25 May 2015

The Hon. Justice Marcia Neave AO
Commissioner
Royal Commission into Family Violence
PO Box 535
Flinders Lane
VICTORIA 8009

Dear Commissioner Neave

SUBMISSION TO THE ROYAL COMMISSION INTO FAMILY VIOLENCE

Thank you for the opportunity to provide a submission to the *Royal Commission into Family Violence* (Royal Commission). This submission focuses on alcohol-related family violence.

The Centre for Alcohol Policy Research at Turning Point, under the direction of Professor Robin Room, has undertaken a range of research into the relationship between alcohol consumption, alcohol policy and family violence.

For example, research by Dr Michael Livingston examined the relationship between the density of alcohol outlets in a neighbourhood and rates of family incidents reported to the police in Melbourne over a ten year period, finding that increases in the density of packaged liquor outlets were associated with increases in rates of family violence[1]. Further analyses of these data identified varying relationships across different types of neighbourhood, with positive relationships in most neighbourhood types[2]. These findings provide local evidence that broad alcohol policies can influence rates of family violence in the community, supporting a growing body of similar international research[3].

The Centre has undertaken a broad program of research into alcohol's harm to others, incorporating a series of studies relevant to family violence. The recent Hidden Harm[4] report describes the ways in which children and families have been affected by others' drinking. The most severe cases of harm show up in the service and social system data; as police and child protection agencies attend to these incidents. In the child protection systems across Australia, research indicates that between 15 and 47 per cent of child protection cases involve carer alcohol abuse as a significant risk factor. If you look at the alcohol-related statistics from the child protection system, in 2006-07 there were 10,166

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[1] Livingston, M. (2011) A longitudinal analysis of alcohol outlet density and domestic violence, *Addiction*, 106, 919-925.
[2] Livingston, M. (2012) *The effects of changes in the availability of alcohol on consumption, health and social problems*, PhD Thesis, Melbourne: University of Melbourne.
[3] E.g. Cunradi, C. B., Mair, C., Ponicki, W. & Remer, L. (2011) Alcohol Outlets, Neighborhood Characteristics, and Intimate Partner Violence: Ecological Analysis of a California City, *Journal of Urban Health-Bulletin of the New York Academy of Medicine*, 88, 191-200.
[4] Laslett, A.-M., Mugavin, J., Jiang, H., Manton, E., Callinan, S., MacLean, S. and Room, R. The hidden harm: Alcohol's impact on children and families (2015). Canberra: Foundation for Alcohol Research and Education. http://www.fare.org.au/wp-content/uploads/2015/03/01-ALCOHOLS-IMPACT-ON-CHILDREN-AND-FAMILIES-web.pdf

children with a carer whose alcohol abuse had been identified as a problem. In 2011 there were almost 30,000 incidents of alcohol-related family or domestic violence reported to police[4].

Looking beyond these figures at the general population, twenty-two per cent of carers reported that children had been adversely affected by others' drinking. Three per cent of Australian children (140,000) were substantially negatively affected by others' drinking, with many more (over 1 million children) affected in some negative way. Seventeen per cent of respondents (an estimated 2,791,964 Australians) had been affected by an intimate partner or relative in the last year[5].

This program of studies highlights alcohol as major preventable cause of harm to children in the general population and the child protection system. The key recommendations of the report include introduction and evaluation of initiatives that minimise alcohol-related harms to children using universal preventative alcohol and welfare strategies, family-focussed alcohol and other drug treatment programs and high risk multi-factorial intervention strategies for those most at risk.

We've attached here key studies from the Centre's program of work in this area:

1. Livingston, M. (2011) A longitudinal analysis of alcohol outlet density and domestic violence, *Addiction*, 106, 919-925.
2. Laslett, A.-M., Mugavin, J., Jiang, H., Manton, E., Callinan, S., MacLean, S. and Room, R. The hidden harm: Alcohol's impact on children and families (2015). Canberra: Foundation for Alcohol Research and Education.
3. Laslett, A.-M., Callinan, S., Mugavin, J., Jiang, H., Livingston, M and Room, R. Beyond the Drinker: Longitudinal patterns in alcohol's harm to others (2015). Canberra: Foundation for Alcohol Research and Education.
4. Laslett, A.-M., Dietze, P., Room R., & Ferris J. (2013) Carer drinking and more serious child protection outcomes. *British Journal of Social Work*; 43(7), 1384-1402.

Thank you for the opportunity to make a submission on this important topic. Professor Room, Dr Laslett and Dr Livingston are all available to provide more detailed evidence to the Commission if required.

Yours sincerely

Robin Room

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Michael Livingston
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[5] Laslett A.-M. (2014) Alcohol and child maltreatment in Australia through the windows of child protection and a national survey. PhD Thesis submitted in requirement of the University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences, Melbourne School of Population and Global Health.

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A longitudinal analysis of alcohol outlet density and domestic violence

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ABSTRACT

Aims A small number of studies have identified a positive relationship between alcohol outlet density and domestic violence. These studies have all been based on cross-sectional data and have been limited to the assessment of ecological correlations between outlet density and domestic violence rates. This study provides the first longitudinal examination of this relationship. **Design** Cross-sectional time-series using aggregated data from small areas. The relationships between alcohol outlet density and domestic violence were assessed over time using a fixed-effects model. Controls for the spatial autocorrelation of the data were included in the model. **Setting** The study uses data for 186 postcodes from within the metropolitan area of Melbourne, Australia for the years 1996 to 2005. **Measures** Alcohol outlet density measures for three different types of outlets (hotel/pub, packaged liquor, on-premise) were derived from liquor licensing records and domestic violence rates were calculated from police-recorded crime data, based on the victim's postcode. **Findings** Alcohol outlet density was associated significantly with rates of domestic violence, over time. All three licence categories were positively associated with domestic violence rates, with small effects for general (pub) and on-premise licences and a large effect for packaged liquor licences. Conclusions: In Melbourne, the density of liquor licences is positively associated with rates of domestic violence over time. The effects were particularly large for packaged liquor outlets, suggesting a need for licensing policies that pay more attention to o off-premise alcohol availability.

Keywords Alcohol availability, domestic violence, outlet density, panel methods.

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INTRODUCTION

Domestic violence is a significant problem in Australia, with the 2005 Personal Safety Survey estimating that 15% of women aged 15 years or older had experienced violence by a current or previous partner [1], and research suggesting domestic violence is a precursor of more than a quarter of homicides in Australia [2]. In 2003, Begg *et al.* [3] estimated that intimate-partner violence was responsible for 1.1% of the burden of disease and injury among Australian women. While there remain debates about the causal role of alcohol in domestic violence [4], there is a substantial body of evidence relating alcohol consumption to domestic violence with, for example, Leonard [5] finding that alcohol is involved in between 25% and 50% of domestic violence incidents. Leonard also discusses the role of general alcohol policy approaches in reducing rates of domestic violence, suggesting that measures focusing on alcohol availability are likely to reduce violence rates. This is given support by one study finding a negative effect of the price of alcohol on domestic violence [6], and some studies in remote Australian towns which are suggestive of reductions in domestic violence following restrictions in trading hours [7,8].

The main theoretical reasons to expect the density of alcohol outlets in an area to be related to domestic violence derive from simple availability theory [9] which, at its most straightforward, suggests that alcohol consumption will increase as alcohol becomes more available. Thus, increases in off-premise alcohol outlets in an area may lead to increased overall consumption (through more convenient access, lower prices due to competition or increasingly visible advertising) which, in turn, will lead to increased heavy drinking occasions and intoxication, thus increasing the risk of domestic violence.

Contrastingly, increases in outlets with a focus on on-premise alcohol consumption may alter drinking practices such that more alcohol is consumed at these venues, which are typically the location of heavier drinking occasions [10], again increasing intoxication and risk of domestic violence taking place.

Similarly, there is a small body of evidence which suggests a significant link between the density of alcohol outlets in an area and the area's rate of domestic violence. This link is an intuitive extension of the previously discussed role of alcohol in domestic violence and the repeated studies demonstrating clear relationships between community-level factors (predominantly measures of disadvantage or social disorganization) and domestic violence [11–15]. An early study in New Jersey [16] found a positive relationship between total alcohol outlet density and police-recorded rates of domestic violence, but this relationship was no longer evident once socio-demographic control variables (e.g. social disadvantage, population movement, etc.) were controlled for. These findings suggest that the geographical relationship between alcohol outlet density and domestic violence is due to a common relationship with other socio-demographic factors. However, two recent studies have found a persistent relationship between alcohol outlet density and domestic violence, even with socio-demographic factors controlled for. In particular, a recent study by McKinney *et al*. [17] combined data from a national (US) population survey and administrative data sources to assess whether self-reported experiences of intimate partner violence were related to alcohol availability, finding a positive link between alcohol outlet density and male-to-female partner violence. McKinney *et al*. also examined whether particular outlet types were problematic, finding that on-premise, but not off-premise, outlet density was related significantly to partner violence. McKinney *et al*. [17] adjusted for a wider range of socio-economic and demographic characteristics, across individual, couple and community levels, finding that the relationship between outlet density and partner violence persisted with these factors controlled for. Similarly, recent work by Livingston [18] in Melbourne, Australia found that while socio-demographic factors reduced the size of the relationship between outlet density and domestic violence, a significant effect remained. This study found a positive relationship between general (pub or hotel) licences and domestic violence and a negative link between on-premise (restaurant, bar, cafe) licences and domestic violence, suggesting very different roles for different types of alcohol outlets.

The development of this literature follows a substantial number of studies demonstrating that alcohol outlet density and rates of assaultive violence in general are related (see [19–21] for reviews). This link has been particularly strengthened by a series of studies which have examined the relationship between alcohol outlet density and violence over time, finding that changes in outlet density are related to changes in violence rates [22–25]. These longitudinal findings provide stronger evidence that the relationship between outlets and violence is causal, and not related to other underlying factors not controlled for in cross-sectional analyses. Thus, while there is a growing number of cross-sectional studies suggesting that alcohol outlet density is related to domestic violence, there remains a need for an assessment of this relationship over time.

This study involves the first longitudinal analysis of the relationship between alcohol outlet densities and rates of domestic violence. The study uses data at the postcode level from Melbourne, Australia from 1996 to 2005 and uses spatial panel data methods. This time-period and setting provide a particularly interesting frame for the study, with significant increases in alcohol availability taking place in Melbourne across the late 1990s and early 2000s [26].

METHODS

This study is a population-level analysis of domestic violence, focusing particularly on the longitudinal relationship between alcohol availability and domestic violence rates at a neighbourhood level.

Geographic units

Postcode-level aggregate data on alcohol outlets and domestic violence were used to assess whether annual changes in alcohol outlet density were related to annual changes in rates of domestic violence. The study uses data from the 186 postcodes from the greater Melbourne region that have not had boundary changes over the 10 years of the study (1996–2005). While some postcodes within the greater Melbourne area were excluded due to boundary changes ($n = 37$), the postcodes used in the study included approximately 85% of the population of Melbourne at the 2001 Census. In 2005, the average postcode was 14.7 km^2, with a resident population of 15 600 people. These are approximately half the size of US zip codes, but much larger than postal areas in the United Kingdom. Postcodes are the best administrative approximation of local suburbs or communities available, although in some of the outer areas of the city some include large non-residential areas such as state parks or industrial areas.

Licensing data

Data on active liquor licences for 30 June for each year of the study were provided by the Licensing Branch of the

Victorian Department of Consumer Affairs. These data included the postcode in which each premise was located, and this field was used to assign outlets to postcodes. A check on the addresses of 200 random records across the study time-period found that the postcode data were accurate in 98% of cases. This study focused on three categories of liquor outlets: those with general licences, those with on-premise licence and those with packaged licences. These licences made up 67% of all licences in Victoria over the study period, with the rest made up of club licences, wholesalers and wineries. General licences (793 in the study area in 2005) allow the sale of alcohol for both on- and off-premise consumption and apply to hotels, pubs and taverns. On-premise licences (3502 in the study area in 2005) allow for on-premise sales only and apply to a diverse range of outlets, including cafes, restaurants, bars and nightclubs. Packaged licences (974 in the study area in 2005) are for outlets that sell alcohol for off-premise consumption only, including retail liquor stores and some small grocery stores. Because this study was concerned with an outcome occurring in domestic settings, alcohol outlet density was calculated for each of these categories as the number of outlets per 1000 residents.

Domestic violence data

Domestic violence incident data were provided by the Victorian Police Service from their Law Enforcement Assistance Program (LEAP) database. The data used are counts of 'family incidents' (incidents of domestic violence) recorded by the police for each postcode in the study area for the period 1996 to 2005. These incidents fall somewhere between calls and arrests—they are incidents where the police deem that an offence has taken place and will thus not include all calls, but will include offences that do not result in an arrest. It should be noted that using a policing driven measure of domestic violence creates the potential for biases in the analyses (e.g. reporting rates may be higher in some areas and thus higher rates recorded in those areas). In addition, many incidents of domestic violence are likely to be excluded from police-based statistics with, for example, the Australian 2005 Personal Safety Survey [1] finding that just 36% of female victims of physical assault reported the incident to the police. This represents a significant source of potential bias to the study, particularly if reporting rates vary along with the availability of alcohol. There is little published research on which factors influence the reporting of domestic violence in Australia, although there is research from the United States indicating, for example, that non-white victims are more likely to report domestic violence, so the risk of bias from this measure is not negligible. However, police data are often used in these kinds of analyses (e.g. [11,27–29]), and the use of a range of control variables related to police reporting rates (e.g. socio-economic disadvantage) will ameliorate this bias somewhat. While some previous studies have used counts or rates based on geographic measures (e.g. [2,3]), the fact that these offences took place in residential settings meant that it made the most sense to use rate per 1000 residents per year.

Population data

Population data for each postcode came from Census data for 1996 and 2001 and Estimated Residential Population data for 2005 [30,31]. For the remaining years (1997–2000, 2002–2004) population estimates were estimated using linear interpolation. While these population figures were thus estimates, they provided a reasonable approximation of population change over the study period.

Socio-economic data

Data on the socio-economic disadvantage of each postcode were derived from the Australian Bureau of Statistics Socio-Economic Index for Areas (SEIFA) index of relative disadvantage [32]. This index is based on a range of variables collected during the 5-yearly national Census and provides a composite measure of socio-economic disadvantage in a neighbourhood. SEIFA scores range from a low of approximately 700 (most disadvantaged) up to a high of approximately 1200 (least disadvantaged) SEIFA data were available for 1996, 2001 and 2006 and data were interpolated linearly for the intervening years.

Analysis

The dependent variable for the regression analyses undertaken in this study was the annual rate of police-recorded domestic violence incidents across each of the 186 postcodes in the study area. The independent variables were the alcohol outlet density rates (both the overall rate and the rates of individual licence categories) along with the residential postcode of the population and the SEIFA index of relative disadvantage. The main aim of the study was to assess how changes in postcode-level outlet density related to changes in domestic violence rates over a 10-year period (1996–2005). As the time-period under analysis is too short to develop reliable time–series models, it was necessary to make use of panel data analysis methods. These methods make up for the small number of time-points in the study by replicating the analyses across the geographical units. This study uses fixed-effects models, which are asymptotically consistent, and appropriate for situations such as this where the units are not part of a random sample from a larger population. In addition, fixed-effects models focus on

maximizing the explained variance within units, reducing the possibility that cross-sectional differences between units will bias the results. To ensure that city-wide trends did not influence the results, the model included time-period fixed-effects as well as postcode-level fixed effects. Thus, this is a very conservative modelling strategy, ignoring cross-sectional differences between postcodes and overall trends, and instead only making use of variation within postcodes. The first model developed examines the relationship between total licence density and domestic violence. This is followed by three models examining each type of licence in turn. Finally, all three licence categories were included in a single model to try to determine which were the most important in explaining rates of domestic violence.

Using spatially based data such as those used in this study can result in a violation of the independence of the study's units, a key assumption of regression modelling. This is due to the presence of spatial autocorrelation in the data. This occurs when data for one region are related in some non-random way to data for nearby regions. If spatial autocorrelation is present in the data but not controlled for in analyses, the regression results can be substantially biased. Thus, this study used a spatial fixed-effects modelling procedure based on maximum likelihood estimators to ensure that non-biased regression results were produced. Conditional auto-regressive (CAR) models were developed, using simple Queen's contiguity weights, whereby the influence of all directly neighbouring postcodes is considered, but not any influence of non-neighbouring postcodes. These models were developed using the Matlab spatial econometrics toolbox developed by Paul Elhorst [33].

RESULTS

Descriptive statistics for each of the measures used in the study are presented in Table 1. There is clearly sufficient variation over time within the postcode units to be able to assess the temporal relationship between outlet density and domestic violence. Even for on-premise outlet density, which has doubled in the study area over the time-frame studied, enough postcodes (10%) have experienced reductions in on-premise density to provide sufficient variance for the fixed-effects modelling.

The results of the fixed-effects regression models are presented in Table 2. For the sake of clarity, the year dummy variables (which control for overall trends) are not presented. These dummies were generally significant and positive in all models, indicating the city-wide increasing trend in domestic violence rates over the time-period.

The overall model found a small but significant positive effect for total licence density, with an increase in the overall rate of alcohol outlet density of one outlet per 1000 residents resulting in an increase in the domestic violence rate of 0.08 per 1000 residents. When the separate outlet categories were analysed, there were significant positive effects for each of the categories examined. The positive effects for general and on-premise licences were relatively small—an increase of one general outlet per 1000 residents in a postcode was associated with an increase of 0.28 domestic violence incidents per 1000, while an increase of one on-premise outlet per 1000 residents was associated with an increase in the domestic violence rate of 0.11. The most substantial effect was found for packaged liquor outlets, with an increase of one packaged outlet per 1000 related to an increase of 1.36 in the domestic violence rate. To provide some context, these effect sizes represent increases of 5.9%, 2.3% and 28.6%, respectively, from the overall mean of the domestic violence rate (4.76 of 1000 residents).

When all three outlet categories were entered into the same model (Table 3), only packaged outlets remained significant, with an increase of 0.66 incidents of domestic violence per 1000 residents for each additional packaged outlet. It is worth noting that the changes in availability across the three types of outlet are correlated over time. The correlation between the changes in packaged liquor density and general licence density are the highest (0.67, $P < 0.01$), while the remaining correlations were non-significant.

Across all five models, the effect of the SEIFA index of relative disadvantage was significant and negative, high-

Table 1 Descriptive statistics of study measures.

	Mean	*SD*	*Min*	*Max*	*Total change*	*Proportion postcodes decreasing*
Domestic violence rate (per 1000)	4.76	0.06	0	19.81	18.30%	33.9%
General licence rate (per 1000)	0.39	1.29	0	18.52	–1.00%	63.4%
On-premise licence rate (per 1000)	0.28	0.21	0	2.06	100.70%	10.2%
Packaged licence rate (per 1000)	1.15	3.35	0	49.35	41.60%	20.3%
SEIFA index of disadvantage	1032.55	78.30	706.96	1162.48	–0.4%	66.7%
Population (×1000)	15.61	10.02	0.39	55.92	11.90%	18.9%

SEIFA: Socio-Economic Index for Areas.

Table 2 Fixed-effects model results—total licence density and separate models for each licence category.

Model 1—total licences				*Model 2—general licences*				*Model 3—packaged licences*				*Model 4—on-premise licences*			
Variable	*B*	*t-value*	*P*	*Variable*	*B*	*t-value*	*P*	*Variable*	*B*	*t-value*	*P*	*Variable*	*B*	*t-value*	*P*
Residential population (1000s)	−0.01	−1.18	0.24	Residential population (1000s)	−0.01	−1.23	0.22	Residential population (1000s)	−0.01	−0.94	0.35	Residential population (1000s)	−0.01	−1.26	0.21
SEIFA	−0.02	−28.25	<0.01	SEIFA	−0.02	−27.99	<0.01	SEIFA	−0.02	−27.51	<0.01	SEIFA	−0.02	−28.32	<0.01
Total licence density	0.08	7.32	<0.01	General licences	0.28	6.93	<0.01	Packaged licences	1.36	5.45	<0.01	On-premise licences	0.11	7.21	<0.01
Spatial autocorrelation	0.60	26.11	<0.01	Spatial autocorrelation	0.59	25.33	<0.01	Spatial autocorrelation	0.59	25.50	<0.01	Spatial autocorrelation	0.60	26.37	<0.01

SEIFA: Socio-Economic Index for Areas.

Table 3 Fixed-effects model results—licence categories in multivariate model.

Variable	*B*	*t-value*	*P*
Residential population (1000s)	−0.01	−0.86	0.39
SEIFA	−0.02	−27.67	<0.01
General licence density	0.05	0.46	0.64
Packaged licence density	0.66	2.35	0.02
On-premise licence density	0.07	1.66	0.10
Spatial autocorrelation	0.60	25.67	<0.01

SEIFA: Socio-Economic Index for Areas.

lighting the relationship between increased levels of disadvantage and increased rates of recorded domestic violence. The results also indicated significant positive spatial autocorrelation in the data across all the models. The spatial autocorrelation coefficients reported are substantial (~0.6), suggesting that rates of domestic violence are correlated highly between neighbouring postcodes and highlighting the risks of modelling these data with non-spatial methods.

CONCLUSIONS

This study adds to the small body of literature examining the connections between alcohol availability and domestic violence, providing the first longitudinal evidence of a relationship between alcohol outlet density and domestic violence. The study's findings contrast with previous cross-sectional work in this jurisdiction [18], which found that only general licences were linked positively to domestic violence, while on-premise licences were linked negatively. This highlights the possibility of misleading results in cross-sectional analyses, with the results of this longitudinal study providing a more intuitive set of relationships. In particular, the longitudinal analyses highlighted the substantial role of packaged liquor outlets in domestic violence, a relationship that was not detected in previous cross-sectional work.

The relationships found by this study suggest that all three types of alcohol outlets are related to increased levels of domestic violence, with general (or pub) licences and on-premise licences having a relatively small effect and packaged (off-premise) licences having a more substantial impact. These findings fit with theoretical justifications of the link between alcohol outlet-density and domestic violence. First, the strongest link is found for the type of outlet that sells alcohol for off-premise consumption. If the density of alcohol outlets is related to consumption levels (as suggested by some previous studies [34]), then it is plausible that increasing density of these particular outlets will result in increasing consumption of off-premise alcohol. This consumption is likely to take

place within the home, increasing the risk of domestic violence. It is worth noting that, while general licences allow off-premise sales, they also sell a significant amount of alcohol for drinking on premises. These licences have been linked previously to general levels of assault [23,35], and are often venues in which alcohol consumption is the main activity. There is some evidence that these types of premises are the sites of particularly heavy drinking [36], and increasing densities of these kinds of outlets may result in higher frequencies of intoxication, and then to higher risks of domestic violence.

Both these rationales rely on a link between outlet density and consumption, which remains somewhat contested (e.g. [37]). This contrasts with studies focusing on outlet density and public violence, where a variety of theoretical justifications have been put forward to explain the link without requiring changes in consumption [19,21,38]. While it is hard to imagine alcohol outlets affecting rates of domestic violence without affecting consumption in some way (e.g. by changing the amount, pattern or location of drinking), it is possible that the relationships found in this study reflect changes in socio-demographic factors which are correlated with both alcohol outlet density and domestic violence, although the incorporation of a broad measure of socio-economic disadvantage in the current study reduces the likelihood of this happening. The positive relationship between on-premise licences and domestic violence rates is harder to interpret, with these outlets selling all their alcohol for consumption on-premises. It is possible that increases in restaurants and bars in an area may change the way in which residents drink (e.g. encouraging heavier on-premise drinking) although, consistent with this study's results, this would be likely to have only a small effect.

The major limitation of the study is its use of a single composite measure of socio-economic disadvantage, due to the limitations of data available between Censuses in Australia. However, given the utility of this measure for assessing overall disadvantage and the conservative modelling design, this limitation is not likely to have influenced the alcohol effects observed.

The results of this study are consistent with a growing number of studies linking alcohol outlet density and domestic violence [17,18,39], adding to the evidence that alcohol availability is risk factor for domestic violence. In particular, the study finds longitudinal relationships between outlet densities and domestic violence rates, while utilizing a very conservative study design, with cross-sectional variation, overall trends and spatial auto-correlation controlled, providing the strongest evidence yet for a direct effect of outlet density on domestic violence. The study particularly implicates hotel-packaged liquor licences which, along with previous analyses linking these outlets to general rates of violence [23], suggests the need for changes to liquor licensing policy in Victoria that will stem the proliferation of these outlets.

Declarations of interest

None.

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FEBRUARY 2015

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.

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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 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.

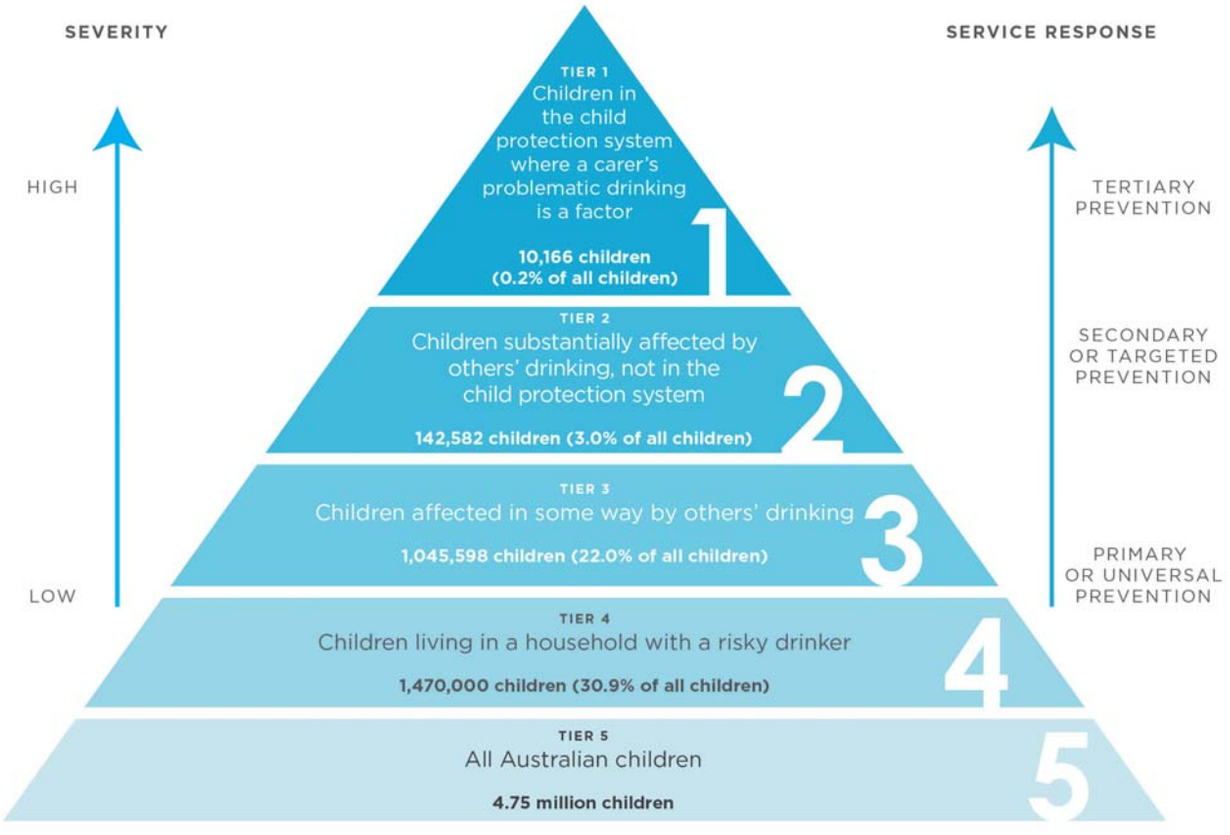


Figure 1 Pyramid model of children at risk of alcohol-related harms

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

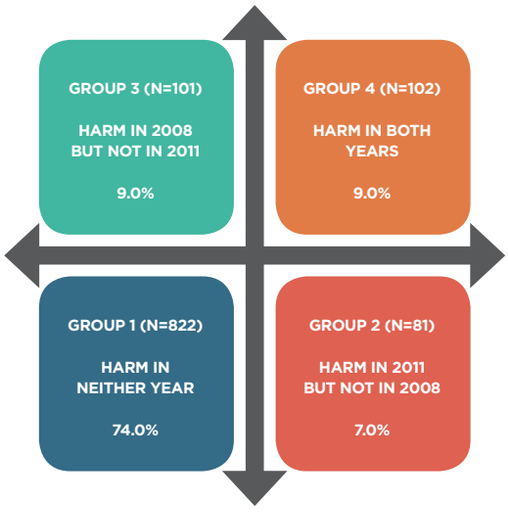
In 2011 a follow-up study of those interviewed in the 2008 HTO Survey was conducted to examine factors predicting whether the effects of others' drinking were transient or persistent. These results were published in *Beyond the drinker: Longitudinal patterns in alcohol's to others* (Laslett et al. 2015). 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

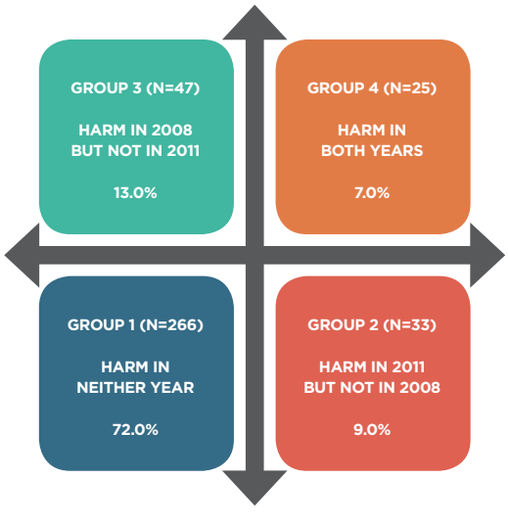
[a] Difference scores = 2011 value – 2008 value for each variable.

[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).

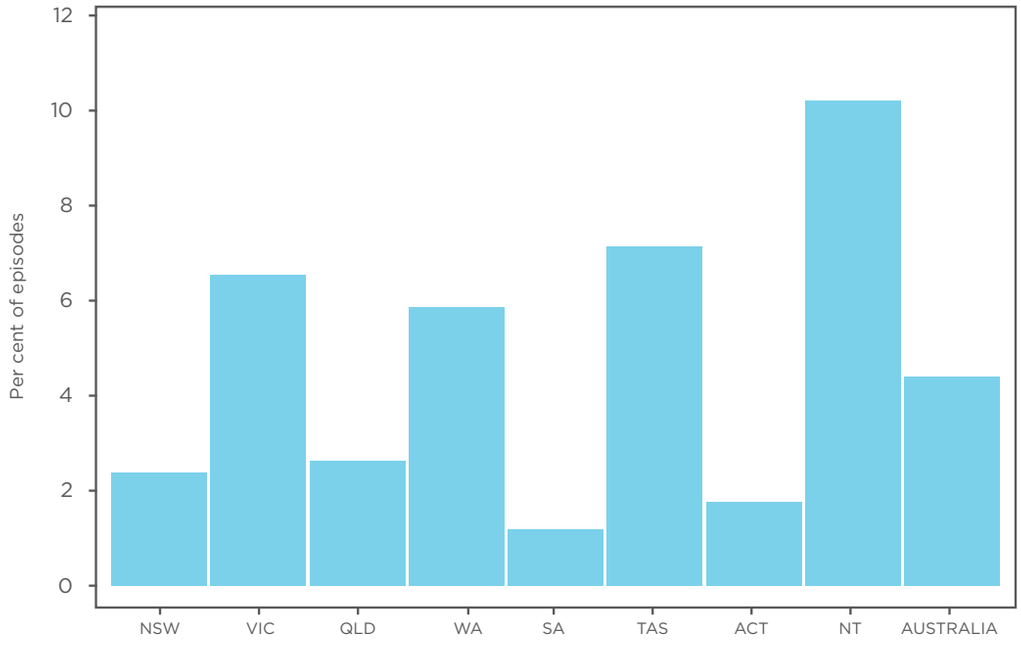


Figure 7.1 Closed episodes of care provided to clients seeking treatment in connection with someone else's alcohol or drug use, AOD services in Australian states and territories, 2011–12

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.

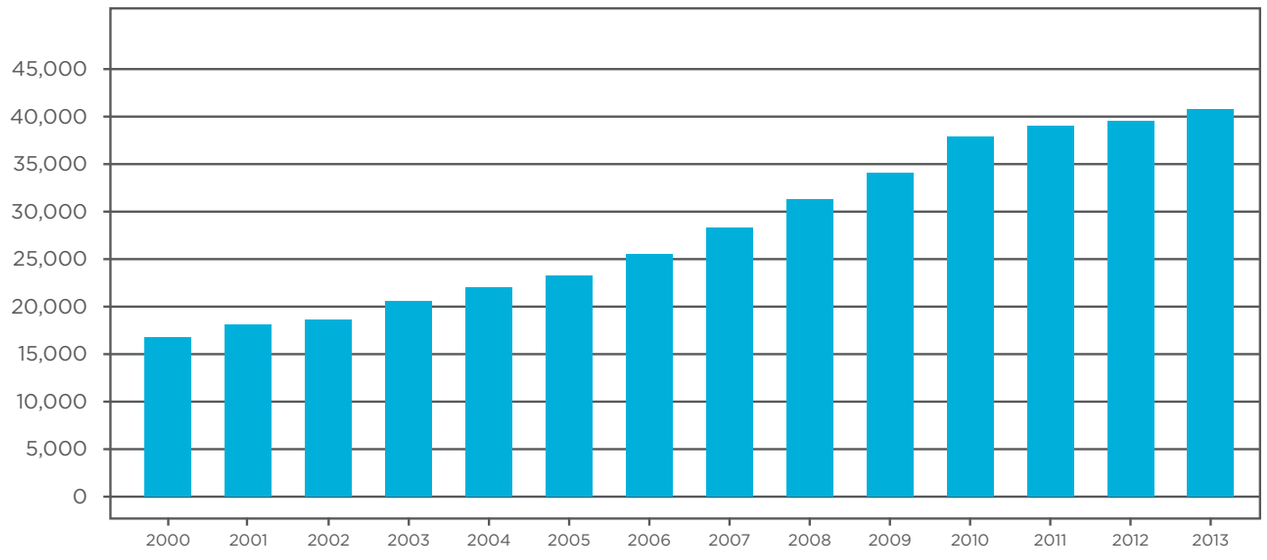


Figure 8.1 Number of children in out-of-home care in Australia 2000–2013

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).

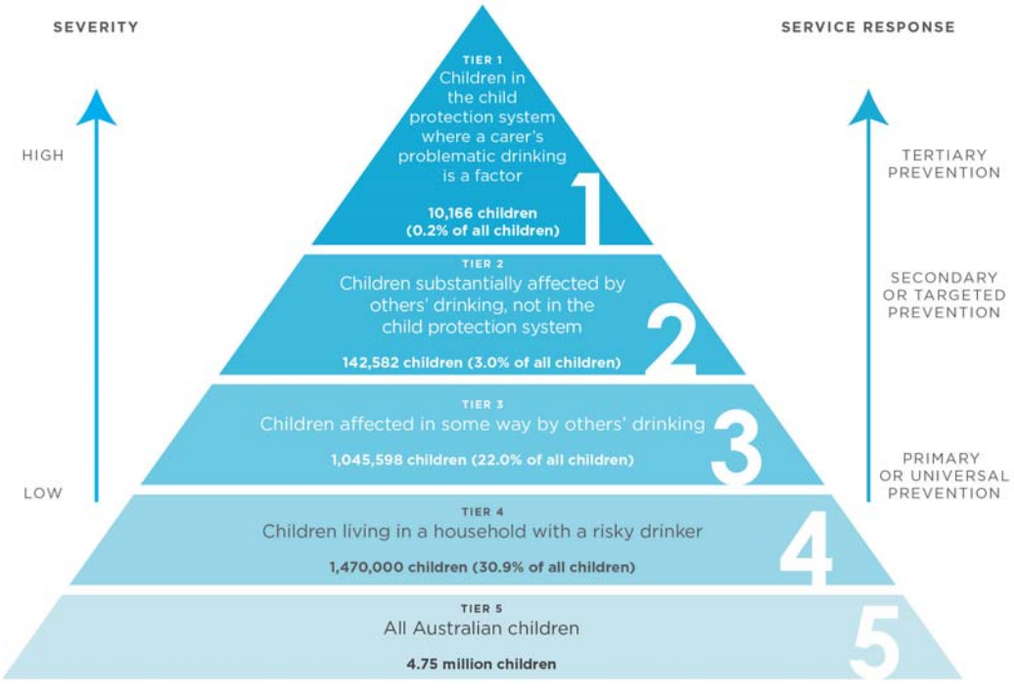

Figure 10.1 Pyramid of risks to children affected by alcohol-related problems in Australia per year

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

LIST OF FIGURES AND BOXES

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

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Beyond the drinker:

Longitudinal patterns in alcohol's harm to others

Anne-Marie Laslett | Sarah Callinan | Janette Mugavin | Heng Jiang | Michael Livingston | 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.

fare
Foundation for Alcohol Research & Education

capr
centre for alcohol policy research

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) which 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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Beyond the drinker:

Longitudinal patterns in alcohol's harm to others

FEBRUARY 2015

Anne-Marie Laslett | Sarah Callinan | Janette Mugavin | Heng Jiang | Michael Livingston | Robin Room

CONTENTS

ACRONYMS AND ABBREVIATIONS

AIHW	Australian Institute of Health and Welfare
ED	Emergency Department
EQ-5D	European Quality of Life-5 Dimensions (self-report questionnaire score)
HH	Household
HREC	Human Research Ethics Committee (Eastern Health)
HRQoL	Health-Related Quality of Life
HTO	(Alcohol's) Harm to Others
NHMRC	National Health and Medical Research Council
NICE	National Institute for Health and Clinical Excellence
NS	Non-significant
PWI	Personal Wellbeing Index
R+I	Relatives and Intimate partners
SHORE	Social Health Outcomes, Research & Evaluation research centre (of Massey University, Auckland, NZ)
SEIFA	Socio-Economic Index For Areas (a measure produced by the Australian Bureau of Statistics)
SRC	Social Research Centre
WHO	World Health Organization

GLOSSARY

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 between October 2011 and February 2012.
Heavy drinker (HD)	Someone who the respondent reports to be "a fairly heavy drinker or drinks a lot sometimes" (in the 12 months prior to each HTO Survey). The terms 'fairly heavy drinker' and 'someone who drinks a lot sometimes' were open to respondent's own interpretation.
Heavy drinking occasions	Occasions on which a respondent drank five or more standard drinks in a single session.
Known problematic drinkers	Household members, non-household relatives and intimate partners, friends and co-workers identified by the respondent as heavy drinkers, and whose drinking adversely affected the respondent in the 12 months prior to each HTO Survey.
Non-household relatives and intimate partners	People who are relatives, girlfriends, boyfriends, or ex-partners of the respondent (but did not live with the respondent in the 12 months prior to each HTO Survey).
Social circle	A respondent's social circle includes household members, relatives, intimate partners, co-workers and friends.
Strangers	Includes people not known and not well-known to the respondent.
Turnover	The gross amount of change in either direction in a measured characteristic.

EXECUTIVE SUMMARY

BACKGROUND

In 2008, the first comprehensive study of the harms from alcohol experienced by people other than the drinker was undertaken in Australia. The study, published in 2010 as *The Range and Magnitude of Alcohol's Harm to Others* (Laslett et al. 2010), involved a population survey (2008 HTO Survey) and analysis of secondary data from a range of government agencies. The study concluded from the population survey that many Australians had been affected by a range of problems caused by the drinkers around them. Serious consequences of others' drinking were also evident in many of Australia's societal response systems. The study identified national annual totals of 14,000 hospitalisations, 70,000 incidents of alcohol-related assault and 20,000 cases of alcohol-related child abuse (Laslett et al. 2010).

The same report showed that almost three-quarters of the population reported that they had experienced at least some negative effect, and 14 per cent reported they had been affected to a large extent, by others' drinking. Furthermore, 29 per cent of respondents experienced harm attributable to the drinking of someone known to them, and 70 per cent experienced harm attributable to the drinking of someone they did not know well, or a stranger (Laslett et al. 2010).

BUILDING THE PICTURE

This report builds upon the 2008 HTO Study by revisiting the people who were surveyed to determine whether they continue to be affected by the harms incurred from others' drinking. The follow-up survey conducted in 2011 (2011 HTO Survey), closely followed the questionnaire used in the initial survey, focusing on adverse consequences to the respondent (or the respondent's child) from the drinking of family, friends, co-workers and strangers.

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. More specifically, the study addressed the following research questions:

1. What percentage of respondents in the 2011 follow-up sample were affected by others' drinking?
2. How did the 2011 HTO Survey findings compare with those of the 2008 HTO Survey?
3. Does a respondent's status in 2008, or changes in his/her circumstances from 2008 to 2011, predict harm from others' drinking in 2011?
4. What factors predict harm from others' drinking in 2011?
5. What predicts who is newly harmed among those who were not previously?
6. Among those harmed in 2008, what predicts who will not be harmed again in 2011?
7. What factors predict persistent harm from others' drinking, in comparison to persistent absence of such harm?
8. How do changes in the number of drinkers in respondents' lives and changing patterns of alcohol's harm to others affect respondents' quality of life and wellbeing?
9. For what proportion of the sample do problems associated with others' drinking result in use of services?
10. What predicts contact with emergency and health-related services because of others' drinking in 2011?

KEY FINDINGS

- In 2008 the first comprehensive study of the harms from alcohol experienced by people other than the drinker was undertaken in Australia.
- In 2011, 1,106 people involved in the original study were re-contacted to participate in a repeat survey to determine the stability and change in harm from others' drinking over time.
- Forty-four per cent of respondents reported having been negatively affected by others' drinking in 2011.
- Sixty-two per cent of respondents had experienced harm from others' drinking in at least one or both surveys.
- Personal experience of harm (or lack of harm) did not change for the majority (70 per cent) of respondents between 2008 and 2011, with almost a third of respondents harmed by others' drinking in both years (32 per cent) and 38 per cent not harmed in either year.
- Past experience of harm was a strong predictor of harm, with 65 per cent of respondents experiencing harm in 2008 reporting this again in 2011.
- The number of heavy drinkers in respondents' households and among other relatives and intimate partners in 2008 was a strong predictor of respondents' experience of alcohol-related harm in 2011.
- For each additional heavy drinker within their households, respondents were almost six times more likely to experience persistent harm from known problematic drinkers in their lives.
- Respondents' socio-economic characteristics and own risky drinking patterns had little bearing on harms arising or subsiding due to the problematic drinking of a family member or friend, suggesting that this type of harm is dispersed throughout the demographic and social groups within the sample.
- To reduce the significant social problem of alcohol's harm to others, policy responses at community, state and national levels are needed to diminish the prevalence of heavy drinking in the population.

THE 2011 HTO SURVEY

A total of 1,106 respondents completed the HTO Survey in 2011. One in six respondents (17 per cent) reported that they had been adversely affected by the heavy drinking of household members and other (non-household) relatives and intimate partners in 2011. A third of respondents (33 per cent) reported that they had been negatively affected by strangers' drinking. Combining adverse effects from any person's drinking (i.e. strangers or known problematic drinkers in the respondent's social circle), 44 per cent of respondents reported having been negatively affected in 2011.

COMPARING THE 2008 AND 2011 HTO SURVEYS

Somewhat smaller percentages of respondents reported being adversely affected by the heavy drinking of problematic drinkers they knew in the 2008 and 2011 HTO Surveys (29 per cent versus 24 per cent respectively). Similarly, a slightly smaller percentage of respondents reported harm from strangers' drinking in the 2011 survey than did so in 2008 (33 per cent versus 37 per cent). Overall, a slightly lower percentage of respondents reported harm from any other's drinking (i.e. strangers or known problematic drinkers) (44 per cent in 2011 versus 50 per cent in 2008). The decrease for those affected by strangers' drinking was statistically significant for the total sample and for men, as was the reduction in harms from others' drinking overall, but not for women. Given that younger respondents reported higher rates of harm from others' drinking, and the respondents in the sample are now three years older, the decrease is likely in part attributable to this age difference.

STABILITY AND CHANGE IN HARMS FROM OTHERS' DRINKING

In analysing the 2008 and 2011 data together, the majority of respondents (62 per cent) had experienced harm from another person's drinking in either or both years. The situation for the majority of respondents did not change between 2008 and 2011. The biggest contributor to this stability was the proportion of respondents for whom harms were not present in either year (38 per cent), although almost a third of respondents were harmed in both years (32 per cent). However, this apparent stability masks the substantial turnover in harms from others' drinking, amounting to around 30 per cent of the sample. For those who have been harmed previously, there is considerable evidence of discontinuation of harm, although this is mostly counterbalanced by the emergence of new harm from others' drinking that was not evident previously.

THE CORRELATES OF STABILITY AND CHANGE

Past harm was a strong predictor of harm from others' drinking in 2011. This suggests that particular attention might be paid to those who report problems, since recurrence of harm to them is more likely than harm occurring to others for the first time.

Harms from known problematic drinkers were predicted by the number, and change in the number, of heavy drinkers who were household members or non-household relatives and intimate partners of a respondent. While the respondent's age and gender were also associated with harm, this was primarily because younger people and women had more heavy drinkers in their household or as an intimate partner.

In examining harms from strangers, age was a factor, and changes in the number of non-household relatives and intimate partners who were heavy drinkers again predicted whether respondents were more likely to experience harm from strangers in 2011. Changes in the number of heavy-drinking friends were also predictive of harm from strangers in 2011.

INITIATION AND DISCONTINUATION OF HARMS IN 2011

Higher numbers of heavy drinkers within a respondent's household and among non-household relatives and intimate partners in 2008, as well as increases in the numbers of these drinkers over time, were significant predictors of new harms from known problematic drinkers in 2011. New harms from strangers' drinking were associated with more heavy-drinking co-workers in 2008, an increase in heavy-drinking co-workers, and younger age.

Having fewer heavy drinkers within the household and among non-household relatives and intimate partners than in 2008 was a predictor of no longer reporting harm from known problematic drinkers in 2011. Decreases in the number of heavy-drinking relatives, intimate partners and friends were associated with discontinuation of harm from strangers in 2011.

PERSISTENCE OF HARMS IN 2011

Contrasting persistence of harm (in both the 2008 and 2011 surveys) with absence of harm in either year starkly differentiates who is most likely to suffer continuing harm from others' drinking. Persistent harm from known heavy drinkers was associated with the number of heavy drinkers in the respondent's social circle, especially household members and relatives and intimate partners, whereas heavy drinking relatives and intimates and heavy-drinking co-workers were associated with persistent harm from strangers' drinking.

In analysing harms from strangers, younger age was associated with persistence of such harms, although age was not a factor in predicting persistent harms from known problematic drinkers. Both for harm from the drinking of strangers and for harm from the drinking of those that they knew, increases in the numbers of heavy-drinking household members and non-household relatives and intimate partners, as well as being younger in age, predicted persistence of harm in respondents' lives.

CHANGES IN QUALITY OF LIFE AND WELLBEING

Lower (self-reported) quality of life and wellbeing were associated with increased exposure to heavy drinkers in respondents' lives who were non-household relatives and intimate partners. However, changes in harms from others' drinking were not significantly associated with changes in quality of life or wellbeing. This means that while the presence of more heavy-drinking non-household relatives and intimate partners was linked to lower quality of life and wellbeing, a reduction or an increase in reported harms from others' drinking was not significantly associated with changes in respondents' reports of their own wellbeing.

HELP-SEEKING BEHAVIOURS OF THOSE AFFECTED BY OTHERS' DRINKING

In 2011, of the respondents harmed by others' drinking, 13 per cent had called the police and seven per cent had called a health-related service because of other people's drinking in the previous 12 months. The majority of calls concerned a stranger's drinking (74 per cent); 16 per cent related to the drinking of people respondents knew, and a further ten per cent to the drinking of both strangers and people known to respondents. Previous calls to police because of others' drinking was the dominant predictor of calls to police in 2011. Reports of harm, especially previous harm from strangers' drinking, also played a significant part in predicting respondents' use of police services.

CONCLUSION

Overall, the 2011 HTO Survey indicated that 44 per cent of respondents were harmed by others' drinking in 2011, a smaller percentage than were harmed in 2008 (50 per cent). This was partly, but not completely, explained by the increasing age of the sample. Harm persisted in 2011 for three in ten respondents, and 62 per cent were harmed in one or both years.

The strongest predictor of harm from others' drinking in 2011 was having experienced harm in the past, even after other variables were controlled for. However, even taking this into account, reporting higher numbers of heavy drinkers in one's life was also a steady predictor of experiencing harm. In particular, the number of heavy drinkers in a respondent's household, or heavy drinkers who were relatives or intimate partners, was an important predictor of harm from known problematic drinkers. In the case of harm from strangers, increases in the number of heavy-drinking friends, along with non-household relatives and intimate partners, were the most significant predictors of harm. This makes intuitive sense, with harm from within the respondent's circles being linked with heavy-drinking family members but harm from strangers having a stronger link to heavy-drinking friends, since having heavy-drinking friends is likely to indicate how often a respondent might be out in a social environment where harm from strangers is more likely.

The demographics of the person being harmed, or even how much they themselves drink, are not strong predictors of experiencing harms from others' drinking. Instead, as described above, the key predictive factors are the number of heavy drinkers in a person's life and changes in this number over time.

The presence of more heavy drinkers in respondents' lives was also associated with lower health-related quality of life scores but, somewhat at odds with this, reported harm and change in harm attributable to these drinkers were not statistically significant as predictors of change in quality of life or wellbeing. Finally, the 2011 HTO Survey suggests that the majority of respondents have not sought assistance for harms caused by others' drinking from emergency or health-related services. Among respondents who had done so, assistance was sought most often from police, and more often when the respondent had sought such assistance in the past.

IMPLICATIONS FOR FUTURE RESEARCH AND POLICY

The social worlds of heavy drinking stretch across economic class and other demographic variables. The 2008 and 2011 HTO Surveys suggest that the size of respondents' heavy-drinking social circles is a strong predictor of the harm they will experience. This suggests that, to reduce the high rates of harm from others' drinking, policy responses at community, state and national levels are needed to diminish the prevalence of heavy drinking in the population.

Alongside heavy-drinking social contexts, younger age is predictive of harms from strangers over time. Therefore policies that aim to control the contexts in which young people drink, such as those policies that limit trading hours, the density of outlets as well as the enforcement of responsible service of alcohol policies and increased late-night public transport options will improve the safety and wellbeing of young people.

The study's results suggest that successful efforts to reduce rates of heavy-drinking individuals could, in turn, reduce the number of people being harmed by the drinking of others. Policy options such as increasing the price of alcohol are likely to contribute to reductions in pre-drinking by younger people and overall alcohol consumption in the population. Such policies that aim to reduce overall alcohol consumption will also reduce the harm to drinkers from their alcohol consumption, as well as diminish the impacts on services, such as police and hospital systems.

1 INTRODUCTION AND OVERVIEW

KEY POINTS

- Australia's first Alcohol's Harm To Others (HTO) Study was conducted in 2008, involving a cross-sectional population survey and analyses of secondary data from a range of sources.
- The 2008 HTO Study found that consequences of others' drinking were widespread and often severe. Another key finding highlighted an association between reduced wellbeing and exposure to heavy drinkers within respondents' social circles.
- The 2008 HTO Study and other studies investigating harm due to others' drinking have relied on cross-sectional data, thus only providing information about a single point in time. In order to understand the long-term impact and influence of problems associated with others' drinking, longitudinal investigations are needed.
- The aim of the current study (the 2011 HTO Study) is to examine the stability and change in harm from others' drinking between 2008 and 2011.

1.1 ALCOHOL'S HARM TO OTHERS: NEW PERSPECTIVES AND UNDERSTANDINGS

Most research on alcohol-related harms focuses predominantly on the harms that are experienced by drinkers themselves. For much of the last century, treatment and public health systems have also focused on managing people who consume alcohol. Researchers, too, with a few exceptions, have focused on drinkers' perceptions, drinkers' problems and responses to these. But drinking can also result in harm to individuals other than the drinker, as highlighted by drink-driving casualties (Gusfield 1981) and Fetal Alcohol Spectrum Disorders (Khalil et al. 2010; May & Gossage 2011; Meyer-Leu et al. 2011; Mullally et al. 2011). More broadly, Orford et al. (2013) have used qualitative data to outline the many ways in which families of alcohol-dependent people are negatively affected, while a number of studies have identified negative impacts on health and wellbeing due to drinking in spousal relationships. In these specific circumstances, recognition of harm to individuals from someone else's drinking has increased in recent decades (Connor et al. 2009; Greenfield et al. 2005; Laslett et al. 2013; Room 1996). Overall, much less attention has been paid to the broader perspective of alcohol's harm in household and family relationships and more widely in the community.

This changed in 2008, when the first comprehensive study of alcohol's harm to others was undertaken in Australia. *The Range and Magnitude of Alcohol's Harm to Others* (2008 HTO Study) examined the harms experienced by people around the drinker as a result of the drinker's alcohol consumption. 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). As part of the 2008 HTO Study, a model for understanding the social roles that may be affected by others' drinking was described (Laslett et al. 2010), which demonstrated the ways in which intimate, family, household, friendship, work and public roles may be affected by heavy drinkers.

1.2 FINDINGS FROM THE 2008 HTO STUDY: UNDERSTANDING THE SIZE OF THE PROBLEM

The broad picture that emerged from the 2008 HTO Study (Laslett et al. 2010) was that many Australian family and community members have been affected by a range of problems because of the drinkers around them. The effects identified were widespread and sometimes severe. Serious consequences of others' drinking were evident in many of Australia's societal response systems, in the police records of those who were victims of street assaults and domestic violence, in child protection cases, and in hospital and mortality databases. The 2008 HTO Study identified annual totals of almost 14,000 hospitalisations, 70,000 incidents of alcohol-related assault and 20,000 cases of alcohol-related child abuse (Laslett et al. 2010).

Alongside these severe harms, the 2008 HTO Survey showed that a much larger proportion of the Australian community was adversely affected by others' drinking, but these harms were generally not registered or managed by societal response systems. Almost three-quarters of the population reported that they had experienced at least some negative effect, and 14 per cent reported they had been affected to a large extent by others' drinking (Laslett et al. 2010). The 2008 HTO Survey found that 29 per cent of respondents experienced harm attributable to the drinking of someone known to them, 70 per cent experienced harm attributable to the drinking of someone they did not know well or a stranger (Laslett et al. 2010), and 22 per cent of those with children in their care felt one or more of these children had experienced harm attributable to the drinking of others in the last 12 months (Laslett et al. 2012).

Furthermore, analysis of the 2008 HTO Survey data found a significant cross-sectional association between reduced health and wellbeing and the number of heavy drinkers that respondents identified in their social circles. In particular, it was found that wellbeing, measured by the Personal Wellbeing Index (PWI) (International Wellbeing Group 2006), was significantly reduced when the respondent reported harm from drinkers outside the his/her household, while health-related quality of life (measured using the EuroQol Group 5-Dimension Self-Report Questionnaire score (EQ-5D) (The EuroQol Group 2009) was reduced by the presence of heavier drinkers both inside and outside the household (Laslett et al. 2010).

These findings have been reproduced in other settings. For example, Casswell et al. (2011) found that exposure to heavy drinkers (both within and outside the household) was associated with reductions in both health-related quality of life and wellbeing in a New Zealand sample (using the same measures as the previous Australian work).

1.3 IDENTIFYING THOSE MOST AFFECTED WHILE UNDERSTANDING THE WIDESPREAD NATURE OF ALCOHOL'S HARM TO OTHERS

Since the Australian 2008 HTO Study, and the New Zealand sister study in 2009 (Casswell et al. 2011), several studies have commenced across the world. Furthermore, conceptual aspects of the 2008 HTO Study and a modified version of the HTO Survey (World Health Organization, 2012) have been adopted as an international collaborative research effort by the World Health Organization (WHO) as part of its implementation of the Global Strategy on Alcohol (World Health Organization, 2010).

The 2008 HTO Study and other studies with similar framings have investigated variations by age and gender in the rates of harms experienced because of others' drinking. Findings suggest that young men are more likely to be physically abused and women sexually abused by someone who has been drinking (Connor et al. 2009), and women are more likely to live with and be affected by a known problematic drinker than men (Laslett et al. 2011). In an Australian population survey carried out in 2010, 18-19 year olds emerged as the age group most likely to experience verbal or physical assault from drinkers (Australian Institute of Health and Welfare 2011). A recent Finnish study found that women were more likely than men to experience harm attributable to the drinking of others, and that within the sphere of private space, the harm to women was more serious (Huhtanen & Tigerstedt 2012).

While gender and age appear to play a strong role in who is affected by others' drinking, the 2008 HTO Survey revealed few differences overall in Australia by socio-economic status (Laslett et al. 2010), suggesting that these harms are not limited to small and marginalised sections of the community.

The 2008 HTO Study and the developing research agenda across the globe (e.g. in Thailand, Nigeria, Chile, Switzerland) paints a troubling picture of the range of effects of individuals' drinking in terms of harm to those around them. However, the picture has been cross-sectional, showing relationships at one particular point in time.

1.4 STUDYING DRINKING PATTERNS AND PROBLEMS LONGITUDINALLY

Public health policy seeks to improve what is happening in a society and its population. To achieve this, it is necessary to measure and understand change and its conditions and determinants. Such studies of change can examine patterns at a population or subpopulation level – for instance, focusing on a particular community, studied continuously or repeatedly over time – or they can focus on a more microcosmic level, following individuals, families or small groups over time. The desire to understand change at these more intimate levels has driven the emergence of longitudinal studies that follow individuals or small groups over time. Such studies often enrol individuals or groups in an initial survey and then re-interview them at a later time to track patterns and predictors of change or continuity.

There have been many studies that have examined the changes in an individual's drinking over time. The application of such a longitudinal design to drinking patterns and problems has a lengthy history. Although data were collected retrospectively, Raymond Pearl's study of the relationship of drinking patterns to later mortality can be regarded as a landmark beginning to this line of research (Pearl 1926). By 1988, there had been sufficient work in the area for a review monograph (Fillmore 1988), and longitudinal studies of drinking patterns have continued to appear (e.g. Kerr et al. 2002).

The basic finding of these studies has been that there is substantial 'turnover', or change, in the amount of drinking from one observation to another. Young adults show greater change in patterns of drinking than older adults, and heavier drinkers show more change than those drinking lightly or abstaining when interviewed (Kerr et al. 2002). Some of this turnover reflects various kinds of measurement error; it is well established that there is substantial misreporting – particularly underreporting – of alcohol consumption (Gmel & Rehm 2004). But there is also a great deal of real change, with significant fluctuation in patterns of drinking among those who have periods of heavy drinking (even among those who are eventually identified as alcohol-dependent), so that many of those who are drinking heavily when interviewed at one time will not be doing so when re-interviewed. This phenomenon of 'regression to the mean' has been recognised as a consideration when, for instance, measuring the effects of a policy or treatment intervention (Skog & Rossow 2006; Babor 2008).

As might be expected, such fluctuations have also been found in patterns of problems arising from drinking when these are measured from the perspective of the drinker; that is, by asking drinkers at two or more time points about problems they have recently experienced with their drinking. Although fluctuations in heavy drinking and associated problems are greater for younger than for older adults, there is still considerable turnover between interviews in reporting of alcohol-related problems among those middle-aged and older (Fillmore 1987).

The 2011 HTO Survey was conducted to follow up respondents in the 2008 HTO Survey to examine stability and change in harm from others' drinking in an Australian sample. In particular, this report of analyses of 2008 and 2011 HTO data aims to determine what factors may predict these patterns over time.

1.5 STUDYING HARM FROM OTHERS' DRINKING LONGITUDINALLY: EXTRA DIMENSIONS OF VARIATION

While the established tradition of research in the area of problem drinking has approached alcohol-related harms from the perspective of the drinker, many of the harms from drinking are incurred by others. For this reason, a major focus of the Centre for Alcohol Policy Research (CAPR) studies of alcohol's harm to others has been to approach the issue of alcohol-related problems from the perspective of the 'others' – people in the Australian community with a variety of connections or relationships to drinkers for whom the drinking may result in harm.

Following a sample over time, and asking them again about harms they have experienced from others' drinking, is addressing a somewhat different range of questions to those posed by a longitudinal follow-up of drinkers about their problems with their own drinking. At follow-up, the person interviewed may still live with, or be strongly linked to, a heavy drinker who was a source of harm at the first interview. For instance, a respondent may be reporting on whether he/she is continuing to experience harms from a spouse's long-term drinking. However, it is also possible that any harm the respondent may be experiencing at follow-up is from another drinker altogether, who may be within the respondent's social circle or a stranger. Thus there may be no connection between the people causing an individual harm in the two time periods.

Over a three-year period, as studied with the HTO Surveys, the chance that any harms experienced at both reporting times are attributable to the same drinker is much less than 100 per cent. However, this chance varies with the drinker's relationship to the respondent: the likelihood that a respondent will be affected by the same drinker who is part of his/her household will probably be greater than the chance that harms will come from the same friend, which in turn will be greater than the likelihood of harms coming from the same stranger. The pattern of harms respondents report experiencing from others' drinking will thus be subject to both variations in the drinking patterns of those around them and to variations in the composition of their social circles.

1.6 DRINKING'S HARM TO OTHERS OVER TIME: REVIEW OF THE EVIDENCE

While there have been few or no studies that have re-interviewed a general population sample across two time points about their experiences of harm from others' drinking, there is some relevant research to explore.

As mentioned in Section 1.4, most of the research to date focused on continuity or change over time in alcohol's harms to others has been conducted with drinkers in treatment, and asked them about how they think their family life has been affected. One Russian study that surveyed the harmful drinker found that baseline levels of drinking were predictive of future harm in the form of family disruption (Keenan et al. 2011). Another study by this group found that, in a 14-year follow-up of married couples, divorce was strongly predicted by both the frequency and the quantity of spirits drunk per occasion by the husband, and even more strongly by the relatively uncommon pattern of binge drinking by the wife – though these patterns showed some variation across regions of Russia (Keenan at al. 2013).

In this review of the literature, studies involving close relatives of the drinker have been deemed as relevant to a longitudinal analysis. Although such (often qualitative) data are not strictly longitudinal, the studies do relate to relationships that continue over time. These studies rarely distinguish between drinking and drug use, though drinking is usually predominant.

Jim Orford and his colleagues have built a suite of literature describing the experiences of affected family members, including studies in a number of cultures (Orford et al. 2010). The informants or respondents in the studies have been members of the family affected by the substance user, and the emphasis has been on the deterioration of close family relationships, ill-health, signs of strain and other adverse effects. In addition, much of Orford's work has focused on how family members cope with the situation (whether by putting up with it, standing up to it, or withdrawing), and on the often-inadequate extent of outside support available to family members dealing with the situation.

A United States (US) study used advertisements in newspapers and other media to recruit 110 "concerned family members and significant others" who were "troubled" about an individual's alcohol and/or drug use. While there were few substantial differences in rates by problem domain between spouses and parents of the user and by gender of the respondent, problems in the "domain of the family" were more often reported by those living with the substance user than those who were not (Benishek et al. 2011). An analysis of the 2008 HTO Survey interviews – the initial survey used in the present analysis – also found that living with the known problematic drinker was a strong predictor of the respondent having been adversely affected "a lot," rather than "a little" (Berends et al. 2012).

Concerning relationships outside the close family, there have been few studies directly addressing harms from drinking which have implications for predicting continuity or change over time. Perhaps most relevant to the issue of continuity versus change are studies which are focused not on harms from drinking but rather on continuities in heavy-drinking cultures – i.e. examining the extent to which social worlds of heavy drinking act as a 'glue,' keeping participants to patterns of heavy drinking (Room 1973). It is clear from the lengthy tradition of observational studies of drinking places that the circles of friendship and mutual support among the 'regulars' at the bar are an important factor in sustaining a pattern of heavy drinking (Room 1972; 1981). Conversely, studies of the work of Alcoholics Anonymous and other mutual-help groups have found that a substantial element contributing to their success is their encouragement and ability to serve as an instrument of changes in patterns of friendship and sociability, away from other 'serious drinkers' to friends supportive of quitting (Humphreys et al. 1999).

These lines of work raise the question of the potential importance of immersion in heavy-drinking worlds in predicting continuity in the experience of harms from the drinking of others – including the drinking of friends, relatives and workmates.

1.7 THE RESEARCH GAP AND KEY QUESTIONS

It is clear from the literature described above that dealing with the resulting incidents and aftermath of someone's drinking, and covering for the drinker's incapacities, absorbs large amounts of time and the emotional energy of close family members. However, these findings provide only the corner of the picture, in which a person's heavy drinking often continues for a considerable time and yet, despite all that occurs, relationships persist. The literature does not address or answer the questions of how much turnover there is in alcohol's harm to others, and whether this varies by relationship. Nor does the literature directly address the extent to which heavy drinking is a part of the social context of a relationship, and the extent to which immersion in a heavy-drinking social circle may predict continuity in harms from others' drinking.

This research gap is addressed in this study. The 2008 HTO Survey enabled the establishment of a baseline, a clear estimate of the range and magnitude of alcohol's harms to others in Australia. The 2011 HTO Survey enables the harm from others' drinking to be followed up over time. The overall aim of the current study is to examine the stability and change in harm from others' drinking between 2008 and 2011.

The key research questions addressed are:

1. What percentage of respondents in the 2011 follow-up sample were affected by others' drinking? (Chapter 3)
2. How did the 2011 HTO Survey findings compare with those of the 2008 HTO Survey? (Chapter 3)
3. Does a respondent's status in 2008, or changes in his/her circumstances from 2008 to 2011, predict harm from others' drinking in 2011? (Chapter 4)
4. What factors predict harm from others' drinking in 2011? (Chapter 4)
5. What predicts who is newly harmed among those who were not previously? (Chapter 4)
6. Among those harmed in 2008, what predicts who will not be harmed again in 2011? (Chapter 4)
7. What factors predict persistent harms from others' drinking, in comparison to persistent absence of such harm? (Chapter 4)
8. How do changes in the number of drinkers in respondents' lives and changing patterns of alcohol's harm to others affect respondents' quality of life and wellbeing? (Chapter 5)
9. For what proportion of the sample do problems associated with others' drinking result in use of services? (Chapter 6)
10. What predicts contact with emergency and health-related services because of others' drinking in 2011? (Chapter 6)

2 METHODS

KEY POINTS

- A follow-up study design of 2008 and 2011 HTO Surveys was used to examine harms from others' drinking over time. This study design incorporated data from those interviewed in both the 2008 and the 2011 HTO Surveys.
- The research approach aims to understand how the baseline variables and changes in these variables over time predict harm in 2011.
- The main outcome variables used in the study are harm from strangers' drinking, harm from problematic drinkers in the respondent's social circle, overall harm from others' drinking, health-related quality of life and wellbeing, and help-seeking behaviours of those affected by others' drinking in 2011.
- Predictor variables used to examine the key outcomes of harm include measures of harm in 2008 (past harm), socio-demographic variables, the respondent's own drinking pattern, and the numbers of heavy drinkers and changes in the numbers of heavy drinkers in different relationships with the respondent.
- Simple descriptive analyses and logistic regression techniques were used to analyse the data bivariately and then multivariately, adjusting for the effects of other variables in the analysis.
- 1,106 participants completed the Harm to Others (HTO) follow-up 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.
- Age was the only significant predictor of attrition from the 2008 to the 2011 HTO Survey.

The 2008 HTO Survey looked at the ways in which Australians had been harmed because of the drinking of others across a full range of possible impacts, from less severe to serious harms, at one point in time (Wilkinson et al. 2009; Laslett et al. 2010). The follow-up 2011 HTO Survey closely followed the questionnaire used in the initial survey. As described in Chapter 1, the key aim of this study is to report upon the longitudinal patterns in harm from others' drinking, and what predicts changes in these harms from 2008 to their new levels in 2011.

In 2011 ethics approval was obtained from the Eastern Health Human Research Ethics Committee (HREC) in Victoria. The Social Research Centre (SRC), which conducted the fieldwork for the initial survey, also conducted the computer-assisted telephone interviews for the follow-up survey on behalf of the CAPR.

2.1 RESEARCH ANALYSIS APPROACH

From the time of development of the 2008 HTO Study, the researchers were aware that longitudinal studies provided a stronger research design to understand patterns of interactions and causation than cross-sectional studies. Provisions were made at the time of the initial study to re-interview participants who agreed to be re-contacted. Both survey questionnaires captured the number of heavy drinkers (if any) in respondents' lives and adverse consequences to respondents (or their children) in the previous 12 months from the drinking of family, friends, co-workers and strangers (or those not well-known to the respondent).

The longitudinal data from the 2008 and 2011 surveys presented a unique opportunity to examine how individual experience of alcohol's harm to others changed over time. However, these opportunities were accompanied by challenges in optimising analysis of these data. The first question was how to analyse the data to account for the respondent's situation in 2008 and in 2011, and the level of change (if any) between the two time points. An option initially considered was the use of change scores, often used as outcome variables in longitudinal studies to measure the difference between initial and follow-up scores describing, for example, changes in levels of anxiety or depression (Christensen et al. 2002). However, in the HTO Study, this approach presents difficulties because changes in harm scores do not account for the original state, so that someone with a change score of 0 may have been harmed at both time points or neither point of time. Furthermore, change scores are not appropriate outcome variables when it is believed that the outcome at time point 1 (in this case, 2008) will affect the outcome at time point 2 (2011) (Allison 1990). As discussed in Chapter 3, those who reported experiencing harm in the 2008 HTO Survey were more likely to experience it again in 2011, so this method was not deemed appropriate in the current study.

To gain greater insight into alcohol's harm to others, both whole-sample holistic models (Chapter 2, Section 2.1.1) and partial-sample models that examine particular changes (Chapter 2, Section 2.1.2) are used in this report. While it is expected that many of these analyses will yield similar results, it is important to examine these questions in different ways. The analyses also examine seemingly similar questions from opposite perspectives. Initiation of harm from others' drinking may not be precipitated simply by the inverse of something that predicts discontinuation.

2.1.1 OVERALL MODELS PREDICTING HARM OVER TIME (WHOLE-SAMPLE MODELS)

The models presented in Chapter 4 (Section 4.2) are logistic regression models with harm in 2011 as a dichotomous (yes/no) outcome variable. Harm in 2008, also a dichotomous variable, is included as a predictor variable. This method enabled an examination of the existence of harm (or lack thereof) in 2008 as a predictor of harm in 2011. Both the starting point of each respondent (i.e. either harmed or not harmed in 2008) is accounted for, as well as changes in a respondent's life between 2008 and 2011. One of the primary advantages of this method is that (unlike the methods outlined below that answer more specific questions on the initiation, discontinuation or persistence of harm) all participants are included in this model. As such, a more global overview of the prediction of harm over time is provided.

Another feature of these models is the use of change scores in the numbers of heavy drinkers in different areas of a respondent's social circle as predictor variables. Therefore, in the multivariate models it is possible to examine how, for example, an increase in the number of heavy drinkers in a respondent's household will affect the likelihood of experiencing harm in 2011, while taking into account both the number of heavy drinkers in the household in 2008 and whether or not the person was harmed then.

2.1.2 INITIATION, DISCONTINUATION AND PERSISTENCE OF HARM MODELS (PARTIAL-SAMPLE MODELS)

The whole-sample models outlined above in effect assume that the predictors of change in one direction will mirror the predictors of change in the other direction. As this may not be true, additional models are presented that predict separately the initiation (Chapter 4, Section 4.3), the discontinuation (Chapter 4, Section 4.4) and the persistence of harm (Chapter 4, Section 4.5). For example, in the case of discontinuation of harm, those who were harmed in 2008 are taken as the starting point of analyses to identify what factors predict not being harmed again in 2011. Previous examples of this mode of analysis include studies investigating discontinuation of smoking (Braverman, Aarø & Hetland 2007) or initiation of substance use (Hartman et al. 2013). One of the real advantages of investigating the data in this way is that the predictors of initiation of harm may not simply be the inverse of the predictors of discontinuation of harm.

Some of those people reporting harm at a given time point may not have been harmed before and may not be harmed again. Conversely there may be some respondents who experienced a brief respite from harm that included the 12 months prior to the survey. This is a confounding factor in any cross-sectional research, so the opportunity to examine those who were harmed at both time points and compare them to those who were harmed at neither provides a more focused, longer term view of the correlates of harm. These models, predicting persistence of harm, are shown in Chapter 4 (section 4.5).

2.2 SAMPLE RESPONSE RATE AND ATTRITION ANALYSIS

The 2008 HTO survey sample was based on a national probability sample intended to be as representative as possible of the population of Australians aged 18 years or older, and the sample was weighted to match census distributions in order to better meet this aim. In the present analyses, which include 2008 and 2011 survey data, sampling weights were not used, since the emphasis of this study is on patterns of change and continuity at the level of the individual respondent and his/her social environment. In part, this is why any percentages that are referred to within the document should not be taken as representative of rates in the Australian population. However, research questions about change at the individual level are less sensitive to the question of representativeness than, for instance, questions about the best estimate of rates overall in a population.

The sampling frame in the 2008 Survey was based upon Australian telephone landlines, excluding business numbers. In 2011 the sampling frame of the longitudinal study was by definition limited to the 2,304 participants (87 per cent of those interviewed in 2008) who agreed then to be re-contacted.

A total of 1,106 respondents completed the follow-up survey between October 2011 and February 2012. The response rate for the 2011 HTO Survey, on the basis of all those interviewed in 2008, was 42 per cent. This response rate was lower than hoped, so it was important to test whether the losses from 2008 to 2011 were random and not systematic. A logistic regression model from the 2008 data, predicting being a respondent in 2011, is shown in Table 2.1.

Reduced alcohol consumption in a follow-up sample has been attributed to differential attrition of heavy drinkers (Grittner et al. 2011). As a parallel phenomenon, it may be that any reduction in harm reported over time is, at least in part, attributable to the attrition of those who were being harmed more. However, as can be seen in Table 2.1, age is the only significant predictor of participation/attrition from the 2008 to 2011 HTO Surveys. Participants in the older age group were more likely to respond in 2011, whilst younger participants were less likely to respond.

Table 2.1 Logistic regression model predicting participation in second survey from first survey responses

Variable	BIVARIATE	MULTIVARIATE
Age		
18-35	1 (Ref)	1 (Ref)
36-55	2.81***	2.85***
56 and over	2.81***	2.80***
Gender		
Female	1 (Ref)	1 (Ref)
Male	0.97	0.99
Rurality		
Cities	1 (Ref)	1 (Ref)
Regional	1.19*	1.19
Remote	1.09	1.06
Neighbourhood affluence		
Most disadvantaged	1 (Ref)	1 (Ref)
2	1.11	1.06
3	1.06	0.97
4	1.22	1.21
Least disadvantaged	1.03	1.08
5+ drinking occasions/week [a]	1.01	1.04
Harm from problematic drinkers		
None	1 (Ref)	1 (Ref)
A little	1.04	1.18
A lot	0.98	1.08
Harm from strangers		
None	1 (Ref)	1 (Ref)
A little	0.80**	0.88
A lot	1.07	1.15

*p < 0.05; ** p < 0.01; *** p < 0.001.

N=2599.

[a] The number of times that the respondent stated he/she drank five or more standard drinks in a session in a week.

In order to further examine the differences between the samples, the demographic characteristics of the sample, in various forms, are shown in Table 2.2. The mean age at the 2008 HTO Survey of those who responded in 2011 was 50.7 years, versus 45.6 years for those who did not respond in 2011. Substantial attrition of young adults is a common problem in longitudinal sampling (e.g. Bergman et al. 2010; Redwood et al. 2011), and none of the other factors were significant in the multivariate model (see Table 2.1).

Table 2.2 Demographic characteristics of the HTO sample

Variable	TOTAL 2008 WEIGHTED	TOTAL 2008 UNWEIGHTED	2008: NOT A RESPONDENT IN 2011	2008: RESPONDENT IN 2011	2011 ANSWER
(N)	**2,646**	**2,646**	**1,543**	**1,103**	**1,103**
Gender (% male)	**48.7**	**41.1**	**40.8**	**41.5**	**41.5**
Average age in 2008	**45.5**	**47.8**	**45.6**	**50.7**	**50.7**
Employment status					
Working (%)	63.3	60.2	60.6	59.7	59.2
Studying (%)	7.1	5.3	6.5	3.5	1.8
Retired (%)	16.8	19.5	17.5	22.2	25.4
Home duties (%)	8.2	9.2	9.3	9.1	6.7
Other (%)	4.4	5.8	6.1	5.4	6.9
Household					
Live alone (%)	9.2	17.8	18.2	17.3	17.8
With under 18s (%)	39.6	39.3	40.1	38.1	35.6
With over 18s only (%)	51.2	42.9	41.7	44.6	46.6
Neighbourhood affluence					
Most disadvantaged (%)	14.9	14.2	14.7	13.5	14.4
2 (%)	17.4	17.2	17.1	17.4	16.8
3 (%)	19.7	19.9	20.0	19.6	19.7
4 (%)	22.1	22.3	21.2	23.8	24.0
Least disadvantaged (%)	25.9	26.5	27	25.7	25.1
Rurality					
City (%)	54.3	55.5	57.2	53.1	52.6
Regional (%)	40.6	39.8	38.1	42.1	42.9
Remote (%)	5.1	4.8	4.8	4.8	4.5

In the first column, the demographics of the full weighted 2008 sample are shown; the second column also shows the full 2008 sample, but without weighting. The 2008 demographics of those who did not respond in 2011 are shown in the third column, and the 2008 demographics of those who did respond in 2011 are shown in the fourth column. Finally, demographics of the 2011 sample are shown in the fifth column. Note that in order to keep comparability, the age shown in this fifth column is the age at the 2008 sample, and thus is the same as that shown in the fourth column.

As can be seen, most of these proportions are similar, with the exception of the proportion of respondents who live alone being lower (9.2 per cent) in the weighted 2008 sample than it is in the other samples. This indication that people living alone are overrepresented in the unweighted samples is most likely to be a reflection of their automatically being the potential respondent if and when they answer the phone, while someone who lived with three other adults would only have a one in four chance of being chosen to participate, and for any of the others there would be a further step of follow-up and recruitment. As would be expected given the attrition analysis, age in 2008 was higher for those also in the 2011 sample than for those who were not. Furthermore, employment status was different, probably due to an increase in the proportion of retired respondents.

Pilot testing for the follow-up survey was undertaken in October 2011 and a total of 15 interviews were completed with an average interview length of 24 minutes. A larger pilot was not conducted as the survey instrument had changed little from 2008.

2.3 SURVEY MEASURES

The original survey was developed specifically for the 2008 HTO Study, drawing on the available literature, in consultation with a team working on a related study at the Centre for Social Health Outcomes Research Evaluation (SHORE) in New Zealand (Wilkinson et al. 2009). For the most part, the 2011 survey instrument 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.

The follow-up 2011 HTO Survey included questions on the number and relationship of heavy drinkers in the respondent's life, and on harm from these heavy drinkers (including the person who had most harmed the respondent) and harm from strangers' drinking. For a copy of the substantive questions in the survey instrument see Appendix B.

2.4 KEY OUTCOME VARIABLES

The key outcome variables collected by the survey are the different types of harm and states of health-related quality of life and wellbeing respondents reported experiencing in the past 12 months in 2011. The outcomes investigated in the study research questions are listed below.

2.4.1 HARM FROM KNOWN PROBLEMATIC DRINKERS' AND STRANGERS' DRINKING

In both iterations of the HTO Survey, respondents were asked about the heavy drinkers in their lives in terms of their relationship to them, and asked to state whether or not the heavy drinker's (or group of heavy drinkers') consumption had negatively affected them. These questions were repeated for:

- household members (including family and non-family members)
- non-household relatives and intimate partners
- friends
- co-workers.

Collectively, the people in these four subcategories of the respondent's social circle whose drinking adversely affected the respondent in the previous 12 months are referred to in this report as 'known problematic drinkers'.

Respondents were then asked to assess the overall level of harm they had experienced from known problematic drinkers in terms of whether they were harmed "a lot" or "a little." In 2011, 266 of the 1,106 respondents (24.1 per cent) stated that they had one or more known problematic drinkers in their lives and they had either been harmed "a little" or "a lot" by the known problematic drinker whose drinking had been most harmful. Typically, known problematic drinkers were people living with the respondent, family members (either co-habiting or not) or a friend.

In addition to examining harm from known problematic drinkers, the analysis also examined harm from the drinking of strangers (including someone not well-known to the respondent). In 2011, 359 (32.5 per cent) of the respondents stated that they considered themselves harmed, either "a little" or "a lot," in the past 12 months by the drinking of strangers.

Respondents' self-assessment of harm from others' drinking was used to generate three main outcome variables, describing harm from known problematic drinkers, harm from strangers, and harm from both of these groups. Finally, a simple measure of experience of harm from either known problematic drinkers' or strangers' drinking was used to measure "any harm."

2.4.2 INITIATION AND DISCONTINUATION OF HARM

Initiation of harm from known problematic drinkers is based on respondents who were not harmed by known problematic drinkers in 2008 but were in 2011, with the measure of harm based on a respondent's own judgement that he/she was harmed either "a little" or "a lot."

Initiation of harm from strangers was similarly identified.

Analogously, discontinuation of harm from known problematic drinkers is based on respondents who were harmed by known problematic drinkers in 2008 but not harmed in 2011. Discontinuation of harm from strangers was similarly identified.

2.4.3 PERSISTENT HARM

A respondent's own judgement of whether he/she was harmed either "a little" or "a lot" at both time points was used as a measure of persistent harm from known problematic drinkers, from strangers, and from both groups. Those harmed at both time points are compared in the persistence analysis with those not harmed at either time point.

2.4.4 PERSONAL WELLBEING

Personal wellbeing was measured using the Personal Wellbeing Index (PWI), a standardised tool developed by Cummins et al. (2003). The PWI measures satisfaction across eight domains (standard of living, health, life achievements, personal relationships, safety, community, security and spirituality) and combines the results to produce a well-validated measure of overall subjective wellbeing with a minimum of 0 (complete dissatisfaction) and maximum of 100 (complete satisfaction). Full details of the scoring method used to create the PWI are available in the PWI manual (The International Wellbeing Group 2006).

2.4.5 QUALITY OF LIFE

Health-related quality of life (HRQoL) was measured using the EQ-5D (European Quality of Life-5 Dimensions), a standardised and non-disease-specific measure (the EuroQol Group 1990). This scale is a well-validated and widely-used measure of HRQoL (Rabin & de Charro 2001). To complete this measure, respondents were required to self-rate their own health across five domains (mobility, self care, usual activities, pain/discomfort and anxiety/depression) with three possible ratings (no problems, some problems, or major problems). The responses for these five items have been converted into a combined utility score, with a score of one equivalent to full health and a theoretical score of zero equivalent to death. This conversion was undertaken using weights derived from a large-scale UK study of health preferences (Dolan et al. 1995) to take into account that problems in some domains are more burdensome than problems in others. In the present analyses, this utility score was then multiplied by 100 to put it in the same metric as the PWI (0-100).

2.4.6 SERVICE USE

Use of services in the last 12 months because of others' drinking was measured as part of the HTO Surveys, with only respondents who reported any harm from another person's drinking asked about service use. Use of services included calls to the police and use of health-related services including:

- hospitals or emergency departments (ED)
- other medical treatment (other than a hospital or ED)
- seeking counselling or professional advice, or contact with self-help groups or organisations.[1]

[1] The use of self-help groups was a new item included in the 2011 survey.

A dichotomous measure of harm was developed that distinguished respondents who reported calling the police due to the drinking of others from those who reported experiencing harm but did not use these services. The four health-related services described above were combined into one dichotomous 'yes'/'no' variable, where a 'yes' response indicated use of at least one health-related service.

Contextual information about the last call respondents made to the police was also collected in the 2011 survey (but not in 2008). Specifically, respondents were asked to indicate if they called police because of strangers' drinking, the drinking of people they knew, or both. Furthermore, respondents were asked to report the main reason for the call from a list of responses, and could choose one or more of: verbal disagreement, noise, physical fight/assault, trespassing, vandalism, robbery and other.

2.5 KEY PREDICTOR VARIABLES

2.5.1 DEMOGRAPHICS

Three main demographic predictors are used in this report: gender, age and neighbourhood affluence (as an indicator of social position). Gender remained constant between the two time points for all respondents, and age obviously changed systematically, with differences in years of age between the two time points being between two and four years. Neighbourhood status varied very little, since respondents of both surveys who moved tended to move into a neighbourhood with the same dichotomised Socio-Economic Index For Areas (SEIFA) level (see Box 2.1) as their previous residence. Because of these considerations, 2008 responses for these three variables are used in all analyses.

Box 2.1 Demographic predictor variables

PREDICTOR VARIABLE	DESCRIPTION
Gender	In regression models the reference category is men, so odds ratio numbers above 1.0 indicate that the outcome variable in question is more common in women.
Age	In most analyses, age is broken into three categories, all of which are based on age as of the time of the 2008 survey; 18-35, 36-55, 56 and older. 18-35 is the reference category for most of these analyses; therefore high numbers (odds ratios above 1.0) would indicate that the outcome variable in question is more common in the older group in question when compared to the youngest group.
Neighborhood affluence	The measure of neighbourhood affluence in this study is based on the SEIFA[2] score for each respondent's postcode. Neighbourhood affluence is measured on a scale of 1 to 5, where 1 is the most disadvantaged and five is the least disadvantaged. In order to facilitate interpretation of results, the 1 to 5 scale was re-coded 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).

2.5.2 RESPONDENTS' RISKY DRINKING

The measure of the respondent's own alcohol consumption used in the current study is the number of times per week that the respondent stated he or she drank five or more standard drinks in a session (i.e. how many 'heavy drinking occasions' in a week). This is the number of drinks that the National Health and Medical Research Council (NHMRC) considers 'risky' in a single session (National Health and Medical Research Council 2009). As some of the frequency response options needed to be converted from answers in terms of 'per month' or 'per year', these were all transformed to a number of times per week, thus resulting in a continuous variable that could range from zero to seven (five plus occasions). For instance, if a respondent reported drinking five or more standard drinks on a single occasion once a fortnight, he/she would have a score of 0.5, if he/she reported doing so three times a week he/she would have a score of three. As there is sometimes interest in the frequency of heavier drinking at either time point and sometimes in the change in the frequency between the two time points, two different predictor variables were used in the analyses (see Box 2.2).

[2] SEIFA stands for Socio-Economic Indexes For Areas and is a measure constructed by the Australian Bureau of Statistics. SEIFA shows how disadvantaged an area is compared with other areas in Australia (ABS 2006).

Box 2.2 Risky drinking predictor variables

PREDICTOR VARIABLE	DESCRIPTION
Five plus occasions/week 2008	The number of times that the respondent reported drinking five or more standard drinks in a session ('heavy drinking occasions') in a week.
Five plus occasions/week difference	The change in the number of heavy-drinking occasions reported by the respondent between 2008 and 2011 (positive values indicate an increase in heavy-drinking occasions, negative values indicate a reduction).

2.5.3 HEAVY DRINKERS IN THE RESPONDENT'S SOCIAL CIRCLE

A common theme throughout this report is that the number of heavy drinkers in a respondent's social circle is examined as a predictor of, among other things, harm. Respondents were asked to nominate heavy drinkers (people who the respondent considered "fairly heavy drinkers, or who drink a lot sometimes") in different relationships to them. These have been summarised into five relationship types:

- people in the respondent's household
- relatives and intimate partners (not living with the respondent)
- friends
- co-workers
- others (including acquaintances, neighbours, etc.).

When examining harm from 'known problematic drinkers', using exposure to heavy drinkers as a predictor could at first glance seem somewhat tautological, as it is not possible for respondents to be harmed by known problematic drinkers if they have no heavy drinkers in their lives. However, the question of whether a person's drinking had "negatively affected you in some way in the last 12 months" was asked separately from asking the respondent to list by relationship persons whom he/she considered to be someone who is "a fairly heavy drinker, or drinks a lot sometimes," and the fact that heavy drinkers in the respondent's social circle may be an important predictor of harm is an issue that deserves further examination.

Apart from this, the contingent relationship between reporting adverse consequences from others' drinking and having a heavy drinker in one's life is dealt with in a number of ways. First of all, in any regression models predicting harm, the number of heavy drinkers, rather than a dichotomous variable indicating the presence or absence of heavy drinkers, is used. This means that much of the variation in the heavy-drinking variable is not attached to the contingency for harm. Secondly, numbers of heavy drinkers in respondents' social circles are analysed in four categories – household members, relatives and intimate partners, friends and co-workers – reducing multicollinearity. For instance, it is possible for a person to be harmed by a co-worker who is a heavy drinker while having no heavy-drinking friends. Finally, the fifth category of drinkers, 'other heavy drinkers', which includes neighbours, acquaintances and classmates, is not included in these analyses, providing an extra degree of freedom.

As with some of the previously mentioned predictors, there is sometimes interest in both the number of heavy drinkers at either time point and the change in this number over time. Therefore there are two types of predictor variable for each heavy drinker category. The key predictor variables are listed in Box 2.3.

Box 2.3 Heavy drinker predictor variables

PREDICTOR VARIABLE	DESCRIPTION
Household heavy drinkers 2008	The number of household members identified in 2008 as "heavy drinkers or people who drink a lot sometimes."
Non-household relatives and intimate partners heavy drinkers 2008	The number of non-household relatives or intimate partners identified in 2008 as "heavy drinkers or people who drink a lot sometimes."
Friend heavy drinkers 2008	The number of friends identified in 2008 as "heavy drinkers or people who drink a lot sometimes."
Co-worker heavy drinkers 2008	The number of co-workers identified in 2008 as "heavy drinkers or people who drink a lot sometimes."
Total number of heavy drinkers 2008	The combined number of household members, non-household relatives and intimate partners, friends and co-workers in respondents' life identified in 2008 as "heavy drinkers or people who drink a lot sometimes."
Household heavy drinkers difference	The change in the number of household heavy drinkers reported by the respondent between 2008 and 2011 (positive values indicate an increase in household heavy drinkers from 2008 to 2011; negative values indicate a reduction).
Non-household relatives and intimate partners heavy drinkers difference	The change in the number of non-household relatives and intimate partners heavy drinkers reported by the respondent between 2008 and 2011 (positive values indicate an increase in relatives and intimate partners heavy drinkers from 2008 to 2011; negative values indicate a reduction).
Friend heavy drinkers difference	The change in the number of heavy-drinking friends reported by the respondent between 2008 and 2011 (positive values indicate an increase in heavy-drinking friends from 2008 to 2011; negative values indicate a reduction).
Co-worker heavy drinkers difference	The change in the number of co-worker heavy drinkers reported by the respondent between 2008 and 2011 (positive values indicate an increase in co-worker heavy drinkers from 2008 to 2011; negative values indicate a reduction).
Number of heavy drinkers difference	The change in the number of all heavy drinkers reported by the respondent between 2008 and 2011 (positive values indicate an increase in heavy drinkers from 2008 to 2011; negative values indicate a reduction).

2.5.4 HARMS

Finally, when predicting the likelihood of harm from known problematic drinkers or strangers in 2011, an important predictor variable was the existence of the corresponding harm in 2008. This was included so that the focus of the multivariate models could be on the change in the existence of harm over time, taking into account the respondent's status prior to the period studied. This predictor variable is always dichotomous and is derived from the 2008 version of the question asked to gain the outcome variable in 2011. Therefore, a model with an outcome variable of harm from known problematic drinkers in 2011 will include the existence of harm from known problematic drinkers in 2008 as a predictor variable. This approach is discussed in more detail in Section 2.6.

Predictor variables based on a continuous measure of harm from drinkers were used in multivariate models predicting quality of life and wellbeing (Chapter 5). Scores from 2011 were calculated using the respondents' gauge of how much harm they experienced from known problematic drinkers and strangers on a scale of 0-10. However, this question was not asked in 2008, so when scores from both time points are of interest, those who stated they were harmed "a little" by either a stranger or a known problematic drinker were given a score of 3.5 and those who stated they were harmed "a lot" were given a score of 8. The rationale behind this scoring is detailed in Appendix C.

In Chapter 6, a further set of harm predictor variables were used in a multivariate model predicting calls to police about others' drinking. These variables are based on the total number of specific harms respondents reported. In both the 2008 and 2011 surveys, respondents were asked if they had experienced any of 14 specific harms in the previous 12 months from the known problematic drinker whose drinking had been most harmful. For example, the specific harms items included "been emotionally hurt or neglected because of their drinking" and "stopped seeing them because of their drinking."

In addition, all respondents, regardless of whether they had been harmed by a known problematic drinker, were asked if they had experienced any of 14 specific harms in the past 12 months from strangers' drinking, including items such as "been involved in a traffic accident because of someone's drinking" and "felt unsafe in a public place because of strangers' drinking."

Within the multivariate models, the predictor variables are based on the totals reported in 2008, as well as the change in the number of specific harms experienced from known problematic drinkers' and strangers' drinking from 2008 to 2011.

The various harm predictor variables used in the multivariate analyses are shown in Box 2.4.

Box 2.4 Harm predictor variables

PREDICTOR VARIABLE	DESCRIPTION
Harm from known problematic drinkers in 2008	This dichotomous variable is a measure of the existence of harm from known problematic drinkers in 2008. When using harm from known problematic drinkers in 2011 as an outcome variable, the existence of harm from known problematic drinkers in 2008 will be used as a predictor variable.
Harm from strangers in 2008	This dichotomous variable is a measure of the existence of harm from strangers' drinking in 2008. For instance, when using harm from a stranger in 2011 as an outcome variable, the existence of harm from a stranger in 2008 will be used as a predictor variable.
Any harm in 2008	This dichotomous variable is a measure of the existence of harm from the drinking of either known problematic drinkers or strangers in 2008. For instance, when using any harm in 2011 as an outcome variable, the existence of any harm in 2008 will be used as a predictor variable.
Known problematic drinkers harm score	The amount of harm the respondent reported from a known problematic drinker (for 2008 responses, "a lot" = a score of 8; a little = a score of 3.5; none = a score of 0).
Stranger harm score	The amount of harm the respondent reported from strangers' drinking (for 2008 responses, "a lot" = a score of 8; a little = a score of 3.5; none = a score of 0).
Known problematic drinkers harm score difference	The difference between the amount of harm respondents report from known problematic drinkers they knew in 2011 and 2008.
Stranger harm score difference	The difference between the amount of harm respondents report from strangers' drinking in 2011 and 2008.
Called police in 2008	This dichotomous variable is a measure whether the respondents called the police because of others' drinking in 2008.
Number of known problematic drinker harms in 2008	The number of specific harms from a known problematic drinkers' drinking (from a list of 14 harm questions) reported by the respondent in 2008.
Number of known problematic drinker harms difference	The change in the number of harms from a known problematic drinker's drinking reported by the respondent between 2008 and 2011 (positive values indicate an increase in number of harms from 2008 to 2011; negative values indicate a reduction).
Number of stranger harms in 2008	The number of specific harms from strangers' drinking (from a list of 14 harm questions) reported by the respondent in 2008.
Number of stranger harms difference	The change in the number of harms from strangers' drinking reported by the respondent between 2008 and 2011 (positive values indicate an increase in number of harms from 2008 to 2011; negative values indicate a reduction).

2.6 DATA ANALYSIS

Analyses in this study are based on the 1,106 Australian adults who participated in both the first and second waves of the HTO Surveys. While there were 2,645 respondents in the 2008 survey, only the 1,106 who also completed the 2011 survey were used in the analyses for this report (including analyses of only the 2008 data). This enables comparisons between responses at the two time points.

All data analysis was conducted with Stata version 12. Throughout the report, simple descriptive statistics have been used, e.g. percentages, means and confidence intervals. Where tests of statistical difference between the 2008 and 2011 surveys have been examined, Chi-square tests have been used for categorical data, and t-tests and Pearson's r correlation coefficients for continuous data. The primary method of analysis in this report is logistic regression. As noted in the section outlining commonly-used outcome variables, many of these are dichotomous (e.g. a respondent either was or was not harmed), with the models providing a way to compare these two groups. In a few cases the outcome variable is continuous, rather than dichotomous, such as the continuous any harm score and PWI. In these instances multiple linear regression models were developed instead.

Where not otherwise noted, analyses are conducted on the entire 2011 sample. However, where a specific question could be better answered by removing some of the sample, then a limited sample is used. Examples of this include analysis of whether respondents report the use of services, or where a particular form of change over time is being examined. For instance, where initiation of harm is examined in Chapter 4, Section 4.3, the sample is made up of those who were not harmed in 2008, with the aim of the analysis to predict who among them went on to be harmed in 2011.

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 '2008 HTO Survey respondents participated in the 2011 HTO Survey (Yes; No)' (see Table 2.1), a '1' is shown before the text '(Ref)', and the '1' denotes the reference value in logistic regression models, however, if the outcome variable is continuous (e.g., Health-Related Quality of Life (HRQoL) score (see Table 5.2), the reference value is '0' in linear regression models. For ease of reading, a zero is not included before the text (Ref).

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.

The use of 'Ref' to notate the reference category (and reference number) is a standard reporting practice.

In Chapter 4, more conventional longitudinal models including the whole sample are used, examining the prediction of harm in 2011 based on a range of variables collected in 2008, as well as the existence of the same type of harm in that year. The strength of including harm in 2008 as a predictor of harm in 2011 is that it allows assessment of what would predict an increase (or decrease) in the likelihood of harm. Coupled with the difference scores for the number of heavy drinkers in respondents lives and the respondent's own drinking, it is possible to assess what changes in a respondent's life predict an increased likelihood of harm.

The use of an earlier measure of an outcome variable in a regression model is sometimes thought to be inappropriate, especially in tightly-controlled experimental research. However, as discussed in Section 2.1, change scores are not appropriate outcome variables when it is believed that the outcome at time point 1 will affect the outcome at time point 2 (Allison 1990). As will be shown in Chapter 4, those who reported experiencing harm in the 2008 HTO Survey (time point 1) are more likely to experience it again in 2011 (time point 2). Accordingly, the use of the existence versus absence of harm in 2008 as a predictor variable, in an analysis predicting harm in 2011, is an appropriate method for examining predictors of change in the existence of harm over time.

3 ALCOHOL'S HARM TO OTHERS REPORTED IN 2011 AND 2008: SIMILARITIES AND DIFFERENCES

KEY POINTS

- One in four respondents (24 per cent) reported that they had been adversely affected by the heavy drinking of household and non-household family members, relatives and intimate partners, co-workers, friends and others they knew in 2011. A third of respondents reported that they had been negatively affected by strangers' drinking. In total, 44 per cent of respondents reported having been negatively affected by others' drinking in 2011.
- In 2011, men were more likely to report the presence of heavy-drinking friends and co-workers than women. Women were more likely than men to report the presence of heavy-drinking family, partners and household members and harm from these drinkers.
- In 2011, younger age was significantly associated both with the presence and average number of reported heavy drinkers in respondents' lives and with harm.
- Examining the distributions of heavy drinkers in respondents' lives and harms to respondents by relationships, age and gender, the 2011 HTO Survey data highlight significant patterns not previously explored. In particular, the number of heavy drinkers in a respondent's life emerged as a strong predictor of harm from others' drinking in 2011.
- There was a significant but small decrease in the percentage of respondents in the sample reporting harm from others' drinking between 2008 and 2011. The decrease predominantly relates to harm from drinkers in more distal relationships (e.g. friend, stranger) to the respondent, and is partly explained by respondents' increased age. There was also a strong relationship between decreasing numbers of heavy drinkers in respondents' lives and increasing age.

This chapter presents the 2011 HTO Survey data, but only briefly, as the most valuable contribution the 2011 data make is by way of comparison with the 2008 HTO Survey.

The research questions addressed in this chapter are:

1. What percentage of respondents in the 2011 follow-up sample were affected by others' drinking?
2. How did the 2011 HTO Survey findings compare with those of the 2008 HTO Survey?

3.1 THE 2011 HTO SURVEY

A total of 1,106 respondents completed the 2011 HTO Survey. One in four respondents (24 per cent) reported that they had been adversely affected by the heavy drinking of family members, others in their household, non-household relatives, intimate partners, co-workers, friends or others they knew (e.g. neighbours, teachers, classmates) in the previous 12 months. A third of respondents reported that they had been negatively affected by strangers' drinking. Counting the adverse effects from any person's drinking (i.e. strangers or known problematic drinkers in the respondent's social circle), 44 per cent of respondents reported having been negatively affected in 2011. Other descriptive results for 2011 are presented in comparison to the 2008 survey data.

In the 2008 and 2011 HTO Surveys, respondents were asked a series of questions on concrete adverse effects from the known problematic drinker whose drinking had been most harmful. In 2011, the most common harms from the most harmful known problematic drinker reported by respondents were being "emotionally hurt or neglected" (62.1 per cent), that the problematic drinker "negatively affected a social occasion" (58.5 per cent), and having a "serious argument (excluding physical violence)" (51.3 per cent). The same three adverse effects were also the most common harms reported in 2008 (see Table 3.1).

Table 3.1 Specific harms from the known problematic drinker who had most negatively affected the respondent in the previous 12 months by gender, 2008 and 2011

VARIABLE	MALE (%)		FEMALE (%)		TOTAL (%)	
(N)	2008 (115)	2011 (94)	2008 (212)	2011 (170)	2008 (328)	2011 (265)
Emotionally hurt or neglected	44.7	56.4	64.3	65.1	57.1	62.1
Negatively affected at a social occasion	60.0	62.8	67.5	55.9	64.9	58.5
Drinker failed to do something they were being counted on to do	62.0	56.4	55.3	48.5	57.5	51.5
Serious argument (excluding physical violence)	53.9	53.2	51.2	50.6	52.0	51.3
Stopped seeing them	33.0	35.5	33.2	31.0	33.3	32.4
Felt threatened	30.4	26.6	21.0	21.2	24.2	23.0
Drinker broke or damaged something that mattered	15.2	11.7	13.3	11.7	14.0	11.7
Physically hurt	5.3	7.5	4.3	3.5	4.6	4.9
At risk in a car when they were driving	4.3	4.7	5.3	7.5	5.8	4.9
Forced or pressured into sex	2.6	2.1	0.5	0.6	1.2	1.1

The denominators are the numbers of respondents who reported harm from a known problematic drinker at that time point

Respondents were also asked a series of questions about concrete adverse effects from the drinking of strangers. As in 2008, the three most common harms from strangers' drinking reported by respondents in 2011 were "kept awake and disturbed at night" (35.6 per cent), "avoided drunk people or places where drinkers are known to hang out" (33.5 per cent), and "annoyed by vomit, urination or littering" (24.1 per cent) (see Table 3.2).

Table 3.2 Specific harms from strangers' drinking reported in the previous 12 months by gender, 2008 and 2011

VARIABLE	MALE (%)		FEMALE (%)		TOTAL (%)	
(N)	2008 (458)	2011 (458)	2008 (645)	2011 (645)	2008 (1,106)	2011 (1,106)
Kept awake and disturbed at night	36.5	34.1	39.7	36.7	38.3	35.6
Avoided drunk people or places where drinkers are known to hang out	43.9	34.3	39.7	32.8	41.5	33.5
Annoyed by vomit, urination or littering	23.3	24.1	23.4	19.4	23.4	21.4
Felt unsafe in public place	21.1	16.2	23.0	18.2	22.1	17.3
Experienced troubles or noise related to licensed venue	20.4	15.3	16.2	15.6	18.0	15.4
Verbally abused	19.7	16.7	13.0	11.2	15.8	13.4
Threatened	12.5	11.1	6.8	4.8	9.1	7.4
Involved in a serious argument	11.6	9.4	7.4	4.7	9.2	6.6
Physically abused	3.7	1.5	2.2	1.2	2.8	1.4
Involved in a traffic accident	1.1	0.2	0.8	0.2	0.9	0.2
Forced or pressured into sexual activity	0.4	0.4	0.2	0.0	0.3	0.2

The denominator is the total sample who completed the 2008 and 2011 surveys.

3.2 NEGATIVE EFFECTS IN DIFFERENT RELATIONSHIP CATEGORIES AND CUMULATIVELY, 2008 AND 2011

Table 3.3 shows, for each gender and for all 1,106 respondents who completed the HTO Survey in both years, the percentages of respondents who report in 2008 and 2011 being negatively affected in the previous year by others' drinking, including that of known problematic drinkers and strangers. The table proceeds cumulatively outwards from the household, adding in the effects of non-household relatives and intimate partners, then friends and co-workers. Lastly, effects on the respondent of the drinking of strangers and others not well-known to the respondent are added in, to tally all harms from others experienced by the respondent in the last 12 months. It should be noted that the denominator for these percentages is all respondents in the sample; those who do not report being adversely affected by a co-worker in the last 12 months, for instance, include those who had been unemployed in that period and thus did not have co-workers.

3.2.1 NEGATIVE EFFECTS DUE TO KNOWN PROBLEMATIC DRINKERS' DRINKING

Similar percentages of respondents reported having heavy drinkers in their family or household who had negatively affected them in 2011 as had reported this in 2008 (18 per cent versus 17 per cent). Female respondents were generally more likely than males to report harm from household members, as was the case in 2008. A similar proportion of respondents (15 per cent versus 13 per cent) reported that the drinking of relatives or girlfriends, boyfriends and ex-partners who do not live in the household had negatively affected them. Again in 2011, as in 2008, women (15 per cent) reported this significantly more often than men (10 per cent). Pooling responses concerning household members and non-household relatives and intimate partners, 17 per cent of the sample reported the drinking of at least one person in these categories had negatively affected them in the last year. The results were very similar in the sample at the two points in time (18 per cent versus 17 per cent).

Ten and eight per cent of respondents in 2008 and 2011 respectively, reported that a friend's drinking negatively affected them, with men and women equally likely to report this in 2011. Men were slightly more likely than women to report that a co-worker's drinking had negatively affected them, with slightly fewer respondents overall reporting this in 2011. Combining the co-worker and friend categories with a residual 'other' category, a significantly smaller percentage of respondents reported harm from this group in 2011 than in 2008 (13 per cent versus 17 per cent).

Pooling responses for all relationship types, around one-quarter (24 per cent) of respondents reported being negatively affected by the drinking of someone in these categories (i.e. known problematic drinkers) in 2011. This was significantly less than in 2008 (29 per cent versus 24 per cent). The reduction in percentages of respondents affected by the drinking of known problematic drinkers between 2008 and 2011 was significant for women (33 per cent versus 27 per cent) but not men (25 per cent versus 20 per cent).

Table 3.3 Percentage of respondents harmed by the drinking of those in different relationships in 2008 and 2011

VARIABLE	MALE (%)		FEMALE (%)		TOTAL (%)	
(N)	2008 (458)	2011 (458)	2008 (645)	2011 (645)	2008 (1,103)	2011 (1,103)
Negatively affected by						
Household (HH) member	3.3	4.2	7.3	6.5	5.6	5.5
Relatives and intimate partners (non- HH)	10.5	9.6	17.4	15.0	14.5	12.8
Household member, or non-HH relative or intimate partner (pooled)	12.9	12.2	22.3	19.5	18.4	16.6
Friend	11.1	9.4	8.7	7.6	9.8	8.3
Co-worker	6.8	4.2	4.0	3.4	5.2	3.7
Friend, co-worker or other[a]	17.0	12.9	16.1	12.7	16.6	12.8*
Negatively affected by any of the above (problematic drinkers)	24.6	20.2	32.8	26.5*	29.4	24.0**
Negatively affected by strangers	38.0	31.4*	35.9	33.2	36.7	32.5*
Respondent negatively affected by any others' drinking	47.2	39.7*	52.6	47.1	50.3	44.1**

Differences in percentages of reported total harms between the 2008 and 2011 surveys are tested for significance with Chi-square tests: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

[a] This category includes other heavy drinkers that do not fit in the listed categories.

3.2.2 NEGATIVE EFFECTS DUE TO STRANGERS' DRINKING

As in the 2008 HTO Survey (Laslett et al. 2010), much higher proportions of respondents reported being negatively affected in the last year by the drinking of a stranger than by someone they knew. In 2011, a total of 33 per cent (compared with 37 per cent in 2008) reported that they had been negatively affected by strangers' drinking. Although men and women were similarly likely to have been troubled by strangers' drinking in 2011 (33 per cent versus 31 per cent), the decrease between the two time points was significant for men but not for women (Table 3.3).

3.2.3 NEGATIVE EFFECTS DUE TO ANY OTHER PERSON'S DRINKING

Counting the adverse effects from any person's drinking (i.e. strangers or known problematic drinkers), 44 per cent of respondents in 2011 and 50 per cent in 2008 reported having been negatively affected. This reduction in reported harms from others' drinking was significant in the overall sample, and significant for men but not for women when analysed by gender.

These findings suggest that the prevalence of alcohol-related harm from others' drinking has significantly but moderately decreased in the sample between 2008 and 2011, with the decline concentrated primarily in the more distal relationships.

3.3 HEAVY DRINKERS IN RESPONDENTS' LIVES

In 2011, each respondent identified 2.75 heavy drinkers (on average) in their life, compared with 3.33 heavy drinkers (on average) in 2008. These heavy drinkers, in various relationships with the respondent, comprise the respondent's social context of heavy drinkers.

Table 3.4 presents the percentages of respondents with heavy drinkers in their lives in 2008 and 2011 by gender, and the mean number of these drinkers in each relationship category per respondent (including in the denominator those with no heavy drinkers in that relationship category). In 2011, respondents were most likely to report the presence of heavy-drinking friends (34 per cent) and non-household relatives and intimate partners (29 per cent), reporting on average 1.44 and 0.40 heavy drinkers in these categories respectively. Respondents reported slightly higher figures for heavy-drinking friends (37 per cent; average 1.52) and non-household relatives and intimate partners (34 per cent; average 0.51) in 2008 than 2011.

In both years, women were more likely to report the presence of heavy-drinking household members as well as non-household relatives and intimate partners, while men were more likely to report the presence of heavy-drinking friends and co-workers. Overall, men reported significantly more heavy drinkers in their lives than women did.

Table 3.4 Percentage of respondents reporting, and average numbers of, heavy drinkers (HD) in each relationship category by gender in 2008 and 2011

VARIABLE	MALE (%)		FEMALE (%)		TOTAL (%)	
(N)	2008 (458)	2011 (458)	2008 (645)	2011 (645)	2008 (1,106)	2011 (1,106)
Heavy Drinker (HD) in household (HH)[a]	8.08	9.4	17.05	12.6	13.3***	11.2
Average no. HH HDs	*0.10*	*0.10*	*0.19*	*0.14*	*0.15****	*0.12*
HD among non-HH relatives and intimate partners (R+I)	28.6	24.2	37.5	31.6	33.8**	28.6**
Average no. R+I HDs	*0.40*	*0.35*	*0.58*	*0.44*	*0.51****	*0.40**
HD in HH and/or non-HH R+I	32.3	29.9	46.4	38.6	40.5***	35.0**
Average no. HH and R+I HDs	*0.50*	*0.45*	*0.77*	*0.58*	*0.66****	*0.52**
HD among friends	45.0	39.7	32.1	30.4	37.4***	34.3***
Average no. friends HDs	*2.22*	*1.86*	*1.02*	*1.15*	*1.52****	*1.44***
HD among co-workers	24.9	18.6	11.9	11.3	17.3***	1.4
Average no. co-worker HDs	*1.84*	*0.96*	*0.38*	*0.45*	*0.99****	*0.66**
HD in 'other'[b] category	14.0	9.4	14.7	11.8	14.4	10.8
Average no. 'other' HDs	*0.16*	*0.10*	*0.16*	*0.13*	*0.16*	*0.12*
Any known HD within social circle	**70.7**	**62.5**	**67.3**	**60.3**	**68.7**	**61.2**
Average no. HD overall	**4.72**	**3.37**	**2.34**	**2.31**	**3.33*****	**2.75****

HD = heavy drinker, someone who is "a fairly heavy drinker, or drinks a lot sometimes." Average numbers of heavy drinkers are calculated on a base of all respondents.

HH = household; non-HH= non-household; R+I = relatives and intimate partners.

Difference by gender in 'any HD' percentages tested for significance with Chi-square (X2) tests; difference by gender in 'average no. HDs' tested by t-test. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

[a] Household members include partner, son or daughter, parent, sibling, and non-family household members.

[b] Other relationship includes neighbours and others not defined.

Table 3.5 presents percentages of respondents who had heavy drinkers of various relationship types in their lives by age group, as well as the average number of heavy drinkers in the relationship category. In 2011 in every relationship grouping, with two exceptions (any heavy drinkers in the household and those in the "other heavy drinker" category), age was significantly inversely associated with both the presence of drinkers and the average number of reported drinkers in respondents' lives. The relationship between age and presence and number of heavy drinkers was strongest for friends, but also apparent for co-workers and non-household relatives and intimate partners. The youngest age group was most likely to report the existence of any heavy drinkers in their social circle, and to have the highest average number of heavy drinkers. Compared to older respondents, the middle-aged group also had higher percentages of heavy drinkers in their lives and reported higher average numbers of drinkers in their lives.

Table 3.5 The percentage of respondents who reported a heavy drinker for each relationship category, and average number of heavy drinkers reported for each relationship category in 2008 and 2011, by age group

VARIABLE	18-35 YEARS (%)		36-55 YEARS (%)		56+ YEARS (%)	
(N)	2008 (119)	2011 (119)	2008 (474)	2011 (474)	2008 (513)	2011 (513)
HD in household (HH)[a]	15.6	16.0	16.0	12.0	9.3**	9.4
Average no. HH HDs	*0.16*	*0.19*	*0.19*	*0.14*	*0.11***	*0.10**
HD among non-HH relatives and intimate partners (R+I)	41.9	31.1	36.0	32.1	28.4**	24.7*
Average no. R+I HDs	*0.63*	*0.43*	*0.56*	*0.46*	*0.40***	*0.33**
HD in HH and/or non-HH R+I	47.5	39.5	43.1	37.8	35.0**	31.3*
Average no. HH and R+I HDs	*0.79*	*0.61*	*0.75*	*0.60*	*0.50****	*0.43***
HD among friends	50.0	45.4	40.0	39.3	30.2***	27.0***
Average no. friends HDs	*2.43*	*2.77*	*1.45*	*1.68*	*1.28**	*0.91****
HD among co-workers	20.6	20.2	24.1	21.9	8.2***	5.9**
Average no. co-worker HDs	*0.98*	*1.17*	*1.32*	*1.13*	*0.59*	*0.10****
HD in 'other'[b] category	15.0	6.7	17.4	12.0	10.9*	10.5
Average no. 'other' HDs	*0.18*	*0.08*	*1.98*	*0.14*	*0.12**	*0.11*
Any known HD within social circle	**78.8**	**72.3**	**75.3**	**67.9**	**57.7*****	**52.2*****
Average no. HD overall	**4.37**	**4.62**	**3.72**	**3.55**	**2.49***	**1.56*****

HD = heavy drinker, someone who is "a fairly heavy drinker, or drinks a lot sometimes." Average numbers of heavy drinkers are calculated on a base of all respondents.

HH = household; non-HH= non-household; R+I = relatives and intimate partners.

Difference by gender in 'any HD' percentages tested for significance with Chi-square (X2) tests; difference by gender in 'average no. HDs' tested by t-test. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

[a] Household members include partner, son or daughter, parent, sibling, and non-family household members.

[b] Other relationship includes neighbours and others not defined.

3.4 CAN AGE EXPLAIN SOME OF THE DECREASE IN HARM AND NUMBER OF HEAVY DRINKERS?

Given that the respondents had aged an average of three years between interviews, and that younger adults are considerably more likely than older people to have been harmed by others' drinking, age was explored as a possible reason behind some of the difference in the overall findings in 2008 and 2011.

In the attrition analysis (Section 2.2) it was noted that younger respondents were less likely to complete the 2011 HTO Survey than older respondents. In response to these findings, a regression analysis was conducted on the 2008 HTO data to ascertain what proportion of the decrease in harm between the two time points could be attributed to age. For this analysis, the outcome variable was a total harm score, where being harmed "a little" by the drinking of known problematic drinkers or strangers was given a score of 3.5, while anyone experiencing "a lot" of harm in either of these three fields was given a score of 8 (see Appendix C). Finally, those who experienced no harm in either of these three fields received a score of 0. As such, each respondent received a harm score between 0 and 16. While the vast majority of the analyses in this study only includes those who participated in both waves, when the full 2008 sample was re-examined, the mean harm score was 2.88 and in the re-interviewed sample in 2011 it was 2.37.

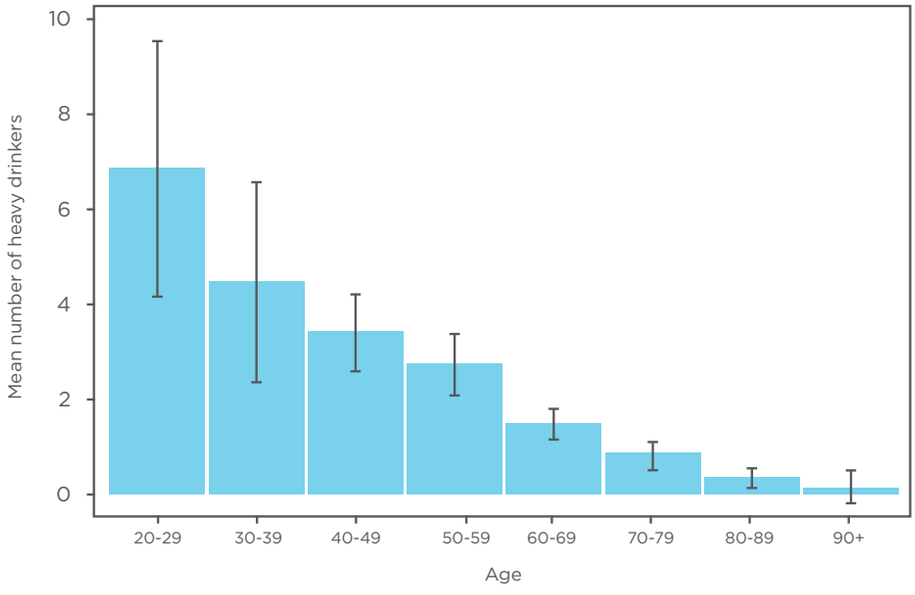
A regression analysis with this harm score as the outcome variable, and with age as the only predictor variable, was calculated on the full 2008 sample in order to ascertain how much respondents' harm scores would be expected to drop per year as they age. On this basis, a person's overall harm score would be expected to drop approximately 0.053 for each year he/she aged, and therefore a respondent's score would be expected to drop 0.16 over the three years between the two surveys. As this drop of 0.16 points is 26.8 per cent of the 0.59 overall drop in harm score in the sample, it could be said that about a quarter of the drop in harm between the two time points could be attributed to the aging of the sample.

3.4.1 AGE AND HEAVY DRINKERS

Given the findings about heavy drinkers and the loss of younger respondents from the sample described in Chapter 2, the relationship between the number of heavy drinkers in respondents' lives and age was also examined.

As can be seen in Figure 3.1, the mean number of heavy drinkers in the lives of respondents steadily dropped as age increased, as the negative correlation between the two would suggest ($r(1105) = -0.217$, $p < .001$). The interaction of exposure to heavy drinkers in respondents' social circles and age will be discussed throughout this report.

Figure 3.1 Mean number of heavy drinkers in the respondents' social circles by age group (2011 respondents, confidence intervals indicated by bars)



3.5 CORRELATES OF EXPOSURE TO HEAVY DRINKERS AND HARM

The next section focuses on the social drinking context of respondents, age, gender and their relationship with harm. Using the 2011 cross-sectional data only, a preliminary analysis was undertaken to determine whether age, gender and the number of drinkers in respondents' lives (and the relationships of these drinkers to the respondent) were potential factors in explaining the harm experienced from others' drinking.

3.5.1 HARM FROM HEAVY DRINKERS AMONG FAMILY AND FRIENDS

As Table 3.6 shows, women were significantly more likely than men to report being harmed by the drinking of family (household members and non-household relatives and intimate partners) or friends in 2011, and younger respondents were significantly more likely than older to report harm from others. These results are consistent with the analysis of the 2008 HTO Survey (Laslett et al. 2011). Harm from known problematic drinkers' alcohol consumption in 2011 was predicted by the number of heavy drinkers who were household members, non-household relatives and intimate partners and friends reported by respondents.

3.5.2 HARM FROM STRANGERS' DRINKING

In terms of those respondents who reported harm from strangers' drinking, bivariate results in Table 3.6 indicate that younger respondents were significantly more likely to report this than older respondents, and there were no significant differences by gender. When the numbers of heavy drinkers in the respondent's life were examined, higher numbers of heavy drinkers among friends, co-workers and non-household relatives and intimate partners significantly predicted harm in 2011. Of all the relationship categories analysed, only the number of heavy-drinking household members was not significantly associated with harm from strangers' drinking.

Table 3.6 Bivariate prediction of harm from drinkers in 2011		
VARIABLE	**KNOWN PROBLEMATIC DRINKERS**	**STRANGERS**
Gender		
Male	1(Ref)	1(Ref)
Female	1.40*	1.09
Age		
18-35	1(Ref)	1(Ref)
36-55	0.93	0.94
56 and over	0.57*	0.49***
Heavy drinkers among:		
Household members	5.55***	1.35
Relatives and intimate partners[a]	3.50***	1.41***
Friends	1.13***	1.12***
Co-worker	1.02	1.05*

$p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

N = 1,096

[a] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent

3.6 CONCLUSION

Almost half of the respondents in the 2011 HTO Survey experienced harm from others' drinking, and similar demographic predictors were identified to those found in the 2008 HTO Study. A modest but significantly smaller percentage of respondents experienced harm from others' drinking in 2011 compared with 2008. This was partly explained by an increase in age of the respondents and is, in considerable part, specific to a decrease in harms from drinkers in more distal relationships to the respondent.

In the 2008 HTO Survey, the existence and correlates of the pools of heavy drinkers in respondents' social circles were not investigated in any detail. However, the impact of heavy drinkers in a respondent's social circle clearly emerged when examined in analyses of the 2011 data. Hence, in future chapters, the numbers of heavy drinkers in respondents' lives and the extent to which they predict the occurrence of, and changes in, harm are systematically considered.

4 CONTINUITY AND CHANGE IN ALCOHOL'S HARM TO OTHERS

KEY FINDINGS

- Almost a third of respondents were harmed by others' drinking in both 2008 and 2011 (32 per cent), although 38 per cent were not harmed in either year. However, this apparent stability masks substantial turnover in harms from others' drinking, amounting to around 30 per cent of the sample.
- Sixty-two per cent of respondents reported they had experienced some harm from others' drinking in at least one of the surveys.
- The strongest predictor of harm from others' drinking in 2011 was having experienced harm from others' drinking in 2008.
- The number of, and increases in the number of, heavy drinkers among respondents' household members were significant predictors of harm from known problematic drinkers.
- Contact with heavy-drinking friends was a strong predictor of harm from strangers' drinking.
- Demographic characteristics do not strongly predict experiencing harm in 2011, once harm in 2008 is controlled.
- Changes in the level of harm from others' drinking are fairly evenly spread across the population, and are not limited to small and marginalised sections of the community.
- Having more heavy drinkers within the household and among non-household relatives and intimate partners was associated with the initiation of harm from the drinking of known problematic drinkers, typically family members or friends.
- Respondents with fewer heavy-drinking household members, relatives and intimate partners were significantly more likely to cease being harmed from the drinking of known problematic drinkers between 2008 and 2011.
- Respondents' socio-economic characteristics and risky drinking patterns had little bearing on harms arising or subsiding due to the problematic drinking of a family member or friend, suggesting that this type of harm is dispersed throughout the demographic and social groups within the sample.
- Being younger, having more heavy-drinking co-workers in 2008, and an increase in the number of heavy drinking co-workers from 2008 to 2011 were associated with the initiation of harm from strangers in 2011.
- Respondents who frequently drank at risky levels in 2008 were more likely to cease being harmed from strangers' drinking, as were respondents with less exposure to heavy-drinking friends and relatives and intimate partners in that year.
- Respondents who experienced persistent harm (i.e. harm in both 2008 and 2011) from known problematic drinkers had more heavy drinkers in their household, and more heavy-drinking non-household relatives and intimate partners in 2008, compared with respondents who reported no harm in either year.
- For each additional heavy drinker in their household, respondents were almost six times more likely to experience persistence of harm from known problematic drinkers.
- Younger age and a higher number of heavy-drinking relatives and intimate partners were positive predictors of persistent harm from strangers' drinking, as was the number of heavy-drinking co-workers in 2008.

This chapter focuses on stability and change in alcohol's harm to others: that is, for what proportion of the sample does their experience of harm from others' drinking remain stable, improve or worsen? The analyses focus on those harmed in neither survey, both surveys and those whose situation changed (i.e. they were harmed in 2008 but then not in 2011 or, conversely, they were harmed in 2011 but not 2008). In both years, respondents were asked about harm from others' drinking in the previous 12 months, so the data relate to two separate periods of 12 months, with no information specifically on the two interim years.

The research questions examined in this chapter are:

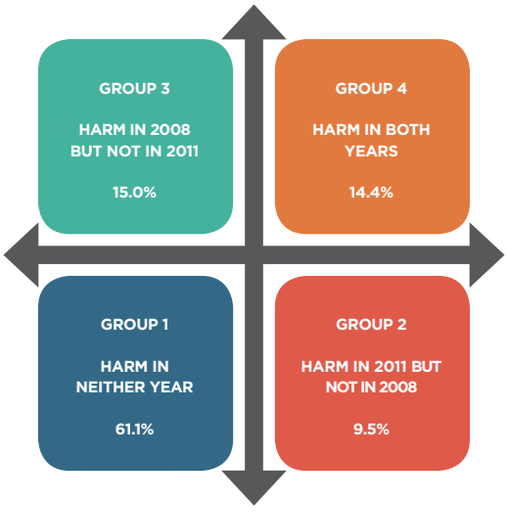
3. Does the respondent's status in 2008, or changes in the respondent's circumstances from 2008 to 2011, predict harm from others' drinking in 2011? (Section 4.1)
4. What factors predict harm from others' drinking in 2011? (Section 4.2)
5. What predicts who is newly harmed among those who were not previously? (Section 4.3)
6. Among those harmed in 2008, what predicts who will not be harmed again in 2011? (Section 4.4)
7. What factors predict persistent harm from others' drinking, in comparison to persistent absence of such harm? (Section 4.5)

4.1 PREVALENCE OF CONTINUITY AND CHANGE IN HARM FROM OTHERS' DRINKING

4.1.1 HARM FROM KNOWN PROBLEMATIC DRINKERS

Respondents were asked to identify heavy drinkers in their social circle (i.e. household members, non-household relatives and intimate partners, friends and work colleagues) and then asked whether these people had negatively affected them (i.e. caused harm) in the last 12 months. Analysing the data from the 1,106 respondents who completed the HTO Surveys in both 2008 and 2011, the majority (61 per cent) of the sample did not report knowing a heavy drinker whose drinking had an adverse effect on them in the past 12 months in either year. Twenty-five per cent of respondents reported knowing a heavy drinker whose drinking adversely affected them (i.e. known problematic drinker) in one of the survey years (with 15 per cent reporting a known problematic drinker in 2008 and not in 2011, and ten per cent of respondents identifying a known problematic drinker in 2011 but not in 2008). A significant minority of respondents, 14 per cent, identified a known problematic drinker at both points in time (See Figure 4.1).

Figure 4.1 Proportion of respondents experiencing harm from known problematic drinkers in 2008 and 2011 (N = 1,106)

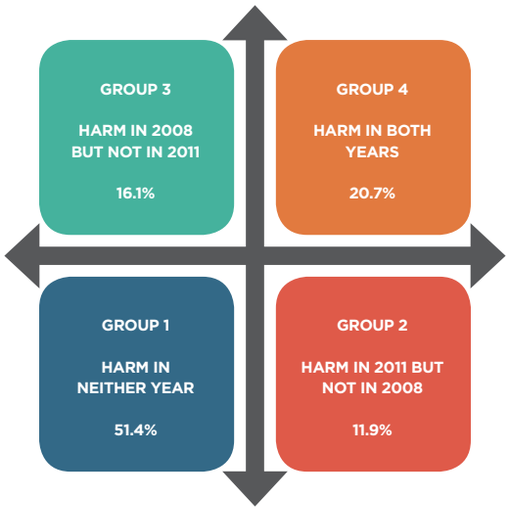


Thus, for the majority (76 per cent) of participants in the survey, presence or absence of harm from known problematic drinkers did not change. For the remaining one-quarter of participants there was change, more often for the better rather than for the worse.

4.1.2 HARM FROM STRANGERS

Harm from strangers' drinking was more widely reported than harm from problematic drinkers the respondent knew. As can be seen in Figure 4.2, 51 per cent of respondents experienced harm in neither year from strangers' drinking, while 21 per cent did so in both years. Again for the majority of respondents (72 per cent), their experience of harms from strangers' drinking remained stable. A total of 28 per cent of respondents reported changes in their situation, with a larger percentage (16 per cent) experiencing respite from harm than the 12 per cent who experienced harm in 2011 when they had not reported this previously.

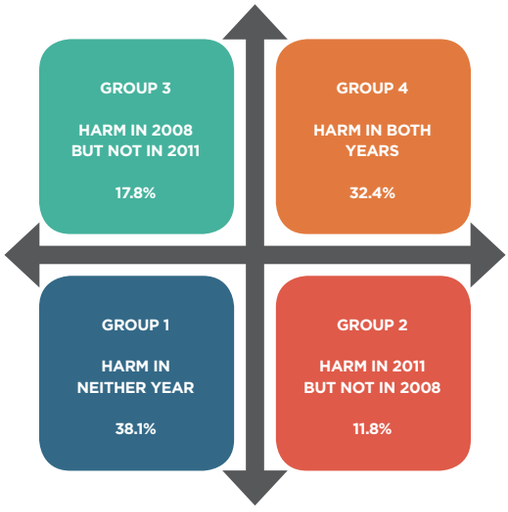
Figure 4.2 Proportion of respondents experiencing harms from strangers' drinking in 2008 and 2011 (N = 1,104)



4.1.3 ANY HARM

Examining whether respondents were harmed in any way by known problematic drinkers' and/or strangers' drinking in the 2008 and 2011 HTO Surveys, it is apparent that a much smaller percentage of the sample avoided harm altogether in the two time periods than in the separate analyses of harm from known problematic drinkers and strangers. Only 38 per cent of respondents were harmed in neither year; the majority were harmed at one or both time points (62 per cent). As can be seen in Figure 4.3, for the majority of respondents (71 per cent) their experience of harm from others' drinking remained stable. When harms from known problematic drinkers and strangers are considered together, the percentage of respondents who experienced harm in both years (32 per cent) begins to approach the level of the group that was harmed in neither year (38 per cent). A total of 30 per cent of respondents reported changes in their situation, and again, a larger percentage reported experiencing respite from harm than those who newly reported experiencing harm in 2011 (18 per cent versus 12 per cent).

Figure 4.3 Proportion of respondents experiencing any harm from known problematic drinkers and/or strangers' drinking in 2008 and 2011 (N = 1,104)



Another way of considering these questions is to ask, what are the chances of being harmed again if you were harmed by others' drinking at the first time point? Answers from this analysis are highlighted in Box 4.1.

Box 4.1 Changing patterns of harm

WHAT ARE THE CHANCES OF BEING HARMED...

by someone you know?

Nearly half (49 per cent) of the 324 respondents who were harmed by known problematic drinkers in 2008 were again harmed by known problematic drinkers in 2011.

Conversely, of the 778 respondents not harmed by known problematic drinkers in 2008, around 14 per cent were harmed by known problematic drinkers in 2011.

by strangers?

A total of 56 per cent of the 406 respondents who were harmed by the drinking of strangers in 2008 reported being harmed by strangers' drinking again in 2011.

Nineteen per cent of the 698 respondents who did not experience harm from strangers' drinking in 2008 reported being harmed by strangers' drinking in 2011.

by anyone?

For the 553 respondents who experienced any harm from other people's drinking in 2008, 65 per cent of them were harmed again by another's drinking in 2011.

Of the 550 respondents who were not harmed by other's drinking in 2008, 24 per cent reported being harmed by someone else's drinking in 2011.

4.2 PREDICTORS OF ALCOHOL'S HARM TO OTHERS OVER TIME

This section examines changes in overall harm, including both changes up and changes down, in a common analysis; that is, taking into account initiation and discontinuation of alcohol-related harm from others in the time span between the 2008 and the 2011 HTO Surveys. The aim of this analysis is to examine whether a respondent's status in 2008, or changes in his/her circumstances between 2008 and 2011, can predict harm in 2011. Thus, by adjusting for baseline sample characteristics including the harm respondents experienced in 2008, and including individual changes in the respondent's drinking networks, the predictors of changes in harm from others' drinking over time are examined.

4.2.1 HARM FROM KNOWN PROBLEMATIC DRINKERS

In 2011, 266 respondents reported harm from known problematic drinkers, while 840 did not. Bivariate and multivariate logistic regression models outlining the differences between these two groups are shown in Table 4.1. As can be seen in the bivariate models, those who reported harm from known problematic drinkers in 2008 were six times more likely to report this again in 2011 than those who did not. Women were more likely to report such harm, and those aged 56 and over were less likely than those in the youngest age group. The number of heavy drinkers in all four relationship categories (i.e. household members, non-household relatives and intimate partners, co-workers, friends) in 2008 was a significant positive predictor of harm in 2011, as was an increase from 2008 to 2011 in heavy drinkers among non-household relatives and intimate partners and friends.

In Model 1, controlling for 2008 harm from known problematic drinkers and examining the strength of the demographic predictors multivariately, older respondents and men were still less likely to report harm in 2011, although the prediction is no longer significant. In Model 2, the two respondent drinking variables (the number of times a respondent reported drinking five or more standard drinks in a session in a week, and the change in this item over time) both remained non-significant predictors of harm, when 2008 harm was controlled. In Model 3, all the heavy drinker variables were entered into the same model, along with the report of harm in 2008. Even after controlling for harm in 2008, the numbers of household, non-household relatives and intimate partners and co-worker heavy drinkers in 2008 were still significant predictors of harm in 2011, as was an increase in household and non-household

relatives and intimate partner heavy drinkers. The importance of the number of heavy-drinking friends decreased, once other types of heavy drinkers and previous harm were controlled for.

Finally, in Model 4, all variables were entered into the model. After controlling for all other variables, those who were harmed in 2008 were still almost four times more likely to be harmed in 2011 than those who were not. None of the demographic predictors remained significant in this model: age, gender and neighbourhood affluence did not predict harm. Finally, the 2008 number and change over time in household and non-household relatives and intimate partner heavy drinkers were significant positive predictors of harm in 2011, along with the number of co-worker heavy drinkers.

Table 4.1 Bivariate and multivariate models predicting harm from known problematic drinkers in 2011

	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Harm from known problematic drinkers in 2008					
No	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)
Yes	6.18***	5.81***	6.06***	4.12***	3.89***
Gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	1.40*	1.25			1.24
Age (2008)					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36-55	1.09	0.97			1.04
56 and over	0.55**	0.65			0.83
Neighbourhood affluence (2008)					
Low affluence	1 (Ref)	1 (Ref)			1 (Ref)
High affluence	1.04	1.08			1.13
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	1.07		1.09		0.92
5+ drinking occasions/week[a] difference[b]	1.05		1.12		0.99
Heavy drinkers among (2008):					
Household members	3.17***			5.03***	5.18***
Relatives and intimate partners[c]	1.74***			2.73***	2.67***
Friends	1.04*			1.03	1.04
Co-worker	1.04*			1.05*	1.05*
Difference[d] in heavy drinkers among:					
Household members	1.31			4.25***	4.18***
Relatives and intimate partners[c]	1.41***			2.99***	2.95***
Friends	1.04*			1.05	1.05
Co-worker	0.98			1.01	1.01

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 1,078.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

4.2.2 HARM FROM STRANGERS

In 2011, 359 respondents stated that they had been harmed as a result of strangers' drinking, with 746 reporting that they had not. Bivariate and multivariate logistic regression models predicting harm from strangers' drinking are shown in Table 4.2. As can be seen in the bivariate results, those who were harmed by strangers in 2008 were more than five times more likely to be harmed again in 2011. Furthermore, older respondents were less likely to be harmed by strangers. Finally, the number of relatives and intimate partner heavy drinkers in 2008 and an increase in the number of heavy-drinking friends between 2008 and 2011 were also significant positive predictors of being harmed by strangers.

In Model 1, containing all the demographic variables, those aged over 55 were less likely to be harmed than those in the youngest age group, with no other significant predictors. The drinking of the respondent was not a significant predictor of harm from strangers in Model 2. In Model 3 an increase in the number of relatives and intimate partners and friend heavy drinkers were significant positive predictors of harm in 2011, even after controlling for harm from strangers in 2008. Finally, in Model 4, when all variables were included, those who were harmed by strangers' drinking in 2008 were still nearly five times more likely to be harmed in this way again in 2011. Older respondents were approximately half as likely to be harmed as those who were under 36 years of age. Interestingly, after controlling for the other predictors of harm, a decrease in the respondent's own frequency of heavier drinking from 2008 to 2011 became a significant predictor of harm from strangers' drinking in 2011.

Table 4.2 Bivariate and multivariate models predicting harm from strangers' drinking in 2011

	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Harm from strangers in 2008					
No	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)
Yes	5.54***	5.10***	5.50***	5.19***	4.79***
Gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	1.09	1.12			1.09
Age (2008)					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36-55	0.82	0.88			0.95
56 and over	0.37***	0.50**			0.55**
Neighbourhood affluence (2008)					
Low affluence	1 (Ref)	1 (Ref)			1 (Ref)
High affluence	0.97	0.90			0.92
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	0.92		0.89		0.80*
5+ drinking occasions/weeka difference[b]	1.04		0.96		0.89
Heavy drinkers among (2008):					
Household members	0.99			0.99	0.95
Relatives and intimate partnersc	1.23**			1.23	1.21
Friends	1.01			1.03	1.04
Co-worker	1.01			1.02	1.02
Difference[d] in heavy drinkers among:					
Household members	1.34			1.32	1.28
Relatives and intimate partners[c]	1.04			1.29*	1.28*
Friends	1.07***			1.07**	1.07**
Co-worker	1.01			1.02	1.02

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 1,089.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

4.3 PREDICTORS OF INITIATION OF HARM FROM OTHERS' DRINKING

The focus of this section is to identify factors associated with harms from others' drinking that arise in respondents' lives between 2008 and 2011 (i.e. initiation of harm).

4.3.1 HARM FROM KNOWN PROBLEMATIC DRINKERS

In the following analysis, the group that did not report being harmed by known problematic drinkers in either year (n=664) is compared to the 104 respondents who were not harmed in 2008 but went on to be harmed in 2011. Therefore, this analysis uses only a part of the total sample re-interviewed in 2011.

Bivariate logistic regression results shown in Table 4.3 indicate that there were significant relationships between demographic variables and initiation of harms from known problematic drinkers. Respondents who were harmed for the first time in 2011 had significantly more heavy-drinking household members, relatives and intimate partners, and co-workers in their social circles in 2008 than those who did not report harm from known problematic drinkers in either 2008 or 2011. There was also a significant association between an increase in heavy-drinking household members and/or heavy drinking non-household relatives and intimate partners from 2008 to 2011 and initiation of harm in 2011.

In Model 1, none of the demographic variables were significant predictors of harm arising in 2011 from known problematic drinkers. These findings suggest that the initiation of harm from these drinkers was not limited to particular gender, age or socio-economic groups within the sample. Similarly, the drinking pattern of the respondent himself/herself did not predict the initiation of harm from known problematic drinkers (see Model 2).

In Model 3, both the number and change over time in heavy drinkers among the respondent's household and non-household relatives and intimate partners were significant predictors of harm arising in 2011, as was the number of (but not change in numbers of) heavy-drinking co-workers. Interestingly, the odds ratios for the number of household heavy drinkers and change over time in household heavy drinkers were higher in Model 3 compared with the bivariate model. This increase is most likely a reflection of a negative correlation between the number of, and change over time in, household heavy drinkers.

Based on the results in the final model, including all the covariates simultaneously, the numbers of household, non-household relatives and intimate partners, and co-worker heavy drinkers in 2008 were still significant predictors of harm from known problematic drinkers, as was an increase in two heavy drinker groups – household members and non-household relatives and intimate partners – from 2008 to 2011.

Table 4.3 Bivariate and multivariate models predicting initiation of harm from known problematic drinkers					
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	1.38	1.35			1.33
Age (2008)					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36-55	0.96	0.96			0.88
56 and over	0.63	0.62			0.66
Neighbourhood affluence (2008)					
Low affluence	1 (Ref)	1 (Ref)			1 (Ref)
High affluence	0.94	0.93			0.93
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	0.97		0.98		0.88
5+ drinking occasions/week[a] difference[b]	1.04		1.03		1.03
Heavy drinkers among (2008):					
Household members	2.52**			6.02***	5.77***
Relatives and intimate partners[c]	1.32*			2.09***	1.97***
Friends	1.03			1.02	1.03
Co-worker	1.04*			1.06*	1.06*
Difference[d] in heavy drinkers among:					
Household members	3.19***			5.26***	5.42***
Relatives and intimate partners[c]	2.02***			2.57***	2.52***
Friends	1.01			1.02	1.02
Co-worker	0.98			1.02	1.02

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 770.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

4.3.2 HARM FROM STRANGERS

In order to investigate factors that may predict the onset of harm from strangers, respondents who reported harm from strangers' drinking in 2011 but not in 2008 (n=131) were compared to respondents who were not harmed from strangers' drinking in either year (n=556).

The bivariate results in Table 4.4 show that younger respondents (aged 18-35) are 2.6 times[3] more likely to report initiation of harm from strangers' drinking compared to respondents aged 56 years and older. This finding was statistically significant and suggests that being younger was a positive predictor of experiencing new harm from strangers' drinking in 2011. Furthermore, there was a significant positive relationship between the initiation of harm from strangers' drinking and the number of non-household relatives and intimate partner heavy drinkers respondents had in their lives. A respondent's own heavy drinking in 2008, and change in drinking pattern over time, was not predictive of initiation of harm from strangers' drinking in 2011.

[3] Result of reversed odds ratio of 0.38 for respondents aged 56 years and older.

The association between age and the initiation of harm from strangers' drinking remained significant in Model 1, after adjusting for the other demographic covariates in the model. In Model 2, neither of the respondent drinking variables significantly predicted harm arising in 2011 from strangers' drinking. In Model 3, with all the heavy drinker covariates included, the 2008 number of and change over time in heavy-drinking co-workers were significant positive predictors of experiencing harm from strangers' drinking in 2011. The number of heavy-drinking non-household relatives and intimate partners in the respondent's life in 2008 was also a significant predictor of harm in 2011.

In the final model, when all covariates were accounted for, younger respondents were still twice as likely as older respondents to report new (i.e. initiation of) harm from strangers. Furthermore, the number of heavy-drinking co-workers and an increase in the number of heavy-drinking co-workers between 2008 and 2011 remained significant predictors. However, the number of heavy-drinking non-household relatives and intimate partners was no longer a significant predictor.

Table 4.4 Bivariate and multivariate models predicting initiation of harm due to strangers' drinking

	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	1.24	1.18			1.22
Age (2008)					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36-55	0.82	0.82			0.93
56 and over	0.38**	0.39**			0.47*
Neighbourhood affluence (2008)					
Low affluence	1 (Ref)	1 (Ref)			1 (Ref)
High affluence	0.98	0.93			0.95
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	1.01		1.00		0.93
5+ drinking occasions/week[a] difference[b]	0.97		0.97		0.99
Heavy drinkers among (2008):					
Household members	0.93			1.06	0.90
Relatives and intimate partners[c]	1.31*			1.40*	1.35
Friends	1.00			1.01	1.02
Co-worker	1.03			1.18**	1.16*
Difference[d] in heavy drinkers among:					
Household members	1.67			1.77	1.63
Relatives and intimate partners[c]	0.90			1.14	1.11
Friends	1.04			1.03	1.02
Co-worker	0.99			1.15*	1.13*

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 690.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

4.4 PREDICTORS OF DISCONTINUATION OF HARM FROM OTHERS' DRINKING

The focus of this section is to identify factors associated with harms from others' drinking that remit (discontinue) in respondents' lives between 2008 and 2011.

4.4.1 HARM FROM KNOWN PROBLEMATIC DRINKERS

In these analyses, respondents who experienced harm from the drinking of known problematic drinkers in 2008, but not in 2011, (n=163) are compared to respondents who were harmed both in 2008 and in 2011 (n=156). For these analyses, the meaning of the odds ratios is reversed: a factor that predicts remission of harm will have an odds ratio below 1.0.

As the bivariate results in Table 4.5 show, having fewer heavy-drinking household members and fewer heavy-drinking non-household relatives and intimate partners was significantly associated with discontinuation of reported harm from known problematic drinkers in 2011. Decreases in the number of heavy-drinking non-household relatives and intimate partners and heavy-drinking friends between 2008 and 2011 were also predictors of discontinued harm.

Models 1 and 2 include all demographic covariates and respondents' own drinking covariates respectively. In these models, the variables remained non-significant predictors of discontinued harm from known problematic drinkers. These results suggest that a shift in harm status was not strongly related to the gender, age, or socio-economic status of respondents within the sample.

The impact of the respondents' networks of heavy drinkers on experience of harm in 2011 from known problematic drinkers was examined in Model 3. Results indicate that respondents with fewer heavy-drinking household members and non-household relatives and intimate partners in 2008 were significantly more likely to cease being harmed, as were respondents who reported a decrease over time in the number of heavy-drinking household members, relatives and intimate partners.

In Model 4, with all the covariates included, results indicate that respondents with fewer heavy drinkers in their household and among their social circles of relatives and intimate partners were significantly more likely to cease being harmed, as were respondents who reported a decrease over time in heavy drinkers among these two groups. Interestingly, after controlling for all the covariates, a decrease in the number of heavy-drinking friends between 2008 and 2011 became a significant predictor of remission of harm.

Table 4.5 Bivariate and multivariate models predicting a discontinuation of harm from known problematic drinkers					
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	0.89	0.88			0.88
Age (2008)					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36-55	1.09	1.00			0.69
56 and over	1.58	1.42			0.78
Neighbourhood affluence (2008)					
Low affluence	1 (Ref)	1 (Ref)			1 (Ref)
High affluence	0.74	0.78			0.63
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	0.91		0.82		1.04
5+ drinking occasions/week[a] difference[b]	0.88		0.78		1.01
Heavy drinkers among (2008):					
Household members	0.47***			0.23***	0.21***
Relatives and intimate partners[c]	0.75**			0.27***	0.26***
Friends	0.96			0.98	0.96
Co-worker	0.97			0.98	0.98
Difference[d] in heavy drinkers among:					
Household members	0.89			0.32**	0.34**
Relatives and intimate partners[c]	0.66***			0.26***	0.25***
Friends	0.94*			0.92	0.91*
Co-worker	1.01			0.99	0.99

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 320.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

4.4.2 HARM FROM STRANGERS

Findings in this section are based on two groups of respondents: those who reported that they experienced harm from strangers' drinking in 2008, but not in 2011 (n=176), and respondents who reported harm from strangers' drinking in both surveys (n=226). Consistent with the previous section, discontinuation of harm refers to being harmed in 2008 but not reporting harm in the second (2011) survey.

The bivariate results in Table 4.6 show that the respondents' own drinking patterns in 2008 were significantly associated with discontinued harm, with respondents who reported higher levels of risky drinking (i.e. frequently drinking five or more standard drinks in a session per week) curiously more likely to report discontinuation of harm in 2011 than respondents reporting lower levels of risky drinking. A decrease in the number of heavy-drinking non-household relatives and intimate partners and friends in respondents' lives between 2008 and 2011 was also significantly associated with discontinued harm from strangers' drinking in 2011.

In Model 1, the demographic variables (gender, age and neighbourhood affluence) continued not to predict discontinuation of harm from strangers' drinking. In terms of respondents' own drinking covariates

included in Model 2, a respondent's risky drinking pattern in 2008 remained a significant predictor of discontinued harm, although changes in the respondent's drinking patterns between 2008 and 2011 were not. In Model 3, all the heavy drinker variables were entered into the same model. Consistent with the bivariate analysis, respondents who reported fewer heavy-drinking relatives and intimate partners and heavy-drinking friends in 2011 (compared with 2008) were more likely to cease being harmed by strangers in 2011. The other heavy drinker variables were not significant predictors of discontinuation of harm.

When all the covariates were entered into Model 4, respondents' riskier alcohol consumption patterns in 2008 remained a significant predictor of discontinued harm from strangers' drinking. As Model 4 shows, for each additional session a respondent had five or more standard drinks per week in 2008, the odds of remission of harm from strangers' drinking increased by a factor of 1.3. Decreases in the number of heavy-drinking friends and non-household relatives and intimate partners continued to have a significant association with discontinuation of harm from strangers. In the final model, exposure to heavy-drinking friends in 2008 became a significant predictor of discontinued harm from strangers' drinking in 2011.

Table 4.6 Bivariate and multivariate models predicting discontinuation of harm due to strangers' drinking

	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Gender					
Male	1 (Ref)	1 (Ref)			1 (Ref)
Female	0.94	0.95			1.06
Age (2008)					
18-35	1 (Ref)	1 (Ref)			1 (Ref)
36-55	1.06	1.09			1.04
56 and over	1.41	1.50			1.51
Neighbourhood affluence (2008)					
Low affluence	1 (Ref)	1 (Ref)			1 (Ref)
High affluence	1.14	1.14			1.14
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	1.29*		1.31*		1.55**
5+ drinking occasions/week[a] difference[b]	0.96		1.05		1.20
Heavy drinkers among (2008):					
Household members	1.13			1.05	0.98
Relatives and intimate partners[c]	1.07			0.86	0.85
Friends	1.01			0.94	0.91*
Co-worker	1.02			1.01	1.01
Difference[d] in heavy drinkers among:					
Household members	0.83			0.98	1.00
Relatives and intimate partners[c]	0.75**			0.66**	0.66*
Friends	0.93**			0.90**	0.88**
Co-worker	0.99			0.99	0.99

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 402.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

4.5 PREDICTORS OF PERSISTENCE OF HARM FROM OTHERS' DRINKING

The analyses described in this section assess whether factors such as age and contact with heavy drinkers have an impact on persistence of harm from others' drinking; that is, respondents' experiences of harm in both 2008 and 2011, as compared to respondents who did not experience that harm in either year.

Within this section, a series of logistic regressions have been used to examine persistent harm. The primary outcome variable is 'persistence of harm', where persistent harm refers to respondents who reported harm due to someone else's drinking in both the 2008 and 2011 HTO Surveys, and compares those who were harmed at both time points with those who were harmed at neither. The logistic regression models also use the core set of socio-demographic and heavy drinking predictor variables outlined in Chapter 2. Around one-third of respondents (32 per cent) were persistently harmed by the drinking of either strangers or known problematic drinkers.

4.5.1 HARM FROM KNOWN PROBLEMATIC DRINKERS

An estimated 14 per cent of respondents reported being harmed by a known problematic drinker in both years. This section examines predictors of the persistence of harm in terms of respondents who experienced harm from known problematic drinkers' drinking in 2008 and again in 2011 (n=157), in comparison to those who did not report harm from known problematic drinkers in either year (n=666).

Based on bivariate results in Table 4.7, women were significantly more likely to report persistent harm from known problematic drinkers than men, and older respondents were significantly less likely to report persistent harm from known problematic drinkers compared with the younger respondents. Bivariate findings also indicate that respondents who experienced persistent harm had significantly more heavy drinkers in each of the four relationship categories (i.e. household members, relatives and intimate partners, friends, co-workers).

In Model 1, women were more likely to report persistent harm from known problematic drinkers' drinking and respondents aged 56 years and older were less likely to report persistent harm than those in the youngest age group. In Model 2, once the four heavy drinker covariates were included, the numbers of heavy drinkers in a respondent's household and among their non-household relatives and intimate partners and co-workers, remained significantly associated with persistent harm. However, the association between the number of heavy-drinking friends in the respondent's life in 2008 and persistent harm from a known problematic drinker was no longer significant.

In the final model, with all the covariates included, only exposure to heavy-drinking household members, and non-household relatives and intimate partners predicted persistent harm over time from the drinking of known problematic drinkers. Based on Model 3 results, each additional heavy drinker in the respondent's household in 2008 raised the odds of reporting persistent harm from known problematic drinkers (typically family members or friends) almost six-fold, compared to those reporting no such harm in either year.

In summary, respondents who experienced persistent harm from known problematic drinkers had more heavy drinkers in their households, and more heavy-drinking non-household relatives and intimate partners, even after demographic variables were taken into account.

Table 4.7 Bivariate and multivariate models predicting persistence of harm from known problematic drinkers				
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3
Gender				
Male	1 (Ref)	1 (Ref)		1 (Ref)
Female	1.65**	1.66**		1.30
Age (2008)				
18-35	1 (Ref)	1 (Ref)		1 (Ref)
36-55	1.36	1.43		1.48
56 and over	0.47**	0.49*		0.71
Neighbourhood affluence (2008)				
Low affluence	1 (Ref)	1 (Ref)		1 (Ref)
High affluence	1.07	0.99		0.97
5+ drinking occasions/week[a] (2008)	1.14		1.07	1.07
Heavy drinkers among (2008):				
Household members	7.21***		6.47***	5.90***
Relatives and intimate partners[c]	2.86***		2.80***	2.66***
Friends	1.03*		0.97	0.98
Co-worker	1.04*		1.04*	1.04

*p < 0.05; **p < .01; ***p < 0.001.

N = 823

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

4.5.2 HARM FROM STRANGERS

Just over one in five respondents (21 per cent) reported being harmed in both years by the drinking of strangers or people they did not know well. This section is focused on the prediction of harm from strangers in both time points (n=226), as compared to those who did not experience such harm at either time point (n=559).

The bivariate results in Table 4.8 show that respondents in the youngest age group are four times[4] more likely to report persistent harm from strangers' drinking compared to respondents aged 56 years and older. No other demographic covariates had a significant association with persistent harm from strangers. The number of heavy-drinking non-household relatives and intimate partners and co-workers in a respondent's life in 2008 were both associated with persistent harm from strangers' drinking.

The inverse association between age and persistent harm from strangers' drinking remained significant in Model 1, which included all the demographic covariates and the respondent's drinking pattern in 2008. In Model 2, with the four heavy drinker covariates accounted for, the number of heavy-drinking non-household relatives and intimate partners and heavy-drinking co-workers in the respondent's life were still significant predictors of persistent harm.

In the final model, with all covariates included (Model 3), younger people continued to be four times more likely to experience persistent harm from strangers, in comparison to respondents aged 56 years and older. With respect to heavy drinkers in a respondent's life in 2008, the number of heavy-drinking non-household relatives and intimate partners was still a positive predictor of persistent harm from strangers' drinking, as was the number of heavy-drinking co-workers. However, there were no significant relationships between persistence of harm from strangers' drinking and the number of heavy drinkers among household members or friends. These statistical findings are not fully consistent with an explanation of the patterning of harm in terms of respondents' global involvement in a heavy-drinking social context. Another discrepancy in such an explanation is the fact that, when heavy drinkers in the respondent's social circle are taken into account (Model 3), respondents who themselves drink five or more standard drinks in a session more frequently are actually significantly less likely to experience persistent harm from strangers' drinking.

[4] Result of reversed odds ratio of 0.26 for respondents aged 56 years and older.

Table 4.8 Bivariate and multivariate models predicting persistence of harm due to strangers' drinking				
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3
Gender				
Male	1 (Ref)	1 (Ref)		1 (Ref)
Female	0.98	0.95		0.87
Age (2008)				
18-35	1 (Ref)	1 (Ref)		1 (Ref)
36-55	0.74	0.74		0.71
56 and over	0.26***	0.26***		0.26***
Neighbourhood affluence (2008)				
Low affluence	1 (Ref)	1 (Ref)		1 (Ref)
High affluence	1.04	0.97		1.02
5+ drinking occasions/week[a] (2008)	0.90		0.84	0.77*
Heavy drinkers among (2008):				
Household members	1.14		1.01	0.91
Relatives and intimate partners[c]	1.51***		1.49***	1.49***
Friends	1.03		1.02	1.02
Co-worker	1.07*		1.06*	1.05*

*p < 0.05; **p < .01; ***p < 0.001.

N = 785

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

4.6 SUMMARY

For the majority of respondents, their experience of harms from others' drinking, including known problematic drinkers and strangers, did not change over the study period. For 38 per cent this was because they were not harmed in either year, although 32 per cent were harmed in both years. Almost two-thirds of the sample (62 per cent) reported being harmed in at least one year studied.

There were a few curious findings in Chapter 4. For example, in Table 4.6, Model 4, respondents' riskier alcohol consumption patterns predicted discontinuation (and not initiation) of harm from strangers' drinking. Perhaps these respondents became accustomed to, or tolerated, a certain level of harm from strangers, perceiving nuisance and even occasionally physical harm as what might be expected from a night out. For example, Huhtanen & Tigerstedt (2012) describe how men tolerate higher levels of alcohol-related problems than women before reporting being affected by them.

In general the findings were consistent across harm types – demographic characteristics did not strongly predict experiencing harm in 2011, once harm in 2008 was controlled for. Changes in the level of harm from others' drinking were fairly evenly spread across the population, and were not limited to small and marginalised sections of the community. Repeatedly, past harm and the number of baseline heavy drinkers in the respondent's social circle, as well as changes in the number of heavy drinkers in these groups over time, were the strongest predictors of harm from others' drinking. A range of models were used to test whether these findings held overall and in both directions. For example, when the numbers of heavy drinkers in the respondents' lives increased, respondents were more likely to report they had been harmed by others' drinking in 2011. When the numbers of heavy drinkers in respondents' lives diminished over time, respondents were less likely to report harm from others' drinking in 2011. The overall (whole-sample) model, which accounted for changes in both directions over time, also successfully predicted harm in 2011. These findings are consistent with a social view of harm to others from drinking, where respondents who live in familial and wider social networks with larger numbers of heavy drinkers appear to be at a greater risk of harm from others' drinking.

Almost a third of respondents were persistently affected by others' drinking in both years, around one-fifth by strangers' drinking and 14 per cent by problematic drinkers they knew. Respondents who experienced persistent harm from a known problematic drinker in their lives had more heavy drinkers in their household, and more heavy-drinking non-household relatives and intimate partners than those who did not experience harm from a known problematic drinker in either year. The bonds of family are perceived to be more binding and less likely to change than friendship, making harm from those in closer relationships more likely to be persistent.

Age, in addition to the number of heavy-drinking relatives and intimate partners, was a positive predictor of persistent harm from strangers' drinking, as was the number of heavy-drinking co-workers. Older age was protective and significantly less likely to predict persistent harm to others in 2011 in comparison to the youngest age group. The number of heavy-drinking friends at baseline (2008) was not associated with persistent harm from strangers.

5 THE RELATIONSHIP BETWEEN OTHERS DRINKING AND QUALITY OF LIFE

KEY POINTS

- Respondents with a higher number of heavy-drinking relatives and intimate partners in their lives in 2008 reported lower personal wellbeing in 2011, and respondents with more heavy-drinking relatives and intimate partners in 2011 than 2008 reported reductions in health-related quality of life over time.
- There was no significant association between the change in the number of household heavy drinkers and either health-related quality of life or wellbeing, although this may in part have been due to the limited amount of change in household heavy drinker exposure in the sample.
- The analyses presented in this chapter found no longitudinal association between respondents' experience of harm from other people's drinking and subjective measures of health and wellbeing (once previous levels of wellbeing were controlled for).

Chapter 5 examines the potential impacts that other peoples' drinking may have on a person's health-related quality of life (HRQoL) and self-reported wellbeing (Personal Wellbeing Index).

The research question addressed in this chapter is:

8. How do changes in the number of drinkers in respondents' lives and changing patterns of alcohol's harm to others affect quality of life and wellbeing?

This chapter is divided into two sections: the first aims to examine whether the number of heavy drinkers in respondents' social circles and changes in this number over time are correlated with their HRQoL and wellbeing. The second explores whether changes in self-reported harms from others' drinking are associated with changes in overall measures of HRQoL and wellbeing.

5.1 RELATIONSHIP BETWEEN KNOWING HEAVY DRINKERS AND HRQoL AND WELLBEING

One of the aims of this follow-up analysis was to examine whether the identified cross-sectional associations between HRQoL (using the EQ-5D score, where a score of one is equivalent to full health and a score of zero is equivalent to death), wellbeing (using the Personal Wellbeing Index - PWI) and the number of heavy drinkers in someone's social circle were evident over time. To assess these relationships, a similar modelling strategy to that used in Chapter 4 (Section 4.2) was employed, with models controlling for previous levels of HRQoL and wellbeing, as well as previous exposure to heavy drinkers, and any change in exposure to heavy drinkers between the two survey waves. In other words, the conceptual framework considers wellbeing (or HRQoL) as a function of:

- previous wellbeing (or HRQoL)
- demographic factors
- previous drinking patterns and exposure to heavy drinkers
- changes in drinking patterns and exposure to heavy drinkers.

The full range of variables used are laid out and discussed in more detail in Chapter 2.

5.1.1 RESULTS

There was little sign of overall change in HRQoL or wellbeing in the sample. The mean EQ-5D score in 2008 was 0.84. In 2011 it had barely changed over time – to 0.83. Similarly, the mean levels of wellbeing in the sample did not change significantly between 2008 and 2011 (77.0 in 2008 versus 77.4 in 2011). This lack of change at the mean level hides a reasonable amount of individual level variation on each measure.

Overall, 319 respondents (29 per cent) reported a decline in HRQoL between 2008 and 2011, 291 (26 per cent) reported improved HRQoL and 496 (45 per cent) reported no change. Similarly, on the PWI, 465 (44 per cent) reported decreased wellbeing, 531 (50 per cent) reported improved wellbeing, 72 (7 per cent) reported no change.

A series of models examining the associations between socio-demographics, drinking behaviour, exposure to heavy drinkers and wellbeing (based on PWI scores) is presented in Table 5.1. In the bivariate models, women reported higher levels of wellbeing than men, as did people living in more socio-economically advantaged suburbs. Respondents in the middle age group reported significantly lower levels of wellbeing than the youngest respondents. Respondents' drinking patterns had no significant relationship with wellbeing, while a greater number of non-household relatives and intimate partners and friends reported to be heavy drinkers was associated with lower wellbeing.

In the final model, with all variables included (Model 4), only previous PWI, age, and heavy-drinking non-household relatives and intimate partners in 2008 were significantly associated with wellbeing in 2011, with PWI in 2008 positively predicting PWI in 2011, and middle and older age, and the existence of more heavy-drinking relatives and intimate partners, predicting lower PWI. The significant relationship with heavy-drinking non-household relatives and intimate partners suggests that respondents who had more of these in their lives in 2008 reported lower wellbeing in 2011, controlling for their 2008 wellbeing level.

Table 5.1 Bivariate and multivariate models predicting Personal Wellbeing Index (PWI) in 2011					
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
PWI in 2008	**0.62*** **	**0.62*** **	**0.62*** **	**0.62*** **	**0.61*** **
Gender					
Male	(Ref)	(Ref)			Ref)
Female	2.07**	0.47			0.64
Age (2008)					
18-35	(Ref)	(Ref)			(Ref)
36-55	-2.65**	-2.23**			-2.49**
56 and over	-0.67	-1.62			-1.94*
Neighbourhood affluence (2008)					
Low affluence	(Ref)	(Ref)			(Ref)
High affluence	1.52*	0.99			0.92
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	-0.39		0.14		0.35
5+ drinking occasions/week[a] difference[b]	-0.27		-0.11		0.08
Heavy drinkers among (2008):					
Household members	-0.50			0.97	0.81
Relatives and intimate partners[c]	-1.26**			-0.96*	-0.96*
Friends	0.01			0.02	0.02
Co-worker	-0.16*			-0.11	-0.15
Difference[d] in heavy drinkers among:					
Household members	0.24			0.61	0.61
Relatives and intimate partners[c]	0.08			-0.62	-0.55
Friends	-0.03			-0.03	-0.04
Co-worker	-0.03			-0.07	-0.10

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 1,054 excludes 38 who did not provide complete responses to the PWI items (in one or both waves), seven who did not provide data on their own drinking, four for whom SEIFA quintile could not be estimated, and three with missing data for gender.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

A similar set of models focusing on health-related quality of life is presented in Table 5.2. In the bivariate models, none of the variables measuring exposure to heavy drinkers were correlated with HRQoL. Significant positive associations were found for previous EQ-5D score and neighbourhood affluence, while older respondents reported significantly lower HRQoL. In the final model, with all the covariates included, the age and gender effects remained significant, as did the effect of previous levels of HRQoL. There were two significant associations with exposure to heavy drinkers. Change in the number of heavy-drinking relatives and intimate partners in respondents' lives was negatively associated with levels of HRQoL – i.e. if a respondent reported more relatives and intimate partner heavy drinkers in 2011 than in 2008, his/her HRQoL generally declined.

Table 5.2 Linear regression models of health-related quality of life (EQ-5D) in 2011

EQ-5D IN 2011	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4	MODEL 5
EQ-5D in 2008	**0.66*** **	**0.63*** **	**0.66*** **	**0.66*** **	**0.63*** **	**0.63*** **
Gender						
Male	(Ref)	(Ref)			(Ref)	(Ref)
Female	-1.84	-2.34*			-2.72*	-2.53*
Age (2008)						
18-35	(Ref)	(Ref)			(Ref)	(Ref)
36-55	-6.17***	-2.76**			-2.86	-2.54
56 and over	-13.91***	-5.75***			-5.93***	-4.38*
Neighbourhood affluence (2008)						
Low affluence	(Ref)	(Ref)			(Ref)	(Ref)
High affluence	4.46***	1.44			1.40	1.42
Frequency of respondent's drinking						
5+ drinking occasions/week[a] (2008)	0.25		0.47		-0.11	-0.11
5+ drinking occasions/week[a] difference[b]	0.28		0.94		0.87	0.85
Heavy drinkers among (2008):						
Household members	1.81			3.43*	3.35*	2.42
Relatives and intimate partners[c]	-0.36			-1.31	-1.33	-1.02
Friends	0.19			0.06	0.00	-0.003
Co-worker	-0.14			0.12	0.00	-0.005
Difference[d] in heavy drinkers among:						
Household members	0.42			2.15	1.96	1.34
Relatives and intimate partners[c]	-1.09			-2.36**	-2.47**	-2.06**
Friends	-0.02			0.02	-0.03	0.02
Co-worker	0.14			0.13	0.05	0.05
Household status						
Lives alone						(Ref)
Lives with other adults and children						3.37*
Lives with other adults and children						-2.63
Lives with children only						4.96**

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 1,091 excludes seven who did not provide data on their own drinking, four for whom SEIFA quintile could not be estimated, and three with missing data for gender.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

[d] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

Puzzlingly, people living in households with more heavy drinkers in 2008 had improvements in their HRQoL between the two survey waves. One possibility is that the effect is, in part, being driven by an overarching positive relationship between living with other people and HRQoL. Indeed, when household status (living with other adults versus not living with other adults) is included in the model results (see Model 5, Table 5.2), the relationship between household heavy drinkers and HRQoL disappears and is replaced by a strong positive association between living with other adults and HRQoL.

5.2 RELATIONSHIP BETWEEN EXPERIENCING ALCOHOL-RELATED HARMS FROM OTHERS AND HRQoL AND WELLBEING OVER TIME

The previous analyses (Section 5.1) focused only on whether knowing heavy drinkers in 2008 (and changes in the number known by 2011) was associated with HRQoL and wellbeing in 2011. A more direct examination of the link between alcohol's harm to others and wellbeing and HRQoL is possible using the self-reported data on experience of harm provided by respondents across the 2008 and 2011 HTO Surveys. To provide an estimate of such a relationship, calculated harm scores for both harms relating to a known problematic drinker and those relating to strangers were used.

Simple analyses undertaken in the 2008 HTO Survey found that respondents who reported higher levels of harm also reported lower average levels of HRQoL. For example, respondents who experienced "a lot" of harm from strangers in 2008 had an average EQ-5D score of 0.80, significantly lower than those who experienced no harm from strangers (mean = 0.86). Similarly, respondents reporting "a lot" of harm from a known problematic drinker had lower levels of HRQoL than those who experienced no such harm (0.79 versus 0.86).

In this modelling approach, rather than focusing on the number of heavy drinkers in respondents' lives, the key independent variables relate to the extent to which respondents report being harmed in any way by others' drinking, using the harm score scales described in Section 2.5.4 and Appendix C. As in the previous section, previous PWI and EQ-5D scores are controlled for, and measures of harm in 2008 and change in harm are included as covariates. The same demographic characteristics (age, gender, socio-economic disadvantage) are included in the final models.

5.2.1 RESULTS

The models incorporating separate stranger and known problematic drinkers harm scores are presented in Tables 5.3 (wellbeing) and 5.4 (HRQoL).

In simple bivariate analyses (see Table 5.3), both harm scores in 2008 were negatively associated with wellbeing (PWI) in 2011, although changes in harm scores had no significant impact. For the analyses focusing on HRQoL (Table 5.4), the amount of harm experienced from known problematic drinkers in 2008 was negatively associated with HRQoL in 2011, but again there were no significant bivariate associations with changes in harm scores. When models were adjusted for previous levels of HRQoL and wellbeing, demographic variables and drinking behaviours, there were no significant associations identified between either harm score and HRQoL or wellbeing.

Table 5.3 Bivariate and multivariate models of Personal Wellbeing Index (PWI) in 2011					
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
PWI in 2008	**0.62*** **	**0.62*** **	**0.62*** **	**0.62*** **	**0.61*** **
Gender					
Male	(Ref)	(Ref)			(Ref)
Female	2.07**	0.47			0.51
Age (2008)					
18-35	(Ref)	(Ref)			(Ref)
36-55	-2.65*	-2.23**			-2.20**
56 and over	-0.67	-1.62			-1.66
Neighbourhood affluence (2008)					
Low affluence	(Ref)	(Ref)			(Ref)
High affluence	1.52*	0.99			0.98
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	-0.39		0.14		0.20
5+ drinking occasions/week[a] difference[b]	-0.27		-0.11		0.03
Known problematic drinker harm score 2008	**-0.42****			**0.01**	**-0.01**
Stranger harm score 2008	**-0.63*****			**-0.21**	**-0.22**
Known problematic drinker harm score difference[c]	**-0.03**			**-0.12**	**-0.14**
Stranger harm score difference[c]	**-0.05**			**-0.18**	**-0.18**

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 1,048.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Difference scores = 2011 score – 2008 score for each variable.

Table 5.4 Bivariate and multivariate models predicting EQ-5D in 2011					
	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4
EQ-5D in 2008	**0.66*** **	**0.63*** **	**0.66*** **	**0.66*** **	**0.63*** **
Gender					
Male	(Ref)	(Ref)			(Ref)
Female	-1.84	-2.34*			-2.54*
Age (2008)					
18-35	(Ref)	(Ref)			(Ref)
36-55	-6.17***	-2.76***			-2.99*
56 and over	-13.91***	-5.75***			-6.14***
Neighbourhood affluence (2008)					
Low affluence	(Ref)	(Ref)			(Ref)
High affluence	4.46***	1.44			1.37
Frequency of respondent's drinking					
5+ drinking occasions/week[a] (2008)	0.25		0.47		-0.06
5+ drinking occasions/week[a] difference[b]	0.28		0.94		0.80
Known problematic drinker harm score 2008	**-0.52***			**-0.01**	**0.01**
Stranger harm score 2008	**-0.25**			**0.11**	**-0.13**
Known problematic drinker harm score difference[c]	**0.16**			**-0.04**	**-0.03**
Stranger harm score difference[c]	**0.29**			**0.01**	**-0.07**

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 1,086..

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Difference scores = 2011 score – 2008 score for each variable.

5.3 SUMMARY

Lower HRQoL and wellbeing were predicted by increased exposure to heavy drinkers in respondents' lives who were non-household relatives and intimate partners. However, changes in harm from others' drinking were not associated with changes in HRQoL or wellbeing. This may in part have been due to the limited amount of change in household heavy drinker exposure in the sample. The analyses presented in this chapter found no longitudinal association between the experience of harm from other people's drinking and subjective measures of health and wellbeing (once previous levels were controlled for).

6 HELP-SEEKING BEHAVIOUR IN RESPONSE TO ALCOHOL'S HARM TO OTHERS

KEY FINDINGS

- In 2011, of the 727 respondents who were harmed by someone else's drinking, 13 per cent called the police and seven per cent called a health-related service at least once because of other people's drinking in the previous 12 months.
- The majority of calls concerned a stranger's drinking (74 per cent), 16 per cent were due to the drinking of people they knew, and a further ten per cent called police due to the drinking of both strangers and people they knew.
- Previous calls to police because of others' drinking appear to be the dominant predictor of calls to police in 2011. Reports of harm, especially previous harm from strangers' drinking, also played a significant part in respondents' use of police services.

Seeking services such as police or professional counselling is an important indicator of the physical and emotional toll people may experience due to others' drinking, as many people will endure substantial problems before they decide to ask for help (Zajdow 2002). While the following analyses are based on a small group of respondents, the findings offer an opportunity to investigate potential impacts on individuals and essential community services, in particular police.

The research questions addressed in this chapter are:

9. For what proportion of the sample do problems associated with others' drinking result in use of services?
10. What predicts contact with emergency and health-related services because of others' drinking in 2011?

To answer these questions, the analysis is primarily focused on respondents who reported that they were harmed "a little" or "a lot" by another person's drinking, including known problematic drinkers, strangers, or both. This group was asked about their use of community services in the last 12 months because of the drinking of others (see Chapter 2, Section 2.4.6 for details).

While this chapter starts by presenting basic frequencies of service use, including police and health-related services, the main analysis focuses on police, since calls to the police are by far the most common service use reported by respondents. The analysis uses the longitudinal strategy outlined in Chapter 2: i.e. the 2008 HTO Survey 'police' variable is included in the logistic regression analysis as a predictor variable. Furthermore, given the likelihood that the respondent's police use in 2008 strongly relates to his/her 2011 police use, and interacts with other predictors, 2008 police use is included as a control variable in all multivariate regression analyses. The other predictor variables are described in Section 2.5.

6.1 TYPE OF SERVICE AND CIRCUMSTANCES OF CALLS

In 2011, of the 727 respondents who were harmed by the drinking of a known problematic drinker and/or a stranger, 13 per cent (N=93) called the police at least once as a result. Concerning the most recent call made to police by these respondents, the majority concerned a stranger's drinking (74 per cent), 16 per cent were due to the drinking of people respondents knew, and a further 10 per cent related to the drinking of both strangers and known people. The three most common reasons for calling the police were noise (43 per cent), physical fight or assault (30 per cent) and verbal disagreement (25 per cent).

Altogether, 47 respondents called one or more health-related services in 2011 for help with problems due to others' drinking. Of this group, 58 per cent received counselling or professional advice because of other people's drinking or the problems it was causing, 51 per cent received support or advice from self-help services and 13 per cent received medical treatment (Table 6.1).

Table 6.1 Service use because of others' drinking, 2011

Of those who were harmed in 2011 (n=727):	
Called police	12.8
Used health-related services	6.5
Of those who called the police (n=93)	
Most recent call to police was made about:	
Strangers	74.2
Known person	16.1
Both strangers and known person	9.7
Reason for calling police[a] (n=93)	
Noise	43.0
Physical fight/assault	30.1
Verbal disagreement	24.7
Vandalism	12.9
Other	10.8
Trespassing	7.5
Of those who used health-related services a (n=47): type of service	
Counselling	57.5
Self-help or support group	51.1
Medical	12.8

[a] Respondents were able to select more than one response.

6.2 PREDICTING CONTACT WITH POLICE

Using logistic regression, the following analyses predicts which respondents harmed by others' drinking called police in 2011 (n=93), compared to respondents who reported being harmed by the drinking of a known problematic drinker or stranger in 2011 but did not call police (n=634). Based on the bivariate results shown in Table 6.2, respondents who called the police in 2008 were nearly seven times more likely than others to take this action again in 2011. The number of heavy drinkers (i.e. heavy-drinking household members, relatives and intimate partners and co-workers) the respondent knew in 2008 and change in this number from 2008 to 2011 had no significant relationship with whether respondents called police in 2011 because of others' drinking and the trouble it caused.

Table 6.2 Factors that predict calling the police in 2011 because of others' drinking

EQ-5D IN 2011	BIVARIATE	MODEL 1	MODEL 2	MODEL 3	MODEL 4	MODEL 5
Called police in 2008						
No	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)	1 (Ref)
Yes	6.71***	6.35***	6.99***	6.7***	5.94***	6.02***
Gender						
Male	1 (Ref)	1 (Ref)				1 (Ref)
Female	0.85	0.79				0.85
Age (2008)						
18-35	1 (Ref)	1 (Ref)				1 (Ref)
36-55	1.53	1.43				1.89
56 and over	0.81	0.98				1.40
Neighbourhood affluence (2008)						
Low affluence	1 (Ref)	1 (Ref)				1 (Ref)
High affluence	0.80	0.86				0.87
Frequency of respondent's drinking						
5+ drinking occasions/week[a] (2008)	1.05		0.90			0.85
5+ drinking occasions/week[a] difference[b]	0.86		0.79			0.72
Number of known heavy drinkers in 2008	1.01			1.03		1.01
Difference in number of known heavy drinkers[c]	1.00			1.02		1.01
Number of known problematic drinkers harms 2008	1.20***				1.08	1.06
Number of stranger harms 2008	1.38***				1.34***	1.33***
Number of known problematic drinkers harms difference[d]	1.12*				1.13	1.14*
Number of stranger harms difference[d]	0.99				0.92	0.91

*p < 0.05; **p < 0.01; ***p < 0.001.

N = 727.

[a] The number of times that the respondent stated they drank five or more standard drinks in a session in a week.

[b] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[c] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

[d] Difference in number of specific harms = 2011 number of specific harms reported – 2008 number of specific harms reported.

In terms of harms experienced (i.e. specific harmful events or circumstances respondents faced), bivariate results indicate that the number of harms reported in 2008 due to strangers' drinking and due to a known problematic drinker's drinking were both significant predictors of police contact in 2011. An increase in the number of harms from a known problematic drinker's drinking since 2008 was also a predictor of calling police in 2011 – i.e. if a respondent reported a higher number of specific harms due to a known problematic drinker's drinking in 2011 than 2008, they were more likely to call police due to others' drinking in 2011.

Although there were no significant differences attributable to age and neighbourhood affluence, the difference in odds ratios suggest that women and respondents living in more affluent neighbourhoods were less likely to call police in 2011 than their counterparts. Furthermore, respondents in the oldest age category were less likely to call police in 2011 compared with those aged 35 years or under, whereas middle-aged respondents were more likely to do so than younger respondents. Neighbourhood affluence and the respondent's own drinking had no statistically significant association with calls to police in 2011.

When models were adjusted for previous calls to police, socio-demographic variables and the respondent's drinking behaviour, the strong association between calls to police in 2008 and calls in 2011 remained (Models 1 and 2). As illustrated in Model 3, previous exposure to heavy drinkers and the difference in exposure to heavy drinkers from 2008 to 2011 did not predict calls to police in 2011. In Model 4, all the specific harm variables were entered into the same model along with previous calls to police. Apart from previous calls to police, the number of harms due to strangers' drinking in 2008 was the only variable significantly associated with calls to police in 2011. This suggests that for each additional harm respondents experienced in 2008 from strangers' drinking, respondents were 1.3 times more likely to call police in 2011.

In the final model, which includes all the covariates, three factors were significantly associated with calls to police in 2011. Previous calls to police was still the strongest predictor, as respondents who called the police previously were six times more likely to call police in 2011 than those who did not call police in 2008. The remaining two predictors related to harms from others' drinking. An increase in the number of harms due to a known problematic drinker's drinking between 2008 and 2011 was predictive of calls to police in 2011. The other predictor in this survey was a higher number of harms from strangers' drinking in 2008.

6.3 SUMMARY

The first (2008) HTO Survey did not examine whether service use due to harm from others' drinking related largely to the drinking of strangers or heavy drinkers the respondents knew. Indeed, about three-quarters of respondents in 2011 who were harmed by others' drinking and contacted the police or health-related services about associated problems did so because of the drinking of strangers. Around 16 per cent of these respondents called a service about the drinking of those they knew, and 10 per cent were concerned about both the drinking of strangers and those they knew.

Previous calls to police (as reported in 2008) because of others' drinking appear to be the dominant predictor of calls to police in 2011. Reports of harm, especially previous harm from strangers' drinking, also play a part in respondents' use of police services. There were too few reported instances of contact to analyse the predictors of health-related service use.

7 SUMMARY AND DISCUSSION

7.1 PREDICTORS OF CHANGE AND STABILITY IN HARMS FROM OTHERS' DRINKING: OVERVIEW ACROSS ANALYSES

The 2008 HTO Study underlined how a cross-section of the adult Australian general population was affected by others' drinking at one point in time (Laslett et al. 2010). The present study adds the substantial dimension of patterns in time to the previous HTO Study.

The picture in 2011 is relatively similar to that in 2008: there are age differences in rates of harms from others' drinking, including harms from strangers and known problematic drinkers in respondents' lives. There was however a moderate but significant decrease in harm from others' drinking in the sample between 2008 and 2011, particularly from those in relationships more distal to the respondent.

This report pays more attention to a dimension which turns out to be important cross-sectionally, as well as in predicting change in the experience of harm: the presence and number of heavy drinkers in the concentric and overlapping circles in which a respondent moves. Often the strongest predictors of harm from others, and of its initiation and persistence, are the numbers of heavy drinkers among household members and non-household relatives and intimate partners – even though respondents name many more friends and co-workers as heavy drinkers than household members or relatives. For harm from strangers, however, the number of heavy-drinking friends is more predictive – most probably because having heavy-drinking friends indicates some propensity to public drinking, with a greater exposure to risk from the drinking of strangers.

Table 7.1 looks across the different analyses reported in Chapter 4 predicting harm in 2011 from another's drinking, summarising the results of the full multivariate models in each of nine analyses. The final two columns are for the overall (full-sample) model (Section 4.2), which considers prediction of harm from known problematic drinkers or from a stranger's drinking, controlling for whether the same harm existed in 2008. The analyses of initiation (Section 4.3) predict harm in 2011 among those who did not experience harm in 2008, while the analyses of discontinuation (Section 4.4) predict whose harm will remit among those suffering harm in 2008. The analyses of persistence (Section 4.5) predict harm both in 2008 and 2011, compared to those with no harm at either time.

The different subsamples on which the analyses were done, and the different dependent variables, mean that there is considerable variation in results. But there is also substantial consistency. Increases in numbers of heavy drinkers in the respondent's circles were often predictive of harms from others' drinking in 2011 even when harms in 2008 were included as a control. This was particularly true for heavy drinkers in the household or non-household relatives and intimate partners when predicting harm from a known problematic drinker. As expected, the relationships identified ran in the same direction as the models for initiation and persistence, and in the opposite direction in analyses of 2008 harms that discontinued in 2011. This consistency of results suggests that the number of heavy drinkers in respondents' lives is critical when discussing continuity and change in alcohol's harm to others.

There is thus consistent evidence suggesting that within networks of heavy drinkers a variety of harms occur, and these results are found both cross-sectionally and longitudinally. This is seen in the occurrence of harm from others' drinking in its entirety over time, and in its persistence, initiation and remission.

In this research, age, gender and a respondent's drinking pattern were linked to harms from others' drinking but, with the exception of age, did not make a further contribution to predicting harm once heavy drinkers in the respondents' social circles were included in the analysis. The findings underline the importance of heavy drinking around the respondent, but do not undercut the importance of demographic factors. Rather, they indicate a common social context both of heavy-drinking social circles and of harm from others' drinking. In particular, the heavy drinking and the harms from others both occur particularly among young adults.

Table 7.1 Predicting harm from others' drinking: Comparisons of multivariate outcome models (including all covariates)

DEPENDENT VARIABLE: HARM FROM	KNOWN PROBLEMATIC DRINKERS	STRANGER	KNOWN PROBLEMATIC DRINKERS	KNOWN PROBLEMATIC DRINKERS	KNOWN PROBLEMATIC DRINKERS	STRANGER	STRANGER	STRANGER
PREDICTING TYPE OF HARM:	OVERALL	OVERALL	INITIATION	DISCONTINUATION	PERSISTENT	INITIATION	DISCONTINUATION	PERSISTENT
Harm from known problematic drinkers/strangers in 2008								
Yes	↑	↑						
Gender								
Female	-	-	-	-	-	-	-	-
Age (Reference age ≤35 years)								
36-55	-	-	-	-	-	-	-	-
56 and over	-	↓	-	-	-	↓	-	↓
Neighbourhood affluence							-	
High affluence	-	-	-	-	-	-	-	-
5+ drinking occasions/week 2008	-	↑	-	-	-	-	-	↓
Difference in 5+ drinking occasions/week[a]	-	-	-	-		-	-	
Heavy drinkers among (2008):								
Household members	↑	-	↑	↓	↑	-	-	-
Relatives and intimate partners[c]	↑	-	↑	↓	↑	-	-	↑
Friends	-	-	-	-	-	-	↓	-
Co-workers	↑	-	↑	-	-	↑	-	↑
Difference in number of heavy drinkers among:[b]								
Household members	↑	-	↑	↓		-	-	
Relatives and intimate partners[c]	↑	↑	↑	↓		-	↓	
Friends	-	↑	-	↓		-	↓	
Co-workers	-	-	-	-		↑	-	

Predicting type of harm: Overview harm models (section 4.2); initiation (Section 4.3); discontinuation (Section 4.4); persistence (Section 4.5).

↑ denotes significant positive relationship; ↓ denotes significant negative relationship

– denotes that the significance values of coefficients or odds ratios did not meet the 0.05 criteria for significance;

blank cells denote that the estimates are unavailable as these variables were not included in these models.

[a] Difference in number of 5+ drinking occasions/week = 2011 number of 5+ drinking occasions/week – 2008 number of 5+ drinking occasions/week.

[b] Difference in number of heavy drinkers = 2011 number of heavy drinkers – 2008 number of heavy drinkers for each variable.

[c] Relatives and intimate partners = Relative, girlfriend, boyfriend, or ex-partner not living with the respondent.

7.2 HEALTH-RELATED QUALITY OF LIFE AND WELLBEING

The results of these analyses provide some longitudinal support for the cross-sectional relationships between exposure to heavy drinkers and reduced HRQoL and wellbeing identified previously. In particular, there was a relationship between increases in the number of heavy-drinking relatives and intimate partners outside the household and reported reductions in HRQoL between 2008 and 2011.

However, somewhat surprisingly, there were no longitudinal associations identified between HRQoL or wellbeing and household heavy drinkers, although this may in part have been due to the limited amount of change in household heavy drinker exposure in the sample. The vast majority of respondents (88 per cent) reported no change in the number of household heavy drinkers in their lives, with most of these (911 out of 977) reporting no household heavy drinkers in either 2008 or 2011.

The overall results may reflect the homeostatic nature of quality of life measures (Cummins et al. 2002), whereby subjective reports of health and wellbeing tend to drift towards a steady level, regardless of changes in people's circumstances. Indeed other studies have also shown minimal change over time in quality of life and wellbeing (e.g. Lucas et al. 2003), and the current study found smaller differences over time in comparison with the size of cross-sectional differences identified in the 2008 HTO Study (Laslett et al. 2010). The idea that some people, despite living in damaging situations, accept and adapt to them is not new, and is discussed particularly in the Al-Anon and domestic violence literature, and in the literature that discusses how spouses and children learn to live in dysfunctional alcoholic families (Zajdow 2002).

However, there is other evidence that indicates that larger social circles are associated with wellbeing and health-related quality of life (Livingston et al. 2010), suggesting that, while a decrease in harm may be associated with decreases in the number of heavy drinkers in a person's life, it may also be the case that if the size of one's social circle decreases because heavy drinkers are lost, and this decrease is not compensated for by other friends and relatives, quality of life and wellbeing may in fact be compromised. Therefore building new social circles as well as decreasing heavy-drinking networks may be important, if more moderate drinking patterns cannot be encouraged within existing social circles.

7.3 HELP-SEEKING BEHAVIOURS

Overall, service use was relatively low across the sample. However, of the small group of respondents who reported service use in 2011, the majority called police. For the most part, calls to police were made due to the drinking of strangers and related to noise, physical fights or assault and verbal disagreements. Based on further analyses, factors that predicted calling police due to others' drinking were previous use of police services due to others' drinking and previous experiences of harm from strangers' drinking. Given only a few factors were found to be associated with police service use over time, this finding suggests that further research should be undertaken to examine whether services are used repeatedly because the problems they are called about are not resolved, or because they have been effective and therefore respondents are more likely to use them again. Larger studies are needed to investigate predictors of use of health and other welfare services and their effectiveness in addressing harms from others' drinking.

7.4 IMPLICATIONS FOR FUTURE RESEARCH, POLICY AND PRACTICE

The research findings in this report emphasise and add to the findings from the first HTO Study, published in *The Range and Magnitude of Alcohol's Harm to Others* in 2010. While the first report indicated that around 52 per cent of Australians had been negatively affected by others' drinking in the past year, the current report underlines that for around one-third of the sample surveyed in both years, harm from others' drinking is persistent. Around one in five respondents reported that they had been affected by strangers' drinking at both time points and 14 per cent reported that they had been affected by the drinking of someone they knew in both 2008 and 2011.

That the social drinking context of the respondent mattered surfaced time after time in these analyses. This meant that respondents who at baseline (2008) lived with more heavy drinkers, who worked with more heavy drinkers, or who had more heavy-drinking friends, were at greater risk of experiencing harm from others' drinking over time. Moreover, the chances of experiencing harm from others' drinking increased

when the numbers of heavy drinkers in respondents' lives increased. These contextual factors were more critical to the prediction of harm from others' drinking than underlying social factors such as age, gender or socio-economic factors. This does not mean that these factors are not relevant, but that, for example, young people experience more harms from others' drinking because of the social contexts within which they live and drink, and because of whom they live with, befriend and drink with, rather than because of their age per se.

That the harms are spread widely across age and income groups and genders suggests that the 'prevention paradox' (Kreitman 1986) applies even more strongly to harm to others from drinking than it does to harm to the drinker. The prevention paradox implies that the majority of cases do not occur in the heaviest-drinking or dependent proportion of the population, but in the proportion of the population that only occasionally drinks heavily. This broad spread of the harms to others from drinking in the population implies that policies need to be equally broad in their application. As has been demonstrated empirically in studies both in Australia (Livingston 2011) and elsewhere (e.g. Cohen et al. 2006), measures that restrict the availability of alcohol, increase alcohol taxes and prices are likely to be particularly effective in reducing alcohol's harms to others in the general population, and among young drinkers (Babor et al. 2010).

While the findings regarding heavy-drinking social contexts were consistent, younger age was predictive of harms from strangers' drinking over time. This suggests that universal alcohol control policies should be supplemented by strategies that target the contexts in which young people drink. The types of options that may benefit young people have been recently summarised in the *Patron Offending and Intoxication in Night-Time Entertainment Districts* (POINTED) study, in which Miller et al. (2013) studied and analysed young people's nights out drinking in entertainment districts across Australia. The results, which showed high rates of intoxication that increased as the night wore on, suggested that policies limiting opening hours and enforcing responsible service (i.e. restricting sales to the under-aged or intoxicated), along with increased availability of later-night public transport, would improve the safety of young people.

Alcohol prices have decreased in Australia relative to spending power, and a range of policies that increase taxes and prices should reduce harms to the drinker (Carragher, Chalmers & Wales, 2011) and those around them. Strategies that increase the price of alcohol are likely to work to decrease harms to others from drinking in the general population and particularly among young people.

Young people are particularly sensitive to price (Godfrey 2007; Babor et al. 2010), and the difference in price between on- and off-premises alcohol consumption can result in incentives that move drinking to different and often unregulated environments (Miller et al. 2013); for example 'pre-drinking' (consumption of alcohol at home, prior to going out). Increasing the price of alcohol may contribute both to reductions in pre-drinking and drinking when young people are out.

Large-scale alcohol policy interventions have acted to reduce mortality and hospitalisations of drinkers, and in the context of harm to others, have also resulted in reductions in alcohol-related violence. However, whether reductions in a broader range of harms to others will result has not been studied. Surveillance research of harms to others from drinking would enable the monitoring and evaluation of the effects of the introduction of such policies over time. Ongoing cross-sectional surveys of the harm to others from drinking would meet this research gap, particularly if complemented with ongoing collection of alcohol sales data.

This study also holds policy implications for institutions of societal response, assistance and support. It is clear from the results in Chapter 4 that the presence of heavy drinkers in the household or family predicts that the respondent will continue to be harmed, or experience new harm from others' drinking if they have not previously. The 2008 HTO Study showed that harms from others' drinking place a heavy burden on government systems, including health, justice, policing, welfare and treatment services. Indeed the annual tangible costs of the harm from others' drinking totalled $13.4 billion. Service use data from the 2008 survey further inform us that 13 per cent of respondents had called the police in the previous 12 months because of others' drinking and five per cent had sought help from a health service because of someone else's drinking (Mugavin, Livingston & Laslett 2014).

Policies that reduce the harms to others from drinking will diminish the strain on a range of service agencies (in particular police) in the longer term. However, it is recognised that if treatment services are modified to improve access to those affected by others' drinking and better target their needs (as opposed to the needs of drinkers per se) there may be an initial increase in demand for treatment from those affected by others' drinking.

Currently, other qualitative studies undertaken by the CAPR (see Manton et al. 2014) suggest that the troubles for individuals around the drinker seem rather invisible to major social response agencies, with respondents surveyed seldom describing the use of services to meet their needs. In the 2008 HTO Survey, 13 per cent of respondents had called the police in the previous 12 months because of others' drinking and five per cent had sought help from a health service. The 2011 data in this report show that the social agency most often called on by those troubled by others' drinking was the police, and most of the calls to the police were about the drinking of strangers.

Only a small proportion (6.5 per cent) of those reporting harm from anyone in 2011 contacted health or counselling services for help with problems "due to other people's drinking." It may not be at all clear to most in this situation what agency they should call. This finding is consistent with a view from another angle offered in the work of Moore et al. (2011), in which asking social agencies and services about cases in their caseloads of teenagers dealing with alcohol problems in their families was not productive; recruiting such cases for the study proved "extremely difficult." This suggests a need to promote greater recognition in social and health agencies of the problems that those around a heavy drinker may be experiencing, and studies and training concerning what responses might be most helpful. The work of Orford et al. (2010) in developing effective treatment for those affected by others' drinking should be considered here; for example, their work has shown that brief interventions may be effective in managing problems of those affected by other drinkers and drug users in their families (Copello et al. 2010).

At the level of treatment policy, Templeton (2013) has noted that the UK National Treatment Agency for Substance Misuse called in 2010 for "developing services for families and carers as well as involving them in treatment," and the 2011 quality standard on alcohol dependence and harmful use of the UK National Institute for Health and Clinical Excellence (NICE) includes a statement that "families and carers of people who misuse alcohol [should] have their own needs identified, including those associated with the risk of harm, and [should be] offered information and support" (NICE 2011, p 10).

There has been some gradual re-orientation of existing treatment systems overseas (Copello et al. 2013) and in Australia to better meet the needs of those affected by others' drinking. South Australian research has been engendering moves to make alcohol and drug systems more family-friendly, not only to involve family members in drinkers' treatment, but also to be more responsive to the needs of family members of clients (Trifonoff et al. 2010). Victoria's plan for managing alcohol and drug problems focuses strongly on reducing the anti-social behaviour and violence associated with alcohol and recognises the importance of ensuring others' needs are met by the treatment system, stating that "improved child and family focused treatment services are essential to meet our shared responsibility to Victoria's vulnerable children" (State Government of Victoria 2013, p 40). Turning Point (a Victorian addiction treatment, education and research agency) has recently developed a brief telephone intervention for alcohol and other drug counsellors working with significant others affected by heavy-drinking (and/or drug-using) family members and friends, based on the 5-step method of Copello et al. (2010) (Best et al. 2014). How best to reach and serve those adversely affected by others' drinking deserves consideration and action by Australian treatment authorities, professionals and agencies.

However, recent Australian government actions, at both federal and state levels, to constrain costs in alcohol and other drug treatment systems are likely to have diminished the capacity of treatment agencies to take on new tasks and streams of clients; services to families of heavy drinkers are not defined as core functions for which governments will pay.

While many studies have focused on managing the violence and health concerns associated with drinking, a wider range of harms from others' drinking and how they have been addressed by alcohol policy interventions has been largely neglected by the research community. Many studies assess the death and injury rates for drinkers associated with the increases or decreases in alcohol controls (Babor et al. 2010), but few pay attention to effects on harms to others from drinking, although there are small studies of how drinking restrictions in small outback communities in Australia can reduce hospital admissions for mothers and children in Indigenous communities (e.g. Gray et al. 2000; Donnelly et al. 2006). While it is known that interventions that limit price, availability and advertising of alcohol have beneficial effects upon drinkers' problems, it is important to test the validity of expectations that these effects will 'spill over' to improve the lives of those affected by others' drinking. Moreover, while there is some surveillance of alcohol-related violence (e.g. domestic assaults and child protection reports), there is acknowledgement that only a fraction of incidents come to the attention of police and/or health and social services. The often-uncounted harms and costs that significantly affect the many more individuals affected by alcohol's

harm to others also deserve further research, policy attention and measured responses. Ongoing research about the harms to others from drinking would highlight the problem, act as a lever for action and enable monitoring of successful alcohol control and harm minimisation strategies.

The recent growth in the body of work internationally on harm to others from drinking has made it even more apparent that the size of the problem merits both individual treatment and community or universal policy interventions. This report makes plain the persistent and ongoing nature of alcohol's harm to others, and underlines important alcohol policy, service and research options to reduce and monitor harms from others' drinking.

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APPENDIX A: FIGURES, BOXES AND TABLES

LIST OF FIGURES

LIST OF BOXES

LIST OF TABLES

APPENDIX B: HARM TO OTHERS' - 2011 SURVEY

Following is a truncated version of the questionnaire as prepared and used by the Social Research Centre (in Computer-Assisted Telephone Interviewing format) for the 2011 re-interview survey on alcohol's harm to others. Introductory questions, e.g. to get to the right respondent, and non-substantive closing questions, e.g., concerning possible recontact, are omitted here. All the substantive questions are reproduced here.

0851 AUSTRALIAN ALCOHOL'S HARM TO OTHERS STUDY: FOLLOW-UP SURVEY

*SECTION A. HOUSEHOLD QUESTIONS

*(ALL)
Aintro I'll begin with some questions about you and your household...
1. Continue
*(ALL)
A1 RECORD GENDER OF RESPONDENT
1. Respondent is male
2. Respondent is female

*(ALL)
A2 Firstly, how old are you?
1. Age given (SPECIFY___)(RANGE 18 TO 99) (GO TO A3)
2. 17 or younger (RESELECT, ELSE GO TO TERM1)
3. Refused

*(REFUSED AGE) (A2=3)
A2a Which of the following age groups are you in? READ OUT
1. 18 - 24 years
2. 25 - 34 years
3. 35 - 44 years
4. 45 – 54 years
5. 55 – 64 years
6. 65 – 74 years
7. 75 + years
8. (Refused) (GO TO TERMINATION SCRIPT 2)

*(ALL)
A3 APART from yourself, how many OTHER people aged 18 years or over usually live in your household?
1. Number given (SPECIFY_____) (RANGE 1 TO 11)
2. No others (GO TO A5X)
3. Refused (GO TO A5X)

PREA5 IF A3=1 IS 1 (ONE OTHER PERSON 18+ IN HOUSEHOLD) GO TO A5 INTROA, OTHERWISE GO TO A5 INTROB

*(OTHERS 18+ IN HOUSEHOLD)
A5 INTROA What is that person's relationship to you?
INTROB Thinking of the (oldest/next oldest) of these people, what is that person's relationship to you?
INTERVIEWER NOTE: IF STEP PARENT (INCLUDING GRANDPARENT CODE AS FATHER, MOTHER, GRANDFATHER, GRANDMOTHER
1. Husband
2. Wife
3. MALE partner / de facto
4. FEMALE partner / de facto
5. Son
6. Daughter
7. Stepson or partner's son
8. Stepdaughter or partner's daughter
9. Father
10. Mother
11. Grandfather
12. Grandmother
13. Brother
14. Sister
15. Other MALE relative

16. Other FEMALE relative
17. MALE friend / flatmate
18. FEMALE friend / flatmate
19. Other MALE (SPECIFY_____)
20. Other FEMALE (SPECIFY _____)
21. (Refused)

*[REPEAT LOOP (A5) FOR ALL HOUSEHOLD MEMBERS - ALLOW UP TO 11 PEOPLE]
*[CLOSE LOOP FOR ALL HOUSEHOLD MEMBERS]
*(ALL)
A5x How many children aged 0 to 17 usually live in your household?
1. Number given (SPECIFY____) (RANGE 1 TO 9)
2. None (GO TO A5DUM)
3. Refused (GO TO A5DUM)

PREA5x1 IF A5x=1 IS 1 (ONE CHILD <18 IN HOUSEHOLD) GO TO A5x1 INTROA, OTHERWISE GO TO A5x1 INTROB
*(CHILDREN <18 IN HOUSEHOLD)
*START LOOP
*PROGRAMMER – MAXIMUM ITERATIONS = 9
A5x1 INTROA What is that child's relationship to you?
INTROB Thinking of the (oldest/next oldest) of these children, what is that child's relationship to you?
1. Son
2. Daughter
3. Stepson or partner's son
4. Stepdaughter or partner's daughter
5. Granddaughter
6. Grandson
7. Other MALE relative
8. Other FEMALE relative
9. Other MALE (SPECIFY_____)
10. Other FEMALE (SPECIFY _____)
11. (Refused)

A5x2 How old is the child?
INTERVIEWER NOTE: IF AGED LESS THAN 12 MONTHS CODE AS 0

1. Age given (SPECIFY___)(RANGE 0 TO 17)
2. Refused

PREA5x3 IF A5x2=0 TO 2 SKIP AUTO CODE A5x3=2
A5x3 Was this child (usually) living in your household when we spoke with you in 2008?

1. Yes
2. No
3. Refused

*REPEAT LOOP (A5x1 THRU TO A5x3) FOR ALL CHILDREN <18 IN HOUSEHOLD – ALLOW UP TO 9 CHILDREN)
*END LOOP
*(ALL)
A5DUM PROGRAMMER CREATE DUMMY VARIABLE FOR PRESENCE OF CHILDREN AGED 13-17 IN HOUSEHOLD
1. One child 13-17 in household (A5X2)
2. Two or more children aged 13-17 in household (A5X2)
3. No children 13-17 in household / Refused (All others) (A5X2)

A6DUM PROGRAMMER CREATE DUMMY VARIABLE FOR PRESENCE OF CHILDREN UNDER 18 IN HOUSEHOLD (SECTION G FILTER)
1. Child/ren under 18 years in household (A5X=1)
2. No children under 18 in household / Refused (All others)

A7DUM PROGRAMMER CREATE DUMMY VARIABLE FOR PRESENCE OF PEOPLE 13+ IN HOUSEHOLD (SECTION D FILTER)
1. One person 13+ in household (A3=1 AND A5DUM=3) OR (A3 NOT=1 AND A5DUM=1)
2. Two or more people 13+ in household (A3 + A5X2 = 2 OR MORE AGED 13+)
3. No people 13+ in household / Refused (All others)

*(ALL)
A7 Which of the following best describes your main activity at the moment? Are you....
1. Self-employed
2. Working in paid employment
3. Doing study or training
4. Unemployed and looking for work
5. Doing unpaid voluntary work
6. Retired

7. Engaged in home duties
8. Unable to work, or
9. Doing something else (SPECIFY____)
10. (Can't Say)
11. (Refused)

*(ALL)
A8 And for most of your life, what has been your MAIN occupation?
1. Manager / administrator
2. Professional
3. Associate professional
4. Trades persons
5. Advanced clerical or service
6. Intermediate clerical or service
7. Intermediate production or transport
8. Elementary clerical or service
9. Labourers and related workers
10. NEVER BEEN IN PAID EMPLOYMENT
11. Other (SPECIFY_____)
12. (Refused)

*SECTION B. PERSONAL WELLBEING INDEX

*(ALL)
Bintro As part of the study, we would like to know a little about your health and wellbeing in the last 12 months.....
The first group of questions uses a scale from zero to 10. Zero means you feel completely dissatisfied. 10 means you feel completely satisfied. And 5 means you feel neutral - neither satisfied nor dissatisfied.
CLARIFY AS NECESSARY: There are no right or wrong answers..... just think about your life as a whole.
Would you like me to go over this again for you? EXPLAIN SCALE AGAIN AS NECESSARY
1. Continue

*(ALL)
B1 So, thinking about your own life and your personal circumstances....
How satisfied are you with....
STATEMENTS
a. Your life as a whole
b. Your standard of living
c. Your health
d. What you are achieving in life
e. Your personal relationships
f. How safe you feel
g. Feeling part of your community
h. Your future security
i. Your spirituality or religion

RESPONSE FRAME
0 Completely dissatisfied
1 .
2 .
3 .
4 .
5 Neutral – neither satisfied nor dissatisfied
6 .
7 .
8 .
9 .
10 Completely satisfied
11 (Can't say)
12 (Refused)

*SECTION C. EUROQOL – 5D

*(ALL)
INTRO NOW I HAVE SOME QUESTIONS ABOUT YOUR HEALTH (I REALIZE SOME OF THESE MAY SEEM REPETITIVE BUT PLEASE BEAR WITH ME - WE ASK THE SAME QUESTIONS OF EVERYONE)...
1. Continue

*(ALL)
C1. Which of these statements best describes your own state of health today.....
1. I have NO problems in walking about
2. I have SOME problems in walking about, or
3. I am confined to bed
4. (Can't say)
5. (Refused)

*(ALL)
C2. (Which of these statements best describes your own state of health today.....)
1. I have NO problems with self care
2. I have SOME problems washing or dressing myself or
3. I am unable to wash or dress myself
4. (Can't say)
5. (Refused)

*(ALL)
C3. (Which of these statements best describes your own state of health today.....)
1. I have NO problems with performing my usual activities
2. I have SOME problems with performing my usual activities or
3. I am unable to perform my usual activities
4. (Can't say)
5. (Refused)

*(ALL)
C4. (Which of these statements best describes your own state of health today.....)
1. I have NO pain or discomfort
2. I have MODERATE pain or discomfort or
3. I have EXTREME pain or discomfort
4. (Can't say)
5. (Refused)

*(ALL)
C5. (Which of these statements best describes your own state of health today.....)
1. I am NOT anxious or depressed
2. I am MODERATELY anxious or depressed or
3. I am EXTREMELY anxious or depressed
4. (Can't say)
5. (Refused)

INTERVIEWER NOTE: IF RESPONDENT SOUNDS UPSET/DEPRESSED, PLEASE SAY SOMETHING LIKE: "THERE'S A TELEPHONE NUMBER I CAN GIVE YOU IF YOU WOULD LIKE TO TALK TO SOMEONE" AND GIVE THEM LIFELINE: 131 114
*(ALL)
TIMESTAMP 1

*SECTION D. HEAVY DRINKERS IN YOUR LIFE

*(ALL)
Dintro Now we are interested in the people you have been in contact with over the last 12 months and their drinking. We do not need to know names, just their relationships to you.
PRED1 IF A3=2 OR 3 (NO OTHER ADULTS IN HOUSEHOLD / REFUSED NUMBER OF PEOPLE IN HOUSEHOLD) AND A5DUM =3 (NO CHILDREN 13-17 IN HOUSEHOLD/REFUSED NUMBER OF CHILDREN IN HOUSEHOLD) GO TO D4. OTHERS CONTINUE
*START LOOP
*PROGRAMMER – MAXIMUM ITERATIONS = NUMBER OF PERSONS IN HOUSEHOLD AGED 13 OR OLDER (FROM A3 AND A5x2)
IN FIRST ITERATION OF LOOP, DISPLAY "....any current member of your household"
IN FOLLOWING ITERATIONS OF LOOP, DISPLAY "...any other current members of your household"
*(OTHER HOUSEHOLD MEMBERS AGED 13 OR OVER)
D1 Thinking about the last 12 months, <has there been any CURRENT MEMBER OF YOUR HOUSEHOLD who you would consider to be / would you consider the OTHER MEMBER OF YOUR HOUSEHOLD to be>a fairly heavy drinker, or someone who drinks a lot sometimes?
PROGRAMMER NOTE: INSERT SECOND PHRASE WHEN A7DUM=1 (ONE OTHER PERSON 13+ IN HH)
1. Yes
2. No (GO TO D4)
3. (Can't say) (GO TO D4)
4. (Refused) (GO TO D4)

PRED2 IF A7DUM=1 (ONE OTHER PERSON 13+ IN HH) AND A5= 1-20 (R PROVIDES RELATIONSHIP), GO TO D3, OTHERWISE CONTINUE
*(FAIRLY HEAVY DRINKER IN HOUSEHOLD) (D1=1)
D2 What is their relationship to you?
DISPLAY CODEFRAME FROM A5. DISPLAY "OTHER SPECIFY" RESPONSE (NOT PRECODE)
10. (Refused)

*(FAIRLY HEAVY DRINKER IN HOUSEHOLD) (D1=1)
D3 And would you say your <INSERT RESPONSE TO D2/ INSERT RESPONSE TO A5 IF ONLY ONE OTHER PERSON IN HOUSEHOLD>'s drinking negatively affected you in some way in the last 12 months?
*PROGRAMMER NOTE: IF "REFUSED" RELATIONSHIP AT D2 (AND EQUIVALENT QUESTIONS THROUGHOUT SECTION D), DISPLAY "that person" AT D3.
1. Yes
2. No
3. (Can't say)
4. (Refused)

*END LOOP
*START LOOP
*PROGRAMMER – MAXIMUM ITERATIONS = 8
IN FIRST ITERATION OF LOOP, DISPLAY "....any relative or boy/girlfriend"
IN FOLLOWING ITERATIONS OF LOOP, DISPLAY "...any other relative or boy/girlfriend"
*(ALL)
D4 (And) at any time in the last 12 months, has there been any RELATIVE OR BOYFRIEND OR GIRLFRIEND who does NOT live with you, who you would consider to be a fairly heavy drinker or someone who drinks a lot sometimes?
INTERVIEWER NOTE: BOY/GIRLFRIEND IS A ROMANTIC RELATIONSHIP, NOT JUST A FRIEND
REMIND AS NECESSARY: We are referring to relatives who you have been in contact with in the last 12 months
1. Yes
2. No (GO TO PRED10)
3. (Can't say) (GO TO PRED10)
4. (Refused) (GO TO PRED10)

*(RELATIVE/ BOYFRIEND/GIRLFRIEND WHO IS A FAIRLY HEAVY DRINKER (D4=1)
D5 What is their relationship to you?

PROGRAMMER NOTE: PLEASE DISPLAY LIST AS TWO COLUMNS LIKE THIS SO FITS ON SINGLE SCREEN

1. Son	11. Daughter
2. Father	12. Mother
3. Brother	13. Sister
4. Grandfather	14. Grandmother
5. Uncle	15. Aunt
6. Ex-husband	16. Ex-wife
7. Ex-partner: MALE	17. Ex-partner: FEMALE
8. Current boyfriend	18. Current girlfriend
9. Ex-boyfriend	19. Ex-girlfriend
0. Other MALE (SPECIFY _____)	20. Other FEMALE (SPECIFY _____)
	21. (Refused)

*(RELATIVE / BOYFRIEND/ GIRLFRIEND WHO IS A FAIRLY HEAVY DRINKER (D4=1)
D6 And would you say your <INSERT RESPONSE TO D5>'s drinking has negatively affected you in some way in the last 12 months?
1. Yes
2. No
3. (Can't say)
4. (Refused

*END LOOP
PRED10 IF A7=1,2,5 (CURRENTLY EMPLOYED/VOLUNTEERING) CONTINUE. OTHERS GO TO D12
*(CURRENTLY EMPLOYED/VOLUNTEERING)
D10 And at any time in the last 12 months, have there been any CO-WORKERS who you would consider to be a fairly heavy drinker or someone who drinks a lot sometimes?
1. Yes
2. No (GO TO D12)
3. (Don't have any co-workers) (GO TO D12)
4. (Can't say) (GO TO D12)
5. (Refused) (GO TO D12)

*(CO-WORKER WHO IS A FAIRLY HEAVY DRINKER) (D10=1)
D10a How many (co-workers fall into this category)?
1. Number given (SPECIFY_____) (RANGE 1 TO 200)
2. (Can't say)
3. (Refused)

*(CO-WORKER WHO IS A FAIRLY HEAVY DRINKER) (D10=1)
D11 Overall, would you say their drinking negatively affected you in some way in the last 12 months?
1. Yes
2. No
3. (Can't say)
4. (Refused)

*(ALL)
D12 And what about FRIENDS who do NOT live with you? In the last 12 months, would you consider any of them to be a fairly heavy drinker or someone who drinks a lot sometimes?
1. Yes
2. No (GO TO PRED14)
3. (Can't say) (GO TO PRED14)
4. (Refused) (GO TO PRED14)

*(FRIEND IS FAIRLY HEAVY DRINKER) (D12=1)
D12a How many MALE (friends fall into this category)?
1. Number given (SPECIFY_____) (RANGE 0 TO 99)
2. (Can't say)
3. (Refused)

*(FRIEND IS FAIRLY HEAVY DRINKER) (D12=1)
D12b How many FEMALE (friends fall into this category)?
1. Number given (SPECIFY_____) (RANGE 0 TO 99)
2. (Can't say)
3. (Refused)

PRED13 IF D12A1=1 TO 99 OR D12B1=1 TO 99 (PROVIDED NUMBER) CONTINUE, ELSE GO TO PRED14.
*(FRIEND IS FAIRLY HEAVY DRINKER) (D12a=1 and/or D12b=1)
D13 Overall, would you say their drinking has negatively affected you in some way in the last 12 months?
1. Yes
2. No (GO TO PRED14)
3. (Can't say) (GO TO PRED14)
4. (Refused) (GO TO PRED14)

*(FRIENDS DRINKING HAD NEGATIVE AFFECT)
D13a How many of these friends have negatively affected you in some way in the last 12 months?
1. Number given (SPECIFY_____) (RANGE 1 TO 99) (MAXIMUM ALLOWABLE RANGE SHOULD BE SET TO THE SUM OF D12A=1 AND D12B=1)
2. (Can't say)
3. (Refused)

PRED14 IF D5=6, 7, 9, 16, 17, 19 (MENTIONED EX-PARTNER PREVIOUSLY) GO TO D14 INTRO B. OTHERS GO TO D14 INTRO A.
*(ALL)
D14 INTRO A And has there been an EX-PARTNER, who has been present in your life in the last 12 months, who you would consider to be a fairly heavy drinker or someone who drinks a lot sometimes?
INTRO B And apart from the ex-partner you've already told me about, has there been any other EX-PARTNER, who has been present in your life in the last 12 months, who you would consider to be a fairly heavy drinker or someone who drinks a lot sometimes?
INTERVIEWER NOTE: Ex-partner includes all ex's - ex-wives, ex-husbands, ex-boyfriend, ex-girlfriend, etc
1. Yes
2. No (GO TO D16)
3. (Can't say) (GO TO D16)
4. (Refused) (GO TO D16)

*(EX-PARTNER IS FAIRLY HEAVY DRINKER) (D14=1)
D15 And would you say their drinking negatively affected you in some way in the last 12 months?
1. Yes
2. No
3. (Can't say)
4. (Refused)

*START LOOP
*PROGRAMMER – MAXIMUM ITERATIONS = 4
*(ALL)
D16 In the last 12 months, has there been ANY OTHER PERSON YOU KNOW WELL who you would consider to be a fairly heavy drinker, or someone who drinks a lot sometimes?
1. Yes
2. No (GO TO DDUM)
3. (Can't say) (GO TO DDUM)
4. (Refused) (GO TO DDUM)

*(OTHER PERSON WHO IS A FAIRLY HEAVY DRINKER) (D16=1)
D17 What is that person's relationship to you? DO NOT PROMPT
1. Neighbour
2. Former house-mate
3. Other (SPECIFY__)
4. (Refused)

*(OTHER PERSON WHO IS A FAIRLY HEAVY DRINKER) (D16=1)
D18 And would you say their drinking negatively affected you in some way in the last 12 months?
1. Yes
2. No
3. (Can't say)
4. (Refused)

*END LOOP
*(ALL)
DDUM PROGRAMMER CREATE DUMMY VARIABLE – FAIRLY HEAVY DRINKER IDENTIFIED?
1. No one identified as fairly heavy drinker whose drinking has negatively affected respondent in some way ((D3=2 OR D3=3 OR D3=4) AND (D6=2 OR D6=3 OR D6=4) AND (D11=2 OR 3 OR 4), AND... ETC. (I.E DK / REF INCLUDED)
2. One person only identified as fairly heavy drinker whose drinking has negatively affected respondent in some way (BASED ON D3=1 OR D6=1 OR D11=1 ETC)
3. Two or more persons identified as fairly heavy drinker whose drinking has negatively affected respondent in some way (BASED ON D3=1 OR D6=1 OR D11=1, ETC)
*(ALL)
TIMESTAMP 2
*(ALL)
PRED19 IF DDUM=1 (NO ONE IDENTIFIED AS FAIRLY HEAVY DRINKER) GO TO PREGIntro. OTHERS CONTINUE
*(AT LEAST ONE FAIRLY HEAVY DRINKER IDENTIFIED) (DDUM=2 OR 3)
PRED19_1 IF DDUM=2 GO TO D19 INTRO A. OTHERS (DDUM=3) GO TO D19 INTRO B
*(AT LEAST ONE FAIRLY HEAVY DRINKER IDENTIFIED WHO HAS NEGATIVELY AFFECTED R) (DDUM=2 OR 3)
D19 INTRO A Now, just thinking about your <insert D2 or D5 or "co-worker" IF F11=1>'s drinking and how this has affected you ... overall in the last 12 months, how much has the drinking of this person affected you negatively? Would you say....
INTRO B Now, just thinking about those people who's drinking and how this has affected you ... overall in the last 12 months, how much has the drinking of all of these people affected you negatively? Would you say....
1. A lot, or
2. A little
3. (Can't say) AVOID
4. (Refused)

PRED19b IF DDUM=2 GO TO D19b INTRO A. OTHERS (DDUM=3) GO TO D19b INTRO B
*(AT LEAST ONE FAIRLY HEAVY DRINKER IDENTIFIED WHO HAS NEGATIVELY AFFECTED R) (DDUM=2 OR 3)
D19b INTRO A And on a scale of 1 to 10, where 1 is a little and 10 is a lot, how much has the drinking of this person affected you negatively in the last 12 months?
INTRO B And on a scale of 1 to 10, where 1 is a little and 10 is a lot, how much has the drinking of all of these people affected you negatively in the last 12 months?
1. Number given (SPECIFY_____) (RANGE 1 TO 10)
2. (Can't say)
3. (Refused)

DDUM4 PROGRAMMER CREATE DUMMY VARIABLE FOR AFFECTED NEGATIVELY BY FAIRLY HEAVY DRINKER (For PreJIntro filter)
1. Affected negatively by fairly heavy drinker (D3=1 OR D6=1 OR D11=1 OR D13=1 OR D15=1 OR D18=1 OR D19=1 OR 2)
2. Not affected negatively by fairly heavy drinker (All others)

PRED20 IF DDUM=2 (ONE PERSON ONLY IDENTIFIED AS FAIRLY HEAVY DRINKER) AUTOFILL D20 AND GO TO DDUM1. OTHERS (DDUM=3) CONTINUE
*(ASKED OF TWO OR MORE PERSONS IDENTIFIED AS FAIRLY HEAVY DRINKER) (DDUM=3) (AUTOFILLED FOR DDUM=2)
D20 And thinking about all of these people, overall, whose drinking has most negatively affected you in the last 12 months?
DISPLAY LIST OF PERSONS IDENTIFIED AS FAIRLY HEAVY DRINKER
DISPLAY CATEGORY AND RELATIONSHIP (WHERE RELEVANT), EG.
1. Household member – partner
2. Immediate family member – son
3. Other relative – brother in law
4. Close friend
5. Co-worker
6. Other person - neighbour
7. (Can't say
8. (Refused)

PREDDRK IF D20 ="Can't say" OR "Refused", CONTINUE; OTHERWISE GO TO PROGRAMMER NOTE THAT FOLLOWS DDRK
DDRK For the rest of this survey, we need to focus on ONE heavy drinker. The computer can select one randomly if you can't decide.

INTERVIEWER NOTE: GO BACK TO D20 IF RESPONDENT PROVIDES A HEAVY DRINKER
PROGRAMMER NOTE: IF D20="Can't say" OR "Refused", SELECT REFERENCE DRINKER ACCORDING TO FOLLOWING HIERARCHY; Current Member Of Your Household, ELSE Relative / boyfriend / girlfriend ELSE Ex-partner ELSE friend ELSE Co-worker ELSE Any other person. (IE FROM "CLOSEST" TO "FURTHEST AWAY")
IF >1 FAIRLY HEAVY DRINKER IN SELECTED CATEGORY, RANDOMLY SELECT REFERENCE DRINKER FROM WITHIN THIS CATEGORY
*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT) (D19=1, 2, OR 3)
DDUM1 PROGRAMMER CREATE DUMMY VARIABLE FOR REFERENCE DRINKER CURRENTLY IN HOUSEHOLD
1. Person whose drinking has most negatively affected respondent in last 12 months is current household member (BASED ON D20 / D3)
2. All others

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
PRED21 IF DDUM1=1 (REFERENCE DRINKER IS CURRENT HOUSEHOLD MEMBER) GO TO DDUM2. OTHERS CONTINUE.
*(REFERENCE DRINKER NOT CURRENT HOUSEHOLD MEMBER)
D21 And just to confirm, have you lived with your <INSERT RESPONSE TO D20> at all in the last 12 months?
1. Yes
2. No
3. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
DDUM2 PROGRAMMER CREATE DUMMY VARIABLE FOR REFERENCE DRINKER LIVED IN HOUSEHOLD AT ANY TIME IN LAST 12 MONTHS
1. Reference drinker lived in respondent's household at some time in last 12 months (DDUM1=1 OR D21=1)
2. All others

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
DDUM3 PROGRAMMER CREATE DUMMY VARIABLE FOR GENDER OF REFERENCE PERSON (USED IN SECTION F) FROM D20
1. Reference person is male (son, father, brother, uncle, nephew, etc)
2. Reference person is female
3. Gender of reference person unknown (e.g. partner, close friend, anyone at work, other person, cousin)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT
D22 When we spoke with you last time, was your <INSERT RESPONSE TO D20>'s drinking negatively affecting you then? IF NECESSARY: We last spoke with you around three years ago.
1. Yes
2. No (GO TO D24)
3. Unsure/Can't remember (GO TO INTGEN)
4. (Refused) (GO TO INTGEN)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT
D23 Did this person's drinking negatively affect you the most at that time?
INTERVIEWER NOTE: THIS PERSON IS THE HEAVY DRINKER THAT NEGATIVELY AFFECTED THE RESPONDENT MORE THAN ANYONE ELSE'S DRINKING IN 2008.
1. Yes (GO TO INTGEN)
2. No
3. Unsure/Can't remember (GO TO INTGEN)
4. (Refused) (GO TO INTGEN)

*(DIFFERENT PERSONS DRINKING NEGATIVELY AFFECTING RESPONDENT (MOST) NOW)
D24 Does the heavy drinker, whose drinking most affected you in 2008, still negatively affect you?
1. Yes
2. No
3. Unsure/Can't remember
4. (Refused)

*SECTION E. DESCRIPTIVE SECTION

Intgen INTERVIEWER RECORD YOUR GENDER

1. Interviewer is male
2. Interviewer is female

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
Eintro Now, I am going to ask you some questions about the impact of your <INSERT RESPONSE TO D20>'s drinking on your life. A few of the questions relate to sensitive topics such as sexual activities and abuse. Not all of the questions may be relevant to you. You can skip any questions that you feel uncomfortable answering.

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
PREE1 IF INTGEN= 1 (INTERVIEWER AND RESPONDENT SAME GENDER) GO TO E1. OTHERS CONTINUE

*(RESPONDENT IS DIFFERENT GENDER TO INTERVIEWER)
PREEintro IF A1=1 (RESPONDENT IS MALE) GO TO INTRO A, OTHERS GO TO INTRO B

*(RESPONDENT IS DIFFERENT GENDER TO INTERVIEWER)
EIntro INTRO A Would you prefer to speak with a male interviewer who could call you back for this section of the questionnaire?
INTRO B Would you prefer to speak with a female interviewer who could call you back for this section of the questionnaire?

1. Continue
2. Make appointment for call back by interviewer of same gender

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E1 Thinking about the last 12 months, please tell me how many times, if any, each of the following have happened because of your <INSERT RESPONSE TO D20>'s drinking, including because they were intoxicated, feeling the effects of alcohol or hung over?
So, how many times in the last 12 months....
STATEMENTS
a. Did you have a serious argument that did NOT include physical violence because of (his / her / their) drinking?
b. Did you feel threatened because of (his / her / their) drinking?
c. Were you emotionally hurt or neglected because of (his / her / their) drinking?
d. Were you physically hurt by them because of (his / her / their) drinking?
e. Did you have to stop seeing them because of (his / her / their) drinking?
f. Were you put at risk in the car when they were driving, because of (his / her / their) drinking?
g. Were you forced or pressured into sex or something sexual because of (his / her / their) drinking?
h. Did they negatively affect a social occasion you were at because of (his / her / their) drinking?
i. Did they fail to do something they were being counted on to do because of (his / her / their) drinking?
j. Did they break or damage something that mattered to you because of (his / her / their) drinking?

RESPONSE FRAME
1. Once
2. Twice
3. Three times
4. Four times
5. Five or more times (SPECIFY___) (RANGE 5 TO 999)
6. None
7. (Can't say)
8. (Refused)

PREE1X2 IF E1j = 1 TO 5 (THEY BROKE SOMETHING THAT MATTERED TO YOU) CONTINUE, OTHERWISE GO TO E1X
*(BROKEN OR DAMAGED SOMETHING) (E1j =1, 2, 3, 4, 5)
E1x2 What was the estimated out of pocket expense because of this?
1. Amount of money given (SPECIFY $_____) (RANGE 1 TO 999999)
2. Item of sentimental value – can't put $ value on it
3. (Can't say)
4. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT AND LIVED IN THE RESPONDENTS HOUSEHOLD IN THE LAST 12 MONTHS)
E1x Still thinking about the last 12 months, how often...
STATEMENTS
k. Could you not bring friends home because of (his / her / their) drinking? (ONLY DISPLAY IF DDUM2=1) (REFERENCE DRINKER LIVED IN RESPONDENT'S HOUSEHOLD AT SOME TIME IN LAST 12 MONTHS)
l. Did they not do their share of work around the house because of (his / her / their) drinking? (ONLY DISPLAY IF DDUM2=1)
m. Did you have to leave home to stay somewhere else because of (his / her / their) drinking? (ONLY DISPLAY IF DDUM2=1)

RESPONSE FRAME
1. Once
2. Twice
3. Three times
4. Four times
5. Five or more times (SPECIFY___) (RANGE 5 TO 999)
6. None
7. (Can't say)
8. (Refused)

PREE1x3 IF E1X(j) = 1 TO 5 (HAD AT LEAST ONE OCCASION WHERE YOU HAD TO LEAVE HOME TO STAY SOMEWHERE) CONTINUE, OTHERWISE GO TO E1x4

*(STAYED SOMEWHERE)
E1x3 And how many days did this involve in total?

INTERVIEWER NOTE: ENCOURAGE BEST ESTIMATE

1. Number of days given (SPECIFY _____) (RANGE 0.5 to 365; ALLOW DECIMALS)
2. (Don't know)
3. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
PREE1x4 IF DDUM2=1, CONTINUE. OTHERWISE, GO TO PREE1x1

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E1x4 Was there less money for household expenses because of (his / her / their) drinking?
RESPONSE FRAME
1. Once
2. Twice
3. Three times
4. Four times
5. Five or more times (SPECIFY___) (RANGE 5 TO 999)
6. None
7. (Can't say)
8. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E2intro Next, some questions about things that you may have done for your <INSERT RESPONSE TO D20> because of (his / her / their) drinking.
1. Continue

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E2 How many times in the last 12 months did you have to SPEND TIME CARING FOR THEM because of (his / her / their) drinking?
1. One or more (SPECIFY_____) (RANGE 1 TO 999)
2. None (GO TO E3)
3. (Can't say) (GO TO E3)
4. (Refused) (GO TO E3)

*(SPENT TIME CARING) (E2=1)
E2a How much time did this take out of your normal routine?
ENCOURAGE BEST ESTIMATE
1. Time given in hours (SPECIFY_____) (RANGE 0.25 TO 99; ALLOW DECIMALS)
2. Time given in days (SPECIFY_____) (RANGE 0.5 TO 365; ALLOW DECIMALS)
3. Time given in weeks (SPECIFY_____) (RANGE 1 TO 52)
4. (Can't say)
5. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E3 How many times in the last 12 months did you have to TAKE ON EXTRA RESPONSIBILITIES CARING FOR CHILDREN OR OTHERS because of (his / her / their) drinking?

1. One or more (SPECIFY_____) (RANGE 1 TO 999)
2. None (GO TO E5)
3. (Can't say) (GO TO E5)
4. (Refused) (GO TO E5)

*(TOOK ON EXTRA CARING RESPONSIBILITIES) (E3=1)
E3a How much time did this take out of your normal routine?
ENCOURAGE BEST ESTIMATE
1. Time given in hours (SPECIFY_____) (RANGE 0.25 TO 99; ALLOW DECIMALS)
2. Time given in days (SPECIFY_____) (RANGE 0.5 TO 365; ALLOW DECIMALS)
3. Time given in weeks (SPECIFY_____) (RANGE 1 TO 52)
4. (Can't say)
5. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E5 How many times in the last 12 months have you had to CLEAN UP AFTER THEM because of (his / her / their) drinking?
1. Once
2. Two or more times (SPECIFY_____) (RANGE 2 TO 999) (GO TO E5b)
3. None (GO TO E6)
4. (Can't say) (GO TO E6)
5. (Refused) (GO TO E6)

*(HAD TO CLEAN UP AFTER THEM ONCE) (E5=1)

E5a How much time did this take (in hours or days)?
ENCOURAGE BEST ESTIMATE
1. Time given in hours (SPECIFY_____) (RANGE 0.25 TO 99; ALLOW DECIMALS) (GO TO E6)
2. Time given in days (SPECIFY_____) (RANGE 0.5 TO 365; ALLOW DECIMALS(GO TO E6)
3. (Can't say) (GO TO E6)
4. (Refused) (GO TO E6)

*(HAD TO CLEAN UP AFTER THEM TWICE OR MORE) (E5=2)
E5b How many hours did this take EACH time, on average?
ENCOURAGE BEST ESTIMATE
1. Time given in hours (SPECIFY_____) (RANGE 0.25 TO 99; ALLOW DECIMALS)
2. Time given in days (SPECIFY_____) (RANGE 0.5 TO 365; ALLOW DECIMALS)
3. (Can't say)
4. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E6 How many times in the last 12 months did you have to take (his / her / their) somewhere or pick them up because of their drinking?
1. Once
2. Two or more times (SPECIFY_____) (RANGE 2 TO 999) (GO TO E6b)
3. (None (GO TO E7)
4. Can't say) (GO TO E7)
5. (Refused) (GO TO E7)

*(HAD TO TAKE THEM SOMEWHERE) (E6=1)
E6a How much time did this take?
ENCOURAGE BEST ESTIMATE
1. Time given in hours (SPECIFY_____) (RANGE 0.25 TO 99; ALLOW DECIMALS) (GO TO E7)
2. (Can't say) (GO TO E7)
3. (Refused) (GO TO E7)

*(HAD TO TAKE THEM SOMEWHERE TWICE OR MORE) (E6=2)
E6b How many hours did this take each time, on average?
ENCOURAGE BEST ESTIMATE
1. Time given in hours (SPECIFY_____) (RANGE 0.25 TO 99; ALLOW DECIMALS)
2. (Can't say)
3. (Refused)

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
E7 Overall, in the last 12 months, how much has the drinking of your <INSERT RESPONSE TO D20> negatively affected you? Would you say....
1. A lot
2. A little, or
3. Not at all (GO TO EDUM)
4. (Can't say) (GO TO EDUM)
5. (Refused) (GO TO EDUM)

*(NEGATIVELY EFFECTED) (E7 = 1 or 2)
E8 And on a scale of 1 to 10, where 1 is a little and 10 is a lot, how much has the drinking of this person affected you negatively in the last 12 months?
1. Number given (SPECIFY_____) (RANGE 1 TO 10)
2. (Can't say)
3. (Refused)

EDUM PROGRAMMER CREATE DUMMY VARIABLE - EXPERIENCED HARM DUE TO REFERENCE DRINKER
1. Experienced a harm: E1(a-j) = 1 TO 5 OR E1x(H-J) = 1 TO 5 OR E1x4 = 1 TO 5 OR E2 = 1 OR E3 = 1 OR E5 = 1,2 OR E6 = 1,2 OR E7 = 1,2
2. Not experienced a harm: (Other than above)

*SECTION F. DEMOGRAPHICS OF IDENTIFIED DRINKER

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
Fintro Now a few questions about your <INSERT RESPONSE TO D20>...
1. Continue

PREF1 IF DDUM3=3 (GENDER OF REFERENCE PERSON UNKNOWN) CONTINUE. OTHERS (GENDER OF REFERENCE PERSON KNOWN) AUTOFILL F1 FROM DDUM3 AND CONTINUE TO F2
*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
F1 PERSON IS: <DISPLAY RESPONSE TO D20>
RECORD GENDER OF PERSON (ASK ONLY IF NECESSARY)
Is your <INSERT RESPONSE TO D20> male or female?
1. Male
2. Female

*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
F2 How old is your <INSERT RESPONSE TO D20>?
1. Number given (SPECIFY_____) (RANGE 1 TO 99) GO TO F3
2. (Can't say/unsure)
3. (Refused) GO TO F3

*(IF UNSURE OF AGE (F2=2))
F2a Would you say they are.. (READ OUT AS APPROPRIATE)
1. Younger than 20
2. In their 20's
3. In their 30's
4. In their 40's
5. In their 50's
6. In their 60's
7. In their 70's
8. Older
9. (Can't say) AVOID
10. (Refused)

*PROGRAMMER NOTE: INSERT "he" OR "she" THROUGHOUT SECTIONS G AND F BASED ON GENDER AT F1.
*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
F3 The next questions are about your <INSERT RESPONSE TO D20 >'s drinking....
You indicated that (he / she) drinks fairly heavily or drinks a lot sometimes. How often does (he / she) drink in this way?
1. Every day (GO TO F4)
2. 5 to 6 days a week (GO TO F4)
3. 3 to 4 days a week (GO TO F4)
4. 1 to 2 days a week (GO TO F4)
5. 2 to 3 days a month (GO TO F4)
6. About 1 day a month (GO TO F4)
7. Less often (GO TO F4)
8. (No longer drink, gave up in the last 12 months) (GO TO F3b)
9. (Can't say)
10. (Refused) (GO TO F4)

*(CAN'T SAY HOW OFTEN REFERENCE DRINKER DRINKS FAIRLY HEAVILY)
F3a Would you say it was....
1. Once a week or more (GO TO F4)
2. Less than once a week (GO TO F4)
3. (Can't say) (GO TO F4)
4. (Refused) (GO TO F4)

*(REFERENCE DRINKER NO LONGER DRINKS) (F3=8)
F3b You indicated that (he / she) USED TO drink fairly heavily or used to drink a lot sometimes. How often did (he / she) used to drink in this way?
1. Every day
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. (Can't say)
9. (Refused)

*PROGRAMMER NOTE: USE PAST TENSE FOR F3=8 IN F4 AND F5, ELSE USE PRESENT TENSE
*REFERENCE TO "pot" IN F4 TO BE TAILORED BY STATE IN SAMPLE RECORD:
STATE= VIC, QLD, TAS: pot
STATE=NSW, WA, ACT: middy
STATE=SA: pot (or schooner)
STATE=NT: pot (or handle)
*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
F4 As you may know, a standard drink is equal to 1 pot or middy of full strength beer, three-quarters of a stubbie, 1 small glass of wine, 1 pub sized shot of spirits, or two-thirds of a can or bottle of premixed spirits or alcoholic soda.
So, to understand what you mean by a fairly heavy drinker....How many standard drinks (does / did) (he / she) have on average when (he / she) (drinks / drank) fairly heavily or a lot? Would you say...
1. 20 or more standard drinks a day (GO TO F5)
2. 11 – 19 standard drinks a day (GO TO F5)
3. 7 – 10 standard drinks a day (GO TO F5)
4. 5 – 6 standard drinks a day (GO TO F5)
5. 3 – 4 standard drinks a day (GO TO F5)
6. 1 – 2 standard drinks a day (GO TO F5)
7. Less than 1 standard drink per day (GO TO F5)
8. (Can't say)
9. (Refused) (GO TO F5)

(CAN'T SAY NUMBER OF STANDARD DRINKS) (F4=8)
F4a Well, would you say it was.....
1. 5 or more standard drinks
2. Less than 5 standard drinks
3. (Can't say)
4. (Refused)

IF NECESSARY: Five or more standard drinks would be about two-thirds of a bottle of wine or three and a half stubbies.
*(REFERENCE DRINKER NEGATIVELY AFFECTED RESPONDENT A LITTLE / A LOT)
F5 How often (did / does) (he / she) have five or more standard drinks?
IF NECESSARY: This would be about two-thirds of a bottle of wine or three and a half stubbies.
1. Every day (GO TO Gintro)
2. 5 to 6 days a week (GO TO Gintro)
3. 3 to 4 days a week (GO TO Gintro)
4. 1 to 2 days a week (GO TO Gintro)
5. 2 to 3 days a month (GO TO Gintro)
6. About 1 day a month (GO TO Gintro)
7. Less often (GO TO Gintro)
8. Never (GO TO Gintro)
9. (Can't say)
10. (Refused) (GO TO Gintro)

*(CAN'T SAY HOW OFTEN HAD FIVE OR MORE STANDARD DRINKS) (F5=9)
F5a Well, would you say it was.....
1. Once a week or more
2. Less than once a week
3. I know they have 5 drinks or more sometimes but I don't know how often
4. (Can't say)
5. (Refused)

*SECTION G. CHILDREN SECTION

* (ALL)
Gintro The next few questions relate to children and other people's drinking, excluding your own drinking.....

INTERVIEWER NOTE: 'OTHER PEOPLE' REFERS TO ANYONE – WHETHER RESPONDENT HAS ALREADY MENTIONED THEM OR NOT

INTERVIEWER NOTE: OTHER PEOPLE DOES NOT MEAN RESPONDENT

1. Continue

PREGintro1 IF A6DUM=1 (CHILDREN UNDER 18 PRESENT IN HOUSEHOLD) CONTINUE. OTHERS GO TO G1

*(CHILDREN UNDER 18 PRESENT IN HOUSEHOLD)
Gintro1 Apart from the children in your household...

1. Continue

*(ALL)
G1 Are there any children 17 or younger NOT living in your household for whom you have some parental responsibility?

1. Yes
2. No (GO TO PREG3)
3. (Can't say) (GO TO PREG3)
4. (Refused) (GO TO PREG3)

*(HAS OTHER CHILDREN 17 AND UNDER NOT LIVING IN HOUSEHOLD) (G1=1)
G2 How many?

1. One
2. Two
3. Three
4. Four
5. Five
6. Six or more (SPECIFY___) (RANGE 6 TO 12)
7. (Refused)

PREG3 IF A6DUM=1 AND G1=2 or 3 or 4 (CHILDREN UNDER 18 PRESENT IN HOUSEHOLD BUT NOT OTHER CHILDREN) GO TO G3 INTROA;
IF A6DUM=2 ANDG1=1 (HAS OTHER CHILDREN UNDER 18 NOT LIVING IN HOUSEHOLD BUT NONE IN HOUSEHOLD) GO TO G3 INTROB
IF A6DUM=1 AND G1=1 (CHILDREN UNDER 18 PRESENT IN HOUSEHOLD AND HAS OTHER CHILDREN UNDER 18 NOT LIVING IN HOUSEHOLD) GO TO G3 INTROC;
OTHERWISE GO TO PREHIntro

*(CHILDREN PRESENT IN HOUSEHOLD / HAS OTHER CHILDREN) (A6DUM = 1 OR G1=1)
G3 INTROA Thinking about the children under 18 who live in your household, how many times, if any, in the last 12 months ...
INTROB Thinking about these children, how many times, if any, in the last 12 months ...
INTROC Thinking about all the children under 18 you've mentioned, whether they live with you or not, how many times, if any, in the last 12 months .....

STATEMENTS
a. Was one or more left in an unsupervised or unsafe situation because of someone else's drinking?
b. How many times) was one or more yelled at, criticised or otherwise verbally abused because of someone else's drinking?
c. (How many times) was one or more physically hurt because of someone else's drinking?
d. (How many times) did one or more of these children witness serious violence in the home because of someone else's drinking?

(How many times) was the child protection agency or family services called because of someone else's drinking?
RESPONSE FRAME
1. Once
2. Twice
3. Three times
4. Four times
5. Five or more times (SPECIFY___) (RANGE 5 TO 999)
6. None
7. (Can't say)
8. (Refused)

PREG3a IF CHILDREN EXPERIENCING HARM (ANY G3 a –e =1 OR 2 OR 3 OR 4 OR 5)CONTINUE. OTHERS GO TO G4
*(CHILDREN EXPERIENCING HARM) (G3a –e =1, 2 ,3 ,4 ,5)
G3a What was the relationship to the child(ren) of that person/those people? (MULTIPLES ACCEPTED)
1. Parent
2. Step parent, or spouse or partner of the child's parent
3. Child's guardian (A PERSON WITH AN ONGOING LEGAL RESPONSIBILITY FOR THE CARE AND PROTECTION OF THE CHILD)
4. Sibling
5. Another relative
6. Family friend or person with whom the child comes into contact, such as a sports coach, teacher, or priest
7. Someone else (SPECIFY _____)

*(CHILDREN PRESENT IN HOUSEHOLD / HAS OTHER CHILDREN) (A6DUM = 1 OR G1=1)
G4 How much has the drinking of other people, negatively affected (this child / these children) in the last 12 months? Would you say....
1. A lot
2. A little
3. Not at all (GO TO PREG6)
4. (Can't say) (GO TO PREG6)
5. (Refused) (GO TO PREG6)

*(CHILDREN NEGATIVELY AFFECTED) (G4 = 1 OR 2)

G5 And on a scale of 1 to 10, where 1 is a little and 10 is a lot, how much has the drinking of other people negatively affected this child/these children in the last 12 months?
1. Number given (SPECIFY_____) (RANGE 1 TO 10)
2. (Can't say)
3. (Refused)

PREG6 IF A6DUM=1 AND G1=2 or 3 or 4 (CHILDREN UNDER 18 PRESENT IN HOUSEHOLD BUT NOT OTHER CHILDREN) GO TO G6 INTROA;
IF A6DUM=2 ANDG1=1 (HAS OTHER CHILDREN UNDER 18 NOT LIVING IN HOUSEHOLD BUT NONE IN HOUSEHOLD) GO TO G6 INTROB
IF A6DUM=1 AND G1=1 (CHILDREN UNDER 18 PRESENT IN HOUSEHOLD AND HAS OTHER CHILDREN UNDER 18 NOT LIVING IN HOUSEHOLD) GO TO G6 INTROC;
OTHERWISE GO TO PREHIntro

*(CHILDREN PRESENT IN HOUSEHOLD / HAS OTHER CHILDREN) (A6DUM = 1 OR G1=1)
G6intro The next few questions relate to children and your drinking in the last 12 months...

1. Continue
*PROGRAMMER NOTE: IF G6A=9 (DON'T DRINK) ASK G7 & G7A PRIOR TO ASKING OTHER STATEMENTS. G7 AND G7A ARE NOT ASKED OF ANYONE IF G6=NOT 9.
*(CHILDREN PRESENT IN HOUSEHOLD / HAS OTHER CHILDREN) (A6DUM = 1 OR G1=1)
G6 INTROA Thinking again about the children under 18 who live in your household, how many times, if any, in the last 12 months ...
INTROB Thinking again about these children, how many times, if any, in the last 12 months ...
INTROC Thinking again about all the children under 18 you've mentioned, whether they live with you or not, how many times, if any, in the last 12 months .....

STATEMENTS
a. Was one or more left in an unsupervised or unsafe situation because of your drinking?
b. (How many times) was one or more yelled at, criticised or otherwise verbally abused because of your drinking?
c. (How many times) was one or more physically hurt because of your drinking?
d. (How many times) did one or more of these children witness serious violence in the home because of your drinking?
e. (How many times) was the child protection agency or family services called because of your drinking?

RESPONSE FRAME
1. Once
2. Twice
3. Three times
4. Four times
5. Five or more times (SPECIFY___) (RANGE 5 TO 999)
6. None
7. (Can't say)
8. (Refused)
9. I don't drink (ONLY DISPLAY FOR G6A)

*DON'T DRINK
G7 Have you been a non-drinker for the last 12 months or more?

1. Yes – have not been drinking during the last 12 months (GO TO IINTRO)
2. No – have been a drinker at some time during the last 12 months
3. Can't say (GO TO IINTRO)
4. Refused (GO TO IINTRO)

*HAVE BEEN A DRINKER DURING THE LAST 12 MONTHS (G7=2)
G7a These questions are about the time in the last 12 months when you were drinking.

1. SNAP BACK TO G6a

PREG8 IF A6DUM=1 OR G1=1 (CHILDREN PRESENT IN HOUSEHOLD/HAS OTHER CHILDREN) CONTINUE, ELSE GO TO IINTRO
*(CHILDREN PRESENT IN HOUSEHOLD / HAS OTHER CHILDREN) (A6DUM = 1 OR G1=1)
G8 How much has your own drinking negatively affected (this child / these children) in the last 12 months? Would you say....
1. A lot
2. A little
3. Not at all (GO TO IINTRO)
4. (Can't say) (GO TO IINTRO)
5. (Refused) (GO TO IINTRO)

*(CHILD/REN NEGATIVELY AFFECTED) (G8 = 1 OR 2)

G9 And on a scale of 1 to 10, where 1 is a little and 10 is a lot, how much has your drinking negatively affected this child/these children in the last 12 months?
1. Number given (SPECIFY_____) (RANGE 1 TO 10)
2. (Can't say)
3. (Refused)

*SECTION I. ALCOHOL-RELATED HARM IN THE COMMUNITY

*(ALL)
Iintro We would now like to ask you about STRANGERS or PEOPLE YOU DON'T KNOW VERY WELL.
1. Continue
*(ALL)
TIMESTAMP3
*(ALL)
I1 In the last 12 months, how many times have you...
STATEMENTS
a. Been kept awake at night or disturbed because of someone's drinking?
b. Been verbally abused because of someone's drinking?
c. Been physically abused because of someone's drinking?
d. Been threatened because of someone's drinking?
e. Been involved in a serious argument because of someone's drinking?
f. Felt unsafe while waiting for or using public transport because of someone's drinking?
g. Felt unsafe in any other public place because of someone's drinking?
h. Gone out of your way to avoid drunk people or places where drinkers are known to hang out?
i. Been annoyed by people vomiting, urinating or littering when they have been drinking?
j. Experienced trouble or noise because of drinkers at a licensed venue?
k. Been involved in a traffic accident because of someone's drinking?
l. Been forced or pressured into sexual activity because of someone's drinking?

RESPONSE FRAME
1. One or more (SPECIFY_____) (RANGE 1 TO 999)
2. None
3. (Can't say)
4. (Refused)

*(ALL)
I4 Still thinking about strangers and people you don't know very well, how many times in the last 12 months did you have your house, car or property damaged because of their drinking?
1. One or more (SPECIFY_____) (RANGE 1 TO 999)
2. None (GO TO PREI5)
3. (Can't say) (GO TO PREI5)
4. (Refused) (GO TO PREI5)

*(HOUSE, CAR OR PROPERTY DAMAGED)
I4a What was the approximate dollar value of the damage to your property?
1. Amount given (SPECIFY $____) (RANGE 1 TO 999999)
2. (Can't say)
3. (Refused)

PREI5 IF I4=2, 3, OR 4 (NO DAMAGE TO HOUSE, CAR OR PROPERTY) GO TO I5 INTRO A. OTHERS GO TO I5 INTRO B
*(ALL)
I5 INTRO A How many times in the last 12 months did any person affected by alcohol damage your clothes or other belongings?
INTRO B Apart from these items, how many times in the last 12 months did any person affected by alcohol damage your clothes or other belongings?
1. One or more (SPECIFY_____) (RANGE 1 TO 999)
2. None (GO TO I8)
3. (Can't say) (GO TO I8)
4. (Refused) (GO TO I8)

*(CLOTHES OR OTHER BELONGINGS DAMAGED) (I5=1)
I5a What is the approximate dollar value of repairing or replacing the damaged item(s)?
1. Amount given (SPECIFY $____) (RANGE 1 TO 99999)
2. (Can't say)
3. (Refused)

*(ALL)
I8 So overall, how much has the drinking of strangers or people you don't know very well negatively affected you in the last 12 months? Would you say...
1. A lot
2. A little, or
3. Not at all
4. (Can't say)
5. (Refused)

IDUM PROGRAMMER CREATE DUMMY VARIABLE - EXPERIENCED HARM FROM STRANGER
1. Experienced harm from stranger: I1a-I =1 or I4=1 or I5=1 or I8=1 or 2
2. Not experienced harm from stranger: (If otherwise)
PREI9 IF I8=1 OR 2 (DRINKING OF STRANGERS HAD A NEGATIVE AFFECT CONTINUE, ELSE GO TO PREJINTRO
*(NEGATIVELY AFFECTED) (I8 = 1 or 2)
I9 And on a scale of 1 to 10, where 1 is a little and 10 is a lot, how much has the drinking of strangers or people you don't know very well negatively affected in the last 12 months?
1. Number given (SPECIFY_____) (RANGE 1 TO 10)
2. (Can't say)
3. (Refused)

*SECTION J. SERVICE USE

*(ALL)
PREJIntro IF DDUM4=1 OR EDUM= 1 OR IDUM=1, (RESPONDENT HAS EXPERIENCED HARM / BEEN NEGATIVELY AFFECTED DUE TO OTHERS' DRINKING) CONTINUE. OTHERWISE GO TO KIntro

*(EXPERIENCED HARM DUE TO OTHERS' DRINKING)
Jintro Now thinking about services you may have used in the last 12 months because of people's drinking, including people you know AND strangers...

1. Continue

*(EXPERIENCED HARM DUE TO OTHERS' DRINKING)
J1 How many times did you call the police (because of other people's drinking)?
1 One or more (SPECIFY____) (RANGE 1 TO 999)
2 None (GO TO J3)
3 (Can't say) (GO TO J3)
4 (Refused) (GO TO J3)

*(CALLED THE POLICE ONE OR MORE TIMES)
J1a How much time in total did this take out of your normal activities in hours or days– this includes time spent waiting for police, time spent with police, and so on?
1. Time given in hours (SPECIFY_____) (RANGE 1 TO 99)
2. Time given in days (SPECIFY_____) (RANGE 1 TO 365)
3. (Can't say)
4. (Refused)

*(CALLED THE POLICE ONE OR MORE TIMES)
J2x Thinking of the (last) time you called the police, did you make the call because of strangers' drinking, people you know or both?
1. Strangers
2. Known persons
3. Both – strangers and known persons
4. (Can't say)
5. (Refused)

*(CALLED THE POLICE ONE OR MORE TIMES)
J2xa And what was the main reason you called the police? (MULTIPLES ACCEPTED)
1. Verbal disagreement
2. Noise
3. Physical fight/assault
4. Trespassing
5. Vandalism
6. Robbery
7. Other (SPECIFY)
8. (Can't say)
9. (Refused)

*(EXPERIENCED HARM DUE TO OTHERS' DRINKING)
J3 (How many times in the last 12 months)
Have YOU been admitted to hospital or an emergency department (due to other people's drinking)?
INTERVIEWER NOTE: THIS QUESTION ASKS ABOUT RESPONDENT'S INJURIES, NOT THE DRINKER'S
1. One or more (SPECIFY____) (RANGE 1 TO 99)
2. None (GO TO J2)
3. (Can't say) (GO TO J2)
4. (Refused) (GO TO J2)

*(ADMITTED TO HOSPITAL OR EMERGENCY DEPARTMENT)
J3a How much time in total did this take out of your normal activities, in hours or days, including time spent getting to and from the hospital?
1. Time given in hours (SPECIFY_____) (RANGE 1 TO 99)
2. Time given in days (SPECIFY_____) (RANGE 1 TO 365)
3. (Can't say)
4. (Refused)

*(ADMITTED TO HOSPITAL OR EMERGENCY DEPARTMENT)
J3b What were your total out of pocket expenses for your treatment?
1. Amount given (SPECIFY_____) (RANGE 1 TO 99999)
2. No out of pocket expenses
3. (Can't say)
4. (Refused)

*(EXPERIENCED HARM DUE TO OTHERS' DRINKING)
J2 (How many times in the last 12 months have you..)
Received any OTHER medical treatment (due to other people's drinking)?
1. One or more (SPECIFY____) (RANGE 1 TO 999)
2. None (GO TO J4)
3. (Can't say) (GO TO J4)
4. (Refused) (GO TO J4)

*(GOT TREATMENT AT A MEDICAL OR HEALTH CENTRE)
J2a How much time in total did this treatment take out of your normal activities, including time spent getting to and from the medical or health centre, in hours or days?
1. Time given in hours (SPECIFY_____) (RANGE 1 TO 99)
2. Time given in days (SPECIFY_____) (RANGE 1 TO 365)
3. (Can't say)
4. (Refused)

*(GOT TREATMENT AT A MEDICAL OR HEALTH CENTRE)
J2b What were your total out of pocket expenses for this medical treatment?
1. Amount given (SPECIFY_____) (RANGE 1 TO 99999)
2. No out of pocket expenses
3. (Can't say)
4. (Refused)

*(EXPERIENCED HARM DUE TO OTHERS' DRINKING)
J4 (How many times in the last 12 months have you)
Received counselling or professional advice, including calling a helpline, because of other people's drinking or the problems it was causing?
1. One or more (SPECIFY____) (RANGE 1 TO 99)
2. None (GO TO J5)
3. (Can't say) (GO TO J5)
4. (Refused) (GO TO J5)

*(GOT COUNSELLING OR PROFESSIONAL ADVICE)
J4a How many hours did this take out of your normal activities over the last 12 months?
1. Time given in hours (SPECIFY_____) (RANGE 1 TO 99)
2. Time given in days (SPECIFY_____) (RANGE 1 TO 365)
3. (Can't say)
4. (Refused)

*(GOT COUNSELLING OR PROFESSIONAL ADVICE)
J4b What were your total out of pocket expenses for this counselling?
1. Amount given (SPECIFY_____) (RANGE 1 TO 99999)
2. No out of pocket expenses
3. (Can't say)
4. (Refused)

*(EXPERIENCED HARM DUE TO OTHERS' DRINKING)
J5 How many times in the last 12 months have you received support or advice from self-help services, because of other people's drinking or the problems it was causing?
IF NECESSARY, A SELF-HELP SERVICE IS PROVIDE BY PEOPLE WHO HAVE EXPERIENCED SIMILAR PROBLEMS EG AL-ANON.
1. One or more (SPECIFY____) (RANGE 1 TO 99)
2. None
3. (Can't say)
4. (Refused)

PREJ6 IF A7 = 1,2,5 (CURRENTLY WORKING/VOLUNTEERING) CONTINUE. OTHERWISE GO TO Kintro
*(EXPERIENCED HARM AND IS WORKING)
J6 And how many days, if any, have you had to take off work in the last 12 months due to other people's drinking?
1. Number of days given (SPECIFY_____) (RANGE 1 TO 365)
2. None
3. (Can't say)
4. (Refused)

*SECTION K. DEMOGRAPHICS FOR THE RESPONDENT

*(ALL)
Kintro Now I have some questions about yourself and your household....
1. Continue
*(ALL)
K4 What is your postcode?
DISPLAY POSTCODE FROM SAMPLE RECORD
1. Postcode correct
2. Postcode incorrect – collect new postcode (SPECIFY_____) (RANGE 800 TO 8999)
3. Don't know postcode – collect suburb / locality (SPECIFY_____)
4. (Refused) (RETURN POSTCODE FROM SAMPLE RECORD)
*(ALL)
K6 What is your total HOUSEHOLD income, FROM ALL SOURCES, BEFORE TAX OR ANYTHING ELSE IS TAKEN OUT? (READ OUT AS REQUIRED)

IF NECESSARY: By household income we mean income earned by you and others living in your household, and any income from other sources, such as child support or pensions.

INTERVIEWER NOTE: IF ON OLD AGE/ DISABILITY PENSION CODE AS 2 ($1-$14,999 PER YEAR)

1.	No income	
2.	$1-$14,999 per year	($1-$287 per week)
3.	$15,000-$29,999 per year	($288-$577 per week)
4.	$30,000-$39,999 per year	($578-$769 per week)
5.	$40,000-$49,999 per year	($770-$962 per week)
6.	$50,000-$74,999 per year	($963-$1442 per week)
7.	$75,000-$109,999 per year	($1,443-$ $2,115 per week)
8.	$110,000-$144,999 per year	($2,115-$2,788 per week)
9.	145,000 or more per year	($2,789 or more per week)
10.	(Don't know)	
11.	(Refused)	

PREK7 IF A3 = 2 AND A5X = 2 (RESPONDENT LIVES ALONE) GO TO L1. OTHERWISE CONTINUE.
*(2+ PEOPLE IN HH)
K7 How much of the total household income do you yourself provide? Would you provide...
(READ OUT)
1. All of it
2. More than half
3. About half
4. Less than half, or
5. None
6. (Can't say)
7. (Refused)

*SECTION L. DRINKING QUESTIONS FOR THE RESPONDENT

*(ALL)
L1 And to finish off, just a few questions about your own drinking..
In the last 12 months, how often did you have an alcoholic drink of any kind?
1. Every day (GO TO L2)
2. 5 to 6 days a week (GO TO L2)
3. 3 to 4 days a week (GO TO L2)
4. 1 to 2 days a week (GO TO L2)
5. 2 to 3 days a month (GO TO L2)
6. About 1 day a month (GO TO L2)
7. Less often (GO TO L2)
8. Gave up in last 12 months (GO TO L5)
9. Not drunk in last 12 months/ Never drunk alcohol (END1)
10. (Can't say)
11. (Refused) (GO TO END1)

INTERVIEWER NOTE: IF SAY DOES NOT DRINK, PROBE WHETHER DRUNK WITHIN LAST 12 MONTHS
*(CAN'T SAY HOW OFTEN HAS ALCOHOLIC DRINK)
L1a Would you say it was....
1. Once a week or more, or
2. Less than once a week
3. (Can't say) (GO TO END1)
4. (Refused) (GO TO END1)

*PROGRAMMER NOTE: SAME DISPLAY RULES RE: "POT" AS FOR F4
*(ALL EXCEPT NO LONGER DRINKS / NEVER DRINKS/ DK / REF HOW OFTEN DRINKS) (L1=8, 9 11 OR L1a=3 OR 4)
L2 On a day that you usually have an alcoholic drink, how many standard drinks do you usually have?
IF NECESSARY BY STANDARD DRINK WE MEAN ANY DRINK EQUAL TO 1 POT OR MIDDY OF FULL STRENGTH BEER, THREE-QUARTERS OF A STUBBIE, 1 SMALL GLASS OF WINE, 1 PUB SIZED SHOT OF SPIRITS OR TWO-THIRDS OF A CAN OR BOTTLE OF PREMIXED SPIRITS OR ALCOHOLIC SODA.
1. 20 or more standard drinks a day (GO TO L3)
2. 11 – 19 standard drinks a day (GO TO L3)
3. 7 – 10 standard drinks a day (GO TO L3)
4. 5 – 6 standard drinks a day (GO TO L3)
5. 3 – 4 standard drinks a day (GO TO L3)
6. 1 – 2 standard drinks a day (GO TO L3)
7. Less than 1 standard drink per day (GO TO L3)
8. (Can't say)
9. (Refused) (GO TO L3)

*(CAN'T SAY HOW MANY STANDARD DRINKS HAS IN A DAY) (L2=8)
L2a Would you say it was....
1. 5 or more standard drinks or
2. Less than 5 standard drinks
3. (Can't say)
4. (Refused)

IF NECESSARY: This would be about two-thirds of a bottle of wine or three and a half stubbies.
*(ALL EXCEPT NO LONGER DRINKS / NEVER DRINK/ DK/REF HOW OFTEN DRINKS) (L1=8, 9, 11 , OR L1a=3 OR 4)
L3 How often do you have five drinks or more?
1. Every day (GO TO L4)
2. 5 to 6 days a week (GO TO L4)
3. 3 to 4 days a week (GO TO L4)
4. 1 to 2 days a week (GO TO L4)
5. 2 to 3 days a month (GO TO L4)
6. About 1 day a month (GO TO L4)
7. Less often (GO TO L4)
8. Never (GO TO L4)
9. (Can't say)
10. (Refused) (GO TO L4)

*(CAN'T SAY HOW OFTEN HAS FIVE DRINKS OR MORE) (L3=9)
L3a Would you say it was....
1. Once a week or more, or
2. Less than once a week
3. (Can't say)
4. (Refused)

*(ALL EXCEPT NO LONGER DRINKS NEVER DRINK/ DK/REF HOW OFTEN DRINKS) (L1=8, 9, 11, OR L1a=3 OR 4)
*(ALL EXCEPT NO LONGER DRINKS NEVER DRINK/ DK/REF HOW OFTEN DRINKS) (L1=8, 9, 11, OR L1a=3 OR 4)
L4 Overall, in the last 12 months, how much would you say your drinking has negatively affected other people? Would you say it was....
(READ OUT)
1. A lot
2. A little, or
3. Not at all (GO TO END1)
4. (Can't say) (GO TO END1)
5. (Refused) (GO TO END1)

*(NEGATIVELY AFFECTED OTHERS) (L4 = 1 OR 2)

L4a And on a scale of 1 to 10, where 1 is a little and 10 is a lot, how much has your drinking negatively affected other people in the last 12 months?
1. Number given (SPECIFY_____) (RANGE 1 TO 10) (GO TO END1)
2. (Can't say) (GO TO END1)
3. (Refused) (GO TO END1)

*(RESPONDENT NO LONGER DRINKS) (L1=8)
L5 You indicated that you USED TO drink. On a day that you usually had an alcoholic drink, how many standard drinks did you usually have?
IF NECESSARY BY STANDARD DRINK WE MEAN ANY DRINK EQUAL TO 1 POT OR MIDDY OF FULL STRENGTH BEER, THREE-QUARTERS OF A STUBBIE, 1 SMALL GLASS OF WINE, 1 PUB SIZED SHOT OF SPIRITS OR TWO-THIRDS OF A CAN OR BOTTLE OF PREMIXED SPIRITS OR ALCOHOLIC SODA.
1. 20 or more standard drinks a day (GO TO L6)
2. 11 – 19 standard drinks a day (GO TO L6)
3. 7 – 10 standard drinks a day (GO TO L6)
4. 5 – 6 standard drinks a day (GO TO L6)
5. 3 – 4 standard drinks a day (GO TO L6)
6. 1 – 2 standard drinks a day (GO TO L6)
7. Less than 1 standard drink per day (GO TO L6)
8. (Can't say)
9. (Refused) (GO TO L6)

*(CAN'T SAY HOW MANY STANDARD DRINKS HAS IN A DAY) (L5=8)
L5a Would you say it was....
1. 5 or more standard drinks
2. Less than 5 standard drinks
3. (Can't say)
4. (Refused)

IF NECESSARY: Five or more standard drinks would be about two-thirds of a bottle of wine or three and a half stubbies.
*(USED TO DRINK L5 = 1, 2, 3, 4, 5, 6, 7, 9 OR L5a=1, 2)
L6 How often do you have five drinks or more?
1. Every day (GO TO END1)
2. 5 to 6 days a week (GO TO END1)
3. 3 to 4 days a week (GO TO END1)
4. 1 to 2 days a week (GO TO END1)
5. 2 to 3 days a month (GO TO END1)
6. About 1 day a month (GO TO END1)
7. Less often(GO TO END1)
8. Never (GO TO END1)
9. (Can't say)
10. (Refused) (GO TO END1)

*(CAN'T SAY HOW OFTEN HAS FIVE DRINKS OR MORE) (L6=9)
L6a Would you say it was....
1. Once a week or more, or
2. Less than once a week
3. (Can't say)
4. (Refused)

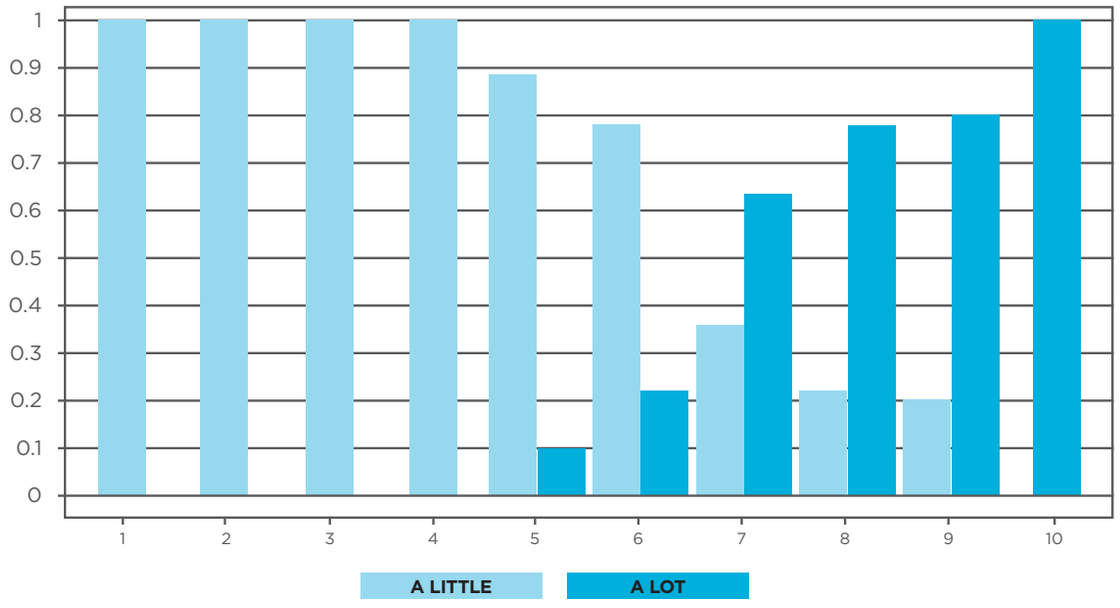
APPENDIX C: COMPARING RESULTS FROM TWO WAYS OF ASKING "HOW MUCH HAS THE DRINKING AFFECTED YOU NEGATIVELY?"

As noted in Chapter 2, respondents were asked about the harm that they had experienced attributable to the drinking of others in a few different ways. Of interest in the current study, they were asked about the most harmful heavy drinker in their lives (if any) and the harm they had experienced attributable to the drinking of strangers or people they do not know well. In 2011, respondents were asked to state whether they were harmed "a little" or "a lot," and also to give the level of harm they experienced on a score of 1-10; however in 2008 they were only asked if they were harmed "a little" or "a lot." Therefore the aim is to ascertain what score from 1-10 could be given to represent being harmed "a little" or "a lot" in 2008 to aid in the longitudinal analysis.

HARM FROM A KNOWN PROBLEMATIC DRINKER

Analyses in this section are based on the 246 respondents who stated that they had experienced harm at the hands of a known problematic drinker in 2011. In Figure C.1 the percentage of respondents who stated that they were harmed "a little" (72 per cent) or "a lot" (28 per cent) for each score is shown. The mean score of the 177 respondents who stated that they were harmed "a little" was 3.81, while the mean score of the 69 respondents who stated they were harmed "a lot" was 8.19.

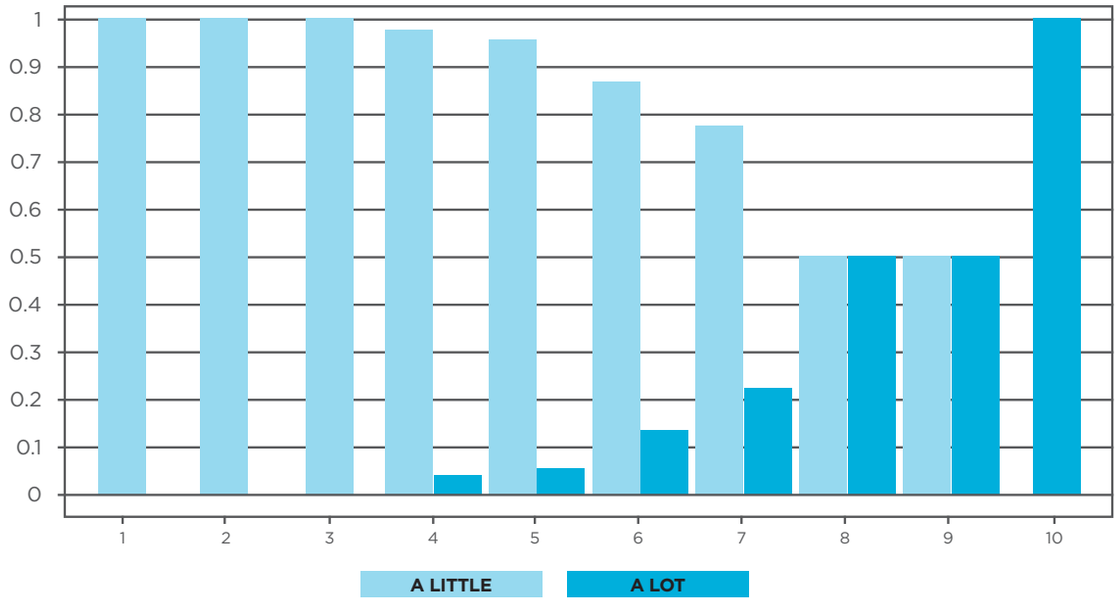
Figure C.1 Proportion of respondents stating they were harmed a little or a lot by a known problematic drinker per 1-10 rating of harm.



HARM FROM STRANGERS

These analyses are restricted to the 359 respondents who stated that they had experienced harm at the hands of strangers in 2011. In Figure C.2 the percentage of respondents who stated that they were harmed “a little” (82.5 per cent) or “a lot” (7.5 per cent) for each score is shown. The mean score of the 322 respondents who stated that they were harmed “a little” was 3.02; while the mean score of the 27 respondents who stated they were harmed “a lot” was 8.26. These mean scores are similar to those given for known problematic drinker harm, despite the percentage of people stating that they were harmed “a lot” being lower. This supports the idea that respondents are calibrating the different types of harm in a similar manner for the two different rating types.

Figure C.2 Proportion of respondents stating they were harmed “a little” or “a lot” by strangers per 1-10 rating of harm.



CONCLUSION

Given the smaller number of respondents with children that were harmed, this analysis was only run for stranger and known problematic drinker harm. Bringing this information on harm from strangers and known problematic drinkers it was decided that when a continuous variable was needed for harm experienced for 2008 or 2008 and 2011 combined that a score of 3.5 would be used for those harmed “a little” and 8 for those harmed “a lot” by known problematic drinkers or strangers, or when reporting harm to children.

APPENDIX D: TECHNICAL REPORT ON PROCEDURES IN THE 2011 FIELDWORK

This section is an excerpt (sections 2-4) from the technical report written by the Social Research Centre at the end of the 2011 HTO Survey. [5]

SAMPLE AND CALL PROCEDURES

RESPONDENT SELECTION

All respondents who had agreed to be re-contacted in the 2008 study were deemed to be in-scope for the follow-up survey. When attempting to re-contact sample members, no identifying information was provided to non-respondents as to the nature of the study or who the study was on behalf of to ensure privacy and confidentiality was maintained, as advised by ethics.

CALL PROCEDURES

The prescribed call procedures for the Harm to Others follow-up survey included:

- no limit specified to the number of calls attempted to establish contact
- controlling the spread of call attempts such that, subject to other outcomes being achieved, contact attempts were spread over weekdays late afternoon to early evening (4.00 pm to 6.00 pm), weekdays mid to late evening (after 6.00 pm to 8.30 pm) and weekends (10.00 am to 6.00 pm). No calls were attempted outside these times, except by firm appointment.

1800 NUMBER OPERATION

The Social Research Centre operated a 1800 number throughout the study period to handle any questions about participation in the survey (setting an appointment time, seeking clarification about the survey, refusing to participate, etc.).

PRE-SURVEY APPROACH LETTERS

While it was planned to send primary approach letters to all respondents that provided a full name and address in 2008 (60.5 per cent of those that agreed to be re-contacted) prior to initiating calls, which would have resulted in this did not eventuate due to time constraints associated with a delay in ethics approval. However, sample members who wanted more information about the survey were given the option of being sent a letter via post, email or fax prior to their participation. There were no requests for further information via this method.

With the continuation of interviewing after the Christmas period, it was deemed appropriate to send out pre-survey approach letters to those sample members whom we were not able to contact. In total, 146 letters were sent out by postal mail, and where address details could not be verified 131 letters were sent via email. Interviewing post-Christmas resulted in 41 additional interviews being completed.

Pre-survey approach letters were also utilised in instances where tracking activities yielded a new address.

[5] Petroulias T & Day K (2012). The Range and Magnitude of Alcohol's Harm to Others – Follow Up: Methodology Report. North Melbourne: Social Research Centre.

SUNDRY RESPONSE MAXIMISATION PROCEDURES

In addition to providing the 1800 number and offering to send an introductory letter, other response maximisation procedures included:

- referring sample members to the Turning Point survey hotline number on an as required basis
- hosting a web-page containing responses to frequently asked questions on the Social Research Centre website
- ensuring appropriately trained interviewers were used on the survey (refer to Field Team Briefing, below).

TRACKING RESPONDENTS

For respondents who were no longer contactable on the telephone number provided in 2008, 'tracking' for a current number was initiated via the following methods:

- seeking forward contact details from the current occupant
- searches using various online tools (such as the White Pages).

Of the 581 records that were identified as numbers suitable for tracking, 259 (44.6 per cent) new numbers were sourced. Where possible, a pre-approach letter was used to establish contact prior to trying the new phone number. Those with full name and postal address details (n=32) were sent a pre-approach letter by postal mail and those who provided an email address during the initial survey (n=15) were sent a pre-approach letter via email. The remaining records (n=212) were not sent a pre-approach letter as they either did not supply an address (postal or email), a complete name or both. In these cases the new phone number was the only form of contact available. In total, 31 interviews were achieved with numbers sourced from tracking activity.

Table C.1 Results from tracking activities

TRACKING ACTIVITIES	n	%	INTERVIEWS ACHIEVED n	INTERVIEWS ACHIEVED %
Total sample members requiring 'tracking' (respondent no longer available on the number provided in 2008)	581	100.0		
No new number sourced	322	55.4		
Possible new number sourced	**259**	**44.6**		
Total letter sent	47	18.1	8	17.0
Pre-approach letter by mail	*32*	*12.4*	*5*	*15.6*
Pre-approach letter by email	*15*	*5.8*	*3*	*20.0*
No letter sent	212	81.9	23	10.8
Interviews achieved as a proportion of sample members requiring 'tracking' (n=581)			**31**	**5.3**

QUESTIONNAIRE DESIGN

QUESTIONNAIRE OVERVIEW

Turning Point provided a near final version of the questionnaire for the follow-up survey.

While the majority of the questionnaire remained unchanged from the version used in 2008, some questions were removed and a number of new questions were included. Refer to Appendix 2 of the technical report for a detailed account of questionnaire changes.

A formal pilot testing phase was used to test the changes.

QUESTIONNAIRE PILOT TESTING

Pilot testing was undertaken between 25 October and 27 October 2011. A total of 15 interviews were completed with an average interview length of 24.0 minutes

Standard operational testing procedures were utilised to ensure the Computer-Assisted Telephone Interview (CATI) script accurately reflected the agreed "hard copy" questionnaire. These included:

- reading directly from the Word version of the questionnaire into the CATI program to eliminate the possibility of typographical errors occurring in the set up process
- programming the skips and sequence instructions as per the hard copy questionnaire
- generating test frequency counts to check the structural integrity of the questionnaire
- checking the questionnaire in "practice" mode to review on-screen presentation and sequencing.

The main areas of interest during pilot testing were questionnaire length, and the testing of new survey questions. Minor changes were made to the questionnaire as a result of pilot testing.

Preliminary pilot test data was provided to Turning Point for review but was not included in the main data set.

The final questionnaire is provided at Appendix B.

DATA COLLECTION AND QUALITY CONTROL

ETHICAL CONSIDERATION

The Eastern Health Human Research Ethics Committee (HREC) approved the survey methodology and content.

Ethical considerations in undertaking the survey included:

- ensuring informed consent
- ensuring the voluntary nature of participation was clearly understood
- protecting the privacy and confidentiality of respondent information.

A 1800 survey hotline number was available to sample members with a view to providing a point of reference for query resolution and for any survey-generated request for information relating to alcohol support services.

The privacy and confidentiality of respondent information was also protected by the Social Research Centre's contract with Turning Point Drug and Alcohol Centre as well as our adherence to the appropriate privacy laws. In addition, the Social Research Centre is bound to adhere to Australian Society for Medical Research Privacy Principles and the Australian Market and Social Research Society Code of Professional Behaviour.

The ethical considerations incumbent upon researchers when undertaking surveys of this nature were duly emphasised in the survey briefing materials and interviewer training provided by the Social Research Centre (see Section 4.2 and Appendix D). In addition, interviewers were provided with appropriate referral numbers to provide to respondents upon request/as required. These included:

- the Social Research Centre 1800 number – for questions about who is conducting the study and how the respondent's telephone number was obtained
- the Chair, the Eastern Health Human Research Ethics Committee (HREC)
- the Survey hotline number staffed by researchers from Turning Point for queries relating to the legitimacy of the survey or any concerns or queries about why the survey was being conducted
- referral to DirectLine – the nominated telephone counselling service.

FIELD TEAM BRIEFING

All interviewers and supervisors selected to work on the Harm To Others follow-up survey attended a comprehensive three hour briefing session prior to commencing work on the project, delivered by the Social Research Centre project manager. The briefing covered:

- project background and context
- respondent selection procedures
- strategies to gain cooperation, deal with reluctant respondents and minimise mid-survey terminations
- a detailed examination of the survey questions and pre-coded response lists, with a focus on ensuring the uniform interpretation of questions and responses
- item-specific data quality issues
- an emphasis on the importance of adhering to sample management protocols
- an emphasis on strict adherence to the call regime designed to protect the privacy and confidentiality of respondents
- response maximisation procedures relevant to the survey.

A comprehensive practice interviewing and role play module, such that the first "live" interview conducted by each interviewer is not a "trial."

An additional briefing on sensitive subject matter was undertaken to ensure interviewers were prepared with techniques to deal with respondents who may be emotionally affected by the subject material.

A total of 17 interviewers worked on the project.

FIELDWORK QUALITY CONTROL PROCEDURES

The in-field quality monitoring techniques applied to this project included:

- validation of 70 interviews (or just over 6 per cent of each interviewer's work, in accordance with ISO 20252 standards) via remote monitoring (covering the interviewer's approach and commitment gaining skills, as well as the conduct of the interview)
- field team de-briefing after the first shift, and thereafter, whenever there was important information to impart to the field team in relation to data quality, consistency of interview administration, techniques to avoid refusals, appointment making conventions or project performance
- maintenance of an "interviewer hand-out" document addressing respondent liaison issues and tips for refusal avoidance
- examination of verbatim responses to "other specify" questions
- monitoring (listening in) by the Social Research Centre project managers.

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Carer Drinking and More Serious Child Protection Case Outcomes

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Abstract

Care-giver 'alcohol abuse' is identified as involved in a significant proportion of child maltreatment cases internationally. This study examines how care-giver 'alcohol abuse' is related to increasing intensity of child protective intervention in a large Australian database. Predictors of child protection outcomes were examined in 38,487 Victorian state Child Protection Services (CPS) cases substantiated between 2001 and 2005. 'Likely alcohol abuse' was identified in 33 per cent of substantiations, 36 per cent of protective interventions and 42 per cent of court orders. Likely alcohol abuse was a significant predictor of more intensive official responses—protective interventions and court orders—after adjusting for 'other drug abuse' and other socio-demographic factors. Supporting multi-factorial theories of alcohol's involvement in child abuse, likely alcohol abuse was one of several risk factors that remained significant in multivariable prediction of more serious child protection outcomes.

Keywords: Alcohol, child abuse, neglect, substantiations, protective interventions, court orders

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Introduction

Alcohol—drinking by parents or care-givers—has always been a concern of child protection systems. These systems were originally developed in the early years of the twentieth century as part of the same impulse of concern about the interests of women and children in family life that was also a major element in the alcohol Temperance movement in the same era (Fitzgerald and Jordan, 2009). In the modern system, the care-giver's alcohol use and other drug use are ambiguously treated as risks that justify child protection interventions. News accounts often foreground a parent's intoxication or alcohol-influenced behaviour, but, on the other hand, thresholds for concern are ill-defined. News headlines such as 'Go and take the grog away, and then we will have mum and dad back' (a child speaking of alcohol problems in the Northern Territory in Australia (Taylor, 2009)) and, a week later, 'Welfare workers are "too powerful"' in a recent case 'in which two children were removed from their cannabis smoking parents despite there being no evidence of neglect or abuse' (Overington, 2009) illustrate the controversy and ambiguity inherent in decisions regarding the impact of drinking or drugs on families' capacity to parent, in a society in which alcohol and, to some extent, drug use are normalised.

Whilst there is a large pool of children in the population exposed to risky drinking patterns (Dawe *et al.*, 2007), some of whom may well end up presenting to the child protection system, the extent of the links between risky drinking and child protection are not straightforward. Whether alcohol has a substantial or a minor role in child maltreatment is a contemporary and important question. This study has two main aims. First, we seek to examine the associations between care-giver 'alcohol abuse' (as assessed by protective workers) and substantiated child protection outcomes to determine whether patterns in Australia are similar to those observed in previous research elsewhere. Second, for the first time, we examine whether care-giver alcohol abuse is associated with progression through to increasingly serious child protective interventions and outcomes in a large sample of child protection cases.

The relationship between alcohol consumption and child maltreatment

Research theories regarding how alcohol affects child maltreatment suggest that alcohol is implicated by its impact on family functioning, causing family and relationship conflicts, social isolation and role reversal by disrupting

parenting (Rossow, 2000). The financial costs of drinking (as a drain on household income) increase pressure on families already under stress (Burke, 1988). Alcohol disinhibition theory, where alcohol affects the ability to control immediate responses, predicts that alcohol will lead to increased levels of physical and sexual abuse (Widom and Hiller-Sturmhöfel, 2001). Alcohol myopia is a concept encapsulating the way in which alcohol impairs perception and thought by blocking response conflict, so that alcohol acts to amplify or tunnel the more immediate and strongest responses to stimuli in any given situation (Steele and Josephs, 1990). In these ways, children may be physically hurt where violent impulses are not controlled by drinkers and neglected where children's needs for food or medicine are perceived as more peripheral than the needs of the drinker. Besides potential specific effects, alcohol may be involved as part of a cluster of precipitating factors. For example, alcohol has been associated with mental health problems (Brady and Sinha, 2005; Kandel *et al.*, 2001) and the prevalence and severity of a range of other social problems, such as unemployment and homelessness, found in contiguity with child abuse (Dawe *et al.*, 2007). Research in the child protection field by Garbarino and others acknowledges the role of underlying psychological factors, and yet also underscores the effects of the social and environmental conditions that coalesce and result in child maltreatment (Garbarino, 1977). Alcohol is a part of this causal complex. While disentangling alcohol effects from other problems that families face is difficult, it is an important task, as alcohol drinking is a modifiable behaviour that can be prevented at individual and population levels (Babor *et al.*, 2010).

Evidence linking alcohol and child maltreatment

Alcohol is commonly associated with child protection issues, but the extent of its causal impact in child protection cases remains contentious.

Internationally, estimates of the rate of involvement of alcohol in reported and substantiated child protection cases ranges from 13 to 70 per cent (Rossow, 2000). Dore, Doris and Wright (1995) reported that between one- and two-thirds of maltreatment cases in the USA involved parental alcohol and other drug abuse. Canadian studies found that 18 per cent of female care-givers and 30 per cent of male care-givers reportedly had confirmed diagnoses of alcohol abuse (Trocme *et al.*, 2005) in substantiated cases of child maltreatment. In Australia, care-giver drinking is implicated in 21–54 per cent of cases (Laslett *et al.*, 2010), with the inconsistency deriving from differences in case types and samples examined. Across different states, 32 per cent of all (initial) reports (Cashmore *et al.*, 2008, New South Wales), one-third of substantiated cases (Laslett *et al.*, 2010), 47 per cent of applications for care or protection (Farate, 2001, Western Australia) and 54 per cent of cases entering alternative

care involved alcohol (Jeffreys *et al.*, 2006, South Australia). This variation by level of intervention suggests that alcohol involvement was greater in more serious cases, although may also reflect, among other factors, substantial differences in recording practices and coding standards in different geographic locations. Dore *et al.* (1995) summarised the prevalence of alcohol involvement across different stages of child protection and suggested on the basis of different studies conducted in different times and places that the prevalence of alcohol and other substance abuse was greater in court cases than in cases that received less intervention. A similar pattern was observed in a small study in the UK, where parental substance misuse cases were more likely to be identified at the 'heavy end' of the child abuse intervention spectrum, with substance misuse identified in 62 per cent of cases involving care proceedings, but only 40 per cent of cases involving listing on a child protection register and only 34 per cent of all cases examined that were being considered for allocation (Forrester and Harwin, 2006). Following up these cases after two years, carer alcohol misuse was associated with remaining at home for longer, and worse child outcomes, and ultimately greater chance of removal, compared with cases in which carer heroin or crack cocaine misuse was identified (Forrester and Harwin, 2008). Aside from these few studies, alcohol's role in a range of child protection outcomes has rarely been examined (Vanderploeg *et al.*, 2007; Burke *et al.*, 2006).

Alcohol abuse: psychiatric and child protection definitions

Alcohol involvement is recorded in a variety of different ways in studies involving child protection databases limiting comparisons that can be made across studies and preventing easy synthesis of previous research.

Alcohol abuse is a concept that includes many different sub-types of alcohol use and related problems, yet is commonly used as a term in child protection systems. In the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), alcohol abuse is 'a maladaptive pattern of substance [alcohol] use leading to clinically significant impairment or distress within a 12-month period'. This impairment includes failure to fulfil major role obligations at home such as 'neglect of children or household' (American Psychiatric Association Task Force on DSM-IV, 1994). Lay concepts surrounding drinking centre upon drunkenness and addiction, and generally not abuse or dependence (Room, 1998). Whether social workers and child protection workers use clinical or lay terminology, or have their own specific understandings of alcohol abuse in the context of child protection, has not been studied. It is likely that individual workers within child protection systems hold a variety of understandings of what alcohol abuse may mean. In Victoria, the variable 'likely alcohol abuse' has three alternative codes: 'yes', 'no'

or 'unknown' (DHS, 2005). The incorporation of 'likely' in Australia acknowledges the reality that confirming alcohol abuse in diagnostic terms is difficult in contexts in which protective workers operate (e.g. families may try to conceal alcohol problems). In practice, child protection workers should be focused on one particular aspect—functionally defining alcohol as problematic in the specific context of whether the behaviour does cause a problem for the child or place them at risk. Whether the alcohol problem is dependence or abuse, as defined in formal diagnostic systems, is largely irrelevant. In this paper, we have, wherever necessary, used the term 'likely alcohol abuse' in consideration of the Victorian context. Nevertheless, we clearly recognise the limitations of this terminology; 'likely alcohol abuse' will probably include some cases in which the level of alcohol involvement is unclear.

The child protection system in Victoria, Australia

Child maltreatment includes exposure to physical, emotional or sexual abuse, as well as medical and physical neglect. Child Protection Services (CPS) in Victoria, Australia, have statutory responsibility to determine whether children in Victoria are being harmed or at risk of harm—triaging families to a range of family and child support services and seeking to strengthen parental capability to provide basic care, ensure safety and promote the child's development, while improving the family's community connections and access to community resources, where possible without any further involvement of CPS (DHS, 2008).

Children and families pass through a number of stages in the Victorian CPS process, including Notification, Investigation, Intervention and Court Order phases. Child protection cases enter the system as a report or notification coming from a source outside the agency (Figure 1). In the Intake phase, following the report, information provided by the person or agency making the report, information gleaned from third parties in contact with the child and family such as schools, as well as any information already on the database, is assessed; the possible outcomes from this are: to close the case, to refer or to investigate. An 'investigate' outcome triggers a phase in which assessments are made of the care-giver's response to the allegations, of the child's well-being, views and wishes, and of any information provided by third parties as part of the investigation (including specialist assessments if necessary). The Investigation phase outcome decisions include: not substantiated; substantiated and no further action taken; or substantiated and protective intervention needed. If further intervention is needed, this triggers the Protective Intervention phase, which usually involves implementation of a plan (commonly involving other services, but sometimes just involving the extended family) to address issues (by agreement with the family where possible). Outcomes (or service

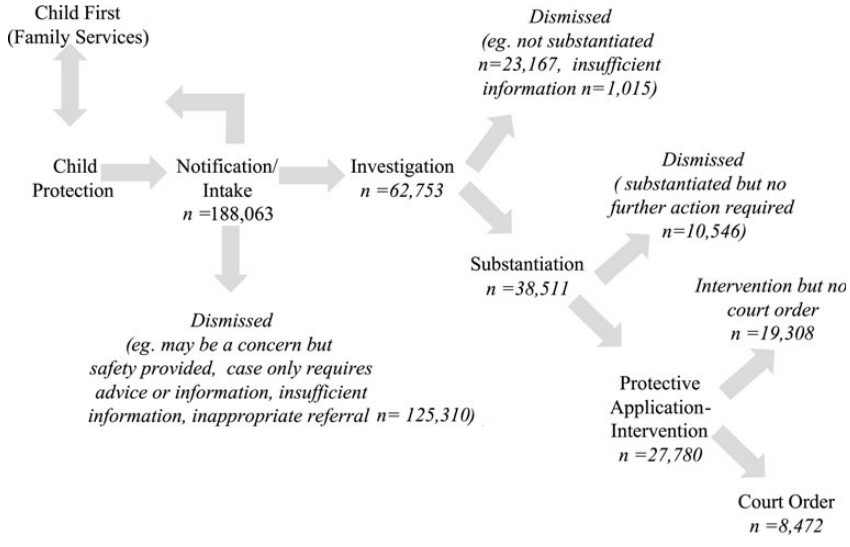

Figure 1 Progression through the Child Protection Services system in Victoria, Australia, 2001–05

dispositions) following substantiation include provision of ongoing child welfare services; referrals to other services; placement of children in out-of-home care (commonly involving the extended family at this stage); or an application to a child welfare court (Bromfield and Higgins, 2005). If a decision is made to issue a protective application to the Children's Court, the Court then decides whether or not to issue a protection order. This triggers the Protection Order phase. This phase involves supervision of the court order (and any associated conditions) imposed by the Children's Court (and may involve removal of children and placement of children in care).

Intensification of the intervention to these later stages is indicative that a child has been significantly and seriously harmed or is at risk of significant harm requiring CPS intervention. These interventions are not undertaken lightly, and vary in nature according to the type of harm, the seriousness of the harm and the care-giver's ability to protect the child from further harm (Bromfield and Higgins, 2005).

Official definitions of the relation of alcohol to child protection issues in Victorian CPS

The child protection system differs significantly in each Australian state in terms of legal definitions and recording systems (Bromfield and Higgins, 2005), and differences are more marked between international jurisdictions (Mathews and Kenny, 2008) yet fundamental similarities in practice and

policies between states (Australian Institute of Health and Welfare, 2008) and countries (Gilbert, 1997) make findings from Victorian data relevant to other states and countries. For example, CPS in Victoria fit generally into Gilbert's 'child protection' classification, with a strong focus on investigation and risk management as is present in the USA, Canada and England. More recently, in Victoria, CPS have shifted to ensure family services are provided earlier, diverting children from child protection where possible (DHS, 2008), as is more common in Scandinavian countries (Gilbert, 1997). In Victoria, reporting by most medical and education professionals (e.g. as in some American states) but not all citizens (as in Canada) is mandatory.

The Victorian protocol between CPS and Drug Treatment Services describes a range of ways in which children in families may be affected by their carer's alcohol or other substance abuse:

> A parent's overriding involvement with alcohol and other drugs (AOD) may leave the parent emotionally and physically unavailable to the child; a parent's mental functioning, judgement, inhibitions, and/or protective capacity may be seriously impaired, placing the child at increased risk of all forms of abuse and neglect; a parent may disappear for hours or days, leaving the child alone or with someone unable to meet the child's basic needs; excessive responsibility may be placed on young children to care for themselves and/or young siblings; a parent may spend the household budget on alcohol and drugs, depriving the child of adequate food, clothing, housing and health care; and consistent exposure in the home may contribute to the child eventually developing AOD problems. (DHS, 2002: 1)

The protocol explicitly states that an example of a situation in which a child protection notification should be made is 'if a parent presents as seriously affected by alcohol or other drugs and has the sole care of a child whose safety would be compromised in the care of that adult' (DHS, 2002: 6). In practice, at a computer prompt, CPS workers were compulsorily required in the period of the study to complete the section entitled 'Parental characteristics', which read 'Likely alcohol abuse'. Workers then had the following response options: 0 = Unknown, 1 = No and 2 = Yes (DHS, 2005). Hereafter, concerning data on alcohol in the Victorian Child Protection System, we refer to the 'Yes' category as 'Likely alcohol abuse'.

The current study

While there is substantial consensus that co-occurrence of care-giver alcohol abuse or alcohol problems and child maltreatment is common, gaps in our understanding of the problem remain. In particular, alcohol's role in increasingly serious outcomes, or stages in the child protection process, has rarely been examined. In this study, we examined cases from a large child protection database in Victoria. On the basis of the research considered above, we expected likely alcohol abuse to be associated with

substantiated child protection cases, even after adjusting for other factors in the social domain. Further, as alcohol does affect parental functioning, we expected that alcohol would increasingly be recorded as a risk factor in more serious cases, such that likely alcohol abuse would be increasingly identified in cases requiring further intervention.

Method

Design and setting

This study involved a retrospective case review from routinely collected records completed by statutory child protection workers in Victoria, Australia. Victoria is the most urbanised state in Australia, with around three-quarters of its population of 5.4 million living in the metropolitan area of its capital city, Melbourne.

Cases were categorised according to their progression across different stages of the child protection system, with the prevalence of recorded likely alcohol abuse noted and described for each stage for substantiated cases, across different abuse categories. The extent to which recorded likely alcohol abuse was associated with progression to more serious stages of the child protection system was then assessed through two different analyses involving measures of outcome severity, after adjusting for a range of other variables recorded in the data system.

The first analysis compares substantiated cases with cases in which there was further processing, involving either a protective intervention or a court order (n = 38,511). The second analysis compares cases that received protective interventions with cases that went further and were issued court orders (n = 27,780). The same independent variables were included in both analyses for comparison.

Data available for analysis

De-identified data were obtained for all child protection notifications in Victoria from the Child and Services Information System (CASIS) database, managed by the Victorian Department of Human Services. The dataset included cases that were open or existed on 1 January 2001 through to cases entered until 31 December 2005. Cases beyond this date were not able to be used because of changes in data collection that made recording of alcohol and other risk factors no longer mandatory. Information on 188,063 cases and 97,684 clients (children whom the department was investigating or acting to protect) was available for analysis. Ethics approval for the project was obtained from the Victorian Department of Human Services Ethics Committee.

Outcome variables

The intensity of the eventual intervention is analysed in terms of the three main phases in the child protection system, linked to key decisions made as part of the process: substantiation, protective intervention and court order phases. These were coded on the basis of start dates for each phase. Each case in the analysis was assigned the most intensive applicable stage in the child protection process (e.g. if maltreatment of a child within the family has been substantiated but the case has not needed a protective intervention or court order, 'substantiation' will be the stage recorded).

Progression through the system was summarised as two outcome variables: (i) progression through to the protective intervention phase and receipt of a protective intervention (yes/no) compared with those cases that were substantiated but did not progress further, and then (ii) cases that receive a court order (yes/no) compared with those with a protective intervention but no court order.

Independent variables

Child's age, child's gender, family type, family accommodation category, income type and the various risk factors (risk factor is the term used in the Victorian CPS recording system, CASIS, Victoria) were all recorded on the CASIS database by CPS workers and were obtained for analysis. Risk factors on which CPS workers were prompted included 'likely care-giver alcohol abuse', 'likely parental other substance abuse', 'likely domestic violence', parental history of child abuse as a child and parental mental health (see Tables 1–3 for variable levels; some prompts read 'likely', whilst others did not). All of these risk factors were coded 'Unknown', 'No' or 'Yes' by CPS workers, with coding mandatory at the completion of the investigative stage (moving on to the next field was not possible unless a code was assigned). Parental likely alcohol abuse may have referred to the alleged maltreating parent, the other protective parent, both parents or non-biological care-givers (DHS, 2005). These risk factors were provided in dichotomised format to the researchers: '1' indicated a child protection worker recorded the presence of a risk factor and '0' that a worker indicated that a risk factor was not present or that they did not know whether the risk factor was present or not.

Analysis

Descriptive statistics on alcohol involvement were generated for the 38,487 cases of child maltreatment substantiated between 2001 and

2005. Family social and demographic variables were analysed where parental likely alcohol abuse was and was not reported. Associations between the two system progression outcomes and the independent variables were examined using bivariate and then multivariable logistic regression. Independent variables significant ($p < 0.05$) at the bivariate level were entered into a multivariable logistic regression to determine whether parental drinking significantly affected child protection outcomes after taking into account these other socio-demographic and risk factors. Model fit was tested using the Hosmer–Lemeshow test and likelihood ratio tests were used to compare the full models with and without alcohol (Hosmer and Lemeshow, 2000). All analyses were conducted using Stata I/C 9.2 (StataCorp, 2009).

Results

Information was available on 188,063 cases and 97,684 clients who were managed in the system (see Figure 1). Many of these were reported upon

Table 1 Socio-demographic characteristics of families with and without reported likely alcohol abuse in substantiated cases, 2001–05

	Total *n*	SES of non-alcohol families (%)	SES of alcohol families (%)
*Family type**			
Blended family	5,171	12.9	14.6
Extended family—couple or one person	1,098	3.0	2.6
Intact family	10,805	28.4	27.5
Sole parent—father or mother	18,360	47.5	48.2
Step-father or step-mother family	2,226	6.0	5.4
Other adults—couple or two others	827	2.3	1.8
*Accommodation status**			
Own/buying	8,763	26.7	14.8
Renting—public housing	14,140	33.0	44.3
Renting—other	12,120	32.4	29.7
Caravan	450	0.9.	1.80
No fixed abode	1,268	2.4	5.1
Other	1,746	4.6	4.3
*Family income type**			
Sole parent pension	16,359	40.2	47.3
Unemployment benefit	3,702	8.1	12.7
Wage/salary high	537	1.6	1.1
Wage/salary medium	6,548	20.2	10.5
Wage/salary low	5,260	14.4	12.2
Other benefit or pension	6,081	15.5	16.4
Domestic violence	20,498	41.8	76.4
Substance abuse	13,579	23.8	58.4
Total	38,487		

* Chi-square tests significant at the $p < 0.001$ level.

Table 2 Factors affecting the likelihood of child protection intervention among substantiated cases

	Percentage of sample	Unadjusted odds ratio	Adjusted odds ratio	95% confidence interval for adjusted odds ratio	
Parental/carer likely 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 client					
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
Step-father or step-mother 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
Parental 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
Parental substance abuse	35.3	2.36***	1.74***	1.64	1.85
Parental history of psychological illness or mental ill health	22.2	1.69***	1.49***	1.41	1.59

Significant at the * $p < 0.05$, ** $p < 0.01$ and *** $p < 0.001$ levels for odds ratios presented.

and investigated but not substantiated over the period 2001–05. Of these cases, 38,487 (or 20.5 per cent) were substantiated (and thus had complete information on risk factors recorded for each). Three-quarters (76.5 per cent) of clients appeared as a 'case' in the data only once. On average, clients were substantiated in the dataset 1.3 (CI: 1.29, 1.32) times across this period. Of those cases that were substantiated, 27.9 per cent were substantiated but no further action was taken, 50.1 per cent received a protective intervention but not a court order and 22.0 per cent received a court order.

Table 3 Factors affecting the likelihood of progression to court order phase amongst cases receiving protection orders

	Unadjusted odds ratio	Adjusted odds ratio	95% confidence interval for adjusted odds ratio	
Parental/carer alcohol abuse	1.40***	1.14***	1.08	1.21
Male children	1.04	1.03	0.98	1.09
Age of client				
0–3 (ref)				
4–11	0.69***	0.77***	0.72	0.82
12 +	0.71***	0.93	0.87	1.01
Accommodation status				
Own/buying (ref)				
Renting	1.41***	1.07	0.98	1.17
Public housing	2.05***	1.38***	1.26	1.51
Caravan	2.39***	1.54***	1.22	1.94
No fixed abode	3.43***	2.00***	1.72	2.32
Other	2.02***	1.29**	1.12	1.50
Family income type				
Sole Parent Pension (ref)				
Unemployment Benefit	1.15**	1.15**	1.04	1.27
Other benefit	1.28***	1.33**	1.18	1.50
Other pension	1.14**	1.16**	1.05	1.27
Wage/salary high	0.31***	0.46***	0.33	0.64
Wage/salary low	0.69***	0.88*	0.80	0.97
Wage/salary medium	0.47***	0.70***	0.62	0.78
Other	1.31*	1.41**	1.13	1.75
Family type				
Intact family (ref)				
Blended family	1.35***	1.37***	1.16	1.62
Extended family—couple or one person	0.89**	0.90*	0.82	0.98
Sole parent—father or mother	1.05	0.98	0.90	1.07
Step-father or step-mother family	1.02	1.12	0.98	1.28
Other adults—couple or one person and other	1.44***	1.52***	1.26	1.84
Parental history of abuse as child	1.62***	1.35***	1.27	1.43
Domestic violence	1.20***	0.95	0.90	1.01
Carer substance abuse	1.85***	1.44***	1.35	1.52
Parental history of psychological illness or mental ill health	1.32***	1.23***	1.15	1.30

Significant at the * $p < 0.05$, ** $p < 0.01$ and *** $p < 0.001$ levels for odds ratios presented.

Alcohol and progression through the Victorian Child Protection System

During the five-year period of the study, rates of annual substantiated CPS cases per 1,000 children in Victoria varied only slightly from 7.1 per 1,000 children in 2001 to 6.7 substantiated cases per 1,000 in 2005. There was little change over time from the rate of 2.4 to 2.3 per 1,000 children in substantiated cases with reported alcohol involvement. Over the period 2001–05, likely alcohol abuse was recorded as a parental or carer risk factor in the

family in a third (33.2 per cent) of all substantiated cases of child abuse. Likely alcohol abuse was recorded in one-quarter (25.4 per cent) of substantiated cases that did not receive further intervention. In cases in which the most serious intervention was a protective intervention (but no court order), 33.8 per cent of cases were identified with care-giver alcohol problems. Of those cases involving an order from the Children's Court, 41.7 per cent involved alcohol. These results suggest that cases that received further and more serious interventions were progressively more likely to be associated with carer drinking.

Relationships between alcohol and other risk factors

Table 1 indicates that those families in which likely alcohol abuse was recorded were more likely to also have a range of other problems and were more likely to be socially disadvantaged. For example, families in which likely alcohol abuse was recorded were more likely to be in public housing and less likely to own or be buying their home, and were more likely to be receiving low incomes. Whilst these families were of a similar family make-up to families without likely alcohol abuse recorded, they were more likely to co-present with substance abuse and mental health problems.

Alcohol and intensification from substantiation to protective intervention

Table 2 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. Cases with likely alcohol abuse identified as a risk factor were 1.23 times more likely to receive a protective intervention than those without, after adjusting for all of the variables in the model. Other notable findings included: the likelihood of intervention was higher in cases involving younger children and in those families in which other risk factors such as care-giver substance abuse, domestic violence, a care-giver history of abuse and a care-giver 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 in which children were living in all other accommodation categories except 'other' were more likely to receive an intervention, particularly those with no fixed abode. In those cases in which 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.

Intensification from protective intervention to court order

Table 3 shows that alcohol was associated with an increased likelihood of receiving a court order following a protection intervention, after taking into account all other variables in the model. While many of the patterns of effects seen for the other independent variables in Table 3 were similar in Table 2, there were some important differences. Examining the alcohol risk factor variable, it is evident that, although the results indicate that alcohol predicts both outcomes (ORs = 1.23 and 1.13), the size of this effect was slightly smaller for the court order outcome. This was also true for other substance 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 2; OR = 1.62), and this association was stronger in relation to the court order phase (Table 3; 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 an income (whether it was low, medium or high) were less likely to receive a protective order and even less likely to receive a court order, meaning that the effect of this income variable increased inversely as the outcomes increased in severity. The fit of each of the models presented in Table 2 ($\chi^2_8 = 12.94$, $p = 0.11$) and Table 3 ($\chi^2_8 = 7.53$, $p = 0.48$) was satisfactory. The inclusion of alcohol added significantly to each of the full models (Table 2: $\chi^2 = 52.64$, $p < 0.001$ and Table 3: $\chi^2_1 = 19.15$, $p < 0.001$). The removal of likely alcohol abuse from the model left the model significantly less able to predict these more serious child protection outcomes.

Discussion

Likely alcohol abuse by a care-giver was recorded in 33 per cent of all substantiated cases of child abuse, with little variation year to year over the five-year period. This finding is somewhat higher than the rate of 21 per cent reported for Victoria in case notes from 1993 and 1994 (DHS, 2001). The percentage of cases involving likely alcohol abuse is also somewhat higher than figures from Canada, where 30 per cent of male care-givers reportedly involved alcohol abuse, although only 18 per cent of female care-givers had such diagnoses (Trocme *et al.*, 2005). However, the systems and definitions of child abuse and alcohol abuse differ between countries (Fallon *et al.*, 2010).

Whilst the relationship between alcohol reporting and substantiation has been the subject of much research, the association of alcohol with what happens next has not been previously studied. Our study shows that a large proportion of alcohol-related cases go on to receive more intensive

attention—protective interventions and court orders—and reveals that alcohol involvement is correlated with this further progression through the system.

Families reported to child protection in Victoria were generally socio-economically disadvantaged and this was at least as true of those families within the child protection system, where likely alcohol abuse by a care-giver is reported. This is consistent with other findings that disadvantage is one of the strongest correlates of child abuse and neglect that is reported to the CPS and that there is a clustering effect of risk factors.

Likely alcohol abuse was significantly associated with intensification of handling and processing 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 rate of carer alcohol abuse reported in court-involved cases (Murphy *et al.*, 1991) and support theories that implicate problematic drinking as strongly associated with progression through the system, and worse outcomes. Likely alcohol abuse may have played a causal role in a number of 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 after they themselves or others have maltreated the child. However, this is only likely to worsen the situation for the child. Problematic drinking might also interfere with care-givers' ability to successfully follow a CPS plan for remediation and thus make progression through the CPS system more likely. If the maltreating parent continues to drink alcohol problematically, a causal role of drinking for more serious outcomes is easy to visualise.

The models showed 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. Other drug abuse, history of parental abuse of a carer as a child and care-giver mental ill health were linked even more strongly than alcohol abuse to higher odds of cases requiring further protective interventions and court orders.

These findings support multifaceted theories regarding individual, family and community-level factors that interact and result in child abuse and neglect (Garbarino, 1977). Indeed, the multi-factorial nature of child abuse is clearly illustrated in this paper, consistent with the small number of quantitative studies that have systematically attempted to measure the effects of multiple factors simultaneously (e.g. Freisthler *et al.*, 2007).

The evidence from this analysis provides numerous reasons as to why alcohol-related problems should be addressed as part of the management of families with children in contact with CPS. A further reason for

focusing on the alcohol dimension is that it is one of a minority of factors that is potentially modifiable, unlike, for example, family structure or history of parental child abuse. Alcohol problems may also prove more easily modifiable than other issues such as unemployment, mental health, and local and social deprivation. 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 the Alcohol and Drug Treatment systems must ensure that effective programmes exist and that there is close communication and referral between these systems.

This study is limited by the nature of the recording of likely alcohol abuse and the lack of clarity about what criteria and thresholds caseworkers use in recording likely alcohol abuse. Further research is required to determine how judgements about alcohol recording are made and whether it can be improved within the system. An additional limitation is the possibility that workers may list more risk factors in cases to justify moving cases further in the system. The retrospective nature of the coding of risk factors precludes drawing causal conclusions regarding relations between likely alcohol abuse and child maltreatment.

Conclusion

Likely alcohol abuse was involved in a third of all substantiated child maltreatment cases in Victoria and was more likely to be involved in more intensive child protection outcomes. These effects were significant even after taking into account other factors such as other drug abuse and domestic violence. While likely alcohol abuse made an independent contribution to the regression predictions, the multi-factorial nature of child abuse has also been underscored in this study.

The findings of this study contribute to the overall debate on the externalities and harm to others from alcohol, in this case children, and lend support to the idea that early intervention around care-givers' drinking behaviours may well be a strategy for preventing further harm to the child in cases in which care-giver alcohol abuse has been identified as an issue (Murphy *et al.*, 1991; Gruenert *et al.*, 2004). In severe cases involving alcohol misuse, Forrester and Harwin's (2008) findings suggest that protective workers in the UK may not be intervening early enough. As likely alcohol abuse was part of a series of factors associated with worsening outcomes, our results support the need for a public health approach to child protection and for comprehensive coordinated multi-sectoral services for families with multiple risk factors that include alcohol treatment programmes.

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