risk assessment into their work (68 per cent), doing safety plans (84 per cent), referring clients to other services (74 per cent).[98] The limitation of CRAF is that it works one way: filtering referrals from other support providers (such as AOD) through to family violence service providers.

The referral protocol

The family violence Referral Protocol (the Referral Protocol) aims to leverage effective referral pathways to better protect women and children and reduce the incidence of family violence. The Referral Protocol operates between Victoria Police and family violence services funded by the Victorian Department of Human Services (DHS). The Referral Protocol "provides guidance on how Victoria Police, DHS and the service agencies it funds can work together to strengthen the collective response to family violence".[99] The Referral Protocol outlines approaches for:

- Formal and informal referrals by police for victims of family violence to family violence services.
- Assessing the risk to any child or children or young person present at a family violence incident, and referring that child to appropriate support services.
- Formal and informal referrals by police of perpetrators of family violence to services and emergency accommodation if required.
- Referral by family violence support agencies for police assistance.[100]

Alcohol and factors that contribute to family violence are complex and often interrelated. This complexity means that victims and perpetrators of family violence require access to multiple support services. The array of these support services is reflected in the CRAF stakeholder list above.

Alcohol cannot be ignored as a contributing factor when considering policy responses to family violence, given the fact that it is involved or possibly involved in nearly half of reported family incidents in Victoria (46 per cent in 2012-13).[101] Disappointingly, the Action Plan does not include AOD treatment as a key part of the plan, and expresses a weaker recognition of the intersection between the AOD and family violence sectors compared to *Reducing the alcohol and drug toll: Victoria's plan 2013–2017*.

The CRAF and the Referral Protocol do not consistently or sufficiently address the role of alcohol in family violence; nor do they adequately address how service providers should assess the contribution of AOD misuse to family violence perpetration and use AOD treatment services as a mechanism to deal with the effects of violence.[102] AOD services have a key role to play in supporting those who have experienced alcohol-related family violence to get as much help as possible from family violence support services. The continued marginalisation of AOD services in family violence response frameworks will only hinder the prevention of alcohol-related family violence.

The demand for services in the AOD sector is high. As noted by Victorian Alcohol and Drug Association (VAADA) in 2013, the implications of this are that in addressing family violence: "The AOD treatment sector has been significantly under resourced in a range of areas which impedes its capacity to maximise the benefits of AOD treatment".[103] The increase in demand for services and the inability of

these services to keep up with demand is exacerbated by the uncertainty of funding provided by all levels of government.

There is a lack of clarity as to improvements in client outcomes from existing coordination structures. The evaluation of CRAF focused on service provider engagement. Its findings of increased sector engagement and identification and reporting of family violence are positive indicators of better service integration. However, a subsequent evaluation has not been undertaken to understand whether the increased engagement and service integration has produced better outcomes for clients of AOD and family violence services.

The Referral Protocol has not been evaluated. As a result, like with the CRAF, the impact of the Referral Protocol on the experience of those who come into contact with the family violence system is not unclearly accounted for.

The Action Plan has three streams of action (prevention, early intervention, and response), each with two areas of focus. What it lacks are clear objectives with measurable performance or progress indicators. Without performance or progress indicators, the reporting on the Action Plan's impact on outcomes for people experiencing family violence are unclear and restricted to limited updates in annual reports for the Victorian Department of Health and Human Services.

Legal responses to alcohol's role in family violence can discourage victims from reporting family violence. A study by Hirschel and Hutchison[104] found that the likelihood of a perpetrator being arrested for intimate partner violence was significantly reduced if only the victim was drinking. Furthermore, victims who were drinking were more likely than those who had not been drinking to end up being arrested themselves. This could be due to victims being perceived by police as unreliable witnesses, less coherent, less cooperative or as partly to blame for the aggression. The Code of Practice and the Referral Protocol acknowledge alcohol as a risk factor in family violence. These resources do not contain advice on how police should respond to alcohol's involvement in family violence incidents in a manner that does not discourage victims from reporting family violence to police.

Policy proposals

The role of alcohol in family violence must be addressed in frameworks, programs, pilots and protocols for victims of family violence. Coordination and collaboration is better for clients and practitioners to address the problems of family violence and related alcohol misuse. At present, the AOD and family violence sectors are not adequately supported to collaborate in addressing a victim's family violence and AOD problems in tandem. At the end of the day, better coordination and collaboration between AOD and family violence sectors serves to enhance the safety and wellbeing of victims of family violence, especially children affected by family violence.

CRAF – Model of Care

The limitation of CRAF is that it works one way: filtering referrals from other support providers (such as AOD) through to family violence service providers. CRAF would be greatly enhanced if its training and materials were built up to work both ways in addressing the role of alcohol in a person's experience of family violence. That is, in terms of supporting professionals in the identification of family violence; and in supporting family violence services on how to identify and respond to client needs where alcohol is involved in their experience of family violence. A 'no wrong doors' approach to support services must be provided by all the sectors so that victims are not turned away from services.

In the United Kingdom, work has been undertaken between AOD and family violence services to improve coordination. The Stella Project in the UK was established in 2003 to provide more inclusive services for victims and perpetrators of family violence who have AOD problems. The project improved cross-sectoral knowledge and service delivery for victims and perpetrators of family violence as well as their children.[105] In 2010, the Stella Project was expanded to include sexual violence and mental health in its work. This expansion reflected the broader needs of women who experience sexual violence and use AOD as a coping mechanism in response to the trauma associated with family and sexual violence.

The National Centre for Education and Training on Addiction (NCETA) at Flinders University has developed best practice principles on the implementation of initiatives to address issues relating to family violence experienced by AOD clients.[106] These principles are explained in the following publications by NCETA:

- *Breaking the silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia*
- *Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence.*

While the focus so far has been on inter-sectoral collaborations, it is equally essential to consider coordination within sectors. For example, a woman experiencing family violence may access a number of services (for instance, multiple hospitals) to treat injuries as they occur, and more than one family violence support organisation. Inter- and intra-sectoral coordination allows better understanding of an individual's situation and avoids requiring people to repeat stories they may find traumatic.[107]

To that end, the Victorian Government should expand the *Strengthening hospital responses to family violence* pilot project beyond the Royal Women's Hospital and Bendigo Health, and should extend the project to beyond 2015.[108]

A more formalised process, such as a Model of Care is needed to enable various sectors to work together to determine the most appropriate support mechanisms for the client. CRAF is a well-established platform which could be repurposed into a Model of Care. This would provide improved referral pathways between services, a shared understanding of the issues through cross-agency training and good communication and information sharing between services. Management commitment at the highest level is essential for change to be successful.[109] Systems need to support safe and effective practice[110] with safety considerations at the forefront of all support services.

The Model of Care proposal is discussed in further detail in FARE's *Policy options paper: Preventing alcohol-related family and domestic violence*.[111] In consultations to expand and improve CRAF's response to alcohol-related family violence, the Victorian Government should consult with relevant stakeholders. This should include VAADA - the peak body representing AOD services in Victoria, DV Victoria and other key players in the Victorian family violence policy and service provision space.

Funding

It is essential that services are available for clients of AOD and family violence services. Presently, funding does not match demand for services. In order to encourage awareness and reporting on family violence, the government needs to anticipate an increase in demand for family violence and AOD support services. These vulnerable clients require services provided by agencies which receive adequate and ongoing funding to provide thorough and consistent support.

Improving the Referral Protocol and Code of Practice

The legal system needs to recognise and appropriately respond to the role of alcohol in family violence for victims and perpetrators. The Referral Protocol and the Code of Practice should go beyond just acknowledging alcohol as a risk factor in family violence. These resources should contain advice on how police should respond to alcohol involvement in family violence incidents in a manner that does not discourage victims from reporting family violence to police.

There is also the need for the Referral Protocol and Code of Practice to recognise that a victim's drinking may be a coping mechanism for abuse and regardless of alcohol use, the victim's protection and safety must be the first priority. There is also the need for the Referral Protocol and Code of Practice to recognise that arresting or prosecuting victims or blaming them for contributing to the violence will lead to future reluctance to contact police.[112]

Recommendations

The Royal Commission should recommend that the Victorian Government:

3. Build on the existing CRAF to develop a comprehensive, integrated Model of Care for alcohol-related family violence.
4. Provide adequate and ongoing funding to alcohol and other drug services and family violence services to meet demand.
5. Improve the Referral Protocol and Code of Practice to recognise and appropriately respond to the role of alcohol in family violence for victims and perpetrators.

3. Develop and fund programs targeted at perpetrators

Responds to:

> Term of reference 1.d. 'Perpetrator accountability'

Alcohol is viewed by some as an excuse for abusive behaviour. Findings from the VicHealth National Community Attitudes Survey (NCAS) [113] and The Line surveys[114] reveal that alcohol is viewed by some as a mitigating factor in perpetrators' accountability for intimate partner abuse. The social expectations around alcohol consumption and violence are also important to understand as they link into how perpetrators use alcohol and perceive their accountability for their actions.

The use of alcohol by perpetrators in intimate partner violence situations is complex. As noted before, the social drinking of both the victim and perpetrator is often a factor or circumstance that leads to physical violence.[115] Alcohol is associated with both the likelihood of family violence occurring and the severity of harms that result from this violence.[116] When a perpetrator is drinking, they are less aware of the physical force they may be using, they are less concerned about consequences, and display increased emotionality which can lead to greater likelihood of violence occurring.[117,118] Some perpetrators of intimate partner violence use their consumption of alcohol as a control mechanism to indicate to the victim that they are at risk of being abused.[119]

A key component of an integrated family violence system is timely and appropriate responses to men who use violent and controlling behaviour. Since April 2009, the Australian Government has committed $3 million for research into perpetrator interventions. In addition, a further $4.6 million of funding was provided in reward and incentive payments to states and territories who promote best practice perpetrator interventions.[120]

In light of these commitments, the Victorian Government released its *Framework for comprehensive assessment in men's behaviour change* (the Framework) in October 2009.[121] The release of the Framework coincided with the release of *Enhancing access to men's behaviour change programs: Service intake model and practice guide* (the Service Intake Model).[122] The DHHS Service Intake Model and Framework are funded as part of the Departments' integrated family violence services for men.

The Framework aims to achieve consistent, common practice among men's behaviour change programs. The four areas of focus in the Framework are:

- initial and continuous identification of risks, threats and dangers to the safety of women and children
- facilitating men's entry into the health and community service system
- assessing men's suitability for participation in a men's behaviour change program
- ongoing review of men's participation in a men's behaviour change program.[123]

The Service Intake model aims to achieve an enhanced intake response for men's behaviour change programs by agencies and service providers funded by the Department. The men's behaviour change peak body, *No To Violence*, has set minimum standards for intake practices. This includes referral, assessment and waitlist management practices. However, these minimum standards allow for considerable variation among program providers. It is intended that the Service Intake model will foster more common and consistent approaches to service intake practices.[124]

In Victoria, perpetrators may be ordered by the Magistrate to attend a behaviour change counselling program to change their violent and abusive behaviour. It is not clear whether Magistrates can order perpetrators to adhere to sobriety conditions if it is established that the perpetrator in question committed acts of violence against their partners or former partners while consuming alcohol.

Existing programs do not adequately address alcohol or provide guidance on coordination between men's behaviour change/family violence service providers and AOD support service providers. Best practice perpetrator treatment programs are available in Victoria. References to alcohol in the Framework and Service Intake Model are light and limited to the context of:

- referral pathways[125]
- risk factors when assessing a perpetrator's suitability for perpetrator programs[126]
- whether the effects of alcohol would make it difficult for the perpetrator to get value from the program.[127]

What is missing from, and should be built into, these programs are effective arrangements to coordinate responses and two-way collaboration with AOD treatment services and men's behaviour change programs. Magistrates should order perpetrators of alcohol-related family violence to engage AOD support services and comply with sobriety conditions, as well as engage with men's behaviour change services.

Policy proposals

System responses to perpetrators of alcohol-related family violence should be focused enhance on the safety and wellbeing of victims of family violence, especially children affected by family violence. To that end, the Victorian Government should enforce perpetrator compliance with sobriety requirements and fund better coordination and collboration between AOD services, men's behaviour change programs and family violence services. Both of these actions will complement the provision of support to families of people accessing perpetrator programs to ensure their safety.

Enforce perpetrator compliance with sobriety requirements

Since 2005, the State of South Dakota in the United States has run the *24/7 Sobriety Program* to enforce sobriety orders imposed on repeat drink-driving offenders.[128] The program required people arrested or convicted for repeat drink-driving offences to take two alcohol breath tests a day or wear a continuous alcohol monitoring bracelet. Those who with contravened the sobriety order with a positive test result were met with "swift, certain and modest sanctions".

As well as a 12 per cent reduction in repeat drink-driving offences, an important side-effect of this program was the nine per cent reduction in intimate partner violence arrests. What the South Dakota experience tells us is that 'frequent alcohol testing with swift, certain, and modest sanctions for violations can reduce problem drinking and improve public health outcomes'.[129]

Victoria should pilot a court-ordered management program that mirrors South Dakota's *24/7 Sobriety Program* and targets repeat offenders of family and intimate partner violence. This pilot should enforce zero alcohol use as a condition to remain in the community and avoid being incarcerated. To monitor compliance with this program, the perpetrator should be required to take two alcohol breath tests a day, or wear a continuous alcohol monitoring bracelet. Contravention of sobriety requirements should be met with swift, certain and modest sanctions. The *24/7 Sobriety Program* targets a critical opportunity to reduce the risk that a perpetrator's consumption of alcohol will result in behaviour that puts women and children at significant risk of injury and death.

This pilot should be formally evaluated to assess its effectiveness in terms of:

- reducing the incidence and severity of violence against women
- developing a sustainable program that can be scaled up and rolled out in other jurisdictions
- reducing recidivism among family violence offenders with alcohol issues.

Evaluations of programs are discussed in further detail in section 5.

Support and fund better integration between men's behaviour change programs and AOD services where appropriate.

To mitigate the risk of further violence, perpetrators of family violence should have access to integrated treatment programs for alcohol problems.

The Framework and Service Intake Model are components of Victoria's progressive and innovative platforms for addressing family violence in the state in an integrated fashion. What they lack is a well-developed systemic response to the involvement of alcohol in perpetrations of family violence.

According to VAADA, AOD treatment for perpetrators of family violence may provide some stability for the perpetrator that enhances the efficacy of other interventions.[130] These platforms should receive ongoing, adequate funding to enhance both AOD and men's behaviour change service providers' efforts in identifying and addressing the role of alcohol in family violence.

Provide support for families of people accessing perpetrator programs to ensure their safety

Care needs to be taken to ensure the safety of family members when a perpetrator undertakes any program. Treatment for alcohol problems increases the risk for family violence due to the discomfort of physiological or psychological withdrawal heightening a perpetrator's anxieties and irritability.[131] Therefore, the treatment of alcohol problems needs to occur only when full attention is given to the dimensions of their situation.

Responding to perpetrators of family violence requires a long term multifaceted approach that addresses the social and health environment of the individual and acknowledges the increased risk of further violence.

Recommendations

The Royal Commission should recommend that the Victorian Government:

6. Pilot a project for perpetrators that require people arrested or convicted for alcohol-related offences to take two alcohol breath tests a day or wear a continuous alcohol monitoring bracelet with "swift, certain and modest sanctions" for people who are found to consume alcohol.
7. Fund intensive programs targeted at perpetrators and ensure these programs are evaluated to inform future practice.
8. Support better integration between perpetrators and AOD services where appropriate.
9. Provide support for families of people accessing AOD or perpetrator programs to ensure their safety.

4. Educate young Victorians on alcohol and family violence

Responds to:

> Term of reference 1.a. 'The prevention of family violence'.

> Term of reference 2: 'Investigate the means of having systematic responses to family violence...'

> Term of reference 3: 'Investigate how government agencies and community organisations can better integrate and coordinate their efforts'.

It is vital to educate young men and women to prevent the reinforcement of gender inequality. School-based education is a form of public education that targets children and young people. This is one way of challenging and changing social norms in order to prevent the emergence of undesirable attitudes and behaviours.[132] In the area of family violence, the need for public awareness has been recognised by the Council of Australian Governments (COAG). On 4 March 2015, COAG announced a $30 million joint commitment to deliver a national awareness campaign aimed at reducing violence against women and their children.[133]

At present, the Victorian Government sponsors the following education programs for young people around issues pertaining to family violence:

- '*Respectful Relationships Education in Schools*' by Our Watch[134]
- '*The Line*' campaign by Our Watch, which targets youth and is a primary prevention social marketing campaign aiming to change attitudes and behaviours that condone and excuse violence against women.

Education on family violence targeted at school children is important because it supports one of the central principles of effective prevention: starting early. Childhood and especially adolescence is a critical period for shaping the quality of relationships later in life. Successful education at these stages of life is likely to prevent the emergence of negative relationship behaviours such as violence.[135]

The Victorian Government funded the *Respectful Relationships Education in Schools* (RREiS) project in support of the Action Plan. The project supports up to 30 schools around Victoria to implement the new Department of Education and Training resource, *Building respectful relationships: Stepping out against gender-based violence*.[136,137] This resource comprises two units (one for Year 8 students and one for Year 9 students) with eight sessions in each unit. The topics examined include gender and power and how these shape relationships and violence; understanding consent and respect; and encouraging respectful behaviour for self and others. The implementation of these units can be tailored to the school's needs and the contexts in which the units are used.

Alcohol as a contributor to family violence is not adequately addressed in alcohol education programs and family violence/respectful relationships programs. Our Watch's campaign *The Line* acknowledges alcohol's contribution to violence against women, and research findings around young people's perceptions on alcohol as an excuse for violence have been used on infographics to share on social media.[138] However there is no specific message communicating that alcohol is never an excuse for violence. There is also no information provided around how individuals can seek help from police and established AOD organisations if they are experiencing, or have experienced, alcohol-related abuse, or if they themselves are consuming alcohol to cope with the trauma they are experiencing.

With school-based education, references to alcohol are largely confined within the context of sexual assault. In the Victorian RREiS project there is a focus on the unacceptability of taking advantage of a

girl or woman who is under the influence of alcohol. However, there is no information about the role of alcohol in family violence.

Alcohol is viewed by some as a mitigating factor in perpetrators' accountability for committing violent acts. NCAS found that one in ten Australians believe that intimate partner violence can be excused if the victim is affected by alcohol; and nine per cent believe that intimate partner violence can be excused if the perpetrator is affected by alcohol.[139] Young people are also likely to see alcohol as an excuse for violence. Research conducted to inform *The Line* campaign revealed that in young people aged 14 to 24 years, 15 per cent consider it acceptable for a guy to pressure girl for sex if they are both drunk. *The Line* research also found that one in four (24 per cent) do not think that it is serious if a guy who is normally gentle slaps his girlfriend during an argument while he is drunk.[140]

Public and school education around the unacceptability of alcohol as an excuse or justification for violence is urgently needed to challenge these views. School-based education projects also need to challenge the use of alcohol as a weapon by perpetrators who put the onus of responsibility on victims to avoid harm. Public and school education campaigns on family violence are often inconsistently or insufficiently funded. Consequently, they are often only of limited duration and unlikely to produce sustained, long term effects.

Policy proposals

Addressing the role of alcohol in family violence

Alcohol as a contributor to family violence should be addressed in both school-based alcohol education programs and in family violence or respectful relationships programs. The Australian Women's Health Network states that the primary aim of anti-family violence campaigns should be to: change attitudes, behaviours and beliefs that normalise and tolerate gender-based violence and violence against children. These campaigns should be victim-centred, hold perpetrators to account and emphasise equality.[141,142] This education approach is urgently needed to address the concerning number of Australians who condone, excuse and justify family violence if alcohol is involved.

All education campaigns regarding alcohol and family violence should provide advice to the audience on avenues of support where they can seek help. This support would serve the interests of young people who are experiencing, or have experienced, alcohol-related abuse; or if they themselves are consuming alcohol to cope with the trauma they are experiencing or have experienced.

Funding education on alcohol in family violence

School-based campaigns that address the role of alcohol in family violence should be well-funded, ongoing, multifaceted, and form part of a wider strategy of legislative change and reform.[143,144] Campaigns and programs must be formally evaluated to assess their effectiveness in changing negative attitudes and behaviours, both in the short and long term. Evaluations of programs are discussed in further detail in section 5.

Recommendations

The Royal Commission should recommend that the Victorian Government:

10. Ensure that school-based education campaigns on respectful relationships acknowledge the role of alcohol in family violence.
11. Provide adequate, ongoing funding to programs that educate school students on alcohol and respectful relationships.
12. Formally evaluate school-based education campaigns on alcohol and respectful relationships to assess their effectiveness in changing negative attitudes and behaviours.

5. Systematically collect data on alcohol-related family violence and undertake evaluations of existing programs

Responds to:

> Term of reference 4: 'Provide recommendations on how best to evaluate and measure the success of strategies, frameworks, policies, programs and services put in place to stop family violence'

There are two main types of data collection methods for family violence and alcohol harms. These are service data (which includes police data and child services data), and survey data (which is usually self-report).

Progress against alcohol and family violence-related strategies and frameworks are described in special evaluation reports, annual reports for the responsible state government department. Presently, the Victorian Government and its agencies collect alcohol harms data on the incidence of:

- family incidents (Victoria Police Law Enforcement Assistance Program)
- the presence of children at reported family incidents (Victoria Police Law Enforcement Assistance Program)
- alcohol involvement in family incidents (Victoria Police Law Enforcement Assistance Program)
- alcohol treatment episodes (Australian Institute of Health and Welfare Alcohol and Other Drug Treatment Services National Minimum Data Set)
- alcohol-related ambulance attendances (Turning Point Alcohol and Drug Centre in collaboration with Ambulance Victoria; via The Victorian drug statistics handbook: patterns of drug use and related harm in Victoria for the period July 2010 to June 2011)
- alcohol-related hospital admissions (Victorian Department of Health)
- alcohol-related assaults (Victoria Police Law Enforcement Assistance Program)
- alcohol-related serious or fatal road injuries (VicRoads).

In December 2013, a liquor licence map was launched by VicHealth, VCGLR and the Emergency Services Telecommunications Agency. The map is an interactive online tool that geo-codes information on the state's individual liquor licences.[145] This tool "provides decision-makers and the community with information at a glance about licence density, and has the potential to improve ambulance response times to alcohol-related accidents and injuries".[146] The map can be used by local councils, government agencies and researchers, to:

- plan and assess liquor licence applications
- research and develop ways to reduce alcohol-related harm in the community
- target high-risk areas for compliance and enforcement action.

What is missing from this tool is geo-located information on the incidence of alcohol harms from ambulance services and police.

In May 2015, the Victorian Government presented *Measuring the toll: The family violence index (Measuring the toll).*[147] This document declares the government's intention to launch a world-first Family Violence Index to better understand the scale of family violence in Victoria.[148] The index would use data collected from the fields of crime, justice, health, education and the community sector. While it is encouraging to see plans to develop such a tool for tracking and monitoring family violence, the proposal neglects to recognise the involvement of alcohol in family violence. Consequently, what is missing from the index's evidence base (as proposed in *Measuring the toll: The family violence index*) is the inclusion of data on alcohol-related family violence.

Collecting data

Collecting data on family violence is complicated and limited. The data collected for Victoria provides an indication of how many victims and perpetrators of family violence come into contact with Victoria Police and family violence support services or self-report their experience of family violence in surveys.

Due to family violence being a largely 'invisible' problem, self-report is important in providing an indication of the nature and extent of alcohol-related family violence. Survey data for Victoria is collected by the National Drug Strategy Household Survey and the Australian Bureau of Statistics (ABS) Personal Safety Surveys. It is important that these surveys are complemented with data collected through service sectors, such as police and health service data. As many as half of family violence occurrences go unreported.[149] Having a cross-section of different data is important to mitigate limitations such as underreporting.

Data collection for alcohol-related child maltreatment is also limited. Police data tends to include incidents of violence, which include both child abuse and intimate partner violence, and they are reported together under the umbrella of 'domestic assault' or 'family incident'. Recording incidents of alcohol-related child maltreatment separately to intimate partner violence would provide greater detail on the interplay between child maltreatment and prevalence of children affected by alcohol-related family violence. Considerable improvement is also needed in the recording of alcohol involvement in incidents and situations, whether in police reports, in child protection investigations, or in records of other involved agencies such as schools and hospitals.

Evaluation

There is a lack of clarity around how well existing strategies, services and programs benefit victims and perpetrators of family violence. The efficacy of family violence programs and systems in Victoria are not clearly or consistently evaluated to measure the outcomes for clients of these services and systems. The only published evaluation of CRAF was an evaluation of the training rollout for the Family Violence Risk Assessment.[150] This evaluation focused on 'practitioner' engagement in terms of the number of family violence service professionals who are using a framework or strategy. What the evaluation does not capture is:

- whether this framework has facilitated better integration of family violence and AOD support services
- whether increased practitioner engagement has led to improved service delivery outcomes for the victims of family violence.

All programs and services related to family violence and AOD support service provision need to be evaluated consistently and regularly to monitor outcomes for clients, and program cost-effectiveness for government.

Policy proposals

Improve data collection

Consistently collected data is crucial to understanding the prevalence of alcohol-related family violence. Such data enables researchers and policy makers to develop, implement and track the progress of evidence-based alcohol policies. Surveillance of trends over time is important for not only policy development but also service planning.

It is also important to consider a tangible range of data sources. Service sector data including police data, family violence services, alcohol and drug treatment data and hospital data should all seek to gain information on alcohol's involvement in alcohol-related family violence.

Privacy and confidentiality is essential to the collection of data about alcohol and family violence: researchers must ensure that they protect data, especially if it is in any way identifiable.

Evaluate strategies, policies and programs

Data collection and surveillance is a fundamental tool in the evaluation process. Evaluation processes should:

- focus on outcomes for clients
- focus on cost-effectiveness for government
- form an integral part of the implementation of any alcohol-related family violence policies.

As part of its annual reporting cycle, DHHS should provide direct reports on progress against the Victorian Government's family violence and alcohol harm prevention objectives.

These objectives are detailed in the following strategies and frameworks:

- *Victoria's vulnerable children: Our shared responsibility. Strategy 2013-2022*
- *Victoria's action plan to address violence against women & children 2012-2015*
- *Reducing the alcohol and drug toll: Victoria's plan 2013-2017*
- *Policing alcohol harm in Victoria*
- *Strong culture, strong peoples, strong families: Towards a safer future for Indigenous families and communities 10 year plan*
- *Victorian homelessness action plan 2011–2015*

Enhance the VCGLR/VicHealth liquor licence map

The VCGLR/VicHealth liquor licence map is an innovative tool which provides the regulatory authority with a partial indication of liquor outlet and alcohol harm dynamics in particular localities.

While the tool geo-locates liquor outlets as an indication of density, it does not provide an indication of the impact of alcohol harms in the area.

This tool should be enhanced to incorporate alcohol harms data from Victorian ambulance services and police to provide greater insights which would inform regulatory, health and policing authorities when:

- planning and assessing liquor licence applications
- researching and developing localised alcohol harm prevention initiatives
- targeting high-risk areas for compliance and enforcement action.

Include alcohol-related family violence data in the Family Violence Index

The proposal for Victoria's Family Violence Index, *Measuring the toll,* does not include the collection on data on alcohol. *Victoria's vulnerable children*, *Victoria's action plan* and *Reducing the alcohol and drug toll* all recognise alcohol's involvement in family violence. In contrast, *Measuring the toll* does not recognise the involvement of alcohol in family violence.

As a result, data, measures and statistics on the involvement of alcohol in family violence are missing from the index's evidence base (as proposed in *Measuring the toll*). This is a concerning omission given the significant involvement of alcohol in family violence.[151]

The Royal Commission should recommend that the Victorian Government include measures, statistics and data on alcohol-related family violence in the Family Violence Index. Inclusion of alcohol-related family violence information would ensure that the involvement of alcohol in family violence and efforts to prevent it are accounted for and monitored.

Recommendations

The Royal Commission should recommend that the Victorian Government:

13. Improve data collection on family violence and the involvement of alcohol, and publically report on this data to inform policy and research.
14. Ensure that plans and programs for family violence are appropriately evaluated so that they can inform future practice.
15. Enhance VCGLR and VicHealth's liquor licence map further by including incidence of alcohol-related harms data, including family violence, on the map to better inform decision-making by VCGLR on future liquor licence applications.
16. Include measures, statistics and data on alcohol-related family violence in the *Family Violence Index*.

Relevant research and experts in the field of alcohol and family violence

Policies at all levels of government which respond to alcohol and family violence should be based on a credible evidence base. Relevant research by FARE in relation to the Australian context of alcohol's involvement in family violence are described in this section. Australian researchers in this field and their key research articles in this area of interest are also listed in this section.

This research evidence should be referred to by the Royal Commission in its report and recommendations to the Victorian Government.

Relevant research

FARE has released the following publications which examine the role of alcohol in the incidence of family and intimate partner violence and policy responses:

- *The range and magnitude of alcohol's harm to others* (August 2010) (*Harm to others*).
- *The hidden harm: Alcohol's impact on children and families* (February 2015) (*The hidden harm*) – Appendix A.
- *Policy options paper: Preventing alcohol-related family and domestic violence* (February 2015) (*Policy options paper*) – Appendix B.

Harm to others (2010) provides both a broad overview and detailed insight into the public health impacts of alcohol from others' drinking on Australians. The report is informed by a survey commissioned for the study, population surveys and data collected from social and health agencies across Australia. *Harm to others* (2010) addresses a number of critical questions:

- How many Australians are affected by others' drinking?
- Who is affected?
- What is the relationship between those who have been affected and the drinker?
- How are Australians affected or harmed?
- What are the costs for others – in trouble, in time, in money?

The hidden harm report focuses on the findings related to children and families from surveys conducted in 2008 and 2011 for FARE's *Harm to others* research. *The hidden harm* also collates other data from a range of sources to supplement these findings to analyse how Australian children and families have been affected by the drinking of others, especially family members.

FARE's *Policy options paper* proposes policies and programs to Australian governments for the prevention of alcohol-related family and intimate partner violence. The policy and program options proposed in the paper have been developed in consultation with professionals with expertise in public health, child protection and intimate partner violence. This *Policy options paper* uses a public health model of prevention to present policy and program options that range from prevention through to supporting those affected by violence.

List of experts in the field of alcohol's involvement in family violence

Victoria has a concentration of world-class experts in the field of alcohol's involvement in family violence. The Royal Commission should consider asking the experts listed below to appear before the Inquiry and provide their expert insights into the involvement of alcohol in family violence.

Alcohol's harm to others: children

- Dr Anne-Marie Laslett, Research Fellow at the Centre for Alcohol Policy Research (CAPR) at Turning Point Alcohol and Drug Centre in Melbourne, Victoria.

Alcohol's harm to others: Beyond the drinker

- Professor Robin Room, Director of CAPR and Professor of Alcohol Policy Research at the School of Population Health of the University of Melbourne.
- Dr Anne-Marie Laslett, CAPR.

Liquor outlets and violence

- Professor Robin Room, CAPR, University of Melbourne.
- Professor Tanya Chikritzhs, National Drug Research Institute at Curtin University.
- Associate Professor Peter Miller, Principal Research Fellow at the Deakin University School of Psychology.
- Dr Michael Livingston, CAPR and National Drug and Alcohol Research Centre (NDARC) at the University of NSW.

Alcohol and family violence: women's experiences

- Professor Angela Taft, Director of the Judith Lumley Centre at La Trobe University School of Nursing and Midwifery.
- Ms Ingrid Wilson, PhD candidate at La Trobe University.

Recommendation

17. The Royal Commission should consider the research referred to in this submission in preparing its policy responses; further, the Royal Commission should consider asking the experts on alcohol and family violence referred to in this submission to appear before the Inquiry.

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The hidden harm:

Alcohol's impact on children and families

Anne-Marie Laslett | Janette Mugavin | Heng Jiang | Elizabeth Manton | Sarah Callinan | Sarah MacLean | Robin Room

This research was funded by the Foundation for Alcohol Research and Education, an independent not-for-profit organisation working to stop the harm caused by alcohol

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ABOUT THE FOUNDATION FOR ALCOHOL RESEARCH AND EDUCATION

The Foundation for Alcohol Research and Education (FARE) is an independent, not-for-profit organisation working to stop the harm caused by alcohol.

Alcohol harm in Australia is significant. More than 5,500 lives are lost every year and more than 157,000 people are hospitalised - making alcohol one of our nation's greatest preventative health challenges.

For over a decade, FARE has been working with communities, governments, health professionals and police across the country to stop alcohol harms by supporting world-leading research, raising public awareness and advocating for changes to alcohol policy. In that time FARE has helped more than 750 communities and organisations, and backed over 1,400 projects around Australia.

FARE is guided by the World Health Organization's 2010 *Global Strategy to Reduce the Harmful Use of Alcohol* for stopping alcohol harms through population-based strategies, problem directed policies, and direct interventions.

If you would like to contribute to FARE's important work, call us on (02) 6122 8600, email info@fare.org.au or visit FARE's website: www.fare.org.au.

ABOUT THE CENTRE FOR ALCOHOL POLICY RESEARCH

The Centre for Alcohol Policy Research (CAPR) is a world-class alcohol policy research institute, led by Professor Robin Room. The Centre examines alcohol-related harms and the effectiveness of alcohol-related policies. CAPR is a joint undertaking of the Victorian Government, the University of Melbourne, Turning Point, Eastern Health and the Foundation for Alcohol Research and Education (FARE). It operates as one of Turning Point's research programs, with core funding from FARE.

CAPR not only contributes to policy discussions in Australia but also contributes to international studies of significance for the World Health Organization (WHO). An example of its international work is the GENACIS project, which examines gender, alcohol and culture in more than 40 countries.

CAPR has also undertaken a pioneering study in Australia: *The Range and Magnitude of Alcohol's Harm to Others* (also known as the 2008 HTO Study) measured alcohol-related harms to people other than the drinker ('third party harms'). The results were included in the WHO's Global Status Report on Alcohol and Health 2011, and the study is being used by the WHO as a model for such studies globally.

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The hidden harm:
Alcohol's impact on children and families

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Laslett AM, Ferris J, Dietze P & Room R (2012). Social demography of alcohol-related harm to children in Australia. Addiction 107(6); 1082-1089.

Manton E, MacLean S, Laslett AM & Room R (2014). Alcohol's harm to others: using qualitative research to complement survey findings. International Journal of Alcohol and Drug Research 3(2); 143-148.

The recommendations that relate to children in the last chapter of this report have been adapted from the dissertation of Laslett:

Laslett AM (2013). Alcohol and child maltreatment in Australia through the windows of child protection and a national survey [Thesis submitted in total requirement of the degree of Doctor of Philosophy]. Melbourne School of Population and Global Health, University of Melbourne.

CONTENTS

ACRONYMS AND ABBREVIATIONS	
ACCP	Australian Centre for Child Protection
ACT	Australian Capital Territory
ADIS	Alcohol and Drug Information System
AIHW	Australian Institute of Health and Welfare
Al-Anon	Al-Anon is a support organisation for friends and relatives of alcoholics and for people who have been affected by someone else's drinking
ANCD	Australian National Council on Drugs
ANPHA	Australian National Preventive Health Agency
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and Other Drug
AODTS-NMDS	Alcohol and Other Drug Treatment System National Minimum Data Set
AUDIT	Alcohol Use Disorder Identification Test
AVO	Apprehended Violence Order
CAPR	Centre for Alcohol Policy Research
Carers	In the context of the 2008 and 2011 Alcohol's Harm To Others (HTO) Surveys, carers are respondents who reported either that they lived in a household with children (under 18 years) or that they had responsibility for children but did not live with them (e.g. a father or mother not currently living with the child or children)
CASIS	Child and Services Information System
CCCC	Counselling, Consultancy and Continuing Care
CEoC	Closed Episode of Care
Cis	Confidence Intervals
CPS	Child Protection Services
CRIS	Client-Related Information System
FAS	Fetal Alcohol Syndrome
FDS	Family Drug Support
FSP	Family Support Program
GENACIS	Gender, Alcohol and Culture: An International Study
HTO	(Alcohol's) Harm To Others
IPV	Intimate partner violence
LEAP	Law Enforcement Assistance Program
NAAA	National Alliance for Action on Alcohol
NMDS	National Minimum Data Set

ACRONYMS AND ABBREVIATIONS

NSW	New South Wales
NT	Northern Territory
PDOC	Principal Drug Of Concern
PFD	Problematic family drinker: a person identified by a HTO Survey respondent amongst his/her family and intimate partners whose heavy drinking had most harmed the respondent in the previous 12 months
PLS	Plain Language Statement
PSS	Personal Safety Survey
PUP	Parents Under Pressure
QLD	Queensland
RGBE	Relatives, Girlfriends, Boyfriends and Ex-partners who do not live the respondent. This definition applies within the context of the HTO Surveys
SA	South Australia
SEIFA	Socio-Economic Index for Areas (a measure produced by the Australian Bureau of Statistics)
UK	United Kingdom
UNICEF	The United Nations Children's Fund
US	United States of America
VCPS	Victorian Child Protection Service
WA	Western Australia

GLOSSARY

Carers	In the context of the 2008 and 2011 Alcohol's Harm To Others (HTO) Surveys, carers are respondents who reported either that they lived in a household with children (under 18 years) or that they had responsibility for children but did not live with them (e.g. a father or mother not currently living with the child or children)
Family members and intimate partners (or 'family members')	Immediate and extended family members and relatives in or outside the household. Family members and intimate partners include current and former partners/spouses, parents, siblings, children, grandparents, aunts, uncles, cousins, other family members and other relatives as well as girlfriends and boyfriends. This definition applies within the context of the HTO Surveys
2008 HTO Study	The study reported in the 2010 document *The Range and Magnitude of Alcohol's Harm to Others*, including results from a survey conducted in 2008 and an analysis of register data from relevant agencies (e.g. health, social, welfare and justice)
2008 HTO Survey	The survey conducted within the 2008 HTO Study
2011 HTO Survey	The follow-up HTO Survey, conducted in 2011 and 2012
Problematic family drinker	A person identified by a HTO Survey respondent amongst their family and intimate partners whose heavy drinking had most harmed the respondent in the previous 12 months
Relatives, Girlfriend, Boyfriends and Ex-partners	A person identified by a HTO Survey respondent as someone who does not live with the respondent but is a relative, girlfriend, boyfriend or ex-partners (including ex-spouses) of the respondent. This definition applies within the context of the HTO Surveys

EXECUTIVE SUMMARY

BACKGROUND

Heavy drinking is linked to a range of negative effects in families from modelling of poor drinking behaviours, family arguments and ruined family occasions and relationships to child injuries, ongoing child neglect and abuse and domestic violence.

The 2008 Harm to Others (HTO) Survey reported in *The Range and Magnitude of Alcohol's Harm to Others* (Laslett et al. 2010) showed that the majority of Australians had been affected by others' drinking in the last year and many had been seriously affected. Amongst those more seriously affected were family members, including children. The Centre for Alcohol Policy Research (CAPR) conducted a follow-up HTO Survey in 2011, which showed that many Australians were affected in an ongoing way by others' drinking.

This report focuses on the findings that relate to children and families from these surveys and collates other data from a range of sources to supplement these findings to analyse how Australian children and families have been affected by the drinking of others, especially family members. The research questions addressed are:

1. How common and what are the effects of heavy drinking upon families and children?
   a. How do these effects vary in different relationships?
   b. Are there differences in the ways in which parents, siblings and grandparents are harmed by and care for those in their families?
   c. Do the effects vary depending on whether the respondent or child is or is not living with the heavy drinker, and whether the drinker is an immediate family member?
2. To what extent do the effects upon children and families persist or change over time?
3. What is the qualitative nature and impact of harms to children and families from others' drinking?
4. What services are available for families and children if they have been affected by the drinking of those around them?
5. What types of service and policy interventions are likely to improve the situations of those affected by others' drinking?

METHODOLOGY

This report includes multiple sub-studies involving a variety of quantitative and qualitative approaches and data sources to elicit the effects of alcohol's harms on children and families in Australia. This includes the nationally-representative cross-sectional 2008 HTO Survey of 2,649 respondents, focusing in particular on the 1,142 respondents in families with children, the follow-up 2011 HTO Survey of 1,106 respondents, and a range of registry or agency response data from the alcohol and other drugs (AOD) treatment, police, family violence and child protection systems. By revisiting a sample of those surveyed in 2008, the 2011 HTO Survey allows examination of the stability and change in harm from others' drinking, and what predicts changes in these harms from 2008 to their level in 2011.

In addition to these quantitative data sources, in-depth qualitative interviews were completed with a sub-sample of those HTO Survey respondents who reported that children in their families had been negatively affected by others' drinking. Finally, to gain insight into the interventions and preventive approaches that would be most effective in reducing alcohol's harm to children and families, individual interviews and focus groups were conducted with key informants from child and family services, AOD service providers, policy makers and academic researchers.

KEY FINDINGS

- Heavy drinking can be linked to a range of negative effects on children and families including modelling of poor drinking behaviours, family arguments, injury, neglect, abuse and violence.
- More than a quarter (26 per cent) of respondents reported experiencing harm from the drinking of family members in at least one of the two HTO Surveys (2008 and 2011).
- Past harm was the strongest predictor of future harm for children and families, as well as the number of adult heavy drinkers in respondents' household and among their relatives, girlfriends, boyfriends and ex-partners. Half (50 per cent) of adult respondents harmed in 2008 were also harmed in 2011 and 35 per cent of children harmed in 2008 continued to be harmed in 2011.
- Interviews revealed that children experienced a range of harms, with the most common of these being witnessing verbal or physical conflict, or witnessing drinking or inappropriate behaviour. Children were also verbally abused, left in an unsupervised or unsafe situation, physically hurt or exposed to domestic violence because of others' drinking.
- Parental or carer drinking plays a large role in child protection cases, with available data indicating that alcohol abuse is associated with between 15 and 47 per cent of child abuse cases each year across Australia.
- In 2011 there were 29,684 police-reported incidents of alcohol-related domestic violence in Australia for states and territories where data is available.
- Over a million children (22 per cent of all Australian children) are affected in some way by the drinking of others, 142,582 children (3 per cent of all Australian children) are substantially affected and 10,166 (0.2 per cent of all Australian children) are already within the child protection system where a carer's problematic drinking has been identified as a factor.
- Findings from this report highlight the need for governments to invest in strategies that reduce alcohol-related problems in families, including primary, secondary and tertiary prevention. It is important to acknowledge that many families struggling with parental alcohol misuse are not in the service system at all and are 'hidden' to authorities. Therefore population-wide policies which reduce alcohol problems across the community are needed to reduce and prevent further harms from occurring in families.

EFFECTS OF OTHERS' DRINKING ON ADULT FAMILY MEMBERS

In 2008, an estimated 2,791,964 Australians (17 per cent of the adult population) were negatively affected "a lot" or "a little" by a family member or intimate partner's drinking. This number includes an estimated 1,300,727 Australians who were substantially negatively affected (i.e. affected "a lot") by that person's drinking.

Of the 446 respondents in the 2008 HTO Survey who reported a family member or intimate partner as the person whose drinking had most affected them:

- 28 per cent named a partner or ex-partner, 14 per cent a parent, 19 per cent a child, 20 per cent a sibling, 17 per cent another relative and three per cent a boyfriend or girlfriend
- 34 per cent lived in the same household as the problematic family drinker
- women who had been affected were more likely to report that they had been negatively affected "a lot" by the family member's drinking (41 per cent) than men (21 per cent)
- being emotionally hurt or neglected (66 per cent) was the most common specified harm reported because of a family member's drinking, followed by having a social occasion negatively affected (65 per cent) and being involved in a serious argument (63 per cent).

EFFECTS OF OTHERS' DRINKING ON CHILDREN

Respondents in the 2008 HTO Survey who lived with or were responsible for children provided insight into the ways their children were affected by the drinking of others, with one in five carers (22 per cent) reporting that their children had been affected in some way by others' drinking in the last year. The harm children were reported to have experienced was most often verbal abuse and described as "a little" harm rather than "a lot":

- twelve per cent of carers reported that their children were verbally abused, left in an unsupervised or unsafe situation, physically hurt or exposed to domestic violence because of others' drinking in 2008

- among respondents who reported that their children were affected, the median number of times their children were affected in the preceding 12 months was three.

Almost half (46 per cent) of the 135 respondents whose children had been affected in one or more of the ways specified in the Survey reported that a child in the family was affected by the drinking of the child's parent or step-parent, the carer's partner or ex-partner or the child's guardian.

Twelve per cent of respondents also reported that their children were negatively affected by the drinking of siblings, and 15 per cent reported that they were affected by other family members and relatives. Fifteen per cent of carers reported that their children were affected by family, friends or people their child was in contact with, such as a coach, teacher or priest, and 12 per cent reported that they had been affected by unspecified others. A small number of respondents reported that their children had been affected by more than one relationship.

There was substantial overlap between harms to children and to the respondent themselves. Altogether 22 per cent of all respondents in the 2008 HTO Survey reported that they themselves or a child in their family had been affected by others' drinking. Based on population figures, this is equivalent to an estimated 3,613,130 Australian adults being affected by a family member's drinking or reporting that their child had been affected by other's drinking. Furthermore, around four per cent of all respondents (equivalent to an estimated 706,202 Australian adults) reported that both they and one or more children in their families had been affected by others' drinking.

STABILITY AND CHANGE IN ALCOHOL'S HARMS TO CHILDREN AND FAMILIES OVER TIME

ADULT FAMILY MEMBERS

Based on the 1,104 respondents who completed both the 2008 and the 2011 HTO Surveys, one-quarter (26 per cent) of respondents reported harm from the drinking of family members in at least one of the HTO Surveys. Overall, nine per cent reported experiencing persistent harm (i.e. harm in both 2008 and 2011). Seven per cent reported new harms from family members' drinking in 2011, while nine per cent reported discontinuation of harms experienced in 2008.

In the model predicting harm to respondents from family members' and intimates partners' drinking, past harm was the strongest predictor of harm in 2011. In addition, the number of adult heavy drinkers in their household and among their relatives, girlfriends, boyfriends and ex-partners had substantial impact.

CHILDREN

According to carers who completed both surveys, children also experienced persistent harm, with seven per cent reporting that children in their family had been harmed by others' drinking in both years and 35 per cent of carers whose children were harmed by others' drinking in 2008 reported that children in their family were harmed again, or still, by the drinking of others in 2011.

This study provides strong longitudinal evidence that past harm and the drinking patterns of others in the carer's household and among their relatives, girlfriends, boyfriends and ex-partners predict whether

children experience harms from others' drinking over time. However, there is also some evidence that continuity in harm to children was less evident than continuity in harm to carers, suggesting that carers may be more likely to tolerate the harms to themselves rather than to their children.

QUALITATIVE ANALYSIS OF HARMS TO CHILDREN FROM OTHERS' DRINKING

In the 20 in-depth interviews held with carers who had reported harms to children in either the 2008 or the 2011 HTO Survey, the drinker reported to be causing harm to children was most often a man, and usually the father of the affected children (in cases where the problematic drinker was a woman, it was usually the mother).

If the drinker who was harming a child was not part of the immediate, or even extended, family, the interviewee was more likely to classify the harm as "a little." This suggests that a family can distance itself from drinkers outside the family who could otherwise harm their child "a lot."

Physical abuse and neglect of children were not common, even where "a lot" of harm was reported, and several respondents emphasised that the drinker had never physically harmed their child. While verbal and emotional abuse were more common, the most common harm reported among children experiencing "a lot" of harm was the witnessing of conflicts such as physical or verbal abuse. For children who were harmed "a little" the most common harm reported was witnessing drinking or inappropriate behaviour, especially beyond the extended family.

Fear, behavioural problems, and shame were some of the outcomes for children (as reported by interviewees). There was no clear pattern about which children suffered and which prospered, as children in the same family reacted differently to the same (or very similar) circumstances.

The main impact on the family of having a parent whose drinking was harming children was that the other parent was prepared to leave the relationship. While separation removed some children from the harm of daily exposure to a problematic drinker, it did not mean that they were now unaffected by that person, as parents still had access rights and the custodial parent worried about the harms the drinker could still inflict.

The most commonly used source of support for dealing with harm to children from another's drinking was the immediate and extended family. If respondents did not have such support they used a variety of other sources, or they did not receive support and struggled. In a culture in which religious communities often do not play a major role in people's lives, their capacity to offer support was limited, although very helpful for those who had such a connection. Friends were not widely favoured as a source of support because of the perceived stigma of having alcohol-related problems in the family.

Formal services and medical professionals were perceived to be focused on supporting the drinker, rather than other family members, in dealing with the impacts of that person's drinking. Clinicians' commitments to confidentiality principles aimed at protecting the rights of the drinker, and the focus by formal services and health professionals on the drinker, meant that sometimes the impact on others of harm from drinking was greater than it might have been.

Another finding was the under-acknowledged role that workplaces could play in supporting those people who were dealing with the unpredictability associated with the drinker in their family, especially when it was disrupting the family routine and affecting children's lives. This included flexibility in terms of hours and work locations.

DOMESTIC VIOLENCE, FAMILY SERVICES AND ALCOHOL-SPECIFIC SERVICES

There are a range of services that respond to families experiencing problems associated with others' drinking, from police to telephone helplines. In general, research rarely records or examines the numbers of services that are used by families and friends affected by others' drinking in the Australian context.

Police responses often reflect the more serious types of alcohol-related harms, such as assaults, but obtaining national estimates on the proportion of family incidents where alcohol is involved is difficult due to different reporting practices across Australian states and territories. This report indicates that in 2011 there were:

- 10,706 incidents of alcohol-related domestic violence in New South Wales (NSW) (2010–2011)
- 11,732 family incidents with definite alcohol involvement in Victoria (2010–2011)
- 4,848 alcohol-related domestic assaults in Western Australia (WA) (2010–2011)
- 2,398 in the Northern Territory (NT) (2011).

This equates to a total of 29,684 incidents, excluding other states and the Australian Capital Territory where this information was not available. In the case of Victoria, WA and the NT, the numbers of alcohol-related family incidents have been steadily rising.

AOD services also provide support to family members of problem drinkers. For example:

- 6,720 closed episodes of care were provided to individuals seeking treatment related to someone else's alcohol and/or drug use by publicly-funded AOD services across Australia in 2011–12
- across Australia in 2012–2013, 5,966 calls were received by the Family Drug Support Helpline and 258 contacts were registered by CounsellingOnline from individuals concerned about a family member's drinking.

ALCOHOL'S INVOLVEMENT IN CHILD PROTECTION CASES

Carer alcohol abuse is associated with between 15 and 47 per cent of child abuse cases across Australia, and predicts protective interventions and court interventions.

In 2006-07 (using the best and most recently available data), 10,166 substantiated cases of child abuse and neglect across Australia are estimated to have involved alcohol; this equates to an estimated 12,658 children in 2012–13.

EXPERTS' OPINIONS ON ALCOHOL-RELATED HARMS TO CHILDREN AND FAMILIES

The current study also sought views of experts in both the child protection and AOD fields. From these interviews it is apparent that the AOD and child protection sectors recognise the importance of each other's work, but have only recently begun to take action to improve the synergy in their practices. The research in this area is underdeveloped, and there is a clear need to develop recommendations for implementation and evaluation of a range of primary, secondary and tertiary prevention interventions that target alcohol problems of families and parents.

To better understand and address the needs of families and children in the future, it would be useful to expand the number of key informants consulted and include more people from diverse sectors, for example relationship services, mental health and domestic violence service managers and researchers, senior police and criminologists. The establishment of an ongoing expert panel is a possible approach to better link professionals in this key area.

A PUBLIC HEALTH APPROACH TO PREVENTING AND MANAGING ALCOHOL-RELATED HARMS FOR FAMILIES AND CHILDREN

This report introduces a pyramid model that describes both the problems associated with others' drinking that families and children experience over a one year period and the various responses required to manage these problems (e.g. child protection and police service responses). The pyramid has five tiers.

This model highlights the numbers of children estimated to be at various levels of risk of alcohol-related harms and demonstrates the varied policy and program responses needed to address the different levels of harms. It examines these responses through a public health lens, focusing on the need to prevent alcohol-related harm among those not currently affected, while also providing targeted support to people who are currently affected.

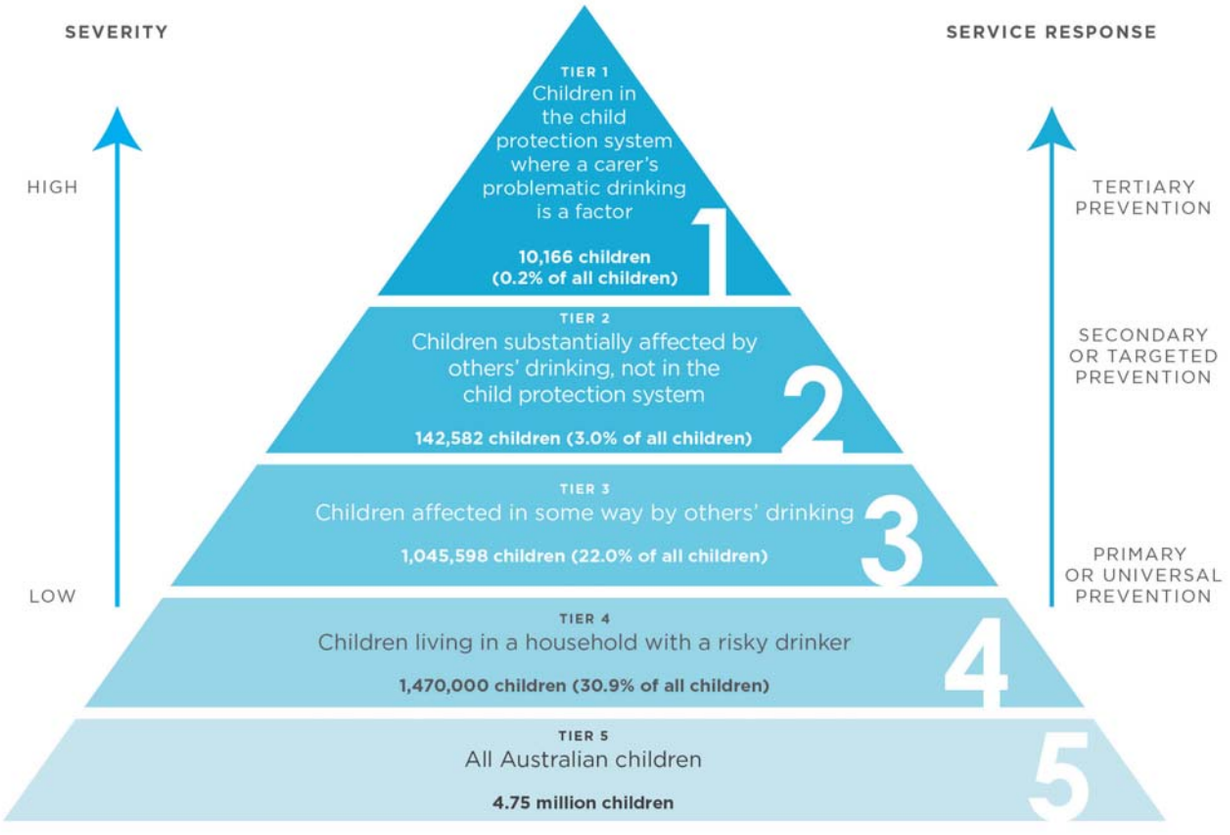


Figure 1 Pyramid model of children at risk of alcohol-related harms

IMPLICATIONS AND RECOMMENDATIONS

A range of service innovations and improvements are recommended in this report. These fall primarily into recommendations to address:

- defining and screening for alcohol and family problems
- improving surveillance and communication between services
- data quality and access to enhance problem management
- specific child protection service initiatives
- specific AOD service initiatives.

A key issue across Child Protection Services (CPS) is the appropriate and consistent collection, collation and availability of data relating to alcohol's involvement in a variety of family and child protection problems.

Governments have considerable opportunities and responsibilities to manage risks to families and children in the broader environment by making policy decisions, including alcohol policy decisions that affect primary, secondary and tertiary prevention. The large numbers of children and families affected at each tier of the pyramid suggest that a public health approach to managing alcohol-related child and family harms is warranted, in addition to tertiary approaches provided by CPS and other family support agencies.

While tertiary services such as CPS have an integral coordinating role in addressing the problems of the children who have been most severely abused or neglected by carers with alcohol misuse problems, AOD services are critical to the prevention of child abuse and neglect. By targeting families at risk and assisting them, they have the potential to address carers' alcohol problems and forestall their entry into a range of crisis response services. Both the service needs of drinkers within families and of other family members affected need to be understood and met by a range of service options at this level.

It is critical that communities and governments invest in strategies that diminish alcohol-related problems in families and communities in general, and in particular amongst those who are most vulnerable and in need. The child protection and AOD sectors must be adequately resourced to allow them to provide effective programs and ensure that there is close communication and referral between these systems.

Many (and arguably most) families struggling with parental alcohol misuse are most likely not in the service system at all and may be 'hidden' to authorities. Therefore, the findings of this report support the implementation of universal measures to prevent or limit the effects of drinking on the families and children of Australia, alongside comprehensive coordinated multi-sectoral services for families with multiple risk factors.

Finally, this report underscores a number of key research gaps that remain, suggesting areas for future population research, service and system evaluation and intervention research.

1 BACKGROUND

Anne-Marie Laslett, Janette Mugavin, Elizabeth Manton, Robin Room

1.1 INTRODUCTION

The nature and extent of harm that drinkers experience because of their own drinking has been well documented both in Australia and internationally. However, far less understood is the harm that drinkers do to others, including families and children, as a result of their problematic drinking.

The first Australian 'Harm to Others' (HTO) study was published in 2010 as *The Range and Magnitude of Alcohol's Harm to Others* (Laslett et al. 2010). This study involved a population survey (2008 HTO Survey) and analysis of secondary data from a range of government department data systems (e.g. health, social, welfare and justice). The findings provided a systematic and detailed insight into the extent to which Australians reported they had been negatively affected by someone else's drinking, including the impact on respondents from the drinking of strangers, co-workers, friends, families and children.

This report aims to expand the knowledge base relating to harm to children and families from others' drinking in Australia by exploring two sets of issues often considered separately: effects on the family generally (including couple relationships) and effects on children. The research takes a mixed methods approach using quantitative and qualitative data to demonstrate how the drinking of carers and others affects children and families, including how these problems present in child protection systems, family support services, alcohol and drug treatment systems and police services, as well as in the general population. Using a public health approach, the data collected through general population surveys and service system data is brought together in a single frame to describe the range of alcohol-related harms experienced by children and families, as well as discuss their prevention and management.

1.2 ALCOHOL'S EFFECTS ON FAMILIES

Families take many forms. They can provide support and love, but they also have the potential to limit or damage the development of their members. The United Nations Children's Fund (UNICEF) states that it is the fundamental right of children to develop and be safe within their family, protected from harm and supported to reach their full potential (UNICEF 1989). Effects of heavy drinking upon families can include arguments, disharmony, divorce, domestic violence and inadequate role performance by various family members. People who are seeking treatment for their own alcohol problems are often dealing with financial problems, separations and divorces, stress, and poor health (Keenan et al. 2013; Orford et al. 2010; Rodriguez et al. 2001; Room et al. 1991) which often have flow-on effects within their families (Orford et al. 2005). Families in which both parents drink heavily have been found to be at even greater risk of harm (Haugland 2005), yet in contrast, the lack of a protective adult in single-parent families is often noted by child protection workers as a feature of child maltreatment (Department of Human Services 1999).

Alcohol is involved in a significant proportion of cases of violence against intimate partners both in and outside the household. In assessing intimate partner violence in population surveys in the United States (US), Leonard (2001) estimated that 25-50 per cent of domestic violence incidents involve alcohol. The Australian component of the International Violence Against Women study found that one in three (35 per cent of) recent domestic violence incidents were alcohol-related, with 32 per cent of women reporting that their partner was drinking at the time of the most recent violent act (Mouzos & Makkai 2004). In analyses based on victimisation data from the 2005 Australian Personal Safety Survey, it was estimated that alcohol contributed to 50 per cent of all partner violence, and 73 per cent of physical assaults by a partner (Laslett et al. 2010).

Alcohol also features strongly in domestic assaults that come to official notice. In an evaluation of trends in police data across the state of New South Wales (NSW) between 2001 and 2010, police recorded 41 per cent of domestic assaults as alcohol-related – i.e. where alcohol was noted as 'present' (Grech & Burgess 2011).

Research on family violence has concentrated on spousal relationships and identified many of the difficulties for female spouses and their children living with heavy drinkers. In Australia, the narrative of the family affected by drinking and domestic violence was elucidated in research conducted with members of Al-Anon (Zajdow 2002) in which children and their mothers were hurt by violent and drunken fathers, financially disadvantaged and isolated. The primary focus of this work was on how spouses of alcohol-dependent men had been affected and coped. Interviews with women in other countries who live with heavy-drinking men also provide moving insights into the many problems they and their children experience, including physical violence, verbal abuse and destruction of their belongings (Kempe et al. 1962; Orford et al. 2005). Quantitative studies, such as Gender, Alcohol and Culture: an International Study (GENACIS), have identified many types, and a range of prevalence, of problems for drinkers' families across many countries, including domestic violence (Graham et al. 2008; Obot & Room 2005).

Family life can be difficult for both those who drink heavily and others who are affected by their drinking. Holmila et al. (2013) describe the dramatically worse outcomes for mothers in Finland who misuse AOD. These mothers are more likely to die, have concomitant mental health problems and have their children removed from their care than other women. The disadvantage apparent in the lives of these mothers is extensive; they are much more likely than those who do not misuse substances to be single parents without support, and to have less education and lower incomes.

The consequences of heavy drinking can be heartbreaking both for the drinkers and for other members of their families. A 2010 issue of *Drugs, Education, Prevention and Policy* focused on understanding families' experience of problems relating to alcohol or drug use. The studies highlighted were predominantly conducted in the United Kingdom (UK), with some from other parts of Europe, Mexico, and one study involving Indigenous Australians. An article in this issue summarised 20 years of qualitative research on the experiences of people affected by a family member's drinking or drug taking, and concluded that the greatest concern interviewees had was the effects on children. The effects emphasised by interviewees included exposure to violence or neglect, interference with the upbringing of children, the effects on home life of late night noise and the presence of drinkers, the restriction of social life, and fear of shame and criticism (Orford et al. 2010).

How other members of the family (including fathers, grandparents and siblings) are affected by the drinking of a family member is less often recorded, although Baldock (2006) has described some of the effects and impacts upon grandparents caring for grandchildren because of their children's drinking. Kunstsche et al. (2009) described how the heavy drinking of older siblings and friends was associated with more delinquent behaviour in younger teenagers. Child-to-mother violence and elder abuse has also begun to be recognised and quantified in Australia, although the involvement of alcohol misuse has not always been identified in these studies (Edenborough et al. 2008).

The causal role of alcohol in adversely affecting relationships can be a matter of dispute. There is no disagreement that a parent's drinking and associated activities can take time away from family life and relationships, can distract or incapacitate a parent from protective and caring roles, or can sap family resources to the detriment of other family members. But the exact role of alcohol in intimate partner violence is complex and contested (Leonard 2005). This reflects differing criteria for causality (Room & Rossow 2001): alcohol is rarely a necessary or sufficient cause of violence, but on the other hand the violence might not have occurred without the drinking. Of concern to those within the domestic violence field is that alcohol may be used to excuse violence against partners. Often, the objection is about moral responsibility and blame; it is feared that describing alcohol as causal will remove responsibility from the drinking perpetrator (Transition House 2013). This report does not address issues of personal responsibility for adverse events and conditions in families. Rather, it examines alcohol's involvement in adverse events and conditions within families and, to the extent this may be determinable, the question of whether the event or condition would not have occurred if the drinking had not occurred (Room & Rossow 2001).

Despite the lack of consensus about the aetiology of alcohol-related intimate partner violence, alcohol emerges as a consistent risk factor in its perpetration (Abramsky et al. 2011). The association of heavy episodic drinking (binge drinking) patterns with more aggression within relationships and increased severity of injury is consistent across several studies (Connor et al. 2011; Foran & O'Leary 2008; Graham, et al. 2011; Testa et al. 2003). Graham et al. (2011) analysed the relationship between alcohol and partner aggression severity using data from a range of 13 developing and developed countries and found a consistent relationship between alcohol use and increased severity of partner aggression even across diverse cultures. Specifically, they found that aggression was more severe when one or both partners

were drinking than when neither was. Studies also show women experience a heightened risk of partner violence on days that men have been drinking (Fals-Stewart et al. 2005).

In terms of prevention, Leonard argued that "...it is critical that research regarding alcohol and domestic violence move beyond simple studies of association and begin to frame these questions with an eye toward policy implications" (Leonard 2001, p. 235). A recent issues paper by Australia's National Research Organisation for Women's Safety (ANROWS) called for urgent responses to this issue, arguing that interventions should address both alcohol misuse and attitudes that are supportive of violence against women (Braaf 2012).

1.3 ALCOHOL'S EFFECTS UPON PARENTING AND CHILDREN

1.3.1 DRINKING AND PARENTING: ATTITUDES AND BEHAVIOUR

Alcohol is widely used in Australia (Bittman & Wajcman 2000). Although most adults consider it inappropriate for an intoxicated adult to be in charge of young children (Dawe et al. 2007; Maloney et al. 2010; NSW Department of Community Services 2006), a recent poll of Australians found that 79 per cent of drinkers with children under 18 years living in their home reported consuming alcohol around their children (FARE 2013). The vast majority of Australian children (and families) are exposed to drinking situations, and it is likely that in these situations alcohol is not always responsibly consumed.

Both norms and behaviours concerning drinking by carers are important in understanding the risks for children and other family members in different contexts. There are situations where drinking by adult carers appears to be more acceptable; for example, if only one or two drinks are consumed. A survey of adults' attitudes to parents drinking around small children in Victoria, Australia found that most respondents felt no drinking (49 per cent) or consumption of only one or two drinks (45 per cent) was considered acceptable (Matthews 2012). Only six per cent thought it was okay to drink "enough to feel the effects." While children may not be at risk because of their parents' moderate drinking, there is evidence that children are exposed to a range of different drinking patterns of their parents and others at social occasions (Adamson & Templeton 2012; Allan et al. 2012; Cook 2005; Jayne et al. 2011; Velleman & Templeton 2007).

In a Finnish study, drinking to intoxication while responsible for small children was unanimously disapproved of. However, 40 per cent of respondents regarded such drinking as acceptable if someone else was in charge of the children – for example, if the mother is in charge, while the father drinks (Raitasalo 2011). Respondents in this study reported that children were present at 12 per cent of their drinking occasions, and that 24 per cent of all drinking occasions were heavy-drinking occasions (estimated to be at a blood alcohol concentration level of .05% or greater), suggesting that while respondents may disapprove of drinking around children, many still do so. Women's attitudes and drinking behaviours were significantly correlated with each other in this study, whereas men's were not, suggesting that men were more likely to drink around children regardless of their reported general disapproval of drinking to intoxication around children. Of course, the lack of correlation may also mean that some men are not drinking around children although approving of it.

Estimates of the proportion of children living with or exposed to heavy drinking of a family member are available from various countries, though the criterion of 'problematic drinking' varies in its designation and meaning. Indeed the estimates of the proportion of children living with problematic drinkers vary widely between countries: in 2006 in Lithuania a reported three per cent of children aged 0-18 years grew up with a parent who misused alcohol, whereas in Finland and Poland the corresponding figures were around ten per cent and 19 per cent respectively (Harwin et al. 2010). In the US it has been estimated that one in four children is exposed to the effects of alcohol abuse or dependence of a family member (Grant 2000), and in the UK an estimated 30 per cent of children (or 3.3-3.5 million) live with at least one binge drinking parent (Manning et al. 2009).

As in other countries, while Australians do not approve of drinking too much when parenting, those of child-bearing and child-raising age often drink at risky levels. Dawe et al. (2007) estimated that 13 per cent of children are at risk of exposure to short-term risky drinking in Australian households by at least one adult. Further analysis suggested that around 25 per cent of fathers and ten per cent of mothers (in couple-plus-children families) had drunk at short-term risky levels (greater than 5/7 drinks

for women/men on an occasion respectively) two or more times a month in the past year (Dawe et al. 2007). Maloney et al. (2010) reported that Australian mothers and fathers are less likely to binge-drink than others in their age group, and that fathers were more likely than mothers to report problematic drinking patterns. However, these parents may choose only to drink at risky levels when their children are not with them, and whether parents' drinking occasions were in the presence or absence of their children was not specified in the Dawe et al. (2007) and Maloney et al. (2010) studies. This is a common feature of national drinking surveys, which often do not ask whether children were present for the parents' drinking, or whether children were harmed because of a carers' or others' drinking.

1.3.2 IMPACTS ON CHILDREN

There is little doubt that living with a problem drinker can have pernicious effects on children. Problematic alcohol use by parents has been shown to produce various impacts for children, both while they are growing up and as adults, particularly in relation to their own subsequent AOD use or depression (Kelley et al. 2011; Morgan & McAtamney 2009).

Velleman and Templeton (2007) summarise years of work and describe a range of ways in which children living in families with a heavy-drinking parent are reported to have been affected, including by disruptions to family rituals such as birthdays, by changes in and reversal of parent-child roles, by disturbed school attendance, eating and bedtime routines, by limited or more aggressive communication, by diminished social connectedness, and by lack of finances and worsening relationships.

At one end of the spectrum of harm, parental drinking may mean parents model poor drinking behaviours. Research suggests that parental drinking patterns, of both mothers and fathers, can contribute to increased problematic drinking patterns for their children (Raitasalo 2011; Smith et al. 1999; Wilks et al. 2006; Yu 2003). Parents may also find it difficult to maintain routines and, for instance, be unable to take children to organised early morning sports matches because they are 'hung over' (Velleman & Templeton 2007). At the other extreme, parental drinking may play a role in accidental child deaths, infanticide, assault, and extreme cases of neglect and child abuse (Victorian Child Death Review Committee 2009). Problems associated with a parent's drinking may be limited (e.g. affecting supervision at one-off social functions) or ongoing, such as potentially affecting a child's development over many years if the child is inadequately fed, clothed and looked after (Laslett et al. 2010).

A small Australian mixed methods action research study of parents in treatment for drug or alcohol dependencies and their children showed that intoxication and withdrawal could impair parents' ability to prepare meals, maintain household cleaning, keep school routines, respond to children's emotional needs, and supervise and manage risk of injury, including neglect or harm of their children by others (Gruenert et al. 2004). Parents in this study reported that during times of active alcohol or other drug use they themselves were more irritable, intolerant or impatient toward their children, used harsher discipline, were less responsive to their children's needs, yelled more and let go of routines, including getting their children to school. They also reported that they let their children take on adult roles, including caring for younger siblings (Gruenert et al. 2004).

Other studies have shown a range of negative effects on children of problem drinkers, including depression and reduced intellectual development (Barber & Crisp 1994; Dawe et al. 2007; Straussner 1994). Dawe et al. (2007) reviewed and summarised case-control studies comparing children of alcohol-dependent parents with children of non-alcohol-dependent parents, and reported that these provide some evidence that higher levels of internalising disorders (e.g. anxiety and depression) and externalising disorders (e.g. conduct disorder and aggression) were more common in children of alcohol-dependent parents than non-alcohol-dependent parents. On the other hand, only a minority of children of alcohol-dependent parents were negatively affected (West & Prinz 1987 cited in Dawe et al. 2007).

Dawe et al (2007) have also summarised the international literature on the impact of a family member's drug use (including alcohol) on children between the ages of two and 12 years. They discuss neglect, harm or abuse (which in severe cases are the potential triggers for intervention by child protection agencies), exposure to hostility and conflict, the impact of alcohol on family functioning, and the associated child behavioural problems.

A few studies have provided the perspective of affected children themselves on the harms experienced from a parent's or carer's drinking. In an Australian survey of children who called the telephone help service

'Childline', parental alcohol misuse was identified by children as connected to a broad range of problems, including the child running away, violence in the home, physical abuse, sexual abuse, neglect and poor family relationships (Tomison 1996). In the UK and Finland, focus groups with children and reviews of the literature revealed that children of substance-using parents felt ashamed, that they had missed out on their childhood, had normalised negative situations that a child should not have to deal with, and had felt anxious about their own safety. In addition, children reported being concerned for their parents in relation to the effects of their drinking. They were upset by their parents' quarrelling and violence when they drank, and felt that their families did not function as they should (Adamson & Templeton 2012; Raitasalo 2011). They felt they were not prioritised in their parents' lives and that they were neglected and physically hurt. Importantly, however, Raitasalo (2011) noted that in Finland many of these children had developed methods for coping with some of these problems and had suggestions about what might help other children in the same situations.

1.3.3 EVIDENCE FROM HEALTH AND SOCIAL STATISTICS

Data relating to alcohol-related harm to children because of their parents' and others' drinking are not routinely collected in health or social statistics. The involvement of alcohol in a person's own injuries is often ascertained, as it affects the way the patient is managed clinically. However, when an injury or problem is caused by someone else, intoxication of that third party is not routinely captured. For example, a child who drowns in a bathtub or falls from a height may not have been adequately supervised at the time of the incident because the carer was intoxicated, but this will not be recorded by medical services. On the other hand, where investigations of child deaths are undertaken in Australia, carer alcohol problems are a common feature. In NSW in 2003, 68 assault and neglect deaths of children aged 0-17 years were investigated, and in 19 per cent of these cases carers with a history of alcohol abuse were identified (NSW Child Death Review Team 2003). In these types of investigations, questions about the drinking patterns of carers are asked, although often in non-standardised ways. In Victoria, a similar review panel found that of the 28 deaths among child clients of Protective Services Victoria in the 2010-2011 year, parental alcohol problems were identified in half of these cases (Victorian Child Death Review Committee 2009).

Additional information about how children have been affected (often severely) by others' drinking comes from child protection sources. Parental substance abuse has been linked to confirmed cases of child abuse in many studies from different countries in the *World Report on Violence Against Children* (Pinheiro 2006; Krug et al. 2002), and in other studies from the UK (Forrester & Harwin 2008) and North America (Fluke & Shusterman 2005; Trocme et al. 2005).

1.3.4 POPULATION SURVEY DATA

Research on the effects of parental drinking upon children in general population samples is rare. Studies of children's exposure to drinking patterns exist, but whether this exposure results in harm is not reported. In part, this may reflect legal requirements that positive answers must be reported to authorities, hence such questions may not be asked. Drinking has been linked to lack of surveillance of children and increased risk of injuries in three large-scale studies in the US. In a large sample of US families, Bijur (1992) found that children of mothers categorised as problem drinkers had twice the risk of serious injury of children of mothers who were non-drinkers, although other measures of mothers' alcohol consumption were unrelated to child injuries, as were all measures of fathers' drinking. In another US study, Crandall et al. (2006) surveyed 5,000 'fragile' families and found that maternal alcohol use in the past month was associated with injury to children under 12 months old.

In a large community sample analysed prospectively, parental substance use (including both alcohol and other drugs) was a significant and strong predictor of physical abuse and neglect, providing longitudinal evidence of the association between substance misuse and child abuse and neglect. The presence of parental substance abuse tripled the risk of experiencing the measures of child abuse or neglect utilised in the study (Chaffin et al. 1996).

A US general population survey found that 2.3 per cent of parent respondents (one randomly selected parent per selected child in the household) reported having been so drunk or high in the last year that they had a problem taking care of their child (Straus et al. 1998). An analysis of Scottish personal safety survey data found that one per cent of children had witnessed partner-to-partner domestic violence in

the household when the adult held responsible had been drinking (Manning et al. 2009). Information on whether children were present in alcohol-related incidents of domestic violence is not available for Australia, although Personal Safety Surveys in Australia reported lower levels of alcohol-related domestic violence incidents in the past year (with such incidents reported by 1.1 per cent of females and 0.4 per cent of males) compared with Scotland (Laslett et al. 2010).

In the US, ecological studies of child maltreatment, parental drinking patterns and alcohol availability (as measured by license outlet density) have been undertaken (Gmel 2014). The results of these studies with respect to alcohol are mixed, with frequency of drinking showing greater effect than volume, and on- and off-premise outlet density showing sometimes positive and sometimes negative associations depending on whether corporal punishment or severe maltreatment of children were examined as outcomes, whether bars and restaurants were examined together, the type of analysis undertaken and whether individual-level factors were taken into account. Although outlet density results were more mixed, these analyses did show that self-reported drinking frequencies in bars and at home/parties were positively associated with corporal punishment and severe physical abuse, and frequencies of drinking in restaurants were negatively associated with these outcomes (Freisthler & Gruenewald 2013).

No such ecological studies exist in Australia and, more generally, there are limited quantitative data on how different drinking patterns of parents (e.g. 'binge drinking') may directly affect children along a continuum of harm in the general population. In the UK, it has been noted that "there is a dearth of work which has considered the numbers of children who are affected by parental alcohol misuse (and who can be affected at all levels of consumption, not just parents who are dependent drinkers). Tackling this gap is a key first step in understanding the size of the problem and developing the most appropriate practice and policy response to what is believed to be a very significant issue" (Adamson & Templeton 2012, p. 33).

The first Australian Harm to Others (HTO) Survey conducted in 2008, and reported in *The Range and Magnitude of Alcohol's Harm to Others*, included a chapter on the effects of alcohol upon children as measured in the Victorian Child Protection Service (VCPS) and a general population survey, and thus began to address this deficit (Laslett et al. 2010). This work is extended in the current report.

1.4 RESEARCH QUESTIONS

This study examines how commonly family members, and particularly children, are adversely affected by others' drinking. The research questions addressed are:

1. How common and what are the effects of heavy drinking upon families and children?
   a. How do these effects vary in different relationships?
   b. Are there differences in the ways in which parents, siblings and grandparents are harmed by and care for those in their families?
   c. Do the effects vary depending on whether the respondent is or is not living with the heavy drinker, and whether the drinker is a nuclear or extended family member?
2. To what extent do the effects upon children and families persist or change over time?
3. What is the qualitative nature and impact of harms to children and families from others' drinking?
4. What services are available for families and children if they have been affected by the drinking of those around them?
5. What types of service and policy interventions are likely to improve the situations of those affected by others' drinking?

2 METHODOLOGY

Anne-Marie Laslett, Janette Mugavin, Sarah Callinan, Elizabeth Manton, Sarah MacLean, Robin Room

This report includes multiple sub-studies involving a variety of quantitative and qualitative data sources and approaches to elicit the effects of alcohol's harms on families and children in Australia. This chapter details the methods used in each of the sub-studies and describes the measures used.

The quantitative data sources used to measure alcohol-related problems for families and children from others' drinking were survey data, registry data and document reviews including existing published data tables. Three chapters use survey data (Chapters 3, 4 and 5). Chapters 7 and 8 detail information on more severe alcohol-related problems of families and children, and describe the AOD treatment system responses using registry data sets and document reviews.

Qualitative data were obtained via individual interview and focus groups to inform two distinct aspects of the report. Chapter 6 provides an in-depth understanding of the nature of harms to children from others' drinking and the impact on children and families and Chapter 9 presents insights based on key informants' views on current service delivery and policy responses to families experiencing alcohol-related harm.

2.1 2008 AND 2011 HTO SURVEY DATA

2.1.1 DATA SOURCES

The 2008 HTO Survey was the first Australian survey to examine alcohol's harm to others, involving a representative cross-sectional national sample of 2,649 Australian adults. The 2008 HTO Survey questionnaire captured the number of heavy drinkers (if any) in respondents' lives, and adverse consequences to the respondent (or the respondent's child) in the previous 12 months from the drinking of family, friends, co-workers and strangers or those not well known to the respondent (Wilkinson et al. 2009; Laslett et al. 2010). These data provide prevalence estimates of alcohol's harm to others. For more detail on this questionnaire and survey methodology see Wilkinson et al. (2009).

The 2011 HTO Survey was a follow-up survey in which individuals who completed the 2008 HTO Survey and agreed to be recontacted were invited to take part. A total of 1,106 respondents completed the 2011 HTO Survey between October 2011 and February 2012. The response rate for the follow-up survey was 42 per cent of the initial 2008 sample and 48 per cent of those in that sample who agreed to participate in future studies. For the most part, the 2011 HTO Survey included the same set of questions as those asked in 2008. However, a small number of additional questions were added, for example to capture change in household composition between 2008 and 2011, and some specific consequences of harm. Details on the rationale, methodology and results of this study have been described fully in the report titled *Beyond the drinker: Longitudinal patterns in alcohol's harm to others* (Laslett et al. 2015).

This report focuses on a sub-sample of 2008 and 2011 HTO Survey respondents who reported experiencing harm from a family member or intimate partner's drinking and/or that a child whom they lived with or had parental responsibility for experienced harm from someone's drinking. Chapters 3 and 4 use the 2008 HTO Survey data, but include a range of new analyses to focus upon and better understand the alcohol-related harms to families and children.

Together, the 2008 and 2011 HTO Survey data have been used to estimate stability and change in harms to children and families from others' drinking, as well as what factors predict harm to children and families from others' drinking over time. Results specific to predicting harms to families and children in the follow-up study are described in Chapter 5.

In both the 2008 and 2011 Surveys, respondents were asked to report if they or someone they knew had been affected "a little" or "a lot" by someone else's drinking. There is no consistent definition of "a little" or

"a lot" as these were based upon the subjective assessment of the respondent. The qualitative component of this study seeks to understand what respondents meant when using this term.

2.1.2 ANALYSIS

STATA v.12 (StataCorp 2011) was used to undertake all descriptive and multivariate analyses in Chapter 3 (2008 HTO Survey data), Chapter 4 (2008 HTO Survey data on families) and Chapter 5 (2008 and 2011 HTO Survey data). Confidence intervals (CIs) were generated for primary survey data results and are presented in square brackets. They provide an estimate of the variability around the prevalence figure, and where these intervals do not overlap this indicates a statistically significant difference between the prevalence estimates. Chi-square and T-tests were used to examine the differences between categorical and continuous outcome variables. The modelling techniques used in Chapter 5 were bivariate and multivariate logistic regression.

2.2 REGISTRY DATABASES

2.2.1 DATA SOURCES

Routinely collected data from a range of service providers such as publicly-funded AOD treatment services, Child Protection Services (CPS) and police have been drawn together to illustrate the extent of alcohol's involvement in a range of services utilised by families and children. The findings that relate to the following data sources are included in Chapters 7 and 8.

Alcohol and Drug Information System, Victorian Department of Health

The Victorian Department of Health funds a range of community-based agencies to provide specialist AOD treatment to people experiencing difficulties related with their own or someone else's substance use. The collection of client information is a mandatory requirement of the funding arrangement, and data are collected and managed through a central depository referred to as ADIS (Alcohol and Drug Information Service).

This report uses aggregated data derived from specialist AOD agencies (including community health centres) contributing to ADIS for the financial years 2007–08 to 2011–12. Approval to use the ADIS data was obtained from the Victorian Department of Health, and the analyses were undertaken by the Population Health team at Turning Point, Eastern Health.

DirectLine, Turning Point, Eastern Health

DirectLine is a 24-hour AOD counselling, information and referral service for Victorians that provides trained AOD counsellors to respond to calls from people concerned about their own and/or others' AOD use. Data relating to calls from concerned 'significant others' in relation to AOD for the financial years 2006–07 to 2012–13 were available for analysis.

CounsellingOnline, Turning Point, Eastern Health

CounsellingOnline is a nation-wide internet-based model of intervention provided by Turning Point, and funded by the Commonwealth Department of Health. It is a text-based counselling service both for individuals concerned with their own substance use problems and for those concerned about the substance use of others. Data relating to contacts from concerned or significant others in relation to AOD for the financial years 2006–07 to 2012–13 were available for analysis.

Family Drug Support Helpline, Family Drug Support Australia

Family Drug Support (FDS) provides a nation-wide telephone helpline dedicated to addressing the support and information needs of family members and significant others who are affected by someone's alcohol or drug use. Data relating to calls from concerned or significant others in relation to AOD for the financial years 2006–07 to 2012–13 were available for analysis.

Child and Services Information System – Child Protection and Family Services, Victorian Department of Human Services

The Child and Services Information System (CASIS) database, (now known as the Client-Related Information System or CRIS), contains de-identified data records for all child protection cases that existed or were subsequently notified to the Victorian Department of Human Services Child Protection Unit in the calendar years 2001-2005[1]. Information relating to 188,063 cases and 97,684 clients (children on whose behalf the department was investigating or acting) was available for analysis. Child maltreatment cases included exposure to physical, emotional and sexual abuse, as well as neglect and domestic violence, and the stage of service involvement and the outcomes in the child protection process are held within the data set. The involvement of alcohol and other risk factors in Victorian child protection cases were recorded for all families, once cases had been substantiated. The social and demographic characteristics of these clients and families were also available from the dataset for analysis.

2.2.2 ANALYSIS

The analyses in Chapters 7 and 8 of the report are descriptive, with cases counted using Excel or STATA v.11 (StataCorp 2009). STATA v.11 was used to undertake descriptive analyses of the VCPS data. See Laslett (2013) for more detail.

In all tables showing regression type analyses, the word 'Ref' in round brackets denotes the reference category of a categorical predicator variable. For example, 'Age' is a predictor variable in many of the analyses, and '18-35' is the reference category. Results reported in regression type analyses indicate whether the 'reference category' (e.g. aged '18-35') makes a difference to the outcome being measured, relative to the other category of the predictor variable (e.g. aged 36-55).

In analyses where the outcome variable is categorical, for example Table 5.2 under 'Male' a '1' is shown before the text '(Ref)', the '1' denotes the reference value in logistic regression models. However, if the outcome variable is continuous the reference value is '0' in linear regression models.

When interpreting the relationship between the predictor and the outcome variable, any significant number above the reference number indicates a positive relationship and any significant number below the reference number indicates a negative relationship.

2.3 PUBLICLY-AVAILABLE DOCUMENTS AND DATA

2.3.1 DATA SOURCES

Publicly-available data such as annual reports were sourced and incorporated with other data sources in cases where primary data were not available. These datasets are identified and referenced in Chapters 7 and 8. The key sources are outlined below.

Alcohol and Other Drug Treatment System

Publicly-funded AOD treatment services across Australia are required to collect a set of standard data items related to treatment provision as part of the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). This information is collated and held by the Australian Institute of Health and Welfare (AIHW). Information on whether a client is seeking treatment because of their own or others' use of AOD is reported for each closed treatment episode provided. Information on the principal drug of concern (PDOC) for which an individual is seeking treatment is recorded. However the PDOC for individuals seeking treatment because of someone else's AOD use is not included in the mandatory set of items. Therefore, it is not possible to discern how many episodes of treatment are provided to individuals seeking treatment because of others' alcohol use (Australian Institute of Health and Welfare 2012).

Law Enforcement Assistance Program – Family Incidents Data

Victoria Police collate statistics on the number of reported 'family incidents' recorded on the Law Enforcement Assistance Program (LEAP), a computerised database established in 1993. 'Family incidents'

[1] The 2001 to 2005 data were used as during this period recording of carer alcohol abuse was mandatory. In 2006 the system changed and this information is no longer recorded in the same way.

are an indicator of domestic violence, and include calls where the police deem that an offence has taken place, in addition to actual arrests (Livingston 2011). Police also assess alcohol involvement in each incident and record the presence of alcohol as 'definite,' 'probable' or 'not' (Laslett et al. 2006). This approach to family incidents has limitations, because the assessment is subjective, and information relating to alcohol involvement will probably vary across reports. The analyses included in this report were performed by the Population Health Team at Turning Point, Eastern Health, and the tables presented have been reproduced with their permission.

Police data on family violence incidents (states other than Victoria)

Police data from annual reports and domestic violence reports were utilised to collate family violence incidence statistics from Western Australia (WA), NSW and the Northern Territory (NT).

A range of child protection data from other states besides Victoria have been used to estimate the prevalence of alcohol-related child protection cases. Child protection data from other states were obtained from published State and Australian Government reports, as indicated by references.

Child and Family Services data

A small amount of data was also available from government websites on child and family services that were funded federally (Department of Social Services 2013).

2.4 IN-DEPTH INTERVIEWS WITH HTO SURVEY RESPONDENTS

To explore the experiences of people who care for a child or children affected by others' drinking (in Chapter 6), a qualitative methodology was adopted entailing 20 in-depth interviews. The interview theme sheet is included at Appendix 3. Ethics approval was sought and received from the Eastern Health Human Research Ethics Committee (E45-1112).

2.4.1 PARTICIPANT RECRUITMENT

Potential participants were those who replied in either the 2008 or 2011 HTO Survey that a child/children for whom they had parental responsibility had been harmed "a lot" or "a little" by others' drinking, and who also indicated that they were happy to be recontacted for future research.

Because participants lived across Australia, the interviews were conducted by telephone. Potential participants were telephoned and a script was read out to them, reminding them of their previous participation, their stated willingness to be recontacted for future research, and an overview of what the current interview entailed. At this stage participants either agreed to be interviewed immediately, agreed to be interviewed but at a more convenient time, sought more information (in which case a Plain Language Statement (PLS) was sent to them and a recontact time was agreed), or refused to be interviewed. At the start of the interview the participants were asked "Do you consent to be interviewed and for this interview to be recorded?"

2.4.2 SAMPLE

Interviews were conducted between April and August 2012. There were 21 prospective interviewees who had answered that a child had been harmed "a lot" by others' drinking in either the 2008 or 2011 Survey (or both) and who were prepared to be recontacted, and ten were interviewed (eight women, two men). Of the 11 who were not interviewed, no contact was ever made with six, one was not interested on first contact, and one was not interested after reading the PLS, which outlined the purpose of the interview and what participating in the interview involved. The remaining three people indicated on first contact that they were interested in being interviewed but at a more convenient time, but on re-call other people answered the phone and the potential interviewee now had no wish to proceed with the interview. The implications of this are discussed further in Section 6.6.1 (Methodological reflections).

There were 87 prospective interviewees who had answered "a little" on either the 2008 or 2011 HTO Survey (or both) and were prepared to be recontacted, and ten were interviewed (seven women, three men). The order in which they were selected for contact was based on a randomly-generated list of these prospective interviewees. On the basis of preliminary analysis of these ten interviews it was decided not to proceed with trying to get larger numbers of those who had answered "a little," as no new themes were arising, and the harms experienced were indeed usually much less than the harms recounted by those who answered "a lot."

The interviewees were usually the parent of the child harmed by another person's drinking (n = 16, including one foster parent). The remaining interviewees were grandparents who had a range of care arrangements for their grandchildren, with often-shifting patterns of formal custody and informal caregiving arrangements. The drinker who was harming these respondents' grandchildren was either their own child (n = 2) or their child's ex-partner (n = 2). A table summarising demographic information about the interviewees, including age, gender, education, and occupation can be found in Chapter 6 (Table 6.1).

2.4.3 ANALYSIS

Interviews were audio recorded and professionally transcribed. The transcribed interviews were stored and analysed using NVivo9, a qualitative software package that enables thematic analysis of large amounts of text (Braun & Clarke 2006). Themes were identified from the interview outline in the first instance but, consistent with an inductive approach, analysis was also allowed to be shaped by new themes arising in the analysis.

2.5 KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

Interviews with key service providers, policy makers and researchers (key informants) about policy and service responses for families and children of heavy drinkers and family members of clients of AOD treatment services were conducted between March and July 2011 and then again in focus groups in November and December 2013. Policy options focused on families and children affected by others' drinking were also canvassed, as were current research gaps and recommendations for future studies. The focus of these interviews was largely on children and child protection responses, although issues for AOD clients and families more broadly were also sought.

2.5.1 PARTICIPANTS

Twenty-one key informants participated in semi-structured interviews for the study, including those who participated in both individual interviews and focus group discussions. Key informants were current employees in senior positions from child protection departments across each state and territory in Australia or researchers or service providers in the fields of AOD treatment and/or child protection. Interview schedules for individual interviews with the child protection and AOD policy, service and researcher key informants were developed by the research team (Appendices D and E).

In order to gather specific information about the child protection recording systems available in all Australian states, a subset of questions were included about how problems were recorded, how child protection workers were trained to record alcohol problems, which data were available electronically, and relevant reports. They were also asked about their understanding of the capacity of the electronic data systems they worked with to record alcohol- (and drug-) related child protection or family concerns. AOD researchers and service providers were also asked how they recorded information on clients' children. Program managers and policy personnel were asked a series of questions about their child protection and alcohol program and service responsibilities (including data collection) within their jurisdictions. Researchers were asked about their current areas of alcohol and child protection research interest, as well as existing research that they knew of regarding carers' alcohol problems and their effects on families and children.

Three additional focus groups were held with senior policy personnel, service providers and researchers (n = 11). These meetings were broader in approach, with an agenda to gain directions for further research

about how alcohol affects children and families, and seek some consensus from experts in the child protection and AOD fields about policy and service recommendations (see Appendix D).

2.5.2 SAMPLING METHOD

Key informants were approached in two ways. Child protection departments were approached through their general enquiries channels (email or phone) with a request to discuss the research with the most appropriate person, or specific people were approached based on the recommendation of researchers in the field within each jurisdiction. Recommendations from those interviewed were also sought and followed up. AOD service providers involved in specialised care of families were also contacted as a result of suggestions from other key informants.

2.5.3 PROCEDURES

Interviews were carried out over the phone or in person, depending on the preference of the key informant. One interview was audio recorded; in the remaining interviews extensive notes were taken. Ethics approval was sought and received from the Eastern Health Research Ethics Committee (EH 119).

2.5.4 ANALYSIS

The research team used the answers to specific questions to better understand the data collection and recording process in relation to alcohol-related harms to families and children undertaken across the Australian states. In addition, key informants' responses to broad questions about their own services and research, and the broader context within which they understood alcohol-related problems for families and children, suggested emerging themes that were followed up by the interviewers. Quotes from the key informants have been used to illustrate the issues that became apparent.

2.6 MEASURES AND DEFINITIONS

The family is seen as the primary unit within which children are cared for. The preamble to the Convention on the Rights of the Child defines 'family' as a "variety of arrangements that can provide for young children's care, nurturance and development, including the nuclear family, the extended family, and other traditional and modern community-based arrangements, provided these are consistent with children's rights and best interests" (United Nations 2006, p. 44). Children in this report are defined as people aged under the age of 18 years, and where information is available only for a subset of these children, this is noted in the text. A vast array of family arrangements exist, and definitions of families differ in different data sources.

2.6.1 DEFINING 'FAMILY'

In the HTO Surveys

The 2008 and 2011 HTO Surveys use limited categories of family types, collapsing families into a few main categories by household living status: couple-only families, two-carer families with children (including adopted, foster care, step and biological families, and combinations), single-carer families with children, and 'other families'. The 'other family' category includes families where there are more than two adults in the family, including multiple generations of families, extended families and families that include 'non-family' members.

In the context of the HTO Surveys, the terms 'family members and intimate partners', and for brevity, 'family members' are used. These terms refer to immediate and extended family members and relatives in or outside the household (parents, siblings, children, grandparents, aunts, uncles, cousins and other family members), as well as current and former partners/spouses, girlfriends and boyfriends.

In Child Protection service system data

In the VCPS data, families were recorded in the period studied in the CASIS and coded as: 'intact' where two biological parents were present; 'extended family' where additional relatives (a couple or one other) had care of the child, or were present in addition to biological parents; 'step,' which included stepfather or stepmother families; 'blended,' which included a non-biological parent and children from different relationships; 'sole parent,' which included sole father and sole mother families; and 'other' families which include a couple or one person without these connections and children (Laslett et al. 2013). These categories were assigned as part of the initial file report on the family.

In service system data

Many of the relevant service system data sets report upon services provided to individuals and do not record, or appear to report upon, the make-up of the families they treat. According to the Australian Government agency's website[2], Family and Children's Services deliver a range of services that include community programs, family and relationship services, specialist services and community playgroups, including specific programs targeted to children of substance users. Family service systems record a number of details about family support services provided, but few demographic details, e.g. information on the numbers of dependent children or family structure (Department of Social Services 2013).

In AOD treatment systems, including face-to-face, telephone counselling and online counselling modalities, whether the client is a user or a concerned and/or affected family member is generally recorded and reported (Australian Institute of Health and Welfare 2012). Detail on the relationship type is also collected uniformly across the states. Information on whether the client has children or not, and the client's living arrangements (e.g. lives alone) may be collected via state and territory reporting systems, however these fields are not routinely reported in the AODTS-NMDS (Australian Institute of Health and Welfare 2012).

2.6.2 MEASURES OF DRINKING

In the HTO Surveys

A number of measures have been used in this report to record the drinking patterns of respondents and those said to be responsible for adverse effects on children, spouses and other family members.

In the 2008 and 2011 HTO Surveys, respondents' drinking patterns were measured using the usual quantity and frequency method and the number of times per week the respondent consumed five drinks or more in a single occasion. Respondents were also asked to estimate how much alcohol was consumed by the person whose drinking most adversely affected them (i.e. the problematic drinker), using questions about the frequency of five or more drinks consumed in a single occasion and the amount usually consumed when drinking heavily (Wilkinson et al. 2009).

In Child Protection Service system data

Across Australian states, alcohol reporting within child protection systems varies both in terms of how alcohol use, misuse, abuse or dependence is defined and whether the reporting is separate or combined with other drug use. The child protection stage at which AOD risk factors are reviewed. In this report, child protection workers compulsorily recorded whether alcohol abuse by one or both parents or carers was a risk factor for children. Recording of carer alcohol abuse is no longer compulsory, although VCPS workers may still choose to enter alcohol and other risk factor data if they think this information is relevant.

In Other service system data

In general the drinking patterns of Australians who are served by the welfare and health service systems are either not recorded, or poorly recorded. For example, Family Services system data does not record AOD use specifically (Department of Social Services 2013).

In the Victorian *DirectLine* service's data (Turning Point Alcohol and Drug Centre 2012a) the *CounsellingOnline* data (Turning Point Alcohol and Drug Centre 2012b) and the FDS Helpline data (Family Drug Support Australia 2014), alcohol problems of various family members were reported. AOD problems

[2] http://www.dss.gov.au/our-responsibilities/families-and-children/programs-services/family-support-program/family-and-children-s-services

were self-defined by callers, and commonly information is provided for the PDOC. In some systems counsellors report whether the client thinks his/her substance use is causing interpersonal problems (Turning Point Alcohol and Drug Centre 2012b), but this question is not mandatorily asked. While it is likely to be commonly asked, it is difficult to assess precisely how often this occurs.

2.6.3 MEASURES OF PROBLEMS FAMILIES AND CHILDREN EXPERIENCE BECAUSE OF OTHERS' DRINKING

In the HTO Surveys

In the 2008 and 2011 HTO Surveys three main series of questions were asked regarding the effects of others' drinking on children and families:

1. Questions were asked regarding which heavy drinkers (amongst those in respondents' families) they had been negatively affected by in the 12 months prior the survey, and by which of these the respondent had been most negatively affected (the latter is commonly termed the 'problematic family drinker' in this report).
2. Questions were asked regarding harms to the respondent and children previous 12 months. Respondents were asked about 14 harms to themselves from family members: put at risk in a car, forced or pressured into sex, social occasion negatively affected, they failed to do something they were being counted on to do, they broke or damaged something that mattered to you, you could not bring friends homea, they did not do their share of work around the houseb, you had to leave home and stay elsewherec, there was less money for household expensesd (a-d only asked if problematic family drinker lived with the respondent. Respondents were also asked about four types of harm to children: verbal abuse, physical harm, supervision/safety issues and exposure to serious violence in the home because of others' drinking.
3. Questions were asked regarding the effects both of the problematic family drinker on the respondent, and the adverse effects of adults' drinking on children under the respondent's care, respondents were asked a summary question on how much harm the drinking did: "a lot," "a little," or "not at all" (following the list of specific harms).

In Child Protection Data

The AIHW publishes the numbers of cases and children in each state and territory reported to, confirmed and managed by the CPS systems (Australian Institute of Health and Welfare 2006; 2010; 2011; 2013b). Reports or notifications, substantiations (confirmed cases), interventions, and out-of-home care cases by primary type of abuse (neglect, physical, sexual or emotional abuse) are documented. Carer alcohol abuse, other drug abuse, or alcohol in combination with other drugs are not reported as risk factors at the national level. Although many states do record the prevalence of carer alcohol and/or other drugs risk factors, they do not report the presence of these risk factors separately, except in Victoria and in NSW (See Chapter 8 for more detail).

In service system data

The Commonwealth publishes the numbers of cases referred to the *Kids in Focus – Family Drug Support* program, but not whether the referrals are for alcohol or other types of drug problems (Department of Social Services 2013). AOD information is not published for other non-alcohol and drug specific service types provided, for example, *Communities for Children* services provided to vulnerable families for early childhood interventions, *Specialised Family Violence Services* and *Family Relationship Services for Humanitarian Entrants*.

The AODTS-NMDS provides data on whether clients were seeking help for their own or others' AOD use, however for episodes of care provided to 'others,' the PDOC is not reported.

Since 2001–02, Victoria Police has collected detailed information about family violence incidents attended by police, including information on whether alcohol was 'definitely,' 'probably' or 'not' involved.

3 EFFECTS UPON FAMILIES OF OTHERS' DRINKING: 2008 HTO SURVEY FINDINGS

Anne-Marie Laslett and Heng Jiang

3.1 INTRODUCTION

In the 2008 HTO Survey (Laslett et al. 2010), more respondents reported being harmed by the drinking of strangers than by the drinking of people they knew. However, if respondents reported they were more severely harmed, they were more likely to report that they had been affected by someone they knew, for example a household member, relative or friend. Of the 2,649 respondents completing the survey, 778 people (29 per cent of the sample; 282 men and 496 women) identified that they knew at least one drinker whose drinking had negatively affected them. Women were more likely to be affected than men by the drinking of those they knew, and this was even more the case for young women (aged 18 to 29 years). Fourteen per cent of women in this age group reported that they had been substantially affected by the drinking of a household member, non-household relative, intimate partner or friend, compared to only five per cent of young men. The majority of the people who were negatively affected by the drinking of someone they knew indicated that they had been affected by a family member (including current spouse) or intimate partner (i.e. boyfriend, girlfriend or ex-partner) or relative in or outside of their household (n = 447/778, 58 per cent) (Laslett et al. 2010).

In total, 17 per cent of respondents reported that they had been affected by a relative or intimate partner in the past year: seven per cent of respondents reported that they were affected by a household member and 11 per cent by a relative or intimate partner outside the household (Laslett et al. 2010).

This chapter draws on the 2008 HTO Survey (Laslett et al. 2010) and presents more detail on how families were affected, describing which relationships respondents reported they had been affected by, as well as whether they were affected by drinkers in or outside the household. This data set still provides the most representative and recent data available on alcohol's harm to others in Australia. Chapter 3 begins to answer the first of this study's research questions: How common and what are the effects of heavy drinking upon families and children?

3.2 DETAILED ANALYSES OF THE 2008 HTO SURVEY

Table 3.1 depicts the family and intimate relationships of the people that respondents reported being affected by in and outside the household, using the whole 2008 HTO Survey sample as a baseline. Examining the individual relationship types more closely, respondents were most likely to report that the drinking of non-household siblings (4 per cent) and household partners (4 per cent) had negatively affected them. Respondents reported that harm was more likely to have been due to the drinking of a range of relationships outside the household compared to inside the household, so siblings outside the household caused more harm to the respondent because of their drinking than siblings in the household. This was also true for parents and children. Only spouses in the household were reported by respondents to more commonly cause problems because of their drinking than ex-spouses and boyfriends/girlfriends outside the household.

In this report Chi-square tests were used to examine the association between gender (of the respondent) and the household status of family members and intimate partners whose drinking had an adverse effect on the respondent. Female respondents (5 per cent) were significantly more likely to report harms from spouses/partners than male respondents (2 per cent), and this was also true for children (2 per cent versus 1 per cent) within the household. For family members not in the household, females were significantly more likely than males to report harms from parents (3 per cent versus 2 per cent), ex-partners (1 per cent versus 0.1 per cent) and others (4 per cent versus 2 per cent) because of their drinking.

Table 3.1 Percentage of respondents identifying family members whose drinking has negatively affected them (2008 HTO Survey)			
	MALE %	FEMALE %	TOTAL %
(n)	(1,089)	(1,560)	(2,649)
Household member			
Spouse/partner (n = 89)	2	5	4***
Parent (n = 6)	0.2	1	0.4
Sibling (n = 4)	0	1	0.3
Child (n = 37)	1	2	2**
Other[a] (n = 16)	2	1	1
Subtotal affected by any household member[b] (n=152)	5	9	7***
Subtotal affected "a lot" by any household member (n=65)	1	4	3***
Family members not in the household			
Parent (n = 61)	2	3	3*
Sibling (n = 92)	3	5	4
Child (n = 63)	2	3	2
Ex-partner (n = 11)	0.1	1	0.3*
Boy/girlfriend (n = 20)	0.4	1	1
Other[c] (n = 84)	2	4	3**
Subtotal affected by any family member not in the household[d] (n = 331)	8	15	12**
Subtotal affected "a lot" by any family member not in the household (n = 91)	2	5	3***
Total affected by family members and intimate partners in or outside the household (n = 447)	**12**	**21**	**17*** **
Total affected "a lot" by family members and intimate partners in or outside the household (n = 161)	**3**	**8**	**6*** **

Note: n = 2,649; Boy/girlfriend includes current (n = 16) and ex-boy/girlfriend (n = 4).

[a] The 'other' group includes male and female friends and other types of relationships in the household.

[b] 7 respondents reported they were negatively affected by more than one household member.

[c] Here the 'other' group includes grandparents, grandchildren, uncles, aunts, cousins, nephews, nieces, and other male and female relatives.

[d] 43 respondents reported they were negatively affected by more than one non-household family member.

Percentages in this table were calculated on the total sample of 2,649 respondents

Differences by gender in each relationship type (row) were tested for significance with Chi-square (χ^2) tests, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, using all female and all male respondents as corresponding denominators.

Examining the figures for those respondents who reported being negatively affected "a lot" by a family member's or intimate partner's drinking, three per cent of respondents reported substantial harm in the household, and the same percentage (3 per cent) reported substantial harm from family members and intimate partners outside the household.

Of the 447 respondents affected by a family member's drinking, 17 per cent (n = 74) reported that they had been negatively affected by two or more heavy drinkers in their lives. Respondents who nominated more than one such person were then asked about whose drinking they had been most adversely affected by in the last year. Only one person of the 447 respondents negatively affected by a drinker who was a household member, family member or intimate partner indicated that another person's drinking (e.g. that of a co-worker or friend) had affected them more than their family member or partner's drinking.

The denominator for all subsequent tables is the 446 respondents who reported that the person whose drinking most negatively affected them was a family member or intimate partners, and this drinker is abbreviated in tables as the 'problematic family drinker.' While this enables analyses of detailed information about the person who has affected respondents the most, it misses information about those other drinkers who have also negatively affected the respondent, as it was not possible within the constraints of a telephone survey to obtain individual socio-demographic information on every problematic family drinker in the respondent's life.

3.2.1 WHICH FAMILY RELATIONSHIPS WERE MOST AFFECTED BY OTHERS' DRINKING?

Among the 446 respondents negatively affected by a family member's drinking, 34 per cent nominated someone in their household, and almost twice as many (66 per cent) identified a family member or intimate partner outside their household as having most negatively affected them (see Table 3.2). A total of 28 per cent named a current or ex-spouse/partner, 14 per cent identified a parent, 19 per cent a child, 20 per cent a sibling, 17 per cent indicated another relative and three per cent indicated that a boyfriend or girlfriend was responsible. A higher proportion of males reported being affected by siblings compared with females, however, a higher proportion of females reported being affected by a spouse or partner than male respondents.

Table 3.3 compares the mean age of respondents and the problematic family drinker. There were no statistical differences between the mean ages of the respondents and the family members that had most negatively affected the respondents, suggesting that people tend to be affected by drinkers of similar ages to themselves (except in parent-child relationships).

The ages of the problematic family drinker reported upon by the respondents in various relationships were generally similar, with expected differences in age between parents and children. The mean age (30 years) of the problematic family drinker who were the children of respondents was higher than expected, indicating that many older respondents were reporting on 'children' who had reached adulthood some time ago.

Table 3.2 Family relationships with the person whose drinking most affected the respondent by respondent gender

	MALE		FEMALE		TOTAL	
	n	%	n	%	n	%
Relationship type—family member						
Spouse/partner	16	15	60	20	76	18
Parent	19	14	46	13	65	14
Sibling	28	23	57	19	85	20
Child	23	17	62	19	85	19
Ex-partner	17	10	35	9	52	10
Boyfriend/girlfriend	5	3	10	4	15	3
Other relative	19	19	49	16	68	17
Subtotal all family members (n = 446)	**127**	**100**	**319**	**100**	**446**	**100**
Family member in the household	31	34	94	34	125	34
Family member not in the household	96	66	225	66	321	66

Note: n = 446

Table 3.3 Comparing respondent and problematic family drinker (PFD) mean ages#

	MALE		FEMALE		TOTAL	
	RESP MEAN AGE	PFD MEAN AGE	RESP MEAN AGE	PFD MEAN AGE	RESP MEAN AGE	PFD MEAN AGE
Relationship type—family member						
Spouse/partner (n = 76)	43	41	41	43	42	42
Parent (n = 65)	32	59***	38	66***	36	64***
Sibling (n = 85)	45	46	40	44	42	45
Child (n = 85)	59	29***	57	30***	57	30***
Ex-partner (n = 52)	36	33	36	39	40	37
Boyfriend/girlfriend (n = 15)	36	30	25	27	28	28
Other relative (n = 68)	36	40	40	41	38	41
Subtotal family members (n = 446)	**42**	**42**	**42**	**43**	**42**	**42**
Family member in the household (n = 125)	41	38	41	38	41	38*
Family member not in the household (n = 321)	43	43	43	45	43	44

Note: n = 446; PFD is the problematic family drinker, i.e. the family member or intimate partner that most affected the respondent; Resp is the respondent.

Two sample t-tests were conducted to compare the difference in the mean ages of the PFDs and affected respondents across different family relationships; * $p < 0.05$, ** $p < 0.01$, ***$p < 0.001$.

#The age of the drinker who had most negatively affected the respondent was obtained in categories and not in years. The midpoints of the age category was used as the PFD's age. For the category <20 years, age 15 was used. In another analysis not shown here, 19 years was used as the average age of category <20 years, assuming that the problematic drinkers were drinking legally (in age of 18-20). There was very little difference between these two analyses, with a change in only one category: the mean age of problematic boy/girlfriends increased by one year using the second method.

3.2.2 DRINKING PATTERN

Respondents consistently reported that the problematic family drinker in their lives commonly drank heavily, with reports of consumption averaging around 11 to 14 drinks about three to five times a week (see Table 3.4). There was little apparent (and no significant) difference between relationship types in the number of drinks that respondents reported these problematic family drinkers were drinking. For example, spouses, siblings and boyfriends/girlfriends all drank an estimated 13 standard drinks in heavy drinking sessions. This suggests that regardless of relationship type, this level of drinking by family members and intimate partners appears to be problematic for respondents.

Table 3.4 Drinking patterns of problematic family drinkers

	THE AVERAGE NO. OF DAYS PER WEEK THE PFD IS DRINKING 5+ STANDARD DRINKS [CIs]	THE AVERAGE NUMBER OF STANDARD DRINKS THE PFD DRINKS IN A HEAVY DRINKING SESSION [CIs]
Relationship type—family member		
Spouse/partner (n = 76)	3 [2, 4]	13 [11, 14]
Parent (n = 65)	4 [4, 5]	11 [9, 12]
Sibling (n = 85)	4 [4, 5]	13 [11, 14]
Child (n = 85)	3 [3, 4]	12 [11, 14]
Ex-partner (n = 52)	4 [3, 5]	12 [10, 14]
Boyfriend/girlfriend (n = 15)	3 [2, 5]	13 [10, 17]
Other relative (n = 68)	5 [4, 5]	14 [13, 16]
Subtotal family members (n = 446)	**4 [4, 4]**	**13 [12, 13]**
Family member in the household (n = 125)	3 [3, 4]	13 [12, 14]
Family member not in the household (n = 321)	4 [4, 5]	12 [12, 13]

Note: n = 446; 95% CIs = Confidence Intervals

3.2.3 EXTENT OF HARM

The 446 respondents reporting most harm from a problematic family drinker were also asked the extent to which they were harmed by that drinker including whether they had been affected "a lot," "a little," or "not at all" by the drinking of that person. Table 3.5 shows the percentages of these respondents that reported being affected "a lot" by the relationship of the problematic drinker to them. Respondents were most likely to report that they were affected "a lot" by their ex-partners', children's and partners' drinking. Females were significantly more likely than males to report that they had been affected "a lot" by spouse/partner and child relationships and family relationships overall both within and outside the household.

Table 3.5 Respondents affected "a lot" by a problematic family drinker

	MALE		FEMALE		TOTAL	
	"A LOT"		"A LOT"		"A LOT"	
	n	%	n	%	n	%
Relationship type—family member						
Spouse/partner	16	6	60	48	76	36***
Parent	19	18	46	38	65	31
Sibling	28	34	57	31	85	32
Child	23	15	62	48	85	38**
Ex-partner	17	22	35	52	52	41
Boyfriend/girlfriend	5	0	10	33	15	24
Other relative	19	24	49	36	68	32
Subtotal all family members (n = 446)	**127**	**21**	**319**	**41**	**446**	**34*** **
Family member in the household	31	13	94	45	125	34***
Family member not in the household *	96	24	225	39	321	34***

Note: n = 446; Difference by gender in 'harmed a lot from family members' is tested for significance with Chi-square (χ^2) tests, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

% The percentage of respondents most negatively affected by this relationships who reported that they had been negatively affected "a lot" (compared to "a little" or "not at all").

Less than 5 per cent of respondents reported they "could not say" how much this drinking had negatively affected them, these respondents have been excluded from this table.

3.2.4 TYPES OF HARMS EXPERIENCED

In addition to information about the level of harm experienced because of the problematic family drinker's drinking, respondents were asked a series of questions concerning whether specific problematic events had occurred or conditions had prevailed in the last year due to the drinking of that person. Table 3.6 provides a breakdown of the ways in which respondents had been negatively affected by the drinking of the problematic family drinker, by respondent's gender and whether they lived with the drinker or not. Ten items were asked of all these respondents, and an additional four items asked only of respondents who indicated they resided in the same household as the person whose drinking had most negatively affected them.

Among the 446 respondents, the most commonly reported harm from the problematic family drinker was being involved in a "serious argument that did not involve physical violence" (63 per cent). Almost three-quarters (74 per cent) of those who lived with the problematic family drinker reported a serious argument. This harm was also common amongst those affected by the dividing of non-household problematic family drinkers.

The majority (66 per cent) of the 446 respondents also reported that that they had been "emotionally hurt or neglected" because of their family member's or intimate partner's drinking, and that that person's drinking "had negatively affected a social occasion" (65 per cent). A larger percentage of female (56 per cent) than male respondents (43 per cent) reported that the problematic family drinker had "failed to do something they were being counted on to do" because of their drinking, regardless of whether they lived

with this family member (57 per cent for females compared to 39 per cent for males) or not (51 per cent for females compared to 41 per cent for males). More than two in five respondents (43 per cent) not living with the problematic family drinker reported that they "stopped seeing" the drinker (suggesting that it was easier for respondents to stop seeing the drinker if they did not live with them, although a proportion of this group may have previously lived with the respondent and be describing a permanent change). Twenty-seven per cent of respondents reported "feeling threatened" as a result of the family member's drinking, but only small percentages reported being physically hurt, being put at risk in a car or being forced or pressured into sex.

Within households, women were more likely than men to report that the problematic family drinker's drinking had negatively affected them in each of the specified ways, with the exception of two harms: "did you have to stop seeing them" (16 per cent vs 12 per cent) and "did they negatively affect a social occasion" (58 per cent versus 53 per cent). Over 90 per cent of men and women who felt they were adversely affected by a family member's drinking reported at least one of these specific effects. Interestingly, respondents tended to be more likely to report at least one of these harms if they were describing the behaviour of a family member outside rather than within the household (94 per cent versus 89 per cent).

Table 3.6 Harms experienced due to the drinking of the problematic family drinker, by gender and household status

CONCRETE HARMS EXPERIENCED BY RESPONDENTS	HOUSEHOLD			NON-HOUSEHOLD			TOTAL		
	MALE %	FEMALE %	TOTAL %	MALE %	FEMALE %	TOTAL %	MALE %	FEMALE %	TOTAL %
(n)	(31)	(94)	(125)	(96)	(225)	(321)	(127)	(319)	(446)
Did you have a serious argument that did not include physical violence	74	75	74	62	57	59	65	63	63
Did you feel threatened	19	30	27	27	27	27	25	28	27
Were you emotionally hurt or neglected	52	76	71	57	66	64	56	70	66
Were you physically hurt by them	<5	7	6	5	6	6	5	7	6
Did you have to stop seeing them	16	12	13	39	41	43	34	34	34
Were you put at risk in the car when they were driving	<5	6	6	5	<5	<5	5	<5	<5
Were you forced or pressured into sex/ something sexual	<5	5	5	<5	<5	<5	<5	<5	<5
Did they negatively affect a social occasion you were at	58	53	54	65	70	69	63	65	65
Did they fail to do something they were being counted on to do	39	57	53	41	51	52	43	56	52
Did they break or damage something that mattered to you	10	23	20	14	15	15	13	17	16
Could you not bring friends home	<5	22	18				13	25	22
Did they not do their share of work around the house	26	45	40				35	45	42
Did you have to leave home and stay somewhere else	10	16	14				17	21	20
Was there less money for household expenses	16	36	32				31	40	37
Total – experienced at least one specific harm	**82**	**89**	**89**	**94**	**95**	**94**	**92**	**93**	**92**

Note: n = 446; Respondents who reported that they did not live with the drinker who had most negatively affected them were only asked about the first 10 harm items.

Respondents reported that they were generally harmed in similar ways, regardless of their relationship with the problematic family drinker with some exceptions (see Table 3.7). For example, "stopped seeing" the drinker was most commonly reported by respondents who were most negatively affected by an ex-partner (64 per cent), parent (49 per cent) or sibling (47 per cent), whereas only 11 per cent of respondents who were most negatively affected by a partner's drinking reported this item. Overall, respondents were more likely to report they were harmed in almost all of these ways by ex-partners and partners than by other relationships.

Table 3.7 Harms experienced due to the drinking of the problematic family drinker, by family relationship

CONCRETE HARMS EXPERIENCED BY RESPONDENTS	PARTNER %	EX-PARTNER %	PARENT %	SIBLING %	CHILD %
(n)	(76)	(52)	(65)	(85)	(85)
Did you have a serious argument that did not include physical violence	78	76	68	59	56
Did you feel threatened	33	44	23	26	22
Were you emotionally hurt or neglected	78	73	63	69	60
Were you physically hurt by them	7	<5	<5	<5	15
Did you have to stop seeing them	11	64	49	47	18
Were you put at risk in the car when they were driving	11	7	<5	<5	<5
Were you forced or pressured into sex/ something sexual	10	10	0	0	0
Did they negatively affect a social occasion you were at	63	70	68	72	45
Did they fail to do something they were being counted on to do	45	66	31	61	60
Did they break or damage something that mattered to you	16	23	6	10	21
Total – experienced at least one specific harm	**94**	**97**	**95**	**97**	**86**

Note: n = 446.

3.2.5 ESTIMATES OF HARM FROM FAMILY MEMBERS' DRINKING

Table 3.8 includes information on all those respondents affected most by family members' drinking and uses the total 2008 HTO Survey sample as the baseline. The figures have been extrapolated to provide estimates of the Australian population affected.

Table 3.8 Harm because of a problematic family drinker – Australian estimates extrapolated from 2008 HTO Survey data

	FAMILY HARM	
Survey respondents (n = 2,649)	**(n)**	**%**
No	2,203	84
Yes	446	17
Negatively affected "a lot"	224	8
Population level estimates (2008)[a]		
Negatively affected "a lot" or "a little"		2,791,964
Substantial harms ("a lot")		1,300,727

[a] The Australian population for age 18-years and above was 16,423,316 in 2008 (Australian Bureau of Statistics 2008).

3.3 CONCLUSION

In 2008, an estimated 2,791,964 Australians (17 per cent of the adult population) were negatively affected "a lot" or "a little" by a family member or intimate partner's drinking. This number includes an estimated 1,300,727 Australians who were substantially negatively affected ("a lot") by that person's drinking.

Of the 446 respondents in the 2008 HTO Survey who reported that a family member's or intimate partner's drinking had affected them most:

- Twenty eight per cent named a named a current or ex-spouse/partner, 14 per cent a parent, 19 per cent a child, 20 per cent a sibling, 17 per cent another relative, and three per cent indicated a boyfriend or girlfriend was responsible.

- Thirty four per cent lived in the same household as the drinker.

- Women (41 per cent) were more likely to report that they had been negatively affected "a lot" by the family member's drinking than men (21 per cent).

- Ninety two per cent reported experiencing one or more incidents of specific harm: being emotionally hurt or neglected (66 per cent), having a social occasion negatively affected (65 per cent) and being involved in a serious argument (63 per cent) because of a family member's drinking were the three most common specified harms reported.

4 EFFECTS OF OTHERS' DRINKING ON CHILDREN: 2008 HTO SURVEY FINDINGS

Anne-Marie Laslett and Heng Jiang

4.1 INTRODUCTION

This chapter draws on and adds to the reported data from the 2008 HTO Survey (Laslett et al. 2010), examining in detail a range of problems carers report their children experiencing because of others' drinking. In the 2010 HTO Report (Laslett et al. 2010), the percentage of children that had been affected by others' drinking was contained in a single table. That information is included here but has been expanded upon as one of the major foci of this report. The baseline here is the 1,142 carers who reported harm to their child/ren. Confidence intervals (in square brackets) have been included to provide an estimate of the variability around the prevalence figures. Chapter 4 continues to address the first of this study's research questions: How common and what are the effects of heavy drinking upon families and children?

In the 2010 HTO Report, the harms to children reported were, in the first instance, based on key markers from response agencies for which statistics were available – Fetal Alcohol Syndrome (FAS), child abuse, child deaths and hospitalisations. The study also used survey responses to measure the prevalence of more widespread harms to children as a result of others' drinking. Respondents who reported either that they lived in a household with children (under 18 years) or that they had responsibility for children but did not live with them (e.g. a father or mother not currently living with the child or children) are termed 'carers'. In response to specific questions about harms children in their families experienced, carers most commonly reported that in the previous 12 months children were yelled at, criticised or verbally abused (8 per cent) because of others' drinking. Smaller percentages reported witnessing serious violence in the home (3 per cent), that children were left unsupervised or in unsafe situations because of others' drinking (3 per cent) or that children were physically hurt because of others' drinking (1 per cent). In response to a more general question in the 2008 HTO Survey, 17 per cent of carers reported that the drinking of other people had negatively affected their child or children "a little" (14 per cent) or "a lot" (3 per cent) in the past year (Laslett et al. 2010).

4.2 HOW WERE CHILDREN AFFECTED BY OTHERS' DRINKING?

Table 4.1 highlights the information provided in the 2010 HTO Report and sums the specific and negative harms carers reported children experiencing. It combines the responses concerning specific harms and the overall judgement and indicates that over one in five carers (22 per cent) reported that their children had been affected in some way.

Interestingly, there was a considerable discrepancy between the listed harms and the response to the general question. This suggests that carers may be concerned by other negative effects aside from the specific items listed in Table 4.1. Some of the other negative effects upon children that carers reported in the 2012 qualitative interviews undertaken for this study are described in Chapter 6.

Table 4.1 Harm to children reported by carers in the 2008 HTO Survey			
	ANY POSITIVE RESPONSE		
	N	%	[95% CIs]
"Because of someone else's drinking how many times in the last 12 months....."			
Were children left in an unsupervised or unsafe situation?	40	3	[2, 5]
Were children yelled at, criticised or verbally abused?	97	9	[7, 11]
Were children physically hurt?	16	1	[1, 2]
Did children witness serious violence in the home?	34	3	[2, 4]
Was a protection agency or family services called?	5	0.3	[0.1, 0.8]
Carers reporting one or more of above	**135**	**12**	**[10, 14]**
"How much has the drinking of other people negatively affected your children/the children you are responsible for?"			
"A lot"	40	3	[2, 4]
"A little"	168	14	[12,16]
Total affected "a lot" or "a little"	**208**	**17**	**[15,19]**
Specifically affected in any way or affected "a lot" or "a little"	**258**	**22**	**[19, 24]**

Note: n = 1,142; The denominator includes respondents in families with children whether within or outside the household.

The figure for the number of positive response in the last row is the any positive response from the four harm, including 'Children were left in an unsupervised or unsafe situation', 'Were yelled out, criticised or verbally abused', 'Children were physically hurt', 'Did children witness serious violence in the home', or overall level of harm, including affected "a lot" or "a little".

Table 4.2 uses the figures in Table 4.1 to produce population estimates. A total of three per cent of carers reported that their children were harmed "a lot" by someone else's drinking. Applying this percentage to the number of Australian families, and multiplying by the average number of children per household, an estimated 142,582 children were harmed "a lot" by others' drinking in 2008. Overall, an estimated 1,045,598 children were affected by others' drinking at least "a little" or in a specific way in the past year.

Table 4.2 Australian population estimate of negative or specific harm to children because of others' drinking	
	CHILD HARM
Number of children negatively affected or affected in specified ways	1,045,598[a]
Number of children negatively affected a lot	142,582[b]

The number of Australian families with children was 2,576,000 in 2006-07, and the average number of children per family was 1.845 according to the Family Characteristics Survey (Australian Bureau of Statistics 2011).

[a]This figure was computed by multiplying the number of Australian families × 0.22 (percentage of children who were harmed negatively or in a specified way) × 1.845 (the average number of children in one family).

[b]This figure was computed by multiplying the number of Australian families × 0.03 (percentage of children who were harmed a lot) × 1.845 (the average number of children in one family).

Table 4.3 focuses upon the frequency of occurrence of specific alcohol-related harms to children, presenting the mean and median number of incidents reported by those who reported any harm of that type. Thus, according to the 40 carers who reported their children had been left unsupervised, this occurred an average of five times in the previous 12 months, and half of this group experienced this two or more times. A child or children being yelled at, criticised or verbally abused – the most common type of harm reported (9 per cent) – occurred an average of 14 times over the year.

The median figures suggest that a majority of the children who do experience specific harms from others' drinking only experience these harms once or twice a year. The average numbers presented are skewed by the high incidence of harms to children reported by a few respondents.

Table 4.3 Number, percent, mean and median of specific alcohol-related harms to children and overall frequency of these harms reported by carers

	n	%	MEAN	MEDIAN
Unsupervised	40	3	5.3	2
Verbally abused	97	9	13.7	2
Physically abused	16	1	3.7	2
Domestic violence exposure	34	3	3.2	1
Sum of specific harms	**135**	**12**	**12.4**	**3**

Note: n = 135

Table 4.4 includes only those carers who reported they have children in the household, and indicates that respondents were statistically significantly more likely to report that their children had been affected by others' drinking in any way if they had older children (13 to 17 years) than if they had children in the younger age group (0 to 12 years). However, for the specific measures of harm, the differences in prevalence between these age groups were not significant (i.e. the confidence intervals overlapped). There was also no statistically significant difference by age in the subjective judgements of whether carers' children had been affected "a lot" or "a little" (although these differences approached significance).

Table 4.4 Harms to children reported by carers with children aged under 12 years only, 13-17 years only, and in both age groups (numbers and percentages)

ANY POSITIVE RESPONSE	CHILDREN UNDER 18 IN THE HOUSEHOLD					
	CHILDREN AGED 0-12 ONLY		CHILDREN AGED 13-17 ONLY		CHILDREN AGED BOTH 0-12 AND 13-17	
Specific harms	**n=580**	**% [95% CIs]**	**n=241**	**% [95% CIs]**	**n=214**	**% [95% CIs]**
"Because of someone else's drinking how many times in the last 12 months were children....."						
Unsupervised	17	2 [1, 4]	12	5 [3, 9]	7	2 [1, 6]
Verbally abused	40	7 [5, 9]	24	11 [7, 16]	23	11 [7, 16]
Physically abused	7	1 [1, 2]	5	1 [0.4, 3]	<5	1 [0.3, 6]
Exposed to domestic violence	14	2 [1, 4]	5	2 [1, 4]	6	2 [1, 4]
Carers reporting one or more of above	**56**	**13 [11, 17]**	**34**	**21 [16, 27]**	**31**	**16 [11, 21]**
"How much has the drinking of other people negatively affected your children/the children you are responsible for?"						
"A lot"	14	2 [1, 4]	15	6 [3, 9]	7	3 [1, 7]
"A little"	72	11 [9, 14]	43	15 [11, 21]	31	13 [9, 18]
Total affected "a lot" or "a little"	**86**	**13 [11, 17]**	**58**	**21 [16, 27]**	**38**	**16 [11, 21]**
Specifically affected in any way or affected "a lot" or "a little"	**107**	**17 [14, 20]**	**73**	**28 [22, 35]**	**52**	**22 [17, 29]**

Note: n=1035; The total denominator for percentages is 1,035 and includes all respondents in families with children in the household. A small number of cases (n=10) are missing because the age of the children was not specified.

Overall, carers with children in the household were not significantly more or less likely to report that their children had been affected by others' drinking than those whose children were not in the household. However, carers with children both in and out of the household were more likely to report that their children had been affected by one or more specific types of harm (Table 4.5). This group of carers was more likely to report that their children had been verbally abused because of others' drinking than those carers with children in the household only (21 per cent versus 7 per cent). Somewhat counter-intuitively, carers with children outside the household were more likely to report that their children witnessed violence in the home because of others' drinking than those with children in the household (10 per cent versus 2 per cent). However, this may be a reflection of a carer's decision to leave a household or the complexities associated with split families where problematic alcohol use is a factor.

Table 4.5 Harms to children reported by the carers that have children living in the household only, children not living in the household only and that have both children living with and not with them

	CHILDREN IN HOUSEHOLD			CHILDREN NOT IN HOUSEHOLD			CHILDREN BOTH IN AND NOT IN HOUSEHOLD		
	n=957	%	% [95% CIs]	n=107	%	% [95% CIs]	n=78	%	% [95% CIs]
"Because of someone else's drinking how many times in the last 12 months were children....."									
Unsupervised	29	3	[2, 4]	4	6	[2, 16]	7	7	[3, 14]
Verbally abused	71	7	[6, 10]	10	10	[6, 20]	16	21	[13, 33]
Physically abused	11	1	[1, 2]	2	2	[0.4, 8]	3	3	[1, 2]
Exposed to domestic violence	18	2	[0.1, 3]	9	10	[5, 19]	7	3	[2, 4]
Carers reporting one or more of above	**98**	**10**	**[8, 13]**	**14**	**14**	**[8, 24]**	**23**	**27**	**[17, 39]**
"How much has the drinking of other people negatively affected your children/the children you are responsible for?"									
"A lot"	27	2	[2, 4]	4	4	[2, 10]	9	11	[6, 22]
"A little"	129	12	[10, 15]	22	23	[15, 34]	17	20	[12, 31]
Total affected "a lot" or "a little"	**156**	**15**	**[12, 17]**	**26**	**27**	**[19, 38]**	**26**	**31**	**[21, 43]**
Specifically affected in any way or affected "a lot" or "a little"	**197**	**19**	**[17, 22]**	**26**	**27**	**[19, 38]**	**35**	**40**	**[28, 52]**

Note: The denominator is 1,142 and includes those carers in families with children in or out of the household.

4.3 WHICH RELATIONSHIPS AFFECTED CHILDREN?

Table 4.6 describes which relationships were reported to be responsible for harms to children, as described by the 135 carers who reported that their child or children had been negatively affected in one of the specified ways.[3] Almost half (46 per cent) of the carers who reported that their child had been negatively affected by others' drinking identified that the drinker's relationship to the child was a parent (n = 58), step-parent or the carer's partner or ex-partner (n = 8), or the child's guardian (n = 2). As carers could report more than one type of harm, the total number of alcohol-related harms due to the drinking of someone in a parental or quasi-parental relationship with the child reported in the year prior to survey completion is 101.

Of the carers who reported children having been negatively affected, 12 per cent reported that their children were negatively affected by the drinking of siblings and 15 per cent reported that they were affected by other family members and relatives. Fifteen per cent of carers reported that their children were affected by family friends or people their child was in contact with, such as a coach, teacher or priest, and 12 per cent reported that they had been affected by unspecified others. A small number of carers (3) reported that their children had been affected by more than one relationship.

Around half (51 per cent) of the incidents of harms to children from all relationship types were forms of verbal abuse, with this figure varying from 46 per cent for 'other' relationships to 56 per cent for siblings. Reports of children being physically hurt were also more common when the drinker was a sibling than for other relationships.

[3] Respondents in the 2008 survey were not asked questions which allowed for the possibility that their own drinking had negatively affected their children. Only respondents who reported that their children had been negatively affected in one of the specific ways listed were asked about the relationship of the drinker to the child who was harmed.

In Table 4.6, the ratio (X/Y) represents how many harms carers reported on average by relationship type. As can be seen, the average number of harms reported was similar across the relationship types, with the average number of harms ranging from 1.2 for 'other relative' to 1.5 for 'parent-like' and 'other' relationships. The average number of types of harms reported to be because of parents' and others' drinking was slightly higher than the average number reported to be because of the drinking of siblings, other relatives or family friends.

Table 4.6 Specific alcohol-related harms to children by relationship of drinker, and percentage of harms attributed to each relationship

RELATIONSHIP	PARENT-LIKE[a]	SIBLINGS	OTHER RELATIVE	FAMILY FRIEND	OTHER	ANY
(n carers) Y	(68)	(12)	(19)	(25)	(14)	(135[b])
% of carers	46	12	15	15	12	100
(n types of harm reported)[#] X	(101)	(18)	(23)	(31)	(22)	(195)
"Because of someone else's drinking how many times in the last 12 months were children....."						
	%	%	%	%	%	%
Verbally abused	52	56	48	52	46	51
Exposed to domestic violence	17	11	30	10	23	17
Unsupervised	21	17	17	26	23	21
Physically abused	7	17	0	13	9	8
Were child protection/family services called?	4	0	4	0	0	3
Ratio X/Y	**1.5**	**1.5**	**1.2**	**1.2**	**1.6**	**1.4**

Notes: n=195 (this is the number of harms reported, not the number of respondents).

[a] Parent like includes parent (n=58), step-parent, and spouse or partner or ex-partner (n=8) of the child's parent, or the child's guardian (n=2).

[b] Three carers reported their children were harmed by other's drinking from two types of relationships.

[#] The number of specific types of harm (Note: this is not the frequency of harm. For example, if a carer reported verbal harm and physical harm from a carer they are included once in the n carers cell and twice in the n types of harms cell, regardless of the number of times they reported the child was verbally or physically harmed).

4.4 REPORTING OF HARM TO ONE'S SELF AND ONE'S CHILDREN

Chapters 3 and 4 describe how respondents themselves were harmed by problematic family drinkers' drinking and whether children were harmed. This section of the report explores the extent of overlap between these elements – how respondents report both their children and themselves have been harmed.

Table 4.7 presents more detailed information on a subset of families and indicates that 219 (92 + 127) or 15 per cent of carers from the 1,130[4] families with children reported that they themselves had been adversely affected "a lot" or "a little" by another family member's drinking. This table also shows that 109 (13 + 96) carers reported that a child in their family had been adversely affected "a lot" or "a little" (but they themselves had not been), and that 120 (35 + 85) carers had been affected but their children had not been. A total of 99 carers (27 + 72) reported that they and a child in their family had been affected by other family members' drinking. Overall, 27 per cent or 328 (109 + 120 + 99) of the 1,130 carers from these families with children were either adversely affected by the drinking of a family member, or were responsible for a child who was negatively affected by others' drinking, or both.

Table 4.7 Cross tabulation of harm to respondent and harm to children, among respondents caring for children (2008 HTO survey)

HARM FROM FAMILY	CHILDREN NEGATIVELY AFFECTED					
RESPONDENT NEGATIVELY AFFECTED	"A LOT"	"A LITTLE"	SUBTOTAL ("A LOT" OR "A LITTLE")	"NOT AT ALL"	TOTAL	%
"A lot"	25	32	55	35	92	7
"A little"	2	40	42	85	127	10
Subtotal (affected)	27	72	99	120	219	17
Not at all	13	96	109	802	911	82
Total	**40**	**168**	**208**	**922**	**1,130**	**100**

Note: n = 1,130

Examining these data differently, of the 219 carers who reported they themselves were harmed by a family member, 99 carers (44 per cent) reported that their children were also harmed. Of the 208 carers who reported that their children were harmed, 99 (46 per cent) reported that they themselves had also been harmed. There was a statistically significant relationship between harm to the carer from a family member's drinking and harm to children ($\chi^2(_1)$ = 129.8, p < 0.001). If a family member's drinking had negatively affected the carer, the odds of reporting harm to children were almost six times the odds of reporting harm to children as if carer did not report being harmed (OR = 6.35, CIs [4.39, 9.18]). However, there was no statistically significant relationship between carers reporting "a lot" of harm from a family member and carers reporting that their children had been harmed "a lot" by others' drinking (although numbers are small in these cells for comparison).

The highlighted cells in Table 4.8 illustrate that in over two-thirds (69 per cent) of the cases where both the carer and the child were negatively affected "a lot" or "a little" it is likely to be a person of the same relationship type within the household that is affecting the child and most affecting the carer. However, this may be an overestimate of overlap: for example, the drinking of a current spouse may be affecting the carer and the drinking of an ex-spouse may be affecting the child or vice versa. There are also multiple children/siblings in many families and not all respondents identified which relationship had affected the child.

[4] Total does not equal 1,142 because 12 people could not say whether they had been affected or not.

Table 4.8 Relationship of persons whose drinking affected the child and the carer				
HARM FROM FAMILY	**CHILDREN NEGATIVELY AFFECTED BY**			
RESPONDENT NEGATIVELY AFFECTED	**CARER[a]**	**SIBLING**	**RELATIVES**	**TOTAL**
Spouse, partner or ex-partner	25	1	2	28
Children	5	5	1	11
Relatives	7	1	7	15
Total	**37**	**7**	**10**	**54**

Note: n = 54; [a] Carer includes parent, step-parent, and spouse or partner or ex-partner of the child's parent.

Table 4.9 includes information on all those affected (or whose children were affected) by family members' drinking and uses the total sample n = 2,649 as the baseline. These figures have been extrapolated to provide estimates of the Australian population affected. Overall, 22 per cent of all respondents in the 2008 HTO Survey reported that they themselves or a child in their family had been affected by others' drinking. This finding is equivalent to an estimated 3,613,130 Australian adults being affected by a family member's drinking or reporting that their child had been affected by other's drinking. Furthermore, around four per cent of all respondents (equivalent to an estimated 706,202 Australian adults) reported that both they and one or more children in their families had been affected by others' drinking.

Table 4.9 Population estimates of harm to carers and children due to a family member's drinking						
	FAMILY HARM		**EITHER CHILDREN OR FAMILY HARM**		**BOTH CHILDREN AND FAMILY HARM**	
	n	**%**	**n**	**%**	**n**	**%**
No	2,203	84	2,068	78	2,526	96
Yes	446	17	581	22	123	4
Negatively affected "a lot"	224	8	234	8	30	1
Population estimates	**n**		**n**		**n**	
Negatively affected "a little" or "a lot"	2,791,964		3,613,130		706,202	
Negatively affected "a lot"	1,300,727		1,369,705		154,379	

Note: n = 2,649

4.5 CONCLUSION

This chapter of the report underlines that:

- One in five carers (22 per cent) reported that their children had been affected in some way by others' drinking in the last year.
- Twelve per cent of carers reported that their children were verbally abused, left in an unsupervised or unsafe situation, physically hurt or exposed to domestic violence because of others' drinking in 2008.
- The harm children are reported to have experienced is most often verbal abuse and described as "a little" harm rather than "a lot."
- Among respondents who reported that their children were affected, the median number of times their children were affected in the last 12 months was three.
- Overall, respondents were more likely to report that older children experienced harm of any type than younger children.
- Respondents with responsibility for children both within and outside their households were more likely to report harm of any type to their children than respondents with children within their household only.

Almost half (46 per cent) of the 135 respondents whose children had been affected in one or more of the specified ways reported that a child in the family was affected by the drinking of their parent, step-parent, or the carer's partner or ex-partner, or the child's guardian. Twelve per cent of respondents also reported that their children were negatively affected by the drinking of siblings, and 15 per cent reported that they were affected by other family members and relatives. Fifteen per cent of carers reported that their children were affected by family friends or people their child was in contact with, such as a coach, teacher or priest, and 12 per cent reported that they had been affected by unspecified others. A small number of respondents reported that their children had been affected by more than one relationship.

The final section of this chapter described the substantial overlap between harms to children and to the respondent:

- Twenty-two per cent of all respondents in the 2008 HTO Survey (equivalent to an estimated 3,613,130 Australian adults) reported that they themselves or a child in their family had been affected by others' drinking.
- Furthermore, around four per cent of all respondents (equivalent to an estimated 706,202 Australian adults) reported that both they and one or more children in their families had been affected by others' drinking.

5 STABILITY AND CHANGE IN ALCOHOL'S HARMS TO FAMILIES AND CHILDREN OVER TIME

Anne-Marie Laslett, Heng Jiang, Sarah Callinan

5.1 INTRODUCTION

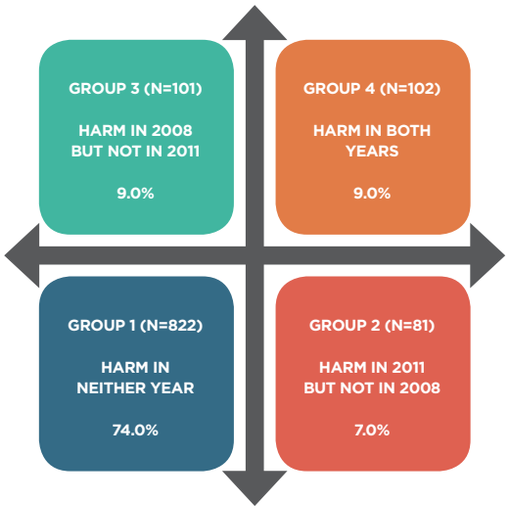
In 2011 a follow-up study of those interviewed in the 2008 HTO Survey was conducted to examine factors predicting whether the effects of others' drinking were transient or persistent. These results were published in *Beyond the drinker: Longitudinal patterns in alcohol's to others* (Laslett et al. 2015). This chapter focuses on answering the research question: To what extent do the effects upon children and families persist or change over time? The first consideration is the effects upon an adult family member (i.e. the respondent) and then effects reported by carers on the children in their families are examined.

5.2 HOW FAMILIES WERE AFFECTED BY OTHERS' DRINKING IN THE HTO SURVEYS

Figure 5.1 describes how respondents' experience of harm from a problematic family drinker changed (or did not change) between 2008 and 2011. The problematic family drinker responsible for any harm reported in 2011 may or may not be the same individual identified in 2008.

The majority of respondents (74 per cent) reported that they were not harmed by family members' drinking at either time point. Nine per cent of respondents reported in both surveys that they had been negatively affected by family members' drinking. Seven per cent of respondents reported new harms in 2011 because of family members' drinking, nine per cent of respondents reported that the problems they experienced in 2008 were no longer while present.

Figure 5.1 Persistence, initiation and discontinuation of harm from family members' drinking between 2008 and 2011 HTO Surveys (n = 1,106)



Another way to look at this is to say that 50 per cent of respondents (102/203) harmed by a family member's drinking in 2008 reported they were also, or still, being harmed by the drinking of a family member in 2011. The incidence of new cases of harm (initiation) in 2011 was nine per cent (81/903).

As Table 5.1 shows, there were significant differences in patterns of harm over time according to the gender of the respondent. For instance, 81 per cent of males did not experience harm from a family member in either year, compared to 70 per cent of females. Eleven per cent of females experienced persistent harm in both years, whereas harm persisted for only six per cent of males.

Multivariate logistic regression was used to test whether individual respondent characteristics in Table 5.1[5] (e.g., gender, after adjusting for the other variables in the models) predicted the experience of the four

[5] Odds ratios not shown in Table 5.1

harm outcomes (i.e. absence of harm, initiation, discontinuation and persistence of harm). Apart from gender, there were no significant differences between the four groups in terms of socio-demographic characteristics in the reporting of harms to respondents from a family member's drinking. With regard to gender, women were significantly more likely to report initiation, discontinuation and persistence of harm from a family member's drinking than men.

Table 5.1 Percentage of respondents reporting alcohol-related harms from family members by socio-demographic characteristics (percentaged across in four right-hand columns)

VARIABLES	N IN SUB-SAMPLE	NEITHER YEAR (ABSENCE)	2011 ONLY (INITIATION)	2008 ONLY (DISCONTINUATION)	BOTH YEARS (PERSISTENCE)
(n)	(1,106)	(822)	(81)	(101)	(102)
Gender of respondents					
Male	485	81	6	7	6
Female	645	70***	8**	11*	11**
Age 2008[a]					
18-35	119	75	7	11	8
36 and over	987	74	7	9	9
Neighbourhood affluence[b]					
Disadvantaged	561	74	7	10	9
Less disadvantaged	541	75	7	8	10
Household status 2008[c]					
Single parent and children	222	73	9	11	8
2 Carers and children	334	73	6	10	11
Other household	550	76	8	8	9
Respondent drinks 5+ at least monthly in the past year - 2008					
Yes	270	73	8	8	11
No	836	75	7	10	9
Respondent drinks 5+ at least monthly in the past year – 2011					
Yes	246	74	9	7	11
No	860	75	7	10	9

Notes: n = 1,106; *p < 0.05, **p < 0.01, ***p < 0.001

Multivariate logistic regressions were conducted for each subcategory of harm, e.g. absence, initiation, etc. enabling the comparison of the presence of harm with absence of harm (e.g. initiation versus not harmed). Harm in neither year was compared with harm in any year. Initiation was compared with absence of harm. Discontinuation was compared with persistent harm and persistent harm was compared with no harm.

[a] Age collapsed to two categories in this table because of small numbers.

[b] The measure of neighbourhood affluence in this study is based on the Socio-Economic Indexes for Areas (SEIFA) which measures how disadvantaged an area is compared with other areas in Australia (ABS, 2006) and allocates a score for each postcode. Neighbourhood affluence is measured on a scale of 1 to 5, where 1 is the most disadvantaged and 5 is the least disadvantaged. Here, the scale was recoded into two groups of roughly equal size, low affluence (score of 1-3) and high affluence (score of 4-5, used as the reference category).

[c] Single parent and two-carer families include children under 18 years within and outside the household.

5.2.1 PREDICTING HARM TO RESPONDENTS FROM FAMILY MEMBERS IN 2011

Bivariate and multivariate logistic regression models predicting harm from family members are shown in Table 5.2. The analyses presented here use harm to respondents from family members in 2011 as a dichotomous (yes/no) outcome variable, with harm to respondents from family members in 2008 included as a predictor variable along with socio-demographic characteristics and drinkers in the respondent's social circle as predictors of harm to respondents from family members.

As the bivariate results demonstrate, respondents reporting harm from problematic family drinkers in 2008 were ten times more likely to report the same type of harm in 2011 than those who did not. Females were more likely to report harm from family members' drinking than males. Age was not significantly associated with reports of being adversely affected by family members, but the number of household heavy drinkers

and the number of non-household relatives, girlfriends, boyfriends and ex-partners of the respondent who were heavy drinkers in 2008 were each positively related with harm in 2011, as was an increase in the number of relatives, girlfriends, boyfriends and ex-partners who were heavy drinkers from 2008 to 2011.

In Model 1, in which all the demographic variables are entered, the relationship between gender and harm from family members is no longer significant. The second model, including the respondent's drinking variables and harm from family in 2008, found that an increase in the respondent's weekly number of five plus drinking occasions since 2008 was more important than his/her baseline consumption in predicting harm from family members. In Model 3, the number of household and non-household relatives, girlfriends, boyfriends and ex-partners who were heavy drinkers in 2008 and an increase in these two groups were significant positive predictors of harm in 2011, even after harm in 2008 was controlled for.

In Model 4, including all the variables, harm in 2008, higher numbers of household and non-household heavy drinkers and an increase in these categories between the two time points were all significant positive predictors of an increased chance of reporting harm from family members in 2011. In Models 3 and 4 the baseline number and changes over time in the number of household and non-household heavy drinkers in the respondent's life were significantly and strongly predictive of harms from family members in 2011. The inclusion of these variables weakened the relationship between harm in 2008 and harm in 2011. The three strongest predictors of harm were the number of heavy drinkers in the respondent's household at baseline, increase in the number of household heavy drinkers and whether the respondent had previously experienced harm. These findings provide the strongest evidence that respondents were significantly affected by family members in their social milieu.

Table 5.2 Harm to the respondent from family members within and outside of the household in 2011

	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Harm from family in 2008					
No	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)
Yes	10.25***	10.08***	10.52***	5.55***	5.94***
Respondent gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	1.74**	1.39			1.49
Respondent age					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36 and over	1.21	1.29			1.66
Neighbourhood affluence					
Disadvantaged	1 (Ref)	1 (Ref)			1 (Ref)
Less disadvantaged	1.04	1.07			1.13
Respondent 5 plus drinks per occasion in 2008 (continuous variable)	1.03		1.11		0.98
Respondent 5 plus drinks per occasion difference[a] (continuous variable)	1.16		1.26*		1.16
Household heavy drinkers	3.95***			7.49***	7.40***
RGBE[b] heavy drinkers	1.93***			4.28***	4.01***
Friends heavy drinkers	1.04*			0.96	0.98
Coworker heavy drinkers	1.03*			0.98	1.00
Household heavy drinkers difference[a]	1.42			6.97***	7.11***
RGBE[b] heavy drinkers difference[a]	1.87***			5.03***	4.93***
Friends heavy drinkers difference[a]	1.01			0.96	0.97
Coworker heavy drinkers difference[a]	0.97*			0.94	0.96

Notes: n = 1,106; *p < 0.05, **p < 0.01, ***p < 0.001

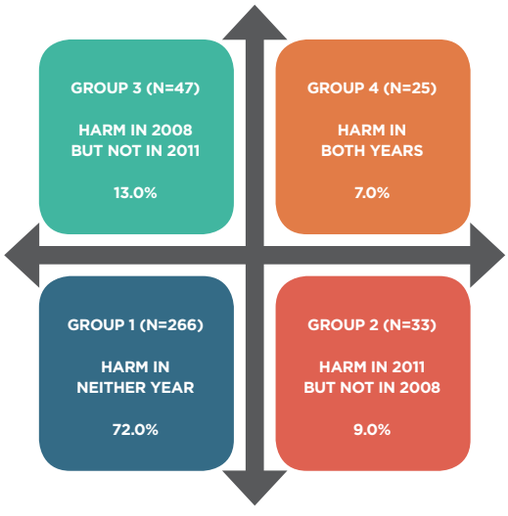
[a] Difference scores = 2011 value – 2008 value for each variable.

[b] RGBE = Relatives, girlfriends, boyfriends and ex-partners not living with the respondent.

5.3 HOW CHILDREN WERE AFFECTED BY OTHERS' DRINKING

Figure 5.2 describes how respondents reported that children in their families had been harmed in 2008 and 2011 and how these experiences changed over this time. The majority (72 per cent) of respondents who lived with or were responsible for children in both 2008 and 2011 (n = 371) reported that their children were not harmed by others' drinking at either point. Seven per cent of these respondents reported in both surveys that a child or children in their family had been negatively affected by others' drinking. Nine per cent of respondents reported new problems for their children in 2011 because of others' drinking, while 13 per cent of respondents reported that the problems experienced in 2008 were no longer present, with the situation improving more often than not.

Figure 5.2 Persistence, initiation and discontinuation of harm to children from others' drinking between 2008 and 2011 HTO Surveys (n = 371)



Note: n = 371, including all respondents who lived with or were responsible for children in both 2008 and 2011.

Another way to look at this is to say that 35 per cent of respondents (25/72) with children being harmed by others' drinking in 2008 reported children were also, or still, being harmed by the drinking of others in 2011. Conversely, 65 per cent of respondents (47/72) with children being harmed by others' drinking in 2008 reported that they were no longer being harmed by the drinking of others in 2011. The incidence of new cases of harm in 2011 was 11 per cent (33/299).

Table 5.3 shows that three-quarters (74 per cent) of males and 70 per cent of females did not report that a child experienced harm in either year, while equal percentages of females and males (7 per cent) reported that children experienced persistent harm.

Multivariate logistic regression was used to test whether respondent characteristics (e.g. gender) predicted whether children experienced the four harm outcomes (i.e. absence, initiation, discontinuation or persistence of harm). There were no significant differences by socio-demographic characteristics in the turnover in harms to children from others' drinking, using conservative statistical thresholds ($p < 0.05$, Odds ratios not shown in Table 5.3). However, although the differences are not statistically significant (cell sizes are small in the initiation, discontinuation and persistence groups), the data suggest that there may be differences between various household compositions, for example that two-carer families with children may be more likely to report the absence of harm than the rest of the sample, and single parent households may be more likely to report initiation of harm in 2011.

Table 5.3 Percentage of respondents reporting alcohol-related harms to children by socio-demographic characteristics (percentaged across in four right-hand columns)

VARIABLES	N IN SUB-SAMPLE	NEITHER YEAR (ABSENCE)	2011 ONLY (INITIATION)	2008 ONLY (DISCONTINUATION)	BOTH YEARS (PERSISTENCE)
(n)	(371)	(266)	(33)	(47)	(25)
Gender of respondents					
Male	141	74	6	13	7
Female	230	70	10	13	7
Age 2008[a]					
18-35	59	73	7	12	9
36 and over	312	72	9	13	6
Neighbourhood affluence[b]					
Disadvantaged	179	70	10	15	6
Less disadvantaged	190	73	8	11	8
Household status 2008[c]					
Single parent and children	26	58	15	15	12
2 Carers and children	309	74	8	13	6
Other household	36	64	11	11	14
Respondent drinks 5+ at least monthly in the past year - 2008					
Yes	92	63	14	17	5
No	279	75	7	11	7
Respondent drinks 5+ at least monthly in the past year – 2011					
Yes	92	61	13	17	9
No	279	75	8	11	6

Notes: n = 371 (sub-sample of respondents with children in both years).

Multivariate logistic regressions are presented for each subcategory of harm, e.g. absence, initiation, etc. enabling the comparison of the presence of harm to children with absence of harm (e.g. initiation versus not harmed). Harm in neither year was compared with harm in any year. Initiation was compared with no harm. Discontinuation was compared with persistent harm and persistent harm was compared with absence of harm. Significant differences are marked as *.

[a] Age collapsed to two categories in this table because of small numbers.

[b] The measure of neighbourhood affluence in this study is based on the Socio-Economic Indexes for Areas (SEIFA) which measures how disadvantaged an area is compared with other areas in Australia (ABS, 2006) and allocates a score for each postcode. Neighbourhood affluence is measured on a scale of 1 to 5, where 1 is the most disadvantaged and 5 is the least disadvantaged. Here, the scale was recoded into two groups of roughly equal size, low affluence (score of 1-3) and high affluence (score of 4-5, used as the reference category).

[c] Single parent and two-carer families include children under 18 years within and outside the household.

5.3.1 PREDICTING HARM TO CHILDREN IN 2011

Here, a logistic regression model (Table 5.4) is developed with harm to children in 2011 as a dichotomous (yes/no) outcome variable, with harm to children in 2008 included as a predictor variable. This method provides a global overview and enables examination of the existence (or lack) of harm to children in 2008 as a predictor of harm to children in 2011. Thus the starting point (i.e. either child harmed or not harmed) is accounted for, as well as changes in the respondent's (and by assumption the child's) life between 2008 and 2011. Particular attention is paid to the number of heavy drinkers in the respondent's social circle, that is, the number of family members who drink heavily, as well as the number of friends and co-workers of the respondent who drink heavily. By examining the drinking circles of the respondent in this way, one aspect of the environment in which the child is living is examined.

In the 2011 HTO Survey, 58 respondents stated that a child or children in the family had been negatively affected (either "a lot" (n=12) or "a little" (n=46)) as a result of the drinking of others, with the other 313 respondents with children in their care reporting that they had not. Bivariate and multivariate logistic regression models predicting harm to the child are shown in Table 5.4. As the bivariate results demonstrate, respondents reporting harm to children in 2008 were four times more likely to report harm in 2011 than those who did not. The respondent's age was not associated with reports of children being adversely affected. Those who increased the number of times per week they consumed five or more standard drinks in a session between 2008 and 2011 were more likely to report harm to children in 2011. The number of household heavy drinkers and the number of heavy-drinking non-household relatives, girlfriends, boyfriends and ex-partners of the respondent in 2008 were each positively related with harm in 2011, as was an increase in the number of non-household heavy drinkers from 2008 to 2011.

In Model 1, in which all the demographic variables and harm in 2008 are entered as variables, the relationship between age and harm to children remained as it was in the bivariate model. It should be noted that this is not simply a reflection of this group being more likely to have children in the home, as those without children are not included in this model. The second model, including respondents' drinking variables and harm from 2008, found that an increase in the respondent's number of five plus drinking occasions since 2008 was more important than the baseline consumption in 2008 in predicting harm to children. In Model 3, the number of household members and relatives, girlfriends, boyfriends and ex-partners who were heavy drinkers in 2008 and the increase in these two groups were significant positive predictors of harm in 2011, even after harm in 2008 was controlled for.

Finally in Model 4, including all the variables, harm in 2008, increased frequency of respondents' five plus drinking sessions, higher numbers of 2008 household and non-household relatives, girlfriends, boyfriends and ex-partners who were heavy drinkers, and an increase in these categories between the two time points were all significant positive predictors of reporting child harm in 2011. In Models 3 and 4 the inclusion of changes over time in the number of household heavy drinkers and non-household relatives, girlfriends, boyfriends and ex-partners who were heavy drinkers in the respondent's life, as well as status in 2008, were significantly and strongly predictive of harms to children in 2011. The inclusion of these others' drinking variables weakened the relationship between harm in 2008 and harm in 2011. In Model 4, the strongest predictor of harm was the number of heavy drinkers in a respondent's household at baseline, followed by whether a child had previously experienced harm. The next strongest predictor of harm, after the social drinking context variables, was the respondent's own drinking. This model provides the strongest evidence that harm to children from others' drinking is significantly affected by the number of adult heavy drinkers in their household and broader family milieu.

It is interesting that the predictive strength of the past (2008) experience of harm the odds ratio was not as strong in the model predicting harm to children as in the model for harm to the respondent from a family member (Table 5.2), suggesting that continuity in harm to children was less evident. This suggests speculatively that carers are more likely to tolerate the harms they experience themselves because of others' drinking than those they see their children experience.

Table 5.4 Predicting harm to children in 2011					
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Harm to children in 2008					
No	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)
Yes	4.29***	3.90***	4.51***	3.15**	3.18***
Respondent gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	1.31	1.29			1.29
Respondent age					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36 and over	1.04	1.15			1.28
Neighbourhood affluence					
Disadvantaged	1 (Ref)	1 (Ref)			1 (Ref)
Less disadvantaged	1.13	1.57			0.58
Household status 2008					
Single parent and children	1 (Ref)	1 (Ref)			1 (Ref)
Two carers and children	0.43	0.45			0.58
Respondent 5 plus drinks per occasion in 2008 (continuous variable)	0.96		0.90		0.72
Respondent 5 plus drinks per occasion difference[a] (continuous variable)	1.60***		1.61**		1.54*
Household heavy drinkers	2.20**			2.89**	3.30**
RGBE[b] heavy drinkers	1.45**			2.31***	1.63*
Friends heavy drinkers	1.06			0.94	0.99
Coworker heavy drinkers	1.01			0.99	1.00
Household heavy drinkers difference[a]	1.46			2.56**	2.73**
RGBE[b] heavy drinkers difference[a]	1.53*			2.45***	1.91**
Friends heavy drinkers difference[a]	1.05			1.05	1.05
Coworker heavy drinkers difference[a]	0.99			0.98	0.98

Notes: n = 371; *p < 0.05, **p < 0.01, ***p < 0.001;

[a] Difference scores = 2011 value – 2008 value for each variable.

[b] RGBE = Relatives, girlfriends, boyfriends and ex-partners not living with the respondent.

5.4 CONCLUSION

Based on the 1,104 respondents who completed the 2011 HTO follow-up survey in conjunction with the 2008 HTO Survey, the study indicated that:

- Nine per cent of respondents reported that they had experienced persistent harm from family members.
- Twenty six per cent of respondents reported harm from the drinking of family members in at least one of the HTO Surveys.

Examining this from another perspective, among those respondents who reported being harmed by family members in the first survey, 50 per cent were again, or still, being harmed by the drinking of family members in 2011.

According to carers who completed both surveys, children also experienced persistent harm:

- Seven per cent of carers completing the surveys reported that children in their family had been harmed by others' drinking in both years.
- Thirty five per cent of carers whose children were harmed by others' drinking in 2008 reported that children in their family were harmed again, or still, by the drinking of others in 2011.

In the model predicting harm to respondents from family members' and intimate partners drinking, the number of heavy drinkers in the respondent's household in 2008 was the strongest predictor of harm in 2011. In addition, past harm and the number of adult heavy drinkers among their relatives, girlfriends, boyfriends and ex-partners had substantial impact.

This chapter also provides strong longitudinal evidence that past harm and the drinking patterns of others in the carer's household and among their relatives, girlfriends, boyfriends and ex-partners predict whether children experience harms from others' drinking over time. Changes in patterns of the drinking of the respondent over time also played a role in predicting harm to children from others' drinking. The predictive strength of the odds ratio for past harm was not as strong in the model predicting harm to children as in the model for harm to the respondent from a family member, suggesting that continuity in harm to children was less evident, and speculatively that carers may be more likely to tolerate harms to themselves than to their children.

6 QUALITATIVE ANALYSIS OF HARMS TO CHILDREN AND FAMILIES FROM OTHERS' DRINKING

Elizabeth Manton and Sarah MacLean

6.1 INTRODUCTION

This chapter reports qualitative findings about the harms to children and families from drinking, based on in-depth interviews with a subset of HTO Survey respondents. This research explores the nature of the impact of someone else's drinking on family functioning and what resources a responsible adult draws on to deal with these problems in far more depth than is possible through survey research. As outlined in Chapter 4, survey responses were used to measure the prevalence of harms to children as a result of the presence of a problem family drinker. Respondents were asked specific questions about harms children in their families experienced as well as a generic question about the effect of other people's drinking on the child/ren they were responsible for. Many respondents, while not reporting specific harms, did report that children in their family had been negatively affected by others' drinking. This qualitative study provides further opportunity to explore the range of ways in which children and their families have been harmed by others' drinking. The research also sought to understand the available social supports and service responses and to explore their perceived effectiveness.

As described in Chapter 2, this study component comprised 20 in-depth qualitative interviews with survey respondents. Ten interviewees had previously reported that a child within his/her care had been harmed "a lot" and ten reported that a child had been harmed "a little" by another person's drinking. The objectives of the interviews were to explore:

1. the nature and impact of harms to children caused by someone else's drinking as perceived by a parental carer
2. the nature of the impact of someone else's drinking on family functioning, family relationships and parental roles
3. the supports received or not received by family members to deal with the impact of someone else's drinking
4. the social and cultural context of the experience of dealing with the impact of someone else's drinking on the family.

The methodology for this component of the study, including details of participant recruitment and the study sample, is described in Chapter 2.

Table 6.1 summarises the demographic information about the interviewees, including age, gender, education, and occupation.

Table 6.1 Demographic[a] profile of interviewees in qualitative study			
	FEMALES (n=15)	MALES (n=5)	TOTAL (n=20)
Age			
Mean age	49	52	49
Age range	28-70	47-57	28-70
Education			
Degree	3	0	3
Diploma	1	0	1
Associate diploma or certificate	1	0	1
Completed secondary school	2	1	3
Did not complete secondary school	7	3	10
Not known	1	1	2
Occupation[b]			
Professional	3	0	3
Community and personal service workers[c]	5	1	6
Clerical and administrative workers	2	0	2
Sales workers	2	0	2
Machinery operators and drivers	0	2	2
Labourers	2	1	3
Not known	1	1	2

Notes: n = 20.

[a] Demographic information was collected during the qualitative interview.

[b] Occupations are based on the Australian and New Zealand Standard Classification of Occupations.

[c] Includes unpaid care for one's own children for the purposes of this table.

Themes identified through analysis of the interviews are illustrated with quotes from the interviewees. All interviewees have been given a pseudonym, and 'A' or 'B' has been added to the name to indicate whether the respondent had answered "a lot" or "a little," respectively.

The interviewees' statements (presented in italics) are reported verbatim, with clarification questions by the interviewer presented in bold.

6.2 THE NATURE OF HARMS TO CHILDREN

6.2.1 WHO IS HARMING THE CHILDREN?

Table 6.2 summarises the relationship of the person causing harm because of their drinking to the child who is being harmed. Of the 18 respondents who nominated a person known to them whose drinking affected their child/ren, in almost three-quarters of cases the drinker was a man (n = 13). Mostly the man was the child's father (n = 9), but he was also reported to be an adult brother (n = 1), an uncle (n = 1), or a friend of the child's parents (n = 2). In only one case was the drinker, a father, the interviewee himself.

Of the five cases where the drinker causing harm was a woman, it was usually the child's mother (n = 4) but in one case it was an aunt (n = 1). Over the course of an in-depth interview three women who had nominated

a male as the primary drinker affecting their children also identified that their own drinking had adversely affected their children. Including these women (who had all answered that someone's drinking affected their children "a lot") brings the number of cases where the problematic drinker was a woman to eight.

One of the remaining two respondents identified a stranger at a party (unspecified gender) as the drinker who had caused harm, and the other could not identify any individual, despite having answered that their child/ren had been harmed "a little" during the survey.

Table 6.2 Who was causing harm and their relationship to the child/ren

RELATIONSHIP OF DRINKER TO THE CHILD/REN	OVERALL LEVEL OF HARM REPORTED		
	TOTAL	"A LOT"	"A LITTLE"
Father	9	5	4
Mother	4	3	1
Brother	1	1	0
Aunt	1	1	0
Uncle	1	0	1
Male family friend	2	0	2
Stranger at party	1	0	1
No answer	1	0	1
Total	20	10	10

Of those who reported "a lot" of harm to a child/ren, eight of the drinkers responsible were parents, and one was a brother. Only one member of the extended family, an aunt, was identified as the drinker causing "a lot" of harm.

Of those who reported "a little" harm to a child or children, five of the drinkers responsible were parents. One was a member of the extended family (an uncle), but more importantly at least three of the drinkers causing harm were outside the extended family (i.e. either family friends or strangers).

6.2.2 NATURE OF HARMS TO CHILDREN

The harms reported to be experienced by children as a result of someone else's drinking may be summarised as:

- physical abuse
- verbal abuse
- emotional abuse (including emotional neglect)
- threat of physical abuse
- fear of physical harm
- sleep disruption
- witnessing conflict (fights, physical abuse, verbal abuse)
- witnessing drinking and inappropriate behaviour
- fear of health risk.

There were only two instances of physical abuse directed toward children reported in this research:

- SallyB reporting that her daughter's husband had dropped his (and SallyB's daughter's) babies when he was drunk and stating that he could not be trusted not to do so again.

- YvonneA's adult son holding a knife to his younger brother's throat when drunk (but not actually cutting him).

Even if the physical abuse did not actually happen, the threat of abuse, such as the knife wielding, was terrifying for those experiencing it:

> *When he's under the influence of alcohol he threatens to kill himself, kill other people, he really hurts animals badly. (YvonneA)*

A few interviewees had also feared physical harm to their children:

> *[My children] were in the car with [my sister] one day when she had been drinking and I followed her and stopped the car and asked them to get out and then took them myself. So there was things like that that happened. I felt they were unsafe so I never let them go to her place. We often had her child with us. (BelindaA)*

More common were reports of verbal abuse directed at the child:

> *She'll be yelling and screaming and get in the f-ing, you know speaking like that, terrible language. [The child] has got in the car crying, the seven year old. (BarbaraA)*

> *Now [the 13 year old's] gone to live with her father she realises that he's worse than the mother because he goes off and then comes home drunk and wakes her up and is abusive. (BarbaraA)*

This latter example also entailed sleep disruption for the child. Although the primary harm experienced by YvonneA's son in the following example was the threat of physical violence, sleep disruption for the child was an associated harm:

> *He [her son] used to wake up during the night sometimes and my son [the drinker] had knives at his throat. (YvonneA)*

Emotional abuse could be active as in the preceding examples, or it could be more akin to emotional neglect:

> *I lost my job and went through a depression and drank at home to the point where it did affect my ability to do as much as I wanted to do with them at times....I withdrew to a degree from family interaction. (IsabelleA)*

Exposure to conflict was more common than direct abuse of the children. Children witnessed fighting, yelling, verbal or physical abuse:

> *I suppose the impact happened when he actually one night was physically abusive to [their] mother and the three of them witnessed it....They'd been out to a party and something she said to him, stop drinking or something...and when he got in the door he actually tried to strangle her. (MargaretB)*

Sometimes participants pointed out that any violence that took place was not directed toward the child:

> *He didn't hurt the baby though. (SharonA)*

> *Oh no, he would never have hurt his son. (NarelleA)*

> *Sometimes he used to take off in the car drunk, risking his own life and others on the road. But never with me.* ***And not with the children?*** *No, definitely not. (AnnaA)*

Almost all the preceding examples were drawn from the interviewees who had originally responded that their children were harmed "a lot," with the exception of MargaretB, quoted above, who actually replied the children in her care were harmed only "a little" by their experiences.

What was more common amongst those who identified that their children were harmed "a little" was their children witnessing drinking and inappropriate behaviour rather than conflict. Examples of this were 'tipsiness', being hard to talk to, inappropriate language, and being inconsistent with emotions:

> *She went out a few times and came back a little bit tipsy and that's all they noticed. (MichaelB)*

The behaviour witnessed by children reported as being harmed "a little" could also be managed better than that witnessed by children harmed "a lot," because the drinker was often not in the immediate family:

> *He would always ring up on the phone and that's when I knew he was drunk and it was always hard to get off the phone. So that's when the kids knew, oh mum's friend. They used to refer to him as 'mum's drunk friend'. (LolaB)*

The children could also be exposed to the effects that drinking had on the drinker's health. In this example the child's caregiver, her mother, is often ill because of her drinking and the child is affected "a lot":

> *I was in the same situation with my dad, where although not violent or terribly behaved or nasty, they did drink themselves into illness. Her mum has actually got the same condition my dad has, which is pancreas trouble and exacerbated by alcohol. (DavidA)*

In a second example, the drinker is a family friend and the children are only affected "a little", presumably reflecting the more distal relationship of the drinker to the children:

> *I think they just saw how unhealthy and how his life was pretty ordinary as a result of it. (DianaB)*

One interviewee identified that his children were affected by his own drinking, because they were aware of the risk that drinking alcohol posed to future health, and they feared for their father's health:

> *It affects them - not affects them physically. They just question, 'oh you shouldn't be drinking'.....because they perceive alcohol as bad.* ***Where are they getting that message from?*** *Probably the drink-drive campaigns, what they see on TV. (ShaneB)*

However this harm was reported as only "a little", probably because it was, as yet, unrealised ill-health.

6.2.3 IMPACT OF HARMS ON CHILDREN

From this qualitative study, the impacts on children of the harms they experienced as a result of someone else's drinking included:

- being scared and needing to sleep with their mother
- behavioural problems
- shame and embarrassment
- schooling instability
- doing well (e.g. seemingly no problems, and/or a decision to not drink themselves).

The children who had witnessed the physical abuse of their mother seemed to be the most affected, especially the youngest children:

> *I did notice that they were scared. They wanted to sleep with their mother....The little one in particular would have taken a couple of years and she possibly, the little one, was the one that suffered the most because I think it was pretty obvious for the last five years prior to what was happening. There must have been tension and sort of arguments in the house. (MargaretB)*

Being emotionally let down was very difficult for one small boy:

> *He's having behavioural problems now....He gets very emotional because his dad doesn't come when he says...because of the drinking, just because he'd had a hard night drinking or because he was hung over the next day or just because he was depressed coming down from the alcohol. (SharonA)*

One of the impacts of another's drinking on the children was the stigma of being related to the drinker; the shame and embarrassment in the face of others' judgement. YvonneA said her youngest son would not go to school "because he would be laughed at and teased about what his brother had done". This eventually led to him relocating to a community school for children who had trouble at other schools. Ironically, this school was one where many children who were experiencing problems associated with their own drug and alcohol use were enrolled.

Witnessing drinking was only one of the problems experienced by one child. Her mother was also violent, and had held up a nearby store with a gun, resulting in a prison sentence. This behaviour, in turn, affected the foster mother interviewed in the study:

> *I guess the biggest effect was I had a foster child whose mother was an alcoholic. It affected the children because we had another child come live with us for nine years..... It was hard for them because she was quite damaged with things that had happened in the home, she was quite selfish and that was difficult as well....It's very hard [for her] because even if you're living in a family that's a loving family, you just feel like you don't really belong. (ClairA)*

Certain children seemed not to be affected by a problematic drinker's drinking, or at least this was the respondent's view. These children were seemingly well-adjusted, and may even have decided not to drink themselves as a result of the exposure.

> *She's a very sensible girl and she just seems to accept it, just says, well, that's mum....When she does go and stay there overnight she comes home and sort of shakes her head. (BarbaraA)*

6.3 IMPACT ON THE CHILDREN'S FAMILIES

6.3.1 NATURE OF IMPACT ON THE CHILDREN'S FAMILIES

The impacts on the children's families of the harm from others' drinking may be summarised as:

- Apprehended Violence Orders (AVO)
- loss of custody
- breakdown of parents' relationship
- issues of access to children after separation
- affected quality of relationship with children
- difficulty of separation if the drinker was an adult son rather than a partner
- financial insecurity.

The most profound instance of someone's drinking impacting on the family in this research was the father who had an AVO taken out against him after physically assaulting his wife under the influence of alcohol. This assault has already been described above in terms of its ongoing effect on the interviewee's grandchildren who witnessed it.

Another major impact of someone's drinking was a mother losing custody of her children. As the child's foster carer explained:

> *Before her child came into our care she was in and out of rehab, so we knew the mother. When she went in [the Department of Community Services in NSW] got involved....[Her children] were taken from the parents and [their case had] gone to court. The mother lost custody of them. Then they were put into our care. (ClairA)*

A grandmother described the chaotic effect that her daughter's drinking and drug use had had on the woman's five children:

> *[The oldest one]'s been with me now for the last six years....I have had custody of the children on and off for years, all of them, but since [fifth grandchild] was born they went back in her custody. [Third grandchild] stays here twice a week, the seven year old, then [fifth grandchild], the one that goes to kinder, stays once or twice a week too. (BarbaraA)*

This interviewee described a complex round of shifting care arrangements including one 13 year old child who lived with her for a while "but she didn't like the rules here", so moved for a while to live with her father:

> *[My daughter] rang [the 13 year old] and said 'you can go back and live with [your] grandmother' and she said she didn't want to. So that's when [my daughter] said, 'well, ring your father and tell him to come and get you.' She went down to live with her father and she's been down there probably two months now. 'He's worse than [my] mother', [the 13 year old] said. (BarbaraA)*

While the above examples are at the more chaotic end of the spectrum, the main observation is that, within this small sample, if the person whose drinking was affecting the child was a parent, the impact on family life had been the breakdown of the parents' relationship. Of the five cases where the drinker was a father and the children had been harmed "a lot", in four cases the parents had separated. In the fifth case, the threat of separation effected a change:

> *My husband was a binge drinker until my daughter was three. My son was five. It came to a head and he stopped. I very much respect him for that....It was mostly conflict between myself and my husband because I got to the point where I told him that I didn't want them growing up with...an alcoholic father.... It was either the over-drinking or the kids. I was at the point where I was prepared to leave. (IsabelleA)*

In the four cases where the drinker was a father and the children had been harmed "a little", in two cases the parents had separated. In the other two cases either the father's drinking was minimal in the first place or he had stopped in time to save the relationship.

In all four cases where the drinker was a mother, the parents had separated.

In addition, the aunt whose drinking was affecting the interviewee's children was separated from her husband, and the interviewee whose adult son's drinking was affecting her remaining children was also separated from her own 'alcoholic' husband.

If the drinker causing harm was not a partner but a child or sibling, this appeared harder to deal with. Separation was no longer a feasible option if 'standing by' the drinker seemed to the interviewee to be the right thing to do:

> *It's ripping us apart....He knows how to work the system and it's ripping his sister apart because we said we would stand by him, get him out of jail, stand by him, put a roof over his head for a fresh start on the condition that he stayed away from alcohol, and he's broke that and he's up to three bottles of vodka a day. (YvonneA)*

Three interviewees mentioned the financial impact of the drinking, which had resulted in a lack of financial security and some material hardship.

6.3.2 IMPACT ON FAMILY AFTER SEPARATION

While separation removed some children from the harm associated with daily exposure to a drinker, it did not mean that they were now unaffected by that drinker, as parents still had access rights. The possibility that the other parent might drink while responsible for children caused anxiety for participants in this situation:

> *There's nothing you can do about it. I just hope he doesn't bend his elbow while he has them....It's just stressful when he has the kids. (SallyB)*

After separation the level of drinking had a key impact on the quality of the relationship between the drinker and both the child and ex-partner:

> *I mean we get along now, he's doing much better now but it was very rocky there for a while and obviously we're not together but we're friends I guess. He's made a really good effort to stop drinking, and it's a shame it's years down the track, but at least he's spending time with his son now and alcohol is not coming first. (SharonA)*

In other cases the relationship between problem drinkers and children with whom they no longer lived appeared to be profoundly damaged:

> *His father is allowed to have contact whenever he wants, but his father just doesn't have contact.* ***Is he still drinking?*** *As far as I know. (NarelleA)*

NarelleA commented that her son now had a better relationship with her new partner, who was doing more for her son than his natural father.

On occasion the children stayed with the drinking parent after separation, and hence they could still be exposed to harm. One interviewee was the affected children's grandfather as well as the father of the drinker. He described a situation where a child was coerced to stay with his father:

> *At the moment he's assumed control of the children from his ex-wife – or ex-partner. She's fighting the courts to get them back. He's since married and he won't let us see them....The eldest is now 12. He's at the age where he's allowed to choose not to live there....He's with his father at the moment because he wasn't allowed to go back to his mother on visitation. He's there. He can't walk out because he knows dad will come round and grab him again. He knows that if he does go then his younger brother will be in strife. (FredA)*

Another participant described how despite a court decision that his daughter should live with her mother, he actually provided a substantial amount of care due to the mother's ill-health:

> ***How old was she when you and her mother split up?*** *Nine months...and I had trouble getting access... that's Family Court. I had some voluminous amount of allegations against me that I couldn't account for. It's [about] residency. We actually share equal custody. But as it turned out, because of [her] mum's ill-health, it was really not much you could do but just relent and let me care for my daughter when necessary. (DavidA)*

Children also suffered financial deprivation as a result of living with a problem drinker:

> *Well it hasn't affected my son at all but it's affected my daughter and she lives with him now and I think she does without certain things because he doesn't have financial security due to his alcohol problem... She asks me for money a lot. (AnnaA)*

6.4 STRATEGIES FOR DEALING WITH ANOTHER'S DRINKING HARMING CHILDREN

Sources of support for families in dealing with another person's drinking harming children include:

- immediate and extended family
- friends and neighbours
- religious community
- support groups
- formal services (e.g. social services, AOD agencies)
- medical professionals
- counsellors
- workplace (especially having a flexible job).

From the qualitative interviews, overwhelmingly the people who helped respondents most were the their immediate or extended family (wives, husbands, parents, sisters, brothers, partner's parents etc.). Nine of the ten people who reported "a lot" of harm to children in their care, and four of the ten people who reported "a little" harm, replied in variations of the following way:

> *Probably my mum and dad [helped the most]. Whenever there was a really big fight that went on, mum and dad would come to my house and sort of be with [my son]. (NarelleA)*

The only respondent who answered "a lot" and did not nominate immediate family as a support was a woman who married into an Indigenous community distant from her family. In this cross-cultural marriage she identified herself as an 'outsider.' She was also the only respondent whose husband had stopped drinking in time to save the marriage.

Not everyone in the family provided support to people dealing with the impact of another person's drinking on children, as some family members "had had enough of the drinker" (BarbaraA). Others were determined to keep it within the immediate family, remarking "you wouldn't talk about that sort of thing" with others (FredA). Still others argued that having someone close to help them had been critical:

> *Even if they're not just your parents that give you that support, you do need the support of someone who's there. (NarelleA)*

While some participants received a high level of support from members of their immediate and extended family, it is unsurprising that those without such support experienced greater difficulties in dealing with problems. Two adoptees who had married each other and lost touch with their adoptive families had only each other for support when their adult son was harming their grandchildren: they were estranged from him and denied access to the grandchildren. This interviewee volunteered that he had himself been a heavy drinker and fairly violent in his family, and had thrown his son out of the house at age 15 for molesting his sister. Although offered referral to support services by the interviewer, this man could not see how any support services would be appropriate for him.

Friends and neighbours did not play nearly as much of a role as family, although several respondents nominated friends as being someone to talk to or help look after a child. DavidA was talking about his daughter who lived with his ex-wife, a drinker:

> *Any time she needs help she can just walk there and it's fine...She's got other friends and their mums in proximity. She knows all their numbers and there are plenty of people to help. It's a good school and a good bunch actually of parents and kids. (DavidA)*

However, others nominated the stigma associated with 'alcoholism' as a reason why they would not feel comfortable talking to friends.

The record on the support provided by formal support services was mixed. There was a common experience that while the services functioned to serve the drinker, they were not interested in those who were supporting the drinker or the children harmed by the drinker. BarbaraA had been initially reluctant to be interviewed, believing that nothing would change as a result of an interview. She received the Plain Language Statement as part of the ethics procedure, and assurances that the point of the interview was to discuss supports for people like her:

> *[The Department of Human Services] do [interview me] when we've had to go to court, but not this last go. They did ring me and I told them everything, and then I haven't heard from them since they've been looking after [my daughter]. (BarbaraA)*

> *I found Social Services very unhelpful in the great support and sympathy that they gave to my daughter's mum....They just made it extremely difficult for me to move to avoid trouble. (DavidA)*

For YvonneA, what she described as her adult son's combined mental health problems and alcohol addiction meant that she believed he was not being treated adequately and this was what affected her and her family:

> *It goes into the situation of whether or not it is a mental illness or an alcohol issue....[The mental health people] won't do it because they believe it's an alcohol issue....They said he does not want to help himself, we cannot go any further. He is not qualifying for involuntary admission. He's not passing all the things for voluntary admission. So I think that's why they put him in jail for 18 months to try to dry him out type of thing....It's all legal loopholes....It just affects me that he knows how to manipulate the system for his addiction and there is nothing that they can do to put him...in hospital involuntarily. (YvonneA)*

YvonneA's son's alcohol problems had been affecting her family for ten years, to such an extent that she found it difficult to articulate what supports she would find useful; the greatest help she identified would be to have her son's dual diagnosis (mental health and alcohol) problems resolved.

Counsellors were turned to by some. IsabelleA, a woman who had no immediate family to turn to, reported that she had found counselling useful, although more for dealing with her own problems than her husband's drinking. However others found them unhelpful. For example, FredA thought that "the counsellors are too young to understand and have any empathy....it would be like opening up to your children." MargaretB's daughter had had a bad experience with a counsellor before the physical abuse which resulted in the issuing of the AVO:

> *I think they tried counselling, but [the counsellor] could only hear the bad side of [MargaretB's daughter], which was nothing....[He] didn't really see the real issue.*

MargaretB had another daughter who had been able to step in to manage the crisis. This daughter was able to attend a crisis in the middle of the night and to alert the police to the situation:

> *It's a very sad situation with external counsellors, because I mean a lot of them are brilliant, but living and seeing and knowing day after day what's actually happening and then all of a sudden being called in to help is of course a different situation, and this other daughter was able to step straight in. Well actually when the incident happened, it was about two o'clock in the morning, and my daughter, who lived about a 40 minute drive away, was here within 20 minutes. She just came in and took over and just rang his brother and just said 'come and collect your brother'....I think the police were called and this is why the AVO was taken out. (MargaretB)*

The failure to include her in the caring process because of confidentiality issues (where health care information is limited or cannot be released to a third party) had a negative impact on one woman's efforts to do something about her sister's alcohol addiction:

> *I think one of the main problems with my sister when she was so unwell was that there's so much legislation around confidentiality with psychiatrists...and then to get the psychiatrist to hear us and listen to what we were saying and then to feed back information to us was near on impossible. So there were times when we were worried for her life and we were worried for her children's lives and to try and get heard about that and for people to take us seriously was really difficult....I think there needs to be much more of a link between the people that are caring for the drinker and the ability to liaise and work with*

the treating professionals....We used the general practitioner a lot and sometimes I would ring the general practitioner, and she would say to me I can't give you any information because of confidentiality, and I'd say, that's fine, just listen to me....But it was talking directly with the psychiatrist that was just so difficult. (BelindaA)

Their religious community was a helpful source of support for several respondents. BelindaA said she found talking to the minister at her church helpful because she could be more open with him than with other people:

I certainly wasn't very open about what was going on. I was with the minister, but not generally. I didn't talk about it much. It was helpful for me to talk to somebody else, so that I knew that there was someone else that knew what was going on in my life [which] would explain [why] I break down every now and then.

ClairA said her religious community had been instrumental both in providing her with the opportunity to foster someone else's child but also offering important practical and spiritual support:

Sometimes they minded her. I guess praying and you know, talking, spending time and understanding.

Finally, BarbaraA, the grandmother who was often looking after her daughter's five children, reported that an organisation that supports grandparents that look after the children of their own drug- or alcohol-affected children had been immensely supportive. She explained that she and other grandparents met monthly, and spoke on the phone in between:

After we've been at a meeting they ring me the next week to see how I am. I don't really ring them unless...no I don't. But they'd be there. (BarbaraA)

The lack of support services was identified by SallyB, who was caring not only for her young children but also for her mother. SharonA also identified the impact that the lack of support had on her family, although she also recognised that she and her husband had some responsibility for not accepting support that was offered:

I would have liked my family to have not broken up, because we didn't have help or support. We're still suffering from that in fact. If he had had, or accepted, help, then we probably would still be together.

One of the strategies that parents used for their children was to shield them as much as possible from the effects of the drinker's alcohol consumption and even from the drinker as well:

We have a family member that has drunk very heavily in the past and my children were probably exposed to that but I tended to protect them as much as I could.... I could say it didn't really affect them because we sheltered them. (BelindaA)

I think they were fairly young. We did try and keep it away from them. We were both conscious of it. (IsabelleA)

I wouldn't encourage [him coming to the house] because I didn't want – just the way they carry on sometimes, I just thought no, not having that around the kids. (LolaB)

I just sort of carried on as normal, you know, watching very carefully in the background, but just carried on and tried to keep life as normal as possible without bringing up any issues....This is why I don't resurrect this with the children, because I know it can create anxiety. (MargaretB)

Finally, DavidA identified that his workplace and work choices allowed him some of the flexibility he needed to cope with the impact of his ex-wife's drinking on their daughter, who still lived with her:

So I drive there, and then I've got to get back to work in time and just find flexibility....It's lucky my job is flexible you know...I can take her with me sometimes. When she was smaller she'd ride in the truck with me during the holidays. (DavidA)

6.5 SOCIAL AND CULTURAL CONTEXT IN DEALING WITH THE IMPACT OF SOMEONE ELSE'S DRINKING ON THE FAMILY

Almost all the interviewees described themselves as coming from an anglo-Australian background (n = 17). One identified herself as having an Italian heritage, although born in Australia. One woman identified herself as adopted and possibly a member of the Stolen Generation,[6] but she did not nominate her possible Indigeneity as a factor in her experiences.

Interviewees noted that drinking alcohol is accepted as part of the Australian culture, with football being mentioned twice in relation to drinking, both from the perspective of a player and as a spectator:

> *Look at it this way, she sees me have a glass of wine or I go to the footy and I have a beer. But I've still got to get home. I can't be getting drunk where I am. (DavidA)*

> *I was trying to understand why he developed the habits. It's mostly football culture I think. He played football. He was very, very good at it. It was the done thing and it still is amongst a lot of young people. They set out to drink to get drunk. (IsabelleA)*

Attitudes expressed ranged from distinguishing excessive from moderate drinking, to total rejection of drinking. The following three quotes come from people who reported "a lot" of harm to their children from others' drinking:

> *But if you go to [outlet name omitted], you see mature-age people pushing shopping trolleys with wine casks and slabs of beer and stuff. It just serves as a bit of a warning for my daughter that if you just assault yourself like this all the time, same as with cigarettes, it will catch you in the end. Because I don't know what the volume of alcohol people are putting into themselves. It's like a teenage riot carried into middle age, you know? (DavidA)*

> *Alcohol is a curse. It's so widely accepted as - it's an Australian culture to drink. Yet it is one of the most destroying things that people do to themselves. (AnnaA)*

> *I just think alcohol's disgusting and destroys people's lives. (ClairA)*

The experience of dealing with harm from alcohol crossed educational boundaries. The most common experience was of people who had not finished school and who had now separated from their partner (whose drinking had caused harms to their children). By contrast all three professional women in the sample were married, and they were touched by alcohol's harm to children through the drinking of their sister, their daughter, or their partner before his reform.

Based on this small sample, and as summarised in Table 6.3 below, it is difficult to determine if there are any difference in the harms experienced by families based on residence in urban, regional or remote areas. The levels of harm (i.e. "a lot" or "a little") seem to be fairly evenly spread in each of these classifications. However, living in a rural centre made the stigma of being closely related to a drinker worse for one respondent:

> *But it's just more what he's doing to himself and this is such a small town, the population is only something like 2,000. So what he does comes back on this family, we're judged by him. (YvonneA)*

She commented further about the social context of living in a small rural town:

> *A lovely town I live in, don't I, because there's nothing to do, so people drink and take drugs. Basically that's their life.*

[6] It is estimated that 100,000 Indigenous children were taken from their families and raised in homes or adopted by non-Indigenous families in Australia up until the 1960s. The policy was designed to 'assimilate' or 'breed out' Indigenous people. These children became known as the 'Stolen Generation' (Reconciliation 2007).

Table 6.3 Harms reported by geographical remoteness (based on interviewees' postcode[7])			
REMOTENESS (AUSTRALIAN STANDARD GEOGRAPHIC CLASSIFICATION)	n	"A LOT"	"A LITTLE"
Major cities	6	7	13
Inner regional	1	2	3
Outer regional	2	0	2
Remote	0	1	1
Very remote	1	0	1

The family which was active in a church provided a high level of support for each other, as reflected in their willingness to foster children and to work together, with several members of the same family fostering children from the one mother.

The cultural and professional context of confidentiality principles aimed at protecting the rights of the drinker, and the focus by formal support services and health professionals on the drinker, meant that some interviewees felt that they had been less able to help or otherwise intervene in the drinker's situation than if the support were less focused on the drinker. This meant that the impact on the person affected by someone else's drinking was greater than it might have been.

6.6 DISCUSSION

The problematic drinker in the family has been identified in the 2008 HTO Survey as usually being a male (Berends et al. 2012). This was also found in the current study based on interviewees drawn from this survey. Based on the 20 cases captured, the male drinker was usually the father of the affected children. In those cases where the drinker was a woman, it was usually the mother. A few women being interviewed about someone else's drinking also identified that their own drinking had affected their children.

Berends et al. (2012) reported that they had found no literature on drinking as a potential factor in sibling violence. In the current study there was one case (that of YvonneA's adult son) which was marked by threats of physical violence toward his younger siblings when drunk, but also by the poignant nature of the impact, as the family, including all the siblings, struggled to keep supporting and 'standing by' the drinker.

Within the limited scope of this qualitative study, it appeared that if the drinker who was harming a child was not part of the immediate, or even extended, family, the interviewee was more likely to classify the harm as less severe (i.e. "a little" harm). This does not mean that family members cannot cause only "a little" harm to children, but it suggests that a family can distance itself from drinkers outside the family who could otherwise harm their child "a lot."

The identified harms experienced by children as a result of someone else's drinking did not differ markedly from those already reported in the literature, both in Australia (Dawe et al. 2007; Gruenert et al. 2004) and internationally (Holmila et al. 2011; Mongan et al. 2009; Orford et al. 2010; Velleman et al. 2008). This literature found neglect, violence, or abuse – or exposure to these – to be the main harms experienced by children. Holmila et al. (2011) differentiated between harmful acts to the child that were direct and intended, such as violence or sadism, and the more common harmful acts that were indirect and unintended. In the current study physical abuse and neglect of children were not common, and several respondents emphasised that the drinker had never physically harmed their child. While verbal and emotional abuse were more common, the most common harm was children witnessing conflicts such as physical or verbal abuse. Sleep disruption was also a factor for several children. Drink driving was a harm reported by one woman, who described taking her children out of a car being driven by her intoxicated sister. This resonated with Connor and Casswell's (2009) finding in New Zealand that children injured in drink driving cases were usually in the same car as the drunk driver.

For children who were harmed "a little" the most common reported harm was witnessing drinking or inappropriate behaviour, especially beyond the extended family. A key theme not found elsewhere in the

[7] The Australian Standard Geographic Classification (ASGC) classifies regions into major Australian cities, inner regional Australia, outer regional Australia, remote Australia and very remote Australia on the basis of postcode (Australian Bureau of Statistics 2006)

literature was that the child came to fear the effects that drinking might have on the drinker's health. This was a subtle harm, one of fear based on the potential impact of drinking alcohol on future health. In this study, one of the interviewees identified that his children, in response to media campaigns, feared for his future health even though he rated his drinking as not having any other impact on the children or family functioning. While the relationship between risk and anxiety has been well established (Wilkinson 2001), it usually relates to a person's fears for their own future health, rather than children's fears for their parent.

When considering the impacts of someone else's drinking on children, the literature reports children feeling fear, anger, frustration or sadness about their parents' violence or quarrels (Holmila et al. 2011; Velleman et al. 2008). Children also report lack of sleep and a restriction of their social life as they choose not to bring friends home (Holmila et al. 2011; Orford et al. 2010). From an adult's perspective, the impacts on children include behavioural problems (Dawe et al. 2007; Velleman et al. 2008) and subsequent alcohol and drug use or depression (Kelley et al. 2011; Morgan & McAtamney 2009). In the current study the most affected children were the youngest, who had witnessed physical violence. Although reported in only one case, the youngest affected child was very frightened and slept in her mother's bed for many years. Neglect by a heavy-drinking father who did not live with his four-year-old child was perceived by the mother to be causing unspecified behavioural problems. One of the interesting outcomes relating to shame and embarrassment was a child changing schools to avoid the stigma, so the drinker's actions in this instance led to schooling instability. Thus fear, behavioural problems, and shame were all present for some children described in this study. However, one child was doing well, or at least appeared to be, but there was no clear pattern about which children might 'do well' in such circumstances, as children in the same family reacted differently.

In the literature, the impacts of problematic drinkers on the family are often framed in terms of children having to assume household responsibilities, or the great strain it placed on the rest of the family (Arcidiacono et al. 2010; Holmila et al. 2011; Mongan et al. 2009; Naylor & Lee 2011; Orford et al. 2010). The family might find it difficult to plan activities or stick to familiar routines (Mongan et al. 2009) and there may be higher levels of intra-family conflict and economic difficulties (Zeitlin 1994). Marital disharmony and breakdown have been identified as key impacts when one parent is a problematic drinker (Templeton et al. 2010; Zeitlin 1994). In the current study, the main impact on the family of having a parent whose drinking was harming children was that the other parent was prepared to leave the relationship. This was a non-gendered finding; both men and women were prepared to end the relationship, and only reducing the drinking to a minimal level or stopping altogether would save it. The findings in this study contrast with findings that wives in Finland and the US were reluctant to separate or divorce, identifying fear of poverty, social pressures and guilt as some of the barriers (Wiseman 1991). While Wiseman's work has been identified as one of the most thorough qualitative research studies on the topic, its scope was confined to wives (Orford et al. 2005), and referred to circumstances up to 40 years ago. Orford et al. also cited a 1980 study which found that husbands did not leave the marriage, deferring to the needs of the children. In Australia, while the divorce rate since the mid-1980s has been fairly stable, it is likely that the increase in cohabiting relationships is masking the extent of increase in relationship breakdown. Divorce, and especially the end of a cohabiting relationship, has become an acceptable solution if the relationship does not work (de Vaus 2004; Qu & Weston 2011). It is this more recent cultural context which may lie behind the preparedness of men and women to leave a relationship in which a problematic drinker is harming their children.

It should be noted that while separation removed some children from the harm of exposure to a harmful drinker on a daily basis, it did not mean that they were now unaffected by the drinker, as parents still had access rights and the custodial parent worried about the harms the drinker could still inflict. Financial insecurity arising from the cost of drinking was an issue for a few families, with some of the financial insecurity related to now living in a single parent home.

In addition, the partner relationship is only one element in family relationships, and, in this qualitative study, the option of separation was less feasible if the drinker was the interviewee's adult child. In these cases the family struggled to provide ongoing support.

It has been argued that children with problem drinking parents are a hidden population, neglected by services (Holmila et al. 2011; Moore et al. 2010). Because children were not interviewed in this study, this issue was not explored. Rather, it was the supports received by the adult interviewees that were the focus. Overwhelmingly, the most common source of support for dealing with another's drinking harming participants' children was their immediate and extended family. If respondents did not have such support,

they used a variety of other sources, or they did not receive support and struggled. In a culture in which religious communities do not always play a major role in people's lives, the capacity of 'the church' to offer support was limited, but invaluable for those who had such a connection. One of the benefits associated with the church was that there was a perception that church leaders would not stigmatise the person seeking support in the same way as a friend might. Friends were not widely favoured as a source of support because of the perceived stigma of alcohol-related problems.

Formal services and medical professionals were perceived to be focused on supporting the drinker, but not the family member dealing with the impacts of that person's drinking, as has been found previously (Orford et al. 2010). This focus, along with the cultural context of confidentiality principles aimed at protecting the rights of the drinker, meant that sometimes the impact of a family member's drinking on interviewees was greater than it might have been. Some participants felt that the effect of client confidentiality principles had been to deny them information from treatment providers that they needed to manage the situation and protect children from harm. This is a difficult problem to address, as professional ethics in relation to confidentiality are unlikely to change. Efforts to broaden the scope of support to include family members in their own right have been predicated not only on helping family members with their immediate problems, but also on addressing the enhanced risk of future addiction among relatives of the drinker (Mongan et al. 2009). For one interviewee in the current study, a dedicated support group for grandparents was highly supportive, particularly as it was perceived to be tailored to their needs and because someone was available to be contacted at any time. There is further scope for the provision of such support services dedicated to the needs of the person whose children have been harmed by another's drinking. The effort of family members in acting to prevent or minimise harm caused by problematic family drinkers has not only an emotional but also an economic toll. While the economic value of the unpaid support that family members provide is usually uncalculated (Copello et al. 2010b), the 2008 HTO Survey findings were used to calculate that time spent in Australia caring for household members affected by alcohol-related harms was worth an estimated 3.1 billion dollars per year (Laslett et al. 2010).

For one woman, the biggest support she could imagine would have been to have her son's dual diagnosis (mental health and alcohol problems) properly addressed by health professionals, and what she perceived as an appropriate treatment plan identified and carried out. For the very small number of cases who had contact with them, counsellors were considered to have significant limitations, not being embedded in the day-to-day reality, not being available when crises occurred, or being 'too young' to be truly empathetic. Another finding was the under-acknowledged role that workplaces could play in supporting those who were dealing with the unpredictability of the drinker in their family, especially when it was disrupting the family routine and affecting children's lives.

6.6.1 METHODOLOGICAL REFLECTIONS

One of the objectives of the current research was to understand the discrepancy in the survey research between the higher levels of responses to a general question about harms to children compared to rates of positive responses to a short list of specified harms. The general question in the survey summed those who answered that their children were affected "a lot" or "a little" by a family member's drinking. In the qualitative study, for children who were only harmed "a little," the most common harm was witnessing drinking or inappropriate behaviour, especially from drinkers beyond the extended family. This implies that survey respondents who replied "a little" should be considered distinctly different from those who answered "a lot." As discussed in section 6.2.2, only one respondent out of ten who reported "a little" harm to children described harms that appeared more serious. For the most part, there was a plausible explanation for the discrepancy in survey responses. This has implications for those who choose to sum the two categories ("a lot" and "a little") to justify policy recommendations or determine the cost of alcohol-related harms, because they represent such different outcomes for children. It should be noted, however, that "a little" harm did not mean "none" (Manton et al. 2014).

The finding that respondents whose heavy-drinking partner was harming children were prepared to end the relationship needs to be considered in the context of the study methodology. The participants' preparedness to be interviewed may have related in the first instance to their having reached a point of resolution, such as a separation, or being sufficiently removed from the situation, for example, as a grandparent or a foster carer, to be able to discuss the issues. As already discussed, there were three prospective interviewees who had answered "a lot" who indicated on first approach that they were interested in talking to the interviewer at a more convenient time, but on re-call at their nominated time decided not to proceed. One

possible explanation was that the potentially harmful drinker was inadvertently involved in the telephone exchange, and as the interviewer could not self-identify for ethical reasons, this led to an uneasy situation. While this can only be speculation, it could be that only people who no longer had the drinker who was harming the children in the background (i.e. who had already separated) felt able to participate in this interview. That is, the high level of separation observed may not reflect the situation of people in the general population in an intimate relationship with a drinker.

Finally, the interview process uncovered some women whose drinking was affecting their children, even if the most problematic drinker had been identified as a man. There remains the possibility that there is an over-emphasis on the most problematic drinker in the survey research, and women's lower level of drinking (while still problematic for the children) may be overshadowed.

A strength of the current study compared to previous qualitative research on alcohol's harm to others was the random sampling approach adopted in the survey from which the interviewees were selected. The resultant sample was Australia-wide, and covered a broad range of socio-economic backgrounds. The interviewees were not drawn from specialist AOD treatment agencies, primary care settings, or through interviewer contacts, as in other studies (Orford et al. 2005; Templeton et al. 2009; Velleman et al. 2008). This gives the current research a unique perspective, looking into more serious alcohol-related harms to children and families through the general population window.

6.7 CONCLUSION

The following findings are based on the in-depth qualitative interviews with the 20 participants who had reported harm to children from others' drinking in the 2008 or 2011 HTO Survey:

The drinker reported to be causing harm to children was most often a man, and usually the father of the affected children. In those cases where the drinker was a woman, it was usually the mother. The interview process uncovered some women whose drinking was affecting their children, even if the problematic drinker had been identified as a man. There remains the possibility that there is an over-emphasis on the most problematic drinker in the survey research, and women's lower (but still problematic for the children) level of drinking may be being overshadowed. If the drinker who was harming a child was not part of the immediate, or even extended, family, the interviewee was more likely to classify the harm as "a little." This does not mean that family members cannot harm a child only "a little," but it suggests that a family can distance itself from drinkers outside the family who could otherwise harm their child "a lot."

Physical abuse and neglect of children were not common, even where "a lot" of harm was reported, and several respondents emphasised that the drinker had never physically harmed their child. While verbal and emotional abuse were more common, the most common harm was children witnessing conflicts such as physical or verbal abuse; while for children who were harmed "a little" the most common reported harm was witnessing drinking or inappropriate behaviour, especially beyond the extended family.

Fear, behavioural problems, and shame were some of the outcomes for children (as reported by interviewees). However, one child was doing well, or at least appeared to be doing so. Overall, there was no clear pattern about which children suffered and which prospered, as children in the same family reacted differently to the same (or very similar) circumstances.

The main impact on the family of having a parent whose drinking was harming children was that the other parent was prepared to leave the relationship. This was a non-gendered finding; both men and women were prepared to end the relationship. Only reducing the drinking to a minimal level or stopping altogether would save the relationship. However, the high level of separation observed may reflect some selection bias in terms of willingness to be interviewed in-depth on the study's topic. While separation removed some children from the harm of daily exposure to a problematic drinker, it did not mean that they were now unaffected by that person, as parents still had access rights and the custodial parent worried about the harms the drinker could still inflict. It was also noted that the partner relationship is only one element in family relationships, and the option of separation from the problematic drinker was less feasible if the drinker was the interviewee's adult child. In these cases the family struggled to provide ongoing support. Financial insecurity arising from the cost of drinking was an issue for a few families, with some of the financial insecurity related to now living in a single parent home.

The most commonly used source of support for dealing with harm to children from another's drinking was the immediate and the extended family. If respondents did not have such support they used a variety of other sources, or they did not receive support and struggled. In a culture in which religious communities often do not play a major role in people's lives, their capacity to offer support was limited, although very helpful for those who had such a connection. One of the benefits associated with 'the church' was that there was a perception that leaders and staff would not stigmatise the person seeking support in the same way as a friend might. Friends were not widely favoured as a source of support because of the perceived stigma of having alcohol-related problems in the family.

Formal services and medical professionals were perceived to be focused on supporting the drinker, but not the adult family members interviewed who were dealing with the impacts of that person's drinking. The cultural context of confidentiality principles aimed at protecting the rights of the drinker, and the focus by formal services and health professionals on the drinker, meant that sometimes the impact on others of harm from drinking was greater than it might have been. It is difficult to see the possibility for change in traditional treatment-based approaches, as the rules about confidentiality are firmly embedded, unless more services are provided explicitly and specifically for families coping with a problem drinking family member.

Counsellors were considered to have significant limitations in their ability to support individuals affected by a family member's drinking, not being embedded in the day-to-day reality, not being available when crises occurred, or being "too young" to be truly empathetic. Conversely, a dedicated support group for grandparents was highly supportive for one interviewee, particularly as it was perceived to be tailored to her needs and because someone was available to be contacted at any time. There is further scope for the provision of such support services dedicated to the needs of the person whose children have been harmed by another's drinking. Another finding was the under-acknowledged role that workplaces could play in supporting those people who were dealing with the unpredictability associated with the drinker in their family, especially when it was disrupting the family routine and affecting children's lives.

A strength of the current qualitative research study compared to previous qualitative research on alcohol's harm to others was the random sampling approach adopted in the HTO Survey from which the interviewees were selected. The resultant sample was Australia-wide, and covered a broad range of socio-economic backgrounds. The interviewees were not drawn from specialist alcohol and drug treatment agencies, primary care settings, or through interviewer contacts, as in other studies. This gives the current research a unique perspective, looking into the more serious end of alcohol-related harm to children and families through a general population window.

7 DOMESTIC VIOLENCE, FAMILY SERVICES AND ALCOHOL-SPECIFIC SERVICES

Janette Mugavin and Anne-Marie Laslett

7.1 INTRODUCTION

It is often only the most serious alcohol-related incidents that come to the attention of service agencies (Hope 2011; Storbjörk & Room 2008). This chapter provides an overview of the services that respond to the problems experienced by the families and friends of drinkers and details (along with Chapter 8) a variety of agencies that respond to these family problems through various 'windows': welfare, support services, police and courts, and AOD services. The content of this chapter is partly about 'what services are available' and partly about 'what data are collected' – either routinely in registries or in special studies – about alcohol's involvement in these problems. This chapter examines service responses from police, family services and AOD treatment services and systems (including face-to-face, telephone and online counselling), addressing the question: What services are available for families and children if they have been affected by the drinking of those around them?

7.2 DOMESTIC VIOLENCE INCIDENTS

Alcohol-related domestic violence incidents are a major problem across Australia but are not consistently recorded across Australian states, with data published quarterly in New South Wales (NSW) (Table 7.1) and annually in Victoria (Tables 7.2 and 7.3), WA (Table 7.4) and the NT (Table 7.5). Recent alcohol-related domestic violence figures were not identified for Queensland (QLD), South Australia (SA), Tasmania or the Australian Capital Territory (ACT). National police figures on alcohol-related domestic violence collated on an annual basis were not identified – alcohol is inconsistently recorded across jurisdictions, making accrual of the data problematic. Each state publishes their findings separately and differently, presenting further difficulties in drawing together data sets.

Table 7.1 indicates that around 10,000-11,000 domestic violence assaults occur in NSW each year, and between 35 and 45 per cent of these are alcohol-related. The alcohol-related domestic violence figures for NSW have been stable over the last two, five and ten years; however, overall domestic violence assaults (not depicted here) show an increase of six per cent over the last two and five years, and an increase of two per cent over the last ten years (New South Wales Bureau of Crime Statistics and Research 2014).

Table 7.1 Alcohol-related domestic violence assaults in New South Wales 2004–2005 to 2013–2014

YEAR REPORTED FROM APRIL UNTIL MARCH	ALCOHOL-RELATED DOMESTIC VIOLENCE ASSAULTS (N)	% OF ALL DOMESTIC VIOLENCE ASSAULTS	ANNUAL % CHANGE	OFFENCE RATES PER 100,000
2004 – 2005	9,902	39	-	148
2005 – 2006	10,927	42	10	162
2006 – 2007	11,089	42	1	162
2007 – 2008	11,376	44	3	164
2008 – 2009	11,817	45	4	168
2009 – 2010	11,371	44	-4	159
2010 – 2011	10,706	40	-6	148
2011 – 2012	10,183	38	-5	139
2012 – 2013	10,338	37	2	140
2013 – 2014	9,948	35	-4	133

Source: NSW Recorded Crime Statistics April 2004 to March 2014 (New South Wales Bureau of Crime Statistics and Research 2014). Population data of New South Wales from June 2004 to March 2014 were collected from Australian Bureau of Statistics (Australian Bureau of Statistics 2014b).

Table 7.2 depicts the number and annual changes in family incident[8] or domestic violence police reports attended by Victoria Police that involve alcohol (both where alcohol is 'definitely' involved and 'possibly' involved but not confirmed). The overall and alcohol-related family incident numbers have risen steadily since 2001–02, although the annual percentage increases and decreases have been inconsistent.

Table 7.2 Number of family incidents with definite and possible alcohol involvement, Victoria, 2001–02 to 2012–13

YEAR	ALL FAMILY INCIDENTS	POSSIBLE ALCOHOL INVOLVEMENT			DEFINITE ALCOHOL INVOLVEMENT			
	n	n	%	ANNUAL % CHANGE	n	%	ANNUAL % CHANGE	OFFENCE RATES PER 100,000[b]
2001–02	23,452	3,030	13		6,637	28		138
2002–03	28,453	3,799	13	25	7,924	28	19	163
2003–04	27,665	3,684	13	-3	7,548	27	-5	153
2004–05	29,162	3,947	14	7	8,131	28	8	163
2005–06[a]	28,301	4,000	14	1	7,463	26	-8	147
2006–07	29,652	4,348	15	8	7,743	26	4	150
2007–08	31,666	4,546	14	5	9,020	28	16	172
2008–09	33,918	5,092	15	12	10,363	31	15	193
2009–10	35,681	5,757	16	13	10,879	30	5	199
2010–11	40,778	7,253	18	26	11,732	29	8	212
2011–12	49,945	9,742	20	34	12,626	25	7	224
2012–13	60,550	9,644	16	1	12,556	23	12	219

Source: Victoria Police Statistical Services Division LEAP, analysis by Turning Point.

All family incident data for 2009-10 to 2012-13 was sourced from Victoria Police, Family Incident Reports – 2009-10 to 2013-14 (Victoria Police 2014).

[a] From 8 Dec 2005, a new family risk assessment protocol was implemented (DVC 2007).

[b] Victorian population data from June 2001 to June 2013 (Australian Bureau of Statistics 2014b).

The incidents recorded in 2010–2011 where alcohol involvement was recorded as 'definite' have been used in Table 7.3. This table indicates that in the majority of family incidents the victim was female and aged 25 years or over. In many incidents victims are middle-aged or older (i.e. 40 years and over), and among these victims the preponderance of females is somewhat less.

Table 7.3 Number of family incidents with definite alcohol involvement by gender and age of victim, Victoria, 2010–11

AGE CATEGORY	FEMALES		MALES		ALL INCIDENTS	
	n	%	n	%	n	%
1–17 years	325	4	141	5	466	4
18–24 years	1423	16	328	12	1,751	15
25–39 years	3718	42	910	33	4,628	40
40 + years	3302	38	1339	49	4,641	40
Total	**8768**	**100**	**2718**	**100**	**11,486**	**100**

Source: Victoria Police Statistical Services Division LEAP, analysis by Turning Point.

Note: Total number of family incidents was 11,732 in 2010–11. Total presented (11,486) excludes 190 cases where age was not specified, 51 cases where gender was not specified, and 5 cases where both age and gender were not specified.

[8] Family incidents are an indicator of domestic violence, for which information is available on the location of the incident (usually the victim's postcode of residence), details of the victim and offender and alcohol involvement. These incidents include some calls where the police deem that an offence has taken place, in addition to cases resulting in arrests (Livingston 2011).

Table 7.4 shows the numbers of overall domestic assaults, the percentages that were alcohol-related and the number of alcohol-related domestic assaults for the years 2005-06 to 2011-12 in WA. An estimated 47 per cent of family violence incidents reported to police in 2011-12 were alcohol-related, and there has been an increase in the number of alcohol-related assaults since 2005–06 (Western Australian Police 2013).

Table 7.4 Domestic assaults in Western Australia, 2005–06 to 2011–12

	NUMBER OF DOMESTIC ASSAULTS	% ALCOHOL-RELATED	NUMBER OF ALCOHOL-RELATED DOMESTIC ASSAULTS	ANNUAL % CHANGE	OFFENCE RATES PER 100,000
2005–06	8,460	50	4,196		205
2006–07	8,843	51	4,501	7	214
2007–08	8,394	51	4,306	-4	198
2008–09	8,321	54	4,527	5	202
2009–10	8,533	53	4,522	0	197
2010–11	9,794	50	4,848	7	206
2011–12	10,857	47	5,092	5	209

Source: Western Australian Police 2013. Population data of Western Australia from June 2005 to June 2012 were collected from Australian Bureau of Statistics (Australian Bureau of Statistics 2014b).

Data in Table 7.5 from the NT demonstrate that the rate of alcohol-related domestic assaults has increased starkly, almost doubling between 2008 and 2013 (Department of the Attorney General and Justice 2013).

Table 7.5 Alcohol-related assaults in the Northern Territory 2008 to 2013

	ALCOHOL-RELATED DOMESTIC ASSAULTS (n)	ANNUAL % CHANGE	OFFENCE RATES PER 100,000
2008	1,768		804
2009	2,181	23	965
2010	2,385	9	1,038
2011	2,398	1	1,037
2012	2,540	6	1,080
2013	3,137	24	1,310

Source: Department of the Attorney General and Justice, Northern Territory Government (Department of the Attorney General and Justice, 2013). Population data of Northern Territory from June 2008 to June 2013 were collected from Australian Bureau of Statistics (Australian Bureau of Statistics, 2014b)

Adding together the figures from 2011 (the year for which data for the most jurisdictions has been found) the total of alcohol-related domestic assaults is 29,684 (NSW – 10,706; Victoria – 11,732; WA – 4,848, and the NT – 2,398). This figure excludes assaults in SA, ACT, QLD and Tasmania, as data were not available for that year.

In addition, these police figures capture only a sliver of the domestic violence that families and children experience each year. The 2012 Personal Safety Survey (PSS) figures indicate that in the 12 months prior to the survey an estimated 184,300 Australians aged 18 years and over, including 132,500 women (1.5 per cent of women) and 51,800 men (0.6 per cent of men) experienced partner violence[12] (Australian Bureau of Statistics 2014a). Applying 2010 HTO Study analyses (which indicated that two in three assaults are alcohol-related) to these PSS figures, an estimated 122,867 of these cases would be alcohol-related.

[12] The term 'partner' in the PSS is used to describe the person the respondent lives with, or lived with at some point, in a married or de facto relationship.

7.3 FAMILY SERVICES

Across Australia a range of services have been developed to assist families in need, with the majority provided by the states. Government and non-government services provided to families vary from state to state, but commonly include parenting assistance, counselling services, relationship services, services that focus on families where children are vulnerable, family violence services and a range of crisis and emergency services (New South Wales Family Services 2011; Victorian Department of Human Services 2011a). Broader welfare services include financial support services and housing and accommodation assistance (Victorian Department of Human Services 2011b). In Victoria *Child FIRST* services have been established to support vulnerable families before they enter the child protection system, including families under pressure due to a family member's substance abuse and a range of other concerns that may adversely affect a child's care or development. The referrals to AOD services by *Child FIRST* are not recorded, nor is there ongoing recording of whether AOD misuse is a problem or risk factor for families who access these services (CPS senior data manager personal communication 2011).

Some services for families are also provided by the Commonwealth Government. The Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (now the Department of Social Services) funded a range of services to vulnerable families affected by issues such as drugs, violence and trauma under the *Family Support Program* (FSP) Specialist Services stream. For example, 2,662 clients received support between July and December 2011 as part of the *Kids in Focus* services, scheme, although whether these referrals were for alcohol or other types of drug problems is not known (Department of Families, Housing, Community Services and Indigenous Affairs 2012). The nature of the work conducted by a family-focused service within the AOD treatment system is described in Box 7.1.

A number of other services were provided under the FSP between July and December 2011: 10,573 clients received support through the Specialised Family Violence Service, but whether AOD were issues for these clients was not reported (Department of Families, Housing, Community Services and Indigenous Affairs 2012). The second largest number of services were provided as Family Relationship Services, including relationship advice, counselling for young people and children, and broader parenting support which was made available to 175,822 clients (Department of Families, Housing, Community Services and Indigenous Affairs 2012). Again, whether alcohol was a concern in these cases was not detailed.

Box 7.1 Case example of a family-specific service: 'Kids in Focus' and 'Mirror Families' at Odyssey House Victoria

Kids in Focus is a Commonwealth-funded service that addresses the needs of parents and children where parents have, or are recovering from, AOD problems. Most referrals to the program are made by Child Protection Services. Clients are typically sole parent mothers resolving parenting problems associated with the misuse of AOD, along with a range of complex problems. A case manager explained:

> *We are dealing with the most marginalised groups within the community – most have a history of family violence and sexual assault; many have a history of childhood in care.*

The program provides case management with assertive and intensive outreach with the aim of supporting parents to retain children safely in their care. The program also supports parents who are working toward reunification with children placed in out-of-home care. A range of approaches is used to support families, including parent-child attachment and trauma-informed practice. *Kids in Focus* also utilises the *Parents Under Pressure* (PUP) program – a home-based parenting, child behaviour and parental emotion regulation program for vulnerable families. While case managers emphasise that a carer's substance use is not always detrimental to children's wellbeing, they note that families with few social networks and limited access to mainstream services are at greater risk for child maltreatment and parental relapse.

In order to address social isolation, the *Kids in Focus* program piloted *Mirror Families*™ [9], an innovative early intervention approach devised in the out-of-home care sector "to create, together with the child or young person and their parents, a functional 'extended family' that reflects what happens in naturally-occurring extended family structures by recruiting and supporting those with an existing connection to the child and/or others who can commit to the child's future" (Brunner & O'Neill 2009 in Tsantefski et al. 2013, p. 76). The original model was adapted for use within the AOD sector to avoid and mitigate the negative effects of substance use for children and families by providing support to parents and/or children and by supporting direct actions made by parents to protect children. In the study examining five families' experiences of the program, only one woman relapsed (she and her children were exposed to domestic violence). The woman in question informed her network members who then supported her. "All the children in the program were safely in maternal care at the end of the intervention…Children's own networks also improved. Social contacts, including friendship with peers, increased" (Tsantefski et al. 2013, p.81). The pilot program has evolved into an intervention model delivered by all *Kids in Focus* staff to assist families to develop their own sustainable networks.

The following comments from the *Mirror Families* staff interviewed (in a focus group held in January, 2014) illustrate the multiple issues facing families, providing insight into one program's methods of managing AOD-related family problems and highlighting positive changes achieved through engagement with the program:

> *It's about them becoming self-managing, breaking intergenerational histories of substance misuse, family violence and lack of meaningful activity. It's about harm reduction.*
>
> *Almost all of the children are parentified*[10] *and observe situations children should not.*
>
> *When I first met the mother there wasn't even any eye contact - and the child was a mess. After six months, she parented so well.*
>
> *They [mothers] are learning how to parent and at the start some don't even know how to form friendships, let alone make play dates or have birthday parties.*

[9] Mirror Families is a trademark of Permanent Care and Adoptive Families. For more information about Mirror Families at Odyssey House Victoria see: Tsantefski et al. (2013).

[10] 'Parentified' is a term widely used in child welfare that indicates that children take on caring roles and responsibilities beyond their years and commonly look after themselves, their parents and siblings.

Family Law Services, which provide alternatives to formal court processes for families (who are separated, separating or in dispute, to improve their relationships and care arrangements in the best interests of their children), were provided to 150,006 clients between July and December 2011 (Department of Families, Housing, Community Services and Indigenous Affairs 2012). These services are provided through a mix of private and public schemes and via a range of providers, including Family Relationship Centres, community organisations, legal aid commissions, and individuals such as lawyers, social workers or psychologists. Again, whether AOD were problems for these clients was not reported.

The Relationships Australia program does not feature AOD use as a key issue for its constituents, although one of its programs, the Referral for Active Intervention (RAI) program, lists drug and alcohol issues first amongst a list of problems families experience (Relationships Australia 2012). Relationships Australia is a leading provider of relationship support services for individuals, families and communities. It is a community-based, not-for-profit organisation.

Thus, the majority of Australian family service systems and data registers do not record alcohol's involvement in the problems of their clients. The limited evidence that does exist suggests that alcohol is implicated in a substantial proportion of cases. These data, from specific AOD services, are provided in the sections below.

7.4 ALCOHOL AND OTHER DRUG (AOD) TREATMENT SERVICES FOR FAMILIES

Within Australia, publicly-funded AOD treatment agencies provide a range of services such as counselling, withdrawal management[11] and information and support for people experiencing difficulties related to their own or someone else's substance use. As part of contractual arrangements between the treatment agencies and government departments, treatment related data are collected and reported in accordance with the AODTS-NMDS. Closed episodes of care (CEoCs)[12] are used as the standard unit of measurement in the AODTS-NMDS, as opposed to individual client numbers (Australian Institute of Health and Welfare 2013a).

In Australia in 2011–12, 6,720 CEoCs were provided to clients seeking treatment for someone else's drug use, including alcohol use, accounting for four per cent of all CEoCs provided (see Figure 7.1). The proportion of CEoCs provided to clients seeking treatment for someone else's alcohol or drug use has remained constant (4 per cent to 5 per cent) over the past years (2006-07 to 2011-12) (Australian Institute of Health and Welfare 2013c). Across Australia, the proportion of CEoCs provided to clients seeking treatment for someone else's AOD use ranged from one per cent in SA to 10 per cent in the NT. The wide variation in percentages is likely to reflect differences in system orientation, emphasis on the provision of family-focused interventions or in recording practices across the states and territories.

[11] Withdrawal management treatment (also referred to as detoxification) includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern.

[12] A closed episode of care refers to a period of contact, with defined start and end dates, between a client and a treatment agency. It is possible that more than one treatment episode may be in progress for a client at any one time; therefore the number of closed treatment episodes captured in the AODTS–NMDS does not equate to the total number of people in Australia receiving treatment for alcohol and other drugs (AIHW 2013a).

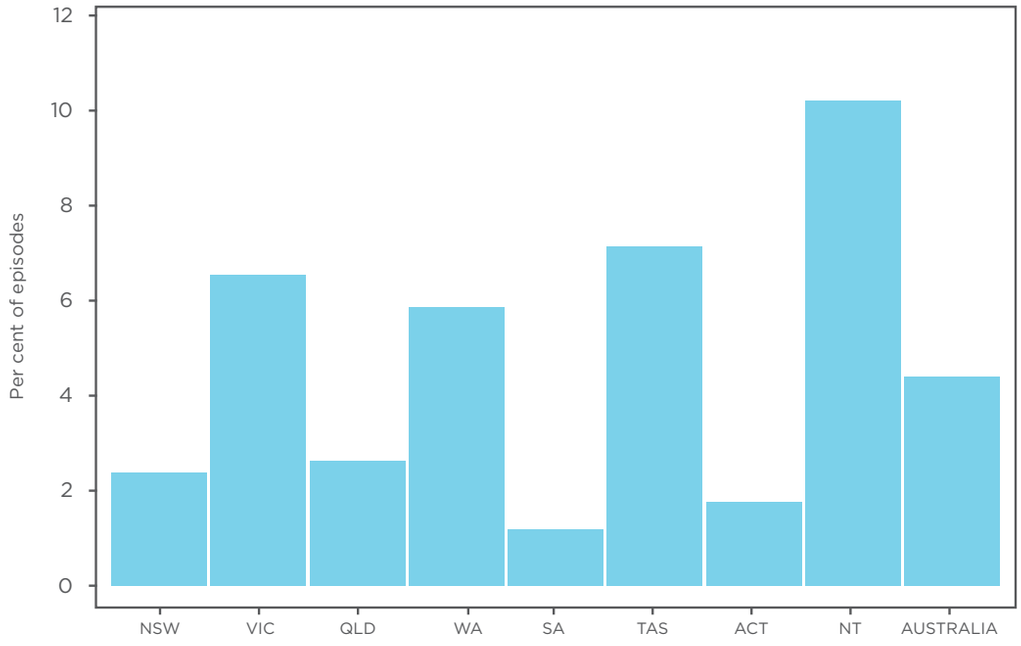


Figure 7.1 Closed episodes of care provided to clients seeking treatment in connection with someone else's alcohol or drug use, AOD services in Australian states and territories, 2011–12

Source: Australian Institute of Health and Welfare (2013c)

Information describing CEoCs provided by Victorian non-government[13] specialist AOD services to clients seeking support due to someone else's alcohol use is shown in Table 7.6. In 2007–08, over half the CEoCs were provided to women, and this proportion increased to 73 per cent in 2009–10. However, ongoing changes to the Victorian AOD service funding arrangements may reduce the provision of services to family members and capacity of the system to meet the needs of family members into the future.

The relationship of the client to the drinker is also captured: the majority of CEoCs are provided to parents and partners, with approximately equal proportions reported for each of the five years. As Table 7.6 shows, the proportion of CEoCs provided to someone who has sought support due to a friend's drinking has decreased over the five years. Although the reasons for this are unknown, it may in part be due to services excluding individuals seeking treatment due to a friend's AOD use, an increased focus in the system on providing services to family members or increased numbers of family members seeking services.

Consistent with the age distribution of the overall treatment population, the majority of CEoCs for those affected by others' drinking are provided to people aged 30 to 59 years. Approximately one-quarter of these were provided to people aged 17 and under and this figure has remained relatively stable over the five years presented.

In 2007–08 and 2008–09, approximately 20 per cent of CEoCs for those affected by others' drinking were provided to clients who identified as Indigenous; however, this proportion decreased to less than five per cent in the following three years.

Counselling, Consultancy and Continuing Care (CCCC) was the most common treatment service provided to clients seeking help due to someone else's drinking, accounting for 58 to 72 per cent of treatment services provided in a year. With the exception of 2008–09, outreach was the second most common treatment service provided, accounting for 12 per cent of AOD treatment provided in 2008–09 but rising to 31 per cent of treatment provided in 2010–11.

[13] Victorian specialist AOD services are publicly funded, however the services are provided by non-government agencies.

Table 7.6 Characteristics of clients (closed episodes of care) contacting specialist AOD services because of someone else's drinking in Victorian publicly-funded non-government agencies[a]

(n)	2007–08	2008–09	2009–10	2010–2011	2011–12
	(896)	(754)	(1052)	(884)	(881)
	%	%	%	%	%
Gender					
Male	45	42	27	32	32
Female	55	58	73	68	68
Relationship to the drinker					
Parent	25	26	32	33	33
Spouse/partner	27	26	31	32	33
Sibling	4	5	5	7	8
Child	11	11	15	14	14
Friend	34	32	16	13	12
Employee	0.1	0.1	0.6	0.1	0.2
Age					
0-17	27	24	25	24	26
18-29	18	18	12	7	8
30-59	43	46	49	53	52
60 and older	9	9	12	12	13
Unknown	2	2	3	4	1
Indigenous status					
Not self-identified as Indigenous	81	74	96	97	97
Self-identified as Indigenous	19	26	4	3	3
Living arrangements					
Lives alone	11	6	9	12	8
Lives with family	81	90	86	83	88
Lives with others	9	4	6	6	5
Treatment type provided					
Counselling, Consultancy and Continuing Care	61	58	72	61	65
Aboriginal A&D Resource Service	9	23	2	0.1	0.1
Outreach	18	12	20	31	24
Aboriginal AOD Worker	6	0.8	0.7	0.8	1
Parent Support	3	4	3	2	7
Other	2	2	2	4	2

Source: Alcohol and Drug Information System, Department of Health Victoria, analysis by Turning Point.

[a] In Victoria, all AOD services are reported to be non-government agencies as they receive government funding but are not part of government departments.

The table excludes missing data as follows: Less than three per cent of cases missing one or more of the following variables: sex, age, treatment type provided; between two and eight per cent of information missing for 'Aboriginal and Torres Strait Islander status' in a given year; between three and 19 per cent of information missing for 'Living arrangements' in a given year.

7.5 TELEPHONE AND ONLINE ADVICE LINES FOR FAMILIES

Specialist AOD information and counselling telephone and internet-based services provide an adjunct or an alternative to face-to-face treatment. Commonly referred to as 'helplines', telephone services offer crisis and ongoing counselling, referral information to other services and other forms of assistance and support. The availability of internet-based services has increased dramatically in Australia over the past 10 years, with services offering online counselling, support groups and information hubs. As with face-to-face services, AOD telephone and internet-based services offer assistance and support to people experiencing difficulties with their own AOD use as well as people affected by or concerned about someone else's AOD use.

This section reports on service use data from one Victorian service and two nation-wide services (one based in Victoria and the other in NSW).

- In Victoria, *DirectLine* provides a state-wide 24 hours per day/7 days per week (24/7) AOD telephone helpline and referral service, managed by Turning Point, part of Eastern Health. Trained AOD counsellors provide counselling, information and referrals both to those calling about their own AOD use and to individuals concerned about someone else's substance use (Department of Health 2014).

- *CounsellingOnline* is a nation-wide internet-based model of intervention provided by Turning Point, Eastern Health, and funded by the Commonwealth Department of Health. It is a text-based counselling service both for individuals concerned with their own substance use problems and for those concerned about the substance use of others. The service is available 24/7.

- *Family Drug Support* (FDS) provides a nation-wide telephone helpline dedicated to addressing the support and information needs of family members who are affected by someone's alcohol or drug use. The *FDS Helpline* is staffed by trained volunteers and the service is available 24/7.

As Table 7.7 shows, the number of close and extended family members calling *DirectLine* about someone else's alcohol use decreased gradually from 2,462 in 2006–07 to 1,638 in 2012–13. In contrast, the number of calls from family members concerned about someone else's other drug[14] use (excluding alcohol) fell from 3,320 in 2006–07 to 2,074 in 2009–10 and then increased sharply to 3,828 in 2012–13. The number of alcohol-related calls received by the *FDS Helpline* from family members has steadily increased from 3,420 in 2006–07 to 5,966 in 2012–2013, whereas the number of calls from family members regarding drugs other than alcohol has remained relatively stable over the past four years. *CounsellingOnline* commenced in 2005, and the number of contacts made by family members concerned about someone else's drinking increased from 110 in 2006–07 to 342 in 2008–09. Since 2008–09, the number of contacts by family members concerned about someone else's drinking has ranged between 223 in 2011–12 to 295 in 2010–2011. Similar to the findings for *DirectLine*, the number of contacts by family members concerned about someone's drug use (excluding alcohol) has increased over the past three years.

Table 7.7 Calls and contacts received from close and extended family members about someone else's AOD use, 2006–07 to 2012–13

	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
	n	n	n	n	n	n	n
DirectLine calls about alcohol	2,462	2,173	1,893	1,740	1,700	1,591	1,638
DirectLine calls about drugs	3,320	3,075	2,503	2,074	2,548	3,152	3,828
Family Drug Support calls about alcohol	3,420	3,363	4,048	4,095	5,505	5,927	5,966
Family Drug Support calls about drugs	18,229	18,909	19,626	17,012	16,683	17,972	16,798
CounsellingOnline contacts about alcohol	110	128	342	286	295	223	258
CounsellingOnline contacts about drugs	283	227	191	328	161	281	308

Source: *DirectLine* and *CounsellingOnline* data were provided by HealthLink, Turning Point. Family Drug Support data were provided by Family Drug Support Australia.

[14] Other drugs, or drugs other than alcohol, include other psychoactive depressants (e.g., cannabis, benzodiazepines, GHB, heroin and other opioids including methadone), stimulants (e.g. methamphetamine, cocaine) and hallucinogens (e.g., ketamine, LSD).

Using 2012–13 data as an example, the main family members contacting each of the services were partners, parents and siblings. However, the proportions of each relationship type varied between the three services. For example, two in three family members calling FDS were parents, whereas parents only accounted for 34 per cent of the family members calling *DirectLine* and 24 per cent of the *CounsellingOnline* contacts from family members. Partners accounted for 60 per cent of the family members contacting *CounsellingOnline* about someone else's drinking, whereas one-third or less of calls to *DirectLine* and FDS were from partners. It's possible that the text-based modality of *CounsellingOnline* may provide partners with a more accessible and private avenue of support, as opposed to a telephone helpline (see Table 7.8).

Table 7.8 Relationship types calling about someone else's alcohol use for each service, 2012–13

	PARTNER		PARENT		SIBLING		SON OR DAUGHTER		OTHER RELATIVE		TOTAL
	n	%	n	%	n	%	n	%	n	%	
DirectLine	525	32	563	34	262	16	132	8	156	10	1,638
Family Drug Support	1,042	17	3,961	66	523	9	75	1	365	6	5,966
Counselling Online	143	60	56	24	12	5	12	5	14	6	237

Source: *DirectLine* and *CounsellingOnline* data were provided by HealthLink, Turning Point. Family Drug Support data were provided by Family Drug Support Australia.

7.6 CONCLUSION

This chapter illustrates the range of services that respond to families experiencing problems associated with others' drinking, from police to telephone helplines. In general, little research records or examines the numbers of services that are used by families and friends affected by others' drinking in the Australian context.

In many respects, police responses often reflect the more serious types of alcohol-related harms, such as assaults. But obtaining national estimates on the proportion of family incidents where alcohol was involved is difficult due to different reporting practices across Australian states and territories. This report indicates that in 2011 there were:

- 10,706 incidents of alcohol-related domestic violence in NSW (2010–2011)
- 11,732 family incidents with definite alcohol involvement in Victoria (2010–2011)
- 4,848 alcohol-related domestic assaults in WA (2010–2011)
- 2,398 alcohol-related domestic assault in the NT (2011).

This equates to a total of 29,684 incidents, excluding other states and the ACT where this information was not available. In the case of Victoria, WA and the NT the numbers of alcohol-related family incidents have been steadily rising. The Victorian data suggest that women were more likely to experience domestic violence.

The data on alcohol-related domestic violence are patchy. Alcohol involvement is not routinely recorded in many family services, and referrals between AOD and other services are not enumerated. There is substantial room to improve data collection, particularly outside AOD-specific services. Providing a clear picture of the proportion of families seeking assistance and support from non-alcohol and drug specific services (such as relationship counselling or parental programs) is challenging, as few services record alcohol as a reason for help-seeking. Although they may have asked about the client's drinking, this is not recorded systematically (especially in electronic records) or published in reports. However, the limited evidence that does exist suggests that alcohol is implicated in a substantial proportion of cases.

AOD services provide some support to family members of problem drinkers. For example:

- 6,720 closed episodes of care were provided to individuals seeking treatment related to someone else's alcohol and/or drug use by publicly-funded AOD services across Australia in 2011–12.
- 881 closed episodes of care were provided to individuals seeking treatment related to someone else's alcohol use by Victorian publicly-funded AOD treatment providers in 2011–12.
- Across Australia in 2012–2013, 5,966 calls were received by the FDS Helpline and 258 contacts were registered by *CounsellingOnline* from individuals concerned about a family member's drinking.
- 1,638 calls were received from Victorians by *DirectLine* in 2012–2013 from individuals concerned about a family member's drinking.

These statistics are all drawn from services that are specifically funded to provide services to those affected by or concerned about the drinking of others in family or intimate relationships. The general AOD service system also provides some data on services to others in drinkers' families, but this aspect of their work has not received policy or research emphasis, is often not specifically funded, and is inadequately recorded or counted.

8 ALCOHOL'S INVOLVEMENT IN CHILD PROTECTION CASES

Anne-Marie Laslett

8.1 INTRODUCTION

Societal and most individual attitudes toward drinking with one's spouse and around children indicate that carers should not drink to the point of intoxication around children (Room 2011). But the reality is that the majority of parents and carers do drink in Australia, and probably in many contexts in the presence of their own and others' children. Parents are expected to remain in control of their own and their children's lives, and to manage the risks associated with their own and others' drinking (Laslett 2013). Where parents are seen to have failed to do so, tension arises both within and beyond the family confines. In extreme cases, when carers and parents' actions or inactions are reported, state and territory Child Protection Services (CPS) are given the task of making decisions on drinking-as-a-risk-factor and its potential effect on parenting capacity. Where this threshold lies in determining capacity is unclear. The aim of child protection is often in conflict with the strong cultural values of family privacy and preservation, so that these systems, in Australia as elsewhere, are a perpetual site of cultural-political conflict. Given the cultural ambiguity about whether and how much drinking is acceptable in parental roles, this issue is often involved in these broader systemic conflicts (Arney & Scott 2010).

This chapter describes how children affected by others' drinking present in child protection systems across Australia. These problems commonly co-exist with other parental problems, including mental illness, family violence and socio-economic disadvantage. This chapter provides information on the cases that are serious enough to warrant child protection assessment and management and focuses on those cases involving parental or carer drinking. These cases commonly require substantial investment by government agencies and other support systems to deal with the numerous complex issues in the family situations of these vulnerable and maltreated children.

Information from all Australian states was sought and is described, summarising where possible the cases in which alcohol is involved. However, this chapter draws heavily on alcohol-specific Victorian data, collected by child protection workers between 2001 and 2005. As will be described, there is inconsistent collection of data on alcohol's involvement in child protection cases across the states. The Victorian data enabled analyses of how alcohol is involved in different stages of, and increasingly serious, child protection cases (Laslett et al. 2013), in repeat child maltreatment cases (Laslett et al. 2012), and in different forms of child abuse and neglect (Laslett et al 2010). These data were used to estimate the cases of child maltreatment involving carer alcohol misuse as a risk factor in Australia in 2006-07 (Laslett et al., 2010). This chapter addresses the research question: What services are available for families and children if they have been affected by the drinking of those around them?

8.2 STATE AND NATIONAL ESTIMATES OF ALCOHOL'S INVOLVEMENT IN CHILD PROTECTION CASES

While there are scant data available regarding estimates of alcohol involvement in child protection cases, there is a mixture of government reports and other studies investigating AOD-related child protection cases over the period 2001 to 2007 (see Table 8.1). For example, in Victoria and QLD there are government reports about alcohol and child protection cases, while in WA and SA there are only studies on specific populations related to child protection. In 2012-13, the national estimate of substantiated[15] child protection cases was 7.8 cases per 1,000 children aged up to 17 years of age (Australian Institute of Health and Welfare 2014), but there is no estimate of how many of these cases involve drinking by a carer. Child abuse cases are substantiated when a child has been, is being, or is likely to be abused, neglected or otherwise harmed (Australian Institute of Health and Welfare 2014).

[15] In the child protection system cases are first reported and then investigated or dismissed. Of those investigated a proportion of cases are confirmed or 'substantiated'. Data are more complete for substantiated cases than those cases that do not reach this stage in the process. Substantiated cases may be dismissed at this stage, receive a number of different protective interventions or, in the most serious cases, require a court order.

Alcohol is commonly involved in child protection cases across all states and territories. The percentages of cases that involve alcohol (or AOD where alcohol-specific information is not available separately) in each of the states and territories are noted in Table 8.1. In terms of government reports, in substantiated child abuse and neglect cases investigated by CPS in Victoria between 2001 and 2005 (calendar years), approximately one-third involved some degree of problematic alcohol use by the child's parents (Laslett et al. 2010). In QLD, 24 per cent of substantiated cases reported in 2007 involved parental alcohol misuse. Carer AOD problems were more commonly identified in substantiated neglect cases, and less commonly in sexual abuse, compared with other types of abuse (Queensland Government Department of Communities 2008). In NSW, only 15 per cent of cases were reported to involve carer alcohol abuse in reports from 2006-07. However, in more detailed study of a sample of 200 families, 35 per cent involved carer alcohol problems (Hopkins & Smoothy 2007).

Studies utilising smaller child protection samples and in different settings were also located. In WA 47 per cent of applications to the Children's Court in 2000 involved alcohol (Farate 2001) and over three-quarters of the families of children entering alternative (out-of-home) care in SA were identified as involving parental misuse of alcohol (Jeffreys et al. 2009). In the NT, while there are limited statistical data, the media and literature around the role of alcohol in child abuse and the 'rivers of grog' is compelling and so severe that a number of inquiries have been implemented into the abuse of children in the territory (see *The little children are sacred* report (Wild & Anderson 2007) and the NT inquiry into child protection (Bamblett et al. 2010)). Both of these reports identify alcohol as an obvious problem, although there are only limited statistical data presented. No government or other reports from Tasmania regarding alcohol and child protection cases were identified.

Table 8.1 Current state/territory estimates of alcohol involvement in child protection cases

Australian Capital Territory	Substantiated cases in 2000–2003: 56 per cent of cases in a study of 150 children from 110 families involved alcohol and drugs (Murray 2004)
New South Wales	Substantiated cases in 2006–07: 15 per cent involved alcohol in the data system; 35 per cent involved carer alcohol in a sample of 200 cases (Hopkins & Smoothy 2007) Court applications: 38 per cent of cases involve alcohol (McConnell et al. 2000)
Northern Territory	Parental/caregiver substance misuse cited as a significant factor in child protection between 2003 and 2010 (Bamblett et al. 2010) but no data provided
Queensland	Substantiated cases in 2007: 47 per cent involved alcohol or drugs, 51 per cent of these cases involved alcohol only (i.e. 24 per cent of all cases). Parental/carer alcohol misuse was most commonly found in neglect cases (Queensland Government Department of Communities 2008)
South Australia	Alternative care: approximately 70 per cent of cases in 2006 involved parental substance misuse (Jeffreys et al. 2009)
Tasmania	No estimates of the percentage of cases that involved alcohol and/or other drugs were identified
Victoria	33 per cent of all substantiated cases involved carer alcohol abuse and 42 per cent of cases involving a court protective order (cases in 2001-2005) (Laslett 2013)
Western Australia	47 per cent of applications in 2000 to Children's Court for care and protection orders involved carer alcohol (Farate 2001)

8.2.1 ALCOHOL RECORDING IN STATE CHILD PROTECTION SYSTEMS ACROSS AUSTRALIA

Table 8.2 illustrates the variability in reporting of alcohol-related problems in CPS across Australia, highlighting the considerable disarray within Australian data sources, with alcohol and other drug misuse by carers in the child protection system inconsistently recorded.

Without continuing mandatory electronic collection of the involvement in cases of carer alcohol and other drug misuse in the various state systems, it is not possible to estimate whether alcohol is becoming an increasing problem within these systems. Where there is mandatory recording, there is usually only a combined flag for alcohol and drug misuse; separate recording would be an important addition to knowledge in the field; and given the substantial size of the problem it is an issue that requires close government monitoring. The mandatory recording of alcohol as a risk factor ceased in Victoria in 2005 (Laslett et al. 2010). The reinstatement of alcohol as a mandatory data field would enable the ongoing surveillance of alcohol's effects upon the Victorian child protection system.

As highlighted in Table 8.2, surveillance in other states should also be enhanced. NSW only records alcohol involvement at the notification stage. Although QLD has an excellent electronic data collection system, it does not distinguish between alcohol and other drug misuse. Simple drop down boxes could be included for a number of risk factors in the different state-based CPS systems across Australia. A number of other changes to child protection data collection – for example the introduction of standardisation of alcohol misuse measures/definitions and the introduction of recording of referrals – are recommended. However, if standardised reporting of alcohol-related diagnoses is introduced, it is critical that child protection workers retain their ability to record the extent and nature of the impact of alcohol on parenting, regardless of the type of alcohol problem recorded. The ongoing reporting of alcohol involvement in CPS cases will enhance surveillance and evaluation of alcohol-related policies in this sector, as well as providing a basis for service systems and governments to plan and evaluate the impact of interventions to reduce rates of alcohol-related child abuse.

Table 8.2 Current state/territory recording of alcohol's involvement in child protection cases

State/territory	Department responsible	Name of CP database	Framework for assessing harm	Recording of alcohol	Mandatory recording of alcohol
Australian Capital Territory	Department of Disability, Housing and Community Services	Children and Young Persons System[16] (since December 1999)	Professional judgement[17]	No	No
New South Wales	Department of Community Services	Key Information and Directory System	Professional judgement: recorded as primary, secondary or tertiary issue	At notification, alcohol recorded separately from other drugs	No
Northern Territory	Department of Health and Families	Community Care Information System	Oracle Policy automation software	Unsure – recent figures from case note reviews	No
Queensland	Department of Communities	Integrated Client Management System	Professional judgement, moving toward structured decision making[18] via the Family Risk Evaluation Tool and Parent Strength and Needs Assessment	As part of alcohol and other drugs field	No
South Australia	Department for Families and Communities	Connected Client Case Management System (currently being developed)	Principal decision making criteria	Substance use recorded in line with National Minimum Dataset[19]	No
		Client Information System	Principal decision making criteria/ professional judgement[20]	In case notes and cannot be extracted, can only be utilised at case level	No
Tasmania	Department of Health and Human Services	Child Protection Information System	Professional judgement	As part of alcohol and other drugs field	No
Victoria	Child, Youth and Families Division, Department of Human Services	Child and Services Information System (CASIS) 1993 – 2005	Victorian Risk Framework (VRF); primarily based on professional judgement[21]	Drop down menu with options 'Yes', 'No' and 'Unknown'	Yes
		Client Relationship Information System (CRIS) 2006 – current		Can be noted, but no longer compulsorily	No
Western Australia	Department for Child Protection[22]	Assist (Since 8 March 2010)	Professional judgement[23] – Signs of Safety approach	Question 'Parental substance abuse' when case is first reported – free text-based reporting	No
		Client Community Services System (prior to 8 March 2010)		In case file notes only; case notes are summarised and entered into the electronic database	No

[16] AIHW (2010)
[17] Bromfield & Higgins (2005)
[18] Bromfield & Higgins (2005)
[19] Personal communication SA Department for Families & Communities
[20] Bromfield & Higgins (2005)
[21] Department of Human Services (1999)
[22] Personal communication WA Department of Child Protection
[23] Bromfield & Higgins (2005)

8.2.2 EXTRAPOLATING TO IDENTIFY NATIONAL LEVELS OF CHILDREN AFFECTED BY CARER ALCOHOL ABUSE

Carer alcohol abuse was identified by child protection workers in 31 per cent of the 29,455 children involved in substantiated cases, and in 33 per cent of the 38,487 substantiated cases themselves, in the Victorian CPS system between 2001 and 2005. While the HTO Survey data are national, the data from CASIS pertain only to one state – Victoria. It has been assumed here that the percentage of cases that involve carer alcohol abuse will be similar to the percentage that will be found for Australia as a whole: however, as Victoria has one of the lowest per capita alcohol consumption levels in the country, it is likely that the calculated figure is an underestimate.

To estimate the number of children affected by alcohol-related child abuse in Australia, the proportion of children identified in the Victorian CASIS data child abuse and neglect cases that involved alcohol was multiplied by the estimated number of children (n = 32,585) who were the subject of substantiated notifications of child abuse in CPS across Australia in 2006-07 (Australian Institute of Health and Welfare 2008). Thus an estimated 10,166 children experienced abuse and neglect related to carer alcohol misuse across Australia in 2005. If the same figure is applied to the 40,571 children substantiated in the system in 2012–13 (Australian Institute of Health and Welfare 2014), an estimated 12,658 children experienced alcohol-related child abuse or neglect in that period.

8.3 ALCOHOL'S INVOLVEMENT IN DIFFERENT TYPES OF CHILD ABUSE AND NEGLECT IN VICTORIA

The Victorian data collected between 2001 and 2005 enabled fine-level analysis of alcohol's involvement in child protection cases. In this period parental or carer 'alcohol abuse' was recorded as a risk factor or not by child protection workers compulsorily and electronically in each substantiated case. Alcohol abuse was not defined for child protection workers in their protocols but child protection workers were directed not to include this risk factor unless its presence could be supported in court (Laslett 2013). Before examining alcohol misuse in different types of abuse the different forms of child abuse are defined here (Victorian Department of Human Services 2007, pp. 3-4):

> ***Emotional abuse*** *occurs when a child is repeatedly rejected, isolated or frightened by threats or the witnessing of family violence. It also includes hostility, derogatory name-calling and putdowns, or persistent coldness from a person, to the extent where the behaviour of the child is disturbed or their emotional development is at serious risk of being impaired.*
>
> ***Neglect*** *includes a failure to provide the child with an adequate standard of nutrition, medical care, clothing, shelter or supervision to the extent where the health or development of the child is significantly impaired or placed at serious risk. A child is neglected if they are left uncared for over long periods of time or abandoned.*
>
> ***Physical abuse*** *consists of any non-accidental form of injury or serious physical harm inflicted on a child by any person. Physical abuse does not mean reasonable discipline though it may result from excessive or inappropriate discipline.*
>
> *A child is* ***sexually abused*** *when any person uses their authority over the child to involve the child in sexual activity.*

Using the Victorian data, it is apparent that carer alcohol misuse is more prominent in emotional child abuse cases (39 per cent of cases), child abandonment (38 per cent) and neglect (35 per cent), than in physical abuse (27 per cent) and sexual abuse (12 per cent) cases (Table 8.3). This is consistent with patterns of alcohol involvement in Canada, where alcohol abuse was also more likely to be reported in neglect and emotional abuse cases than in cases of physical and sexual abuse (Trocme et al. 2005). In a study of court cases in Boston, USA, Famularo et al. (1992) found that alcohol abuse was associated more with physical maltreatment and less with sexual abuse.

In Victoria, carer alcohol abuse was most commonly identified in the child abuse cases where parents were deceased or incapacitated (Table 8.3).

Table 8.3 Alcohol's involvement in substantiated child protection cases by type of primary harm, Victoria, 2001–2005							
	CHILD ABANDONED	PARENTS DECEASED OR INCAPACITATED	PHYSICAL HARM	SEXUAL ABUSE	EMOTIONAL HARM	NEGLECT	TOTAL
Total	**647**	**442**	**9,478**	**3,121**	**17,144**	**7,655**	**38,487**
n with alcohol involvement	245	245	2,554	385	6,661	2,681	12,771
% with alcohol involvement	38	55	27	12	39	35	33

8.4 ALCOHOL'S INVOLVEMENT IN MORE SERIOUS CHILD ABUSE AND NEGLECT CASES

The Victorian data also reveal that as child protection cases become more serious and require more intervention, alcohol is more likely to be identified as a factor. Of the 38,487 Victorian child abuse and neglect cases that were substantiated over the period 2001–2005, carer alcohol abuse was recorded as a risk factor in the family in one-third (33 per cent). Partitioning these cases by the level of intervention reached, carer alcohol abuse was recorded in one-quarter (25 per cent) of substantiated cases that did not receive further intervention. In cases where the most serious intervention was a protective intervention (but no court order), 34 per cent of cases were identified with carer alcohol abuse. Of those cases involving an order from the Children's Court, 42 per cent involved alcohol. Thus, cases that received further and more serious interventions were progressively more likely to involve alcohol. These results are presented in Table 8.4.

Table 8.4 Alcohol involvement by most serious stage in Victorian CPS 2001-2005				
	CHILD PROTECTION STAGE 2001-2005			
	SUBSTANTIATED INVESTIGATIONS	PROTECTIVE INTERVENTIONS	PROTECTIVE ORDERS	TOTAL
n	10,722	19,297	8,468	38,487
n with alcohol involvement	2,717	6,523	3,531	12,771
% with alcohol involvement	25	34	42	33

To test whether alcohol predicts progression through these stages of the system after adjusting for a range of other factors, multiple logistic regression was used. Table 8.5 presents an overview of the relationships between alcohol, other risk factors and socio-demographic factors, and the odds of a case receiving a protective intervention outcome over the five years for which data were obtained.

The bivariate analyses indicate that all of the independent variables in the model were significantly associated with the likelihood of receiving a child protection intervention. Carer alcohol abuse was strongly associated with an increased likelihood of receiving a protective intervention. The odds of a child receiving a protective intervention if they lived in a family where there was carer alcohol abuse case were 1.67 times those for a child living in a family where there was no such alcohol problem. Male children were more likely to receive a protective intervention than female children, although only 1.07 times more likely, suggesting that difference was not of great clinical significance, particularly given the power of the large sample to distinguish even small differences. Young children in the 0-3 year old age group were much more likely to receive protective interventions than children in the 4-11 and 12 years and older age groups. The accommodation status of the family was also correlated with the likelihood of protective intervention: with the exception of those with 'other' living arrangements, children from families who were buying their own home were less likely to receive such an intervention, and those who were homeless or lived in a caravan or public housing were most likely. Those renting were also more likely to receive an intervention than children from families who were buying their own home. Income type was also predictive of protective intervention, with wage earning groups all less likely to receive interventions, and those on unemployment benefits or other benefits and pensions more likely than families on sole parent pensions to receive protective intervention. Interestingly, step-parent and extended families were less likely than intact families to receive protective intervention. Other risk factors included in the model all were strongly associated with protective intervention, with parental other drug use having the highest odds ratio.

Table 8.5 Factors affecting the likelihood of child protection intervention among substantiated cases

	% OF SAMPLE	BIVARIATE ODDS RATIO	MULTIVARIATE ODDS RATIO	MULTIVARIATE OR 95% CIs
Carer alcohol abuse	33.2	1.67***	1.23***	[1.16, 1.30]
Male child	50.0	1.07**	1.06*	[1.01, 1.11]
Age of child				
0-3 (ref)	29.3			
4-11	44.6	0.66***	0.76***	[0.72, 0.81]
12+	26.2	0.64***	0.90**	[0.84, 0.96]
Accommodation status				
Own/buying (ref)	22.8			
Renting	31.5	1.33***	1.04	[0.97, 1.11]
Public Housing	36.7	1.98***	1.33***	[1.23, 1.43]
Caravan	1.2	2.02***	1.21	[0.95, 1.53]
No Fixed Abode	3.3	2.96***	1.62***	[1.37, 1.91]
Other	4.5	1.26***	0.88*	[0.78, 0.99]
Family income type				
Sole Parent Pension (ref)	42.5			
Unemployment Benefit	9.6	1.34***	1.23***	[1.12, 1.36]
Other Benefit	5.1	1.26***	1.26***	[1.11, 1.42]
Other Pension	9.2	1.25***	1.24***	[1.12, 1.36]
Wage/Salary High	1.4	0.57***	0.83	[0.68, 1.01]
Wage/Salary Low	13.7	0.74***	0.94	[0.86, 1.01]
Wage/Salary Medium	17.0	0.55***	0.81***	[0.75, 0.88]
Other	1.5	0.73***	0.93	[0.77, 1.12]
Family type				
Intact Family (ref)	28.1			
Blended Family	13.4	1.04	1.05	[0.90, 1.22]
Extended Family – Couple or one person	2.9	0.90**	0.94	[0.87, 1.01]
Sole Parent – Father or mother	47.7	0.96	0.90*	[0.84, 0.98]
Stepfather or Stepmother Family	5.8	0.79***	0.87*	[0.78, 0.97]
Other adults - Couple or one person and other	2.2	0.96	1.09	[0.92, 1.30]
Carer history of:				
Abuse as child	21.3	1.66***	1.31***	[1.23, 1.39]
Domestic violence	53.3	1.46***	1.10***	[1.04, 1.15]
Other drug abuse	35.3	2.36***	1.74***	[1.64, 1.85]
Mental illness	22.2	1.69***	1.49***	[1.41, 1.59]

Note: n = 38,487; *** p < 0.001, ** p < 0.01, *p < 0.05; CIs = Confidence Intervals
ref: the category with which other sub-categories are compared.

After adjusting for all of the variables in the multivariate model, cases with carer alcohol abuse identified as a risk factor were 1.23 times as likely to receive a protective intervention as those without. This figure, while still statistically significant, was reduced in comparison to the bivariate result. Bivariate associations were, in the majority of cases, also evident at the multivariate level: the likelihood of intervention was higher in cases involving younger children and in those families where other risk factors such as caregiver other drug abuse, domestic violence, a caregiver history of abuse, and a caregiver history of mental ill-health were identified, after taking into account all of the factors in the model. Compared with people who lived in a home they owned or were buying, cases where children were living in all accommodation categories except 'other' were more likely to receive an intervention, particularly those with no fixed abode. In those cases where families were earning a wage, the odds of intervention were lower than for those on a sole parent pension, and the odds were higher for those with unemployment benefits or a pension (Table 8.5).

The prediction of a court order being issued in the case, among those receiving protective intervention, was then analysed. The bivariate analyses (Table 8.6) indicate that boys were more likely to receive court orders than girls, as was the youngest age group in comparison to the middle and the older aged groups of children. Children who were homeless or lived in a caravan or public housing were more likely to receive court orders than those living in forms of housing that had been bought or were being purchased. Children from families where the sole parent pension was the form of income received were also more likely to receive a court order than children living in families receiving a wage or salaried income. In contrast, children from families receiving other benefits and pensions were more likely to receive court orders than children where their families received sole parent pensions. Children from blended and 'other' family types were more likely to be the subjects of court orders than children from intact families. Children from sole parent families and in step-families were as likely as intact families to receive court orders. Carer history of alcohol abuse, domestic violence, other drug abuse, mental ill-health and abuse as a child were also all significantly associated with receipt of court orders. Carer other drug abuse had the largest odds ratio, indicating that other drug abuse was most strongly associated with court-ordered care, including removal from the family and other court orders.

The multivariate analyses in Table 8.6 show that carer alcohol abuse was associated with an increased likelihood of receiving a court order following a protective intervention, after taking into account all other variables in the model. While many of the patterns of effects seen for court orders (Table 8.6) and protective intervention (Table 8.5) were similar, there were some important differences. Examining the alcohol risk factor variable (i.e. carer alcohol abuse), it is evident that although alcohol predicts both outcomes (ORs = 1.23 and 1.14), the size of this effect was slightly less for the court order outcome. This was also true for carer other drug abuse. For other variables the effects were more accentuated for court orders. Families who had no fixed accommodation were more likely to receive protective interventions (Table 8.5, OR = 1.62), and this association was even stronger in relation to the court order phase (Table 8.6, OR = 2.00). This was also true for those families living in caravans. In general, families receiving some form of government benefit were more likely to receive protective interventions, and again even more likely to receive court orders. In contrast, families earning a wage or salary (whether it was low, medium or high) were less likely than others to receive protective intervention, and even less likely to receive a court order.

Table 8.6 Factors affecting the likelihood of progression to court order phase amongst cases receiving protection interventions

	% OF SAMPLE	BIVARIATE ODDS RATIO (OR)	MULTIVARIATE ODDS RATIO (OR)	MULTIVARIATE OR 95% CIs
Carer alcohol abuse	36.2	1.40***	1.14***	[1.08, 1.21]
Male child	50.5	1.04	1.03	[0.98, 1.09]
Age of child				
0-3 (ref)	31.6			
4-11	43.3	0.69***	0.77***	[0.72, 0.82]
12+	25.1	0.71***	0.93	[0.87, 1.01]
Accommodation status				
Own/buying (ref)	20.2			
Renting	30.7	1.41***	1.07	[0.98, 1.17]
Public Housing	39.7	2.05***	1.38***	[1.26, 1.51]
Caravan	1.3	2.39***	1.54***	[1.22, 1.94]
No Fixed Abode	3.8	3.43***	2.00***	[1.72, 2.32]
Other	4.4	2.02***	1.29**	[1.12, 1.50]
Family income type				
Sole Parent Pension (ref)	43.8			
Unemployment Benefit	10.6	1.15**	1.15**	[1.04, 1.27]
Other Benefit	5.6	1.28***	1.33**	[1.18, 1.50]
Other Pension	10.0	1.14**	1.16**	[1.05, 1.27]
Wage/Salary High	1.2	0.31***	0.46***	[0.33, 0.64]
Wage/Salary Low	12.9	0.69***	0.88*	[0.80, 0.97]
Wage/Salary Medium	14.5	0.47***	0.70***	[0.62, 0.78]
Other	1.4	1.31*	1.41**	[1.13, 1.75]
Family type				
Intact Family (ref)	27.8			
Blended Family	13.7	1.35***	1.37***	[1.16, 1.62]
Extended Family – Couple or one person	2.9	0.89**	0.90*	[0.82, 0.98]
Sole Parent – Father or mother	48.0	1.05	0.98	[0.90, 1.07]
Stepfather or Stepmother Family	5.5	1.02	1.12	[0.98, 1.28]
Other adults - Couple or one person and other	2.2	1.44***	1.52***	[1.26, 1.84]
Carer history of:				
Abuse as child	23.5	1.62***	1.35***	[1.27, 1.43]
Domestic violence	55.9	1.20***	0.95	[0.90, 1.01]
Other drug abuse	40.3	1.85***	1.44***	[1.35, 1.52]
Mental illness	24.6	1.32***	1.23***	[1.15, 1.30]

Note: n = 27,765; ***p < 0.001, **p < 0.01, *p < 0.05; CIs = Confidence Intervals

While the relationship between alcohol reporting and substantiation has been the subject of considerable research, the association of alcohol with what happens next has not been previously studied. This study shows that a large proportion of the 12,771 Victorian alcohol-related cases studied go on to receive more intensive attention – 51 per cent to protective interventions and 28 per cent to court orders (see Table 8.4) – and that carer alcohol misuse is predictive of this further progression through the system.

Carer alcohol abuse was thus significantly associated with intensification of handling through to the more serious stages of child protection actions, after taking into account a range of other factors. These findings are consistent with the high prevalence of carer alcohol abuse reported in court-involved cases (Murphy et al. 1991), and support analyses that implicate problematic drinking in progression through the system. Carer alcohol abuse may have played a causal role in numerous cases, but could also, in turn, be a consequence of maltreatment in others. For example, some research suggests that women victimised by an intimate partner may turn to alcohol to cope (Wingood et al. 2000), and it is plausible that a parent may turn to alcohol because they cannot cope with the fact that they themselves or others maltreat the child. Even so, this is only likely to worsen the situation for the child. Problematic drinking may also interfere with caregivers' ability to successfully follow a CPS plan for remediation, and thus make more serious intervention from the CPS system more likely. If a parent continues to drink alcohol problematically the drinking may well play a causal role for more serious outcomes.

Overall, the models presented in this chapter show that the odds of more serious outcomes were also increased for cases involving younger children, families that were not intact, and families in worse living conditions and who were unemployed or on other benefits, suggesting disadvantage was important. The results in Tables 8.5 and 8.6 suggest the youngest age group of children is more likely than older age groups to be the subject of more serious interventions, after adjusting for all other factors. This is consistent with the international and Victorian evidence discussed in the previous chapter, and evidence that infants aged 0-4 years are at a higher risk of more severe outcomes than other age groups (Jordan & Sketchley 2009). However, it differs from the results of the 2008 HTO Survey that found carers were more likely to report that older children were affected by others' drinking (Laslett et al. 2010).

Child protection workers may be particularly concerned about combinations of child and carer risk factors. Indeed, that alcohol use, child's age group and other factors all remain significant in the model suggests that child protection workers do take these factors into consideration in their decisions regarding interventions. Other drug abuse, parental history of abuse as a child, and caregiver mental ill-health were linked even more strongly than carer alcohol abuse to higher odds of cases receiving further protective interventions and court orders. These findings of independent effects of these variables suggest that numerous factors are part of the causal chain and are taken into account when interventions are undertaken and court orders implemented: carer risk factors appear to play a strong role in the decisions child protection workers make.

Regarding the relationships identified between predictor and outcome variables, there are two possibilities. It is possible that the CPS worker's coding of these variables, for example, carer alcohol abuse, influences the handling of the case in a way which results in a more severe outcome. Alternatively, the carer's drinking may directly influence the child in a more serious way.

One outcome of the child protection system not explicitly highlighted in the previous analysis is the very serious step of removal of the child from the family and placement in out-of-home care. Figure 8.1 illustrates the substantial numbers of children across Australia in out-of-home care and that these numbers have been growing. While the level of alcohol involvement in these cases in each of these years is unclear, other work by Delfabbro et al. (2012) indicates that 69 per cent of children in out-of-home care have parents or carers with substance abuse problems.

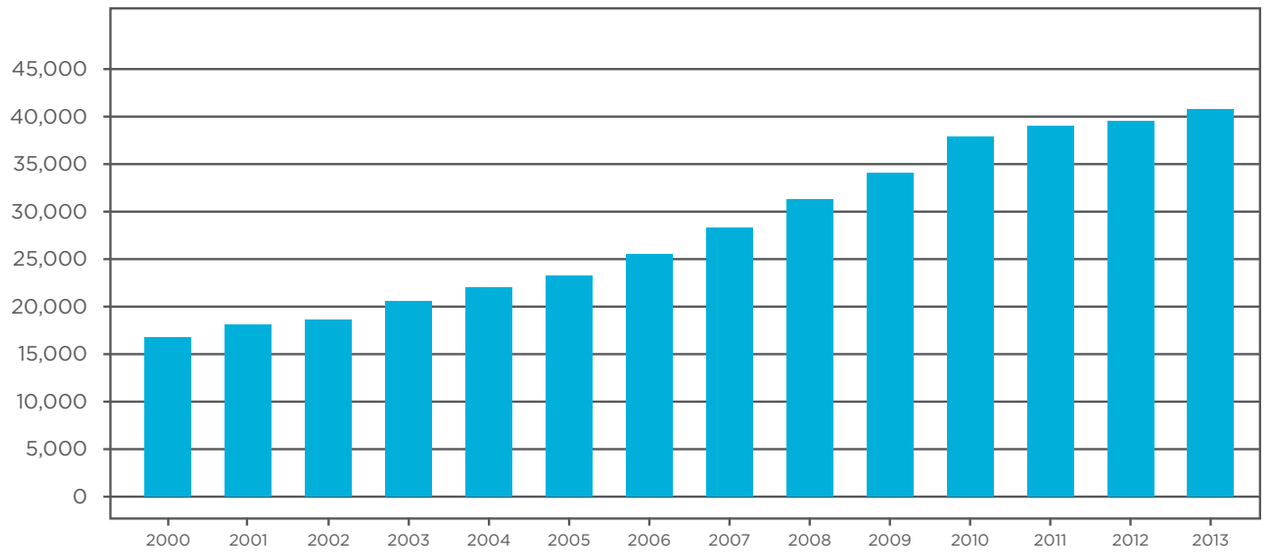


Figure 8.1 Number of children in out-of-home care in Australia 2000–2013

Source: Delfabbro et al. 2012

8.5 ALCOHOL'S INVOLVEMENT IN REPEAT CASES OF CHILD ABUSE AND NEGLECT

Twenty-nine per cent of the children who experienced alcohol-related child abuse or neglect in Victoria between 2001 and 2005 experienced repeated abuse or neglect (Laslett et al. 2013). Table 8.7 presents the distribution of the number of times children experienced maltreatment. The majority of children (77 per cent) appeared in the Victorian data system (CASIS) only once, and on average, children appeared 1.3 times in the system over the five year period studied. Children from families where carer alcohol abuse was identified were less likely to experience a single substantiation (71 per cent versus 79 per cent for others, $\chi^2 = 219.63$, $p < 0.001$), and more likely to experience re-substantiations (a second or further substantiation once the case has been closed in the five year period) (Laslett et al. 2012). The final column in Table 8.7 shows that as the number of recurrences increased, carer alcohol abuse was more likely to be reported (using Poisson regression, $p < 0.001$). Overall, 31 per cent of children (and 33 per cent of cases) were from families where one or more carers had been identified with alcohol abuse.

Table 8.7 Substantiations of child maltreatment with and without carer alcohol recorded as a risk factor#, Victoria, 2001-2005

NUMBER OF SUBSTANTIATIONS	CHILDREN	CASE FILES	ALL CHILDREN IN FILES (%)	AMONG CHILDREN WITH ALCOHOL RECORDED (% OF 9,194)	AMONG CHILDREN WITHOUT ALCOHOL RECORDED (% OF 20,261)	ALCOHOL RECORDED AMONG CHILDREN WITH N SUBSTANTIATIONS (I.E. % OF N CHILDREN IN COLUMN 2)
1	22,614	22,614	77	71	79	29
2	5,079	10,158	17	21	16	38
3	1,412	4,236	5	6	4	39
4	278	1,112	0.9	2	0.7	51
5	65	325	0.2	0.3	0.2	42
6	7	42	0.0	0.04	0.01	57
Total	29,455	38,487	100	100	100	31

Note: #Carer risk factor diagnosed at first substantiation.

8.6 CONCLUSION

This chapter underlines the role of parental or carer alcohol misuse in child protection cases, highlighting that:

- carer alcohol abuse is associated with between 15 (in NSW) and 47 (in WA) per cent of child abuse cases across Australia
- carer alcohol abuse is involved in a third (33 per cent) of substantiated cases of child abuse and neglect in Victoria
- carer alcohol abuse predicts protective interventions, court interventions and recurrent child abuse and neglect
- in 2006-07 (using the best and most recently available data), 10,166 substantiated cases of child abuse and neglect across Australia are estimated to have involved alcohol; this equates to an estimated 12,658 children in 2012–13 (if the same extrapolation method is used).

9 EXPERTS' OPINIONS ON ALCOHOL-RELATED HARMS TO CHILDREN AND FAMILIES

Anne-Marie Laslett and Janette Mugavin

9.1 INTRODUCTION

This report has presented an overview of the ways in which alcohol affects families and children across Australia. Based on the 2008 HTO Survey, an estimated 17 per cent of Australians have been affected by the drinking of at least one person in their family in the last year, and 22 per cent of respondents with children in their families report that the children experience some type of harm linked to others' drinking at least once in a year. A smaller proportion of families and children experience substantial harm and present to service response systems. However, this report shows that alcohol is implicated in a third of all child protection cases (in Victoria between 2001 and 2005) and 23 per cent (in Victoria in 2012-13) to 45 per cent of domestic violence cases (in NSW in 2008-09) (Laslett et al. 2010). That alcohol is often present in such cases is acknowledged by government agencies but rarely responded to in targeted ways.

In this chapter the research questions addressed are: What types of service and policy interventions are likely to improve the situations of those affected by others' drinking? What innovations in service systems and government policies will begin to improve the situations of the families and children affected by alcohol-related problems? What research is needed to understand the alcohol-related problems of and solutions for families and children? Some responses exist for those children and families most seriously affected (see Chapters 7 and 8), and this chapter examines how these services might be improved. Other alcohol-related problems for families and children identified in this report are less serious but far more prevalent. How this spectrum of issues might be addressed by policies will also be with the key informants.

9.2 KEY INFORMANTS' REFLECTIONS ON EXISTING SERVICE SYSTEMS

The key informants in this consultation comprised mainly researchers, policy makers and service providers from the child protection and AOD sectors across all Australian states and territories (See Chapter 2 for details).

As described in Chapters 7 and 8, alcohol-related problems for families and children place a substantial resource burden on current service systems. Child protection key informants commented about the involvement of alcohol in problems they responded to:

> *There is a consistent message about alcohol – its presence, overuse and misuse permeate child protection. It gets tangled up with drugs, [with AOD] amplifying the effects of each other – [I'm] not sure they can be distinguished.*

> *Alcohol is one of the single largest threats to the wellbeing of children.*

Chapters 7 and 8 make apparent that, with a small number of exceptions, little information is gathered routinely from these family or child protection systems about alcohol-related problems experienced by individuals that present to their services. This is also the case for information on referrals to and from AOD services and how alcohol treatment services record or address problems of their clients' families, or target families and individuals affected by the drinking of their family members and intimate partners.

These challenges were apparent from discussions with the key informants interviewed:

> *[We] should be able to get information on risk factors [for child protection cases] in every state but it is only entered in free text fields [i.e. entered in hand-written or electronic case notes in an ad hoc way] in some states and even if categorised could be hard to extract.*

It became evident that the issue was not simply about recording of data, although what different agencies

record may be emblematic of their priorities to an extent. Key informants made it clear that sometimes these issues were related to differing priorities of different sectors:

> *A big issue is that adult services won't address child issues. [There is a] failure to consider child protection issues in the AOD sector. They often don't even ask whether they have children.*

> *[Child protection workers] are not encouraged to know a great deal about alcohol or encouraged to work with the AOD sector, they are very compartmentalised – we are trying to break this down.*

Both AOD and child protection sector key informants were aware of these issues and were keen to address them. They described new multi-sectoral programs being introduced that build capacity through training and that supported assessments:

> *The Building Capacity: Building Bridges program is developing accredited training for domestic violence, AOD, mental health and other sectors. It provides training in how to assess parenting and children's needs and provides additional enabling, supportive environments for [parents to access] adult services, enabling connections between adult-focused services and child and family services.*

There was evidence that the AOD sector was changing and becoming more aware of the needs of families, and not only their adult clients. As one key informant said, "there has been a shift in AOD services – an acknowledgement that AOD clients are situated in families." Another explained, "a priority for the AOD field is having consistent intake questions…like 'Are you a parent?'" Furthermore, new training initiatives have been developed to support the workforce to provide family-sensitive services. One key informant explained:

> *There is growing interest in child protection and child-sensitive practice. They [the AOD sector] established an initial survey of the AOD workforce on family-sensitive practice and went on to produce a toolkit.*[24]

The complex nature of problems

Most programs focused on how AOD and family concerns operate in areas where the problems for families are often multiple and severe, and commonly involve child protection. These programs operate at the severe end of the spectrum. AOD and child protection key informants described the evidence of the effectiveness of a number of programs, e.g. the *PUP, Brighter Futures* and *Odyssey House* programs (for an example of these programs see Box 7.1 in Chapter 7).

> *PUP draws on theories of mother and child attachment and clinical and developmental psychology and targets vulnerable families in the child protection system. PUP is a clinical intervention that trains parents in parenting and evaluates the program's progress.*

However, another researcher key informant was concerned about entrenched problems:

> *Where AOD problems are well established, outcomes for children are appalling. There is a need to identify where to get change, [how to ensure families] engage in services, [and] understand the nature of interventions.*

There was consensus that the evidence of effective programs was mostly from small-scale studies. Again, *PUP* was mentioned and the fact that a trial of this intervention was underway in the UK.

Alcohol-related management in child protection situations was discussed, including the importance of facilitating or empowering the parent to change. As one child protection service manager explained:

> *[There is a] need [for] realistic discussions with people about what is realistic – will you be drinking forever? If so, this is not acceptable. [Child protection workers] need to make realistic assessments and decisions about parenting ability – need to tell them [the parents] what is acceptable; need to have behavioural change (it's not just about going to an AOD counsellor)…and facilitate, not force, change.*

Child protection service providers identified interventions and strategies used with parents to identify and address risks associated with alcohol use.

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[24] See Battams 2010; Trifonoff et al. 2010

We use the 'Signs of Safety' approach. In this, if alcohol is a concern, it goes to the top of the list. It's scenario-based behavioural management. If you drink, these things happen. So parents can be responsible when drinking (i.e. they can slip their kids off to parents or you can drink between 12 and 2, but don't drink and drive and [make sure you] are sober to pick up the kids).[25] Signs of Safety provides a usable model for how functioning families operate.

The need for more effective services targeting those most at risk was identified, with key informants mentioning a number of effective existing services as well as potential program and service innovations. Some of the existing programs suggested by the key informants included:

- *Parents Under Pressure* (PUP) – clinical intervention programs that train parents in parenting, usually because of multiple family concerns, including substance misuse.
- *Family Drug Treatment Courts* – these courts incorporate AOD treatment into conditions of sentences relating to families and parental access.
- *Queensland Indigenous Alcohol Diversion Program* (QIADP) – this program involves diversions from criminal and child protection systems into the AOD treatment system.

A number of potential programs were also suggested by key informants in the focus group. An example of this was the introduction of better assessment and family-sensitive practice through brief general practitioner interventions:

Getting them to think of putting questions to patients about their drinking like: 'How is this affecting your 5 year old?' 'How is this affecting your parenting?'

The need for services that assisted with planning for pregnancies that took into account children's concerns was noted. Key informants thought such planning should be a routine part of psychosocial risk assessment in the AOD field (noting that smoking efforts to promote cessation in pregnancy has worked, improving outcomes for existing and future children). Key informants suggested that services for pregnant women in situations of high psychosocial risk need to take into account potential effects of alcohol on subsequent children, particularly if mothers are drinking before they are aware they are pregnant.

Most of this section has been about the service system changing the drinker, not about what can be done to fortify or change the 'other' or affect the family system. In discussions of the treatment service system the key informants' concerns appear still to be focused on the drinker, and less on 'others'.

According to key informants in the focus groups, AOD family-sensitive practice aims to identify families in the AOD treatment system earlier to ensure that children's and families' needs could be identified and managed earlier, without necessarily involving child protection. Family-sensitive AOD practice is an example of secondary prevention – targeted services that address families' needs so that they do not enter emergency services that manage child and family breakdowns and crises. There was further consensus by both AOD and child protection key informants that there was a need for interventions that acted earlier in children's and families' lives:

We need a range of programs, from universal to high risk FAS management.

The focus group was clear that:

While there are groups at risk, which are not being managed by systems, it is inadvisable to channel more children and families into the child protection system.

There was a strong sense that a range of secondary and primary prevention initiatives were needed to address alcohol-related problems for families and children earlier:

We know the key drivers of child protection are parental problems – domestic violence, AOD, mental health. It doesn't make sense to wait until the children end up in child protection.

PUP is an exemplary program, working at the severe end, but what about a step back, a transition to primary and secondary prevention measures?

[25] See Turnell & Edwards 1999.

9.3 RESEARCH DIRECTIONS SUGGESTED BY KEY INFORMANTS

The key informants interviewed felt that many of the risk factors for child abuse and neglect and family violence, including AOD and mental ill-health were already patent. However, whether alcohol-specific interventions were effective in reducing harms to children of heavy drinkers was not clear. There was also little evidence to suggest that domestic violence interventions were effective and, indeed, concerns about the general effectiveness of interventions for vulnerable families were also apparent. Key informants suggested the effectiveness of tertiary and secondary treatment services and primary prevention initiatives all need to be examined (see Chapter 10).

Summarising the findings from those interviewed individually and/or in the focus groups, key informants indicated that existing programs should continue to be evaluated and funded where successful, models should be developed that inform alcohol-related research with families, and data-driven research should be more nuanced. One researcher underlined the need for well-resourced, longitudinal assessments of program and service outcomes.

One of the focus groups discussed conceptual models for research, and suggested models should:

- provide a sophisticated model for understanding alcohol-related child protection problems, e.g. by adding tiers of child protection interventions, such as out-of-home care groups, and by focusing on heavier drinking groups as well as general population drinking patterns
- incorporate conceptual shifts apparent in domestic violence and child protection presentations, where issues are about complex problems of 'violent families' versus more traditional characterisations of 'single violent offenders within families'
- consider gender issues, and take into account potential reactions of different interest groups with different perspectives about the role of alcohol in violence when results are presented (e.g. men's and women's groups)
- take into account contributing and exacerbating factors of child abuse and neglect, including how alcohol can fragment protective factors.

The key informants also indicated that existing data-driven research should:

- better take into account the problems of existing data, as attendance and reporting vary depending on police numbers, regulations and laws around reporting (e.g. in some states different types of child abuse are mandated to be reported, by law or by standing orders, and in others it is discretionary)
- include discussion of the range of thresholds apparent in different data sets (i.e. there are high thresholds before courts manage cases, larger groups of those affected fly under the radar)
- pay attention to the number of family violence calls police attend where children were present, both in situations where alcohol was and was not involved.

The key informants recommended that future research should also:

- differentiate between risks for children exposed to consistent heavy drinking and risks associated with exposure to episodic drinking
- acknowledge that many children not exposed to child protection services may still be harmed or traumatised by their parents' or other family members' drinking
- be better resourced, for example via the creation of a hypothecated tax to enable grants and ongoing resources to be provided to investigate priority areas (e.g. the nexus between AOD and child protection).

The group was asked specifically about relevant alcohol's harm to others research and there was consensus that this field of research, particularly child and family research, could and should be an important rationale for policy change. The comments of the key informants mirror some of the findings from the *Protecting Victoria's Vulnerable Children Inquiry* (Cummins et al. 2012), which made clear the links between alcohol misuse and child abuse and neglect, describing the need for prevention initiatives and research in this area:

> *Parental alcohol misuse is a significant risk factor for child abuse and neglect. The Inquiry considers that further investigation of the potential preventative benefits of public education and mechanisms such as minimum pricing of alcohol and volumetric taxing has merit. (Cummins et al. 2012, Volume 2, p.131)*

In the same report there was an associated recommendation (p. 178 of volume 2) to conduct an audit of adult specialist services, commencing with AOD services, to ascertain the degree to which they are 'family-sensitive.'

9.4 CROSS-SECTORAL COLLABORATION

The need for cross-sectoral support for effective services, policy advocacy and research was also highlighted by key informants. A number of policy players are relevant and supportive of programs that focus on the harms to others from drinking: the Australian National Preventive Health Agency (ANPHA), National Alliance for Action on Alcohol (NAAA), Australian Centre for Child Protection (ACCP) and Australian National Council on Drugs (ANCD). The key informants from the child protection sector spoke of existing connections between AOD and child protection researchers in some states:

> *The Australian Centre for Child Protection is doing relevant HTO workforce development – a $2.4m national workforce development grant to strengthen 'family-sensitive practice' in the AOD, mental health, family violence and homelessness sectors in 12 sites – and evaluating this.*

Some key informant researchers who had focused on the nexus between AOD and child protection felt more isolated and were keen to garner support and develop ongoing connections. They felt that some form of expert group could play an important role to develop and push forward services, research and policy in this space.

9.5 CONCLUSION

The opportunity to listen to and understand the views of experts in both the child protection and AOD fields was illuminating. It is apparent that the AOD and child protection sectors recognise the importance of each other's work but they have only recently begun to take action to improve the synergy in their practice. The research in this area is underdeveloped and there is a clear need to develop recommendations for evaluation of a range of primary, secondary and tertiary prevention interventions that target alcohol problems of families and parents and measure consequences for families and children.

To better understand and address the needs of families and children in the future, it would be useful to expand the number of key informants consulted and include more people from diverse sectors, for example relationship services, mental health and domestic violence service managers and researchers, senior police and criminologists. The establishment of an ongoing expert panel may be a way to better link professionals in this key area.

10 SUMMARY, FRAMEWORK FOR INTERVENTIONS AND RECOMMENDATIONS

Anne-Marie Laslett

10.1 INTRODUCTION

This report highlights the role of alcohol in a range of problems experienced by families and children because of a family member's drinking. A key question is, how can alcohol-related child abuse, family violence, family dysfunction and associated harms be diminished, other than by treating AOD cases? The answer may be by improving the responses of family, police and other social response services, including by recognising that there are various elements of family interaction and functioning which can be changed to improve the situation – and also by paying attention to factors in policies which may improve things. For instance, rates of family violence may go down if alcohol is less available, or if other alcohol control policies are introduced, or indeed if other non-alcohol policy levers are pulled.

Chapter 10 summarises the findings of the report, introduces a public health model of prevention and care for families and children, and provides recommendations for public policy interventions.

Public policies and programs aim to protect, promote and restore the people's health and wellbeing and emphasise the prevention of disease and the health needs of the population as a whole (Last 1988). A public health model of care allows assessment and response to a range of health and social problems (Last 1988), and has been applied already in the child protection field (Holzer 2007). In this chapter, a pyramidal public health model is introduced to illustrate the increasing risk of problems and the types of problems families and children face because of others' drinking. This model also describes the potential responses to these problems.

The purpose of this model is to demonstrate the varied policy and program responses needed to address the different levels of harms inflicted on children and families from alcohol. The model examines these responses through a public health lens, highlighting the need to prevent alcohol harm among those people not currently affected, while also providing targeted support to people who are currently harmed. A number of detailed and specific service and research recommendations are presented to set an agenda for future work in this area.

10.2 SUMMARY OF FINDINGS

The evidence presented throughout this report clearly underlines the effects of alcohol on family members and children. It documents the events that can occur when a family member, and particularly a parent or carer, drinks problematically. As described in Chapter 3, 17 per cent of adult Australians report they have been adversely affected by the drinking of a family member or intimate partner in the previous year. Moreover, in Chapter 4, one in five carers reported that their children had been affected adversely in some way by others' drinking in the last year. Twelve per cent of carers reported that their children were verbally abused, left in an unsupervised or unsafe situation, physically hurt or exposed to domestic violence because of others' drinking in 2008. These results are drawn from the 2008 HTO Survey and the follow-up 2011 HTO Survey.

The 2011 HTO Survey indicated that one in 11 respondents (9 per cent) reported that they had experienced persistent harm from family members or intimate partners in 2008 and 2011, with 26 per cent of families reporting harm in at least one of those years. Examining this from another perspective, 50 per cent of respondents being harmed by family members' drinking in 2008 reported they were also, or still, being harmed by the drinking of family members in 2011. Children also experienced persistent harm: seven per cent of families in the surveys reported that their children had been harmed in both years, with 35 per cent of families where children were harmed by others' drinking in 2008 reporting that their children were harmed by the drinking of others again, or still, in 2011.

The 2011 HTO Survey also presented the opportunity to seek permission to understand qualitatively how families and children were affected because of others' drinking. Chapter 6 describes the range of ways that respondents and their families were affected. Harm reported because of another person's drinking was most often due to verbal and emotional abuse, for example, when children were exposed to arguments and domestic violence.

Chapters 7 and 8 provide data from services that respond to alcohol-related problems of families and children. While there is often little information recorded about alcohol in the systems that provide general assistance to families and children across Australia, those services that do collect such information (e.g. police domestic violence and child protection services) report that large proportions of the people that they assist are affected by others' drinking. This report indicates that:

- Parental or carer drinking plays a large role in child protection cases, with available data indicating that 15 per cent of CPS reports (NSW), at least 30 per cent of CPS substantiated cases (Victoria) and up to three-quarters of cases of children in out-of-home care (SA) involve carer alcohol abuse.

- Alcohol abuse by parents or others caring for children is predictive of protective interventions and court intervention.

However, there is a disconnect between the high extent to which services report alcohol as a problem and HTO Survey respondents' reported access to a range of support services. For example, large numbers of alcohol-related cases appear in the police, domestic violence and child protection crisis response systems, yet the AOD treatment systems are largely focused on the needs of their individual clients' problems. Only a small minority of AOD system clients (4 to 5 per cent) are there because of others' drinking. The majority of family, financial support, justice and police and welfare services do not document whether the concern of the family member is linked to alcohol. It must be noted that data collection is limited about whether family members seek a range of services for managing problems associated with their family members' or intimate partners' drinking.

Perhaps the most important issue is that currently across Australian states and territories there is not consistent funding of interventions that address the needs of family members. Funding models and service targets for AOD treatment services have a large impact on treatment of family members. Services for family members are not always included in service agreements, and such systems can discourage treatment of family members and/or create inappropriate reporting incentives within the system.

Chapter 9 summarises the views of service providers, policy makers and researchers (primarily researchers active in the child protection and AOD areas), and draws attention to services, policy areas and research endeavours that should be developed. These key informants identified the following main concerns and priorities:

- improved collaboration and communication between the AOD, child protection and other welfare and family services

- improved definition, screening and surveillance of AOD problems in child protection services and child protection problems in AOD services

- innovations for high risk FAS management

- multi-disciplinary intensive services for families most at risk

- brief interventions for vulnerable families

- implementation of universal policies that prevent or limit alcohol misuse in Australian families.

10.3 A RESEARCH-BASED PUBLIC HEALTH MODEL OF CARE FOR FAMILIES AND CHILDREN AFFECTED BY OTHERS' DRINKING

This section introduces a pyramid model that describes both the problems associated with others' drinking that families and children experience and the responses required to manage these problems (e.g. child protection and police service responses). The pyramid model estimates the number of children at different levels of risk of alcohol-related harms. The pyramid draws together data from the 2008 HTO Survey presented in Chapter 4 and the child protection data from Chapter 8 into a comparative frame. From this it is apparent that much larger numbers of children than are seen in the apex of the pyramid are affected by the drinking of their families (See Figure 10.1).

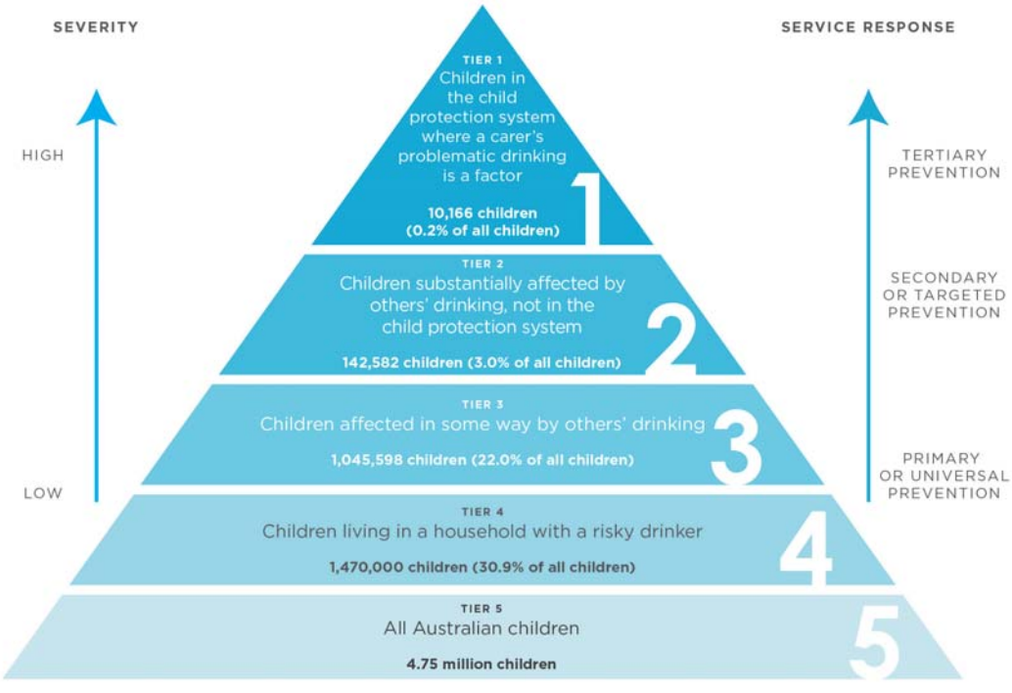

Figure 10.1 Pyramid of risks to children affected by alcohol-related problems in Australia per year

Figure 10.1 broadly describes the proposed prevention strategies inherent in the pyramid model for public policy responses. Tier one (Children in child protection system where a carer's problematic drinking is a factor) of the pyramid model addresses the most serious instances of alcohol-related harms to children and families. For example, alcohol-related child abuse and neglect and domestic violence deaths, injuries and harms appear in the apex of the pyramid and are managed by police, legal and social services. The services that meet the most serious needs in the public health model are described as 'tertiary preventive services.' Where possible tertiary preventive services aim to manage severe problems, limit further complications and prevent re-entry to the system (Holzer 2007; Last 1988).

Tier two (Children substantially affected by others' drinking, not in the child protection system) of the pyramid includes children who have been affected substantially or "a lot" by alcohol, but who have not come to the attention of child protection authorities. This may include families in which one or more members are seeking assistance for their alcohol problems. These problems may not require action by police or child protection services, and may or may not be known to more than one social support service. In this tier, targeted services aim to prevent harms to the drinker but also to prevent families and children from progressing into a higher tier. Vulnerable families may also be receiving general services, e.g. Family Services, but may not have the alcohol-related problems of their family members identified or responded to.

There are no data for the second tier on either the number of children living in families where a member of the family is in treatment for alcohol problems, or the number of children in families receiving other

services where alcohol is identified as a problem for one or more members of the family. While there does seem to be the potential to record this information in the Victorian AOD data system, and the Auditor General's report indicates that about one-third of AOD clients have dependent children, completion of this data field is not compulsory in AOD services, and therefore it is not well completed (Victorian Auditor General 2011). Thus, there is no accurate estimate of the number of vulnerable families that should be targeted with secondary prevention initiatives.

Tier three (Children affected in some way by others' drinking) of the model includes a range of more minor problems (e.g. serious family arguments with heavy drinkers in the family, verbal abuse of children) that may not require service responses, and are not brought to the attention of any official services, but nevertheless affect a range of families, sometimes escalating and requiring attention from services at higher tiers of the pyramid. Although this group is described as being affected at least "a little," the aim is not to diminish the seriousness of the situation for these children. It is also acknowledged that carers may not recognise that others' drinking had affected (or how much it had affected) their child/ren. These more prevalent problems are best met by universal services and broad policies such as maternal and child services, financial aid, various forms of welfare, and universal alcohol harm prevention policies (Arney & Scott 2010).

The third tier, as well as the second tier, may hold children from families where more serious and/or sporadic alcohol-related problems are hidden from authorities and services. As child protection researchers have noted, only a proportion of child abuse and neglect incidents will be observed by others beyond the parent and the child (Creighton 2004). These children are not necessarily experiencing less harm than children in families who have come to the attention of authorities or service providers: in fact, in some cases these children in families in which there has been no motivation to seek help for problems, or no intervention from authorities, may be suffering more severe harms.

Tier four includes those families at risk because they live with someone consuming alcohol at risky levels, but are not currently affected by that person's drinking. The available evidence does not indicate whether this drinking is taking place in the presence or absence of children, therefore it is not clear whether children in this tier are witnessing their parent/s affected by alcohol or any after effects such as a hangover.

Tier five comprises all Australian children who are at some additional risk because of exposure to general societal heavy drinking problems (Hope 2011). Alcohol is a legal product in Australia and its use has been normalised in everyday life. Even children in households where nobody consumes alcohol are still likely to be exposed to alcohol advertising and to people outside their household drinking.

In order to better reflect the harm to other family members as well as children caused by a family member's drinking, further work is required: future iterations of this pyramid should incorporate national data on a broader range of problems and services.

10.4 A PUBLIC HEALTH APPROACH TO PREVENTING MANAGING ALCOHOL-RELATED HARMS FOR FAMILIES AND CHILDREN

There is substantial agreement about how drinking can be problematic for families and children. However, there are less consistent understandings about how different types of problems, for example child maltreatment, should be managed (Beck 1992; Douglas 1992; Goddard 1999; Tomison 2001). Expanding on this example, there is some consensus in Australia and elsewhere that channelling increasing numbers of children and families into child protection services is not the best way to provide care to families and children most at risk, and that keeping families intact as much as possible is preferable (Cummins et al. 2012; Tomison 2001). On the other hand, there may be unintended consequences of acting on these sentiments. In the UK, researchers have found, in cases involving substance misuse, and particularly in

those cases involving alcohol, that the system was too slow to intervene to remove children, and that children who were removed earlier did better (Forrester & Harwin 2008). The present report does not address whether removal of children is or is not a better option. It does acknowledge that child protection services are inevitable, and will always be an important element of the service system. This study constructs the problem as a pyramid of risk, acknowledges that children are at varying risk levels and that, alongside child protection services for cases that are the most acute, universal primary prevention and secondary targeted interventions should also be emphasised to prevent children from moving up the pyramid.

It is also important to highlight that alcohol's harm to others inherently involves interaction between individuals, and thus may be prevented in essentially three ways, by:

1. changing the drinking of the drinker
2. fortifying or treating the other
3. insulating contact between them.

In some instances it may be that approaches other than managing the drinker's drinking may result in better outcomes for the family member affected by the drinker. But this type of solution may not always be easy to initiate or sustain, and in some cases even when some harmful aspects of the drinkers' behaviour are modified other more intractable problems may remain.

Services targeted to the children and families of heavy drinkers operate to manage problems and ensure that children and families do not end up in crises, such as those responded to by police and welfare services. These services may operate to manage families' 'second-hand' problems and seek to enable the family to remain in contact with the drinker, or act to separate members of the family from the heavy drinker for the partner's or children's protection. These services may be generic (e.g. provided by general practitioners and psychologists and other counsellors, although little is known about how these services address such problems) or include peer organisations like Family Drug Help or Al-Anon. Crisis response services, like child protection and domestic violence services, come into operation alongside these when stronger interventions are required to separate the drinker from the family. These tertiary services also have a role to work to prevent and minimise harm from the drinker within the family through interpersonal violence offender programs and child protection interventions.

10.4.1 TERTIARY PREVENTION RESPONSES

Tertiary prevention strategies and programs care for families who have experienced a range of alcohol-related problems, including domestic violence and child maltreatment or neglect. These strategies seek to prevent incidents from recurring and limit long-term implications (Holzer 2007), and include the provision of intensive child protection, family-based support and AOD services to families already involved with police, family services and child protection services.

Where there is evidence that children have been harmed or are at risk of significant harm, society has a particularly acute ethical responsibility to try to address these problems. In these situations, child protection workers assess and manage risks to children, including alcohol-related problems of carers who are held responsible for various forms of child abuse and neglect. This report underlines that a large proportion of child protection casework is related to families with carers who drink problematically and often have a range of other risk factors. The evidence in Chapter 8 suggests that children whose carers have alcohol problems are more likely to be repeatedly harmed, at least when this was studied in the VCPS. Interventions aimed at reducing alcohol misuse by carers may result in better outcomes for children who are clients of child protection services. However, Dawe et al. (2007) see supply reduction and harm minimisation strategies specific to AOD use as likely to result only in short-term gains unless accompanied by strategies that address the underlying multiple causes of child maltreatment, causes that extend beyond alcohol problems alone. These conclusions support the idea that interventions should not be undertaken in isolation, but in conjunction with other programs that provide additional supports.

Currently a small number of Australian programs exist in which vulnerable families are identified on the basis of their substance use, e.g. in the PUP program described by Dawe et al. (2008). This program focuses on high-risk families and provides intensive support to those in crisis, incorporating individual-level parental education about strategies that minimise the harms for their children associated with a range of

substances (i.e. not specific to drinking-related problems). Although such programs are promising amongst families affected by multiple risk factors, there is limited evidence on how effective parent on programs can be and whether they result in sustained change in parental drinking and other behaviours, particularly in situations where threats to children are considered more minor (Dawe et al. 2003). Dawe et al. (2007) consider multiple factors, including broader contextual problems such as housing and unemployment and stigmatisation of substance-using parents, and co-occurring problems such as parental problems and domestic violence. Program strategies should include access to shelters and safe houses, social services and community supports, couple and family-based interventions, and supports for grandparents and other carers. However, there has been little movement to translate these recommendations into broader public policy responses, and programs like this have not been implemented widely. Moreover, recent reductions to single parent pensions in Australia are likely to worsen such problems in already disadvantaged and at-risk families (Australian Council of Social Service 2013).

In the UK, Forrester and Harwin (2010, p. 116) write of their concerns about the ability of child protection services to respond to individual and complex AOD problems in families:

> *In general, there appeared to be a strong institutional tendency toward under-responding to alcohol and drug misuse...a pervasive sense that social workers did not know how to work with parental alcohol or drug problems...[They had] minimal training and often had limited supervision and support: a toxic cocktail that is almost certain to produce poor practice.*

Australian researchers are also concerned about how child protection workers assess and respond to risk factors, including alcohol, more broadly (Dawe et al. 2007; O'Donnell et al. 2008; Scott 2009). In Australia there is equal concern that AOD services are not well-placed to respond to the children of their clients (Nicholas et al. 2012), although there have been recent moves to make AOD treatment more family-sensitive (Trifonoff et al. 2010), including production of guidelines for AOD workers on how to ask about child abuse and neglect and how best to respond. Section 10.5.1 discusses recommendations for improving data collection and use of screening systems such as the Alcohol Use Disorders Identification Test (AUDIT).

A note on stigma and barriers to tertiary preventive care

A potential side effect of focusing on carers and parents and vulnerable families already under pressure is that they will be stigmatised, and problems individualised, creating a climate that may push drinking parents further away from help and create further risks to children (Room 2005). Berger et al. (2010) were concerned that child protection service decisions in the US appeared heavily influenced by caseworker perceptions of carer illicit drug abuse, regardless of more relevant risk and protective factors that may affect parenting, for instance, domestic violence or lack of supports for single parents. In highlighting problems for families (and particularly children) associated with a family member's drinking, there is a need to ensure that unintended consequences such as increasing stigmatisation of certain groups is countered and barriers to care are minimised.

10.4.2 SECONDARY PREVENTION OR TARGETED INTERVENTIONS

Secondary prevention strategies focus on risk factors such as AOD misuse. Such strategies target families where additional assistance is required because of these risk factors, but who have not yet entered the system (Cummins et al. 2012). Interventions in this layer include the provision of AOD services to families, regardless of evidence of child maltreatment; the multifactorial nature of child maltreatment and domestic violence indicates that a range of other targeted services should be provided to these families also.

Many organisations, such as government agencies, welfare organisations, schools and religious communities bear a secondary layer of responsibility to ensure that families and children are supported, and risks to children are managed, by provision of a range of services (e.g. mental health services, parenting support groups and financial aid). National, state and local governments fund and support such programs. This means that some communities may have more limited supports and community services, including AOD

services, than others (Dawe et al. 2007; Gruenert et al. 2004). The provision of a range of family and welfare services is critical to creating supportive environments in which children can prosper (Tomison 2001), and linkages between agencies (in particular linkages between AOD services, family services and child protection services) are critical to ensuring children in families at risk of child abuse and neglect are supported. These linkages have the potential to enable and optimise both tertiary and secondary prevention strategies.

10.4.3 PRIMARY OR UNIVERSAL PREVENTION POLICY STRATEGIES

Alcohol has long been recognised as a relevant factor in a spectrum of problems that families and children face. As Dorothy Scott (2009), an eminent child protection researcher, noted:

> *Alcohol abuse is involved in every type of child maltreatment, with 50 per cent of children entering state care having at least one parent with alcohol problems, and 13 per cent of Australian children living in a household with at least one adult who regularly binge drinks. The scale of the problem is such that we cannot solve it case by case. We must go from case to cause.*

Primary prevention or universal strategies focus on whole communities and include a wide range of fundamental supports such as education and health services, but also include other more specific primary prevention strategies (Holzer 2007). The three primary prevention strategies most often considered are those that affect the availability, price and marketing of alcohol (Babor et al. 2010).

There is a growing body of ecological evidence linking the physical availability of alcohol to the risk of intimate partner violence. Recent research has found associations between the density and type of alcohol outlets within a specific geographical location and rates of domestic violence. The study by Liang and Chikritzhs (2010) based on alcohol sales volume in WA, found a strong association between assaults in residential premises and sales in off-premises outlets. However, the count of on-premises outlets was more significantly related to rates of impaired community amenity and public violence (Liang & Chikritzhs 2011). Livingston's (2011) longitudinal study on outlet density and domestic violence found positive associations between domestic violence and all three types of outlets (hotel/pub, on-premise and packaged liquor); however, a stronger relationship was found with packaged liquor outlets (Livingston 2011). Conversely, McKinney et al. (2009) found that intimate partner violence was associated with on-premises alcohol outlet density and not off-premise density. Of interest, Liang and Chikritzhs (2011) concluded that it was economic rather than physical availability that was the influencing factor in their findings, suggesting that pricing strategies would have a bigger influence.

The results of cross-sectional studies on the relationship between child maltreatment and alcohol availaility in the US are mixed, with poverty showing a more consistent relationship with harm than alcohol availability. However, in Australia there is some limited evidence that restriction of alcohol availability may be an effective way to decrease alcohol-related intimate partner violence. In Tennant Creek, a community-wide alcohol ban, introduced with the backing of Indigenous leaders and community members, led to a reduction in hospital admissions of women due to partner violence. This intervention appeared to work because heavy-drinking episodes were reduced, and because some drinkers moved away from the town, separating women at-risk from the problematic drinkers in their lives (d'Abbs et al. 2010; Gray et al. 2000). No Australian studies have been published on the relationship between alcohol availability and child maltreatment.

Regarding pricing and taxation, one study in the US showed that an increase in the price of beer resulted in a decrease in intimate partner violence (Markowitz 2000), as well as a decrease in child abuse by women, though not by men (Markowitz & Grossman 2000). The link between marketing of alcohol and alcohol-related violence against children and families has not been studied, and will be harder to evaluate.

In theory, reducing risky and heavy alcohol consumption amongst carers across Australia would result in reductions in incidence of the types of harms described in the general population surveys (e.g. verbal abuse of children and children left in unsupervised or unsafe situations). Whether such strategies result in reduced alcohol-related harms to children needs to be further examined. In addition it is not known if general population-based strategies – such as those that decrease harmful drinking overall – would result in changes for children at the apex of the pyramid; this warrants further study.

The potential exposure of children to the risky drinking of their parents or caregivers has been highlighted

in studies of the general population (Dawe et al. 2007; Hope 2011; Manning et al. 2009). Part of the reason why parents consume alcohol at risky levels around children may be because heavy drinking patterns are broadly accepted and encouraged in Australian society (Fitzgerald & Jordan 2009; Roche et al. 2009). For example, heavy drinking by carers at sporting clubs and school-based family functions (where children are in attendance) may model poor drinking patterns. They may also place children at greater risk if their own carers and other children's carers are intoxicated. Where risky drinking and associated risky behaviours are prevalent, children are more likely to be put at risk by their carers' drinking and, later, more likely to be put at risk because of their own drinking patterns. Examples of successful health promotion change in Australia combine changes in informal norms with legal and policy changes. For example, such programs have been very effective in changing patterns of cigarette smoking and drink driving. However, cultural change is difficult and requires a comprehensive approach, particularly in an environment that promotes heavy drinking as a normal part of contemporary Australia.

10.5 DETAILED RECOMMENDATIONS FOR SERVICE SYSTEMS

A range of service innovations and improvements are recommended in this report. These fall primarily into recommendations to address:

- defining and screening for alcohol and family problems
- improving surveillance and communication between services
- improving data quality and access to enhance problem management
- specific child protection services initiatives
- specific AOD service initiatives.

10.5.1 DEFINING AND SCREENING FOR ALCOHOL PROBLEMS

Screening, for example using the using the AUDIT (Saunders et al. 1993), would enable rapid understanding of how problematic a carer's drinking may be. The AUDIT is useful for both clinical screening in primary healthcare settings and as a standardised form of reporting on alcohol problems that has been utilised in research (Saunders et al. 1993). Its use would enable more comparable estimates of alcohol involvement in child abuse and inform clinical decisions about whether services should be provided to carers at an individual level, as well as the level of services that would be required to meet the needs of these carers. However, further research should be undertaken into whether measures such as AUDIT should be adapted to take into account whether children are present when their carers are drinking.

In addition, where possible, information should be obtained about intoxication, usual carer drinking patterns and drinking patterns when children are present at the time of a range of events (e.g. relationship breakdown, physical violence, child abuse and neglect). Currently the patterns of drinking which are affecting children and families are very poorly recorded, if at all.

10.5.2 IMPROVEMENTS IN SURVEILLANCE

There is a patent need to improve recording about carers' children within AOD treatment systems data. Only recently have screening tools begun to collect information on the number of children of clients in treatment, and still little is known about the age or situations of many children of AOD clients (Gruenert et al. 2004).

The inclusion of risk factors in the Child Protection AIHW National Minimum Data Set (NMDS) is important. Currently this NMDS includes the numbers of reports, substantiated cases, interventions and placements in out-of-home care but does not report on carer risk factors. Highlighting alcohol and other risk factors as issues would enable ongoing surveillance via national and state child protection data collection systems.

10.5.3 SPECIFIC CHILD PROTECTIVE SERVICES INNOVATIONS

AOD screening tools (such as the AUDIT suggested above) should be considered for use within child protection services as a means of identifying carers who drink problematically. Initial screens should be followed up with evaluations of service referrals and the effectiveness of these services. In this report, *Mirror Families* and the *Parents Under Pressure* (PUP) program are noted as examples of services that address complex AOD and child protection problems. Other examples of innovations in the child protection sector aimed at decreasing harms to children include, for example, current *Child Aware Approaches* (Hunter & Price-Robertson 2014). A review of general child protection interventions is beyond the scope of this report, but recent systems reviews provide more comprehensive evaluations of CPS-specific interventions (e.g. Cummins et al. 2012).

10.5.4 SPECIFIC ALCOHOL AND OTHER DRUG SERVICE INNOVATIONS

Whether an individual is presenting to the AOD treatment system for their own or another person's drinking is recorded in the Victorian and other states' electronic reporting systems. However, the family circumstances and the presence or absence of children in that client's life is not recorded. Whether referrals are made for clients in the system who have children and who may benefit from additional family support services is also not recorded, and family members of these clients are not targeted for specific interventions. While this is partly because the AOD system was developed for people drinking at problematic levels, a gradual reorientation of AOD treatment services seems to have been underway in Australia, although this may well be reversed by changes in rules for state payments for services, as has occurred in 2014 in Victoria. The effects of AOD system treatment are currently measured only in terms of outcomes for the drinker, and not for their families. Services should consider and seek to improve the outcomes for family members as well as drinkers, and these outcomes should be measured.

Recently, brief interventions for family members affected by others' drinking have been developed and could be considered for implementation. For example, Copello et al. (2010a) have developed a five-step brief intervention that focuses on how family members affected by others' drinking can be assisted. The program encourages use of strategies that aim to decrease stress levels of those affected, to better enable them to care for themselves and to ensure they maintain appropriate boundaries. These types of interventions may be effective particularly for older children affected by a family member's drinking.

10.6 AN AGENDA FOR FURTHER RESEARCH ON ALCOHOL-RELATED HARMS TO CHILDREN AND FAMILIES

This report underscores the wide range of problems children and families may experience because of the drinking of their parents, other carers and family members. A number of research gaps remain, and this section of the report suggests areas for future descriptive survey research, service and system evaluation and intervention research.

A number of recommendations are listed below about how the existing knowledge base might be improved upon. In addition, new areas of research are highlighted that would improve understanding of the problems experienced by families and children because of others' drinking and inform their evaluation and management.

Both research and policy-making would benefit from an agreement on standardised electronic recording and reporting of alcohol consumption in child maltreatment, domestic violence and other cases that come to the attention of police, justice and social services.

It should also be noted that data from CPS, Children's Courts, police, and AOD services are often difficult to access by researchers outside these sectors. Research collaborations or enabling of greater access to and linkage of de-identified files within and across sectors would shed light on a range of complex legal, police and welfare cases. For example, it is not possible to access de-identified unit-level police data on family violence incidents or access de-identified case note files from CPS. The electronic systems that exist can provide efficient access to large numbers of case files, but usually these have not been designed (even secondarily) with research purposes in mind. Collaborative research in these areas would enable better

understanding of the proportion of these police, welfare, alcohol treatment system, hospital and court case data that may involve carer alcohol misuse.

10.6.1 DESCRIPTIVE EPIDEMIOLOGICAL RESEARCH

Recording carer drinking and other family member problems in registry databases

Information relating to alcohol misuse by parents and other family members is not uniformly collected within Australia or in similar western developed countries such as Canada and the US, let alone in a wider range of nations, including low-income countries. Some data on alcohol abuse are reported in child protection data systems and by police that attend to domestic violence cases, but this is not the case for the majority of service systems that provide care to children and families.

In Australia, child maltreatment diagnoses are collected routinely in inpatient hospital and emergency department data, using International Classification of Disease coding, but the incidence of such diagnoses is very low (Laslett et al. 2010), particularly given the levels of alcohol-related physical child abuse and neglect revealed in this report. Instead, or in addition, a broader range of child injury diagnoses within particular age groups could be selected as markers of potential child abuse. These should be analysed in conjunction with alcohol sales data which are available in some Australian states, as are liquor licence density measures across postcodes in all states. Studies should examine alcohol data and child outcomes cross-sectionally and longitudinally.

Population studies and qualitative interviews

Repeated collection of representative data on alcohol's harm to others via national surveys would enhance surveillance. At the very least, the National Drug Strategy Household Surveys should be enhanced to collect more data on the situations of those affected by others' drinking, in particular how families and children report they have been affected. However, there is also a need to conduct representative cross-sectional national surveys, such as the HTO Surveys, on a regular basis to examine whether harms from others' drinking are stable or in flux, particularly given the most recent survey of this kind is now seven years old.

While survey data are available on drinking levels of adults in families, whether the heavy drinking occasions of parents occurred in the presence or absence of their children is often not specified. More importantly, whether these patterns of drinking cause harm is the critical issue. These issues could be followed up with new surveys in the tradition of the 2008 and 2011 HTO Surveys (such as those carried out in the World Health Organization's *Harm from Others Drinking* study in seven low- and middle-income countries as well as new studies in a number of other high-income countries) and can be pursued also with other study methods and designs. This research could involve interviewing all or selected members of families about whether and how alcohol affects different family members and to what extent, how often and in what ways.

In addition, alcohol consumption and drinking consequences questions should be added to existing longitudinal studies of children and families. Such studies would inform understandings of what children's and families' needs are, as well as whether they are in contact with services, and how they are affected and assisted (or not) by services, families and peers. In the US, when parents were surveyed about their own drinking patterns and injuries to their children, more injuries to children were identified where parental histories of alcohol treatment were identified (Bijur et al. 1992; Crandall et al. 2006). Undertaking these large community studies, involving carers reporting upon injuries to their children, and self-reporting their drinking patterns, amongst other risk factors, could be considered in Australia, potentially in intervention and control populations. Existing national health studies and longitudinal studies of children with existing data on carer drinking patterns and child outcomes should be identified through research networks and analysed further.

10.6.2 SERVICE EVALUATION AND INTERVENTION RESEARCH

Child Protective Services (CPS) Research

The interviews with key informants described in Chapter 9 were instrumental in gaining an understanding of the alcohol-related service and research needs of the child protection field. The research experience using child protection data gained as part of this project also provides insight into the gaps in this knowledge and highlights recommendations for research.

Within CPS, future research should investigate in detail the types of problems that children experience that involve alcohol, how these cases are managed by workers and systems, the factors that influence how decisions are made regarding identification and management of alcohol problems of carers, and the outcomes that flow from different professional decisions and policies.

As described in Chapter 9, there is support for the implementation and evaluation of a range of services that target families at higher risk, in particular children with one or more parents in the AOD treatment system. Implementation and evaluation of interventions for those affected by others' drinking which have been recently developed should be considered in the Australian context (see 10.5), and randomised controlled trials for individual treatment interventions could be undertaken.

Research with families in the alcohol and drug treatment system

There are few large scale studies that measure the effectiveness of family-focused interventions and how well they target, assess and manage the needs of families of heavy drinkers. Anecdotally, few participants in the in-depth qualitative interviews described in Chapter 6 reported accessing health or other advice services to manage problems associated with the drinking of their family members. Where participants had been in contact with services, they commented that these services were targeted to the drinker and their own needs were not addressed. A number of participants were not aware of any such services (and reported also being reluctant to confide in family and friends).

Other strategies that focus on reducing harmful drinking may also have an impact on alcohol-related intimate partner violence. Intimate partner violence is highly prevalent amongst those seeking treatment for substance abuse. A systematic review of seven naturalistic (uncontrolled) studies of partner abuse before and after substance use treatment found reductions in partner violence after treatment (Murphy & Ting 2010). However, a recent review was more critical of the long-term effectiveness of these programs (Wilson et al. 2014).

10.6.3 COMMUNITY RESEARCH

Randomised controlled community trials, wherein different alcohol-related policies (e.g. minimum pricing of alcohol sold in bottle shops) are implemented and studied, should be undertaken and include analysis of the impacts of these strategies upon children and families. Prospective evaluation of outcomes for children in the child protection system and in community samples under different alcohol policy scenarios, or retrospective examination of outcomes over time with existing alcohol consumption, sales and availability data, would also enable better decision making around alcohol-related primary prevention policy priorities for preventing alcohol-related family harms.

Research has begun to examine the impact of alcohol policy interventions (e.g. reducing alcohol's availability through limits on trading hours, outlet density and the volume of alcohol sold in outlets) on rates of domestic violence. For example, an evaluation of community interventions that restricted the hours of sale of alcohol in a number of remote and regional Australian communities found reductions in hospital presentations for domestic violence and declines in refuge numbers (d'Abbs & Togni 2000).

10.6.4 RESEARCH WITH THOSE AFFECTED BY THE DRINKING OF NON-PARENTAL FAMILY MEMBERS

We know little about how parents and grandparents may have been affected and even abused because of the drinking of their own children. There is likely to be strong reluctance by parents to report how they have been negatively affected by the drinking of their own children. Sibling research on alcohol's harm to others is also relatively limited.

While family members often provide incredible support to problematic drinkers in their social milieu, often these family members have their own needs that need to be understood and met. Both immediate and extended family members are an important social resource in present day Australia – one that needs support. This support may be provided by peer organisations (e.g. *Family Drug Help* and *Family Drug Support* provide a range of resources to family members who are affected by the AOD use of someone close to them) or alternatively by non-government and state agencies.

11 CONCLUSION

Around one-third (31 per cent) of the adult Australian population that lives with or is responsible for children consumes at least five standard drinks on one occasion at least monthly (Laslett 2013). This report indicates that an estimated 17 per cent of adult Australians are affected by the drinking of a family member or intimate partner and that over one in five children have been affected by others' drinking in the past 12 months. A smaller but significant minority are affected far more seriously by the drinking of those they are closest to.

Alcohol consumption is a modifiable behaviour both at individual and population levels (Babor et al. 2010). There is an urgent need to develop a suite of individual- and community-level prevention strategies and examine whether these interventions reduce the burden of problems that families and children experience because of others' drinking. Where successful, these strategies should then be introduced more widely.

Governments have considerable opportunities and responsibilities to manage risks to families and children in the broader environment by making policy decisions, including alcohol policy decisions, that affect primary, secondary and tertiary prevention priorities. The large numbers of children and families affected at each tier of the pyramid described in Chapter 10 suggest that a public health approach to managing alcohol-related child and family harms is warranted, in addition to tertiary approaches provided by CPS and other family support agencies.

While tertiary services such as CPS have an integral coordinating role in addressing the problems of the children who have been most severely abused and/or neglected, AOD services are critical to the secondary prevention of child abuse and neglect. By targeting families at risk and assisting them, they have the potential to address carers' alcohol problems and prevent their entry into a range of crisis response services. The needs of drinkers within families and other family members affected need to be understood and met by a range of service options at this level.

It is critical that communities and governments invest in strategies that diminish alcohol-related problems in families and communities in general, and in particular amongst those who are most vulnerable and in need. The CPS and AOD treatment sectors must be adequately resourced to allow them to provide effective programs and ensure that there is close communication and referral between these systems.

Many (and arguably most) families struggling with parental alcohol misuse are probably not in the service system at all and may be 'hidden' to authorities. Given the findings in this report, a focus on population-wide alcohol problems of families would result in a reduction both in the prevalent alcohol-related harms seen in the population, and potentially, also, in reduction or prevention of the problems experienced by the families and children most seriously affected by problematic drinkers within them. Therefore, the findings of this report support the implementation of universal measures to prevent or limit the effects of drinking on the families and children of Australia, alongside comprehensive coordinated multi-sectoral services for families with multiple risk factors.

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APPENDIX A: LIST OF TABLES

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APPENDIX B: LIST OF FIGURES AND BOXES

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APPENDIX C: THEMES AND PROMPTS FOR IN-DEPTH QUALITATIVE INTERVIEWS WITH SUBSET OF HTO SURVEY RESPONDENTS

1. IMPACTS OF DRINKING FOR CHILDREN OVER THE PAST FEW YEARS

- How many children do you have and what are their ages and are they boys or girls?
- Is there anyone whose drinking is affecting or has, in the past, affected this child / these children in your care?
- What is the relationship of this person to you? To your children?
- Can you tell me how this person's drinking has affected / affects children in your care?
- What were/are short-term effects? (probe for effects on behaviour, schooling, physical harms etc.)?
- What were/are long-term effects? (probe for effects on behaviour, schooling, physical harms etc.)?
- Can you tell me any story of a time when it was apparent that a child in your care was affected by another person's drinking?

2. NATURE OF IMPACTS OF DRINKING FOR FAMILY FUNCTIONING

- How does the drinker you referred to make it easier or harder for you to parent children in your care?
- Do you drink alcohol too when the drinker is around? How do you manage this situation?
- Can you tell me about a time that the drinker's alcohol consumption interfered with a family occasion? If so, what happened?
- Are there times when the family is not affected by drinking? If so, what is different about these times?

3. CURRENT SITUATION

- What has changed in relation to how your children are affected by another person's drinking, if anything, over the years?
- If so, what was this change and why do you think the change occurred?

4. WHAT HELPED AND WHAT DIDN'T HELP?

- Did you turn to family for support? If so, what help were they able to give you? What were they unable to help with?
- Did you turn to friends for support? If so, what help were they able to give you? What were they unable to help with?
- Did you approach any alcohol or other drug services for support? If so, what help were they able to give you? What were they unable to help with?
- Did you approach other agencies such as churches for support? If so, what help were they able to give you? What were they unable to help with?
- Can you think of anything that would have helped you better cope with the situation that wasn't available to you?

5. SOME DEMOGRAPHIC INFORMATION

- Respondent information – age, gender, occupation, metropolitan/regional town/small town/rural
- Cultural background

APPENDIX D: INTERVIEW GUIDE FOR RESEARCHERS

CURRENT RESEARCH PROGRAM

- Are you currently conducting any research on child maltreatment and alcohol or other drugs? What are your main areas of interest?

HISTORY OF CHILD PROTECTION SYSTEM AND ALCOHOL AND OTHER DRUG (AOD) SERVICE AND POLICY SECTORS IN RELATION TO ALCOHOL-RELATED CHILD MALTREATMENT

- What is the relationship between AOD services and child protection agencies in your jurisdiction, and how has it developed/changed?

  For example: Do you think alcohol and other drugs have been recognised as important factors at senior/grass roots levels by child protection staff? On the other hand, how important/effective are A&D workers and government departments and systems at identifying issues for children that may flow from their carers' alcohol or drug use? Do you think there is dialogue between AOD and child protection departments, and referrals to and from workers from each sector?

CHILD PROTECTION DATA

- Do you use any reports or data from your State Government child protection agency in your research?
- Have you tried to access departmental (e.g. Department of Community Services/ Department of Human Services data in the past?
- Are you aware of how alcohol is recorded in the child protection system?

  Do you know anything about the child protection protocols for alcohol involvement that child protection workers use? (For example, how alcohol use is defined, when would alcohol involvement be recorded?)

  How reliable do you consider child protection data to be in your jurisdiction? (How could it be improved?)

CONTACTS RELEVANT TO CHILD PROTECTION AND ALCOHOL DATA

- Do you have any contacts in the Department of Families and Communities (relevant state child protection department) who might have relevant knowledge on child protection data and alcohol and other drug involvement, or who might be useful if we were to seek access to de-identified data in the future?
- Do you know of anyone who is costing alcohol involvement in child protection in our State? (Ie an economist?)

GREY LITERATURE

- Are there any critical grey literature reports that have been produced in your jurisdiction that focus on or include alcohol involvement in child protection?
- In your opinion, how should we go about finding the best estimate of alcohol involvement in child protection in your State?

INTERESTS FOR THE FUTURE

- We are interested in pushing this area forward and wonder whether you think there is value in this?
- Do you have any interests in research in the area of alcohol and child protection in the future?
- Would you be interested in discussing this further?

APPENDIX E: INTERVIEW GUIDE FOR CHILD PROTECTION KEY INFORMANTS

1. Is alcohol a factor/problem in the caseloads of your agency/department? How much so?
2. Is there a section of the Child Protection System or your agency's manual or website that highlights alcohol and other drug use in the context of child protection issues? (e.g., as part of assessment)
3. Recording and defining 'alcohol involvement'
4. Is there a protocol or defined procedures for how this is defined and recorded by CP workers?
5. How is alcohol involvement recorded? (i.e., in a database, in case notes, in both – and if both which data are entered in each?)
6. Are you able to please provide a copy of what the questions on screen look like if they are recorded electronically? May we please have a copy of the blank paper based forms used in investigations and to record case notes?
7. How is alcohol involvement defined? (Is there a formal scale or type of measurement? Is it confirmed or alleged? What level of detail is involved in the reporting?)
8. Is alcohol involvement defined as being alcohol "use"," problematic use"/"abuse"/"dependence", "binge drinking", or about "hangovers"?
9. Is reporting of caregiver alcohol use mandatory? (If yes, what stage is this reported?) Are there any implications when alcohol is recorded as a risk factor? (further investigation etc.)
10. Under what circumstances is alcohol involvement likely to be reported as a risk factor?
11. More details about what is recorded in the database/case notes....
12. Does parental/caregiver alcohol consumption get recorded, or if someone else's drinking (i.e., a sibling) is affecting the child, would this be recorded? Is it usually the drinking of the protective parent or the alleged maltreating parent's drinking that is recorded? How much detail is collected on the alleged perpetrator?
13. How does alcohol involvement in child protection generally come to a CP worker's attention? How significant is alcohol involvement in the decision making process?
14. What kind of training do child protection workers receive for recognising or diagnosing alcohol involvement in a CP case?
15. Is there any process for referring the caregiver to treatment if alcohol use is identified?
16. If there is no recording of caregiver alcohol use, is there are a way to estimate the percentage of cases that do involve alcohol use? What is the reason that alcohol use is not recorded?
17. Are there any reports that have been produced in your jurisdiction that focus on or include alcohol involvement in child protection?
18. In your opinion, how should we go about finding the best estimate of alcohol involvement in child protection in this jurisdiction?

APPENDIX F: AGENDA FOR DISCUSSION: ALCOHOL'S HARM TO OTHERS – FOCUSING ON FAMILIES AND CHILDREN

1. THE REPORT
2. FINDINGS TO DATE
3. RESEARCH GAPS
   a. Service system response agency data (CPS, Family Services, Domestic Violence, Relationships)
   b. More detailed nature of alcohol-related harms in general population, CPS cases, Family Services
   c. Policy research: alcohol policies and child and family-based outcomes?
   d. Collaborative opportunities
4. POLICY DIRECTIONS
   a. National Framework for Child Protection
   b. The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021
   c. Family-sensitive AOD practice
   d. Universal alcohol policies
   e. Targeted interventions to high risk families
5. KEY NETWORKS TO DEVELOP
6. LUNCH

FOUNDATION FOR ALCOHOL RESEARCH AND EDUCATION LTD

PO Box 19, Deakin West, ACT 2600

Policy options paper:

Preventing alcohol-related family and domestic violence

fare

February 2015

About the Foundation for Alcohol Research and Education

The Foundation for Alcohol Research and Education (FARE) is an independent, not-for-profit organisation working to stop the harm caused by alcohol.

Alcohol harm in Australia is significant. More than 5,500 lives are lost every year and more than 157,000 people are hospitalised making alcohol one of our nation's greatest preventative health challenges.

For over a decade, FARE has been working with communities, governments, health professionals and police across the country to stop alcohol harms by supporting world-leading research, raising public awareness and advocating for changes to alcohol policy.

In that time FARE has helped more than 750 communities and organisations, and backed over 1,400 projects around Australia.

FARE is guided by the World Health Organization's *Global Strategy to Reduce the Harmful Use of Alcohol*[a] for stopping alcohol harms through population-based strategies, problem directed policies, and direct interventions.

If you would like to contribute to FARE's important work, call us on (02) 6122 8600 or email fare@fare.org.au.

[a] World Health Organization (2010). *Global strategy to reduce the harmful use of alcohol.* Geneva: World Health Organization.

About this paper

Purpose

The purpose of this *Policy Options Paper* is to propose policies and programs to Australian governments for the prevention of alcohol-related family and domestic violence (FDV). The policy and program options being proposed have been developed in consultation with professionals with expertise in public health, child protection and domestic violence. This *Policy Options Paper* is not a final draft and FARE welcomes further input from people with an interest in this area. Further details about this consultation process are outlined below. The final Policy Paper will be presented to decision makers in June 2015.

Approach

This *Policy Options Paper* uses a public health model of prevention to present policy and program options. The public health model of prevention is grounded in scientific principles and evidence and has been used extensively to address a range of health issues. The public health model aims to improve social equity as a way to reduce health disparities across populations. FDV *is* a health disparity issue, as well as a social justice issue. These two issues are inextricably interlinked and interwoven when examining alcohol-related FDV. Using a public health model allows for a comprehensive framework to be developed that acknowledges the need to address health and gender inequalities to overcome FDV. The policy and program options are presented through the four levels of prevention: primordial, primary, secondary and tertiary. This allows for the *Policy Options Paper* to propose policies from prevention through to supporting those affected by violence.

Consultation process

This paper is presented as a *Policy Options Paper*, rather than a final Policy Paper. It has been informed by reviews of evidence, consultation meetings with professionals working in the alcohol and other drugs and family and domestic violence fields and the findings from the study *The hidden harm: Alcohol's impact on children and families.*[1]

This *Policy Options Paper* is presented as part of an ongoing consultation process to inform the development of a final Policy Paper. This process involves:

- consultation through meetings with stakeholders and development of the *Draft Policy Options Paper* (October 2014 – January 2015)
- refinement of *Draft Policy Options Paper* based on written feedback received by stakeholders and preparation of this *Policy Options Paper* (January 2015 – February 2015)
- public release of the *Policy Options Paper* and roundtable event with stakeholders (24 February 2015)
- open consultation (24 February – 31 March 2015)
- presentation of Final Policy Paper to decision makers (June 2015).

Feedback

FARE seeks your feedback on this *Policy Options Paper*. We have prepared some questions to help to guide your input:

1. What are your overall views on the *Policy Options Paper*?
2. What are your views on the public health model that has been used in the framing of the document?
3. Do you agree with the policy options presented?
4. Are there any additional policy options that you can suggest?
5. Should the proposed policies be more specific (eg. specify funding requirements), or remain as high level policy asks?
6. Do you have any other feedback for FARE?

Please submit your feedback online at www.fare.org.au by 31 March 2015.

If you have any questions about the consultation process or the *Policy Options Paper* more broadly, please contact Sarah Ward at [redacted] or [redacted].

Contents

1. Introduction

Family and domestic violence (FDV) often occurs in the home, where one should feel safest, perpetrated by a loved one, with whom one should feel safest. It is sometimes a one off event but is often a pattern of behaviour characterised by one person exerting power and control over another in the context of an intimate partnership or within a family situation. FDV may persist for years and sometimes involves multiple forms of abuse. In Australia at least one woman dies each week at the hands of her partner or ex-partner[2] and a significant number of children die as a result of abuse and neglect, although exact figures are not known.[3]

FDV can happen to anyone regardless of gender, sexuality, class, culture or family type. Some communities are more likely to experience FDV and may find it difficult to access mainstream support that meets their needs. Aboriginal and Torres Strait Islander women; culturally and linguistically diverse (CALD) women; lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people and families; women with a disability; and older and young women, all face significant barriers to identifying FDV, seeking help and accessing culturally appropriate support.

The impacts of FDV include complex trauma, physical injuries, poor mental health and the development of behaviours that are harmful to health such as alcohol misuse.[4] These impacts are cumulative, with the frequency and severity of abuse being associated with greater physical and mental health impacts on the victim.[5] The impacts of trauma may also persist long after the abuse has stopped.[6]

The effects of violence and abuse also go beyond those directly involved. Witnesses are often traumatised. In many cases it is children who witness these events. This sometimes results in children themselves growing up to use violence. They are also more likely to experience domestic violence themselves. These children can also grow up to experience alcohol and other drug issues in their lives.[7] FDV impacts on children whether or not they witness it. It is more difficult to estimate the impacts of FDV on other family members and communities, but again there is significant evidence to suggest that FDV has widespread immediate and intergenerational consequences.

FDV, and particularly violence between intimate partners, is not a gender neutral issue. Domestic violence is overwhelmingly perpetrated by men against women.[8] This is due to the unequal power dynamics between women and men, the gendered distribution of resources, and an “adherence to rigidly defined gender roles expressed institutionally, culturally, organisationally and individually.”[9] Child maltreatment is also more likely to be perpetrated by males than females.[10]

The interplay between alcohol and FDV is complex. Alcohol is a contributing factor to FDV, increasing both the likelihood of violence occurring and the severity of harms.[11] Alcohol misuse can cause or exacerbate relationship stressors thereby increasing the probability of violence. Alcohol use can be both a consequence to and precursor of relationship stress and violence. Alcohol use also affects cognitive functioning and physical functioning, [12] affecting the likelihood of perpetration, and making those who are impacted by FDV more vulnerable. Some perpetrators of violence may try to blame the misuse of alcohol and/or drugs or use intoxication as an excuse. This is not the case. Alcohol use

and intoxication are never an excuse for violence. Victims may use alcohol as a coping mechanism for dealing with trauma and pain. There are also intergenerational impacts, with children who witness domestic violence being more likely to have problems with alcohol later in life.[13]

Alcohol is involved in a significant proportion of reported domestic violence and child protection incidents. In 2010-11 there were 29,684 reported incidents of alcohol-related domestic violence to police across four Australian states; Victoria, New South Wales (NSW), Western Australia (WA) and the Northern Territory (NT).[14] Due to challenges with data collection across all jurisdictions, as well as under-reporting of these crimes, these figures are likely to be significant underestimates. This equates to approximately half of domestic assaults reported to police involving alcohol. In addition, a carer's alcohol use is a factor for 10,166 children in the child protection system.[15]

Australia is committed to addressing FDV by being a signatory to the *Convention on the Elimination of All Forms of Discrimination Against Women*, the *Declaration to End Violence Against Women* and the *Beijing Declaration*.[16] The association between alcohol and FDV has been recognised by the World Health Organization (WHO), which has identified action on alcohol misuse as one of several strategies to reduce violence against women and children.[17,18] There is also recognition of the association between alcohol and FDV by Australian Governments. National, as well as some state and territory, strategies and frameworks have acknowledged the role of alcohol in FDV and have recognised the need to address alcohol as part of an overall strategy to reduce FDV. However, to date, there has been a lack of coordinated action to bring these strategies together to produce effective policies and programs.

This *Policy Options Paper* draws on the following principles based on the literature of what is known about alcohol-related FDV in Australia and internationally. These principles are:

- The consumption of alcohol is <u>never</u> an excuse for violence.
- Policies that address gender inequalities and alcohol misuse are critical to reducing FDV.
- The WHO socio-ecological model acknowledges that no single factor explains why people engage in violence, instead there are multiple factors, at the individual, relationship, community and societal levels. Responses to FDV need to be targeted at all levels.
- No single response is likely to reduce alcohol-related FDV. Australia needs a comprehensive and coordinated approach to address alcohol-related FDV, as part of an overall strategy to reduce violence against women and children.
- A public health approach is needed to reduce alcohol-related FDV, with a focus on prevention across the spectrum, including primordial prevention, primary prevention, secondary prevention and tertiary prevention.

2. Definitions and concepts

Many definitions are used in the FDV and alcohol and other drug (AOD) sectors. This section provides definitions for the terms used in the *Policy Options Paper*. These terms and definitions are outlined below.

Family and domestic violence (FDV) refers to violence between family members (including parents, step-parents or guardians, siblings, cousins, aunts/uncles, and grandparents).[19] It may be perpetrated between adults, by adults on children or by children on parents. For the purpose of this paper, use of the term family and domestic violence covers violence between family members. In some instances, domestic violence and child maltreatment will be discussed separately, in other instances, they will be considered together under the umbrella term of FDV.

Domestic violence refers to acts of abuse that occur between people who have, or have had, an intimate relationship. While there is no single definition, domestic violence is usually an ongoing pattern of behaviour aimed at controlling a partner through fear, often using behaviour that is violent and psychologically threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over a partner or ex-partner and their children, and can encompass acts that are both criminal and non-criminal.[20] The term domestic violence has been used to cover violence between intimate partners (both former and current relationships).

It can include acts of physical aggression (slapping, hitting, kicking or beating), psychological abuse (intimidation, constant belittling or humiliation), forced sexual intercourse or any other controlling behaviour (isolating a person from family and friends or culture, monitoring their movements, stalking and restricting access to information or assistance).[21] Other psychological threats include threatening to hurt children, family members or pets. Domestic violence is more commonly perpetrated by males against their female partners or ex-partners, but it also includes violence against men by their female partners or ex-partners and violence within same-sex relationships.[22]

In this paper, the term domestic violence is used rather than intimate partner violence.

Violence against women refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women. This can include threats to commit such acts, coercion or arbitrary deprivation of liberty. These can occur in public or private life.[23]

Child maltreatment refers to any intentional or unintentional behaviour by parents, caregivers or other adults that poses a substantial risk of causing physical or emotional harm to a child or young person. These can include acts of omission (i.e., neglect) and commission (i.e., abuse).[24] The responsibility for child maltreatment or abuse always rests with the perpetrator and never with the child.

Strong associations have been found between commonly identified forms of child maltreatment and the misuse of alcohol, including: physical abuse (non-accidental use of physical force resulting in harm to the child), emotional maltreatment (failing to provide the emotional support a child needs

to feel safe and valued or requiring children to take on responsibility that is beyond the child's level of maturity such as caring for younger siblings[25]), neglect (failing to provide basic needs such as food, health care, warmth, educational opportunities), sexual abuse and being a witness to family violence (parents who drink alcohol excessively may fail to be aware of the predatory behaviour of others towards their children).[26]

Children's exposure to domestic violence refers to the child who directly witnesses or overhears physical or psychological violence between adults as it occurs, or sees its results such as injuries and emotional effects. This mostly refers to violence involving the child's parents/caregivers but may also include children witnessing violence between a caregiver and another adult in the home.[27]

Victim refers to people who are targets of family and domestic violence, consistent with the language used in the *National Plan to Reduce Violence Against Women and their Children 2010–2022* (the National Plan). This paper uses the term 'victim' rather than 'survivor' to highlight the fact not everyone survives or continues to live their lives to full capacity after experiencing violence.[28]

Harmful alcohol use refers to a pattern of use that causes damage to health which could be either physical, psychological or both. Consistent with terminology used by the WHO,[29] this paper uses the term 'harmful alcohol use' to include use that is associated with adverse health and social consequences for the individual drinker and those around them.

3. Setting the framework

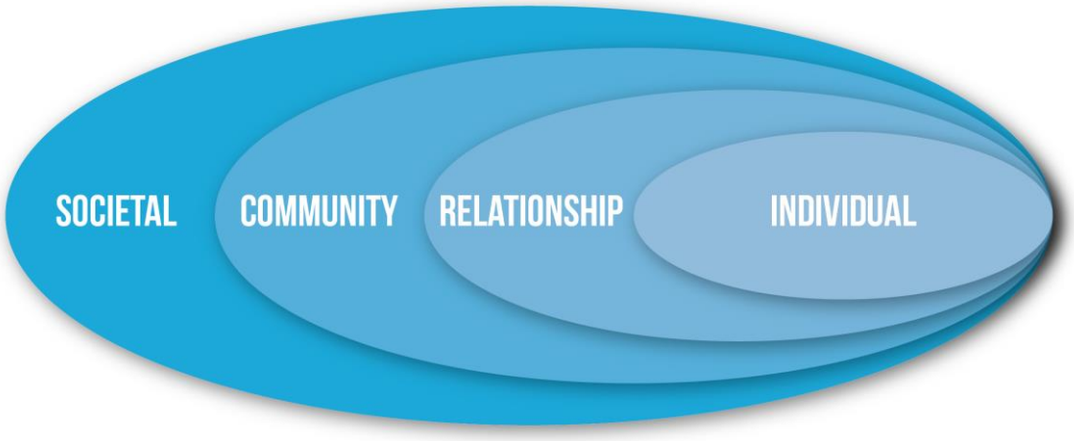
There are many different models available that can be applied to address alcohol-related FDV. Two of these models, the socio-ecological and the public health model are explored in this section. A public health model of prevention has been adopted for this paper. The approach adopted recognises that consistent with the ecological framework, FDV is multifaceted and exacerbated by a range of complex and interrelated factors.

Adopting a public health approach to reducing alcohol-related family and domestic violence

Both alcohol misuse and family violence (including domestic violence and child maltreatment) are considered by the WHO to be major public health issues that demand urgent attention.[30] The public health approach has been used to guide actions to address alcohol misuse, and is increasingly used in family and domestic violence reduction strategies in Australia. [31]

Australian responses to FDV have largely been based on ecological models and this has been instrumental in achieving reform, particularly legal reforms.[32] In 2002 the WHO presented a socio-ecological model that recognised that there is no single factor that explains why certain individuals engage in violence; rather, there are multiple possible factors, categorised across four broad levels, which are complex and interactive.[33] These factors are outlined in the model in Figure 1 below and examples of strategies by level of influence are outlined in Table 1 overleaf.

Figure 1: The socio-ecological model



Reproduced from: Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1–56[34] and Heise, L. (1998). Violence against women, an integrated, ecological framework. Violence Against Women, 4 (4), 262–290.[35]

Table 1: Outline of the socio-ecological model, risk factors and strategies by level of influence.

Level	Definition of Risk Factors	Examples of Strategies to Alleviate
Individual level	The development experiences, individual histories and personality factors that can increase the likelihood of an individual becoming a victim or perpetrator of violence.	Interventions with children, young people and their families at particular points of relationship and family formation, development or dissolution. School-based education that helps students develop life skills and challenge beliefs of rigid gender roles.
Relationship level	Relationships within families (this may include parents, step-parents, siblings, grandparents, cousins), friends, intimate partners and peers and how these can influence violent behaviour.	Programs that aims to change perceptions of gender, violence and behaviour, promote an understanding of positive relationships.
Community level	The context where social relationships occur (e.g. in schools, workplaces and neighbourhoods) and the characteristics of these settings that increase the risk of violence.	A town or city implementing a program that encourages the participation of women in leadership.
The broader societal level	The social norms which may accept or encourage violence. This also takes into account health, economic, educational and social policies that maintain economic or social inequalities between groups. [36]	Legislation that promotes gender equality, e.g. encouraging employers to become more family-friendly and offer workplace flexible schedules to both men and women.

Adapted from: Centers for Disease Prevention, National Centre for Injury Prevention and Control. *The socio-ecological model: A framework for violence prevention*[37] and VicHealth. *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*.[38]

This paper recognises that consistent with the ecological framework, FDV is multifaceted and exacerbated by a range of complex and interrelated factors. Strategies for addressing FDV using the ecological framework include social policy initiatives that address gender inequality and improve the status of women.[39]

Consistent with the socio-ecological model, it is unlikely that one single factor is responsible for someone committing an act of violence. For example, not all FDV involves alcohol, and not all people who drink alcohol will become violent. Similarly, growing up in a violent household is not an inevitable precursor to using violence as an adult and only a minority of men are violent despite living in a society where gender inequality persists.[40] An understanding of the complexities of FDV and its contributing factors is needed to develop multiple policies and programs to prevent FDV. FARE recognises that policies and programs to address gender inequalities are critical to reducing FDV and should be progressed.

Because alcohol is a contributing factor to FDV, policies and programs that aim to reduce alcohol-related harm should be pursued when developing policies and programs to reduce FDV.[41] Alcohol interventions should form part of a suite of comprehensive measures to reduce FDV.

This paper adopts a public health approach, which has enjoyed widespread application in the field of alcohol harm prevention and is increasingly being adopted in the FDV sphere. The focus on prevention is advantageous because rather than being reactive (i.e. only addressing the problem once it has occurred), it is proactive. This paper uses a public health framework broken down into four temporal points:

1. *Primordial prevention* – These policies and programs target the whole population and the structural conditions of society at a broad level and aim to address factors that determine health in the population as a way of reducing the likelihood of problems occurring among citizens. Primordial prevention involves strategies that improve the environmental, economic, legal and social circumstances of the population.
2. *Primary prevention* – These policies and programs target the whole-of-population, especially focusing on those things that reduce individuals' exposure to risks or strengthening individuals' resilience. Primary prevention emphasises preventing a problem before it occurs.
3. *Secondary prevention* – These policies and programs are also known as early intervention and targets individuals or segments of the population who are showing signs of vulnerability, early indicators of trouble or due to co-occurring difficulties and are at particular risk of developing the problem.
4. *Tertiary prevention* – These policies and programs target people who have already been affected and aim to reduce the harm or damage associated with this and prevent the recurrence of a problem once it has been identified.

The public health prevention approach is holistic view of health and life circumstance. These areas are explored further throughout the paper.

4. The situation and context

This section explores the intersection between FDV and alcohol, describing both the problem and current situation in Australia. This section outlines alcohol's involvement in domestic violence and child maltreatment and why action on the issue is critical.

4.1 Domestic violence

Domestic violence is not a gender neutral issue. Statistics published by Australia's National Research Organisation for Women's Safety (ANROWS) highlight that since the age of 15, one in six women (16.8 per cent) had experienced physical or sexual violence from a current or former partner, compared to 5.1 per cent of men who had experienced physical or sexual violence from a current or former female partner. One in four women (24.5 per cent) have experienced emotional abuse by a current or former partner compared to one in seven men (14.4 per cent). Men too can be victims of domestic violence, although this violence is more likely to be perpetrated by a male than a female, as explained in ANROWS's *Violence against women: Key statistics*.[42]

The effects of domestic violence are numerous and devastating. These negative impacts include injury, physical health disorders such as gastrointestinal and reproductive health effects, psychosomatic disorders, poor mental health, suicidal ideation and the development of habits that are harmful to health such as alcohol misuse.[43] Victims also suffer from social difficulties which affect their relationships with friends, family and colleagues. The Victorian Health Promotion Foundation (VicHealth) publication: *The health costs of violence: Measuring the burden of disease caused by intimate partner violence* found that domestic violence within relationships are responsible for more preventable ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking.[44] These effects can persist long after the abuse has stopped. The effects are also likely to be cumulative, with more episodes of abuse, and the greater the severity of the abuse, contributing to increased impact on the physical and mental health of the victim.[45]

In Australia a number of communities and population groups are disproportionately affected by domestic violence, including Aboriginal and Torres Strait Islander peoples, women from CALD backgrounds, especially those who are exposed to violence as a refugee (before coming to Australia); and people who identify as LGBTQI.[46]

In addition women with disabilities are more likely to experience domestic violence[47,48] and this violence is likely to be more severe and extend for prolonged periods of time.[49] Violence perpetrated against women with a disability includes perpetration by partners or other family members, as by well as those outside family relationships including carers, friends and healthcare professionals.[50] Women with a disability are particularly vulnerable because of potential limitations to accessing support, social and cultural disadvantage. Poverty, low education and low employment contribute further to their vulnerability and increases dependence which in turn increases power imbalances. Other groups at risk of experiencing FDV include women living regional, rural and remote areas, older women, young women and women who are pregnant.[51] This demonstrates the breadth of the issue and how it impacts on many women across the lifespan.

It is also vital to consider the effect of domestic violence on parenting and children as research has shown that violence is more likely to occur between couples with children, often commencing during pregnancy. For children there are physical as well as psychological effects of witnessing domestic violence incidents, as well as stress and complex trauma from living in a perpetual state of alert and living in a situation that is volatile and unstable. This can have profound long term psychological impacts. This situation is explored in more detail in the section on Child Maltreatment.

Domestic violence also affects other family members. It is estimated that more than a million children are affected by domestic violence in Australia.[52] Witnessing domestic violence is variously described as being exposed to violence, experiencing direct abuse, hearing or seeing violence, and living with domestic violence. Witnessing domestic violence is known to impact on children regardless of whether the child sees physical incidents; hears threats or fights from other rooms; observes the aftermath such as blood, bruises, torn clothing, and broken items or lives in a home where violence is taking place placing them in fearful and stressful situations.[53]

4.1.1 Alcohol's involvement in domestic violence

The relationship between alcohol use and domestic violence is complex. The WHO has gathered a body of evidence on the relationship between alcohol use and domestic violence that demonstrated that:[54]

- alcohol contributes to the incidence and the severity of domestic violence
- heavy alcohol use may cause or exacerbate relationship stress which increases the risk of conflict
- alcohol use affects cognitive and physical function and may result in perpetrators of domestic violence using a violent resolution to relationship conflicts, rather than a non-violent resolution[b]
- excessive drinking by at least one partner can aggravate existing relationship stressors such as financial problems, thus increasing the probability of violence
- alcohol use is often used by perpetrators as a justification to violence, or excuse for the violence
- experiencing domestic violence can result in increased alcohol consumption by the victim as a coping mechanism
- intergenerational effects may occur; children who witness FDV are more likely to develop heavy drinking patterns and alcohol dependence later in life often as a way of coping or self-medicating.[55]

[b] This is not to say, that other forms of domestic violence, such as controlling behaviour, will cease even if alcohol consumption is reduced.

Alcohol is implicated in a significant number of reported domestic violence incidents. The Australian Institute of Criminology describes that within intimate partner relationships the consumption of alcohol can facilitate the escalation of an incident from verbal to physical abuse because it can lower inhibitions and increases feelings of aggression. In turn the consumption of alcohol, either by the perpetrator or victim, may also increase the seriousness and severity of a domestic violence incident, with almost half of all intimate partner homicides found to be alcohol-related.[56,57] Further to this, a 15 month longitudinal study involving 272 men entering a domestic violence treatment program or alcohol treatment program in United States of America (USA), also found that reported that domestic violence incidents inflicted by men on women were approximately eight times higher on the days when the man consumed alcohol, compared to the days that he did not drink.[58] Alcohol is also associated with an increase in the severity of violence. Compared to a physical assault where alcohol is not involved, alcohol-related physical assault from a partner is more likely to result in the victims sustaining an injury and experiencing anxiety or fear for personal safety.[59]

Research from Europe has found that the availability of alcohol generally in society affects the rates of FDV. In 1978 a strike at government liquor stores in Norway cut the availability of alcohol by ten to 15 per cent, the rate of "home quarrels" dealt with by the police dropped by about one-quarter.[60] In addition a study of the effects of changes in the number of off-sale alcohol outlets in neighbourhoods in the Melbourne region between 1996 and 2005 found that adding a new outlet in a postcode increased the domestic violence rate in police statistics by an average of 28.6 per cent.[61]

The financial cost of alcohol-related domestic violence in Australia is significant. It is estimated that each alcohol-related assault recorded by police costs $1,615, bringing the tangible cost of alcohol-related domestic violence to between $40 million and $52 million in 2005.[62]

Perpetrators

Alcohol consumption should not be seen as a mitigating factor in domestic violence. In 1990 Heather McGregor, Co-ordinator of Domestic Violence Crisis Service in the Australian Capital Territory (ACT) explained that "Regardless of how much a man drinks… he has no right to possess and control anybody… he is absolutely responsible for his own behaviour, no matter what…"[63] It is clear from research that addressing alcohol use alone will not necessarily result in the cessation of violence by perpetrators. Domestic violence is a pattern of controlling behaviours through which the perpetrator seeks power and control over the victim. However, addressing alcohol consumption across the population may reduce the levels and severity of domestic violence and improve the safety of women and children.[64,65,66]

The use of alcohol by perpetrators in domestic violence situations is complex. An issues paper by Rochelle Braaf in 2010 outlined the research evidence indicating an association between the frequency of a perpetrator's drinking and the severity of the violence within intimate partner relationships, with incidents of violence found to be higher on days when the male partners is drinking.[67] This association has also been found on days of national celebration and holiday, such as the Australian Football League (AFL) Grand Final, Christmas and New Year periods, most school holidays, and Easter;[68] occasions when alcohol consumption is also highly present. Research in the United Kingdom (UK) has found strong links between alcohol, sport and domestic violence. This

research used police data from the north west of England for the last three FIFA World Cups (from 2002 – 2010). It found that the risk of domestic violence increased by 26 per cent when the English team won or drew, and by 38 per cent when the English team lost.[69] There was also an increase of 37.5 per cent of assault attendance across 15 hospital emergency departments across England on match days, and alcohol consumption was heavily associated with these occasions.

When a perpetrator is drinking they are less aware of physical force they are using; they are less concerned about consequences; and display increased emotionality which can lead to greater likelihood of violence occurring. In addition heavy and/or frequent drinking can cause dissatisfaction and conflict within relationships and this, alongside social expectations about the effects of alcohol on aggression, can amplify its effect.[70]

The social expectations about alcohol consumption and violence are also important to understand. VicHealth's *Australians' Attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey* (NCAS) found that nine per cent of people believed that violence against women can be excused in certain circumstances if the perpetrator is affected by alcohol. In addition to these societal attitudes being expressed by respondents to the survey, NCAS also revealed that some men consciously drink to give themselves 'time-out' to behave in ways they know are unacceptable and this includes violence against women.[71] The survey highlights that only a small proportion of women become aggressive when intoxicated, suggesting that social expectations of men are important when examining the behaviour of men who use violence while intoxicated.

South Dakota's 24/7 Sobriety Project required people arrested or convicted for alcohol-related offences to take two alcohol breath tests a day or wear a continuous alcohol monitoring bracelet with 'swift, certain and modest sanctions.' This project found a nine per cent reduction in domestic violence arrests following the implementation of the program.[72]

Targeting the problematic drinking of perpetrators could be an important preventative measure for alcohol-related domestic violence, although further research on the effectiveness of this approach is required. Perpetrator treatment programs are available in some states and territories in Australia, unfortunately these are rarely linked with existing AOD treatment services.

Responding to perpetrators of domestic violence requires a long term multifaceted approach that addresses the social and health environment of the individual and acknowledges the increased risk of further violence. Care needs to be taken to ensure the safety of other family members when a perpetrator undertakes any treatment program. Treatment for alcohol problems increases the risk for domestic violence due to the discomfort of physiological or psychological withdrawal heightening a perpetrator's anxieties and irritability.[73] Therefore, the treatment of alcohol problems needs to occur only when full attention is given to the dimensions of their situation. This is discussed in further detail in section 6.5.3.

Victims

A meta-analysis in 1999 found that women affected by domestic violence were almost six times more likely than other women to have problems with alcohol.[74] Alcohol use by victims raises two important issues, the first is the heightened risk of an individual becoming a victim of domestic violence and the second is the use of alcohol by a victim as a method to cope with the violence and trauma.[75]

Alcohol is often used as a form of self-medication, to cope with the abuse itself and associated effects such as isolation, lack of support and feelings of self-blame or shame.[76] However, the risk of being a victim of domestic violence increases with increasing levels of alcohol consumption,[77] demonstrating that the link between victimisation and alcohol problems is an important one. There is evidence to suggest that the use of alcohol by victims can impair judgement, reduce an individual's capacity to implement safety strategies, and may impact on their capacity to seek help from police or services.

Unfortunately victims who are intoxicated are more likely to be blamed for the violence than a victim who is sober.[78] The NCAS results show that one in ten Australians believe that domestic violence can be excused if the victim is affected by alcohol.[79] This belief demonstrates the need for attitudinal change across society to ensure that violence is not excused when alcohol is involved.

Problematic alcohol use also tends to exclude women from domestic violence support services and refuges, and can increase the likelihood of a woman losing custody of her children.[80] If a woman does seek treatment for her alcohol problems she may encounter additional barriers. Her partner may stall or prevent access to treatment as a way of maintaining control over her. Indeed, victims of domestic violence are less likely than non-victims to complete substance misuse treatment.[81] The perpetrator may also become more violent as a reaction to the perceived loss of control.

Other issues that prevent women seeking support or disclosing domestic violence include a lack of access to support services, especially in rural and remote communities,[82] issues of anonymity within the community and kinship groups. Some Aboriginal and Torres Strait Islander peoples may feel unwilling to access support, report to police or leave a situation due to concerns that they will "fragment their identity by leaving the community, kin, family or partners."[83] Fear is also another significant barrier for women accessing support services; fear based on others' experiences of the criminal justice system, fear that perpetrators will die in custody and the very real fear that the disclosure of violence and neglect will result in having children removed from the family.[84,85] In addition to these, other barriers include financial pressures, medical costs, difficulty accessing social supports or services such as childcare, low self-esteem, low self-efficacy and limited life skills.[86]

Prevalence and trends

Data on the prevalence and trends of alcohol-related FDV is accessed through two main channels: service data and survey data.

Service data

Service data refers to sources of data that come from legal and health services such as police, hospitals and emergency services. Police data is used to determine the extent of reported alcohol-related FDV around Australia. Police data is valuable because police respond to incidents as they occur. Police data, however, does have limitations. It represents a severe underestimate of the true incidence of alcohol-related FDV because as many as half of domestic violence occurrences go unreported.[87] This is particularly the case when the violence is non-physical. Other limitations include that:

- some states and territories do not formally record the involvement of alcohol in FDV
- those jurisdictions that do collect data on alcohol involvement in FDV do not collect it in a consistent manner, making national estimates difficult
- the role of alcohol is determined by attending officers using their own judgement and the reports of the people involved, rather than more objective measures such as breathe testing for blood alcohol content.

Data on reported alcohol-related FDV incidents is collected by police in NSW, Victoria, the NT and WA. Where this data is available, it highlights that alcohol is involved in almost half of all reported domestic violence incidents[88,89] Data needs to be collected consistently across Australia in order to have more accurate understanding of alcohol's involvement in FDV incidents. Furthermore, in the past decade there has been an increase in the number of reported alcohol-related domestic assaults across the country. The data reported in Table 2 overleaf is derived from NSW Bureau of Crime Statistics and Research (BOCSAR), Victoria Police, NT Department of the Attorney-General and Justice, and WA Police.

Table 2: Alcohol's involvement in domestic violence using Police data (where available) across Australia.

Jurisdiction	Latest available year of data	Proportion of domestic violence incidents[c] involving alcohol	Total alcohol-related domestic assaults	Trend in alcohol-related FDV
New South Wales[90]	April 2013 – March 2014	35%	9,948	0.46 % increase from 2004-05.
Victoria[91]	July 2012 – June 2013	23%	14,015[d]	85% increase from 2003-04.
Northern Territory[92]	Jan 2013 – Dec 2013	65%	3,137	77% increase from 2008.
Western Australia[93]	July 2011 – June 2012	47%	5,092	21% increase from 2005-06

As outlined in Table 2, police data shows that men are more likely to be perpetrators of FDV. For example, for alcohol-related domestic assaults in NSW, in the year leading to September 2014, there were five times as many male as female perpetrators and half as many male as female victims.[94] Data from BOCSAR's Crime tool shows that between October 2013 and September 2014 there were 5,629 male perpetrators compared to 1,122 female perpetrators; (3,584 male victims compared to 7,295 female victims).

Survey data

Survey data may provide a more accurate estimate of the extent of alcohol-related FDV because it captures people who may not have reported violence to the police. Survey data is also more able to explore different forms of less serious violence including those that do not usually come to the attention of the police, such as verbal abuse. Survey data relies on self-report which has advantages and disadvantages. On the one hand, the anonymity involved may encourage greater disclosure, on the other hand, self-report may also be inaccurate.[95,96] Some caution also needs to be applied as it is not known from these survey results if the incidents of violence that are reported are part of ongoing pattern of violence that is likely to occur regardless of whether alcohol is involved or not.

The National Drug Strategy Household Survey 2013 (NDSHS 2013) found that more than five million Australians (aged 14 and over) had been a victim of any alcohol-related incident in the 12 months prior to the survey, with men more likely than women to report this. However, women are more likely than men to have experienced an alcohol-related incident perpetrated by a current or former spouse/partner or from another relative, whereas men are more likely than women to have experienced an alcohol-related incident perpetrated by people outside the family, including strangers. This applies similarly across the types of incident, whether it be physical abuse, verbal

[c] Domestic violence is defined by Police as anyone with a domestic relationship with the victim, for example, ex or current spouse/partner, child or sibling.

[d] This figure includes incidents that are recorded has having had definite alcohol involvement (n=14,015). Police also recorded incidents that had possible alcohol involvement (n=13,834)

abuse or being 'put in fear'.[97] Table 3 below, reproduced from the NDSHS 2013, shows the proportion of male and female victims of alcohol-related incidents, by incident type and relationship to perpetrator.

Table 3: Relationship of perpetrators to victims of alcohol-related incidents, victims aged 14 years or older, by sex, 2013 (per cent).

Incident and relationship of perpetrator	Males (%)	Females (%)	Persons (%)
Verbal abuse			
Current or ex-spouse or partner	10.5	29.0	18.4
Other relative	8.6	15.7	11.6
Friend	12.2	10.2	11.3
Other person known to me	24.1	16.9	21.0
Someone not known to me	67.9	49.3	59.9
Physical abuse			
Current or ex-spouse or partner	10.1	33.9	19.4
Other relative	9.5	14.9	11.6
Friend	12.2	*5.0	9.4
Other person known to me	24.2	13.6	20.1
Someone not known to me	65.9	42.8	56.9
Put in fear			
Current or ex-spouse or partner	5.0	19.8	13.2
Other relative	8.9	13.3	11.3
Friend	5.9	8.5	7.3
Other person known to me	18.4	16.3	17.3
Someone not known to me	76.6	60.1	67.4

Notes

1. Base is respondents who reported being a victim of each form of alcohol-related incidents in the 12 months prior to the survey.
2. Respondents were able to select more than one response.

* relative standard error between 25% and 50%. Interpret results with caution.

Table 3. Reproduced from Australian Institute of Health and Welfare. (2014). 2013 National Drug Strategy Household Survey. *Table 4.27 Relationship of perpetrators to victims of alcohol-related incidents, victims aged 14 years or older, by sex, 2013 (per cent)*

When incorporating a broader range of harms by the drinking of a partner or close other, results from a separate survey on alcohol's harm to others and reported in: *The Range and Magnitude of Alcohol's Harm to Others* (HTO) show that women disproportionately experienced higher levels of harms such as lost productivity, financial impacts and emotional distress, as a result of the drinking of someone close to them. For example, young women (27 per cent) were more than twice as likely as young men (11 per cent) to report that the drinking of at least one household member, relative or intimate partner had negatively affected them in the previous 12 months.[98]

4.2 Child maltreatment

The WHO describes child maltreatment as a global problem with lifelong consequences. International estimates reveal that a quarter of all adults report having been physically abused as children and one in five women and one in 13 men report having been sexually abused as a child. [99] The WHO defines child maltreatment as including: physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.[100]

Physical impacts include injuries and impairments, disruption to early brain development, stress-related symptoms such as sleep disorders and impacts to the nervous and immune systems. Psychological distress includes fear, depression and attempted suicide both in childhood and later in life. All forms of child maltreatment are likely to result in emotional difficulties and the longer the abuse continues the more serious these effects are likely to be.[101]

Being a witness to FDV has serious emotional, psychological, social, behavioural and developmental consequences for children. It places significant stress on their physical, emotional and social development and can impair cognitive and sensory growth. It can also result in behaviour changes that include excessive irritability, sleep problems, emotional distress, fear of being alone, immature behaviour, and problems with toilet training and language development.[102] Children can be also be exposed to violence from birth, or even before birth, with pregnancy being a time of increased risk of violence for women.[103]

As adults, people who have experienced child maltreatment are at increased risk of behavioural, physical and mental health problems such as: perpetrating or being a victim of violence; depression; alcohol and other drug use and abuse; high risk sexual behaviours, unintended pregnancy; homelessness and involvement with the criminal justice system.[104] In turn these consequences contribute to heart disease, cancer, suicide and sexually transmitted infections. This also impacts at a societal level including the costs of hospitalisation, mental health treatment, child welfare, and longer term health costs.[105]

There are a number of risk factors that increase the likelihood of child maltreatment. Some of these risk factors include: the age of the child, being Aboriginal or Torres Strait Islander and being a child with special needs. Australian statistics demonstrate that children under one year of age are most likely to be involved in substantiated cases of abuse or neglect (13.2 per 1,000 children), followed by children aged 1–4 years (8.4 per 1,000 children) and children aged 15–17 years (3.2 per 1,000 children).[106] Children with special needs such as physical and intellectual disabilities, mental health issues, and chronic physical illnesses are at increased risk of victimisation and maltreatment. [107]

Aboriginal and Torres Strait Islander children are eight times more likely to be a substantiated case of child maltreatment, with rates of 41.9 per 1,000 Indigenous children compared with 5.4 per 1,000 non-Indigenous children.[108] The Australian Institute of Health and Welfare report *Child Protection Australia 2012-2013* outlines that "the reasons for the over-representation of Indigenous children in child protection substantiations are complex. The legacy of past policies of forced removal; intergenerational effects of previous separations from family and culture; lower socio-economic

status; and perceptions arising from cultural differences in child-rearing practices are all underlying causes for their over-representation in the child welfare system."[109]

Other risk factors for child maltreatment include the parent's own history of child maltreatment, parental mental health issues and use of alcohol and other drugs (including during pregnancy), transient caregivers, low levels of education and income of the parents, having large number of dependent children and limited access to support services or employment. There are also relationship risk factors such as family breakdown and violence, isolation and lack of support networks and a number of risk factors at a community and societal level including gender and social inequality, lack of housing, high levels of unemployment, poverty, easy availability of alcohol and drugs, a lack of services to support vulnerable families and cultural norms that promote or glorify violence towards others.[110,111]

4.2.1 Alcohol's involvement in child maltreatment

Alcohol is consistently identified as a significant contributor to child protection cases across Australia.[112] Data indicates that within child maltreatment cases alcohol is the most common substance being used by carers, followed by cannabis, psychostimulants and opioids.[113] Alcohol's use and misuse is also strongly associated with FDV, mental health issues, incarceration and child protection.[114]

The drinking of parents can impede their capacity to take care of their children. The focus of acquiring and drinking alcohol, and becoming intoxicated, distracts from basic responsibilities for children such as providing food, supervision and protection.[115] Other impacts include arguments, disharmony, divorce, domestic violence and inadequate role performance by various family members and together these impacts may result in child physical and sexual abuse.[116] In addition, alcohol has a negative impact on education. Late night antics of intoxicated people interrupt children's sleep which compromises their school attendance and performance.[117,118]

There are a wide range of risk factors that are known to increase a child's risk of experiencing child maltreatment, including parental alcohol and drug use. However, it is important to note that alcohol and drug use by parents is not in itself a risk of child maltreatment or harm to children. Alcohol use does not always lead to poor parenting, but alcohol use by parents and carers is generally considered problematic when it is at level that impairs the judgement or alters the mood of parents, placing the child at risk of abuse or neglect.[119] The abuse is not necessarily from the drinking parent; an intoxicated parent may lack the capacity to protect the child from abuse by someone else. This poor supervision can range from children's needs not being met (not having regular healthy meals, clothes being washed) to placing children at risk of sexual assault and abuse.

Where issues with alcohol do occur they are often associated with other problems that families are likely to be experiencing, such as poverty, violence, housing and employment issues. It is this constellation of issues and stressors that put families and children at risk.[120] In addition, if both parents are experiencing problems with alcohol, the risk of maltreatment is higher.[121]

Children who are experiencing child maltreatment or living within relationships undergoing significant stress are like to develop a range of behavioural problems from early childhood. In turn

these can lead to difficulties settling into the school system; and by middle childhood, without help or support these children may be failing to meet educational standards for literacy and numeracy.[122] This can create a cycle where children who are maltreated achieve lower education levels, struggle with employment opportunities, go on to have relationships that are violent and experience alcohol, other drug and mental health issues. This creates a cycle of violence from one generation to another.[123]

Alcohol policies have a role to play. The WHO has highlighted that neighbourhoods, which have higher densities of alcohol outlets (both on and off licenses) also have greater child maltreatment problems. These neighbourhoods are also more socially disadvantaged with fewer resources available to support families. This finding is supported by research in Victoria that found that people living in disadvantaged areas had greater access to off-licence (bottle-shops) as wealthier areas. This situation can lead to increased stress for families and restrict development of social networks that can prevent child maltreatment.[124]

According to the WHO, alcohol and child maltreatment are connected in the following ways:

- Alcohol affects physical and cognitive function, which may reduces self-control and increases the propensity to act violently, including towards children, and may also incapacitate the parent from protecting the child from abuse by others.
- Harmful alcohol use can impair responsible behaviour and decrease the amount of time and money that can be spent on a child.
- Harmful parental alcohol use is associated with other factors that increase the risk of child maltreatment such as mental health issues and anti-social personality characteristics.
- Experiencing child maltreatment is associated with problematic alcohol use later in life, to cope or self-medicate.
- Child maltreatment associated with alcohol misuse is not confined to any one socio-economic group or cultural identity.[125]

Children can also be affected by alcohol exposure before birth, and the consumption of alcohol during pregnancy is associated with a range of adverse consequences, including miscarriage, still birth, low birth weights and Fetal Alcohol Spectrum Disorders (FASD). FASD is a lifelong condition that impacts individuals, their family and their community over their lifespan. The primary disabilities associated with FASD are linked to underlying brain damage including poor memory, impaired language and communication skills, poor impulse control, and mental, social and emotional delays.[126] Children born with FASD most often come from heavy drinking families, with 75 per cent of children with FASD in a USA study having a biological father who was a heavy drinker and having extended families with heavy alcohol consumption.[127]

There is strong evidence internationally[128, 129, 130] and emerging evidence from Australia[131] that children with FASD are disproportionately represented in the child protection system. A study of 250 children in the NT child protection system found that 21 per cent of all children (under investigation and on orders) were recorded as having been exposed to alcohol consumption before birth. For those

children in care (on orders), within this sample 38 per cent were found to have been exposed to alcohol before birth (with 18 per cent confirmed and 20 per cent probable exposure).[132]

The Range and Magnitude of Alcohol's Harm to Others estimated the cost of alcohol-related child maltreatment in Australia to be $675 million. This estimate includes the costs of child protection services, out-of-home care services, intensive family support services and morbidity costs. When the intangible or indirect costs are included, this figure is likely to be much higher.[133]

Prevalence and trends

Like alcohol-related domestic violence, information on the prevalence and patterns of alcohol-related child maltreatment are derived from a variety of sources: service systems data such as child protection data and survey data.

Service data

The hidden harm: Alcohol's impact on children and families, a report that examines the impact of alcohol on women, children and families, collated data from across Australia to estimate alcohol's involvement in child protection cases. These are outlined in Table 4 below.

Table 4: Alcohol's involvement in child maltreatment by Australian jurisdiction.

Jurisdiction	Alcohol's involvement in child maltreatment
New South Wales	• Fifteen per cent of substantiated cases involved alcohol in 2006-07.
Victoria	• One-third (33 per cent) of all substantiated cases between 2001 and 2005 involved carer alcohol abuse.
Queensland	• One-quarter (24 per cent) of all substantiated cases in 2007 involved alcohol only and there is likely to be more that involved alcohol and drugs together.
Northern Territory	• No percentages provided however carer substance misuse noted as a significant factor in child protection cases between 2003 and 2010.
Western Australia	• Almost half (47 per cent) of applications to Children's Court for care and protection orders involved carer alcohol abuse.
South Australia	• Approximately 70 per cent of alternative care cases in 2006 involved parental substance misuse.
Australian Capital Territory	• In a study of 150 children involved in substantiated cases between 2000 and 2003, 56 per cent of cases involved substance misuse.
Tasmania	• No estimates identified.

Data source: Laslett, AM,. Mugavin, J. Jiang. H., Manton, E., Callinan, S., MacLean, S., and Room R. (2015). *The hidden harm: Alcohol's impact on children and families*. Centre for Alcohol Policy Research, Foundation for Alcohol Research and Education, Canberra.

Parent or carer alcohol misuse is significantly involved in child maltreatment. Data from Victoria indicates that as child protection cases become more serious, the involvement of alcohol increasingly becomes identified as a factor. In the period 2001 to 2005, alcohol was recorded as a familial risk factor in one-third (33 per cent) of all substantiated child abuse cases. Breaking this down by level of seriousness and intervention required, carer alcohol abuse was recorded in 25 per cent of

substantiated cases that did not require further intervention, 34 per cent of cases where the most serious intervention was a protective intervention, and 42 per cent of cases requiring an order from the Children's Court.

Table 5 below provides an overview of alcohol involvement in substantiated cases in Victoria 2001-2005, by primary type of harm.

Table 5: Alcohol's involvement in child maltreatment in Victoria 2001-05 by type of harm.

	Child abandoned	Parents deceased or incapacitated	Physical harm	Sexual harm	Emotional harm	Neglect	Total
Alcohol involved (n)	245	245	2,554	385	6,661	2,681	12,771
Alcohol involved (%)	38	55	27	12	39	35	33

Data source: Laslett, AM,. Mugavin, J. Jiang. H., Manton, E., Callinan, S., MacLean, S., and Room R. (2015). *The hidden harm: Alcohol's impact on children and families*. Centre for Alcohol Policy Research, Foundation for Alcohol Research and Education, Canberra.

Service data collated within *The hidden harm: Alcohol's impact on children and families* shows that large numbers of children are being substantially affected by others drinking, such as experiencing alcohol-related child abuse, neglect (being left unsupervised or in an unsafe situation), being verbally or physically abused, being exposed to FDV, deaths and injuries. An estimated 10,166 children are already within the child protection system due to the drinking of a carer but an additional 142,582 children are affected by others drinking but are not within the child protection system. There are also more than one million children who have been affected in some way by others drinking such as being verbally abused, witnessing serious family arguments for example.[134]

When taking into account unreported cases of abuse, or abuse that may not necessarily come to the attention of authorities, e.g. neglect, verbal abuse, well-hidden physical abuse, the estimated effects are even greater.

Survey data

As with domestic violence, child maltreatment is likely to be largely unreported or unsubstantiated. Many of the cases coming to the attention of child protection authorities will have come to light in "crisis" situations, but do not include many serious cases where there has not been an obvious crisis. Survey data provides valuable insight into the true extent of alcohol-related child maltreatment in Australia. Data from the Harm to Other surveys and in *The hidden harm: Alcohol's impact on children and families* shows that one in five carers (22 per cent) reported that their children had been adversely affected in some way by other's drinking in the year 2008. This was most commonly due to drinking by the child's parent, step-parent or carer's parent or ex-partner. There was substantial harm was also persistence in the harm, with 35 per cent of those reporting harm to their children in 2008 reporting harm again 2011.[135]

Of the carers surveyed, nine per cent reported that their children were verbally abused, three per cent reported that their children were left in an unsupervised or unsafe situation, three per cent reported that their children witnessed serious violence in the home, one per cent reported that their children were physically hurt and 0.3 of a percent reported that a protection agency or family services was called.

Almost half (46 per cent) of respondents whose children were affected by someone else's drinking reported that the child was affected by the drinking of someone in a parental role (parent, step-parent, guardian, partner or ex-partner of the parent or guardian), 12 per cent reported being negatively affected by the drinking of siblings and 15 per cent reported being negatively affected by other family members and relatives. Others reported negative impacts by people outside the family such as people their child was in contact with, e.g. teachers, sports coaches (15 per cent) or unspecified others (12 per cent).[136]

5. Family and domestic violence policy frameworks

This section reviews the existing government frameworks for FDV in Australia. The aim is to provide an indication of the extent to which alcohol is referenced within a plan or strategy and the specific alcohol harm reduction initiatives (if any) made within the plan.

The following approach was undertaken for this review:

- a search was undertaken for the most recent domestic violence and child protection[e] strategies nationally and in each state or territory[f]
- a global search was made for references to 'alcohol' within the plan
- an examination was undertaken of the initiatives proposed in the plan (if proposed) and listing of those initiatives specifically mentioning alcohol harm reduction strategies.

A table of all the strategies considered in the review is in Appendix 2: Analysis of existing strategies for Domestic Violence and Child Protection Strategies in Australia.

This review found that there is considerable variation in how alcohol is referred to as a contributing factor to Domestic Violence in Australian governments' strategic plans. Examining the plans focused on domestic violence, the NT plan places emphasises on the importance of collaboration between alcohol and domestic violence agencies. But other strategies such as those in Queensland and South Australian make no reference to the role of alcohol in domestic violence, nor do they suggest any alcohol-related initiatives. Other domestic violence plans do mention alcohol as a contributing factor to domestic violence, but stop short of specific recommendations to reduce alcohol-related domestic violence.

Similar results are found when looking at Child Protection plans. For example NSW outlines specific initiatives to provide clinical services (including drug and alcohol counselling) to children, young people who experience abuse and neglect, but the ACT plan outlines no specific initiatives to reduce alcohol harms.

In addition, where specific alcohol harm reduction initiatives are listed, these are often targeted to Aboriginal and Torres Strait Islander peoples only. Also there are no initiatives that aim to target the availability, affordability or promotion of alcohol.

Most critically, there is a lack of detail in the National Plan (*The National Plan to Reduce Violence Against Women and their Children 2010 – 2022* and *National Framework for Protecting Australia's Children*) about the contribution of alcohol as a risk factor in FDV. Again the initiatives listed to achieve reductions in alcohol-related harm within these plans focus on measures for Aboriginal and Torres Strait Islander peoples. Other initiatives include the implementation of the *National Binge Drinking Strategy,* which ceased in June 2014.

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[e] Plans that covered child protection and wellbeing were included in the review as this reflects the terminology within the plans.

[f] In order to limit the analysis to strategic policy only this review has not included legal frameworks or legislative Act (such as Child Protection Acts in each jurisdiction).

It should be noted that as there is no current National Alcohol Strategy (the previous *National Alcohol Strategy - Towards Safer Drinking Cultures 2006-2011* lapsed in 2011).[137] Policies to reduce alcohol harm at a national level are now considered to be a sub-set within Australia's *National Drug Strategy 2010-2015.*[138] When the *National Drug Strategy* is reviewed for mentions of FDV, these are also found to be limited. FDV is mentioned under the second objective of the plan to "Reduce harms to families", and an action listed within this includes a "review of existing national frameworks which address some of the causes of drug use, for example domestic violence strategies, and consider related actions that could be taken."[139] To our knowledge, this review has not been undertaken.

These gaps in the FDV and child protection strategies and the *National Drug Strategy* highlight a lack of critical recognition between the sectors as to the cross-over and interconnections between of the issues. This highlights the need for a comprehensive Policy Paper, such as this one, to be developed to highlight opportunity for a joint approach to reducing alcohol-related FDV.

6. Exploration of policy options

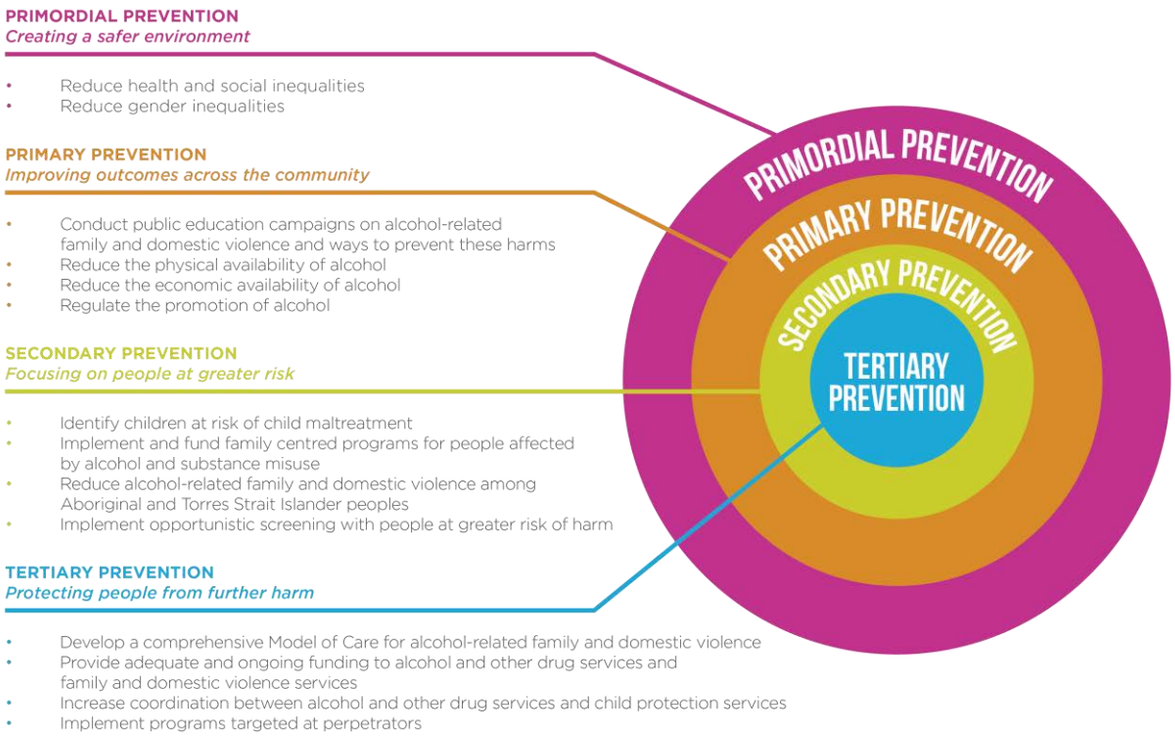
This section explores the policy options to prevent and reduce alcohol-related FDV. These options are presented using a public health model of prevention across the four levels of prevention: primordial, primary, secondary and tertiary.

6.1 Using a public health model

Using a public health model allows for a comprehensive framework to be developed that acknowledges the need to address social justice and health disparities, which are inextricably interlinked and interwoven in alcohol-related FDV. Applying a public health model to preventing alcohol-related FDV aims to improve social equity as a way to reduce health disparities across populations and to have recourse to cost-effective population-wide policy responses.

These are described in more detail in the sections that follow. Figure 2 overleaf shows an overview of these sections in a model explaining levels of prevention and Appendix 1: Overview of policy options to reduce alcohol-related FDV further details these options. Policy options are numbered in the Appendix and throughout the following sections.

Figure 2: Levels of prevention and proposed policy options to prevent alcohol-related family and domestic violence



6.2 Primordial prevention

Primordial prevention refers to initiatives and strategies that aim to prevent the emergence of predisposing environmental, economic, social, behavioural and cultural factors known to increase the risk of disease and harm across populations.[140]

Over the last decade our understanding of the factors that contribute to a person's health and life outcomes have improved significantly. It is now known that the primary determinants of the health of an individual are a combination of the circumstances of where people are born, live, work and grow (known as the social determinants).[141] These social determinants are very differentially distributed, resulting in inequities between countries, within countries and even within local communities. Improving these circumstances often falls outside of the traditional health portfolio.

The importance of implementing initiatives that address the social determinants of health has been recognised by the WHO and by the Australian Parliament, through the 2012 Inquiry by the Senate Standing Committee on Community Affairs on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report* (Social Determinants Inquiry). The Social Determinants Inquiry recognised that there are significant differences in the life

expectancies and health outcomes between groups in society, and that factors such as education, income, gender, power and conditions of employment all impact on health outcomes.[142]

Primordial prevention strategies aim to influence the whole population to reduce health inequalities and reduce gender inequalities in Australia. Reforms in these areas need to be multi-sectoral, involving governments, industry, manufacturers and non-government organisations, and across settings that include workplaces, schools, health services, sporting clubs and community groups. Strategies to address both health inequalities and gender inequalities are outlined below.

6.2.1 Reduce health and social inequalities

Alcohol consumption, and the ways in which alcohol is consumed is influenced by people's age, gender, cultural background and place of residence. Alcohol is both a consequence of and contributor to poor health and inequity.[143] For example, rates of harmful alcohol consumption can be influenced by a poor living conditions and lack of employment, and heavy drinking can also lead to these circumstances as well, due to alcohol-related problems.

Understanding the social determinants of health and how these contribute to risky alcohol consumption and increase health inequalities is important for governments across Australia to recognise. A submission by the NT Department of Health and Families to the Social Determinants Inquiry acknowledges that "many of the modifiable risk factors that influence the development of chronic conditions such as smoking, consumption of excess alcohol, poor diet and limited physical activity are linked to the social determinants of health, and are exacerbated by other social determinants of health such as level of income, limited education and unemployment which are risk factors for chronic conditions in their own right."[144]

The Social Determinants Inquiry highlighted that alcohol and drug misuse are closely associated with social and economic disadvantage and are a significant cause of health problems and premature death in Australia. Research has shown that even though people from lower socio-economic groups are more likely to abstain from alcohol than those from higher socio-economic groups, alcohol misuse disproportionately affects people experiencing socio-economic disadvantage. This is thought to be due to factors associated with socio-economic disadvantage, such as poverty, stress and difficulty accessing quality healthcare, which is likely to compound the harmful social and health impacts from alcohol leading to greater harms.[145]

Therefore addressing the discrepancies in health outcomes, which arise from the social determinants means addressing the causes of those determinants; such as improving access to education, reducing insecurity and unemployment, improving housing standards, as well as and increasing the opportunities for social engagement available for all citizens.[146]

Aboriginal and Torres Strait Islander peoples are disproportionately affected by alcohol-related FDV. Alcohol use by Aboriginal and Torres Strait Islander peoples is both as a consequence of and a contributor to continued social disadvantage,[147] and the importance of addressing this disadvantage cannot be minimised. The ongoing legacy of trauma, colonisation, dispossession, powerlessness and a breakdown in social identity and practice has contributed to the significant ongoing and sustained

disadvantage experienced by many Aboriginal and Torres Strait Islander peoples.[148] This has resulted in intergenerational disadvantage, loss of culture and community, poverty and alcohol and drug abuse are seen as part of the "ongoing legacy of colonisation, dispossession, powerlessness and a breakdown in social identity and practice has contributed to the disadvantage experienced by many Aboriginal and Torres Strait Islander peoples."[149]

Holistic strategies are needed to improve housing, education and employment opportunities for Aboriginal and Torres Strait Islander peoples to reduce social disadvantage. This need has been recognised by all governments in the *Closing the Gap* framework and in the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*.[150] Aboriginal and Torres Strait Islander peoples' experience of FDV and strategies to prevent and reduce these harms are explored further under the section on Secondary Prevention.

The South Australian Government has begun to implement strategies to reduce health inequalities through the release of its *Health in All Policies* strategy.[151] This strategy provides an example for how governments across Australia can adopt a social determinants approach. This strategy recognises that health and wellbeing are influenced by measures often outside of the health domain and aims to integrate health, wellbeing and equity in the development of all government policies and services.

The South Australian Government has also developed mechanisms for cross-sector problem solving.[152] A whole of government commitment is achieved by engaging the head of government, Cabinet and administrative leadership, and embedding responsibilities into government strategies through performance indicators, benchmarks and targets. The South Australian strategy provides a blueprint which other governments can follow.

Policy options

PO1. Implement strategies that target the environmental, economic and social determinants that contribute to health inequality. This includes improving health, housing, education and employment.

PO2. Adopt a health-in-all policies approach to public policy to ensure that the health outcomes of the community are considered in policy development.

PO3. Close the gap on higher prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples, and implement strategies to improve housing, education and employment.

6.2.2 Reduce gender inequalities

Gender inequality involves the unequal distribution of power and resources that typically favours men over women. An example of this is the under-representation of women holding key government positions. These inequalities result from systematic legal structures that limit opportunities for women as well as societal and personal views on how gender roles are defined including appropriate roles and behaviours for men and women.[153]

Gender inequality and the attitudes that are supportive of it are consistently associated with violence against women. Violence against women is one avenue for men to assert their dominance over

women.[154] At a societal level, women are at higher risk of experiencing violence where women have less access than men to education and employment, where there is little or no protection of women's economic, social and political rights, or where there are strong distinctions between the roles of men and women. At the relationship level, violence features more in relationships where women have less autonomy and have less power in making decisions for the relationship or family.

Men's personal attitudes and beliefs are also important; those that are consistent with traditional gender roles and supportive of male authority are consistently associated with the perpetration of violence against women.[155] The NCAS findings confirm this relationship, demonstrating that a person's attitudes on gender inequality are predictive of their attitudes to violence than demographic variables such as age and place of birth.[156] In addition, the association between alcohol and domestic violence is stronger where the perpetrator holds attitudes that support male dominance.[157]

There is also evidence that gender inequality and holding the core belief of male authority over women is associated with serious incidents of violence against children,[158,159] although the reasons for this relationship are less understood and researched.

The promotion of gender equality has been recognised by the *The National Plan to Reduce Violence Against Women and their Children 2010 – 2022* as a key factor in preventing violence against women. Measures to advance gender equality include increasing women's economic wellbeing (e.g. superannuation reform, improving child care support introducing paid parental leave, enhancing support for child care) and increasing women's leadership opportunities in government and private sectors.

To prevent the reinforcement of gender inequality (and consequently, violence against women) in the first place (and thus to diminish rates of violence against women), it is vital to educate young men and women. The National Plan has acknowledged this, with recommendations centring on introducing the incorporation of respectful relationships education in the curricula and syllabi of Australian schools.

Policy option

PO4. Implement strategies that promote gender equality for women, including but not limited to, increasing leadership opportunities for women, increasing access to paid maternity leave, introducing flexible work arrangements, making available varied and flexible childcare arrangements and developing equitable superannuation arrangements.

6.3 Primary prevention

Primary prevention aims to limit or reduce the incidence of a health issue by implementing strategies that address the causes of that issue. Primary prevention consists of policies or programs that affect the whole community with the intention of reducing problems across society.[160]

Many factors impact on the consumption of alcohol including the physical availability, the economic availability and the promotion of alcohol in our society. In understanding risk factors for FDV it is important to understand how factors affecting the consumption of alcohol can contribute to the increased risk of violence and severity of violence.

This is a complex milieu, factors that impact the *physical* availability of alcohol include: the location, number and density (concentration in a particular area) of alcohol outlets, and the hours and days of the week that alcohol can be sold. Factors that affect the *economic* availability of alcohol include the price of alcohol in relation to disposable income and the cost of other beverages and consumer products, and the price of drinks in a given outlet at a given time of the day (e.g. happy hour prices). Factors that affect the *social norms* about alcohol include both the promotion of alcohol and public awareness of the negative impacts (both health and social) associated with alcohol consumption.[161]

In addition there are attitudes, beliefs and social structures that increase gender inequality in Australia. It is important that Australia is able to implement initiatives that build respect and equality between men and women to reduce the incidence of FDV in society. It is also important to address attitudes about alcohol in relation to gender roles, violence and how these contribute to the use of alcohol as an excuse for the perpetration of FDV. These areas and their intersection with FDV are explored below.

6.3.1 Conduct public education campaigns on alcohol-related family and domestic violence and ways to prevent these harms

Public education campaigns are one way of challenging and changing social norms.[162] The WHO explains that social norms are unspoken rules or expectations within societies about appropriate and inappropriate behaviours. These norms persist because of individuals' desire to conform, as well as expectations by others that people will conform.[163] Public education campaigns have been most successfully used in the tobacco control field, where social norms about the acceptability of smoking have changed dramatically. Research from the tobacco control field has found that public education campaigns are most successful when they are well-funded, repetitive, and ongoing.[164, 165] Public education has also been pivotal to the reduction of drink driving. The introduction of Random Breath Testing (RBT) and the public education campaigns on RBT and drink driving have resulted in decreases not only in drink driving fatalities,[166] but also in the social acceptability of drink driving.[167] These campaigns are most effective when part of wider strategies that involve legislative change and reform.

Alcohol-related public education campaigns in Australia, with the exception of those relating to drink driving, have had little impact.[168] This has been because they are often ad-hoc, not sustained and have had ambiguous messaging.

There are a small number of campaigns that focus on both alcohol consumption and FDV. Past campaigns, particularly those targeted at Aboriginal and Torres Strait Islander peoples have included messages about alcohol misuse. An example was the "Walk Away Cool Down", a non-gender-specific campaign in Northern Queensland introduced in the early 2000s by the Queensland Police.[169] This campaign and others like it have tried to change attitudes and behaviours towards FDV and challenge perceptions of alcohol as being a cause of or excuse for violence.[170] This campaign and others like it tend to be confined within a local area and tend to be of limited duration due to funding and other pragmatic issues.

A public education campaign that aims to raise awareness of alcohol and FDV needs to take into consideration the theories and lessons learnt from both previous alcohol harm prevention and FDV campaigns.

A public education campaign needs to be multifaceted and use a range of media to promote its key messages including television, digital media and print. A clear target and message is also essential. The campaign rationale must clearly identify the target audience and the behaviour change sought. Understanding the target audience includes securing information about their knowledge, attitudes and current behaviours relevant to the public education campaign's objective.[171] The campaign should also be reinforced with more formal messaging in other settings, such as school-based educational programs.

Research by VicHealth found that campaigns to reduce FDV now need to move beyond the knowledge and awareness raising awareness and on to challenging attitudes. Where social marketing campaigns do exist these have generally been targeted towards sexual violence seeking to encourage men to take responsibility for consent and not focused on changing attitudes towards violence against women.[172]

The Australian Women's Health Network has said that the primary aim of campaigns on FDV should be to change attitudes, behaviours and beliefs that normalise and tolerate gender-based violence. Furthermore, they should be victim-centred, hold perpetrators to account and emphasise equality.[173] These strategies need to be well informed and tested with target audiences, emphasising goals for victim safety, prevention of violence, access to support services and accountability for perpetrators. They also require evaluation.

One of the central principles of prevention is to start early. Therefore, any public education needs to be reinforced with formal messaging, such as school-based education programs. Effective AOD education programs for young people have inclusive, interactive teaching strategies that actively engage students in the learning process.[174,175] Such programs are comprehensive and involve whole of school and community support for classroom drug education messages. AOD education programs should be also based on the experiences and interests of the students it is designed to influence, and should be timed such that the intervention starts before AOD experimentation begins and continues as young people mature.

This support can be reinforced by education programs targeted at young people that aim to teach respect and reduce violence. The Department of Education and Training in Victoria has developed a secondary school resource called *Building respectful relationships: Stepping out against gender-based violence* as part of a broader strategy to prevent violence against women.[176]

Education plays an important role in providing young people with the knowledge and skills to develop and maintain non-violent, respectful and equitable relationships. School-based approaches can that help young people identify inappropriate sexual or violent behaviour, and shape their expectations and capacity to build and sustain respectful relationships.

A campaign on preventing alcohol-related FDV should be developed and existing school-based education programs on respectful relationships and alcohol and other drugs should acknowledge the role of alcohol and other drugs in FDV. For example this could include emphasising that the use of alcohol and/or intoxication is never a justification, or excuse for violent or inappropriate behaviour. The programs should also highlight that alcohol contributes to increases in the severity and incidence of FDV. The campaign and education programs should be based on best practice, should be supported over a long period of time and should be reinforced by a range of media.

Policy options

PO5. Conduct ongoing national public education campaigns on preventing alcohol-related family and domestic violence; in conjunction with other preventative measures.

PO6. Implement school-based education campaigns on alcohol and also on respectful relationships.

PO7. Ensure that school-based education campaigns on alcohol and respectful relationships acknowledge the role of alcohol in family and domestic violence.

6.3.2 Reduce the physical availability of alcohol

The physical availability of alcohol is one of the most important predictors of alcohol harms. Increased availability of alcohol through the increase in the number of outlets is associated with an increase in assault, FDV, drink-driver road traffic accidents and chronic disease.[177,178]

The physical availability of alcohol relates to how easily a person can access and purchase alcohol, by the number of outlets available (the concentration of licensed premises within a given area) and trading hours (days and hours of alcohol sale). Across Australia legislation limits the times when alcohol can be sold, where alcohol can be sold and the types of premise that can sell alcohol (i.e. off-licence or on-licence including restaurants, pubs, bars, club and nightclubs). The legislation that controls the availability of alcohol was introduced because of the harms that alcohol causes.[179]

There has been unprecedented growth in the availability of alcohol in Australia over the last 15 years and the number of liquor licenses and licensed premises has increased dramatically.[180] For example, in Victoria the number of liquor licenses has increased by 120 per cent between 1996 and 2010.[181] Trading hours for alcohol sales, and in particular late night trading, has also increased dramatically in recent decades.[182] This increase in outlets and concentration of outlets and trading hours has

resulted in alcohol becoming more readily available, and more affordable than it has been in the past three decades.[183]

The increase in the physical availability of alcohol is concerning because increased availability of alcohol results in increased harms. Research from WA in 2010 found that for every 10,000 additional litres of pure alcohol sold at a packaged liquor outlet, the risk of violence experienced in a residential setting increased by 26 per cent.[184] In addition a longitudinal study of alcohol outlet density and domestic violence in Victoria from 1996 to 2005 a strong association between family violence and the density of off-licence (take-away) liquor outlets in an area. An increase in one off-premise licence per 1,000 residents was associated with a 28.6 per cent increase in the mean domestic violence rate.[185] A smaller, but still positive association, between the densities of on-premise licenses was also found.[186]

A systematic review of alcohol interventions and impacts on FDV in 2014 found that there is clear and consistent evidence of an association between alcohol consumption and FDV. Further research is needed to understand the relationship between FDV and type of outlet.[187]

The proliferation of alcohol outlets in areas of social and economic disadvantage further exacerbates the situation. Research published in *Using geocoded liquor licensing data in Victoria* in 2011 found that people living in disadvantaged areas in and around Melbourne had access to twice as many bottle-shops as those in the wealthiest areas. For rural and regional Victoria, there were six times as many packaged liquor outlets and four times as many pubs and clubs per person.[188] Given the interrelationship between alcohol misuse, FDV and socio-economic disadvantage, this is concerning.

A small number of studies have also found a link between alcohol outlet density and the increased incidence of child maltreatment. In the USA it is estimated that one less outlet per 1,000 people reduces the likelihood of severe violence towards children by four per cent.[189]

Understanding that the concentration of alcohol outlets is higher in disadvantaged communities is important when determining appropriate policy options. A review by Michael Livingston in 2012 suggested that the increased access to alcohol in disadvantaged communities may help explain some of the socio-economic disparities in health outcomes and that it might be harder for disadvantaged communities to influence planning and zoning decisions and thereby be unable to limit the continuing proliferation of outlets.[190]

Alongside the density of alcohol outlets, the physical availability of alcohol is influenced by the hours when alcohol is available for sale. Research evidence has consistently found that increases in trading hours are associated with increases in alcohol harms.[191]

Across Australia there are examples of communities and local governments that have introduced restrictions to address the trading hours of alcohol in their area. An example is the City of Newcastle which introduced a 3.00am close time and 1.00am lockout (later amended to 3.30am and 1.30am) for all on-licensed premises in Newcastle in 2008. An evaluation found that the restrictions resulted in a 37 per cent reduction in night-time alcohol-related assaults[192] and no geographic displacement

to the nearest late night district of Hamilton.[193] These positive effects were sustained over time with an evaluation undertaken five years later finding sustained reduction in alcohol-related assaults, with an average of a 21 per cent decrease in assaults per hour.[194]

Restrictions on hours of sale for alcohol are often critical features of Alcohol Management Plans (AMPs) and alcohol restrictions in Aboriginal and Torres Strait Islander communities.[195,196] For example alcohol restrictions were introduced to the Fitzroy Valley in WA in 2007 that limited the types of alcohol that can be sold and the times when alcohol can be sold.[197] Community leaders in Fitzroy lobbied for the introduction of the measures as a response to 13 suicides in one year and increasing rates of community dysfunction.[198] An evaluation in 2010 found reductions in rates and severity of domestic violence; reduced street violence; reduced street drinking; less litter; less anti-social behaviour; generally better care of children and a reduction in the amount of alcohol being consumed by residents.[199]

Policy options

PO8. Intervene to reduce the density of liquor licenses in areas where there are significant levels of harm and reform licensing approval processes to consider community, police and public health views, as well as factors such as socio-economic status.

PO9. Introduce restrictions to the hours that alcohol is available for sale for both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops).

6.3.3 Reduce the economic availability of alcohol

Economic availability of alcohol refers to the affordability of alcohol, which is consistently shown as one of the most important predictors of alcohol harms. Lower prices are associated with higher consumption and this, in turn, is associated with increased harm.[200,201] Conversely, increases in the price of alcohol result in a decrease in harms.

The price of alcohol is partly influenced by taxes that the government sets on alcohol products or the setting of a minimum below which alcohol cannot be sold (known as minimum floor price). In addition to these, other factors such as point of sale promotions, bulk discounts, two-for-one offers can influence the affordability and price of alcohol products at point of purchase.

How alcohol is priced and taxed influences what alcohol is consumed as well as how it is consumed. For example, wine is by far the cheapest form of alcohol available in Australia due to how it is taxed. A standard drink of containing 12.5 ml of alcohol can be obtained for 36 cents by buying cask wine, compared with $1.75 for beer and $2.52 for ready-to-drink beverages.[202]

Several studies in the USA have examined the impacts of alcohol price on violence and crime. A study by Markowitz found that a one per cent increase in the price of alcohol was associated with a 3.1 to 3.5 per cent increase in ‘wife abuse’ [sic], although no corresponding link was found for ‘husband abuse’ [sic].[203] Another study by Markowitz and Grossman estimated that a 10 per cent increase in the excise tax on beer was estimated to reduce the probabilities of overall child abuse and severe child abuse by 1.2 per cent and 2.3 per cent, respectively.[204] Even though the percentages appear

small, applying these to the US population at the time would result in at least 100,000 fewer women being abused, and at least 100,000 fewer severely abused children.[205]

The systematic reviews by Wilson, Graham and Taft[206] and by Kearn, Reidy and Vale[207] found that the existing evidence base for the association between the price (and by association, the taxation) of alcohol and the incidence of FDV was indirect. This was primarily due to study designs and the authors see value in further investigating the association between alcohol price and FDV using stronger study designs.[208]

In Australia volumetric tax is applied to all alcohol products, other than wine. This tax is applied at a rate per litre of pure alcohol, this means that higher strength products, such as spirits, are taxed at higher rates than lower strength products, such as beer. However, wine is taxed according to the product's wholesale price (at 29 per cent), known as the Wine Equalisation Tax (WET). In addition to the WET, a rebate exists (WET Rebate) which provides rebates of up to $500,000 to wine producers across Australia. Together the WET and the WET rebate result in billions of forgone revenue being collected by the Australian Government, which could be dedicated to reducing alcohol harms.[209]

Nine separate government reviews have concluded that the current alcohol taxation system needs to be overhauled, finding that it does not adequately recognise the extent and costs of alcohol-related harms to the Australian community.[g] Most damningly the Australia's Future Tax System Review (known as the Henry Review; 2009) described Australia's alcohol taxation system as "incoherent".[210] A recent Australian study also found that alcohol taxation reform is cost beneficial, showing that this reform meets the gold-class standard required for policy reform in Australia.[211]

The price of alcohol and its consumption is also influenced by promotions at the point of sale (POS). POS marketing refers to promotional materials that are found within or on the exterior of a licensed store or venue at the point where an alcohol purchase will be made (e.g. happy hours, free gifts with purchase, prominent signage, competitions, price discounts for bulk purchases, and sale prices).

POS promotions have been found to encourage the purchase of increased volumes of alcohol[212] and are likely to affect overall consumption patterns of underage, harmful, and regular drinkers.[213] POS marketing is being increasingly used, to the point that it has been coined as "ubiquitous" and "aggressive".[214] Between Jan to April 2009 liquor outlets in Sydney alone host an average of 30 POS promotions per outlet.[215] The prolific nature of POS marketing is concerning because it results in young people (including minors) being regularly exposed to advertisements and promotions that depict alcohol consumption as a fun, social and inexpensive activity.[216]

[g] Reviews that have recommended a volumetric tax be applied to wine include: the 1995 Committee of Inquiry into the Wine Grape and Wine Industry; 2003 Federal Standing Committee on Family and Community Affairs Inquiry into Substance Abuse; the 2006 Victorian Inquiry Into Strategies to Reduce Harmful Alcohol Consumption; the 2009 Australia's future tax system (Henry Review); the 2009 National Preventative Health Taskforce report on Preventing Alcohol Related Harms; the 2010 Victorian Inquiry into Strategies to Reduce Assaults in Public Places; the 2011 WA Education and Health Standing Committee Inquiry Into Alcohol: the 2012 House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Fetal Alcohol Spectrum Disorders and the 2012 Australian National Preventive Health Agency Exploring the public interest case for a minimum (floor) price for alcohol, draft report.

Guidelines on the promotion of alcohol exist under most State and Territory Liquor Licensing legislation but fail to adequately address promotions that are currently taking place particularly in off-licence premises. For example, existing legislation is often about what constitutes extreme discounting or harmful promotions, with the judgement of these left largely to the licensee. As a result bulk buying specials, are common practice by retailers. For example, Beer Wine Spirits (BWS) in October 2014 had a promotion that sold three five litre casks of wine for $33, this is the equivalent of 22 cents a standard drink.[217]

Policy options

PO10. Reform the alcohol taxation system to increase the prices of the cheapest alcohol products.

PO11. Eliminate reckless liquor promotions that encourage excessive and harmful consumption in both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops).

6.3.4 Regulate the promotion of alcohol

The WHO has outlined that societal beliefs about alcohol consumption as well as beliefs about gender roles and violent behaviour can affect the risk of alcohol-related violence. In particular, beliefs or expectations that increase the risk of committing violence towards a partner include:

- the association of heavy drinking and violent behaviours with masculinity
- the expectation that alcohol consumption will lead to aggressive behaviour and that acts of violence are expected
- that the consumption of alcohol by the victim is seen as a cause of violence or a mitigating factor in the violence[218]
- alcohol being consumed in contexts where violence is more likely to occur.[219]

There is evidence from the NCAS that a sizeable number of Australians hold the belief that alcohol justifies anti-social and violent behaviour.[220] In order to understand the behaviour of men who use violence while under the influence of alcohol, it is essential to consider the role that the environment plays in shaping expectations of men on their use of alcohol as well as their attitudes towards gender roles and violence. A factor which plays into these attitudes, helping to reflect and reinforce gender norms, is the promotion and advertising of alcohol.

Advertising and promotion is a pervasive feature of modern Australian life and has a powerful influence in shaping how we view the world. Alcohol advertising in Australia is prolific and presented through television, radio, newspapers, magazines, billboards, merchandising and sponsorship of sporting and cultural events. Australians also receive alcohol marketing through the internet, on mobile phones and on social media platforms such as Facebook, YouTube and Twitter.

Research has demonstrated that the ubiquitous presence of sexually attractive female models in advertising contributes to an environment where sexual harassment, sexual aggression and domestic violence are tolerated in society.[221] Advertisements that are sexist limit women's aspirations, achievement, self-esteem and equity in society.[222] Alcohol is one product in particular where advertising has been highly associated with sexual appeal. Alcohol advertising often portrays alcohol

as an integral part of a sexually active and fun lifestyle among young people and promotes the idea that this lifestyle is stimulated or enhanced by the consumption of alcohol.[223] Alcohol advertisements often contain images that imply that certain irresponsible sexual behaviour (or treatment of women) is appropriate in the context of alcohol consumption.[224]

Given the gendered nature of domestic violence, it is vital that alcohol advertising and promotion does not perpetuate sexist attitudes or behaviours towards women. This is in line with the First Action Plan of the *The National Plan to Reduce Violence Against Women and their Children* Plan, under Strategy 1.1: to "promote positive media representations of women."[225]

The content of alcohol adverts in Australia is currently self-regulated through a complex mix of industry codes. The main code is the Alcohol Beverages Advertising (and Packaging) Code (ABAC), administered and governed by members of the alcohol industry, which has essentially not changed since it was established in 1998.[226,227] The ABAC has responsibility for the 'content' of alcohol advertisements. Other industry codes attempt to cover the 'placement' of alcohol advertising such as outdoors, on radio, television, and in cinemas.

The only major review of the ABAC took place in 2003 by the National Committee for the Review of Alcohol Advertising (NCRAA), appointed by the Ministerial Council on Drug Strategy (MCDS).[h] This review found substantial flaws in the system including: a lack of transparency about how decisions are made, that the general public was largely unaware of the system, that it did not cover all forms of advertising and that did not address public health concerns with alcohol adverts.[228] Unfortunately little has changed since this time.

The ABAC specifies the alcohol marketing must not "show (visibly, audibly or by direct implication) the consumption or presence of an Alcohol Beverage as a cause of or contributing to the achievement of personal, business, social, sporting, sexual or other success."[229] However, the ABAC contains no reference to sexism or marketing that may be considered sexist.

Unfortunately the majority of young people (aged 15-24 years) believe that alcohol advertisements are designed to appeal to them. They imply from the existing advertisements that the consumption of alcohol confers more confidence, greater sociability, and better success with the opposite sex, among other things.[230]

In 2014 the former Government agency the Australian National Preventive Health Agency (ANPHA) found that the current regulatory system, including the ABAC failed to protect children from exposure to alcohol advertising. *Alcohol advertising: The effectiveness of current regulatory codes in addressing community concern, Draft report* found that children and adolescents are exposed to significant amounts of alcohol advertising and that this exposure influences young people's drinking intentions and behaviours.[231,232,233] Put simply, the more alcohol advertising that young people are exposed to,

[h] Changes to ABAC have been proposed several times since 2003, including recommendations to forward to the Council of Australian Governments in 2009 and the Review of the Effectiveness of Current Regulatory Codes on Alcohol Advertising in Addressing Community Concerns by the former Australian National Preventative Health Agency in 2014. However no other reviews of ABAC itself have been undertaken since 2003.

the earlier they will start to consume alcohol, and the more they will consume if they already drink. This is consistent with a well-established body of evidence that shows there is also a significant relationship between exposure to alcohol advertising, and young people's drinking intentions and behaviours.[234,235,236]

Overall the regulation of alcohol advertising needs to address the volume, timing and targeting of alcohol advertisements currently taking place. This includes a fundamental shift away from focusing only on content or placement and includes all forms of marketing, including through not only traditional media but also online media, POS promotions, product placement, on sporting team uniforms, on sporting grounds, at cultural events, in branded merchandise and POS promotions in retail spaces and pub/bars.[237] Leaving the policing of alcohol marketing in the hands of the alcohol industry is unlikely to result in any change, and fundamental reform is required.[238] This regulatory systems should include guidelines on how women are portrayed in alcohol marketing.

Policy options

PO12. Introduce independent regulation of alcohol marketing to protect children from its exposure.

PO13. Eliminate negative and sexist representations of women in alcohol marketing.

6.4 Secondary prevention

Secondary prevention aims to reduce the average risk of harm across the population by focusing on early detection and groups at highest risk. Secondary prevention aims to slow the progression of disease or reduce the impact of particular harms on individuals and communities. In the context of examining alcohol-related FDV it is the recognition that particular groups are at great vulnerability and proposes tailored solutions for those groups. Secondary prevention is also focused on the early identification of problems and the implementation of programs or services that reduce or mitigate these issues.

Governments across Australia recognise that alcohol and FDV cause harm in the community and fund screening programs, 24 hour help lines, specialist training for health professionals, diversion, counselling, treatment, rehabilitation, relapse prevention, aftercare and social integration services.[239,240]

As outlined earlier, certain groups within the population are at higher risk of alcohol-related FDV than others. This section focuses on two discrete groups experiencing high levels of harm, Aboriginal and Torres Strait Islander peoples and children and young people. It also examines the implementation of opportunistic screening to target other groups at higher risk of alcohol-related FDV, including women from CALD communities, women with disabilities and people who identify LGBTIQ.

6.4.1 Identify children and young people at risk of child maltreatment

Children and young people from families with alcohol problems and/or violence are more likely to experience mental health issues, current or future alcohol misuse, and current or future FDV perpetration or victimisation.[241,242]

Screening for child maltreatment tends to be reactive. Often enquiries are not made until indicators of harm pertaining to child abuse (e.g. bruises, broken bones) are present or a report from a third party is given. It is vital to try to identify children being effected early and reducing their risk of present and/or future harms. This is often done through opportunistic proactive screening, though this practice is not widespread.[243]

The need for proactive screening for child maltreatment is acknowledged within the *National Framework for Protecting Australia's Children 2009–2020* which includes actions to:
"Increase capacity and capability of:

- adult focused services to identify and respond to the needs of children at risk
- child-focused services to identify and respond to the needs of vulnerable families
- the broader system to identify children at risk." [244]

Screening within the broader system is identified by the Victorian Department of Human Services in the *Child abuse: Reporting procedures* as including doctors, nurses, school teachers and police. These professions have legal obligations to report suspected child abuse. These reporting procedures also recommend that people working with children should be alert to warning signs of potential abuse, including alcohol or drug misuse.[245] However, no routine screening procedures are recommended for people in contact with children showing signs of risk, and the detection of risk is still largely reliant on personal and professional judgement.

General Practitioners (GPs) are often a first point of contact for families experiencing stress and are well placed to screen for child maltreatment and alcohol issues. The Royal Australian College of General Practitioners (RACGP) has developed clinical guidelines to help in the detection of FDV.[246] Sample questions for GPs to ask during a routine visit include:

- "Sometimes kids worry about lots of things, like when they have a fight with their friend, or they feel their teacher was mean to them. Kids also worry about things in their homes, maybe about mum and dad fighting or when their mum or dad was mean to them. Sometimes kids are scared and don't know what to do. Do you sometimes worry about things like that?"
- "Sometimes I see children I worry about. I saw another child who was sore like you, what do you think happened to them?"

This proactive screening method could be applied to other relevant health professionals, including those in the alcohol and domestic violence sectors. Schools may also provide an appropriate setting in which to screen children for possible problems with the family.

Following a positive identification or a strong indicator of risk, the child and their family can be referred to interventions designed to diminish or eliminate the likelihood of harms occurring. Programs may be targeted at the child's family, with the principal aim of addressing the factors that contribute to poor parenting, and ultimately improving the relationship between parents and their child or children. Programs may also be targeted at the children themselves, focusing primarily on building their resilience and providing practical solutions to enhance their safety.[247]

Less is known about the efficacy of programs targeting children only. A review of early intervention strategies for 8-14 year olds concluded that there are a variety of school-based interventions that target specific outcomes such as preventing substance misuse or depression.[248] However, many behaviours and outcomes are interrelated and linked to the same underlying factors. Therefore there is value in implementing programs that develop and improve upon protective factors (such as teaching positive coping skills, building resilience and improving positive social connections with people outside the family),[249,250] with the aim of reducing a variety of negative outcomes including substance misuse, mental health issues and aggression.

Policy options

PO14. Encourage health professionals and educators to undertake screening to identify children at risk of child maltreatment.

6.4.2 Implement and fund family centred programs for people affected by alcohol and substance misuse

Family centred programs are needed for families with a parent that has alcohol or substance misuse issues.

Family Sensitive Practice involve alcohol interventions that are sensitive to, and incorporate the needs of families. The guiding principle is that alcohol affects family members other than the drinker; therefore, interventions that target the family, particularly children, will not only enhance outcomes for the person misusing alcohol but will also prevent or at least mitigate harms to the children. Family Sensitive Practice is increasingly being used in the alcohol and drug field. The National Centre for Education and Training on Addiction (NCETA) at Flinders University has produced a resource for Family Sensitive Policy and Practice in the alcohol and other drugs sector. The focus of the resource is to provide guidance for alcohol and other drug interventions that are sensitive to the needs of families in which parents or caregivers misuse alcohol and have children under 18 years in their care. Existing programs tend to use one or a combination of the following delivery models:

1) Home visits: Trained professionals (e.g. nurses, social workers, AOD workers) visit the homes of clients with alcohol problems and support them with their parenting.
2) Residential: This involves programs that accommodate parents and children in alcohol residential treatment programs.
3) Non-residential: This includes community based parenting programs and intensive play groups for children whose parents are having problems with alcohol.
4) Assertive Outreach: Actively following up people who misuse alcohol in the community, regardless of where they may be currently living. This includes on the streets or in residential care settings.[251]

An example of a successful Australian program that targets the family and parenting is the *Parents under Pressure* program (PuP), designed by Professor Sharon Dawe and Dr Paul Harnett. The program targets all families with difficult life circumstances, although it has been especially applied to families with alcohol and other drug use and/or child protection concerns. The program is delivered by a PuP

therapist, usually in the clients' home, and adopts a model of empowerment to enable parents to harness their strengths to improve their relationship with their child or children. The program consists of ten modules that take 3-4 months to complete. These are designed to complement the care provided by the alcohol treatment services.[252] An evaluation of the program on children aged 3-8 years whose parents were on methadone found significant reductions in potential child abuse and child behaviour problems.[253] Although there has been no similar evaluation looking specifically at alcohol, it is reasonable to consider that this program or others like it will have similar impacts.

Another example of a family service is *Kids in Focus* a Commonwealth-funded service that addresses the needs of parents and children where parents have, or are recovering from, AOD problems. Most referrals to the program are made by child protection services. Clients are typically sole parent mothers resolving parenting problems associated with the misuse of AOD, along with a range of complex problems. The program provides case management with assertive and intensive outreach with the aim of supporting parents to retain children safely in their care. The program also supports parents who are working towards reunification with children placed in out-of-home care. A range of approaches is used to support families, including parent-child attachment and trauma-informed practice. Between July and December 2011, 2,662 clients received support as part of the *Kids in Focus services,* scheme, although whether these referrals were for alcohol or other types of drug problems is not known.[254]

It is difficult to gauge the exact extent of alcohol's involvement in family services as data registers do not routinely collect this level of information of their clients.[255] The limited evidence that does exist suggests that alcohol is implicated in a substantial proportion of cases.[256]

It is also important that family services focus on the importance of increasing a child's capacity to identify inappropriate behaviour and to teach safety and resilience skills. It is essential for family services to identify the strengths and supports available to children and families. These strengths and supports are known as "protective factors" and they help build resilience against risk.

Policy options

PO15. Fund programs such as the Parents under Pressure (PuP) for children and families identified as being affected by parental alcohol misuse and other risk factors.

PO16. Establish programs that increase children's capacity to identify inappropriate or abusive behaviours and teach safety and resilience skills.

6.4.3 Reduce the prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples are disproportionately affected by FDV and alcohol-related FDV.[257] The level of harmful use of alcohol is about twice as high among Aboriginal and Torres Strait Islanders peoples as among other Australians,[258] even though more Aboriginal and Torres Strait Islander peoples abstain from alcohol (23 per cent compared to 17 per cent).

Addressing alcohol misuse has been recognised by governments as being central to reducing FDV among Aboriginal and Torres Strait Islander peoples. The 2007 *Little Children are Sacred* report

recognised that "unless alcoholism is conquered, there is little point in attending to any of the other worthwhile proposals in this report. It is a priority!"[259] The statistics are alarming:, almost half (42 per cent) of Aboriginal and Torres Strait Islander peoples aged 14 years and over report having been victims of alcohol-related incidents such as physical abuse, verbal abuse or being put in fear, with between 30 to 40 per cent of these incidents being committed by a current or ex-partner or relative.[260] The majority (87 per cent) of intimate partner homicides among Aboriginal and Torres Strait Islander peoples from 2000 to 2006 were alcohol-related, compared to 44 per cent in the general population.[261]

Children can also be affected by alcohol before they are born, with Aboriginal and Torres Strait Islander peoples being disproportionately affected by FASD.[262] FASD impairs cognitive functions, affecting the development of language, social skills and memory. This can exacerbate the loss of traditional Aboriginal culture reliant on oral transmission and good memory[263] FASD is also linked social and emotional delays, which can impact on people's ability to later parent a child, increasing the risk of harm for that child and creating a vicious cycle of alcohol harm.

Policies to address alcohol-related FDV in Aboriginal and Torres Strait Islander communities must be holistic and recognise the intricate and complex links between alcohol misuse, family violence and other stressors. Policies and practices must be community-led and driven and involve strong leadership from men as well as from women.

A number of programs have been introduced to Aboriginal and Torres Strait Islander communities to address FDV and support families in a culturally appropriate way.[264] Two programs with some success include the Aboriginal Family and Community Healing Program and the Mildura Family Violence and Sexual Assault Campaign. The Aboriginal Family and Community Healing Program, developed in South Australia, offered a structured eight-week family wellbeing course for women, a men's group, individual counselling and camps. The Mildura Family Violence and Sexual Assault Campaign, developed by a number of Aboriginal justice, family and other organisations and Victoria Police. This consisted of an educational and awareness raising program, with posters and television commercials on the impact of family violence and offering suggestions for help. The campaign targeted three groups: men, women and children. While not formally evaluated, Victoria Police report that there has been an increase in community awareness and knowledge about family violence and an improved relationship between the police and Aboriginal community.[265]

Cultural sensitivity is vital. Cultural values can affect the willingness of Aboriginal and Torres Strait Islander peoples to access services. The practice of men's business and women's business is particularly relevant where certain customs and practices are performed separately by men and women. These practices relate to gender specific knowledge and practices on issues such as health, wellbeing and religious matters.[266] This is particularly challenging in areas where services are scarce. Other cultural considerations include the concept of family in Indigenous culture where responsibility for raising children is shared, rather than being the sole responsibility of biological parents.[267]

Community-led alcohol controls should be supported to be implemented in communities where a need has been identified and agreed upon to address the risk associated with harmful use of alcohol

use, through AMPs or like mechanisms. It is essential that Aboriginal and Torres Strait Islander communities define the problem and set the parameters defining engagement with the issue, and developing appropriate and relevant interventions that recognise the diversity and cultural values of the community and foster community engagement in decision making.[268] Interventions should use local structures and develop relationships with key players in the community such as existing services (particularly Aboriginal and Torres Strait Islander specific services and organisations), Elders and community members. Interventions should also provide clear leadership and decision making processes and services should work together on the basis of respect and equality.[269] This approach strengthens the capacity of the community and leads to a more sustainable commitment to reduce FDV.

Targeted public education campaigns on alcohol and FDV are required, these also need to be community driven and culturally sensitive. Such programs are essential to raise awareness of the issue and to get people to confront the violence in their own homes or within their community. Importantly, such campaigns provide information and resources to support families, engage with community members about issues within their community and challenge them to do something about it,[270] noting that public education campaigns are most effective when implemented in conjunction with other strategies to reduce alcohol harm.[271]

Policy options

PO17. Implement community-led and comprehensive alcohol controls in communities where a need has been identified and agreed.

PO18. Conduct ongoing public education campaigns on alcohol and FDV that are community driven and culturally sensitive.

6.4.4 Undertake opportunistic screening with people at greater risk of harm

Opportunistic screening is an effective, evidence based approach that has the potential to identify harmful alcohol use and/or FDV and take action to prevent future harm from occurring.

Screening is a common strategy that is used to determine whether a person is at risk of harms (such as from smoking, alcohol consumption, diet and lack of physical activity). Where a risk is identified, a brief intervention such as providing information on the risks associated with their behaviour or formal counselling can then be provided. Identifying a risk early through screening and brief interventions (SBI) can save the health system resources in the long term because it can ameliorate the need for later stage treatment which may be more intensive and costly.

Screening an individual about their alcohol use can identify whether their consumption is placing themselves or others at harm and identify individuals who may be developing alcohol-related problems. SBIs have been shown to reduce the quantity of alcohol consumed per week by individuals and have been proven effective in different settings such as primary care and Emergency Departments as well as across different age groups.[272,273,274] There are tools available to health professionals to support them to assess a person's alcohol use, these include the Alcohol Use Disorder Identification Test (AUDIT), a ten item tool developed by the WHO. A shorter three item tool, the AUDIT C, focused on consumption levels, has also been developed.

Screening for harmful alcohol use and/or FDV does not occur universally in Australia because of reluctance to talk about sensitive issues by health practitioners, lack of training and resources to support implementation, additional time in already time pressured environments, lack of knowledge about what to do next and poor awareness of referral pathways contribute to reluctance of services to conduct screenings. Language barriers and lack of privacy also act as barriers to conducting screening.[275,276] Where screenings have occurred, these have not always been successful in achieving disclosure of violence which has further deterred services from continuing the practice.[277]

Some states and territories do try to routinely screen women for FDV through early identification programs. Examples include ante natal and post natal screening programs in Queensland,[278] the Domestic and Family Violence Framework in NSW[279] and the development of the Common Risk Assessment and Risk Management Framework in WA.[280] These programs place a heavy emphasis on screening, brief intervention and support. However, these programs are not widespread nor universally employed.

Women often experience barriers to disclosure and seeking support if experiencing FDV. These include issues such as fear of further harm from their partner, financial concerns, impact on family and pressure to stay in the relationship.[281] For women in rural and remote locations, Aboriginal and Torres Strait Islander communities and other close knit communities, other factors such as confidentiality, lack of services, transport issues and isolation may also be a factor.[282] Language barriers and cultural beliefs may prevent women from accessing services.[283] Some groups such as CALD women and LGBTIQ populations fear that mainstream services may not understand their particular needs.[284,285]

Contact with the health sector presents an opportunity to screen for harmful alcohol use and FDV and provide a brief intervention or referral where necessary. Services such as GP practices are generally in a position of trust and are well placed to deliver screening for harmful alcohol use and FDV.[286,287] Screening for harmful alcohol use and/or FDV does not occur universally in Australia because of reluctance to talk about sensitive issues by health practitioners, lack of training and resources to support implementation, additional time in already time pressured environments, lack of knowledge about what to do next and poor awareness of referral pathways.[288,289,290] Language barriers and lack of privacy also act as barriers to conducting screening.[291,292] Where screenings have occurred, these have not always been successful in achieving disclosure of violence which has further deterred services from continuing the practice.[293]

Toolkits and guidelines already exist to assist health professionals. For example Women's Legal Service NSW produced a toolkit *When she talks to you about the violence: A toolkit for GPs* on FDV.[294] This covers indicators of FDV in adults and children, how to ask a patient about FDV they may be experiencing and how to respond to disclosures of violence. It also details initial safety planning, legal obligations and continuing care. This toolkit also covers how GPs can respond if the patient is a perpetrator of violence. The NSW toolkit supports the use of the RACGP's Clinical Guidelines on *Abuse and violence: Working with our patients in general practice* (known as the White Book).[295]

Screening for the perpetration of domestic violence is rare.[296] Many perpetrators will not admit to using violence, whether it be for self-protective reasons, shame or lack of perception that their behaviour is classed as domestic violence. Traditional approaches to reducing and managing FDV such as punishment, deterrence, incapacitation and rehabilitation are proving to be ineffective and so new approaches, including individualised and comprehensive approaches to treatment and outcome-orientated partnerships that integrate policing and judicial responses with health and welfare services, are being introduced.[297] Violence prevention and perpetrator programs are voluntary or court ordered.[298]

Opportunistic screening for alcohol and for FDV followed by brief intervention or referral is needed in Australia. This should be targeted at high risk population groups and occur in a variety of health and social settings including AOD and FDV services and police. Given the association between FDV and alcohol for both perpetrators and victims, it is important to screen for the presence of the other condition when one has already been identified. For example, a person identified as consuming alcohol at harmful levels should also be screened for domestic violence. Likewise, where domestic violence is identified, the person should be screened for harmful alcohol consumption. This is particularly important where the perpetrator is screened since action to address their alcohol consumption and/or FDV is likely to reduce the risk and severity of FDV.

Screening is recognised within the National Plan and by women themselves. An evaluation of NSW Health's pilot domestic screening project found that women considered it appropriate for a range of health professionals to routinely screen for FDV.[299] The vast majority (95 per cent) of women who received screening indicated that they were happy to be asked. This suggests that women are receptive to being screened for FDV by people other than those directly related to FDV. Embedding FDV screening as a routine measure for all women, as opposed to indicator-based assessment, validates FDV "as a central and legitimate health care issue."[300]

The implementation of screening should be supported by the development of training and resources to provide confidence in undertaking the screening and brief intervention or referral. In addition, good collaboration between health and other sectors will ensure the safety of those affected, allow easier access to support services by both victim and perpetrator and reduce the trauma on a group of people who have already experienced significant distress. Screening by areas outside the health sector such as police and criminal justice services is important so that early action can be taken to prevent further harm. In addition screening should take place when women and men present to AOD and/or FDV services to determine their risk and to assist in the development of pathways for them.

Policy option

PO19. Support professionals in health and community organisations to screen for harmful alcohol use and family and domestic violence. Screening programs should include support resources, clear referral options and training for professionals administering the screening.

6.5 Tertiary prevention

Tertiary prevention targets the prevention of recurrence or re-victimisation of FDV of people who have already been affected by the violence as well as reducing or aiming to minimise the harm being experienced. This can be achieved by improving service integration and service responses.

The purpose of service integration is to treat the victims' and perpetrators' issues with FDV and alcohol in a holistic manner to ensure that no one falls through the cracks. The aim is to prevent further harms, whether it be re-offending or re-victimisation.

Improved service responses (such as police and legal responses), although not considered prevention in the pure sense, can form part of tertiary prevention responses in that they may prevent the re-offending or re-victimisation of FDV. They also feed into primary prevention by sending an unequivocal message to the community that FDV is unacceptable and punishable by law.[301]

6.5.1 Develop a comprehensive Model of Care for alcohol-related family and domestic violence

Greater coordination is needed between AOD and FDV services to reduce alcohol-related FDV and minimise the risk of further harm. At a minimum, services should have a basic level of awareness of the issues associated with harmful alcohol use and FDV and a knowledge of the organisation's policies and procedures. Information should be made available within the service including posters and leaflets of who to contact if people need support.

Integrated and coordinated service models within the AOD and FDV sectors in Australia are rare. Historically, the sectors have worked independently of each other despite the long recognised association between alcohol misuse and FDV. Part of the reason is that models of treatment for alcohol use disorders have traditionally geared towards the needs of individuals and in particular men. Nearly all AOD treatment (96 per cent) in Australia is for the individual's own AOD use and most of this treatment is provided to men (68 per cent).[302] As a result, the specific needs of women are not always addressed. For example, a woman is unlikely to disclose her experiences of FDV if asked to join a mixed-gender counselling group. Staff also do not always feel equipped to deal with the issues outside their area of expertise, they may feel awkward or that they are opening a "can of worms" that they are unprepared to provide assistance for.[303] Differences in the professional backgrounds of staff within each sector and between service models also bring challenges to introducing new ways of working.[304]

Integrated models of care are found for other co-occurring conditions. For example, the AOD and mental health sectors have been working towards achieving greater coordination and integration of services to improve outcomes for clients. The National Comorbidity Initiative and the *National Action Plan on Mental Health* encouraged AOD and mental health services to improve service coordination and treatment outcomes.

Within the AOD sector, best practice principles have been developed by NCETA to support the implementation of initiatives to address issues relating to FDV in clients, this includes the *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment*

practice in Australia and *Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence.*

Both of these publications outline in detail ten principles of best practice (and reproduced in full in Appendix 3), these principles include:

1. incorporating evidence- based policy and practice responses
2. ensuring organisational awareness of family issues
3. prioritising safety for clients, their families and staff
4. coordinating services between multiple organisations
5. developing policies and systems that support safe and effective practice
6. developing standard assessment and response frameworks
7. including broad-based interventions that address a variety of risk and protective factors
8. accessing highly skilled practitioners if needed
9. workforce development
10. monitoring accountability and evaluation.[305]

In the UK work has been undertaken between AOD and FDV services to work together. The Stella Project in the UK, established in 2003, improved cross-sectoral knowledge and service delivery for victims and perpetrators of domestic violence as well as their children.[306] In 2010, the Stella Project was expanded to include sexual violence and mental health in its work, in light of the levels of sexual violence experienced by women (in particular) who access AOD treatment services and the use of AOD as a coping mechanism in response to the trauma associated with FDV.

Greater collaboration is needed not just between services providing AOD treatment and FDV services, but also with mental health and child protection services to meet the complex trauma-related support needs of these clients. Coordination both within and between sectors provides a better understanding of an individual's situation and avoids requiring people to repeat stories they may find traumatic.[307] A 'no wrong doors' approach to support services must be provided by all the sectors so that victims are not turned away from services.

A more formalised process, such as a Model of Care is needed to enable various sectors work together to determine the most appropriate support mechanisms for the client. A Model of Care would require improved referral pathways between services, a shared understanding of the issues through cross-agency training, and good communication and information sharing between services. Management commitment at the highest level is essential for change to be successful.[308] Systems need to support safe and effective practice[309] with safety considerations at the forefront of all support services.

It is important to also acknowledge that women who are receiving treatment for their own alcohol problems are at a particularly elevated risk of domestic violence because the perpetrator may be concerned about losing control over her and use further violence to regain control.[310] He may also stall or prevent her access to treatment. A study from the US found that women who were currently experiencing domestic violence were much less likely than women who were not experiencing

domestic violence to complete substance misuse programs.[311] When providing alcohol services to the perpetrators of domestic violence, it is essential to note that alcohol withdrawal is likely to increase irritability and agitation which may lead to increased rates and severity of domestic violence.

Policy options

PO20. Improve collaboration between services providing alcohol and other drug services, mental health services, family and domestic violence services and child protection services by supported a funded Model of Care which incorporates:

- Clear Referral pathways between services
- Cross-workforce training on alcohol and family and domestic violence
- Holistic interventions and treatment for people affected by alcohol or family and domestic violence
- Improved collaboration between service response sectors e.g. integration between specialist alcohol and family and domestic violence courts.

6.5.2 Provide adequate and ongoing funding to alcohol and other drug services and family and domestic violence services

It is essential that services are available for people in the AOD, FDV and family sectors when needed. It is clear that the need for services across these sectors is high and the availability and, as outlined below, access to the relevant services are not being met.

The demand for services in the AOD sector is high. In Australia there are 714 AOD treatment agencies and these provided 162,400 episodes of treatment in 2012-13 to 108,000 people.[i] Alcohol was the principal drug of concern in 41 per cent of treatment episodes (the highest of any drug of concern).[312]

In 2014, across the community sector, services are struggling to meet demand, 80 per cent of sector services have reported being unable to fully meet demand.[313] The issue of unmet demand is also seen in state and territory AOD services. The Victorian Auditor General's report found that since 2005-06, waiting times for residential-based AOD treatment nearly doubled.[314]

The demand for FDV and family services is also high. An example of this can been seen in the increase in demand for services provided by state and territory agencies. In 2013-14 the ACT Domestic Violence Crisis Service dealt with 15,644 calls to its crisis line, and provided direct intervention for 1,408 people. This increased from 1,096 in 2012-13.[315] The ACT Domestic Violence Crisis Service has reported that there has been a 45 per cent increase in demand for services in the past six years.[316]

This increase in demand is also supported by the Australian Council of Social Services finding that in 2014, 40 per cent of family and child protection services were unable to meet demand, and 47 per cent of counselling and individual support services were unable to meet demand.[317]

This level of increase of demand for services and the inability of these services to keep up with demand is the exacerbated by the uncertainty of funding provided by all levels of government. Over

[i] Only closed treatment episodes are presented. The Australian Institute of Health and Welfare considers a treatment episode to be closed when: the treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months and there is a change in the main treatment type, principal drug of concern or delivery setting.

half (56 per cent) of services delivering AOD treatment are in the non-government sector. Agencies delivering domestic violence and family services are also heavily dependent on government funding.

Over the past year there have been numerous cases of specialist agencies and services that provide AOD and/or FDV support services having their government funding cancelled, been impacted by funding cuts, new models for funding distribution, or being given no indication that future government funding would be provided.[318] An example of this was the program provided by the ACT non-government agency AOD, Karralika. Funding for their Family Program was not included in the Department of Social Service's funding round, this thereby leaving the only program in the ACT and Southern NSW providing rehabilitation treatment for couples or parents with children in uncertainty whether it would be able to continue.[319] This funding has now been assured until end of June 2015.

Cuts to funding and related uncertainty are deeply concerning, especially as there is insufficient funding to meet the demand for treatment in both the AOD and FDV sectors. This uncertainty of funding affects the financial viability of services, ability to plan and ability to offer the services currently being provided. This uncertainty also makes it difficult to recruit and retain staff, leading to loss of staff members. This loss is not just to the specific organisation's capacity but also to both sectors and the community as a whole.[320]

It is essential that both AOD and FDV services are available. There is a small window of opportunity to support vulnerable people who want to access these services. The issue of access to community services was highlighted in the 2014 Australian Community Sector Survey, which found that the largest gaps in the capacity to meet demand in the community sector exists in areas of the greatest need: among services working most closely with those on the lowest incomes and with the highest levels of need in their communities.[321]

Policy option

PO21. Ensure there is adequate and ongoing funding available to services to meet the demand for people requiring alcohol and other drugs and family and domestic violence services.

6.5.3 Increase coordination between alcohol and other drug services and child protection services

The AOD and child welfare sectors have largely operated in isolation, as a result of the nature of funding arrangements and service delivery targets.[322] Greater coordination between AOD and child protection services is needed to ensure that both child and carers are getting the assistance and support needed. A large proportion of child protection casework is related to families with carers who drink problematically and often have a range of other risk factors.[323] Research has shown that children whose carers have alcohol problems are more likely to be repeatedly harmed.[324]

Similar to the Model of Care needed between AOD and FDV services, a model or framework is needed to ensure that AOD services and child protection services are working together. This coordination of services relies on the sharing of information between services. The need for information sharing is crucial when a child is in danger and when the service providers believe adverse outcomes cannot be predicted unless service provision is coordinated.[325]

The sharing and disclosure of client information among agencies has been highlighted as a key challenge in the implementation of policies, this is due to the sensitive nature of the information such as client confidentiality, client and practitioner relationship and existing interagency communication. The South Australian Government's Child Protection Reform Program, has developed the Information Sharing Guidelines for Promoting Safety and Wellbeing.[326] The guidelines have been produced to provide guidance for agencies to appropriately share information with each other.

It is essential that these information sharing mechanisms exist in each state and territory to support agencies and organisations in providing integrated support for children, young people and their families.

Concern has also been raised among researchers about how child protection workers assess and respond to risk factors, including alcohol and that AOD services are not well placed to respond to the children of their clients.[327]

The presence of a carers AOD problem alone is not sufficient to warrant involvement of child protection authorities in Australia. However, problematic carers AOD use may be a contributor to child maltreatment, which can trigger responses from child protection authorities. All states and territories have mandatory child abuse reporting requirements. However, individuals mandated to report, and the types of abuse that are required to be reported, vary significantly between Australian states and territories.[328]

In 2009, the Council of Australian Governments released a *Protecting Children is Everyone's Business, National Framework for Protecting Australia's Children.*[329] This framework includes a strategy for how all levels of governments to work in partnership with non-government organisations and work more effectively across silos that have existed between AOD and FDV services. Although these documents and frameworks are in place, there have been limited changes in the way that programs and policies are implemented.[330]

There are clear barriers to how AOD and child protection services work together, these barriers can exist at an organisational, client and staff level. These organisational barriers include the lack of training and knowledge of those working in the AOD sector to recognise or respond to child welfare issues.[331] Other organisational barriers include assessment processes of clients, confidentiality and privacy policies, funding mechanisms and access to resources.

Barriers also exists for the client, as those seeking AOD treatment can be reluctant to seek assistance in regards to parenting, for the fear of stigmatisation. Staff within the AOD services can be reluctant to expand their treatment focus, as some see family issues outside their role. It has been stated that 'Some alcohol and other drug workers have traditionally refrained from asking clients about their children in order to avoid any perceived potential conflicts of interest or a need to make child protection notifications, which could jeopardise their working relationship with clients.'[332]

A survey of Australian AOD workers found that most clients had children and that most believed identifying and addressing their child's needs are important.[333] However, few AOD workers reported having received any training in this area and therefore not having the confidence to address the needs of the child.[334]

It has also been reported that many child welfare workers lack knowledge in assessment of AOD problems.[335] Studies from the USA suggest that training in AOD positively impacts child welfare workers' knowledge, skills and practices.[336] AOD screening tools (such as the AUDIT) should be considered for use within child protection services as a means of identifying carers who drink problematically. Initial screens should be followed up with evaluations of service referrals and the effectiveness of these services.

Policy options

PO22. Develop joint guidelines and systems that facilitate information sharing about the wellbeing and safety of clients' children between alcohol and other drugs services and child protection services.

PO23. Improve collaboration between alcohol and other drug services and child protection services by cross-workforce training for alcohol and other drug services and child protection services.

6.5.4 Implement programs targeted at perpetrators

While SBIs are an important first step in trying to prevent harm from occurring and are more likely to be successful when the risk of perpetrating FDV is low, a proportion of the population will require treatment to address their behaviour. The higher the risk and the more entrenched the behaviour, the greater the requirement for more intensive treatment programs.

Perpetrator treatment programs offer one way to address the intergenerational cycle of violence given the entrenched nature of FDV. Such programs began to appear in the late 1970's and early 1980's and were developed in the context of gender and power relationships. Models of service delivery vary across Australia, however, the typical approach focuses on changing attitudes towards women and in particular, intimate partners. Challenges to current programs include lack of adequate funding, individualised treatment and motivation among participants. In addition, change takes time and perpetrators may take years to recognise that they have a problem.[337]

Three principles for effective perpetrator treatment programs have been identified. These include providing more intensive services to people at higher risk of offending, addressing the particular needs of the individual that relate to treatment, and being responsive and flexible to the learning styles and motivations of the perpetrator.[338] In situations where FDV is alcohol-related, integration and/or collaboration between AOD treatment services and domestic violence services will increase program effectiveness.[339]

The safety of family members needs to be the primary priority if and when a perpetrator undertakes treatment. Treatment for alcohol problems increases the risk for FDV due to the discomfort of physiological or psychological withdrawal heightening a perpetrator's anxieties and irritability.[340]

Policy options

PO24. Fund intensive programs targeted at perpetrators and ensure these programs are evaluated to inform future practice.

PO25. Support better integration between perpetrators and AOD services where appropriate.

PO26. Provide support for families of people accessing perpetrator programs to ensure their safety.

6.6 Improve data collection and evaluation

As previously highlighted in this paper there are two main types of data collection methods, these are survey and service data for FDV and alcohol harms. The collection and surveillance of data and harms is important as it provides information on the extent of the issues and of FDV which enables researchers and policy makers to develop, implement and track the progress of evidence based policies.

It is also crucial that there is consistency in data surveillance in order to understand patterns of change over time and comparing between one time period and another. Surveillance of trends over time is important for not only policy development but also service planning.

Data on alcohol-related FDV is mostly sourced through self-report surveys such as the National Drug Strategy Household Survey and the Australian Bureau of Statistics (ABS) Personal Safety Surveys. Due to FDV being a largely 'invisible' problem, self-reporting is considered a more reliable gauge of the nature and extent of alcohol-related FDV.

There are advantages and disadvantages to self-reported data. Anonymity may encourage greater disclosure but self-reported data can also lend itself to biased reporting. It is important that survey data is complimented with data collected through service sectors such as police and health service data. It is important to note that this data also has limitations such as underreporting, with as many as half of domestic violence occurrences going unreported[341] and not being collected consistently in all Australian jurisdictions.

Ensuring data is collected in a consistent manner is a crucial to understanding the prevalence of alcohol-related FDV. Currently police use a combination of judgement for signs of intoxication, as well as reports from the people involved. There are also different reporting requirements for each state and territory which contribute to consistency issues. The reporting of alcohol's involvement varies depending on the regulations and laws around reporting requirements in each jurisdiction. To support the data already being collected by police, other service sectors such as AOD treatment data and hospital data should all seek to gain information on alcohol's involvement in alcohol-related FDV.

Data collection for alcohol-related child maltreatment is limited. Police data tends to include incidences of violence, which include both child abuse and intimate partner violence, and they are reported together under the umbrella of 'domestic assault' or 'family incident'. Recording incidences of alcohol-related child maltreatment separately to intimate partner violence would provide greater detail on the interplay between child maltreatment and prevalence of children affected by alcohol-related family violence. Considerable improvement is also needed in the recording of alcohol involvement in incidents and situations, whether in police reports, in child protection investigations, or in records of other involved agencies such as schools and hospitals. A combination is needed of a mandatory check-box on whether and to what extent alcohol is involved in the situation or incident with rules for narrative recording of the nature and extent of alcohol involvement. Improvements in the way data is collected and reported are necessary to understand the extent of alcohol's involvement in FDV.

Consideration also needs to be given to the way in which alcohol-related FDV data is published, this includes privacy and confidentiality of individuals, service provider organisations in collection and reporting. Privacy and confidentiality is essential to collection of data about alcohol and domestic violence due to the sensitivity of the information being collected and reported. A breach of confidentiality may risk the safety of the individuals involved as well as their family or friends. It could also lead to stigmatisation for those involved.

Researchers must ensure that they protect data, especially if it is in any way identifiable. An understanding of the difference between anonymous and identifiable data is essential to devising the most appropriate plan to protect individuals' confidentiality and safety. It is important that there are effective practices in place for documenting client information and that services advise individuals of situations if their right to confidentiality cannot be guaranteed.

Agencies responsible for collecting alcohol-related FDV data should ensure that policies are in place that clearly outline the requirements for data collection. This will assist agencies to collect consistent and comparable data.

As part of the National Plan, all jurisdictions have committed to a national data collection and reporting framework.[342] The aim of the framework is to create a nationally consistent data definitions and collection methods, it is intended that this framework will be operational by 2022.[343] As part of this framework there is potential for the collection and reporting of alcohol-related FDV incidents to be included as part of this work.

Evaluation processes should form an integral part of the implementation of any alcohol-related FDV policies. Without an appropriate evaluation framework in place, the efficacy of trials and policy initiatives cannot be properly assessed. This results in a loss of valuable information that could be used to assess the effectiveness of a new policy and to guide future policy directions.

Data collection and surveillance is a fundamental tool in the evaluation process. Strong reliable data enables a more complete analysis of the impacts of alcohol policies on the relevant outcome measures.

An evaluation framework should form part of any national or state government plan to prevent alcohol-related FDV. The development of any evaluation framework needs to ensure that it is developed in consultation with a range of experts including researchers and the agencies that are collecting and reporting the data.

Policy options

PO27. Improve data collection on family and domestic violence and the involvement of alcohol across all jurisdictions and publically report on this data to inform policy and research.

PO28. Evaluate policies and programs on alcohol and family and domestic violence and disseminate the findings to ensure that they inform future practice.

Appendix 1: Overview of policy options to reduce alcohol-related family and domestic violence

The suggested policy options from this paper are summarised below (PO = Policy Option).

Level	Aim	Target	Policy Options
Primordial: *Creating a safer environment*	Preventing the emergence of predisposing social and environmental conditions that lead to harm	Whole population	**Reduce health and social inequalities** PO1. Implement strategies that target the environmental, economic and social determinants that contribute to health inequality. This includes improving health, housing, education and employment. PO2. Adopt a health-in-all policies approach to public policy to ensure that the health outcomes of the community are considered in policy development. PO3. Close the gap on the higher prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples, and implement strategies to improve housing, education and employment. **Reduce gender inequalities** PO4. Implement strategies that promote gender equality for women, including but not limited to, increasing leadership opportunities for women, increasing access to paid maternity leave, introducing flexible work arrangements, making available varied and flexible childcare arrangements and developing equitable superannuation arrangements.
Primary prevention: *Improving outcomes across the community*	Reducing the average risk of harm among the whole population	Whole population	**Conduct public education campaigns on alcohol-related family and domestic violence and ways to prevent these harms** PO5. Conduct ongoing national public education campaigns on preventing alcohol-related family and domestic violence; in conjunction with other preventative measures. PO6. Implement school-based education campaigns on alcohol and also on respectful relationships. PO7. Ensure that school-based education campaigns on alcohol and respectful relationships acknowledge the role of alcohol in family and domestic violence. **Reduce the physical availability of alcohol** PO8. Intervene to reduce the density of liquor licenses in areas where there are significant levels of harm and reform licensing approval processes to consider community, police and public health views, as well as factors such as socio-economic status.

Level	Aim	Target	Policy Options
Primary prevention: *Improving outcomes across the community*	Reducing the average risk of harm among the whole population	Whole population	PO9. Introduce restrictions to the hours that alcohol is available for sale for both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops). **Reduce the economic availability of alcohol** PO10. Reform the alcohol taxation system to increase the prices of the cheapest alcohol products. PO11. Eliminate reckless liquor promotions that encourage excessive and harmful consumption in both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops). **Regulate the promotion of alcohol** PO12. Introduce independent regulation of alcohol marketing to protect children from its exposure. PO13. Eliminate negative and sexist representations of women in alcohol marketing.
Secondary prevention: *Focusing on people at greater risk*	Early detection and intervention among people at greater risk of harm	People at greater risk of harm • Aboriginal and Torres Strait Islander peoples • Children and young people at risk • High risk populations: women with disabilities, Culturally and Linguistically Diverse communities, lesbian, gay, bisexual, transgender, intersex and queer communities, pregnant women and heavy drinkers.	**Identify children and young people at risk of child maltreatment** PO14. Encourage health professionals and educators to undertake screening to identify children at risk of child maltreatment. **Implement and fund family centred programs for people affected by alcohol and substance misuse** PO15. Fund programs such as the Parents under Pressure (PuP) for children and families identified as being affected by parental alcohol misuse and other risk factors. PO16. Establish programs that increase children's capacity to identify inappropriate or abusive behaviours and teach safety and resilience skills. **Reduce the prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples** PO17. Implement community-led and comprehensive alcohol controls in communities where a need has been identified and agreed. PO18. Conduct ongoing public education campaigns on alcohol and family and domestic violence that are community driven and culturally sensitive. **Undertake opportunistic screening with people at greatest risk of harm** PO19. Support professionals in health and community organisations to screen for harmful alcohol use and family and domestic violence. Screening programs should include support resources, clear referral options and training for professionals administering the screening.

Level	Aim	Target	Policy Options
Tertiary prevention: *Protecting people from further harm*	Preventing the recurrence of harm	• Victims • Perpetrators of family and domestic violence • Witnesses to family and domestic violence	**Develop of a comprehensive Model of Care for alcohol-related family and domestic violence** PO20. Improve collaboration between services providing alcohol and other drug services, mental health services, family and domestic violence and child protection services by supported a funded Model of Care which incorporates: — Clear Referral pathways between services — Cross-workforce training on alcohol and family and domestic violence — Holistic interventions and treatment for people affected by alcohol or FDV — Improved collaboration between service response sectors e.g. integration between specialist alcohol and family and domestic courts. **Provide adequate and ongoing funding to alcohol and other drug services and family and domestic violence services** PO21. Ensure there is adequate funding available to services to meet the demand for people requiring alcohol and other drugs and family and domestic violence services. **Increase coordination between alcohol and other drug services and child protection services** PO22. Develop joint guidelines and systems that facilitate information sharing about the wellbeing and safety of clients' children between alcohol and other drugs services and child protection services. PO23. Improve collaboration between alcohol and other drug services and child protection services by cross-workforce training for alcohol and other drug services and child protection services. **Implement programs targeted at perpetrators** PO24. Fund intensive programs targeted at perpetrators and ensure these programs are evaluated to inform future practice. PO25. Support better integration between perpetrators and alcohol and other drug services where appropriate. PO26. Provide support for families of people accessing perpetrator programs to ensure their safety.
Data collection and evaluation	Building the evidence base and evaluating measures	Whole population	**Improve data collection and evaluation** PO27. Improve data collection on family and domestic violence and the involvement of alcohol across all jurisdictions and publically report on this data to inform policy and research. PO28. Evaluate policies and programs on alcohol and family and domestic violence and disseminate the findings to ensure that they inform future practice.

Appendix 2: Review of existing domestic violence and child protection strategies in Australia

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
National			
Domestic Violence: *The National Plan to Reduce Violence Against Women and their Children 2010 – 2022.*[344]	Released by the Council of Australian Governments (COAG) in 2011. Aims to coordinate action across Australian jurisdictions, over 12 year timeframe and supported by three year implementation plans.	Alcohol is recognised under the first outcome area stating: "The impact of alcohol and other drugs is recognised in this first national priority area" a key action is to ''foster community initiatives to reduce alcohol and substance use."	Initiatives to achieve this: • Continuation of the National Binge Drinking Strategy • Support Indigenous communities to take action against the supply of alcohol where it is leading to high levels of violence.
National Implementation Plan for the First Action Plan 2010-2013: Building a strong foundation safe and free from violence.[345]	Released in 2011, it focuses on: • Building primary prevention capacity; • Enhancing service delivery; • Strengthening justice responses; and • Building the evidence base.	Acknowledges the role of other national agendas including the National Binge Drinking Strategy but does not go further into these areas.	No specific initiatives mentioned.
The Second Plan Second Action Plan 2013-2016: Moving Ahead: Of the National Plan to Reduce Violence Against Women and their Children 2010-2022.[346]	Released in June 2014, it recognises that FDV does not occur in insolation and aims to strengthen linkages with other national reforms agendas to drive a holistic response to stop violence against women.	The only reference to alcohol is the continuation of 1800RESPECT, a national helpline for domestic, family and sexual violence.	Initiative to achieve this: • 1800RESPECT to continue to provide support to frontline workers, including those in the alcohol sector.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
National			
Child Protection and Wellbeing: *Protecting Children is Everyone's Business – National Framework for Protecting Children 2009 – 2020*	Released by the Australian Government in 2009 to work in tandem with the National Plan to bring about positive change for both women and children. Adopts a public health approach for the prevention and treatment of child abuse and neglect.	Alcohol use is acknowledged as a risk factor for child abuse and neglect and within mentions the need to: "Enhance alcohol and substance abuse initiatives to provide additional support to families."	Initiatives to achieve this: • Implement the National Binge Drinking Strategy. • Support Aboriginal and Torres Strait Islander children through Alcohol Diversion Program for parents of children at risk. • Implement Healthy lifestyle interventions to disadvantaged communities and address alcohol abuse.
New South Wales			
Domestic Violence: *It Stops Here: Standing together to end domestic and family violence in NSW (NSW Government).*[347]	Released in 2012 in response to the NSW Auditor General and the NSW Parliament's Standing Committee on Social Issues Inquiry into domestic violence. The strategy aims to strength prevention, coordinate service delivery, support victims and hold perpetrators to account to and reduce re-offending.	Alcohol is recognised in the Strategy under barriers stating: "women with mental health and/or drug and alcohol issues are more vulnerable and face additional barriers in seeking support." The strategy does not outline these barriers or how to overcome them.	No specific initiatives mentioned.
Child Protection and Wellbeing: *Keep Them Safe: A shared approach to child wellbeing 2009-2014.*[348]	Released in 2009 after a Special *Commission of Inquiry into Child Protection* in NSW that followed two deaths of children in 2007. The goal of this strategy is to see fewer children and young people reported to the Department of Community Services.	Alcohol is acknowledged in the need for programs to support women who have alcohol and drug issues and families with complex needs. It is also acknowledged in the section to better support Aboriginal children and families.	Initiatives to achieve: • Expand the Drug and Alcohol Expertise Unit to cover mental health and domestic violence. • Provide clinical services (drug and alcohol counselling) to children, young people experiencing abuse.

Victoria			
Domestic Violence: *Victoria's Action Plan to Address Violence Against Women and Children 2012-2015.*[349]	Released in 2012, this strategy sits alongside the *Strong Culture, Strong Peoples, Strong Families – Towards a safer future for Indigenous families and communities,* which is a 10 year plan to specifically addresses family violence in Aboriginal communities. This strategy recognises that government agencies have a role to play, including health, mental health, housing, crime prevention, Aboriginal affairs, education, local government, employment and sport.	Alcohol is acknowledged as an issue among women who are most vulnerable and as contributing factor to men's violence against women.	Initiatives to achieve this: • Current initiative: Perinatal Emotional Health Program Model to identify women experiencing mental health problems, including alcohol and drug issues. • Future initiative: Extend Family Violence Risk Assessment and Risk Management Frameworks to Mental Health and Drug and Alcohol providers, Hospitals, GPs, Ambulance staff.
Child Protection and Wellbeing: *Victoria's Vulnerable Children: Our shared responsibility Strategy 2013-2022.*[350]	Released in 2013 in response to the Victorian Inquiry into *Protecting Victoria's Vulnerable Children* in 2012. It outlines whole of government response to Child Protection and Wellbeing to: • Building effective and connected services. • Enhancing education and capacity building. • Making a child friendly legal system. • Providing safe, stable and supportive out-of-home care. Introducing accountability and transparency.	Recognises the co-occurrence of multiple and complex problems and the strong associations between family and domestic violence and alcohol abuse. The plan also recognises risk factors that make children vulnerable as including: a history of family and domestic violence; parental or familial alcohol and other substance misuse; parental mental health problems; intellectual disability, parental history of abuse and neglect and situational stress.	Initiatives to achieve: • Outcome 1.2 – Parental risk factors that contribute to abuse and neglect are identified and addressed (alcohol identified within this) • Outcome 1.3 – Families effectively protect and nurture their children.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Queensland			
Domestic Violence *For our sons and daughters: Queensland Government Strategy to Reduce Domestic and Family Violence (2009-2014).*[351]	Released in 2009 it identifies the key actions the Government will focus on: • Prevention • Early identification and intervention • Connected victim support services • Perpetrator accountability • System planning and coordination	Does not mention alcohol.	No specific initiatives mentioned.
Child Protection and Wellbeing *Queensland Youth Strategy – connecting young Queenslanders 2013.*[352]	Released in 2013 the strategy aims to improve connections for young people (12 to 21 years) across six areas: • Family, friends and social networks • Education, training and employment • Health and wellbeing • Volunteering and participation • Supports and services • Arts and culture	Alcohol is acknowledged as a risk factor along with family conflict, parental stress, abuse or neglect, poverty, housing stress, unemployment, disengagement from school, teen pregnancy and drug and alcohol misuse. The Strategy recognises that these can increases children's vulnerability and dim their hopes.	Initiatives to achieve this: • Consult with key community stakeholders, including youth groups and services in reviewing alcohol management plans in discrete Indigenous communities. • Regional Network of Indigenous Alcohol, Tobacco and other Drugs (ATODS) Youth Program to provide treatment for young Indigenous people.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Western Australia			
Western Australia's FDV Prevention Strategy to 2022: Creating safer communities [353]	Released in 2012 the strategy focuses on prevention and provides a framework for a comprehensive and shared response to FDV. Has a long-term focus on early intervention, victim safety and perpetrator accountability.	Does not mention alcohol. The previous strategy Western Australia (*WA) Strategic Plan for FDV 2009-2013* mentioned that children subject to family violence are likely to have problems with alcohol later in life and that representatives from the WA Drug and Alcohol Authority were involved in the development of the strategy.	No specific initiatives mentioned.
Child Protection and Wellbeing *Our youth, our future: Western Australia's Youth Strategic Framework.* [354]	Released in 2012 this strategy brings together the plans and commitments across 14 government departments into one framework. The strategy aims to enable children to be happy, healthy, working towards financial independence, living life to the full and making a difference in society.	Alcohol is acknowledged within the strategic approach to provide information to young people, families, carers, teachers and the wider community about issues which impact on young people such as mental health, body image, bullying, and alcohol and other drug use.	Achieved through: • Programs implemented by the School Drug Education and Road Aware (SDERA) – Drug and Alcohol Office to teach young people about resilience, drugs and road safety.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
South Australia			
Domestic Violence *A right to safety: The next phase of South Australia's Women's Safety Strategy 2011-2022.*[355]	Released in 2011 this strategy builds on reforms undertaken in the first phase of the *Women's Safety Strategy* to improve legislation, services and to strengthen community understanding of the effects of violence against women. The second phase of this strategy focuses on early intervention and prevention.	References the South Australian Government's Strategic Plan which has a specific target (Target 18: Violence against women) to achieve "a significant and sustained reduction in violence against women through to 2022." But does not outlines how this target will be achieved.	No specific initiatives mentioned.
Child Protection and Wellbeing *South Australia's Strategic Plan.*[356]	Released in 2011, *South Australia's Strategic Plan* includes child wellbeing and protection. The Strategic Plan recognises the importance of early childhood and the need for supportive relationships, both within the family and community. A separate plan for child does not exist.	The Strategic Plan includes the specific target (Target 81: Alcohol consumption) to: "Reduce the proportion of South Australians who drink at risky levels by 30% by 2020 (baseline: 2007)."	No specific initiatives mentioned.
Tasmania			
Domestic Violence *Taking action: Tasmania's primary prevention strategy to reduce violence against women and children 2012-22.*[357]	Released in 2011 this Strategy adopts a public health approach to reducing violence against women and children with social justice as a core value. It focuses on primary prevention and sits alongside the *Tasmanian Implementation Plan of the National Plan to Reduce Violence Against Women and their Children.*	Alcohol is acknowledged as a contributor to the occurrence and severity of family violence and sexual assault. It is also acknowledged when referring to effective strategies to prevent family violence and sexual assault alongside gender equality and, changing social and cultural gender norms."	Initiatives to achieve: • Action 2.9 states: "Address the contributing factors that increase the incidence and severity of family violence and sexual assault: abuse of alcohol or drugs." Identifies Department of Health and Human Services as the most appropriate agency to address this.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Tasmania continued			
Child Protection and Wellbeing *New Directions for Child Protection in Tasmania: An Integrated Strategic Framework.*[358]	Released in 2008 after the reform of the Tasmanian child protection system in 2007. This strategy aims to improve services are delivery to at risk and vulnerable children and young people.	Alcohol is acknowledged in reference to children and young people in care demonstrating "higher degrees of vulnerability to drug and alcohol abuse and self-harm." It also recognises community risk factors that include high crime rates, alcohol and drug use and violence.	Initiatives to achieve: • Joint training opportunities to be provided to human services and other services that work with common clients, including drug and alcohol services.
Northern Territory			
Domestic Violence *Domestic and Family Violence Reduction Strategy 2014-17: Safety is Everyone's Right.*[359]	Released in 2014, this strategy has five key action areas for change: 1. Prevention 2. Early intervention 3. Protection – safety for victims 4. Rebuilding the lives of victims and survivors 5. Perpetrators taking responsibility for their actions	Alcohol is acknowledged within the Family Safety Framework[360] which is key component of the strategy. The Family Safety Framework acknowledges the involvement of alcohol in domestic and family violence as an 'aggravating' factor.	Initiatives to achieve: Implement family safety meetings between services (including Alcohol and Drug treatment) and share information, agree on actions to increase safety, jointly monitor and review if these actions have improved safety.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Northern Territory continued			
Child Protection and Wellbeing *Safe Children, Bright Futures Strategic Framework 2011 to 2015.*[361]	Released in 2011 in response to the Inquiry into child protection, *Growing them strong, together.* It sets out an agenda for reform across seven areas: • Keeping Kids Safe • Supporting and Strengthening Families • A Strong and Effective Legal Framework • Working Together • Our People • Healing, Growing, Walking Together • Building a Better, Stronger, More • Accountable System	Alcohol is acknowledged particularly noting that there are insufficient programs in regional and remote areas to provide support to families struggling with issues of mental illness, drug and alcohol abuse, and intergenerational abuse and neglect.	Initiatives to achieve: • Establish Child Safety and Wellbeing Teams and localised child safety and wellbeing plans in the Territory Growth Towns and elsewhere. However alcohol is not specifically mentioned within the actions in the Framework.
Australian Capital Territory			
Domestic Violence *The ACT Prevention of Violence Against Women and Children Strategy 2011–2017 (ACT Government).*[362]	Released in 2011 this strategy outlines that ACT Government's commitment to the National Plan. It focuses on four objectives which are: • Women and children are safe because an anti-violence culture exists in the ACT. • Aboriginal and Torres Strait Islander women and children are supported and safe in their communities. • Women and children's needs are met through joined up services and systems.	Alcohol is acknowledged as an issue for perpetrators and victims and advises that "Often women will disclose their experience of violence when accessing support for another issue from a service provider which does not specialise in violence against women. Identifying and strengthening this first point of contact (or first point of disclosure) is a key focus and will include a broad range of services."	Initiatives to achieve: • Mentions interventions alcohol and drug issues for Aboriginal and Torres Strait Islander people such as the proposed Ngunnawal Bush Healing Farm initiated by Elders of the ACT Aboriginal and Torres Strait Islander community stating that: "this environment provides an optimum setting for addressing issues of violence in a holistic way."

	• Men who use violence are held accountable and supported to change their behaviour.		
Child Protection and Wellbeing *ACT Children's Plan 2010-2014: Vision and Building Blocks for a Child friendly City.*[363]	Released in 2010 this plan sets out the vision for Canberra to be a child and youth friendly city.	Alcohol is acknowledged as a personal safety issue. Children who were consulted in the development of the plan also recommended banning substances such as alcohol, cigarettes and drugs.	No specific initiatives mentioned.

Appendix 3: Principles of best practice for AOD organisations to address family and domestic violence

This table is reproduced with permission NCETA and appears in both the following publications: *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia* and *Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence.*

There is a number of principles and strategies that AOD organisations should employ in implementing initiatives to address FDV issues among their clients:

1. Evidence based policy and practice responses	Interventions should be based upon well-tested models of therapeutic practice and sound theories of child development. Where appropriate, interventions should include methods for improving the parent-child relationship (Asmussen & Weizel, 2009). The interventions should also use a partnership and empowerment approach involving clients and their families (Battams & Roche, 2011).
2. Organisational awareness of family issues	Like other common issues that co-occur with AOD problems, FDV and family issues are an essential but ancillary part of alcohol and other drug work; that is not all clients have FDV or family issues. As a result AOD workers may need structures in place to ensure that they attend to these issues on a routine basis. Although the involvement of families can be valuable, the ways that this occurs needs to be carefully considered. This is because other family members may have similar problematic AOD use issues, FDV or parenting difficulties (Asmussen & Weizel, 2009). Awareness of FDV issues includes: • the prevalence of FDV • the indicators of FDV • the impact on partners and children • the importance of addressing FDV to reduce AOD use and minimise harm.
3. Prioritising safety	Given the high prevalence of FDV within the AOD treatment population, it is essential to adopt practices throughout organisations that prioritise the safety of those who experience violence (both partners and children) as well as the safety of staff (Alcohol Concern, 2009). A number of legislative changes have prioritised particularly the safety of children when dealing with FDV situations and organisations and workers should be cognisant of their legal and duty of care responsibilities.

4. Coordination of services	Interventions that address complex family problems are likely to involve input from multiple organisations. Service planning should therefore consider methods for sharing information and referring families. Partnerships are crucial to coordinated service provision. This will involve multi-organisation and cross-sectoral work engaging with services such as FDV organisations, child care providers, supported accommodation services, maternal and child health and disability services, mental health services and child protection organisations (Alcohol Concern, 2009; Asmussen & Weizel, 2009; Battams & Roche, 2011).
5. Policies and systems	AOD organisations need to develop systems and tools to support safe and effective practice. These should include policies, procedures and protocols concerning screening and assessment tools, information sharing, and referral pathways (Alcohol Concern, 2009).
6. Standard response frameworks	It is important to develop assessment and response frameworks that are standard across an organisation. Assessments should identify the individual strengths and challenges of parents who have problematic AOD use. Assessment procedures should address risk and protective factors, the presence of FDV, child care responsibilities and arrangements, measures of family functioning, cultural influences and involvement with statutory child protection services (Asmussen & Weizel, 2009; Battams & Roche, 2011).
7. Broad-based interventions	Interventions should address a variety of risk and protective factors because people who experience FDV, and who use alcohol or other drugs, are likely to be coping with numerous problems. Practitioners need to be able to accurately assess each family's needs and identify resources so that they can provide the appropriate type and level of support (Asmussen & Weizel, 2009).
8. Access to highly skilled practitioners if required	Clients with FDV and AOD problems can require a high degree of intervention, by qualified practitioners, particularly if child protection is an issue. AOD services may not always have practitioners within their services with the required level of skill to respond intensively to FDV issues. It is important for AOD services to ensure that clients can access the requisite level of expertise if necessary and links with external practitioners for this purpose should be identified for both secondary consultation and referral.

9. Workforce development	Increasing the emphasis on FDV may require a range of additional workforce development activities. All staff require basic awareness training and information on organisational policies and procedures. Some staff will require specialist training on assisting clients who experiences violence and clients who use violence in their relationships. Staff also need to be informed of their duty of care concerning child safety and welfare. Other relevant workforce development activities include incorporating FDV intervention practices into job descriptions, mentoring and clinical supervision and in support programs for staff (Battams & Roche, 2011). Commitment is needed at all levels of the organisation from reception and other frontline staff to senior management. In some organisations, the introduction of routine assessments or responses to FDV may require a large cultural shift and requires both strong commitment and robust lines of reporting within the organisation. It is important to have designated individuals at both service delivery and strategic development levels to drive organisational change (Alcohol Concern, 2009).
10. Monitoring, accountability and evaluation	The evidence base in this field is limited and much of the clinical work that is taking place is not recorded. It is, therefore, important for organisations to develop simple and robust recording and monitoring systems which record their work and its outcomes (Alcohol Concern, 2009).

Note: For more information on the references referred to in the table please see the original sources.

Appendix 4: Abbreviations

ABAC	Alcohol Beverages Advertising (and Packaging) Code
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AFL	Australian Football League
AIHW	Australian Institute of Health and Welfare
AMP	Alcohol Management Plans
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
ANPHA	Australian National Preventive Health Agency
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and other drug
ATODS	Alcohol, Tobacco and other Drugs
AUDIT	Alcohol Use Disorders Identification Test
BOCSAR	NSW Bureau of Crime Statistics and Research
BWS	Beer Wine Spirits
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
FARE	Foundation for Alcohol Research and Education
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorders
FDV	Family and domestic violence
GENACIS	Gender, Alcohol and Culture: An International Study
GLADA	Greater London Alcohol and Drug Alliance
GLDVP	Greater London Domestic Violence Project
GP	General Practitioner
HTO	(Alcohol's) Harm to Others
LGBTIQ	People who identify as lesbian, gay, bisexual, transgender, intersex and queer
MCDS	Ministerial Council on Drug Strategy
NCAS	National Community Attitudes towards Violence Against Women Survey
NCETA	National Centre for Education and Training on Addiction
NCRAA	National Committee for the Review of Alcohol Advertising
NDSHS	National Drug Strategy Household Survey
NHMRC	National Health and Medical Research Council
NT	Northern Territory
NSW	New South Wales
POS	Point of sale
PSS	Personal Safety Survey
PuP	Parents under Pressure program
RACGP	Royal Australian College of General Practitioners
RBT	Random Breath Testing
SBI	Screening and brief interventions
UK	United Kingdom
USA	United States of America
WA	Western Australia
WET	Wine Equalisation Tax
WHO	World Health Organization

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