Policy options paper:

Preventing alcohol-related family and domestic violence

fare

February 2015

About the Foundation for Alcohol Research and Education

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

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

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

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

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

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

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

About this paper

Purpose

The purpose of this *Policy Options Paper* is to propose policies and programs to Australian governments for the prevention of alcohol-related family and domestic violence (FDV). The policy and program options being proposed have been developed in consultation with professionals with expertise in public health, child protection and domestic violence. This *Policy Options Paper* is not a final draft and FARE welcomes further input from people with an interest in this area. Further details about this consultation process are outlined below. The final Policy Paper will be presented to decision makers in June 2015.

Approach

This *Policy Options Paper* uses a public health model of prevention to present policy and program options. The public health model of prevention is grounded in scientific principles and evidence and has been used extensively to address a range of health issues. The public health model aims to improve social equity as a way to reduce health disparities across populations. FDV *is* a health disparity issue, as well as a social justice issue. These two issues are inextricably interlinked and interwoven when examining alcohol-related FDV. Using a public health model allows for a comprehensive framework to be developed that acknowledges the need to address health and gender inequalities to overcome FDV. The policy and program options are presented through the four levels of prevention: primordial, primary, secondary and tertiary. This allows for the *Policy Options Paper* to propose policies from prevention through to supporting those affected by violence.

Consultation process

This paper is presented as a *Policy Options Paper*, rather than a final Policy Paper. It has been informed by reviews of evidence, consultation meetings with professionals working in the alcohol and other drugs and family and domestic violence fields and the findings from the study *The hidden harm: Alcohol's impact on children and families.*[1]

This *Policy Options Paper* is presented as part of an ongoing consultation process to inform the development of a final Policy Paper. This process involves:

- consultation through meetings with stakeholders and development of the *Draft Policy Options Paper* (October 2014 – January 2015)
- refinement of *Draft Policy Options Paper* based on written feedback received by stakeholders and preparation of this *Policy Options Paper* (January 2015 – February 2015)
- public release of the *Policy Options Paper* and roundtable event with stakeholders (24 February 2015)
- open consultation (24 February – 31 March 2015)
- presentation of Final Policy Paper to decision makers (June 2015).

Feedback

FARE seeks your feedback on this *Policy Options Paper*. We have prepared some questions to help to guide your input:

1. What are your overall views on the *Policy Options Paper*?
2. What are your views on the public health model that has been used in the framing of the document?
3. Do you agree with the policy options presented?
4. Are there any additional policy options that you can suggest?
5. Should the proposed policies be more specific (eg. specify funding requirements), or remain as high level policy asks?
6. Do you have any other feedback for FARE?

Please submit your feedback online at www.fare.org.au by 31 March 2015.

If you have any questions about the consultation process or the *Policy Options Paper* more broadly, please contact Sarah Ward at sarah.ward@fare.org.au or 02 6122 8600.

Contents

1. Introduction

Family and domestic violence (FDV) often occurs in the home, where one should feel safest, perpetrated by a loved one, with whom one should feel safest. It is sometimes a one off event but is often a pattern of behaviour characterised by one person exerting power and control over another in the context of an intimate partnership or within a family situation. FDV may persist for years and sometimes involves multiple forms of abuse. In Australia at least one woman dies each week at the hands of her partner or ex-partner[2] and a significant number of children die as a result of abuse and neglect, although exact figures are not known.[3]

FDV can happen to anyone regardless of gender, sexuality, class, culture or family type. Some communities are more likely to experience FDV and may find it difficult to access mainstream support that meets their needs. Aboriginal and Torres Strait Islander women; culturally and linguistically diverse (CALD) women; lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people and families; women with a disability; and older and young women, all face significant barriers to identifying FDV, seeking help and accessing culturally appropriate support.

The impacts of FDV include complex trauma, physical injuries, poor mental health and the development of behaviours that are harmful to health such as alcohol misuse.[4] These impacts are cumulative, with the frequency and severity of abuse being associated with greater physical and mental health impacts on the victim.[5] The impacts of trauma may also persist long after the abuse has stopped.[6]

The effects of violence and abuse also go beyond those directly involved. Witnesses are often traumatised. In many cases it is children who witness these events. This sometimes results in children themselves growing up to use violence. They are also more likely to experience domestic violence themselves. These children can also grow up to experience alcohol and other drug issues in their lives.[7] FDV impacts on children whether or not they witness it. It is more difficult to estimate the impacts of FDV on other family members and communities, but again there is significant evidence to suggest that FDV has widespread immediate and intergenerational consequences.

FDV, and particularly violence between intimate partners, is not a gender neutral issue. Domestic violence is overwhelmingly perpetrated by men against women.[8] This is due to the unequal power dynamics between women and men, the gendered distribution of resources, and an "adherence to rigidly defined gender roles expressed institutionally, culturally, organisationally and individually."[9] Child maltreatment is also more likely to be perpetrated by males than females.[10]

The interplay between alcohol and FDV is complex. Alcohol is a contributing factor to FDV, increasing both the likelihood of violence occurring and the severity of harms.[11] Alcohol misuse can cause or exacerbate relationship stressors thereby increasing the probability of violence. Alcohol use can be both a consequence to and precursor of relationship stress and violence. Alcohol use also affects cognitive functioning and physical functioning, [12] affecting the likelihood of perpetration, and making those who are impacted by FDV more vulnerable. Some perpetrators of violence may try to blame the misuse of alcohol and/or drugs or use intoxication as an excuse. This is not the case. Alcohol use

and intoxication are never an excuse for violence. Victims may use alcohol as a coping mechanism for dealing with trauma and pain. There are also intergenerational impacts, with children who witness domestic violence being more likely to have problems with alcohol later in life.[13]

Alcohol is involved in a significant proportion of reported domestic violence and child protection incidents. In 2010-11 there were 29,684 reported incidents of alcohol-related domestic violence to police across four Australian states; Victoria, New South Wales (NSW), Western Australia (WA) and the Northern Territory (NT).[14] Due to challenges with data collection across all jurisdictions, as well as under-reporting of these crimes, these figures are likely to be significant underestimates. This equates to approximately half of domestic assaults reported to police involving alcohol. In addition, a carer's alcohol use is a factor for 10,166 children in the child protection system.[15]

Australia is committed to addressing FDV by being a signatory to the *Convention on the Elimination of All Forms of Discrimination Against Women*, the *Declaration to End Violence Against Women* and the *Beijing Declaration*.[16] The association between alcohol and FDV has been recognised by the World Health Organization (WHO), which has identified action on alcohol misuse as one of several strategies to reduce violence against women and children.[17,18] There is also recognition of the association between alcohol and FDV by Australian Governments. National, as well as some state and territory, strategies and frameworks have acknowledged the role of alcohol in FDV and have recognised the need to address alcohol as part of an overall strategy to reduce FDV. However, to date, there has been a lack of coordinated action to bring these strategies together to produce effective policies and programs.

This *Policy Options Paper* draws on the following principles based on the literature of what is known about alcohol-related FDV in Australia and internationally. These principles are:

- The consumption of alcohol is never an excuse for violence.
- Policies that address gender inequalities and alcohol misuse are critical to reducing FDV.
- The WHO socio-ecological model acknowledges that no single factor explains why people engage in violence, instead there are multiple factors, at the individual, relationship, community and societal levels. Responses to FDV need to be targeted at all levels.
- No single response is likely to reduce alcohol-related FDV. Australia needs a comprehensive and coordinated approach to address alcohol-related FDV, as part of an overall strategy to reduce violence against women and children.
- A public health approach is needed to reduce alcohol-related FDV, with a focus on prevention across the spectrum, including primordial prevention, primary prevention, secondary prevention and tertiary prevention.

2. Definitions and concepts

Many definitions are used in the FDV and alcohol and other drug (AOD) sectors. This section provides definitions for the terms used in the *Policy Options Paper*. These terms and definitions are outlined below.

Family and domestic violence (FDV) refers to violence between family members (including parents, step-parents or guardians, siblings, cousins, aunts/uncles, and grandparents).[19] It may be perpetrated between adults, by adults on children or by children on parents. For the purpose of this paper, use of the term family and domestic violence covers violence between family members. In some instances, domestic violence and child maltreatment will be discussed separately, in other instances, they will be considered together under the umbrella term of FDV.

Domestic violence refers to acts of abuse that occur between people who have, or have had, an intimate relationship. While there is no single definition, domestic violence is usually an ongoing pattern of behaviour aimed at controlling a partner through fear, often using behaviour that is violent and psychologically threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over a partner or ex-partner and their children, and can encompass acts that are both criminal and non-criminal.[20] The term domestic violence has been used to cover violence between intimate partners (both former and current relationships).

It can include acts of physical aggression (slapping, hitting, kicking or beating), psychological abuse (intimidation, constant belittling or humiliation), forced sexual intercourse or any other controlling behaviour (isolating a person from family and friends or culture, monitoring their movements, stalking and restricting access to information or assistance).[21] Other psychological threats include threatening to hurt children, family members or pets. Domestic violence is more commonly perpetrated by males against their female partners or ex-partners, but it also includes violence against men by their female partners or ex-partners and violence within same-sex relationships.[22]

In this paper, the term domestic violence is used rather than intimate partner violence.

Violence against women refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women. This can include threats to commit such acts, coercion or arbitrary deprivation of liberty. These can occur in public or private life.[23]

Child maltreatment refers to any intentional or unintentional behaviour by parents, caregivers or other adults that poses a substantial risk of causing physical or emotional harm to a child or young person. These can include acts of omission (i.e., neglect) and commission (i.e., abuse).[24] The responsibility for child maltreatment or abuse always rests with the perpetrator and never with the child.

Strong associations have been found between commonly identified forms of child maltreatment and the misuse of alcohol, including: physical abuse (non-accidental use of physical force resulting in harm to the child), emotional maltreatment (failing to provide the emotional support a child needs

to feel safe and valued or requiring children to take on responsibility that is beyond the child's level of maturity such as caring for younger siblings[25]), neglect (failing to provide basic needs such as food, health care, warmth, educational opportunities), sexual abuse and being a witness to family violence (parents who drink alcohol excessively may fail to be aware of the predatory behaviour of others towards their children).[26]

Children's exposure to domestic violence refers to the child who directly witnesses or overhears physical or psychological violence between adults as it occurs, or sees its results such as injuries and emotional effects. This mostly refers to violence involving the child's parents/caregivers but may also include children witnessing violence between a caregiver and another adult in the home.[27]

Victim refers to people who are targets of family and domestic violence, consistent with the language used in the *National Plan to Reduce Violence Against Women and their Children 2010–2022* (the National Plan). This paper uses the term 'victim' rather than 'survivor' to highlight the fact not everyone survives or continues to live their lives to full capacity after experiencing violence.[28]

Harmful alcohol use refers to a pattern of use that causes damage to health which could be either physical, psychological or both. Consistent with terminology used by the WHO,[29] this paper uses the term 'harmful alcohol use' to include use that is associated with adverse health and social consequences for the individual drinker and those around them.

3. Setting the framework

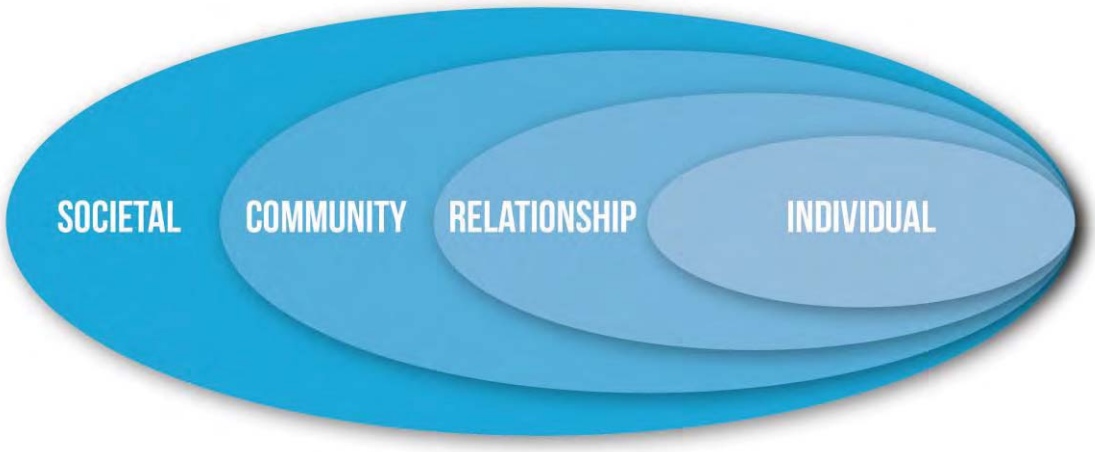
There are many different models available that can be applied to address alcohol-related FDV. Two of these models, the socio-ecological and the public health model are explored in this section. A public health model of prevention has been adopted for this paper. The approach adopted recognises that consistent with the ecological framework, FDV is multifaceted and exacerbated by a range of complex and interrelated factors.

Adopting a public health approach to reducing alcohol-related family and domestic violence

Both alcohol misuse and family violence (including domestic violence and child maltreatment) are considered by the WHO to be major public health issues that demand urgent attention.[30] The public health approach has been used to guide actions to address alcohol misuse, and is increasingly used in family and domestic violence reduction strategies in Australia. [31]

Australian responses to FDV have largely been based on ecological models and this has been instrumental in achieving reform, particularly legal reforms.[32] In 2002 the WHO presented a socio-ecological model that recognised that there is no single factor that explains why certain individuals engage in violence; rather, there are multiple possible factors, categorised across four broad levels, which are complex and interactive.[33] These factors are outlined in the model in Figure 1 below and examples of strategies by level of influence are outlined in Table 1 overleaf.

Figure 1: The socio-ecological model



Reproduced from: Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1–56[34] and Heise, L. (1998). Violence against women, an integrated, ecological framework. Violence Against Women, 4 (4), 262–290.[35]

Table 1: Outline of the socio-ecological model, risk factors and strategies by level of influence.

Level	Definition of Risk Factors	Examples of Strategies to Alleviate
Individual level	The development experiences, individual histories and personality factors that can increase the likelihood of an individual becoming a victim or perpetrator of violence.	Interventions with children, young people and their families at particular points of relationship and family formation, development or dissolution. School-based education that helps students develop life skills and challenge beliefs of rigid gender roles.
Relationship level	Relationships within families (this may include parents, step-parents, siblings, grandparents, cousins), friends, intimate partners and peers and how these can influence violent behaviour.	Programs that aims to change perceptions of gender, violence and behaviour, promote an understanding of positive relationships.
Community level	The context where social relationships occur (e.g. in schools, workplaces and neighbourhoods) and the characteristics of these settings that increase the risk of violence.	A town or city implementing a program that encourages the participation of women in leadership.
The broader societal level	The social norms which may accept or encourage violence. This also takes into account health, economic, educational and social policies that maintain economic or social inequalities between groups.[36]	Legislation that promotes gender equality, e.g. encouraging employers to become more family-friendly and offer workplace flexible schedules to both men and women.

Adapted from: Centers for Disease Prevention, National Centre for Injury Prevention and Control. *The socio-ecological model: A framework for violence prevention*[37] and VicHealth. *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*.[38]

This paper recognises that consistent with the ecological framework, FDV is multifaceted and exacerbated by a range of complex and interrelated factors. Strategies for addressing FDV using the ecological framework include social policy initiatives that address gender inequality and improve the status of women.[39]

Consistent with the socio-ecological model, it is unlikely that one single factor is responsible for someone committing an act of violence. For example, not all FDV involves alcohol, and not all people who drink alcohol will become violent. Similarly, growing up in a violent household is not an inevitable precursor to using violence as an adult and only a minority of men are violent despite living in a society where gender inequality persists.[40] An understanding of the complexities of FDV and its contributing factors is needed to develop multiple policies and programs to prevent FDV. FARE recognises that policies and programs to address gender inequalities are critical to reducing FDV and should be progressed.

Because alcohol is a contributing factor to FDV, policies and programs that aim to reduce alcohol-related harm should be pursued when developing policies and programs to reduce FDV.[41] Alcohol interventions should form part of a suite of comprehensive measures to reduce FDV.

This paper adopts a public health approach, which has enjoyed widespread application in the field of alcohol harm prevention and is increasingly being adopted in the FDV sphere. The focus on prevention is advantageous because rather than being reactive (i.e. only addressing the problem once it has occurred), it is proactive. This paper uses a public health framework broken down into four temporal points:

1. *Primordial prevention* – These policies and programs target the whole population and the structural conditions of society at a broad level and aim to address factors that determine health in the population as a way of reducing the likelihood of problems occurring among citizens. Primordial prevention involves strategies that improve the environmental, economic, legal and social circumstances of the population.
2. *Primary prevention* – These policies and programs target the whole-of-population, especially focusing on those things that reduce individuals' exposure to risks or strengthening individuals' resilience. Primary prevention emphasises preventing a problem before it occurs.
3. *Secondary prevention* – These policies and programs are also known as early intervention and targets individuals or segments of the population who are showing signs of vulnerability, early indicators of trouble or due to co-occurring difficulties and are at particular risk of developing the problem.
4. *Tertiary prevention* – These policies and programs target people who have already been affected and aim to reduce the harm or damage associated with this and prevent the recurrence of a problem once it has been identified.

The public health prevention approach is holistic view of health and life circumstance. These areas are explored further throughout the paper.

4. The situation and context

This section explores the intersection between FDV and alcohol, describing both the problem and current situation in Australia. This section outlines alcohol's involvement in domestic violence and child maltreatment and why action on the issue is critical.

4.1 Domestic violence

Domestic violence is not a gender neutral issue. Statistics published by Australia's National Research Organisation for Women's Safety (ANROWS) highlight that since the age of 15, one in six women (16.8 per cent) had experienced physical or sexual violence from a current or former partner, compared to 5.1 per cent of men who had experienced physical or sexual violence from a current or former female partner. One in four women (24.5 per cent) have experienced emotional abuse by a current or former partner compared to one in seven men (14.4 per cent). Men too can be victims of domestic violence, although this violence is more likely to be perpetrated by a male than a female, as explained in ANROWS's *Violence against women: Key statistics*.[42]

The effects of domestic violence are numerous and devastating. These negative impacts include injury, physical health disorders such as gastrointestinal and reproductive health effects, psychosomatic disorders, poor mental health, suicidal ideation and the development of habits that are harmful to health such as alcohol misuse.[43] Victims also suffer from social difficulties which affect their relationships with friends, family and colleagues. The Victorian Health Promotion Foundation (VicHealth) publication: *The health costs of violence: Measuring the burden of disease caused by intimate partner violence* found that domestic violence within relationships are responsible for more preventable ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking.[44] These effects can persist long after the abuse has stopped. The effects are also likely to be cumulative, with more episodes of abuse, and the greater the severity of the abuse, contributing to increased impact on the physical and mental health of the victim.[45]

In Australia a number of communities and population groups are disproportionately affected by domestic violence, including Aboriginal and Torres Strait Islander peoples, women from CALD backgrounds, especially those who are exposed to violence as a refugee (before coming to Australia); and people who identify as LGBTQI.[46]

In addition women with disabilities are more likely to experience domestic violence[47,48] and this violence is likely to be more severe and extend for prolonged periods of time.[49] Violence perpetrated against women with a disability includes perpetration by partners or other family members, as by well as those outside family relationships including carers, friends and healthcare professionals.[50] Women with a disability are particularly vulnerable because of potential limitations to accessing support, social and cultural disadvantage. Poverty, low education and low employment contribute further to their vulnerability and increases dependence which in turn increases power imbalances. Other groups at risk of experiencing FDV include women living regional, rural and remote areas, older women, young women and women who are pregnant.[51] This demonstrates the breadth of the issue and how it impacts on many women across the lifespan.

It is also vital to consider the effect of domestic violence on parenting and children as research has shown that violence is more likely to occur between couples with children, often commencing during pregnancy. For children there are physical as well as psychological effects of witnessing domestic violence incidents, as well as stress and complex trauma from living in a perpetual state of alert and living in a situation that is volatile and unstable. This can have profound long term psychological impacts. This situation is explored in more detail in the section on Child Maltreatment.

Domestic violence also affects other family members. It is estimated that more than a million children are affected by domestic violence in Australia.[52] Witnessing domestic violence is variously described as being exposed to violence, experiencing direct abuse, hearing or seeing violence, and living with domestic violence. Witnessing domestic violence is known to impact on children regardless of whether the child sees physical incidents; hears threats or fights from other rooms; observes the aftermath such as blood, bruises, torn clothing, and broken items or lives in a home where violence is taking place placing them in fearful and stressful situations.[53]

4.1.1 Alcohol's involvement in domestic violence

The relationship between alcohol use and domestic violence is complex. The WHO has gathered a body of evidence on the relationship between alcohol use and domestic violence that demonstrated that:[54]

- alcohol contributes to the incidence and the severity of domestic violence
- heavy alcohol use may cause or exacerbate relationship stress which increases the risk of conflict
- alcohol use affects cognitive and physical function and may result in perpetrators of domestic violence using a violent resolution to relationship conflicts, rather than a non-violent resolution[b]
- excessive drinking by at least one partner can aggravate existing relationship stressors such as financial problems, thus increasing the probability of violence
- alcohol use is often used by perpetrators as a justification to violence, or excuse for the violence
- experiencing domestic violence can result in increased alcohol consumption by the victim as a coping mechanism
- intergenerational effects may occur; children who witness FDV are more likely to develop heavy drinking patterns and alcohol dependence later in life often as a way of coping or self-medicating.[55]

[b] This is not to say, that other forms of domestic violence, such as controlling behaviour, will cease even if alcohol consumption is reduced.

Alcohol is implicated in a significant number of reported domestic violence incidents. The Australian Institute of Criminology describes that within intimate partner relationships the consumption of alcohol can facilitate the escalation of an incident from verbal to physical abuse because it can lower inhibitions and increases feelings of aggression. In turn the consumption of alcohol, either by the perpetrator or victim, may also increase the seriousness and severity of a domestic violence incident, with almost half of all intimate partner homicides found to be alcohol-related.[56,57] Further to this, a 15 month longitudinal study involving 272 men entering a domestic violence treatment program or alcohol treatment program in United States of America (USA), also found that reported that domestic violence incidents inflicted by men on women were approximately eight times higher on the days when the man consumed alcohol, compared to the days that he did not drink.[58] Alcohol is also associated with an increase in the severity of violence. Compared to a physical assault where alcohol is not involved, alcohol-related physical assault from a partner is more likely to result in the victims sustaining an injury and experiencing anxiety or fear for personal safety.[59]

Research from Europe has found that the availability of alcohol generally in society affects the rates of FDV. In 1978 a strike at government liquor stores in Norway cut the availability of alcohol by ten to 15 per cent, the rate of "home quarrels" dealt with by the police dropped by about one-quarter.[60] In addition a study of the effects of changes in the number of off-sale alcohol outlets in neighbourhoods in the Melbourne region between 1996 and 2005 found that adding a new outlet in a postcode increased the domestic violence rate in police statistics by an average of 28.6 per cent.[61]

The financial cost of alcohol-related domestic violence in Australia is significant. It is estimated that each alcohol-related assault recorded by police costs $1,615, bringing the tangible cost of alcohol-related domestic violence to between $40 million and $52 million in 2005.[62]

Perpetrators

Alcohol consumption should not be seen as a mitigating factor in domestic violence. In 1990 Heather McGregor, Co-ordinator of Domestic Violence Crisis Service in the Australian Capital Territory (ACT) explained that "Regardless of how much a man drinks… he has no right to possess and control anybody… he is absolutely responsible for his own behaviour, no matter what…"[63] It is clear from research that addressing alcohol use alone will not necessarily result in the cessation of violence by perpetrators. Domestic violence is a pattern of controlling behaviours through which the perpetrator seeks power and control over the victim. However, addressing alcohol consumption across the population may reduce the levels and severity of domestic violence and improve the safety of women and children.[64,65,66]

The use of alcohol by perpetrators in domestic violence situations is complex. An issues paper by Rochelle Braaf in 2010 outlined the research evidence indicating an association between the frequency of a perpetrator's drinking and the severity of the violence within intimate partner relationships, with incidents of violence found to be higher on days when the male partners is drinking.[67] This association has also been found on days of national celebration and holiday, such as the Australian Football League (AFL) Grand Final, Christmas and New Year periods, most school holidays, and Easter;[68] occasions when alcohol consumption is also highly present. Research in the United Kingdom (UK) has found strong links between alcohol, sport and domestic violence. This

research used police data from the north west of England for the last three FIFA World Cups (from 2002 – 2010). It found that the risk of domestic violence increased by 26 per cent when the English team won or drew, and by 38 per cent when the English team lost.[69] There was also an increase of 37.5 per cent of assault attendance across 15 hospital emergency departments across England on match days, and alcohol consumption was heavily associated with these occasions.

When a perpetrator is drinking they are less aware of physical force they are using; they are less concerned about consequences; and display increased emotionality which can lead to greater likelihood of violence occurring. In addition heavy and/or frequent drinking can cause dissatisfaction and conflict within relationships and this, alongside social expectations about the effects of alcohol on aggression, can amplify its effect.[70]

The social expectations about alcohol consumption and violence are also important to understand. VicHealth's *Australians' Attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey* (NCAS) found that nine per cent of people believed that violence against women can be excused in certain circumstances if the perpetrator is affected by alcohol. In addition to these societal attitudes being expressed by respondents to the survey, NCAS also revealed that some men consciously drink to give themselves 'time-out' to behave in ways they know are unacceptable and this includes violence against women.[71] The survey highlights that only a small proportion of women become aggressive when intoxicated, suggesting that social expectations of men are important when examining the behaviour of men who use violence while intoxicated.

South Dakota's 24/7 Sobriety Project required people arrested or convicted for alcohol-related offences to take two alcohol breath tests a day or wear a continuous alcohol monitoring bracelet with 'swift, certain and modest sanctions.' This project found a nine per cent reduction in domestic violence arrests following the implementation of the program.[72]

Targeting the problematic drinking of perpetrators could be an important preventative measure for alcohol-related domestic violence, although further research on the effectiveness of this approach is required. Perpetrator treatment programs are available in some states and territories in Australia, unfortunately these are rarely linked with existing AOD treatment services.

Responding to perpetrators of domestic violence requires a long term multifaceted approach that addresses the social and health environment of the individual and acknowledges the increased risk of further violence. Care needs to be taken to ensure the safety of other family members when a perpetrator undertakes any treatment program. Treatment for alcohol problems increases the risk for domestic violence due to the discomfort of physiological or psychological withdrawal heightening a perpetrator's anxieties and irritability.[73] Therefore, the treatment of alcohol problems needs to occur only when full attention is given to the dimensions of their situation. This is discussed in further detail in section 6.5.3.

Victims

A meta-analysis in 1999 found that women affected by domestic violence were almost six times more likely than other women to have problems with alcohol.[74] Alcohol use by victims raises two important issues, the first is the heightened risk of an individual becoming a victim of domestic violence and the second is the use of alcohol by a victim as a method to cope with the violence and trauma.[75]

Alcohol is often used as a form of self-medication, to cope with the abuse itself and associated effects such as isolation, lack of support and feelings of self-blame or shame.[76] However, the risk of being a victim of domestic violence increases with increasing levels of alcohol consumption,[77] demonstrating that the link between victimisation and alcohol problems is an important one. There is evidence to suggest that the use of alcohol by victims can impair judgement, reduce an individual's capacity to implement safety strategies, and may impact on their capacity to seek help from police or services.

Unfortunately victims who are intoxicated are more likely to be blamed for the violence than a victim who is sober.[78] The NCAS results show that one in ten Australians believe that domestic violence can be excused if the victim is affected by alcohol.[79] This belief demonstrates the need for attitudinal change across society to ensure that violence is not excused when alcohol is involved.

Problematic alcohol use also tends to exclude women from domestic violence support services and refuges, and can increase the likelihood of a woman losing custody of her children.[80] If a woman does seek treatment for her alcohol problems she may encounter additional barriers. Her partner may stall or prevent access to treatment as a way of maintaining control over her. Indeed, victims of domestic violence are less likely than non-victims to complete substance misuse treatment.[81] The perpetrator may also become more violent as a reaction to the perceived loss of control.

Other issues that prevent women seeking support or disclosing domestic violence include a lack of access to support services, especially in rural and remote communities,[82] issues of anonymity within the community and kinship groups. Some Aboriginal and Torres Strait Islander peoples may feel unwilling to access support, report to police or leave a situation due to concerns that they will "fragment their identity by leaving the community, kin, family or partners."[83] Fear is also another significant barrier for women accessing support services; fear based on others' experiences of the criminal justice system, fear that perpetrators will die in custody and the very real fear that the disclosure of violence and neglect will result in having children removed from the family.[84,85] In addition to these, other barriers include financial pressures, medical costs, difficulty accessing social supports or services such as childcare, low self-esteem, low self-efficacy and limited life skills.[86]

Prevalence and trends

Data on the prevalence and trends of alcohol-related FDV is accessed through two main channels: service data and survey data.

Service data

Service data refers to sources of data that come from legal and health services such as police, hospitals and emergency services. Police data is used to determine the extent of reported alcohol-related FDV around Australia. Police data is valuable because police respond to incidents as they occur. Police data, however, does have limitations. It represents a severe underestimate of the true incidence of alcohol-related FDV because as many as half of domestic violence occurrences go unreported.[87] This is particularly the case when the violence is non-physical. Other limitations include that:

- some states and territories do not formally record the involvement of alcohol in FDV
- those jurisdictions that do collect data on alcohol involvement in FDV do not collect it in a consistent manner, making national estimates difficult
- the role of alcohol is determined by attending officers using their own judgement and the reports of the people involved, rather than more objective measures such as breathe testing for blood alcohol content.

Data on reported alcohol-related FDV incidents is collected by police in NSW, Victoria, the NT and WA. Where this data is available, it highlights that alcohol is involved in almost half of all reported domestic violence incidents[88,89] Data needs to be collected consistently across Australia in order to have more accurate understanding of alcohol's involvement in FDV incidents. Furthermore, in the past decade there has been an increase in the number of reported alcohol-related domestic assaults across the country. The data reported in Table 2 overleaf is derived from NSW Bureau of Crime Statistics and Research (BOCSAR), Victoria Police, NT Department of the Attorney-General and Justice, and WA Police.

Table 2: Alcohol's involvement in domestic violence using Police data (where available) across Australia.

Jurisdiction	Latest available year of data	Proportion of domestic violence incidents[c] involving alcohol	Total alcohol-related domestic assaults	Trend in alcohol-related FDV
New South Wales[90]	April 2013 – March 2014	35%	9,948	0.46 % increase from 2004-05.
Victoria[91]	July 2012 – June 2013	23%	14,015[d]	85% increase from 2003-04.
Northern Territory[92]	Jan 2013 – Dec 2013	65%	3,137	77% increase from 2008.
Western Australia[93]	July 2011 – June 2012	47%	5,092	21% increase from 2005-06

As outlined in Table 2, police data shows that men are more likely to be perpetrators of FDV. For example, for alcohol-related domestic assaults in NSW, in the year leading to September 2014, there were five times as many male as female perpetrators and half as many male as female victims.[94] Data from BOCSAR's Crime tool shows that between October 2013 and September 2014 there were 5,629 male perpetrators compared to 1,122 female perpetrators; (3,584 male victims compared to 7,295 female victims).

Survey data

Survey data may provide a more accurate estimate of the extent of alcohol-related FDV because it captures people who may not have reported violence to the police. Survey data is also more able to explore different forms of less serious violence including those that do not usually come to the attention of the police, such as verbal abuse. Survey data relies on self-report which has advantages and disadvantages. On the one hand, the anonymity involved may encourage greater disclosure, on the other hand, self-report may also be inaccurate.[95,96] Some caution also needs to be applied as it is not known from these survey results if the incidents of violence that are reported are part of ongoing pattern of violence that is likely to occur regardless of whether alcohol is involved or not.

The National Drug Strategy Household Survey 2013 (NDSHS 2013) found that more than five million Australians (aged 14 and over) had been a victim of any alcohol-related incident in the 12 months prior to the survey, with men more likely than women to report this. However, women are more likely than men to have experienced an alcohol-related incident perpetrated by a current or former spouse/partner or from another relative, whereas men are more likely than women to have experienced an alcohol-related incident perpetrated by people outside the family, including strangers. This applies similarly across the types of incident, whether it be physical abuse, verbal

[c] Domestic violence is defined by Police as anyone with a domestic relationship with the victim, for example, ex or current spouse/partner, child or sibling.

[d] This figure includes incidents that are recorded has having had definite alcohol involvement (n=14,015). Police also recorded incidents that had possible alcohol involvement (n=13,834)

abuse or being 'put in fear'.[97] Table 3 below, reproduced from the NDSHS 2013, shows the proportion of male and female victims of alcohol-related incidents, by incident type and relationship to perpetrator.

Table 3: Relationship of perpetrators to victims of alcohol-related incidents, victims aged 14 years or older, by sex, 2013 (per cent).

Incident and relationship of perpetrator	Males (%)	Females (%)	Persons (%)
Verbal abuse			
Current or ex-spouse or partner	10.5	29.0	18.4
Other relative	8.6	15.7	11.6
Friend	12.2	10.2	11.3
Other person known to me	24.1	16.9	21.0
Someone not known to me	67.9	49.3	59.9
Physical abuse			
Current or ex-spouse or partner	10.1	33.9	19.4
Other relative	9.5	14.9	11.6
Friend	12.2	*5.0	9.4
Other person known to me	24.2	13.6	20.1
Someone not known to me	65.9	42.8	56.9
Put in fear			
Current or ex-spouse or partner	5.0	19.8	13.2
Other relative	8.9	13.3	11.3
Friend	5.9	8.5	7.3
Other person known to me	18.4	16.3	17.3
Someone not known to me	76.6	60.1	67.4

Notes

1. Base is respondents who reported being a victim of each form of alcohol-related incidents in the 12 months prior to the survey.
2. Respondents were able to select more than one response.

* relative standard error between 25% and 50%. Interpret results with caution.

Table 3. Reproduced from Australian Institute of Health and Welfare. (2014). 2013 National Drug Strategy Household Survey. *Table 4.27 Relationship of perpetrators to victims of alcohol-related incidents, victims aged 14 years or older, by sex, 2013 (per cent)*

When incorporating a broader range of harms by the drinking of a partner or close other, results from a separate survey on alcohol's harm to others and reported in: *The Range and Magnitude of Alcohol's Harm to Others* (HTO) show that women disproportionately experienced higher levels of harms such as lost productivity, financial impacts and emotional distress, as a result of the drinking of someone close to them. For example, young women (27 per cent) were more than twice as likely as young men (11 per cent) to report that the drinking of at least one household member, relative or intimate partner had negatively affected them in the previous 12 months.[98]

4.2 Child maltreatment

The WHO describes child maltreatment as a global problem with lifelong consequences. International estimates reveal that a quarter of all adults report having been physically abused as children and one in five women and one in 13 men report having been sexually abused as a child. [99] The WHO defines child maltreatment as including: physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.[100]

Physical impacts include injuries and impairments, disruption to early brain development, stress-related symptoms such as sleep disorders and impacts to the nervous and immune systems. Psychological distress includes fear, depression and attempted suicide both in childhood and later in life. All forms of child maltreatment are likely to result in emotional difficulties and the longer the abuse continues the more serious these effects are likely to be.[101]

Being a witness to FDV has serious emotional, psychological, social, behavioural and developmental consequences for children. It places significant stress on their physical, emotional and social development and can impair cognitive and sensory growth. It can also result in behaviour changes that include excessive irritability, sleep problems, emotional distress, fear of being alone, immature behaviour, and problems with toilet training and language development.[102] Children can be also be exposed to violence from birth, or even before birth, with pregnancy being a time of increased risk of violence for women.[103]

As adults, people who have experienced child maltreatment are at increased risk of behavioural, physical and mental health problems such as: perpetrating or being a victim of violence; depression; alcohol and other drug use and abuse; high risk sexual behaviours, unintended pregnancy; homelessness and involvement with the criminal justice system.[104] In turn these consequences contribute to heart disease, cancer, suicide and sexually transmitted infections. This also impacts at a societal level including the costs of hospitalisation, mental health treatment, child welfare, and longer term health costs.[105]

There are a number of risk factors that increase the likelihood of child maltreatment. Some of these risk factors include: the age of the child, being Aboriginal or Torres Strait Islander and being a child with special needs. Australian statistics demonstrate that children under one year of age are most likely to be involved in substantiated cases of abuse or neglect (13.2 per 1,000 children), followed by children aged 1–4 years (8.4 per 1,000 children) and children aged 15–17 years (3.2 per 1,000 children).[106] Children with special needs such as physical and intellectual disabilities, mental health issues, and chronic physical illnesses are at increased risk of victimisation and maltreatment. [107]

Aboriginal and Torres Strait Islander children are eight times more likely to be a substantiated case of child maltreatment, with rates of 41.9 per 1,000 Indigenous children compared with 5.4 per 1,000 non-Indigenous children.[108] The Australian Institute of Health and Welfare report *Child Protection Australia 2012-2013* outlines that "the reasons for the over-representation of Indigenous children in child protection substantiations are complex. The legacy of past policies of forced removal; intergenerational effects of previous separations from family and culture; lower socio-economic

status; and perceptions arising from cultural differences in child-rearing practices are all underlying causes for their over-representation in the child welfare system."[109]

Other risk factors for child maltreatment include the parent's own history of child maltreatment, parental mental health issues and use of alcohol and other drugs (including during pregnancy), transient caregivers, low levels of education and income of the parents, having large number of dependent children and limited access to support services or employment. There are also relationship risk factors such as family breakdown and violence, isolation and lack of support networks and a number of risk factors at a community and societal level including gender and social inequality, lack of housing, high levels of unemployment, poverty, easy availability of alcohol and drugs, a lack of services to support vulnerable families and cultural norms that promote or glorify violence towards others.[110,111]

4.2.1 Alcohol's involvement in child maltreatment

Alcohol is consistently identified as a significant contributor to child protection cases across Australia.[112] Data indicates that within child maltreatment cases alcohol is the most common substance being used by carers, followed by cannabis, psychostimulants and opioids.[113] Alcohol's use and misuse is also strongly associated with FDV, mental health issues, incarceration and child protection.[114]

The drinking of parents can impede their capacity to take care of their children. The focus of acquiring and drinking alcohol, and becoming intoxicated, distracts from basic responsibilities for children such as providing food, supervision and protection.[115] Other impacts include arguments, disharmony, divorce, domestic violence and inadequate role performance by various family members and together these impacts may result in child physical and sexual abuse.[116] In addition, alcohol has a negative impact on education. Late night antics of intoxicated people interrupt children's sleep which compromises their school attendance and performance.[117,118]

There are a wide range of risk factors that are known to increase a child's risk of experiencing child maltreatment, including parental alcohol and drug use. However, it is important to note that alcohol and drug use by parents is not in itself a risk of child maltreatment or harm to children. Alcohol use does not always lead to poor parenting, but alcohol use by parents and carers is generally considered problematic when it is at level that impairs the judgement or alters the mood of parents, placing the child at risk of abuse or neglect.[119] The abuse is not necessarily from the drinking parent; an intoxicated parent may lack the capacity to protect the child from abuse by someone else. This poor supervision can range from children's needs not being met (not having regular healthy meals, clothes being washed) to placing children at risk of sexual assault and abuse.

Where issues with alcohol do occur they are often associated with other problems that families are likely to be experiencing, such as poverty, violence, housing and employment issues. It is this constellation of issues and stressors that put families and children at risk.[120] In addition, if both parents are experiencing problems with alcohol, the risk of maltreatment is higher.[121]

Children who are experiencing child maltreatment or living within relationships undergoing significant stress are like to develop a range of behavioural problems from early childhood. In turn

these can lead to difficulties settling into the school system; and by middle childhood, without help or support these children may be failing to meet educational standards for literacy and numeracy.[122] This can create a cycle where children who are maltreated achieve lower education levels, struggle with employment opportunities, go on to have relationships that are violent and experience alcohol, other drug and mental health issues. This creates a cycle of violence from one generation to another.[123]

Alcohol policies have a role to play. The WHO has highlighted that neighbourhoods, which have higher densities of alcohol outlets (both on and off licenses) also have greater child maltreatment problems. These neighbourhoods are also more socially disadvantaged with fewer resources available to support families. This finding is supported by research in Victoria that found that people living in disadvantaged areas had greater access to off-licence (bottle-shops) as wealthier areas. This situation can lead to increased stress for families and restrict development of social networks that can prevent child maltreatment.[124]

According to the WHO, alcohol and child maltreatment are connected in the following ways:

- Alcohol affects physical and cognitive function, which may reduces self-control and increases the propensity to act violently, including towards children, and may also incapacitate the parent from protecting the child from abuse by others.
- Harmful alcohol use can impair responsible behaviour and decrease the amount of time and money that can be spent on a child.
- Harmful parental alcohol use is associated with other factors that increase the risk of child maltreatment such as mental health issues and anti-social personality characteristics.
- Experiencing child maltreatment is associated with problematic alcohol use later in life, to cope or self-medicate.
- Child maltreatment associated with alcohol misuse is not confined to any one socio-economic group or cultural identity.[125]

Children can also be affected by alcohol exposure before birth, and the consumption of alcohol during pregnancy is associated with a range of adverse consequences, including miscarriage, still birth, low birth weights and Fetal Alcohol Spectrum Disorders (FASD). FASD is a lifelong condition that impacts individuals, their family and their community over their lifespan. The primary disabilities associated with FASD are linked to underlying brain damage including poor memory, impaired language and communication skills, poor impulse control, and mental, social and emotional delays.[126] Children born with FASD most often come from heavy drinking families, with 75 per cent of children with FASD in a USA study having a biological father who was a heavy drinker and having extended families with heavy alcohol consumption.[127]

There is strong evidence internationally[128, 129, 130] and emerging evidence from Australia[131] that children with FASD are disproportionately represented in the child protection system. A study of 250 children in the NT child protection system found that 21 per cent of all children (under investigation and on orders) were recorded as having been exposed to alcohol consumption before birth. For those

children in care (on orders), within this sample 38 per cent were found to have been exposed to alcohol before birth (with 18 per cent confirmed and 20 per cent probable exposure).[132]

The Range and Magnitude of Alcohol's Harm to Others estimated the cost of alcohol-related child maltreatment in Australia to be $675 million. This estimate includes the costs of child protection services, out-of-home care services, intensive family support services and morbidity costs. When the intangible or indirect costs are included, this figure is likely to be much higher.[133]

Prevalence and trends

Like alcohol-related domestic violence, information on the prevalence and patterns of alcohol-related child maltreatment are derived from a variety of sources: service systems data such as child protection data and survey data.

Service data

The hidden harm: Alcohol's impact on children and families, a report that examines the impact of alcohol on women, children and families, collated data from across Australia to estimate alcohol's involvement in child protection cases. These are outlined in Table 4 below.

Table 4: Alcohol's involvement in child maltreatment by Australian jurisdiction.

Jurisdiction	Alcohol's involvement in child maltreatment
New South Wales	• Fifteen per cent of substantiated cases involved alcohol in 2006-07.
Victoria	• One-third (33 per cent) of all substantiated cases between 2001 and 2005 involved carer alcohol abuse.
Queensland	• One-quarter (24 per cent) of all substantiated cases in 2007 involved alcohol only and there is likely to be more that involved alcohol and drugs together.
Northern Territory	• No percentages provided however carer substance misuse noted as a significant factor in child protection cases between 2003 and 2010.
Western Australia	• Almost half (47 per cent) of applications to Children's Court for care and protection orders involved carer alcohol abuse.
South Australia	• Approximately 70 per cent of alternative care cases in 2006 involved parental substance misuse.
Australian Capital Territory	• In a study of 150 children involved in substantiated cases between 2000 and 2003, 56 per cent of cases involved substance misuse.
Tasmania	• No estimates identified.

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

Parent or carer alcohol misuse is significantly involved in child maltreatment. Data from Victoria indicates that as child protection cases become more serious, the involvement of alcohol increasingly becomes identified as a factor. In the period 2001 to 2005, alcohol was recorded as a familial risk factor in one-third (33 per cent) of all substantiated child abuse cases. Breaking this down by level of seriousness and intervention required, carer alcohol abuse was recorded in 25 per cent of

substantiated cases that did not require further intervention, 34 per cent of cases where the most serious intervention was a protective intervention, and 42 per cent of cases requiring an order from the Children's Court.

Table 5 below provides an overview of alcohol involvement in substantiated cases in Victoria 2001-2005, by primary type of harm.

Table 5: Alcohol's involvement in child maltreatment in Victoria 2001-05 by type of harm.

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

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

Service data collated within *The hidden harm: Alcohol's impact on children and families* shows that large numbers of children are being substantially affected by others drinking, such as experiencing alcohol-related child abuse, neglect (being left unsupervised or in an unsafe situation), being verbally or physically abused, being exposed to FDV, deaths and injuries. An estimated 10,166 children are already within the child protection system due to the drinking of a carer but an additional 142,582 children are affected by others drinking but are not within the child protection system. There are also more than one million children who have been affected in some way by others drinking such as being verbally abused, witnessing serious family arguments for example.[134]

When taking into account unreported cases of abuse, or abuse that may not necessarily come to the attention of authorities, e.g. neglect, verbal abuse, well-hidden physical abuse, the estimated effects are even greater.

Survey data

As with domestic violence, child maltreatment is likely to be largely unreported or unsubstantiated. Many of the cases coming to the attention of child protection authorities will have come to light in "crisis" situations, but do not include many serious cases where there has not been an obvious crisis. Survey data provides valuable insight into the true extent of alcohol-related child maltreatment in Australia. Data from the Harm to Other surveys and in *The hidden harm: Alcohol's impact on children and families* shows that one in five carers (22 per cent) reported that their children had been adversely affected in some way by other's drinking in the year 2008. This was most commonly due to drinking by the child's parent, step-parent or carer's parent or ex-partner. There was substantial harm was also persistence in the harm, with 35 per cent of those reporting harm to their children in 2008 reporting harm again 2011.[135]

Of the carers surveyed, nine per cent reported that their children were verbally abused, three per cent reported that their children were left in an unsupervised or unsafe situation, three per cent reported that their children witnessed serious violence in the home, one per cent reported that their children were physically hurt and 0.3 of a percent reported that a protection agency or family services was called.

Almost half (46 per cent) of respondents whose children were affected by someone else's drinking reported that the child was affected by the drinking of someone in a parental role (parent, step-parent, guardian, partner or ex-partner of the parent or guardian), 12 per cent reported being negatively affected by the drinking of siblings and 15 per cent reported being negatively affected by other family members and relatives. Others reported negative impacts by people outside the family such as people their child was in contact with, e.g. teachers, sports coaches (15 per cent) or unspecified others (12 per cent).[136]

5. Family and domestic violence policy frameworks

This section reviews the existing government frameworks for FDV in Australia. The aim is to provide an indication of the extent to which alcohol is referenced within a plan or strategy and the specific alcohol harm reduction initiatives (if any) made within the plan.

The following approach was undertaken for this review:

- a search was undertaken for the most recent domestic violence and child protection[e] strategies nationally and in each state or territory[f]
- a global search was made for references to 'alcohol' within the plan
- an examination was undertaken of the initiatives proposed in the plan (if proposed) and listing of those initiatives specifically mentioning alcohol harm reduction strategies.

A table of all the strategies considered in the review is in Appendix 2: Analysis of existing strategies for Domestic Violence and Child Protection Strategies in Australia.

This review found that there is considerable variation in how alcohol is referred to as a contributing factor to Domestic Violence in Australian governments' strategic plans. Examining the plans focused on domestic violence, the NT plan places emphasises on the importance of collaboration between alcohol and domestic violence agencies. But other strategies such as those in Queensland and South Australian make no reference to the role of alcohol in domestic violence, nor do they suggest any alcohol-related initiatives. Other domestic violence plans do mention alcohol as a contributing factor to domestic violence, but stop short of specific recommendations to reduce alcohol-related domestic violence.

Similar results are found when looking at Child Protection plans. For example NSW outlines specific initiatives to provide clinical services (including drug and alcohol counselling) to children, young people who experience abuse and neglect, but the ACT plan outlines no specific initiatives to reduce alcohol harms.

In addition, where specific alcohol harm reduction initiatives are listed, these are often targeted to Aboriginal and Torres Strait Islander peoples only. Also there are no initiatives that aim to target the availability, affordability or promotion of alcohol.

Most critically, there is a lack of detail in the National Plan (*The National Plan to Reduce Violence Against Women and their Children 2010 – 2022* and *National Framework for Protecting Australia's Children*) about the contribution of alcohol as a risk factor in FDV. Again the initiatives listed to achieve reductions in alcohol-related harm within these plans focus on measures for Aboriginal and Torres Strait Islander peoples. Other initiatives include the implementation of the *National Binge Drinking Strategy,* which ceased in June 2014.

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[e] Plans that covered child protection and wellbeing were included in the review as this reflects the terminology within the plans.

[f] In order to limit the analysis to strategic policy only this review has not included legal frameworks or legislative Act (such as Child Protection Acts in each jurisdiction).

It should be noted that as there is no current National Alcohol Strategy (the previous *National Alcohol Strategy - Towards Safer Drinking Cultures 2006-2011* lapsed in 2011).[137] Policies to reduce alcohol harm at a national level are now considered to be a sub-set within Australia's *National Drug Strategy 2010-2015.*[138] When the *National Drug Strategy* is reviewed for mentions of FDV, these are also found to be limited. FDV is mentioned under the second objective of the plan to "Reduce harms to families", and an action listed within this includes a "review of existing national frameworks which address some of the causes of drug use, for example domestic violence strategies, and consider related actions that could be taken."[139] To our knowledge, this review has not been undertaken.

These gaps in the FDV and child protection strategies and the *National Drug Strategy* highlight a lack of critical recognition between the sectors as to the cross-over and interconnections between of the issues. This highlights the need for a comprehensive Policy Paper, such as this one, to be developed to highlight opportunity for a joint approach to reducing alcohol-related FDV.

6. Exploration of policy options

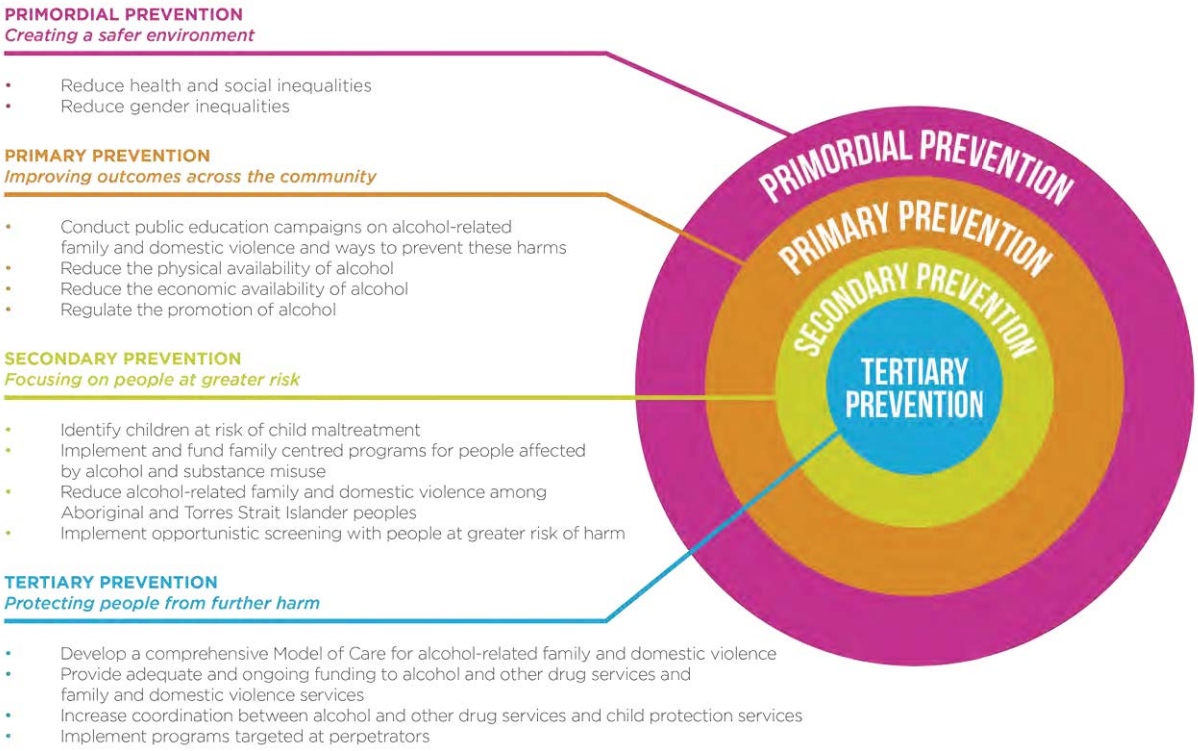
This section explores the policy options to prevent and reduce alcohol-related FDV. These options are presented using a public health model of prevention across the four levels of prevention: primordial, primary, secondary and tertiary.

6.1 Using a public health model

Using a public health model allows for a comprehensive framework to be developed that acknowledges the need to address social justice and health disparities, which are inextricably interlinked and interwoven in alcohol-related FDV. Applying a public health model to preventing alcohol-related FDV aims to improve social equity as a way to reduce health disparities across populations and to have recourse to cost-effective population-wide policy responses.

These are described in more detail in the sections that follow. Figure 2 overleaf shows an overview of these sections in a model explaining levels of prevention and Appendix 1: Overview of policy options to reduce alcohol-related FDV further details these options. Policy options are numbered in the Appendix and throughout the following sections.

Figure 2: Levels of prevention and proposed policy options to prevent alcohol-related family and domestic violence



6.2 Primordial prevention

Primordial prevention refers to initiatives and strategies that aim to prevent the emergence of predisposing environmental, economic, social, behavioural and cultural factors known to increase the risk of disease and harm across populations.[140]

Over the last decade our understanding of the factors that contribute to a person's health and life outcomes have improved significantly. It is now known that the primary determinants of the health of an individual are a combination of the circumstances of where people are born, live, work and grow (known as the social determinants).[141] These social determinants are very differentially distributed, resulting in inequities between countries, within countries and even within local communities. Improving these circumstances often falls outside of the traditional health portfolio.

The importance of implementing initiatives that address the social determinants of health has been recognised by the WHO and by the Australian Parliament, through the 2012 Inquiry by the Senate Standing Committee on Community Affairs on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report* (Social Determinants Inquiry). The Social Determinants Inquiry recognised that there are significant differences in the life

expectancies and health outcomes between groups in society, and that factors such as education, income, gender, power and conditions of employment all impact on health outcomes.[142]

Primordial prevention strategies aim to influence the whole population to reduce health inequalities and reduce gender inequalities in Australia. Reforms in these areas need to be multi-sectoral, involving governments, industry, manufacturers and non-government organisations, and across settings that include workplaces, schools, health services, sporting clubs and community groups. Strategies to address both health inequalities and gender inequalities are outlined below.

6.2.1 Reduce health and social inequalities

Alcohol consumption, and the ways in which alcohol is consumed is influenced by people's age, gender, cultural background and place of residence. Alcohol is both a consequence of and contributor to poor health and inequity.[143] For example, rates of harmful alcohol consumption can be influenced by a poor living conditions and lack of employment, and heavy drinking can also lead to these circumstances as well, due to alcohol-related problems.

Understanding the social determinants of health and how these contribute to risky alcohol consumption and increase health inequalities is important for governments across Australia to recognise. A submission by the NT Department of Health and Families to the Social Determinants Inquiry acknowledges that "many of the modifiable risk factors that influence the development of chronic conditions such as smoking, consumption of excess alcohol, poor diet and limited physical activity are linked to the social determinants of health, and are exacerbated by other social determinants of health such as level of income, limited education and unemployment which are risk factors for chronic conditions in their own right."[144]

The Social Determinants Inquiry highlighted that alcohol and drug misuse are closely associated with social and economic disadvantage and are a significant cause of health problems and premature death in Australia. Research has shown that even though people from lower socio-economic groups are more likely to abstain from alcohol than those from higher socio-economic groups, alcohol misuse disproportionately affects people experiencing socio-economic disadvantage. This is thought to be due to factors associated with socio-economic disadvantage, such as poverty, stress and difficulty accessing quality healthcare, which is likely to compound the harmful social and health impacts from alcohol leading to greater harms.[145]

Therefore addressing the discrepancies in health outcomes, which arise from the social determinants means addressing the causes of those determinants; such as improving access to education, reducing insecurity and unemployment, improving housing standards, as well as and increasing the opportunities for social engagement available for all citizens.[146]

Aboriginal and Torres Strait Islander peoples are disproportionately affected by alcohol-related FDV. Alcohol use by Aboriginal and Torres Strait Islander peoples is both as a consequence of and a contributor to continued social disadvantage,[147] and the importance of addressing this disadvantage cannot be minimised. The ongoing legacy of trauma, colonisation, dispossession, powerlessness and a breakdown in social identity and practice has contributed to the significant ongoing and sustained

disadvantage experienced by many Aboriginal and Torres Strait Islander peoples.[148] This has resulted in intergenerational disadvantage, loss of culture and community, poverty and alcohol and drug abuse are seen as part of the "ongoing legacy of colonisation, dispossession, powerlessness and a breakdown in social identity and practice has contributed to the disadvantage experienced by many Aboriginal and Torres Strait Islander peoples."[149]

Holistic strategies are needed to improve housing, education and employment opportunities for Aboriginal and Torres Strait Islander peoples to reduce social disadvantage. This need has been recognised by all governments in the *Closing the Gap* framework and in the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*.[150] Aboriginal and Torres Strait Islander peoples' experience of FDV and strategies to prevent and reduce these harms are explored further under the section on Secondary Prevention.

The South Australian Government has begun to implement strategies to reduce health inequalities through the release of its *Health in All Policies* strategy.[151] This strategy provides an example for how governments across Australia can adopt a social determinants approach. This strategy recognises that health and wellbeing are influenced by measures often outside of the health domain and aims to integrate health, wellbeing and equity in the development of all government policies and services.

The South Australian Government has also developed mechanisms for cross-sector problem solving.[152] A whole of government commitment is achieved by engaging the head of government, Cabinet and administrative leadership, and embedding responsibilities into government strategies through performance indicators, benchmarks and targets. The South Australian strategy provides a blueprint which other governments can follow.

Policy options

PO1. Implement strategies that target the environmental, economic and social determinants that contribute to health inequality. This includes improving health, housing, education and employment.

PO2. Adopt a health-in-all policies approach to public policy to ensure that the health outcomes of the community are considered in policy development.

PO3. Close the gap on higher prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples, and implement strategies to improve housing, education and employment.

6.2.2 Reduce gender inequalities

Gender inequality involves the unequal distribution of power and resources that typically favours men over women. An example of this is the under-representation of women holding key government positions. These inequalities result from systematic legal structures that limit opportunities for women as well as societal and personal views on how gender roles are defined including appropriate roles and behaviours for men and women.[153]

Gender inequality and the attitudes that are supportive of it are consistently associated with violence against women. Violence against women is one avenue for men to assert their dominance over

women.[154] At a societal level, women are at higher risk of experiencing violence where women have less access than men to education and employment, where there is little or no protection of women's economic, social and political rights, or where there are strong distinctions between the roles of men and women. At the relationship level, violence features more in relationships where women have less autonomy and have less power in making decisions for the relationship or family.

Men's personal attitudes and beliefs are also important; those that are consistent with traditional gender roles and supportive of male authority are consistently associated with the perpetration of violence against women.[155] The NCAS findings confirm this relationship, demonstrating that a person's attitudes on gender inequality are predictive of their attitudes to violence than demographic variables such as age and place of birth.[156] In addition, the association between alcohol and domestic violence is stronger where the perpetrator holds attitudes that support male dominance.[157]

There is also evidence that gender inequality and holding the core belief of male authority over women is associated with serious incidents of violence against children,[158,159] although the reasons for this relationship are less understood and researched.

The promotion of gender equality has been recognised by the *The National Plan to Reduce Violence Against Women and their Children 2010 – 2022* as a key factor in preventing violence against women. Measures to advance gender equality include increasing women's economic wellbeing (e.g. superannuation reform, improving child care support introducing paid parental leave, enhancing support for child care) and increasing women's leadership opportunities in government and private sectors.

To prevent the reinforcement of gender inequality (and consequently, violence against women) in the first place (and thus to diminish rates of violence against women), it is vital to educate young men and women. The National Plan has acknowledged this, with recommendations centring on introducing the incorporation of respectful relationships education in the curricula and syllabi of Australian schools.

Policy option

PO4. Implement strategies that promote gender equality for women, including but not limited to, increasing leadership opportunities for women, increasing access to paid maternity leave, introducing flexible work arrangements, making available varied and flexible childcare arrangements and developing equitable superannuation arrangements.

6.3 Primary prevention

Primary prevention aims to limit or reduce the incidence of a health issue by implementing strategies that address the causes of that issue. Primary prevention consists of policies or programs that affect the whole community with the intention of reducing problems across society.[160]

Many factors impact on the consumption of alcohol including the physical availability, the economic availability and the promotion of alcohol in our society. In understanding risk factors for FDV it is important to understand how factors affecting the consumption of alcohol can contribute to the increased risk of violence and severity of violence.

This is a complex milieu, factors that impact the *physical* availability of alcohol include: the location, number and density (concentration in a particular area) of alcohol outlets, and the hours and days of the week that alcohol can be sold. Factors that affect the *economic* availability of alcohol include the price of alcohol in relation to disposable income and the cost of other beverages and consumer products, and the price of drinks in a given outlet at a given time of the day (e.g. happy hour prices). Factors that affect the *social norms* about alcohol include both the promotion of alcohol and public awareness of the negative impacts (both health and social) associated with alcohol consumption.[161]

In addition there are attitudes, beliefs and social structures that increase gender inequality in Australia. It is important that Australia is able to implement initiatives that build respect and equality between men and women to reduce the incidence of FDV in society. It is also important to address attitudes about alcohol in relation to gender roles, violence and how these contribute to the use of alcohol as an excuse for the perpetration of FDV. These areas and their intersection with FDV are explored below.

6.3.1 Conduct public education campaigns on alcohol-related family and domestic violence and ways to prevent these harms

Public education campaigns are one way of challenging and changing social norms.[162] The WHO explains that social norms are unspoken rules or expectations within societies about appropriate and inappropriate behaviours. These norms persist because of individuals' desire to conform, as well as expectations by others that people will conform.[163] Public education campaigns have been most successfully used in the tobacco control field, where social norms about the acceptability of smoking have changed dramatically. Research from the tobacco control field has found that public education campaigns are most successful when they are well-funded, repetitive, and ongoing.[164, 165] Public education has also been pivotal to the reduction of drink driving. The introduction of Random Breath Testing (RBT) and the public education campaigns on RBT and drink driving have resulted in decreases not only in drink driving fatalities,[166] but also in the social acceptability of drink driving.[167] These campaigns are most effective when part of wider strategies that involve legislative change and reform.

Alcohol-related public education campaigns in Australia, with the exception of those relating to drink driving, have had little impact.[168] This has been because they are often ad-hoc, not sustained and have had ambiguous messaging.

There are a small number of campaigns that focus on both alcohol consumption and FDV. Past campaigns, particularly those targeted at Aboriginal and Torres Strait Islander peoples have included messages about alcohol misuse. An example was the "Walk Away Cool Down", a non-gender-specific campaign in Northern Queensland introduced in the early 2000s by the Queensland Police.[169] This campaign and others like it have tried to change attitudes and behaviours towards FDV and challenge perceptions of alcohol as being a cause of or excuse for violence.[170] This campaign and others like it tend to be confined within a local area and tend to be of limited duration due to funding and other pragmatic issues.

A public education campaign that aims to raise awareness of alcohol and FDV needs to take into consideration the theories and lessons learnt from both previous alcohol harm prevention and FDV campaigns.

A public education campaign needs to be multifaceted and use a range of media to promote its key messages including television, digital media and print. A clear target and message is also essential. The campaign rationale must clearly identify the target audience and the behaviour change sought. Understanding the target audience includes securing information about their knowledge, attitudes and current behaviours relevant to the public education campaign's objective.[171] The campaign should also be reinforced with more formal messaging in other settings, such as school-based educational programs.

Research by VicHealth found that campaigns to reduce FDV now need to move beyond the knowledge and awareness raising awareness and on to challenging attitudes. Where social marketing campaigns do exist these have generally been targeted towards sexual violence seeking to encourage men to take responsibility for consent and not focused on changing attitudes towards violence against women.[172]

The Australian Women's Health Network has said that the primary aim of campaigns on FDV should be to change attitudes, behaviours and beliefs that normalise and tolerate gender-based violence. Furthermore, they should be victim-centred, hold perpetrators to account and emphasise equality.[173] These strategies need to be well informed and tested with target audiences, emphasising goals for victim safety, prevention of violence, access to support services and accountability for perpetrators. They also require evaluation.

One of the central principles of prevention is to start early. Therefore, any public education needs to be reinforced with formal messaging, such as school-based education programs. Effective AOD education programs for young people have inclusive, interactive teaching strategies that actively engage students in the learning process.[174,175] Such programs are comprehensive and involve whole of school and community support for classroom drug education messages. AOD education programs should be also based on the experiences and interests of the students it is designed to influence, and should be timed such that the intervention starts before AOD experimentation begins and continues as young people mature.

This support can be reinforced by education programs targeted at young people that aim to teach respect and reduce violence. The Department of Education and Training in Victoria has developed a secondary school resource called *Building respectful relationships: Stepping out against gender-based violence* as part of a broader strategy to prevent violence against women.[176]

Education plays an important role in providing young people with the knowledge and skills to develop and maintain non-violent, respectful and equitable relationships. School-based approaches can that help young people identify inappropriate sexual or violent behaviour, and shape their expectations and capacity to build and sustain respectful relationships.

A campaign on preventing alcohol-related FDV should be developed and existing school-based education programs on respectful relationships and alcohol and other drugs should acknowledge the role of alcohol and other drugs in FDV. For example this could include emphasising that the use of alcohol and/or intoxication is never a justification, or excuse for violent or inappropriate behaviour. The programs should also highlight that alcohol contributes to increases in the severity and incidence of FDV. The campaign and education programs should be based on best practice, should be supported over a long period of time and should be reinforced by a range of media.

Policy options

PO5. Conduct ongoing national public education campaigns on preventing alcohol-related family and domestic violence; in conjunction with other preventative measures.

PO6. Implement school-based education campaigns on alcohol and also on respectful relationships.

PO7. Ensure that school-based education campaigns on alcohol and respectful relationships acknowledge the role of alcohol in family and domestic violence.

6.3.2 Reduce the physical availability of alcohol

The physical availability of alcohol is one of the most important predictors of alcohol harms. Increased availability of alcohol through the increase in the number of outlets is associated with an increase in assault, FDV, drink-driver road traffic accidents and chronic disease.[177,178]

The physical availability of alcohol relates to how easily a person can access and purchase alcohol, by the number of outlets available (the concentration of licensed premises within a given area) and trading hours (days and hours of alcohol sale). Across Australia legislation limits the times when alcohol can be sold, where alcohol can be sold and the types of premise that can sell alcohol (i.e. off-licence or on-licence including restaurants, pubs, bars, club and nightclubs). The legislation that controls the availability of alcohol was introduced because of the harms that alcohol causes.[179]

There has been unprecedented growth in the availability of alcohol in Australia over the last 15 years and the number of liquor licenses and licensed premises has increased dramatically.[180] For example, in Victoria the number of liquor licenses has increased by 120 per cent between 1996 and 2010.[181] Trading hours for alcohol sales, and in particular late night trading, has also increased dramatically in recent decades.[182] This increase in outlets and concentration of outlets and trading hours has

resulted in alcohol becoming more readily available, and more affordable than it has been in the past three decades.[183]

The increase in the physical availability of alcohol is concerning because increased availability of alcohol results in increased harms. Research from WA in 2010 found that for every 10,000 additional litres of pure alcohol sold at a packaged liquor outlet, the risk of violence experienced in a residential setting increased by 26 per cent.[184] In addition a longitudinal study of alcohol outlet density and domestic violence in Victoria from 1996 to 2005 a strong association between family violence and the density of off-licence (take-away) liquor outlets in an area. An increase in one off-premise licence per 1,000 residents was associated with a 28.6 per cent increase in the mean domestic violence rate.[185] A smaller, but still positive association, between the densities of on-premise licenses was also found.[186]

A systematic review of alcohol interventions and impacts on FDV in 2014 found that there is clear and consistent evidence of an association between alcohol consumption and FDV. Further research is needed to understand the relationship between FDV and type of outlet.[187]

The proliferation of alcohol outlets in areas of social and economic disadvantage further exacerbates the situation. Research published in *Using geocoded liquor licensing data in Victoria* in 2011 found that people living in disadvantaged areas in and around Melbourne had access to twice as many bottle-shops as those in the wealthiest areas. For rural and regional Victoria, there were six times as many packaged liquor outlets and four times as many pubs and clubs per person.[188] Given the interrelationship between alcohol misuse, FDV and socio-economic disadvantage, this is concerning.

A small number of studies have also found a link between alcohol outlet density and the increased incidence of child maltreatment. In the USA it is estimated that one less outlet per 1,000 people reduces the likelihood of severe violence towards children by four per cent.[189]

Understanding that the concentration of alcohol outlets is higher in disadvantaged communities is important when determining appropriate policy options. A review by Michael Livingston in 2012 suggested that the increased access to alcohol in disadvantaged communities may help explain some of the socio-economic disparities in health outcomes and that it might be harder for disadvantaged communities to influence planning and zoning decisions and thereby be unable to limit the continuing proliferation of outlets.[190]

Alongside the density of alcohol outlets, the physical availability of alcohol is influenced by the hours when alcohol is available for sale. Research evidence has consistently found that increases in trading hours are associated with increases in alcohol harms.[191]

Across Australia there are examples of communities and local governments that have introduced restrictions to address the trading hours of alcohol in their area. An example is the City of Newcastle which introduced a 3.00am close time and 1.00am lockout (later amended to 3.30am and 1.30am) for all on-licensed premises in Newcastle in 2008. An evaluation found that the restrictions resulted in a 37 per cent reduction in night-time alcohol-related assaults[192] and no geographic displacement

to the nearest late night district of Hamilton.[193] These positive effects were sustained over time with an evaluation undertaken five years later finding sustained reduction in alcohol-related assaults, with an average of a 21 per cent decrease in assaults per hour.[194]

Restrictions on hours of sale for alcohol are often critical features of Alcohol Management Plans (AMPs) and alcohol restrictions in Aboriginal and Torres Strait Islander communities.[195, 196] For example alcohol restrictions were introduced to the Fitzroy Valley in WA in 2007 that limited the types of alcohol that can be sold and the times when alcohol can be sold.[197] Community leaders in Fitzroy lobbied for the introduction of the measures as a response to 13 suicides in one year and increasing rates of community dysfunction.[198] An evaluation in 2010 found reductions in rates and severity of domestic violence; reduced street violence; reduced street drinking; less litter; less anti-social behaviour; generally better care of children and a reduction in the amount of alcohol being consumed by residents.[199]

Policy options

PO8. Intervene to reduce the density of liquor licenses in areas where there are significant levels of harm and reform licensing approval processes to consider community, police and public health views, as well as factors such as socio-economic status.

PO9. Introduce restrictions to the hours that alcohol is available for sale for both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops).

6.3.3 Reduce the economic availability of alcohol

Economic availability of alcohol refers to the affordability of alcohol, which is consistently shown as one of the most important predictors of alcohol harms. Lower prices are associated with higher consumption and this, in turn, is associated with increased harm.[200,201] Conversely, increases in the price of alcohol result in a decrease in harms.

The price of alcohol is partly influenced by taxes that the government sets on alcohol products or the setting of a minimum below which alcohol cannot be sold (known as minimum floor price). In addition to these, other factors such as point of sale promotions, bulk discounts, two-for-one offers can influence the affordability and price of alcohol products at point of purchase.

How alcohol is priced and taxed influences what alcohol is consumed as well as how it is consumed. For example, wine is by far the cheapest form of alcohol available in Australia due to how it is taxed. A standard drink of containing 12.5 ml of alcohol can be obtained for 36 cents by buying cask wine, compared with $1.75 for beer and $2.52 for ready-to-drink beverages.[202]

Several studies in the USA have examined the impacts of alcohol price on violence and crime. A study by Markowitz found that a one per cent increase in the price of alcohol was associated with a 3.1 to 3.5 per cent increase in ‘wife abuse’ [sic], although no corresponding link was found for ‘husband abuse’ [sic].[203] Another study by Markowitz and Grossman estimated that a 10 per cent increase in the excise tax on beer was estimated to reduce the probabilities of overall child abuse and severe child abuse by 1.2 per cent and 2.3 per cent, respectively.[204] Even though the percentages appear

small, applying these to the US population at the time would result in at least 100,000 fewer women being abused, and at least 100,000 fewer severely abused children.[205]

The systematic reviews by Wilson, Graham and Taft[206] and by Kearn, Reidy and Vale[207] found that the existing evidence base for the association between the price (and by association, the taxation) of alcohol and the incidence of FDV was indirect. This was primarily due to study designs and the authors see value in further investigating the association between alcohol price and FDV using stronger study designs.[208]

In Australia volumetric tax is applied to all alcohol products, other than wine. This tax is applied at a rate per litre of pure alcohol, this means that higher strength products, such as spirits, are taxed at higher rates than lower strength products, such as beer. However, wine is taxed according to the product's wholesale price (at 29 per cent), known as the Wine Equalisation Tax (WET). In addition to the WET, a rebate exists (WET Rebate) which provides rebates of up to $500,000 to wine producers across Australia. Together the WET and the WET rebate result in billions of forgone revenue being collected by the Australian Government, which could be dedicated to reducing alcohol harms.[209]

Nine separate government reviews have concluded that the current alcohol taxation system needs to be overhauled, finding that it does not adequately recognise the extent and costs of alcohol-related harms to the Australian community.[g] Most damningly the Australia's Future Tax System Review (known as the Henry Review; 2009) described Australia's alcohol taxation system as "incoherent".[210] A recent Australian study also found that alcohol taxation reform is cost beneficial, showing that this reform meets the gold-class standard required for policy reform in Australia.[211]

The price of alcohol and its consumption is also influenced by promotions at the point of sale (POS). POS marketing refers to promotional materials that are found within or on the exterior of a licensed store or venue at the point where an alcohol purchase will be made (e.g. happy hours, free gifts with purchase, prominent signage, competitions, price discounts for bulk purchases, and sale prices).

POS promotions have been found to encourage the purchase of increased volumes of alcohol[212] and are likely to affect overall consumption patterns of underage, harmful, and regular drinkers.[213] POS marketing is being increasingly used, to the point that it has been coined as "ubiquitous" and "aggressive".[214] Between Jan to April 2009 liquor outlets in Sydney alone host an average of 30 POS promotions per outlet.[215] The prolific nature of POS marketing is concerning because it results in young people (including minors) being regularly exposed to advertisements and promotions that depict alcohol consumption as a fun, social and inexpensive activity.[216]

[g] Reviews that have recommended a volumetric tax be applied to wine include: the 1995 Committee of Inquiry into the Wine Grape and Wine Industry; 2003 Federal Standing Committee on Family and Community Affairs Inquiry into Substance Abuse; the 2006 Victorian Inquiry Into Strategies to Reduce Harmful Alcohol Consumption; the 2009 Australia's future tax system (Henry Review); the 2009 National Preventative Health Taskforce report on Preventing Alcohol Related Harms; the 2010 Victorian Inquiry into Strategies to Reduce Assaults in Public Places; the 2011 WA Education and Health Standing Committee Inquiry Into Alcohol: the 2012 House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Fetal Alcohol Spectrum Disorders and the 2012 Australian National Preventive Health Agency Exploring the public interest case for a minimum (floor) price for alcohol, draft report.

Guidelines on the promotion of alcohol exist under most State and Territory Liquor Licensing legislation but fail to adequately address promotions that are currently taking place particularly in off-licence premises. For example, existing legislation is often about what constitutes extreme discounting or harmful promotions, with the judgement of these left largely to the licensee. As a result bulk buying specials, are common practice by retailers. For example, Beer Wine Spirits (BWS) in October 2014 had a promotion that sold three five litre casks of wine for $33, this is the equivalent of 22 cents a standard drink.[217]

Policy options

PO10. Reform the alcohol taxation system to increase the prices of the cheapest alcohol products.

PO11. Eliminate reckless liquor promotions that encourage excessive and harmful consumption in both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops).

6.3.4 Regulate the promotion of alcohol

The WHO has outlined that societal beliefs about alcohol consumption as well as beliefs about gender roles and violent behaviour can affect the risk of alcohol-related violence. In particular, beliefs or expectations that increase the risk of committing violence towards a partner include:

- the association of heavy drinking and violent behaviours with masculinity
- the expectation that alcohol consumption will lead to aggressive behaviour and that acts of violence are expected
- that the consumption of alcohol by the victim is seen as a cause of violence or a mitigating factor in the violence[218]
- alcohol being consumed in contexts where violence is more likely to occur.[219]

There is evidence from the NCAS that a sizeable number of Australians hold the belief that alcohol justifies anti-social and violent behaviour.[220] In order to understand the behaviour of men who use violence while under the influence of alcohol, it is essential to consider the role that the environment plays in shaping expectations of men on their use of alcohol as well as their attitudes towards gender roles and violence. A factor which plays into these attitudes, helping to reflect and reinforce gender norms, is the promotion and advertising of alcohol.

Advertising and promotion is a pervasive feature of modern Australian life and has a powerful influence in shaping how we view the world. Alcohol advertising in Australia is prolific and presented through television, radio, newspapers, magazines, billboards, merchandising and sponsorship of sporting and cultural events. Australians also receive alcohol marketing through the internet, on mobile phones and on social media platforms such as Facebook, YouTube and Twitter.

Research has demonstrated that the ubiquitous presence of sexually attractive female models in advertising contributes to an environment where sexual harassment, sexual aggression and domestic violence are tolerated in society.[221] Advertisements that are sexist limit women's aspirations, achievement, self-esteem and equity in society.[222] Alcohol is one product in particular where advertising has been highly associated with sexual appeal. Alcohol advertising often portrays alcohol

as an integral part of a sexually active and fun lifestyle among young people and promotes the idea that this lifestyle is stimulated or enhanced by the consumption of alcohol.[223] Alcohol advertisements often contain images that imply that certain irresponsible sexual behaviour (or treatment of women) is appropriate in the context of alcohol consumption.[224]

Given the gendered nature of domestic violence, it is vital that alcohol advertising and promotion does not perpetuate sexist attitudes or behaviours towards women. This is in line with the First Action Plan of the *The National Plan to Reduce Violence Against Women and their Children* Plan, under Strategy 1.1: to "promote positive media representations of women."[225]

The content of alcohol adverts in Australia is currently self-regulated through a complex mix of industry codes. The main code is the Alcohol Beverages Advertising (and Packaging) Code (ABAC), administered and governed by members of the alcohol industry, which has essentially not changed since it was established in 1998.[226,227] The ABAC has responsibility for the 'content' of alcohol advertisements. Other industry codes attempt to cover the 'placement' of alcohol advertising such as outdoors, on radio, television, and in cinemas.

The only major review of the ABAC took place in 2003 by the National Committee for the Review of Alcohol Advertising (NCRAA), appointed by the Ministerial Council on Drug Strategy (MCDS).[h] This review found substantial flaws in the system including: a lack of transparency about how decisions are made, that the general public was largely unaware of the system, that it did not cover all forms of advertising and that did not address public health concerns with alcohol adverts.[228] Unfortunately little has changed since this time.

The ABAC specifies the alcohol marketing must not "show (visibly, audibly or by direct implication) the consumption or presence of an Alcohol Beverage as a cause of or contributing to the achievement of personal, business, social, sporting, sexual or other success."[229] However, the ABAC contains no reference to sexism or marketing that may be considered sexist.

Unfortunately the majority of young people (aged 15-24 years) believe that alcohol advertisements are designed to appeal to them. They imply from the existing advertisements that the consumption of alcohol confers more confidence, greater sociability, and better success with the opposite sex, among other things.[230]

In 2014 the former Government agency the Australian National Preventive Health Agency (ANPHA) found that the current regulatory system, including the ABAC failed to protect children from exposure to alcohol advertising. *Alcohol advertising: The effectiveness of current regulatory codes in addressing community concern, Draft report* found that children and adolescents are exposed to significant amounts of alcohol advertising and that this exposure influences young people's drinking intentions and behaviours.[231,232,233] Put simply, the more alcohol advertising that young people are exposed to,

[h] Changes to ABAC have been proposed several times since 2003, including recommendations to forward to the Council of Australian Governments in 2009 and the Review of the Effectiveness of Current Regulatory Codes on Alcohol Advertising in Addressing Community Concerns by the former Australian National Preventative Health Agency in 2014. However no other reviews of ABAC itself have been undertaken since 2003.

the earlier they will start to consume alcohol, and the more they will consume if they already drink. This is consistent with a well-established body of evidence that shows there is also a significant relationship between exposure to alcohol advertising, and young people's drinking intentions and behaviours.[234,235,236]

Overall the regulation of alcohol advertising needs to address the volume, timing and targeting of alcohol advertisements currently taking place. This includes a fundamental shift away from focusing only on content or placement and includes all forms of marketing, including through not only traditional media but also online media, POS promotions, product placement, on sporting team uniforms, on sporting grounds, at cultural events, in branded merchandise and POS promotions in retail spaces and pub/bars.[237] Leaving the policing of alcohol marketing in the hands of the alcohol industry is unlikely to result in any change, and fundamental reform is required.[238] This regulatory systems should include guidelines on how women are portrayed in alcohol marketing.

Policy options

PO12. Introduce independent regulation of alcohol marketing to protect children from its exposure.
PO13. Eliminate negative and sexist representations of women in alcohol marketing.

6.4 Secondary prevention

Secondary prevention aims to reduce the average risk of harm across the population by focusing on early detection and groups at highest risk. Secondary prevention aims to slow the progression of disease or reduce the impact of particular harms on individuals and communities. In the context of examining alcohol-related FDV it is the recognition that particular groups are at great vulnerability and proposes tailored solutions for those groups. Secondary prevention is also focused on the early identification of problems and the implementation of programs or services that reduce or mitigate these issues.

Governments across Australia recognise that alcohol and FDV cause harm in the community and fund screening programs, 24 hour help lines, specialist training for health professionals, diversion, counselling, treatment, rehabilitation, relapse prevention, aftercare and social integration services.[239,240]

As outlined earlier, certain groups within the population are at higher risk of alcohol-related FDV than others. This section focuses on two discrete groups experiencing high levels of harm, Aboriginal and Torres Strait Islander peoples and children and young people. It also examines the implementation of opportunistic screening to target other groups at higher risk of alcohol-related FDV, including women from CALD communities, women with disabilities and people who identify LGBTIQ.

6.4.1 Identify children and young people at risk of child maltreatment

Children and young people from families with alcohol problems and/or violence are more likely to experience mental health issues, current or future alcohol misuse, and current or future FDV perpetration or victimisation.[241,242]

Screening for child maltreatment tends to be reactive. Often enquiries are not made until indicators of harm pertaining to child abuse (e.g. bruises, broken bones) are present or a report from a third party is given. It is vital to try to identify children being effected early and reducing their risk of present and/or future harms. This is often done through opportunistic proactive screening, though this practice is not widespread.[243]

The need for proactive screening for child maltreatment is acknowledged within the *National Framework for Protecting Australia's Children 2009–2020* which includes actions to:
"Increase capacity and capability of:

- adult focused services to identify and respond to the needs of children at risk
- child-focused services to identify and respond to the needs of vulnerable families
- the broader system to identify children at risk." [244]

Screening within the broader system is identified by the Victorian Department of Human Services in the *Child abuse: Reporting procedures* as including doctors, nurses, school teachers and police. These professions have legal obligations to report suspected child abuse. These reporting procedures also recommend that people working with children should be alert to warning signs of potential abuse, including alcohol or drug misuse.[245] However, no routine screening procedures are recommended for people in contact with children showing signs of risk, and the detection of risk is still largely reliant on personal and professional judgement.

General Practitioners (GPs) are often a first point of contact for families experiencing stress and are well placed to screen for child maltreatment and alcohol issues. The Royal Australian College of General Practitioners (RACGP) has developed clinical guidelines to help in the detection of FDV.[246] Sample questions for GPs to ask during a routine visit include:

- "Sometimes kids worry about lots of things, like when they have a fight with their friend, or they feel their teacher was mean to them. Kids also worry about things in their homes, maybe about mum and dad fighting or when their mum or dad was mean to them. Sometimes kids are scared and don't know what to do. Do you sometimes worry about things like that?"
- "Sometimes I see children I worry about. I saw another child who was sore like you, what do you think happened to them?"

This proactive screening method could be applied to other relevant health professionals, including those in the alcohol and domestic violence sectors. Schools may also provide an appropriate setting in which to screen children for possible problems with the family.

Following a positive identification or a strong indicator of risk, the child and their family can be referred to interventions designed to diminish or eliminate the likelihood of harms occurring. Programs may be targeted at the child's family, with the principal aim of addressing the factors that contribute to poor parenting, and ultimately improving the relationship between parents and their child or children. Programs may also be targeted at the children themselves, focusing primarily on building their resilience and providing practical solutions to enhance their safety.[247]

Less is known about the efficacy of programs targeting children only. A review of early intervention strategies for 8-14 year olds concluded that there are a variety of school-based interventions that target specific outcomes such as preventing substance misuse or depression.[248] However, many behaviours and outcomes are interrelated and linked to the same underlying factors. Therefore there is value in implementing programs that develop and improve upon protective factors (such as teaching positive coping skills, building resilience and improving positive social connections with people outside the family),[249,250] with the aim of reducing a variety of negative outcomes including substance misuse, mental health issues and aggression.

Policy options

PO14. Encourage health professionals and educators to undertake screening to identify children at risk of child maltreatment.

6.4.2 Implement and fund family centred programs for people affected by alcohol and substance misuse

Family centred programs are needed for families with a parent that has alcohol or substance misuse issues.

Family Sensitive Practice involve alcohol interventions that are sensitive to, and incorporate the needs of families. The guiding principle is that alcohol affects family members other than the drinker; therefore, interventions that target the family, particularly children, will not only enhance outcomes for the person misusing alcohol but will also prevent or at least mitigate harms to the children. Family Sensitive Practice is increasingly being used in the alcohol and drug field. The National Centre for Education and Training on Addiction (NCETA) at Flinders University has produced a resource for Family Sensitive Policy and Practice in the alcohol and other drugs sector. The focus of the resource is to provide guidance for alcohol and other drug interventions that are sensitive to the needs of families in which parents or caregivers misuse alcohol and have children under 18 years in their care. Existing programs tend to use one or a combination of the following delivery models:

1) Home visits: Trained professionals (e.g. nurses, social workers, AOD workers) visit the homes of clients with alcohol problems and support them with their parenting.
2) Residential: This involves programs that accommodate parents and children in alcohol residential treatment programs.
3) Non-residential: This includes community based parenting programs and intensive play groups for children whose parents are having problems with alcohol.
4) Assertive Outreach: Actively following up people who misuse alcohol in the community, regardless of where they may be currently living. This includes on the streets or in residential care settings.[251]

An example of a successful Australian program that targets the family and parenting is the *Parents under Pressure* program (PuP), designed by Professor Sharon Dawe and Dr Paul Harnett. The program targets all families with difficult life circumstances, although it has been especially applied to families with alcohol and other drug use and/or child protection concerns. The program is delivered by a PuP

therapist, usually in the clients' home, and adopts a model of empowerment to enable parents to harness their strengths to improve their relationship with their child or children. The program consists of ten modules that take 3-4 months to complete. These are designed to complement the care provided by the alcohol treatment services.[252] An evaluation of the program on children aged 3-8 years whose parents were on methadone found significant reductions in potential child abuse and child behaviour problems.[253] Although there has been no similar evaluation looking specifically at alcohol, it is reasonable to consider that this program or others like it will have similar impacts.

Another example of a family service is *Kids in Focus* a Commonwealth-funded service that addresses the needs of parents and children where parents have, or are recovering from, AOD problems. Most referrals to the program are made by child protection services. Clients are typically sole parent mothers resolving parenting problems associated with the misuse of AOD, along with a range of complex problems. The program provides case management with assertive and intensive outreach with the aim of supporting parents to retain children safely in their care. The program also supports parents who are working towards reunification with children placed in out-of-home care. A range of approaches is used to support families, including parent-child attachment and trauma-informed practice. Between July and December 2011, 2,662 clients received support as part of the *Kids in Focus services,* scheme, although whether these referrals were for alcohol or other types of drug problems is not known.[254]

It is difficult to gauge the exact extent of alcohol's involvement in family services as data registers do not routinely collect this level of information of their clients.[255] The limited evidence that does exist suggests that alcohol is implicated in a substantial proportion of cases.[256]

It is also important that family services focus on the importance of increasing a child's capacity to identify inappropriate behaviour and to teach safety and resilience skills. It is essential for family services to identify the strengths and supports available to children and families. These strengths and supports are known as "protective factors" and they help build resilience against risk.

Policy options

PO15. Fund programs such as the Parents under Pressure (PuP) for children and families identified as being affected by parental alcohol misuse and other risk factors.

PO16. Establish programs that increase children's capacity to identify inappropriate or abusive behaviours and teach safety and resilience skills.

6.4.3 Reduce the prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples are disproportionately affected by FDV and alcohol-related FDV.[257] The level of harmful use of alcohol is about twice as high among Aboriginal and Torres Strait Islanders peoples as among other Australians,[258] even though more Aboriginal and Torres Strait Islander peoples abstain from alcohol (23 per cent compared to 17 per cent).

Addressing alcohol misuse has been recognised by governments as being central to reducing FDV among Aboriginal and Torres Strait Islander peoples. The 2007 *Little Children are Sacred* report

recognised that “unless alcoholism is conquered, there is little point in attending to any of the other worthwhile proposals in this report. It is a priority!”[259] The statistics are alarming:, almost half (42 per cent) of Aboriginal and Torres Strait Islander peoples aged 14 years and over report having been victims of alcohol-related incidents such as physical abuse, verbal abuse or being put in fear, with between 30 to 40 per cent of these incidents being committed by a current or ex-partner or relative.[260] The majority (87 per cent) of intimate partner homicides among Aboriginal and Torres Strait Islander peoples from 2000 to 2006 were alcohol-related, compared to 44 per cent in the general population.[261]

Children can also be affected by alcohol before they are born, with Aboriginal and Torres Strait Islander peoples being disproportionately affected by FASD.[262] FASD impairs cognitive functions, affecting the development of language, social skills and memory. This can exacerbate the loss of traditional Aboriginal culture reliant on oral transmission and good memory[263] FASD is also linked social and emotional delays, which can impact on people’s ability to later parent a child, increasing the risk of harm for that child and creating a vicious cycle of alcohol harm.

Policies to address alcohol-related FDV in Aboriginal and Torres Strait Islander communities must be holistic and recognise the intricate and complex links between alcohol misuse, family violence and other stressors. Policies and practices must be community-led and driven and involve strong leadership from men as well as from women.

A number of programs have been introduced to Aboriginal and Torres Strait Islander communities to address FDV and support families in a culturally appropriate way.[264] Two programs with some success include the Aboriginal Family and Community Healing Program and the Mildura Family Violence and Sexual Assault Campaign. The Aboriginal Family and Community Healing Program, developed in South Australia, offered a structured eight-week family wellbeing course for women, a men’s group, individual counselling and camps. The Mildura Family Violence and Sexual Assault Campaign, developed by a number of Aboriginal justice, family and other organisations and Victoria Police. This consisted of an educational and awareness raising program, with posters and television commercials on the impact of family violence and offering suggestions for help. The campaign targeted three groups: men, women and children. While not formally evaluated, Victoria Police report that there has been an increase in community awareness and knowledge about family violence and an improved relationship between the police and Aboriginal community.[265]

Cultural sensitivity is vital. Cultural values can affect the willingness of Aboriginal and Torres Strait Islander peoples to access services. The practice of men’s business and women’s business is particularly relevant where certain customs and practices are performed separately by men and women. These practices relate to gender specific knowledge and practices on issues such as health, wellbeing and religious matters.[266] This is particularly challenging in areas where services are scarce. Other cultural considerations include the concept of family in Indigenous culture where responsibility for raising children is shared, rather than being the sole responsibility of biological parents.[267]

Community-led alcohol controls should be supported to be implemented in communities where a need has been identified and agreed upon to address the risk associated with harmful use of alcohol

use, through AMPs or like mechanisms. It is essential that Aboriginal and Torres Strait Islander communities define the problem and set the parameters defining engagement with the issue, and developing appropriate and relevant interventions that recognise the diversity and cultural values of the community and foster community engagement in decision making.[268] Interventions should use local structures and develop relationships with key players in the community such as existing services (particularly Aboriginal and Torres Strait Islander specific services and organisations), Elders and community members. Interventions should also provide clear leadership and decision making processes and services should work together on the basis of respect and equality.[269] This approach strengthens the capacity of the community and leads to a more sustainable commitment to reduce FDV.

Targeted public education campaigns on alcohol and FDV are required, these also need to be community driven and culturally sensitive. Such programs are essential to raise awareness of the issue and to get people to confront the violence in their own homes or within their community. Importantly, such campaigns provide information and resources to support families, engage with community members about issues within their community and challenge them to do something about it,[270] noting that public education campaigns are most effective when implemented in conjunction with other strategies to reduce alcohol harm.[271]

Policy options

PO17. Implement community-led and comprehensive alcohol controls in communities where a need has been identified and agreed.

PO18. Conduct ongoing public education campaigns on alcohol and FDV that are community driven and culturally sensitive.

6.4.4 Undertake opportunistic screening with people at greater risk of harm

Opportunistic screening is an effective, evidence based approach that has the potential to identify harmful alcohol use and/or FDV and take action to prevent future harm from occurring.

Screening is a common strategy that is used to determine whether a person is at risk of harms (such as from smoking, alcohol consumption, diet and lack of physical activity). Where a risk is identified, a brief intervention such as providing information on the risks associated with their behaviour or formal counselling can then be provided. Identifying a risk early through screening and brief interventions (SBI) can save the health system resources in the long term because it can ameliorate the need for later stage treatment which may be more intensive and costly.

Screening an individual about their alcohol use can identify whether their consumption is placing themselves or others at harm and identify individuals who may be developing alcohol-related problems. SBIs have been shown to reduce the quantity of alcohol consumed per week by individuals and have been proven effective in different settings such as primary care and Emergency Departments as well as across different age groups.[272,273,274] There are tools available to health professionals to support them to assess a person's alcohol use, these include the Alcohol Use Disorder Identification Test (AUDIT), a ten item tool developed by the WHO. A shorter three item tool, the AUDIT C, focused on consumption levels, has also been developed.

Screening for harmful alcohol use and/or FDV does not occur universally in Australia because of reluctance to talk about sensitive issues by health practitioners, lack of training and resources to support implementation, additional time in already time pressured environments, lack of knowledge about what to do next and poor awareness of referral pathways contribute to reluctance of services to conduct screenings. Language barriers and lack of privacy also act as barriers to conducting screening.[275,276] Where screenings have occurred, these have not always been successful in achieving disclosure of violence which has further deterred services from continuing the practice.[277]

Some states and territories do try to routinely screen women for FDV through early identification programs. Examples include ante natal and post natal screening programs in Queensland,[278] the Domestic and Family Violence Framework in NSW[279] and the development of the Common Risk Assessment and Risk Management Framework in WA.[280] These programs place a heavy emphasis on screening, brief intervention and support. However, these programs are not widespread nor universally employed.

Women often experience barriers to disclosure and seeking support if experiencing FDV. These include issues such as fear of further harm from their partner, financial concerns, impact on family and pressure to stay in the relationship.[281] For women in rural and remote locations, Aboriginal and Torres Strait Islander communities and other close knit communities, other factors such as confidentiality, lack of services, transport issues and isolation may also be a factor.[282] Language barriers and cultural beliefs may prevent women from accessing services.[283] Some groups such as CALD women and LGBTIQ populations fear that mainstream services may not understand their particular needs.[284,285]

Contact with the health sector presents an opportunity to screen for harmful alcohol use and FDV and provide a brief intervention or referral where necessary. Services such as GP practices are generally in a position of trust and are well placed to deliver screening for harmful alcohol use and FDV.[286,287] Screening for harmful alcohol use and/or FDV does not occur universally in Australia because of reluctance to talk about sensitive issues by health practitioners, lack of training and resources to support implementation, additional time in already time pressured environments, lack of knowledge about what to do next and poor awareness of referral pathways.[288,289,290] Language barriers and lack of privacy also act as barriers to conducting screening.[291,292] Where screenings have occurred, these have not always been successful in achieving disclosure of violence which has further deterred services from continuing the practice.[293]

Toolkits and guidelines already exist to assist health professionals. For example Women's Legal Service NSW produced a toolkit *When she talks to you about the violence: A toolkit for GPs* on FDV.[294] This covers indicators of FDV in adults and children, how to ask a patient about FDV they may be experiencing and how to respond to disclosures of violence. It also details initial safety planning, legal obligations and continuing care. This toolkit also covers how GPs can respond if the patient is a perpetrator of violence. The NSW toolkit supports the use of the RACGP's Clinical Guidelines on *Abuse and violence: Working with our patients in general practice* (known as the White Book).[295]

Screening for the perpetration of domestic violence is rare.[296] Many perpetrators will not admit to using violence, whether it be for self-protective reasons, shame or lack of perception that their behaviour is classed as domestic violence. Traditional approaches to reducing and managing FDV such as punishment, deterrence, incapacitation and rehabilitation are proving to be ineffective and so new approaches, including individualised and comprehensive approaches to treatment and outcome-orientated partnerships that integrate policing and judicial responses with health and welfare services, are being introduced.[297] Violence prevention and perpetrator programs are voluntary or court ordered.[298]

Opportunistic screening for alcohol and for FDV followed by brief intervention or referral is needed in Australia. This should be targeted at high risk population groups and occur in a variety of health and social settings including AOD and FDV services and police. Given the association between FDV and alcohol for both perpetrators and victims, it is important to screen for the presence of the other condition when one has already been identified. For example, a person identified as consuming alcohol at harmful levels should also be screened for domestic violence. Likewise, where domestic violence is identified, the person should be screened for harmful alcohol consumption. This is particularly important where the perpetrator is screened since action to address their alcohol consumption and/or FDV is likely to reduce the risk and severity of FDV.

Screening is recognised within the National Plan and by women themselves. An evaluation of NSW Health's pilot domestic screening project found that women considered it appropriate for a range of health professionals to routinely screen for FDV.[299] The vast majority (95 per cent) of women who received screening indicated that they were happy to be asked. This suggests that women are receptive to being screened for FDV by people other than those directly related to FDV. Embedding FDV screening as a routine measure for all women, as opposed to indicator-based assessment, validates FDV "as a central and legitimate health care issue."[300]

The implementation of screening should be supported by the development of training and resources to provide confidence in undertaking the screening and brief intervention or referral. In addition, good collaboration between health and other sectors will ensure the safety of those affected, allow easier access to support services by both victim and perpetrator and reduce the trauma on a group of people who have already experienced significant distress. Screening by areas outside the health sector such as police and criminal justice services is important so that early action can be taken to prevent further harm. In addition screening should take place when women and men present to AOD and/or FDV services to determine their risk and to assist in the development of pathways for them.

Policy option

PO19. Support professionals in health and community organisations to screen for harmful alcohol use and family and domestic violence. Screening programs should include support resources, clear referral options and training for professionals administering the screening.

6.5 Tertiary prevention

Tertiary prevention targets the prevention of recurrence or re-victimisation of FDV of people who have already been affected by the violence as well as reducing or aiming to minimise the harm being experienced. This can be achieved by improving service integration and service responses.

The purpose of service integration is to treat the victims' and perpetrators' issues with FDV and alcohol in a holistic manner to ensure that no one falls through the cracks. The aim is to prevent further harms, whether it be re-offending or re-victimisation.

Improved service responses (such as police and legal responses), although not considered prevention in the pure sense, can form part of tertiary prevention responses in that they may prevent the re-offending or re-victimisation of FDV. They also feed into primary prevention by sending an unequivocal message to the community that FDV is unacceptable and punishable by law.[301]

6.5.1 Develop a comprehensive Model of Care for alcohol-related family and domestic violence

Greater coordination is needed between AOD and FDV services to reduce alcohol-related FDV and minimise the risk of further harm. At a minimum, services should have a basic level of awareness of the issues associated with harmful alcohol use and FDV and a knowledge of the organisation's policies and procedures. Information should be made available within the service including posters and leaflets of who to contact if people need support.

Integrated and coordinated service models within the AOD and FDV sectors in Australia are rare. Historically, the sectors have worked independently of each other despite the long recognised association between alcohol misuse and FDV. Part of the reason is that models of treatment for alcohol use disorders have traditionally geared towards the needs of individuals and in particular men. Nearly all AOD treatment (96 per cent) in Australia is for the individual's own AOD use and most of this treatment is provided to men (68 per cent).[302] As a result, the specific needs of women are not always addressed. For example, a woman is unlikely to disclose her experiences of FDV if asked to join a mixed-gender counselling group. Staff also do not always feel equipped to deal with the issues outside their area of expertise, they may feel awkward or that they are opening a "can of worms" that they are unprepared to provide assistance for.[303] Differences in the professional backgrounds of staff within each sector and between service models also bring challenges to introducing new ways of working.[304]

Integrated models of care are found for other co-occurring conditions. For example, the AOD and mental health sectors have been working towards achieving greater coordination and integration of services to improve outcomes for clients. The National Comorbidity Initiative and the *National Action Plan on Mental Health* encouraged AOD and mental health services to improve service coordination and treatment outcomes.

Within the AOD sector, best practice principles have been developed by NCETA to support the implementation of initiatives to address issues relating to FDV in clients, this includes the *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment*

practice in Australia and *Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence.*

Both of these publications outline in detail ten principles of best practice (and reproduced in full in Appendix 3), these principles include:

1. incorporating evidence- based policy and practice responses
2. ensuring organisational awareness of family issues
3. prioritising safety for clients, their families and staff
4. coordinating services between multiple organisations
5. developing policies and systems that support safe and effective practice
6. developing standard assessment and response frameworks
7. including broad-based interventions that address a variety of risk and protective factors
8. accessing highly skilled practitioners if needed
9. workforce development
10. monitoring accountability and evaluation.[305]

In the UK work has been undertaken between AOD and FDV services to work together. The Stella Project in the UK, established in 2003, improved cross-sectoral knowledge and service delivery for victims and perpetrators of domestic violence as well as their children.[306] In 2010, the Stella Project was expanded to include sexual violence and mental health in its work, in light of the levels of sexual violence experienced by women (in particular) who access AOD treatment services and the use of AOD as a coping mechanism in response to the trauma associated with FDV.

Greater collaboration is needed not just between services providing AOD treatment and FDV services, but also with mental health and child protection services to meet the complex trauma-related support needs of these clients. Coordination both within and between sectors provides a better understanding of an individual's situation and avoids requiring people to repeat stories they may find traumatic.[307] A 'no wrong doors' approach to support services must be provided by all the sectors so that victims are not turned away from services.

A more formalised process, such as a Model of Care is needed to enable various sectors work together to determine the most appropriate support mechanisms for the client. A Model of Care would require improved referral pathways between services, a shared understanding of the issues through cross-agency training, and good communication and information sharing between services. Management commitment at the highest level is essential for change to be successful.[308] Systems need to support safe and effective practice[309] with safety considerations at the forefront of all support services.

It is important to also acknowledge that women who are receiving treatment for their own alcohol problems are at a particularly elevated risk of domestic violence because the perpetrator may be concerned about losing control over her and use further violence to regain control.[310] He may also stall or prevent her access to treatment. A study from the US found that women who were currently experiencing domestic violence were much less likely than women who were not experiencing

domestic violence to complete substance misuse programs.[311] When providing alcohol services to the perpetrators of domestic violence, it is essential to note that alcohol withdrawal is likely to increase irritability and agitation which may lead to increased rates and severity of domestic violence.

Policy options

PO20. Improve collaboration between services providing alcohol and other drug services, mental health services, family and domestic violence services and child protection services by supported a funded Model of Care which incorporates:

- Clear Referral pathways between services
- Cross-workforce training on alcohol and family and domestic violence
- Holistic interventions and treatment for people affected by alcohol or family and domestic violence
- Improved collaboration between service response sectors e.g. integration between specialist alcohol and family and domestic violence courts.

6.5.2 Provide adequate and ongoing funding to alcohol and other drug services and family and domestic violence services

It is essential that services are available for people in the AOD, FDV and family sectors when needed. It is clear that the need for services across these sectors is high and the availability and, as outlined below, access to the relevant services are not being met.

The demand for services in the AOD sector is high. In Australia there are 714 AOD treatment agencies and these provided 162,400 episodes of treatment in 2012-13 to 108,000 people.[i] Alcohol was the principal drug of concern in 41 per cent of treatment episodes (the highest of any drug of concern).[312]

In 2014, across the community sector, services are struggling to meet demand, 80 per cent of sector services have reported being unable to fully meet demand.[313] The issue of unmet demand is also seen in state and territory AOD services. The Victorian Auditor General's report found that since 2005-06, waiting times for residential-based AOD treatment nearly doubled.[314]

The demand for FDV and family services is also high. An example of this can been seen in the increase in demand for services provided by state and territory agencies. In 2013-14 the ACT Domestic Violence Crisis Service dealt with 15,644 calls to its crisis line, and provided direct intervention for 1,408 people. This increased from 1,096 in 2012-13.[315] The ACT Domestic Violence Crisis Service has reported that there has been a 45 per cent increase in demand for services in the past six years.[316]

This increase in demand is also supported by the Australian Council of Social Services finding that in 2014, 40 per cent of family and child protection services were unable to meet demand, and 47 per cent of counselling and individual support services were unable to meet demand.[317]
This level of increase of demand for services and the inability of these services to keep up with demand is the exacerbated by the uncertainty of funding provided by all levels of government. Over

[i] Only closed treatment episodes are presented. The Australian Institute of Health and Welfare considers a treatment episode to be closed when: the treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months and there is a change in the main treatment type, principal drug of concern or delivery setting.

half (56 per cent) of services delivering AOD treatment are in the non-government sector. Agencies delivering domestic violence and family services are also heavily dependent on government funding.

Over the past year there have been numerous cases of specialist agencies and services that provide AOD and/or FDV support services having their government funding cancelled, been impacted by funding cuts, new models for funding distribution, or being given no indication that future government funding would be provided.[318] An example of this was the program provided by the ACT non-government agency AOD, Karralika. Funding for their Family Program was not included in the Department of Social Service's funding round, this thereby leaving the only program in the ACT and Southern NSW providing rehabilitation treatment for couples or parents with children in uncertainty whether it would be able to continue.[319] This funding has now been assured until end of June 2015.

Cuts to funding and related uncertainty are deeply concerning, especially as there is insufficient funding to meet the demand for treatment in both the AOD and FDV sectors. This uncertainty of funding affects the financial viability of services, ability to plan and ability to offer the services currently being provided. This uncertainty also makes it difficult to recruit and retain staff, leading to loss of staff members. This loss is not just to the specific organisation's capacity but also to both sectors and the community as a whole.[320]

It is essential that both AOD and FDV services are available. There is a small window of opportunity to support vulnerable people who want to access these services. The issue of access to community services was highlighted in the 2014 Australian Community Sector Survey, which found that the largest gaps in the capacity to meet demand in the community sector exists in areas of the greatest need: among services working most closely with those on the lowest incomes and with the highest levels of need in their communities.[321]

Policy option

PO21. Ensure there is adequate and ongoing funding available to services to meet the demand for people requiring alcohol and other drugs and family and domestic violence services.

6.5.3 Increase coordination between alcohol and other drug services and child protection services

The AOD and child welfare sectors have largely operated in isolation, as a result of the nature of funding arrangements and service delivery targets.[322] Greater coordination between AOD and child protection services is needed to ensure that both child and carers are getting the assistance and support needed. A large proportion of child protection casework is related to families with carers who drink problematically and often have a range of other risk factors.[323] Research has shown that children whose carers have alcohol problems are more likely to be repeatedly harmed.[324]

Similar to the Model of Care needed between AOD and FDV services, a model or framework is needed to ensure that AOD services and child protection services are working together. This coordination of services relies on the sharing of information between services. The need for information sharing is crucial when a child is in danger and when the service providers believe adverse outcomes cannot be predicted unless service provision is coordinated.[325]

The sharing and disclosure of client information among agencies has been highlighted as a key challenge in the implementation of policies, this is due to the sensitive nature of the information such as client confidentiality, client and practitioner relationship and existing interagency communication. The South Australian Government's Child Protection Reform Program, has developed the Information Sharing Guidelines for Promoting Safety and Wellbeing.[326] The guidelines have been produced to provide guidance for agencies to appropriately share information with each other.

It is essential that these information sharing mechanisms exist in each state and territory to support agencies and organisations in providing integrated support for children, young people and their families.

Concern has also been raised among researchers about how child protection workers assess and respond to risk factors, including alcohol and that AOD services are not well placed to respond to the children of their clients.[327]

The presence of a carers AOD problem alone is not sufficient to warrant involvement of child protection authorities in Australia. However, problematic carers AOD use may be a contributor to child maltreatment, which can trigger responses from child protection authorities. All states and territories have mandatory child abuse reporting requirements. However, individuals mandated to report, and the types of abuse that are required to be reported, vary significantly between Australian states and territories.[328]

In 2009, the Council of Australian Governments released a *Protecting Children is Everyone's Business, National Framework for Protecting Australia's Children.*[329] This framework includes a strategy for how all levels of governments to work in partnership with non-government organisations and work more effectively across silos that have existed between AOD and FDV services. Although these documents and frameworks are in place, there have been limited changes in the way that programs and policies are implemented.[330]

There are clear barriers to how AOD and child protection services work together, these barriers can exist at an organisational, client and staff level. These organisational barriers include the lack of training and knowledge of those working in the AOD sector to recognise or respond to child welfare issues.[331] Other organisational barriers include assessment processes of clients, confidentiality and privacy policies, funding mechanisms and access to resources.

Barriers also exists for the client, as those seeking AOD treatment can be reluctant to seek assistance in regards to parenting, for the fear of stigmatisation. Staff within the AOD services can be reluctant to expand their treatment focus, as some see family issues outside their role. It has been stated that 'Some alcohol and other drug workers have traditionally refrained from asking clients about their children in order to avoid any perceived potential conflicts of interest or a need to make child protection notifications, which could jeopardise their working relationship with clients.'[332]

A survey of Australian AOD workers found that most clients had children and that most believed identifying and addressing their child's needs are important.[333] However, few AOD workers reported having received any training in this area and therefore not having the confidence to address the needs of the child.[334]

It has also been reported that many child welfare workers lack knowledge in assessment of AOD problems.[335] Studies from the USA suggest that training in AOD positively impacts child welfare workers' knowledge, skills and practices.[336] AOD screening tools (such as the AUDIT) should be considered for use within child protection services as a means of identifying carers who drink problematically. Initial screens should be followed up with evaluations of service referrals and the effectiveness of these services.

Policy options

PO22. Develop joint guidelines and systems that facilitate information sharing about the wellbeing and safety of clients' children between alcohol and other drugs services and child protection services.

PO23. Improve collaboration between alcohol and other drug services and child protection services by cross-workforce training for alcohol and other drug services and child protection services.

6.5.4 Implement programs targeted at perpetrators

While SBIs are an important first step in trying to prevent harm from occurring and are more likely to be successful when the risk of perpetrating FDV is low, a proportion of the population will require treatment to address their behaviour. The higher the risk and the more entrenched the behaviour, the greater the requirement for more intensive treatment programs.

Perpetrator treatment programs offer one way to address the intergenerational cycle of violence given the entrenched nature of FDV. Such programs began to appear in the late 1970's and early 1980's and were developed in the context of gender and power relationships. Models of service delivery vary across Australia, however, the typical approach focuses on changing attitudes towards women and in particular, intimate partners. Challenges to current programs include lack of adequate funding, individualised treatment and motivation among participants. In addition, change takes time and perpetrators may take years to recognise that they have a problem.[337]

Three principles for effective perpetrator treatment programs have been identified. These include providing more intensive services to people at higher risk of offending, addressing the particular needs of the individual that relate to treatment, and being responsive and flexible to the learning styles and motivations of the perpetrator.[338] In situations where FDV is alcohol-related, integration and/or collaboration between AOD treatment services and domestic violence services will increase program effectiveness.[339]

The safety of family members needs to be the primary priority if and when a perpetrator undertakes treatment. Treatment for alcohol problems increases the risk for FDV due to the discomfort of physiological or psychological withdrawal heightening a perpetrator's anxieties and irritability.[340]

Policy options

PO24. Fund intensive programs targeted at perpetrators and ensure these programs are evaluated to inform future practice.

PO25. Support better integration between perpetrators and AOD services where appropriate.

PO26. Provide support for families of people accessing perpetrator programs to ensure their safety.

6.6 Improve data collection and evaluation

As previously highlighted in this paper there are two main types of data collection methods, these are survey and service data for FDV and alcohol harms. The collection and surveillance of data and harms is important as it provides information on the extent of the issues and of FDV which enables researchers and policy makers to develop, implement and track the progress of evidence based policies.

It is also crucial that there is consistency in data surveillance in order to understand patterns of change over time and comparing between one time period and another. Surveillance of trends over time is important for not only policy development but also service planning.

Data on alcohol-related FDV is mostly sourced through self-report surveys such as the National Drug Strategy Household Survey and the Australian Bureau of Statistics (ABS) Personal Safety Surveys. Due to FDV being a largely 'invisible' problem, self-reporting is considered a more reliable gauge of the nature and extent of alcohol-related FDV.

There are advantages and disadvantages to self-reported data. Anonymity may encourage greater disclosure but self-reported data can also lend itself to biased reporting. It is important that survey data is complimented with data collected through service sectors such as police and health service data. It is important to note that this data also has limitations such as underreporting, with as many as half of domestic violence occurrences going unreported[341] and not being collected consistently in all Australian jurisdictions.

Ensuring data is collected in a consistent manner is a crucial to understanding the prevalence of alcohol-related FDV. Currently police use a combination of judgement for signs of intoxication, as well as reports from the people involved. There are also different reporting requirements for each state and territory which contribute to consistency issues. The reporting of alcohol's involvement varies depending on the regulations and laws around reporting requirements in each jurisdiction. To support the data already being collected by police, other service sectors such as AOD treatment data and hospital data should all seek to gain information on alcohol's involvement in alcohol-related FDV.

Data collection for alcohol-related child maltreatment is limited. Police data tends to include incidences of violence, which include both child abuse and intimate partner violence, and they are reported together under the umbrella of 'domestic assault' or 'family incident'. Recording incidences of alcohol-related child maltreatment separately to intimate partner violence would provide greater detail on the interplay between child maltreatment and prevalence of children affected by alcohol-related family violence. Considerable improvement is also needed in the recording of alcohol involvement in incidents and situations, whether in police reports, in child protection investigations, or in records of other involved agencies such as schools and hospitals. A combination is needed of a mandatory check-box on whether and to what extent alcohol is involved in the situation or incident with rules for narrative recording of the nature and extent of alcohol involvement. Improvements in the way data is collected and reported are necessary to understand the extent of alcohol's involvement in FDV.

Consideration also needs to be given to the way in which alcohol-related FDV data is published, this includes privacy and confidentiality of individuals, service provider organisations in collection and reporting. Privacy and confidentiality is essential to collection of data about alcohol and domestic violence due to the sensitivity of the information being collected and reported. A breach of confidentiality may risk the safety of the individuals involved as well as their family or friends. It could also lead to stigmatisation for those involved.

Researchers must ensure that they protect data, especially if it is in any way identifiable. An understanding of the difference between anonymous and identifiable data is essential to devising the most appropriate plan to protect individuals' confidentiality and safety. It is important that there are effective practices in place for documenting client information and that services advise individuals of situations if their right to confidentiality cannot be guaranteed.

Agencies responsible for collecting alcohol-related FDV data should ensure that policies are in place that clearly outline the requirements for data collection. This will assist agencies to collect consistent and comparable data.

As part of the National Plan, all jurisdictions have committed to a national data collection and reporting framework.[342] The aim of the framework is to create a nationally consistent data definitions and collection methods, it is intended that this framework will be operational by 2022.[343] As part of this framework there is potential for the collection and reporting of alcohol-related FDV incidents to be included as part of this work.

Evaluation processes should form an integral part of the implementation of any alcohol-related FDV policies. Without an appropriate evaluation framework in place, the efficacy of trials and policy initiatives cannot be properly assessed. This results in a loss of valuable information that could be used to assess the effectiveness of a new policy and to guide future policy directions.

Data collection and surveillance is a fundamental tool in the evaluation process. Strong reliable data enables a more complete analysis of the impacts of alcohol policies on the relevant outcome measures.
An evaluation framework should form part of any national or state government plan to prevent alcohol-related FDV. The development of any evaluation framework needs to ensure that it is developed in consultation with a range of experts including researchers and the agencies that are collecting and reporting the data.

Policy options

PO27. Improve data collection on family and domestic violence and the involvement of alcohol across all jurisdictions and publically report on this data to inform policy and research.

PO28. Evaluate policies and programs on alcohol and family and domestic violence and disseminate the findings to ensure that they inform future practice.

Appendix 1: Overview of policy options to reduce alcohol-related family and domestic violence

The suggested policy options from this paper are summarised below (PO = Policy Option).

Level	Aim	Target	Policy Options
Primordial: *Creating a safer environment*	Preventing the emergence of predisposing social and environmental conditions that lead to harm	Whole population	**Reduce health and social inequalities** PO1. Implement strategies that target the environmental, economic and social determinants that contribute to health inequality. This includes improving health, housing, education and employment. PO2. Adopt a health-in-all policies approach to public policy to ensure that the health outcomes of the community are considered in policy development. PO3. Close the gap on the higher prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples, and implement strategies to improve housing, education and employment. **Reduce gender inequalities** PO4. Implement strategies that promote gender equality for women, including but not limited to, increasing leadership opportunities for women, increasing access to paid maternity leave, introducing flexible work arrangements, making available varied and flexible childcare arrangements and developing equitable superannuation arrangements.
Primary prevention: *Improving outcomes across the community*	Reducing the average risk of harm among the whole population	Whole population	**Conduct public education campaigns on alcohol-related family and domestic violence and ways to prevent these harms** PO5. Conduct ongoing national public education campaigns on preventing alcohol-related family and domestic violence; in conjunction with other preventative measures. PO6. Implement school-based education campaigns on alcohol and also on respectful relationships. PO7. Ensure that school-based education campaigns on alcohol and respectful relationships acknowledge the role of alcohol in family and domestic violence. **Reduce the physical availability of alcohol** PO8. Intervene to reduce the density of liquor licenses in areas where there are significant levels of harm and reform licensing approval processes to consider community, police and public health views, as well as factors such as socio-economic status.

Level	Aim	Target	Policy Options
Primary prevention: *Improving outcomes across the community*	Reducing the average risk of harm among the whole population	Whole population	PO9. Introduce restrictions to the hours that alcohol is available for sale for both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops). **Reduce the economic availability of alcohol** PO10. Reform the alcohol taxation system to increase the prices of the cheapest alcohol products. PO11. Eliminate reckless liquor promotions that encourage excessive and harmful consumption in both on-licence premises (bars, pubs and clubs) and off-licence premises (bottle-shops). **Regulate the promotion of alcohol** PO12. Introduce independent regulation of alcohol marketing to protect children from its exposure. PO13. Eliminate negative and sexist representations of women in alcohol marketing.
Secondary prevention: *Focusing on people at greater risk*	Early detection and intervention among people at greater risk of harm	People at greater risk of harm • Aboriginal and Torres Strait Islander peoples • Children and young people at risk • High risk populations: women with disabilities, Culturally and Linguistically Diverse communities, lesbian, gay, bisexual, transgender, intersex and queer communities, pregnant women and heavy drinkers.	**Identify children and young people at risk of child maltreatment** PO14. Encourage health professionals and educators to undertake screening to identify children at risk of child maltreatment. **Implement and fund family centred programs for people affected by alcohol and substance misuse** PO15. Fund programs such as the Parents under Pressure (PuP) for children and families identified as being affected by parental alcohol misuse and other risk factors. PO16. Establish programs that increase children's capacity to identify inappropriate or abusive behaviours and teach safety and resilience skills. **Reduce the prevalence of alcohol-related family and domestic violence among Aboriginal and Torres Strait Islander peoples** PO17. Implement community-led and comprehensive alcohol controls in communities where a need has been identified and agreed. PO18. Conduct ongoing public education campaigns on alcohol and family and domestic violence that are community driven and culturally sensitive. **Undertake opportunistic screening with people at greatest risk of harm** PO19. Support professionals in health and community organisations to screen for harmful alcohol use and family and domestic violence. Screening programs should include support resources, clear referral options and training for professionals administering the screening.

Level	Aim	Target	Policy Options
Tertiary prevention: *Protecting people from further harm*	Preventing the recurrence of harm	• Victims • Perpetrators of family and domestic violence • Witnesses to family and domestic violence	**Develop of a comprehensive Model of Care for alcohol-related family and domestic violence** PO20. Improve collaboration between services providing alcohol and other drug services, mental health services, family and domestic violence and child protection services by supported a funded Model of Care which incorporates: — Clear Referral pathways between services — Cross-workforce training on alcohol and family and domestic violence — Holistic interventions and treatment for people affected by alcohol or FDV — Improved collaboration between service response sectors e.g. integration between specialist alcohol and family and domestic courts. **Provide adequate and ongoing funding to alcohol and other drug services and family and domestic violence services** PO21. Ensure there is adequate funding available to services to meet the demand for people requiring alcohol and other drugs and family and domestic violence services. **Increase coordination between alcohol and other drug services and child protection services** PO22. Develop joint guidelines and systems that facilitate information sharing about the wellbeing and safety of clients' children between alcohol and other drugs services and child protection services. PO23. Improve collaboration between alcohol and other drug services and child protection services by cross-workforce training for alcohol and other drug services and child protection services. **Implement programs targeted at perpetrators** PO24. Fund intensive programs targeted at perpetrators and ensure these programs are evaluated to inform future practice. PO25. Support better integration between perpetrators and alcohol and other drug services where appropriate. PO26. Provide support for families of people accessing perpetrator programs to ensure their safety.
Data collection and evaluation	Building the evidence base and evaluating measures	Whole population	**Improve data collection and evaluation** PO27. Improve data collection on family and domestic violence and the involvement of alcohol across all jurisdictions and publically report on this data to inform policy and research. PO28. Evaluate policies and programs on alcohol and family and domestic violence and disseminate the findings to ensure that they inform future practice.

Appendix 2: Review of existing domestic violence and child protection strategies in Australia

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
National			
Domestic Violence: *The National Plan to Reduce Violence Against Women and their Children 2010 – 2022.*[344]	Released by the Council of Australian Governments (COAG) in 2011. Aims to coordinate action across Australian jurisdictions, over 12 year timeframe and supported by three year implementation plans.	Alcohol is recognised under the first outcome area stating: "The impact of alcohol and other drugs is recognised in this first national priority area" a key action is to "foster community initiatives to reduce alcohol and substance use."	Initiatives to achieve this: • Continuation of the National Binge Drinking Strategy • Support Indigenous communities to take action against the supply of alcohol where it is leading to high levels of violence.
National Implementation Plan for the First Action Plan 2010-2013: Building a strong foundation safe and free from violence.[345]	Released in 2011, it focuses on: • Building primary prevention capacity; • Enhancing service delivery; • Strengthening justice responses; and • Building the evidence base.	Acknowledges the role of other national agendas including the National Binge Drinking Strategy but does not go further into these areas.	No specific initiatives mentioned.
The Second Plan Second Action Plan 2013-2016: Moving Ahead: Of the National Plan to Reduce Violence Against Women and their Children 2010-2022.[346]	Released in June 2014, it recognises that FDV does not occur in insolation and aims to strengthen linkages with other national reforms agendas to drive a holistic response to stop violence against women.	The only reference to alcohol is the continuation of 1800RESPECT, a national helpline for domestic, family and sexual violence.	Initiative to achieve this: • 1800RESPECT to continue to provide support to frontline workers, including those in the alcohol sector.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
National			
Child Protection and Wellbeing: *Protecting Children is Everyone's Business – National Framework for Protecting Children 2009 – 2020*	Released by the Australian Government in 2009 to work in tandem with the National Plan to bring about positive change for both women and children. Adopts a public health approach for the prevention and treatment of child abuse and neglect.	Alcohol use is acknowledged as a risk factor for child abuse and neglect and within mentions the need to: "Enhance alcohol and substance abuse initiatives to provide additional support to families."	Initiatives to achieve this: • Implement the National Binge Drinking Strategy. • Support Aboriginal and Torres Strait Islander children through Alcohol Diversion Program for parents of children at risk. • Implement Healthy lifestyle interventions to disadvantaged communities and address alcohol abuse.
New South Wales			
Domestic Violence: *It Stops Here: Standing together to end domestic and family violence in NSW (NSW Government).*[347]	Released in 2012 in response to the NSW Auditor General and the NSW Parliament's Standing Committee on Social Issues Inquiry into domestic violence. The strategy aims to strength prevention, coordinate service delivery, support victims and hold perpetrators to account to and reduce re-offending.	Alcohol is recognised in the Strategy under barriers stating: "women with mental health and/or drug and alcohol issues are more vulnerable and face additional barriers in seeking support." The strategy does not outline these barriers or how to overcome them.	No specific initiatives mentioned.
Child Protection and Wellbeing: *Keep Them Safe: A shared approach to child wellbeing 2009-2014.*[348]	Released in 2009 after a Special *Commission of Inquiry into Child Protection* in NSW that followed two deaths of children in 2007. The goal of this strategy is to see fewer children and young people reported to the Department of Community Services.	Alcohol is acknowledged in the need for programs to support women who have alcohol and drug issues and families with complex needs. It is also acknowledged in the section to better support Aboriginal children and families.	Initiatives to achieve: • Expand the Drug and Alcohol Expertise Unit to cover mental health and domestic violence. • Provide clinical services (drug and alcohol counselling) to children, young people experiencing abuse.

Victoria			
Domestic Violence: *Victoria's Action Plan to Address Violence Against Women and Children 2012-2015.*[349]	Released in 2012, this strategy sits alongside the *Strong Culture, Strong Peoples, Strong Families – Towards a safer future for Indigenous families and communities,* which is a 10 year plan to specifically addresses family violence in Aboriginal communities. This strategy recognises that government agencies have a role to play, including health, mental health, housing, crime prevention, Aboriginal affairs, education, local government, employment and sport.	Alcohol is acknowledged as an issue among women who are most vulnerable and as contributing factor to men's violence against women.	Initiatives to achieve this: • Current initiative: Perinatal Emotional Health Program Model to identify women experiencing mental health problems, including alcohol and drug issues. • Future initiative: Extend Family Violence Risk Assessment and Risk Management Frameworks to Mental Health and Drug and Alcohol providers, Hospitals, GPs, Ambulance staff.
Child Protection and Wellbeing: *Victoria's Vulnerable Children: Our shared responsibility Strategy 2013-2022.*[350]	Released in 2013 in response to the Victorian Inquiry into *Protecting Victoria's Vulnerable Children* in 2012. It outlines whole of government response to Child Protection and Wellbeing to: • Building effective and connected services. • Enhancing education and capacity building. • Making a child friendly legal system. • Providing safe, stable and supportive out-of-home care. Introducing accountability and transparency.	Recognises the co-occurrence of multiple and complex problems and the strong associations between family and domestic violence and alcohol abuse. The plan also recognises risk factors that make children vulnerable as including: a history of family and domestic violence; parental or familial alcohol and other substance misuse; parental mental health problems; intellectual disability, parental history of abuse and neglect and situational stress.	Initiatives to achieve: • Outcome 1.2 – Parental risk factors that contribute to abuse and neglect are identified and addressed (alcohol identified within this) • Outcome 1.3 – Families effectively protect and nurture their children.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Queensland			
Domestic Violence *For our sons and daughters: Queensland Government Strategy to Reduce Domestic and Family Violence (2009-2014).*[351]	Released in 2009 it identifies the key actions the Government will focus on: • Prevention • Early identification and intervention • Connected victim support services • Perpetrator accountability • System planning and coordination	Does not mention alcohol.	No specific initiatives mentioned.
Child Protection and Wellbeing *Queensland Youth Strategy – connecting young Queenslanders 2013.*[352]	Released in 2013 the strategy aims to improve connections for young people (12 to 21 years) across six areas: • Family, friends and social networks • Education, training and employment • Health and wellbeing • Volunteering and participation • Supports and services • Arts and culture	Alcohol is acknowledged as a risk factor along with family conflict, parental stress, abuse or neglect, poverty, housing stress, unemployment, disengagement from school, teen pregnancy and drug and alcohol misuse. The Strategy recognises that these can increases children's vulnerability and dim their hopes.	Initiatives to achieve this: • Consult with key community stakeholders, including youth groups and services in reviewing alcohol management plans in discrete Indigenous communities. • Regional Network of Indigenous Alcohol, Tobacco and other Drugs (ATODS) Youth Program to provide treatment for young Indigenous people.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Western Australia			
Western Australia's FDV Prevention Strategy to 2022: Creating safer communities [353]	Released in 2012 the strategy focuses on prevention and provides a framework for a comprehensive and shared response to FDV. Has a long-term focus on early intervention, victim safety and perpetrator accountability.	Does not mention alcohol. The previous strategy Western Australia (*WA) Strategic Plan for FDV 2009-2013* mentioned that children subject to family violence are likely to have problems with alcohol later in life and that representatives from the WA Drug and Alcohol Authority were involved in the development of the strategy.	No specific initiatives mentioned.
Child Protection and Wellbeing *Our youth, our future: Western Australia's Youth Strategic Framework.*[354]	Released in 2012 this strategy brings together the plans and commitments across 14 government departments into one framework. The strategy aims to enable children to be happy, healthy, working towards financial independence, living life to the full and making a difference in society.	Alcohol is acknowledged within the strategic approach to provide information to young people, families, carers, teachers and the wider community about issues which impact on young people such as mental health, body image, bullying, and alcohol and other drug use.	Achieved through: • Programs implemented by the School Drug Education and Road Aware (SDERA) – Drug and Alcohol Office to teach young people about resilience, drugs and road safety.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
South Australia			
Domestic Violence *A right to safety: The next phase of South Australia's Women's Safety Strategy 2011-2022.*[355]	Released in 2011 this strategy builds on reforms undertaken in the first phase of the *Women's Safety Strategy* to improve legislation, services and to strengthen community understanding of the effects of violence against women. The second phase of this strategy focuses on early intervention and prevention.	References the South Australian Government's Strategic Plan which has a specific target (Target 18: Violence against women) to achieve "a significant and sustained reduction in violence against women through to 2022." But does not outlines how this target will be achieved.	No specific initiatives mentioned.
Child Protection and Wellbeing *South Australia's Strategic Plan.*[356]	Released in 2011, *South Australia's Strategic Plan* includes child wellbeing and protection. The Strategic Plan recognises the importance of early childhood and the need for supportive relationships, both within the family and community. A separate plan for child does not exist.	The Strategic Plan includes the specific target (Target 81: Alcohol consumption) to: "Reduce the proportion of South Australians who drink at risky levels by 30% by 2020 (baseline: 2007)."	No specific initiatives mentioned.
Tasmania			
Domestic Violence *Taking action: Tasmania's primary prevention strategy to reduce violence against women and children 2012-22.*[357]	Released in 2011 this Strategy adopts a public health approach to reducing violence against women and children with social justice as a core value. It focuses on primary prevention and sits alongside the *Tasmanian Implementation Plan of the National Plan to Reduce Violence Against Women and their Children.*	Alcohol is acknowledged as a contributor to the occurrence and severity of family violence and sexual assault. It is also acknowledged when referring to effective strategies to prevent family violence and sexual assault alongside gender equality and, changing social and cultural gender norms."	Initiatives to achieve: • Action 2.9 states: "Address the contributing factors that increase the incidence and severity of family violence and sexual assault: abuse of alcohol or drugs." Identifies Department of Health and Human Services as the most appropriate agency to address this.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Tasmania continued			
Child Protection and Wellbeing *New Directions for Child Protection in Tasmania: An Integrated Strategic Framework.*[358]	Released in 2008 after the reform of the Tasmanian child protection system in 2007. This strategy aims to improve services are delivery to at risk and vulnerable children and young people.	Alcohol is acknowledged in reference to children and young people in care demonstrating "higher degrees of vulnerability to drug and alcohol abuse and self-harm." It also recognises community risk factors that include high crime rates, alcohol and drug use and violence.	Initiatives to achieve: • Joint training opportunities to be provided to human services and other services that work with common clients, including drug and alcohol services.
Northern Territory			
Domestic Violence *Domestic and Family Violence Reduction Strategy 2014-17: Safety is Everyone's Right.*[359]	Released in 2014, this strategy has five key action areas for change: 1. Prevention 2. Early intervention 3. Protection – safety for victims 4. Rebuilding the lives of victims and survivors 5. Perpetrators taking responsibility for their actions	Alcohol is acknowledged within the Family Safety Framework[360] which is key component of the strategy. The Family Safety Framework acknowledges the involvement of alcohol in domestic and family violence as an 'aggravating' factor.	Initiatives to achieve: Implement family safety meetings between services (including Alcohol and Drug treatment) and share information, agree on actions to increase safety, jointly monitor and review if these actions have improved safety.

Plan name	Description of the plan	References to alcohol	Specific alcohol harm reduction strategies
Northern Territory continued			
Child Protection and Wellbeing *Safe Children, Bright Futures Strategic Framework 2011 to 2015.*[361]	Released in 2011 in response to the Inquiry into child protection, *Growing them strong, together*. It sets out an agenda for reform across seven areas: • Keeping Kids Safe • Supporting and Strengthening Families • A Strong and Effective Legal Framework • Working Together • Our People • Healing, Growing, Walking Together • Building a Better, Stronger, More • Accountable System	Alcohol is acknowledged particularly noting that there are insufficient programs in regional and remote areas to provide support to families struggling with issues of mental illness, drug and alcohol abuse, and intergenerational abuse and neglect.	Initiatives to achieve: • Establish Child Safety and Wellbeing Teams and localised child safety and wellbeing plans in the Territory Growth Towns and elsewhere. However alcohol is not specifically mentioned within the actions in the Framework.
Australian Capital Territory			
Domestic Violence *The ACT Prevention of Violence Against Women and Children Strategy 2011–2017 (ACT Government).*[362]	Released in 2011 this strategy outlines that ACT Government's commitment to the National Plan. It focuses on four objectives which are: • Women and children are safe because an anti-violence culture exists in the ACT. • Aboriginal and Torres Strait Islander women and children are supported and safe in their communities. • Women and children's needs are met through joined up services and systems.	Alcohol is acknowledged as an issue for perpetrators and victims and advises that "Often women will disclose their experience of violence when accessing support for another issue from a service provider which does not specialise in violence against women. Identifying and strengthening this first point of contact (or first point of disclosure) is a key focus and will include a broad range of services."	Initiatives to achieve: • Mentions interventions alcohol and drug issues for Aboriginal and Torres Strait Islander people such as the proposed Ngunnawal Bush Healing Farm initiated by Elders of the ACT Aboriginal and Torres Strait Islander community stating that: "this environment provides an optimum setting for addressing issues of violence in a holistic way."

	• Men who use violence are held accountable and supported to change their behaviour.		
Child Protection and Wellbeing *ACT Children's Plan 2010-2014: Vision and Building Blocks for a Child friendly City.*[363]	Released in 2010 this plan sets out the vision for Canberra to be a child and youth friendly city.	Alcohol is acknowledged as a personal safety issue. Children who were consulted in the development of the plan also recommended banning substances such as alcohol, cigarettes and drugs.	No specific initiatives mentioned.

Appendix 3: Principles of best practice for AOD organisations to address family and domestic violence

This table is reproduced with permission NCETA and appears in both the following publications: *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia* and *Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence.*

There is a number of principles and strategies that AOD organisations should employ in implementing initiatives to address FDV issues among their clients:

1. Evidence based policy and practice responses	Interventions should be based upon well-tested models of therapeutic practice and sound theories of child development. Where appropriate, interventions should include methods for improving the parent-child relationship (Asmussen & Weizel, 2009). The interventions should also use a partnership and empowerment approach involving clients and their families (Battams & Roche, 2011).
2. Organisational awareness of family issues	Like other common issues that co-occur with AOD problems, FDV and family issues are an essential but ancillary part of alcohol and other drug work; that is not all clients have FDV or family issues. As a result AOD workers may need structures in place to ensure that they attend to these issues on a routine basis. Although the involvement of families can be valuable, the ways that this occurs needs to be carefully considered. This is because other family members may have similar problematic AOD use issues, FDV or parenting difficulties (Asmussen & Weizel, 2009). Awareness of FDV issues includes: • the prevalence of FDV • the indicators of FDV • the impact on partners and children • the importance of addressing FDV to reduce AOD use and minimise harm.
3. Prioritising safety	Given the high prevalence of FDV within the AOD treatment population, it is essential to adopt practices throughout organisations that prioritise the safety of those who experience violence (both partners and children) as well as the safety of staff (Alcohol Concern, 2009). A number of legislative changes have prioritised particularly the safety of children when dealing with FDV situations and organisations and workers should be cognisant of their legal and duty of care responsibilities.

4. Coordination of services	Interventions that address complex family problems are likely to involve input from multiple organisations. Service planning should therefore consider methods for sharing information and referring families. Partnerships are crucial to coordinated service provision. This will involve multi-organisation and cross-sectoral work engaging with services such as FDV organisations, child care providers, supported accommodation services, maternal and child health and disability services, mental health services and child protection organisations (Alcohol Concern, 2009; Asmussen & Weizel, 2009; Battams & Roche, 2011).
5. Policies and systems	AOD organisations need to develop systems and tools to support safe and effective practice. These should include policies, procedures and protocols concerning screening and assessment tools, information sharing, and referral pathways (Alcohol Concern, 2009).
6. Standard response frameworks	It is important to develop assessment and response frameworks that are standard across an organisation. Assessments should identify the individual strengths and challenges of parents who have problematic AOD use. Assessment procedures should address risk and protective factors, the presence of FDV, child care responsibilities and arrangements, measures of family functioning, cultural influences and involvement with statutory child protection services (Asmussen & Weizel, 2009; Battams & Roche, 2011).
7. Broad-based interventions	Interventions should address a variety of risk and protective factors because people who experience FDV, and who use alcohol or other drugs, are likely to be coping with numerous problems. Practitioners need to be able to accurately assess each family's needs and identify resources so that they can provide the appropriate type and level of support (Asmussen & Weizel, 2009).
8. Access to highly skilled practitioners if required	Clients with FDV and AOD problems can require a high degree of intervention, by qualified practitioners, particularly if child protection is an issue. AOD services may not always have practitioners within their services with the required level of skill to respond intensively to FDV issues. It is important for AOD services to ensure that clients can access the requisite level of expertise if necessary and links with external practitioners for this purpose should be identified for both secondary consultation and referral.

9. Workforce development	Increasing the emphasis on FDV may require a range of additional workforce development activities. All staff require basic awareness training and information on organisational policies and procedures. Some staff will require specialist training on assisting clients who experiences violence and clients who use violence in their relationships. Staff also need to be informed of their duty of care concerning child safety and welfare. Other relevant workforce development activities include incorporating FDV intervention practices into job descriptions, mentoring and clinical supervision and in support programs for staff (Battams & Roche, 2011). Commitment is needed at all levels of the organisation from reception and other frontline staff to senior management. In some organisations, the introduction of routine assessments or responses to FDV may require a large cultural shift and requires both strong commitment and robust lines of reporting within the organisation. It is important to have designated individuals at both service delivery and strategic development levels to drive organisational change (Alcohol Concern, 2009).
10. Monitoring, accountability and evaluation	The evidence base in this field is limited and much of the clinical work that is taking place is not recorded. It is, therefore, important for organisations to develop simple and robust recording and monitoring systems which record their work and its outcomes (Alcohol Concern, 2009).

Note: For more information on the references referred to in the table please see the original sources.

Appendix 4: Abbreviations

ABAC	Alcohol Beverages Advertising (and Packaging) Code
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AFL	Australian Football League
AIHW	Australian Institute of Health and Welfare
AMP	Alcohol Management Plans
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
ANPHA	Australian National Preventive Health Agency
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and other drug
ATODS	Alcohol, Tobacco and other Drugs
AUDIT	Alcohol Use Disorders Identification Test
BOCSAR	NSW Bureau of Crime Statistics and Research
BWS	Beer Wine Spirits
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
FARE	Foundation for Alcohol Research and Education
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorders
FDV	Family and domestic violence
GENACIS	Gender, Alcohol and Culture: An International Study
GLADA	Greater London Alcohol and Drug Alliance
GLDVP	Greater London Domestic Violence Project
GP	General Practitioner
HTO	(Alcohol's) Harm to Others
LGBTIQ	People who identify as lesbian, gay, bisexual, transgender, intersex and queer
MCDS	Ministerial Council on Drug Strategy
NCAS	National Community Attitudes towards Violence Against Women Survey
NCETA	National Centre for Education and Training on Addiction
NCRAA	National Committee for the Review of Alcohol Advertising
NDSHS	National Drug Strategy Household Survey
NHMRC	National Health and Medical Research Council
NT	Northern Territory
NSW	New South Wales
POS	Point of sale
PSS	Personal Safety Survey
PuP	Parents under Pressure program
RACGP	Royal Australian College of General Practitioners
RBT	Random Breath Testing
SBI	Screening and brief interventions
UK	United Kingdom
USA	United States of America
WA	Western Australia
WET	Wine Equalisation Tax
WHO	World Health Organization

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