Foundation for Alcohol Research & Education

National framework for action **to prevent alcohol-related family violence**

June 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 info@fare.org.au.

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

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Foreword

In Australia at least one woman dies each week at the hands of her partner or ex-partner and a significant number of children die as a result of abuse and neglect, although exact figures are not known. It is estimated that alcohol is involved in up to 65 per cent of family violence incidences reported to the police and up to 47 per cent of child abuse cases each year across Australia.

This number is too high.

But to date, efforts by governments to prevent these tragedies have been insufficient.

Family violence is a crime and alcohol should not excuse or justify violence. Family violence often occurs in the home, where one should feel safest, perpetrated by those we should feel safest with. It can be 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. Family violence may persist for years and involve multiple forms of abuse.

And while these harms occur most often behind closed doors, we are, as a nation, no longer blind to the problem.

We are rightly outraged by these stories and are now more engaged in this national emergency that concerns us all.

But if we are determined to seriously address family violence in Australia, then our ultimate goal must be one of prevention.

That cannot be achieved without embracing evidence-based solutions.

Up until now, the role of alcohol has not been adequately recognised in national or state and territory plans and strategies to address the issue.

This is despite the fact that alcohol is significantly implicated in family violence.

Alcohol increases both the incidence and severity of family violence.

This *National framework for action to prevent alcohol-related family violence* (Framework) recognises that implementing actions that address alcohol will also contribute to reducing family violence.

This Framework is the culmination of nine months of consultation and reviews of the evidence. The development of this Framework involved a series of consultations with experts between October 2014 and May 2015. This included the release of a *Draft Policy Options Paper* (development from October 2014 – January 2015), the refinement and public release of a *Policy Options Paper* and roundtable event with stakeholders (24 February 2015), open consultation, then finally the formation of this holistic Framework (24 February – 30 May 2015).

This Framework is also informed by the results of a new study *The hidden harm: Alcohol's impact on children and families* which highlighted that more than one million Australian children are affected in some way by others drinking, 140,000 are substantially affected and more than 10,000 are in the child protection system because of a carers' drinking.

This Framework proposes policies and programs that Australian Governments can implement which will have a tangible impact on preventing and reducing incidents of alcohol-related family violence.

Governments must embrace and introduce evidence-based measures today if we wish to prevent and reduce family violence in the days, months and years ahead. We cannot wait for generational change; we must act now. This Framework provides governments with a plan for action.

Rosie Batty
Australian of the Year
and Founder
Luke Batty Foundation

Michael Thorn
Chief Executive
Foundation for Alcohol Research
and Education

Introduction

In recent years Australian governments have committed to taking action to reduce family violence, this is demonstrated by the release of the *National Plan to Reduce Violence against Women and their Children 2010 – 2022* (National Plan) in 2011. The National Plan was the first time that governments committed to coordinated action. The National Plan is support by three action plans, as well as by state and territory plans on family violence and child protection.

The Australian and Victorian Governments have recently recognised the role of prevention in family violence and established Our WATCh. Our WATCh is charged with driving nation-wide change in the culture, behaviours and attitudes that lead to violence against women and children.

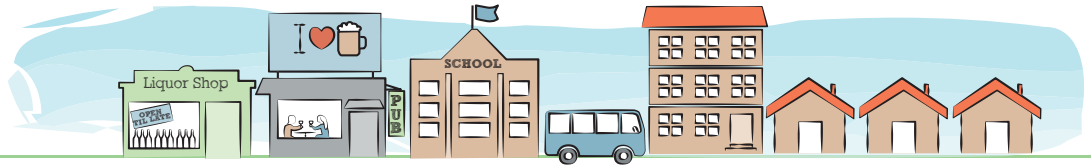
Governments should be congratulated for these efforts as they demonstrate Australia's commitment to upholding the human rights of Australian women and children. However, rarely do these efforts give serious consideration to alcohol and its contribution to family violence and no plans, at any level, address the issue adequately. This is a significant failing of Australia's response to family violence to date.

While government plans on family violence and child protection often acknowledge that alcohol is a contributing factor to family violence, they frequently stop short of outlining specific actions to reduce alcohol harms. Most critically, there is a lack of detail in the National Plan and in the *National Framework for Protecting Australia's Children 2009–2020: Protecting Children is Everyone's Business* about the contribution of alcohol as a risk factor in family violence.

In the rare instance where alcohol-specific actions are listed in Australian and state and territory family violence plans, these are often too narrow in focus or only make recommendations in regard to particular population groups such as Aboriginal and Torres Strait Islander peoples. None of these plans include a focus on primary prevention initiatives that target the physical availability, economic availability or promotion of alcohol. When government plans and strategies for alcohol and other drugs are examined, references to family violence are just as scarce.

These gaps highlight the critical lack of recognition of the significant role of alcohol in family violence. For too long actions to reduce family violence have overlooked the need for prevention and failed to include the role of significant contributors such as alcohol. This failure needs to be urgently addressed. This Framework focuses on this crucial gap by highlighting why action must be taken to prevent alcohol-related family violence and what that action needs to be.

Alcohol-related family violence: Why we should act



ALCOHOL IN THE COMMUNITY

The increased physical availability of alcohol contributes to increases in family violence.

The economic availability of alcohol and promotion of alcohol contributes to increased alcohol consumption and a range of health and social harms.

Societal views about alcohol, including that alcohol leads to, or excuses violence, contributes to the normalisation of excessive alcohol use, aggression and family violence.

WHY WE SHOULD ACT

Family violence does not occur in a vacuum. Community and societal factors, including the availability of alcohol, contributes to this violence and must be addressed to achieve systemic and generational change.

ALCOHOL USE BY PERPETRATORS

Alcohol increases the severity and incidence of family violence.

Alcohol makes perpetrators less aware of physical force and less concerned with the consequences.

Alcohol is used as an excuse for violence.

Alcohol is used as a form of intimidation and control and alcohol use may indicate to partners that violence is likely to occur.

WHY WE SHOULD ACT

Alcohol is used by perpetrators of family violence.

ALCOHOL USE BY VICTIMS

Alcohol is used as a coping mechanism to deal with family violence and trauma.

Alcohol excludes victims from being able to access support services.

Alcohol increases the likelihood of losing custody of children.

Alcohol impairs the victim's ability to implement safety strategies when violence occurs and increases their vulnerability to violence.

WHY WE SHOULD ACT

Alcohol is a barrier to seeking or receiving support for family violence.

ALCOHOL'S IMPACT ON CHILDREN

Alcohol impedes a parent's capacity to care for their children and protect them from harm.

Alcohol is often part of a range of issues impacting on the health and welfare of families.

Alcohol is responsible for some children being taken into care.

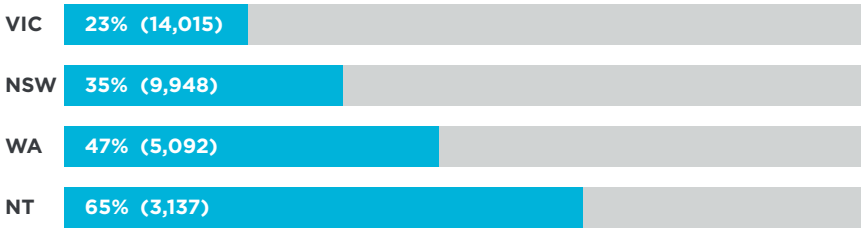
WHY WE SHOULD ACT

Children notice family violence. Children who experience family violence or child maltreatment can go on to develop a range of problems including alcohol and other drug problems later in their lives.

Alcohol's involvement in family violence

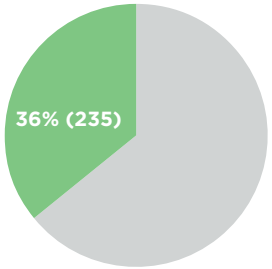
Alcohol is a significant contributor to family violence in Australia. For the four Australian states where data is available on alcohol-related family violence, there were a total of 29,684 incidents in one year (New South Wales, Victoria, Western Australia and the Northern Territory). In three of these states (Victoria, Western Australia and the Northern Territory), the numbers of alcohol-related family violence incidents are increasing.[1] Alcohol is involved in between 23 per cent[2] and 65 per cent[3] of family violence incidents reported to police, and from 2002-03 to 2011-12, 36 per cent of perpetrators of intimate partner homicides had used alcohol.[4]

GRAPH 1: Alcohol's involvement in family violence



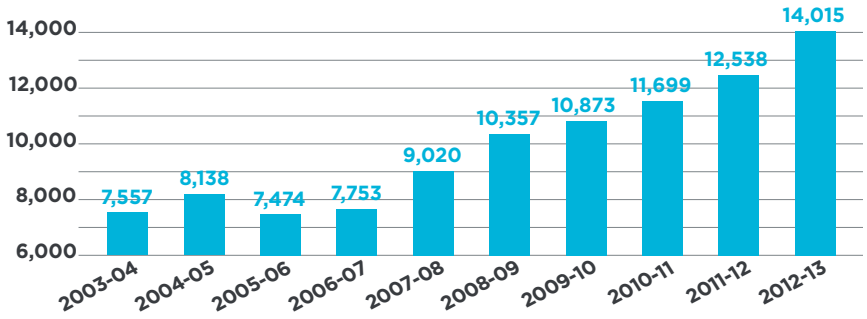
Sources: Victoria Police Law Enforcement Assistance Program (2012-2013); NSW Bureau of Crime Statistics and Research (2013-2014); Northern Territory Department of the Attorney-General and Justice (2013); Western Australia Police submission to the review of the Liquor Control Act (2011-2012).

GRAPH 2: Perpetrator's use of alcohol in intimate partner homicide



Source: Cussen, T. and Bryant, W. (2015). *Domestic/family homicide in Australia. Research in Practice No 38 May 2015.* Canberra: Australian Institute of Criminology.

GRAPH 3: Alcohol's involvement in family incidents in Victoria



Source: Victoria Police Law Enforcement Assistance Program (2003-04 to 2012-13)

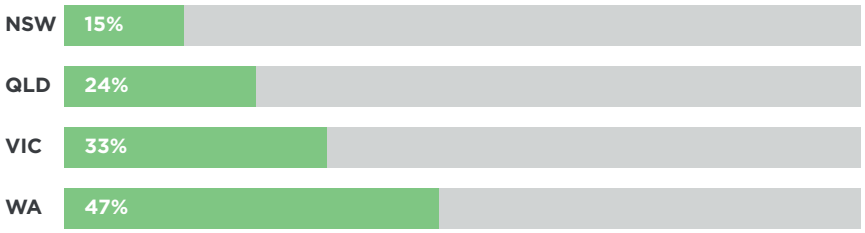
Alcohol's involvement in intimate partner violence

According to the World Health Organization (WHO), the association between alcohol and intimate partner violence includes that:

- Alcohol use contributes to the incidence and the severity of intimate partner 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 intimate partner violence using a violent resolution to relationship conflicts, rather than a non-violent resolution.
- Excessive drinking by at least one partner can aggravate existing relationship stressors such as financial problems, thus increasing the probability of violence.
- Alcohol is often used by perpetrators as a justification to violence, or excuse for the violence.
- Experiencing intimate partner violence can result in increased alcohol consumption by the victim as a coping mechanism.
- Intergenerational effects may occur, with children who witness intimate partner violence being more likely to develop heavy drinking patterns and alcohol dependence later in life often as a way of coping or self-medicating.[5,6]

Large numbers of children are also being substantially affected by others drinking, such as experiencing alcohol-related child abuse and neglect (being left unsupervised or in an unsafe situation or being verbally or physically abused). An estimated 10,166 children are in the child protection system, at least partly due to the drinking of a carer and an additional 142,582 children are not within the child protection system but are substantially affected by someone's alcohol consumption.[7] In the states and territories where data is available, carer alcohol abuse is associated with between 15 per cent and 47 per cent of child abuses cases across Australia.[8]

GRAPH 4: Alcohol's involvement in child maltreatment



Source: Laslett, AM,. Mugavin, J. Jiang. H., Manton, E., Callinan, S., MacLean, S., and Room R. (2015). *The hidden harm: Alcohol's impact on children and families*. Canberra: Centre for Alcohol Policy Research, FARE. NSW (2006-07); Queensland (2007); Victoria (2001-05); WA (2000).

Alcohol's involvement in child maltreatment

According to WHO, the association between alcohol and child maltreatment includes that:

- 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.
- Exposure to alcohol before birth may result in Fetal Alcohol Spectrum Disorders (FASD), which is associated with increased risk of maltreatment and other problems including violence later in life. Children with FASD are also over-represented in child protection systems, and more likely to remain in care for longer periods.
- 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.[9]

Approach

In developing the Framework, FARE acknowledges that preventing alcohol-related family violence requires an understanding of the wider social context in which violence occurs in the community.

FARE's *Policy options paper: Preventing alcohol-related family and domestic violence* (Options Paper) explores in depth the relationship between alcohol and family violence, the broader factors that contribute to family violence and the significant evidence-base surrounding these issues. The Options Paper should be viewed as an accompanying document to this Framework.

The actions within this Framework are multi-sectoral and acknowledge that addressing both gender inequalities and alcohol misuse are critical to preventing and reducing family violence, these areas are explored below.

Health and social inequality contributes to family violence

The Framework acknowledges the need to:

- Implement strategies that target the environmental, economic and social determinants that contribute to health inequality. This includes improving health, housing, education and employment.
- Adopt a health-in-all policies approach to public policy to ensure that the health outcomes of the community are considered in policy development.
- Implement strategies to improve housing, education and employment for Aboriginal and Torres Strait Islander peoples to close the gap on the higher prevalence of alcohol-related family violence.

Understanding differences in health and social inequalities and how these impact on and contribute to harmful alcohol consumption is important for governments across Australia. These issues were recognised by a Parliamentary Inquiry in 2012 on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health* (Social Determinants Inquiry).[10] The Social Determinants Inquiry highlighted that alcohol and other drug misuse is 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 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.[11]

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.[12]

Aboriginal and Torres Strait Islander peoples in particular are disproportionately affected by alcohol-related family violence. Alcohol use by Aboriginal and Torres Strait Islander peoples is both as a consequence of and a contributor to continued social disadvantage, and the importance of addressing this disadvantage cannot be minimised.[13,14] This need has been recognised by the Australian Government in the *Closing the Gap* framework and in the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*.[15] Aboriginal and Torres Strait Islander peoples' experience of alcohol harms and family violence is explored further in *Priority Area 2: Assist people most at risk of family violence through early identification and support.*

Gender inequality contributes to family violence

The Framework acknowledges the need to:

- Urgently implement strategies that promote gender equality for women.
- This includes but is not limited to, increasing leadership opportunities for women, increasing access to paid maternity leave, equal pay, introducing flexible work arrangements, making available varied and flexible childcare arrangements and developing equitable superannuation arrangements.

Gender inequality is the unequal distribution of power and resources that results from systematic structures that limit opportunities for women.[16] 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.[17]

Men's personal attitudes and beliefs about gender roles are also important. Those that are consistent with traditional gender roles and supportive of male authority over women are consistently associated with the perpetration of violence against women.[18] There is also evidence that gender inequality and this core belief of male authority is associated with serious incidents of violence against children,[19,20] although the reasons for this relationship are less understood and researched. The association between alcohol and family violence is stronger where the perpetrator holds attitudes that support male dominance.[21]

'Women-centred practice' or 'gender-responsiveness' are terms that consider the needs of women in all aspects of design and delivery, this includes the location and accessibility of services, staffing, program development, content and materials.[22,23] It is important that 'women-centred' practice be adopted by services. Practically this means that services need to offer a safe environment which is free from violence and encourages trust. Services also need to offer childcare. One of the most consistent factors that restrict women's access to treatment is the lack of childcare options.[24,25]

Cultural taboos and stigma attached to women's drinking are often not acknowledged by society, by the woman, their families or health professionals.[26] Substance use and/or alcohol consumption by women is often seen by child welfare and child protection authorities as abuse or neglect. This contributes to the marginalisation of vulnerable women who fear the loss of custody of their children and therefore feel unable to seek help. To break the cycle, effective services need to put women's rights and concerns at the centre of service delivery and link treatment programs, family violence services, child protection services and other health and social services.[27]

The promotion of gender equality has been recognised by the National Plan as a key factor in preventing violence against women. Measures to advance gender equality include increasing women's economic wellbeing (e.g. superannuation reform, equality in pay, improving child care support introducing paid parental leave, enhancing support for child care) and increasing women's leadership opportunities in government and private sectors. The implementation of these measures is central to the National Plan.

A public health model for preventing alcohol-related family violence

This Framework puts forward actions to prevent alcohol-related family violence across four priority areas. The Framework uses a public health model of prevention as its foundation. A public health model acknowledges the need to address social justice and health disparities in order to overcome alcohol-related family violence. This model is grounded in scientific principles and has been used extensively to address a range of health issues, such as cardiovascular disease, health and nutrition of children, diabetes and tobacco use.[28]

Over the last decade our understanding of factors that contribute to a person's health and life outcomes have improved significantly. It is now known that the primary determinants of an individual's health are a combination of the circumstances in which they are born, live, work and grow.[29] These social determinants explain differences in life expectancies and health outcomes across populations. Improving social determinants often falls outside of the traditional health portfolio, as their impact on health outcomes is influenced by education, income, gender, power and conditions of employment.[30]

The public health model of prevention aims to improve social equity as a way to reduce health disparities across populations. In the context of health, social equity is defined as: 'the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage.'[31] It considers initiatives and strategies to prevent the emergence of predisposing environmental, economic, social, behavioural and cultural factors known to increase the risk of disease and harm across populations.[32] The focus on prevention is advantageous because it is proactive, rather than reactive.

Family violence is a health disparity issue, as well as a social justice issue. Health disparity and social justice (including gender inequality) are inextricably interlinked and interwoven. A public health model allows for a comprehensive framework that acknowledges the need to address these issues to overcome family violence.

This Framework presents priority areas for action and specific actions across three levels of prevention:

1. ***Primary prevention*** – These policies and programs target the whole population, especially focusing on actions that reduce individuals' exposure to risks and strengthening individuals' resilience. Primary prevention emphasises preventing violence before it occurs. *Priority Area 1: Introduce whole of community action to prevent family violence* speaks to this level of prevention.

2. ***Secondary prevention*** – These policies and programs are also known as early intervention and target individuals or segments of the population who are showing signs of vulnerability, early indicators of trouble, or due to co-occurring difficulties are at particular risk of being affected by violence. *Priority Area 2: Assist people most at risk of family violence through early identification and support* speaks to this level of prevention.

3. ***Tertiary prevention*** – These policies and programs target people who have already been affected by violence and aim to reduce the harm or damage associated with this and prevent the recurrence of violence once it has been identified. *Priority Area 3: Provide support for people affected by family violence and protect them from future harm* speaks to this level of prevention.

A fourth priority area, *Priority Area 4: Continue to build the evidence-base by investing in data collection and evaluation* recognises the need for appropriate data collection and evaluation to help assess and measure changes in issues taking place.

Taken together these priority areas present actions to be implemented by all Australian governments as part of a suite of comprehensive measures to prevent and reduce family violence.

Levels of prevention and priority areas for action to prevent alcohol-related family violence

1. Introduce whole of community action to prevent family violence

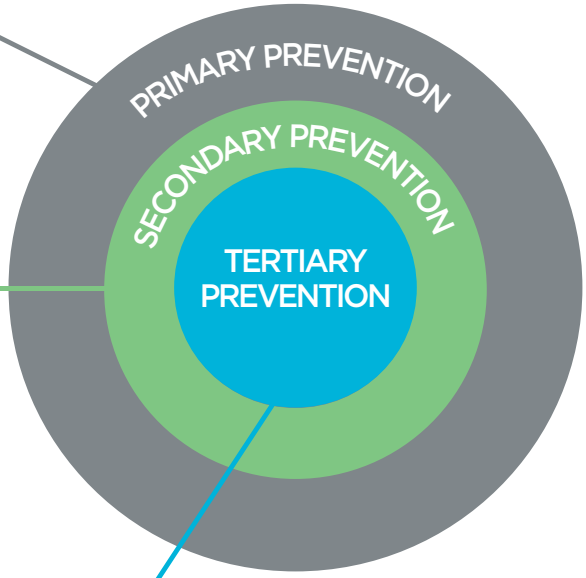
- Reduce the physical availability of alcohol.
- Reduce the economic availability of alcohol.
- Regulate the promotion of alcohol.
- Conduct sustained social marketing campaigns and school-based education on preventing family violence and ensure that the role of alcohol is adequately featured.

2. Assist people most at risk of family violence through early identification and support

- Support family-centred programs for people with alcohol and other drug problems.
- Conduct screening programs for alcohol in healthcare settings.
- Identify and support children and young people at risk of child maltreatment.
- Close the gap on the higher prevalence of alcohol-related family violence among Aboriginal and Torres Strait Islander peoples.

3. Provide support for people affected by family violence and protect them from future harm

- Facilitate collaboration between alcohol and other drug services and family violence services to ensure a 'no wrong doors' approach.
- Support and develop viable alcohol and other drug services and family violence services sectors.
- Ensure that perpetrator programs adequately address the use of alcohol and pilot innovative perpetrator programs.



4. Continue to build the evidence-base by investing in data collection and evaluation

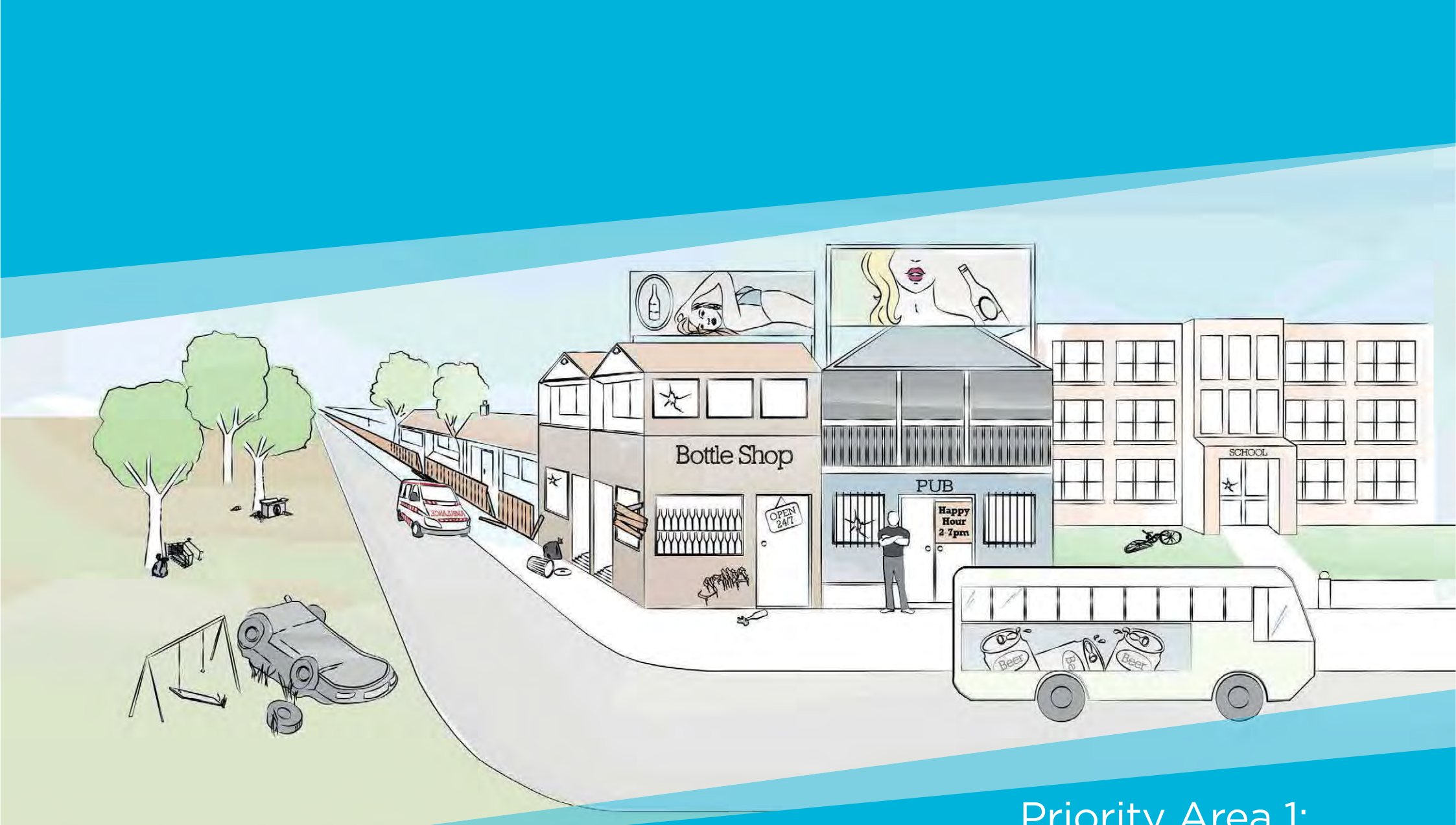
- Invest in data collection and public reporting of alcohol's involvement in family violence.
- Consistently and systematically invest in the evaluation of policies and programs to prevent alcohol-related family violence.

RESEARCH AND EVALUATION

Overview of National framework for action to prevent alcohol-related family violence

For each priority area, areas for action have been established to guide the work to be undertaken by Australian governments.

	Primary prevention	Secondary prevention	Tertiary prevention	Research and evaluation
Priority area	**1. Introduce whole of community action to prevent family violence**	**2. Assist people most at risk of family violence through early identification and support**	**3. Provide support for people affected by family violence and protect them from future harm**	**4. Continue to build the evidence-base by investing in data collection and evaluation**
Target group	Whole population	Aboriginal and Torres Strait Islander peoples and children and young people	People who are victims, witnesses and/or perpetrators of family violence	Whole population
Areas for action	1.1 Reduce the physical availability of alcohol. *State and Territory Governments* 1.2 Reduce the economic availability of alcohol. *Australian Government* 1.3 Regulate the promotion of alcohol. *Australian, State and Territory Governments* 1.4 Conduct sustained social marketing campaigns and school-based education on preventing family violence and ensure that the role of alcohol is adequately featured. *Australian, State and Territory Governments*	2.1 Support family-centred programs for people with alcohol and other drug problems. *Australian, State and Territory Governments* 2.2 Conduct screening programs for alcohol in healthcare settings. *State and Territory Governments* 2.3 Identify and support children and young people at risk of child maltreatment. *State and Territory Governments* 2.4 Close the gap on the higher prevalence of alcohol-related family violence among Aboriginal and Torres Strait Islander peoples. *Australian, State and Territory Governments*	3.1 Facilitate collaboration between alcohol and other drug services and family violence services to ensure a 'no wrong doors' approach. *State and Territory Governments* 3.2 Support and develop viable alcohol and other drug services and family violence services sectors. *Australian, State and Territory Governments* 3.3 Ensure that perpetrator programs adequately address the use of alcohol and pilot innovative perpetrator programs. *Australian, State and Territory Governments*	4.1 Invest in data collection and public reporting of alcohol's involvement in family violence. *Australian, State and Territory Governments* 4.2 Consistently and systematically invest in the evaluation of policies and programs to prevent alcohol-related family violence. *Australian, State and Territory Governments*



Priority Area 1:

Introduce whole of community action to prevent family violence

Priority Area 1:
Introduce whole of community action to prevent family violence

This priority area seeks to limit or reduce the incidence of family violence across the whole population. This is also known as primary prevention.[33] Community action to prevent family violence should encompass factors that influence the consumption of alcohol.

Many factors impact on the consumption of alcohol. These include the physical availability, economic availability and promotion of alcohol in our society. In understanding risk factors for family violence, it is important to understand how factors that affect alcohol consumption also contribute to the increased risk of violence and severity of violence.

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, the cost of other beverages and consumer products and the price of alcohol 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 and education of the negative impacts (both health and social) associated with alcohol consumption.[34]

1.1 Reduce the physical availability of alcohol

There has been unprecedented growth in the physical availability of alcohol in Australia over the last 15 years. The number of liquor licenses and licensed premises has increased dramatically.[35] For example, in Victoria the number of liquor licenses increased by 120 per cent between 1996 and 2010.[36] Trading hours for alcohol sales, and in particular late night trading, have also increased dramatically in recent decades.[37] This increase in outlets and trading hours has resulted in alcohol becoming more readily available than it ever has been and more affordable than it has been in the past three decades.[38] In some states and territories, such as the Australian Capital Territory (ACT), alcohol can be sold in supermarkets, alongside groceries and other everyday items.

Across Australia, liquor licensing legislation limits the times when alcohol can be sold, where alcohol can be sold and the types of premises that can sell alcohol. The number, placement and trading hours of licensed outlets is largely the responsibility of liquor licensing authorities in each state and territory. The Objects of liquor licensing legislation in each state and territory specify the overarching principles that must be at the forefront of liquor licensing decisions. The majority of liquor licensing legislation in the states and territories contain Objects that emphasise the importance of business and commercial development, which need to be balanced by harm minimisation. However, there are differences in how or indeed, whether, states and territories prioritise harm minimisation over commercial interests. Harm minimisation is an official policy concept that underpins national and state responses to alcohol and other drug issues and is also a concept used in liquor licensing legislation. Harm minimisation aims to reduce the net impact of harm by introducing policies that address the supply and demand for these products as well as developing harm reduction strategies that target reductions in immediate harms.[39]

It is well-established that increases in the availability of alcohol contributes to increases in alcohol-related violence. Research in Melbourne has found that there is a strong association between family violence and the concentration of off-licence (packaged or take-away) liquor outlets in an area. The study concluded that a ten per cent increase in off-licence liquor outlets is associated with a 3.3 per cent increase in family violence. Increases in family violence were also apparent with the increase in general (pub) licences and on-premise licences.[40] In Western Australia (WA), a study concluded that for every 10,000 additional litres of pure alcohol sold at an off-licence liquor outlet, the risk of violence experienced in a residential setting increased by 26 per cent.[41]

A small number of studies have also found a link between alcohol outlet density and the increased incidence of child maltreatment. In the United States of America (USA) it is estimated that one less outlet per 1,000 people reduces the likelihood of severe violence towards children by four per cent.[42]

The proliferation of alcohol outlets in areas of social and economic disadvantage further exacerbates the potential for harm. People living in disadvantaged areas have 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 in disadvantaged areas.[43]

Longer and/or later trading hours also contribute to alcohol harms, such as drink driving, assaults and hospital presentations.[44,45] There is also some research demonstrating the effects of changes to trading hours on family violence specifically. An evaluation of interventions in Tennant Creek, Northern Territory (NT) found that restricted hotel opening hours and restrictions on take-away sales on Thursdays led to a decline in admission to women's refuges.[46] Fitzroy Valley, WA introduced restrictions in 2007 limiting the types and times that alcohol could be sold. The evaluation of these measures found reductions in alcohol consumption, reductions in the rates and severity of intimate partner violence, and generally better care of children.[47]

The City of Newcastle, New South Wales (NSW) introduced a 3am close and 1am lockout (later amended to 3.30am and 1.30am) for all on-licence premises in Newcastle in 2008. An evaluation found that the restrictions resulted in a 37 per cent reduction in night-time alcohol-related assaults[48] with no geographic displacement to the nearest late night district of Hamilton.[49] These positive effects were sustained over time with an evaluation undertaken five years later finding sustained reductions in alcohol-related assaults, with an average of a 21 per cent decrease in assaults per hour.[50]

The NSW Government introduced a similar set of measures in February 2014 to address concerns about alcohol-related violence. The measures included a 3am close and a 1.30am lockout for pubs, clubs and bars in the Sydney Central Business District (CBD) Entertainment precinct, and a 10pm close for take-away alcohol across NSW. According to a recent report released by the NSW Bureau of Crime Statistics and Research, non-domestic assaults had fallen by 32 per cent in Kings Cross and 26 per cent in the Sydney CBD Entertainment precinct since the implementation of the measures.[51]

There is significant community concern about the availability of alcohol in Australia. Almost half of Australians (48 per cent) feel that they do not have enough input in the number of licensed venues in their community, which is twice as many as those who feel they do have enough input (24 per cent).[52] Furthermore, there is widespread support for policies to reduce the availability of alcohol in the community. For example, 81 per cent of Australians support a closing time of no later than 3am and 64 per cent support a 1am lockout for pubs, clubs and bars.[53]

Under licensing regimes around Australia, the burden of proof is on objectors to demonstrate that foreseeable harms from a licence approval outweigh any foreseeable benefits. This hinders community engagement and input in licensing matters. Community objectors do not necessarily have the capability (in terms of time, financial costs, and research capacity) required to meet the burden of proof. These barriers to effective engagement and input may be elevated for disadvantaged communities. Increased access to alcohol in disadvantaged communities is partly explained by the fact that it might be harder for disadvantaged communities to influence planning and zoning decisions to control the continuing proliferation of outlets.[54]

Policy proposals

Decreasing the availability of alcohol reduces alcohol harms. This effect can extend to reductions in the incidence of family violence and child maltreatment. Governments can reduce the incidence of alcohol harms by:

- Preventing areas from becoming saturated with liquor outlets.
- Reducing the excessive availability of alcohol in areas already saturated with liquor outlets.
- Introducing trading hour restrictions to reduce the excessive availability of alcohol.

All types of liquor licences should be time-limited and subject to reviews at least every five years. Revisions of liquor licences and licence applications should primarily consider the density of existing liquor licences in the area; the socio-economic status of the area, existing levels of alcohol-related harms in the area and community views.

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

To guide decision-making for all licence applications and amendments, it is essential to ensure that all state and territory jurisdictions elevate harm minimisation to be the primary Object of their liquor licensing legislation, with all other Objects subordinate to this. To support the harm minimisation Object, liquor licensing legislation must develop and implement an assessment framework for liquor licensing decisions that takes into account and prioritises the potential impact on community safety and wellbeing. This is particularly important for disadvantaged communities that are often powerless to stem the proliferation of outlets in their area, and experience disproportionate levels of health and social harms including family violence.

To address outlet density and the excessive availability of liquor, saturation zones should be implemented. In the United Kingdom (UK), operational saturation zones have been created, based on existing outlet density, crime data and intimate partner violence statistics.[55,56] When an area is deemed to be saturated, no further licences are permitted and the onus of proof is placed on the applicant to prove that a new licence will not further increase harms. In Australia, jurisdictions should introduce saturation zone policies in areas deemed to host too many liquor outlets, to prevent alcohol-related violence. These policies could include licence freezes, restrictions on the days and hours of trading, and licence buy-back schemes.

Trading hours for alcohol in Australia can also be reduced in order to decrease alcohol harms. Communities that have had reduced trading hours have benefited from significant reductions in violence. The positive impacts were immediate and often sustained over time.

To reduce trading hours, policies such as those implemented in Newcastle and Sydney should be implemented across Australia. This includes limiting off-licence trading hours to between 10am and 10pm, a closing time of no later than 3am for on-licence venues (with a 1am lockout) and removing all 24 hour licences.

Actions	Government responsible
1. Task the Council of Australian Governments to implement uniform minimum principles for liquor licensing legislation across states and territories to limit the excessive availability of alcohol which is leading to increased violence. The consistent principles should address three priority areas: • Preventing areas from becoming saturated with liquor licences, by: – Introducing time-limited liquor licences, which are reviewed at least every five years. – Elevating harm minimisation as the only primary Object of liquor licensing legislation. – Reforming licence application processes to include as primary considerations the density of liquor licences in an area, the socio-economic status of the area, the existing levels of alcohol-related violence, and community views. • Reducing the excessive availability of alcohol in areas saturated with liquor licences, by: – Undertaking assessments of existing liquor licence density and levels of alcohol-related violence to determine whether areas are 'saturated' with liquor licences. – Where an area is deemed to be saturated, a licence freeze should be imposed and licence buy-backs undertaken. • Introducing restrictions to reduce the excessive availability of alcohol, by: – Introducing a closing time of no later than 3am for on-licence venues (pubs, clubs or bars) and a 1am lockout. – Limiting off-licence (packaged liquor) trading hours to between 10am and 10pm. – Terminating all 24 hour liquor licences. – Introducing precinct-wide measures including restrictions to days or hours of trading.	State and Territory Governments

1.2 Reduce the economic availability of alcohol

The economic availability of alcohol refers to its affordability, which is one of the most important predictors of alcohol harms. Lower alcohol prices are associated with higher consumption and harms.[57,58] Conversely, increases in the price of alcohol results in a decrease in harms.

The price of alcohol is a significant influence for Australian drinkers. FARE's *2013 Annual Alcohol Poll* found that over half (54 per cent) of Australian adult drinkers consider price when purchasing alcohol, which increases to 63 per cent for heavier drinkers.[59]

The price of alcohol is significantly influenced by taxes that the Australian Government sets on alcohol products or the setting of a minimum price, below which alcohol cannot be sold (known as minimum floor price). How alcohol is priced and taxed influences what alcohol is consumed as well as how it is consumed. For example, due to current alcohol taxation arrangements, wine is by far the cheapest form of alcohol available in Australia. 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. For all other alcohol products, a differentiated or category-based volumetric tax is applied at a rate per litre of pure alcohol, meaning that higher strength products such as spirits are taxed at higher rates than lower strength products such as beer.

Volumetric taxation has been found to be effective in reducing alcohol consumption and consequent harms among targeted groups (for instance, young people and harmful drinkers). Policies that increase the price of alcohol lead to a reduction in the proportion of young people who are heavy drinkers, a reduction in underage drinking, and a reduction in per occasion 'binge drinking'.[60] Research from the USA found that a one per cent increase in price due to taxation resulted in a 1.4 per cent reduction in binge drinking by adults.[61] This research builds on the evidence for the effectiveness of increasing the price of alcohol through taxes in reducing not just overall consumption but high risk consumption.[62,63]

Several studies, primarily from the USA, have demonstrated the links between the increased economic availability of alcohol and increases in family violence specifically. 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 decrease in intimate partner violence towards women.[64] A further study estimated that a ten 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.[65]

Policy proposals

Reforming the alcohol taxation system would contribute significantly to reducing alcohol-related harms because of the ability for this policy measure to target heavy drinkers. Policies that increase the price of alcohol have been found to be associated with decreased alcohol consumption and harms.

Nine government reviews have concluded that the current alcohol taxation system needs to be overhauled. The reviews have found that the current alcohol taxation system does not adequately recognise the extent and costs of alcohol-related harms to the Australian community.[b] The alcohol taxation system should allow each product to be priced according to the volume of alcohol and its potential to cause harm. This should include abolishing the tax that results in the cheapest alcohol products, the WET and the WET rebate. A new taxation rate on wine should be phased in until it is consistent with other products of a similar alcohol content.

In Australia there is a significant gap between the social costs of alcohol, including government services' responses to alcohol-related family violence, and the amount of tax collected by the Government. In 2013-14, the Government raised $5.1 billion in alcohol tax revenue. This is the tax on beer, spirits and other excisable beverages.[66] This is despite the social costs of alcohol being estimated as being as high as $36 billion.[67] The Australian Government should introduce a levy on alcohol products to fund policies and programs to prevent family violence.

Actions	Government responsible
2. Reform the alcohol taxation system to allow alcohol to be priced according to the volume of alcohol within a product and the potential of the product to cause harm, by: • Abolishing the Wine Equalisation Tax and replacing it with a volumetric tax rate for all alcohol. The rate for wine should be transitioned to a differentiated rate that is based on the alcohol content of wine. • Applying a levy through the alcohol taxation system to pay for the costs incurred by Government in responding to family violence.	Australian Government

[b] 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.

1.3 Regulate the promotion of alcohol

Alcohol advertising and promotions are prolific in Australia and presented through a variety of media, including print media, broadcast (i.e. television, radio), digital media (i.e. SMS, websites and social media platforms such as Facebook and Twitter), merchandising, sponsorship of sporting and cultural events and product placement.

The volume of alcohol advertising young people are exposed to has been demonstrated to impact on their future alcohol consumption behaviour. A review of 12 longitudinal studies of over 38,000 young people has shown that the volume of advertising they are exposed to influences the age that they start drinking as well as their consumption levels.[68] This review demonstrated that the more alcohol advertising that young people are exposed to, the earlier they will start to drink, and the more they will consume if they already drink.

There are two regulatory structures for alcohol advertising and marketing in Australia at both an Australian Government and state and territory government level. At the Australian Government level, the content of alcohol advertising is the responsibility of the industry self-regulatory code, the *Alcohol Beverages Advertising (and Packaging) Code* (ABAC). The ABAC specifies that alcohol advertising must not encourage irresponsible consumption, infer that its consumption will change mood and/or contribute to financial, social and sexual success or have evident appeal to young people.[69] The ABAC has been repeatedly found to be a non-objective and ineffective regime which fails to serve the public interest.[70,71]

The ABAC also contains no reference to sexism or marketing that may be considered sexist. Alcohol is one product where advertising has been highly associated with sexual appeal. Often, alcohol is portrayed as an integral part of a sexually active and fun lifestyle among young people, and notions that this lifestyle is stimulated or enhanced by the consumption of alcohol are promoted.[72] Alcohol advertisements contain images that imply that certain irresponsible sexual behaviour (or treatment of women) is appropriate in the context of alcohol consumption.[73] The ubiquitous presence of sexually attractive female models in advertising contributes to the sexual objection of women in society.[74]

Alcohol advertising that appears on television, sponsorship of sporting events and social media advertising is self-regulated through industry codes. Alcohol advertising on television is self-regulated by Free TV Australia, the peak national industry body representing the interests of free-to-air commercial television stations in Australia. Free TV Australia's *Commercial Television Industry Code of Practice* covers the time limits on non-program matter, and the classification and placement of commercials. Under this code, alcohol advertising is permitted during M or MA15+ classification zones from 8.30pm onwards, or as an accompaniment to a sports broadcast on a Weekend or a Public Holiday.[75]

Australians are very exposed to high levels of alcohol advertising on television. For example, during the Bathurst 1000 in 2012, those who watched the whole 6.5 hour-long broadcast (including nearly 117,000 minors aged five to 17 years) were exposed to 35 minutes of alcohol advertising including in-break alcohol advertisements and sponsorship.[76]

Both of these codes and the myriad of other industry self-regulatory alcohol advertising codes are ineffective because of their limited capacity to act in the public interest, failure to counter sexist advertising content, failure to protect the interests of minors and failure to address alcohol advertising on social media.

The mix of opt-in regulatory codes and bodies for alcohol advertising is confusing for the public to navigate, and confounds quick and effective regulatory responses to complaints. Where a complaint is upheld by a regulatory body, little comes of the decision. These regulatory bodies are not designed to effectively act on complaints. They are established on a membership basis and consequently they do not cover all advertisers and alcohol brands. If the offending advertiser is not a signatory to the code in question, then the regulatory body has no remit to enforce any penalties against the offending advertiser. Even if the offending advertiser is a signatory to the code in question, there are no penalising sanctions nor active enforcement of the codes to address the offending advertisement and ensure compliance.

At the state and territory government level, point of sale promotions in and around licensed premises and signage such as advertising on buses and

trams, are regulated through liquor licensing legislation and guidelines. Point of sale marketing is being increasingly used, to the extent that it has been labelled as 'ubiquitous' and 'aggressive'.[77] From January to April 2009, liquor outlets in Sydney alone hosted an average of 30 point of sale promotions per outlet.[78] Point of sale promotions have been found to encourage the purchase of increased volumes of alcohol[79] and are likely to affect overall consumption patterns of underage, harmful, and regular drinkers.[80]

Liquor licensing legislation provides liquor regulatory authorities in each jurisdiction with the power to stop a promotion or caution a licensee regarding an inappropriate promotion. Such promotions are usually articulated in promotion guidelines which mainly cover the activities that occur in on-licence premises. This is despite 80 per cent of all alcohol consumed being purchased from off-licence venues.[81] Off-licence venues can also be attended by people under the age of 18 years, who are then exposed to the promotions that occur throughout the store.

There is an uneven focus in liquor licensing regulations, on promotions at on-licence premises. This does not recognise consumer behaviours of where and how alcohol is purchased, which is predominantly through off-license premises. There are opportunities to further minimise alcohol harms by ensuring that promotion guidelines have an equal focus on both on- and off-licence promotions to recognise both where the majority of alcohol is purchased and reduce public exposure to harmful promotions.

Policy proposals

Alcohol advertising contributes to alcohol harms and sexist attitudes towards women, and the alcohol brands themselves cannot be trusted to continue regulating their marketing in the public interest. The best answer to the current state of ineffective, limited and non-objective regulation of alcohol advertising is a legislative solution that phases out alcohol advertising.

Alcohol marketing control policies have a substantial and significant role to play in addressing alcohol harms, family violence and the portrayal of women. This is a shared responsibility between the Australian Government and state and territory governments.

The Australian Government should model legislative bans on alcohol advertising on the *Tobacco Advertising Prohibition Act 1992 (Cth)* and provides a precedent for this to occur. This Act comprehensively imposes restrictions on the broadcasting and publishing of tobacco advertisements. All tobacco advertisements which take the form of the following media are prohibited: print; films, videos, television or radio and the internet; tickets; sponsorship; the sale or supply of any item containing a tobacco advertisement; and outdoor advertising on billboards or public transport.[82]

State and territory governments should not profit from or facilitate the promotion or advertising of alcohol companies and retailers. To that end, all jurisdictions should follow the example set by their tobacco legislation,[83] and prohibit alcohol promotions and advertisements from appearing on public property. Prohibiting alcohol advertisements from being displayed on public property would reduce the presence of alcohol advertising that perpetuates sexist attitudes and behaviours towards women. This would also reduce the exposure of children to liquor promotions.

Existing regulations and guidelines that focus predominantly or solely on on-licence promotions also need to be redrafted with a view to better reflect the regulation of promotions in off-licence settings. To ensure that harmful liquor promotions serve to prevent alcohol harms across the community, liquor promotion controls should be applied with equal weight for on- and off-licence premises.

Actions	Government responsible
3. Introduce national legislation modelled on *Tobacco Advertising Prohibition Act 1992 (Cth)* to phase out alcohol advertising from print, films, videos, television, radio, the internet, tickets, sponsorship, and outdoor advertising on billboards.	Australian Government
4. Strengthen state and territory regulation of alcohol advertising and promotions by: • Prohibiting alcohol advertising from taking place on public property. • Applying alcohol promotion regulations equally to both on- (bars, pubs and clubs) and off-licence (packaged liquor) premises.	State and Territory Governments

1.4 Conduct sustained social marketing campaigns and school-based education on preventing family violence and ensure that the role of alcohol is adequately featured

WHO defines social norms as the 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.[84] Public awareness campaigns are one way of challenging and changing social norms in order to prevent the emergence of undesirable attitudes and behaviours.[85] In the area of family violence, the need for public awareness has been recognised by the Council of Australian Governments (COAG), which on 4 March 2015 announced a $30 million joint commitment to deliver a national awareness campaign aimed at reducing violence against women and their children.[86]

In June 2013 the Australian and Victorian Governments established Our WATCh, which is an independent, not-for-profit organisation that aims to achieve attitudinal change by raising awareness and engaging the community in action to prevent violence against women and their children.[87,88] One campaign that is currently being run by Our WATCh is *The Line*. The campaign targets young people and is a primary prevention social marketing campaign aiming to change attitudes and behaviours that 'condone, justify and excuse' violence against women.

School-based education is a form of public education that targets children and young people. Primary prevention for school children is important because it supports one of the central principles of effective prevention – starting early. Childhood and especially adolescence is a critical period for shaping the quality of relationships later in life. Successful education at these stages of life are likely to prevent the emergence of negative relationship behaviours such as violence.

In school settings, primary prevention is often centred on promoting respectful relationships. A respectful relationship is defined as one of trust, equality, respect and the absence of violent and intimidating behaviour. Gender relations, in particular, promoting positive attitudes towards girls and women, feature significantly in respectful relationships education. The implementation of respectful relationships education in school and other youth settings is noted as a priority in the National Plan.

On 11 May 2012, the then Australian Minister for the Status of Women, the Hon Julie Collins, announced $3.7 million (as part of the Government's $9.1 million *Respectful Relationships* initiative) to be shared among 11 community projects to encourage healthy relationships among young people.[89] This included the YWCA Canberra's programs *Respect Communicate Choose* (aimed at children aged 8-12 years),[90] and *Relationship Things* (aimed at young people aged 14-17 years).[91] These programs aimed to provide young people with the tools and support they need to develop and promote safe, equal and respectful relationships in order to prevent gender-based violence. Unfortunately the funding was not continued.

There are no public awareness campaigns or school-based education programs in Australia that adequately integrate the relationship between alcohol and family violence. For example, the Our WATCh campaign *The Line* acknowledges alcohol's contribution to violence against women and research conducted by the campaign around young people's perceptions on alcohol as an excuse for violence have been used on infographics to share on social media.[92] However, there is no specific message communicating that alcohol is never an excuse for violence and there is also no information provided about how individuals can seek help from police and alcohol and other drug organisations if they are experiencing, or have experienced, alcohol-related harms.

References to alcohol in school-based education are largely confined within the context of sexual assault. However, there is no information about the role of alcohol in family violence. There is also no advice about where and how a young person can seek help if they are experiencing, or have experienced, alcohol-related harms, or if they themselves are consuming alcohol to cope with the trauma they are experiencing.

Public and school education about the unacceptability of alcohol as an excuse or justification for family violence is urgently needed. The *2013 National Community Attitudes towards Violence Against Women Survey* found that one in ten Australians believe that intimate partner violence can be excused if the victim is affected by alcohol. Nine per cent believe that intimate partner violence can be excused if the perpetrator is affected by alcohol.[93] Young

people are also likely to see alcohol as an excuse for violence. Research conducted to inform *The Line* campaign revealed that in young people aged 14 to 24 years, 15 per cent consider it acceptable for 'a guy to pressure girl for sex if they are both drunk'. This research also found that one in four do not think that it is serious 'if a guy who is normally gentle slaps his girlfriend during an argument while he is drunk'.[94]

One example of a campaign that did integrate alcohol and family violence was *Walk Away Cool Down*. This was a non-gender-specific campaign in Northern Queensland introduced in the early 2000s by the Queensland Police.[95] The aim of the campaign was to change attitudes and behaviours towards family violence and challenge perceptions of alcohol as being a cause of or excuse for violence.[96] Unfortunately, this campaign and others like it tend to be confined within a local area and be of limited duration due to funding and other pragmatic issues.

Policy proposals

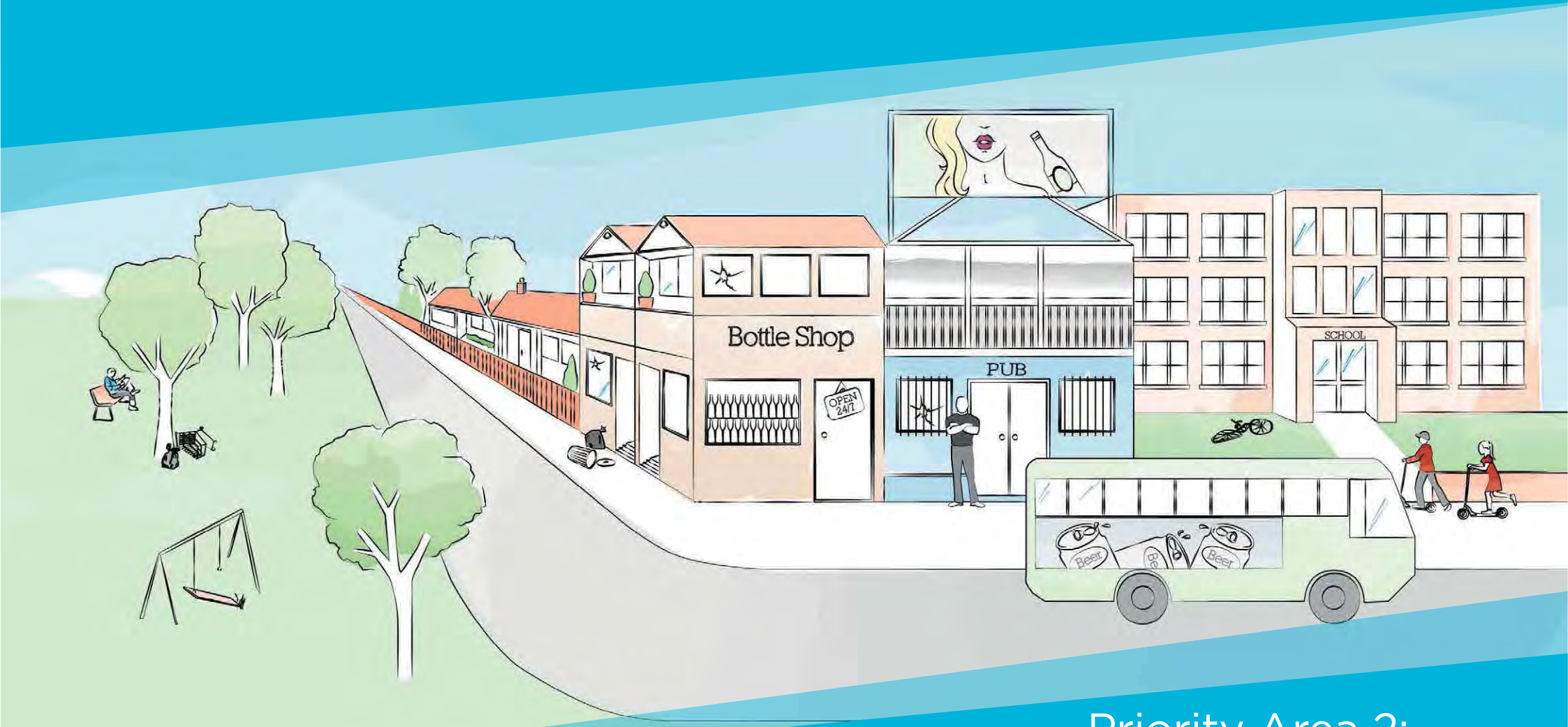
Public and school-based education programs that appropriately and comprehensively integrate the role of alcohol in family violence are urgently needed. Public and school education programs on family violence need to be consistently and sufficiently funded. This would enable them to provide continuity in messaging, which would produce sustained, long-term change. These programs need to be multifaceted, and form part of a wider strategy of legislative change and reform.[97,98] Programs must also be formally evaluated to assess their effectiveness in changing negative attitudes and behaviours, both in the short and long-term.

All schools in Australia should receive funding to provide respectful relationships education to students on family violence or including the role of alcohol in intimate partner violence and child maltreatment. Alcohol's involvement in family violence should also be included in the national awareness campaign aimed at reducing violence against women and their children.

The Australian Women's Health Network states that the primary aim of anti-family violence campaigns should be to change attitudes, behaviours and beliefs that normalise and tolerate gender-based violence and violence against children. Furthermore, they should be victim-centred, hold perpetrators to account and emphasise equality.[99,100]

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

Actions	Government responsible
5. Include information on the role of alcohol in family violence in the $30 million Council of Australian Governments' awareness raising campaign to reduce family violence.	Australian Government
6. Require all school-based respectful relationships programs to include information on the role of alcohol in family violence.	State and Territory Governments



Priority Area 2:

Assist people most at risk of family violence through early identification and support

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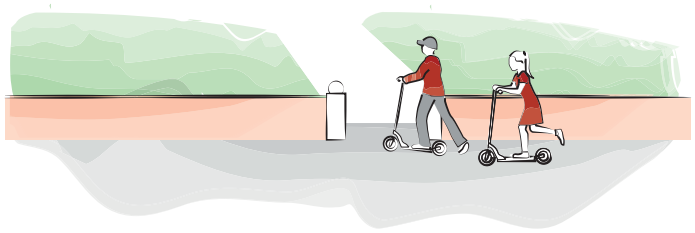
Assist people most at risk of family violence through early identification and support

This priority area targets individuals or segments of the population who show signs of vulnerability. This is also known as secondary prevention.

This priority area recognises that particular groups are more vulnerable and at greater risk of experiencing family violence and proposes tailored solutions for these groups. It recognises that alcohol is part of a constellation of issues impacting families that include poverty, housing and employment issues. This priority area focuses on two discrete groups at risk of higher levels of harm, Aboriginal and Torres Strait Islander peoples, and children and young people.



2.1 Support family-centred programs for people with alcohol and other drug problems

At the national level, both the *National Framework for Protecting Australia's Children 2009-2020: Protecting Children is Everyone's Business*, and the *National Drug Strategy 2010-2015* have highlighted the need for alcohol and other drug (AOD) services to adopt child and family sensitive policies and practices.[101,102] There are also a number of state and territory policies and frameworks that acknowledge this need.[103]

In the context of alcohol service delivery, child and family sensitive practice involves interventions that are sensitive to, and incorporate the needs of families. The guiding principle is that alcohol also affects family members other than the drinker. Interventions that target the family unit, particularly children, will enhance outcomes for the person misusing alcohol and prevent or at least mitigate harms to the children 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 residential alcohol 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.[104]

There are a number of AOD services across Australia that integrate child and family sensitive practice to varying degrees. One example is *Kids in Focus,* an Australian Government-funded service that addresses the needs of parents and children where parents have, or are receiving treatment for, AOD problems. Most referrals to the program are made by child protection services. Clients are typically sole parents seeking help with 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 by 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 are 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*,* although whether these referrals were for AOD problems is unknown.[105]

Another example of a successful Australian program that targets families and parenting is the *Parents under Pressure* program. The program targets families with difficult life circumstances, although it has been especially applied to families with AOD use and/or child protection concerns. The program is delivered by a therapist, usually in the client's 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 three to four months to complete. These are designed to complement the care provided by AOD treatment services.[106] An evaluation of the program on children aged three to eight years whose parents were on methadone found significant reductions in potential child abuse and child behaviour problems.[107] There has been no similar evaluation examining alcohol.

There is an increasing recognition of the need for AOD services to address the needs of children and families.[108] Unfortunately, these needs are not being met because child and family sensitive practice is still the exception rather than the rule in AOD service delivery.[109] Residential programs that accommodate children while their parents are receiving treatment are particularly rare due to the infrastructure and resources required to deliver such services. An example of such a program is *The Family Program* provided by the not-for-profit organisation Karralika, in the ACT. The dearth of residential programs accommodating children is concerning because the responsibility of caring for children is likely to prevent a person with AOD issues from seeking treatment. This is due to the practical difficulties of leaving children in care while undergoing treatment, as well as fears of stigmatisation or having children placed in the child protection system.[110]

For Aboriginal and Torres Strait Islander families, it is especially important that culturally-sensitive approaches to residential care are available. Residential programs for Aboriginal and Torres Strait Islander families should also be well-funded and readily available to families in need. An example of such a program is the 12 week residential alcohol and drug program as part of the Council for Aboriginal Alcohol Program Services' *Healthy Families Programs*. This program reflects the *National Drug Strategy 2010-2015* harm minimisation approach, and is based in a 'semi bush setting with a community feel'.[111] The education sessions during the residential program are designed to be accessible to a variety of clients, including people who speak English as a second, third or fourth language, have low or varying literacy levels and are from traditional or urban backgrounds. Clients in the residential program also participate in art therapy and cultural activities, inclusive of recreation and community events.[112]

Providing child and family sensitive practice is resource intensive and requires adequate and sustained funding. Many agencies are unable to provide child and family-centred practice under existing funding models, forcing them to self-fund for 'non-client' services or source funding from outside the AOD sector, including through philanthropic resources.[113] Difficulties in acquiring sufficient funding is likely to be further exacerbated by recent cuts to the Australian Government's Drug Strategy Program, with further reductions planned in the future years.[114]

Policy proposals

The growing recognition of the family as a unit of AOD intervention, rather than just the individual, must be matched by expanding the provision of services incorporating child and family sensitive practice. At a minimum, funding should be provided for AOD services to have child and family sensitive policies and procedures in place. This includes procedures to identify whether clients have children, and whether it is likely that the client's alcohol use is affecting their children and families. There should also be a referral process in place if child abuse or neglect is identified or suspected.

There should be funding allocated to extend the capacity of existing residential rehabilitation programs such as those delivered by Karralika to continue to deliver family inclusive services. Funding should also enable the establishment of more residential programs that accommodate children to address the demand for such services. This is of particular importance as having children has been identified as a significant barrier to seeking treatment, especially for more intensive longer term treatment models such as residential rehabilitation.[115] Residential programs for Aboriginal and Torres Strait Islander families should also be well-funded and readily available to families in need. Culturally-sensitive residential family services need to be adequately funded on an ongoing basis to provide continuity of care and service delivery.

It may not be possible for all AOD services to fully incorporate child and family sensitive practice into their existing structures. Therefore positive parenting programs provide a useful complement to traditional, individualised modes of AOD service delivery. Programs such as *Parents under Pressure* can be provided alongside a client's AOD treatment. Programs such as these should be replicated in more settings and implemented for more families across Australia who are affected by, or at risk due to parental alcohol misuse. Formal evaluations must be conducted to provide decision-makers with guidance on where to direct resources in the future.

Actions	Government responsible
7. Fund alcohol and other drug services to adopt child and family sensitive practice in all their programs.	Australian, State and Territory Governments
8. Fund residential alcohol and other drug services for families, including culturally-sensitive residential services for Aboriginal and Torres Strait Islander families.	Australian, State and Territory Governments
9. Extend funding for positive parenting programs, such as *Parents Under Pressure* and *Kids in Focus*, for children and families identified as being affected by, or at risk due to parental alcohol misuse.	Australian, State and Territory Governments

2.2 Conduct screening programs for alcohol in healthcare settings

In order to manage alcohol misuse among people experiencing family violence, the identification of alcohol problems is a necessary first step. Methods for alcohol screening in health settings include assessment of a person's alcohol consumption using the Alcohol Use Disorder Identification Test (AUDIT) and brief interventions. Contact with the health sector presents an opportunity to screen for harmful alcohol use and provide a brief intervention or referral where necessary. General Practitioners (GPs) are often in a position of trust and are well placed to identify risky alcohol use and any negative impacts to the drinker's family.[116,117]

Opportunistic screening is an effective, evidence-based approach that has the potential to identify harmful alcohol use and take action to prevent future harm from occurring. 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 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.[118,119,120]

There are validated and reliable tools available for health professionals to assess a person's alcohol use. This includes the AUDIT, which is a ten item tool developed by WHO. The items contain questions to determine the amount and frequency of alcohol consumption including high risk consumption and whether there are any adverse impacts on the drinker or others around them as a result of their drinking (for example, failing to do what was expected of them, injuries to themselves or others, feeling guilty and remorseful after drinking). While the primary function of the AUDIT is to provide an indicator of risky drinking, it can also signal the incidence and extent of harms that the drinker's family may be experiencing. Once problems with alcohol are identified, the client and their family (if appropriate) can be referred to alcohol services and family violence services.

Brief interventions are valuable to the initial management of individuals' alcohol-related problems. According to WHO, 'Brief interventions are those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it'.[121] Brief interventions are a low-cost and effective approach for addressing the spectrum of alcohol problems. For people with serious alcohol use disorders, these programs bridge the gap between primary interventions and more intensive treatment. Individuals with alcohol dependence generally require more intensive clinical management and should be referred to appropriate AOD services.[122]

Despite the evidence supporting the success of brief interventions, screening for risky alcohol use does not occur universally in Australia. This is due to health professionals reluctance in talking to patients about sensitive issues. To get past this hurdle, health practitioners need training and resources to support implementation, a user-friendly knowledge base and greater awareness of referral pathways.[123,124]

Policy proposals

Universal screening for risky alcohol consumption using the AUDIT can identify alcohol misuse and gauge whether the patient's alcohol use is harming members of their family. Health professionals, such as GPs, are well placed to conduct this screening given that they are a common point of first contact for individuals and families who are experiencing stress and trauma.

The implementation of screening and brief interventions in health settings should be supported by the development of training and resources for health professional and their patients. This will build health professionals' confidence in undertaking alcohol screening tests, brief interventions and referrals to specialist AOD and family support services. Resources should include leaflets and online tools for health professionals about the evidence for alcohol and harms, and how to raise the topic of alcohol consumption with clients. Training courses should be developed to assist health professionals through Continuing Professional Development (CPD) modules. There should also be leaflets aimed at patients and provided by the health professional after the consultation on alcohol.

Actions	Government responsible
10. Implement a screening and brief intervention program for risky alcohol use in health settings, which includes: • Training for health professionals on how to administer screening tools and the advice to provide. • Developing clear referral pathways between healthcare, alcohol and other drug and family support services.	State and Territory Governments

2.3 Identify and support children and young people at risk of child maltreatment

Experience of parental alcohol problems and family violence places children and young people at greater risk of mental health issues, current or future alcohol misuse, and current or future family violence perpetration or victimisation.[125,126] It is vital that children affected by violence are identified early to reduce their risk of present and/or future harms.

The need for early identification of child maltreatment is acknowledged in the *Framework for Protecting Australia's Children 2009–2020: Protecting Children is Everyone's Business.* This Framework 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'.[127]

GPs may be 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 family violence.[128] The RACGP guidelines have provided sample questions for GPs to ask during a routine visit, including:

- '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?'

The need for early identification of family violence within the broader system is identified in various policy instruments across Australian states and territories. For example, the Victorian Government in *Child abuse: Reporting procedures* includes the need for health professionals, school teachers and police to report suspected child maltreatment. These reporting procedures also recommend that people working with children should be alert to warning signs of potential abuse, including alcohol or other drug misuse.[129] However, no routine procedures are recommended for people in contact with children showing signs of being at risk of significant harm. The detection of this risk is also still largely reliant on personal and professional judgement.

The identification and reporting of possible child maltreatment tends to be reactive. Often investigations 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.

Less is known about the efficacy of programs targeting prevention efforts at children only. A review of prevention and early intervention strategies for eight to 14 year olds concluded that there are a variety of school-based interventions that target specific outcomes such as preventing substance misuse or depression.[130] Many behaviours and outcomes are interrelated and linked to the same underlying factors. 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), with the aim of reducing a variety of negative outcomes including substance misuse and mental health issues.[131,132]

Policy proposals

Health professionals and educators across Australia should be trained and encouraged to identify children who could be at risk of child maltreatment. Early identification methods such as those suggested by RACGP should be applied to other relevant health professionals, including those in the alcohol and intimate partner 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.[133]

Actions	Government responsible
11. Require health professionals and educators to be trained in the early identification and referral processes for child maltreatment.	State and Territory Governments

2.4 Close the gap on the higher prevalence of alcohol-related family violence among Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples are disproportionately affected by alcohol misuse, family violence, and alcohol-related family violence.[134] The reasons for this are complex and stem from underlying issues of intergenerational grief and loss.[135,136,137] The Australian Institute of Health and Welfare report *Child Protection Australia 2012-2013* attributes the over-representation of Aboriginal and Torres Strait Islander children in child protection substantiations to '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…'[138]

Even though Aboriginal and Torres Strait Islander peoples are more likely to abstain from alcohol compared to other Australians, their level of risky alcohol use is about twice as high.[139] The harms associated with alcohol use applies especially to family violence. 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.[140] The majority (87 per cent) of intimate partner homicides among Aboriginal and Torres Strait Islander peoples from 2000 to 2006 were alcohol-related.[141]

Substance abuse, especially alcohol, has been noted as a principal factor in child abuse and neglect among Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander children are more likely to be represented in child protection systems. In 2012–13, Aboriginal and Torres Strait Islander children were eight times as likely as non-Indigenous children to be receiving child protection services (150.9 per 1,000 children compared with 18.5 per 1,000 children respectively).[142]

The insidious and pervasive effects of alcohol in family violence has led to a recognition by governments that addressing alcohol misuse is central to reducing family violence among Aboriginal and Torres Strait Islander peoples. The 2007 *Little Children are Sacred* report acknowledged 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!'[143]

The success of policies, interventions and services addressing family violence and alcohol use for Aboriginal and Torres Strait Islander communities is contingent upon a number of principles. They must be holistic and recognise the intricate and complex links between alcohol misuse, family violence and other stressors. Interventions must be community driven and involve strong leadership from men as well as from women.[144] Historical and cultural issues must be understood as these can affect the ability and willingness of Aboriginal and Torres Strait Islander peoples to disclose alcohol use and/or violence and access and benefit fully from support services. These issues include addressing the 'code of silence', particularly in relation to situations or behaviours (such as family violence or alcohol misuse) that could lead to the forced removal of children or a fragmentation in family and kinship groups.[145]

Alcohol interventions have been consistently noted as a vital component in the reduction of family violence in Aboriginal and Torres Strait Islander communities. Alcohol Management Plans (AMPs) are a relatively new strategy to address alcohol supply and consumption, and these have been primarily applied in Aboriginal and Torres Strait Islander communities where problematic drinking has been identified as a major concern. The central principle of AMPs is harm minimisation across a community, particularly in relation to women and children. Strategies for AMPs vary across communities and can encompass a variety of measures such as restrictions on the hours of alcohol sale, restrictions on particular types of alcohol known to be associated with problematic drinking, the declaration of dry areas, awareness and education campaigns, youth diversion activities, and setting up or strengthening the capacity of women's shelters and support groups.[146] There are currently several AMPs across Australia including in 19 discrete Aboriginal and Torres Strait Islander communities across Queensland (as at May 2015),[147] three in regional centres (Alice Springs, Tennant Creek and Katherine) in the NT and one in a remote community in the NT (as at April 2015).[148]

Evaluations on AMPs show that they are often successful in producing desired outcomes. 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.[149] Community leaders in Fitzroy advocated for the introduction of the measures as a response to 13 suicides in one year and increasing rates of community dysfunction.[150] An evaluation in 2010 found reductions in rates and severity of intimate partner 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.[151]

AMPs result in better and more enduring outcomes from the community if they involve high community engagement,[152] are adequately resourced and funded, are supported by governments and are culturally appropriate.[153] Unfortunately, these factors are not consistent features of AMPs. The Menzies School of Health Research conducted an evaluation of the Alice Springs AMP, finding that the lack of communication about the AMP had led to a degree of hostility and opposition from the community towards the plan. The community felt that the AMP was a Government imposed initiative rather than community-led.[154] Bureaucratic processes at the government level can also impede the approval of AMPs, causing community disillusionment and the continuation of alcohol-related problems. For example, in the NT, despite considerable effort by a number of communities, only one community's AMP (out of 35 developed or redeveloped plans) has been approved as at April 2015.[155] Clear goals need to be set to measure change and establish the local evidence-base for the measures to be achieved. This is to enable a better understanding of what works and what does not. Evaluations on the effectiveness of AMPs have remained limited partly due to a lack of clear measurable goals being established at the beginning and the ability for local communities to assess change over time.[156]

AMPs will not succeed without sufficient and longer term financial support and resources, which are needed to build capacity to train local workforce on developing and implementing AMPs.[157] Without this investment of funds and capacity building, communities will be forced to rely on staff from government agencies in developing their AMP.[158] This would result in community ownership and cultural sensitivity being lost, rendering the AMPs ineffective.

Policy proposals

Policies and programs targeting a reduction of alcohol-related family violence in Aboriginal and Torres Strait Islander communities must engage and empower the community in decision-making, and recognise the diversity and cultural values of the community.[159] Interventions should use local structures and develop relationships with key stakeholders 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. The relevant services such as family violence and AOD should work together on the basis of respect and equality, ensuring that they provide holistic and coordinated care to people who are experiencing complex issues.[160]

Community-led AMPs should be supported to be implemented in communities where a need has been identified and agreed upon to address the risks associated with harmful alcohol use. AMPs must clearly articulate who in the community is responsible for the establishment of the plan. Evaluations of AMPs in the NT recommended the establishment of Alcohol Working Groups to oversee AMPs. To be effective these Alcohol Working Groups require a diverse range of stakeholders, including local government, health and education authorities, relevant law enforcement and criminal justice agencies, alcohol and other drug service users and community representatives, as well as representatives from local liquor outlets and licensees and businesses.[161,162,163] Clarity on the roles and responsibilities of these organisations within the Alcohol Working Group is also critical to the success of the AMP.[164]

Adequate and sustained funding, including funding for treatment services, is paramount to the long term success of AMPs. The evaluation of the Alice Springs AMP found that government funding is required for at least five years to enable communities to develop and imbed AMPs. The evaluation also found that community development positions need to be created to coordinate the Alcohol Working Group and maintain relationships between different interest groups involved. These positions should be jointly funded by the Australian Government and NT Government for at least five years to ensure that the AMP is embedded into the community.[165]

Actions	Government responsible
12. Support policies and programs targeting the reduction of alcohol-related family violence in Aboriginal and Torres Strait Islander communities. Ensure that these policies and programs are community driven, culturally-sensitive, use existing local resources and structures and engage with community leaders including Elders.	Australian, State and Territory Governments
13. Fund and implement community-led Alcohol Management Plans in communities where a need has been identified and agreed upon and according to the following principles: • That plans clearly articulate who within the community is responsible for the establishment plan. • That stakeholders implementing the plan include community representatives as well as local government, health and education authorities, relevant law enforcement, criminal justice agencies, alcohol and other drug services and service users and representatives from local liquor outlets, licensees and businesses. • That clear goals are set to measure change and establish the local evidence-base for the measures to be achieved. • That funding is required for at least five years, including funding for treatment services, to enable communities to undertake and implement these plans. • That funding be allocated to the creation of community development positions to coordinate the work of implementing and evaluating the plans.	Australian, State and Territory Governments

Priority Area 3:

Provide support for people affected by family violence and protect them from future harm

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Provide support for people affected by family violence and protect them from future harm

This priority area responds to the needs of people who have already been affected by family violence in order to prevent further harm. This is also known as tertiary prevention.

Improving service integration and responses can help to prevent the recurrence of violence. Service integration aims to treat the victims' and perpetrators' issues in a holistic manner to ensure that no one falls through the cracks. The aim is to prevent further harms, whether it be by targeting re-offending or re-victimisation.

3.1 Facilitate collaboration between alcohol and other drug services and family violence services to ensure a 'no wrong doors' approach

Integrated and coordinated service models within the AOD and family violence sectors in Australia are rare. Historically, the sectors have worked independently of each other despite the long-recognised association between alcohol and family violence. Part of the reason is that models of treatment for alcohol use disorders have traditionally been focused 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).[166] As a result, the specific needs of women are not always addressed. For example, a woman is unlikely to disclose her experiences of family violence if asked to join a mixed-gender counselling group.

Similar issues exist in child protection and child maltreatment, with a significant proportion of child protection casework related to families with carers who drink problematically or have other risk factors.[167] Research has shown that children whose carers have alcohol problems are more likely to be repeatedly harmed,[168] highlighting the need for child protection services and alcohol services to work together in order to prevent the recurrence of harms.

Unfortunately, significant barriers have existed that prevent effective collaboration between the family violence and alcohol sectors, including lack of knowledge and training. Staff also do not always feel equipped to deal with the issues outside their area of expertise. They may feel awkward or concerned that they are opening a 'can of worms' they are unprepared to provide assistance for.[169] Differences in the professional backgrounds of staff within each sector and between service models also bring challenges to introducing new ways of working.[170] There are also no standardised and comprehensive frameworks that ensure that the complex needs of clients experiencing family violence and alcohol misuse are being met. The family violence sector has also been reluctant to fully embed alcohol issues within

their practice given concerns that doing so would convey alcohol use as an excuse for violence, detracting from the message that family violence, particularly against women, is a result of gender inequality.[171]

Similar issues exist between AOD services and child welfare sectors. Barriers, for the AOD sector, include lack of training and knowledge on how to recognise or respond to child welfare issues.[172] A survey of Australian AOD workers found that most of their clients had children and that most believed identifying and addressing those child's needs were important.[173] However, few AOD workers report having received any training in this area and therefore, not having the confidence to address the needs of the child.[174]

Staff within AOD services may also be reluctant to expand their treatment focus, perceiving family issues as 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.'[175] Other organisational barriers include assessment processes of clients, confidentiality and privacy policies, funding mechanisms and access to resources. [176]

Researchers have also raised concerns about the ways in which child protection workers assess and respond to risk factors, including alcohol. Similarly, there have been concerns that AOD services are not well placed to respond to the children of their clients.[177] It has also been reported that many child welfare workers lack knowledge in the assessment of AOD problems.[178] Studies from the USA suggest that training in AOD positively impacts child welfare workers' knowledge, skills and practices.[179] 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 or losing custody of their children.[180]

Ultimately the sectors have largely operated in isolation. This is often as a result of the nature of funding arrangements and service delivery targets.[181] In 2009, COAG released a *National Framework for Protecting Australia's Children 2009–2020: Protecting Children is Everyone's Business,* acknowledging these divisions.[182] Although these documents and frameworks are in place, there have been limited changes in the way that programs and policies are implemented.[183]

Models of Care, can overcome these barriers and enable systems to work collaboratively, providing a 'no wrong doors' approach. Models of Care broadly define the manner in which health services should be delivered to meet the needs of clients. Such models outline best practice patient care delivery '…through the application of a set of service principles across identified clinical streams and patient flow continuums'.[184] In Australia, 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. To address the complex service needs of family violence victims and their families, Models of Care should be developed to integrate service delivery responses and coordinate the handling of client information.

Policy proposals

All jurisdictions should develop and fund integrated Models of Care for alcohol-related family violence. It is important that states and territories are provided with the necessary funding and resources to develop and implement their own Model of Care to enable various sectors to work together to determine the most appropriate support mechanisms for the client. To these ends, a Model of Care would require:

- Common risk assessment frameworks and shared understanding of alcohol and family violence.
- Inter-sectoral and joint training.
- Standardised approach to information sharing.

For a Model of Care to have an impact on the client's experience of the system, it would require organisational commitment to change and improved referral pathways between services. These commitments and referral pathways should be structured by common risk assessment frameworks, and supported by shared understanding of alcohol and family violence.

The Victorian Government has developed the *Victorian Family Violence Risk Assessment and Risk Management Framework*, also known as the common risk assessment framework (CRAF). CRAF is designed to assist a range of professionals in identifying and responding to family violence, and to foster common understanding and information sharing within and between sectors.[185,186] *Victoria's Action Plan to Address Violence Against Women and Children 2012-2015*[187] has recommended that CRAF be extended for AOD providers, mental health providers, hospitals, GPs and ambulance staff.

A 'no wrong doors' approach to support services must be provided by all sectors so that victims are not turned away from services. The Model of Care should provide structure for collaboration between services to meet the complex trauma-related support needs of these clients in contact with AOD treatment, family violence, mental health and child protection services. 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.[188]

In the UK, work has been undertaken between AOD and family violence services to work together based on a shared understanding of alcohol and family violence. The *Stella Project*, established in 2003, improved cross-sectoral knowledge and service delivery for victims and perpetrators of intimate partner violence as well as their children.[189] 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 family violence.

Embrace was a three year pilot project across England to build capacity within AOD services to work more effectively with families experiencing alcohol and family violence issues. It provided cross sectoral training as well as resources for joint working including the development of template policies and procedures. The evaluation of the project demonstrated that the pilot sites and the staff within these services reported increased confidence in working with families experiencing alcohol and violence issues, and that linkages between local AOD services and family violence services had been cemented.[190]

Within the AOD sector, best practice principles have been developed by National Centre for Education and Training on Addition to support the implementation of initiatives to address issues relating to family violence 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, these principles are:

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.[191]

Professionals across the AOD, family violence and other related sectors should receive inter-sectoral and joint training. This training needs to focus on developing professionals' shared understanding of the issues through cross-agency training and establishing clear governance arrangements and formal partnerships for delivery of training.

Victoria's CRAF materials and training is a model that could be used to broaden sector capability to handle family violence and child protection issues as they arise.

An evaluation of the CRAF training program found that since completing the course, almost three-quarters of participants (72 per cent) were asking questions about family violence, 84 per cent were doing safety plans, and 74 per cent were referring clients to other services. Importantly, 55 per cent had used CRAF since receiving training, and two-thirds (67 per cent) reported that changes to practice took place at an organisational level.[192] The impact of CRAF implementation on clients has not yet been evaluated.

Family violence and child protection workers should ask about AOD use at the same time as they ask about other risk factors such as mental health problems and homelessness. AOD screening tools (such as the AUDIT) should be considered for use within family violence and child protection services as a means of identifying carers who consume alcohol at risky levels. Training should be provided to ensure that staff are confident in using screening tools and providing advice and referrals consistent with the results. Early identification should be followed up with evaluations of service referrals and the effectiveness of these services.

Greater coordination between AOD, family violence and child protection services similarly relies on the sharing of information between services. For the Model of Care to protect the privacy, safety and wellbeing of clients and their children, it needs to deliver a standardised approach to information. This needs to include secure and complementary communication and information sharing between services and consistent data collection and quality assurance processes.

Women who are receiving treatment for their own alcohol problems are at a particularly elevated risk of intimate partner violence because the perpetrator may be concerned about losing control over her and use further violence to regain control.[193] The perpetrator may also stall or prevent her access to treatment. A study from the USA found that women who were currently experiencing intimate partner violence were much less likely than women who were not experiencing intimate partner violence to complete AOD treatment.[194] This needs to be considered and well understood in the delivery of services, in order to keep people safe.

When providing alcohol services to the perpetrators of intimate partner violence, it is essential to note that reductions or stopping alcohol consumption is likely to increase irritability and agitation, which may lead to increased rates and severity of intimate partner violence. The safety of family members needs to be the primary priority if and when a perpetrator undertakes AOD treatment.

Information sharing mechanisms are essential to support agencies and organisations in providing integrated support for children, young people and their families. The sharing and disclosure of client information among agencies has been highlighted as a key challenge in the implementation of policies. The information which is to be shared is highly sensitive in nature, covering 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* to provide guidance for agencies to appropriately share information with each other.[195] These guidelines emphasise 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.[196]

Actions	Government responsible
14. Fund and develop Models of Care between alcohol and other drug services, mental health services, intimate partner violence services, perpetrator programs and child protection services, which incorporate: • Common risk assessment frameworks with a shared understanding of alcohol and family violence. • Inter-sectoral and joint training between sectors. • Joint guidelines and systems that facilitate information sharing about the wellbeing and safety of clients' children between alcohol and other drug services and child protection services.	State and Territory Governments

3.2 Support and develop viable alcohol and other drug services and family violence services sectors

It is essential that both AOD and family violence services are available to support people when they need it the most. There is a small window of opportunity to support vulnerable people who want to access these services.

The *2014 Australian Community Sector Survey* found that the largest gaps in the capacity to meet demand in the community sector exist in areas of the greatest need. That is, among services working most closely with those on the lowest incomes and with the highest levels of need in their communities.[197] An overwhelming majority (80 per cent) of sector services reported they were unable to meet demand, 40 per cent of family and child protection services and 47 per cent of counselling and individual support services were unable to meet demand.[198] Over half (56 per cent) of services delivering AOD treatment are in the not-for-profit sector. Agencies delivering family violence services are also heavily dependent on government funding.

The demand for family violence services is high. An example of this can be seen in the increase in demand for services provided by state and territory agencies. For example, in 2013-14 the ACT Domestic Violence Crisis Service had 15,644 calls to its crisis line, and provided direct intervention for 1,408 people. This increased from 1,096 in 2012-13.[199] 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.[200]

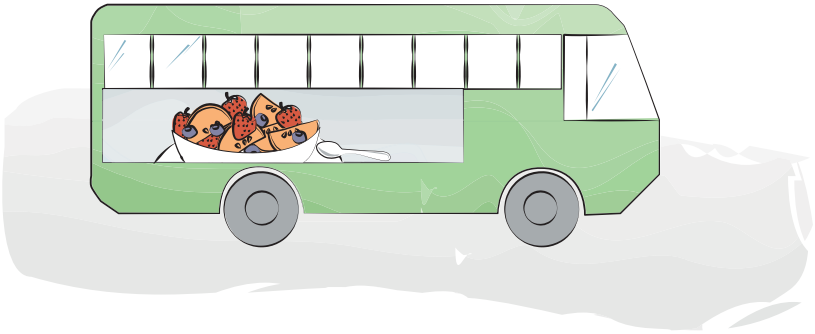
The demand for services in the AOD sector is also high. In Australia there were 714 AOD treatment services which provided 162,400 episodes of treatment in 2012-13 to 108,000 people.[c] Alcohol was the principal drug of concern in 41 per cent of treatment episodes (the highest of any drug of concern).[201] In Victoria, the Auditor General found that since 2005-06 waiting times for residential-based AOD treatment nearly doubled.[202]

The full picture of funding for family violence services in Australia is unclear and as yet, unconfirmed. The 2015-16 Australian Government budget announced two-year extensions in funding to existing Australian Government programs that assist women experiencing family violence.[203,204]

It is disappointing that funding for a long-term and entrenched problem like family violence receives such short-term funding support from governments in Australia.

The Australian Government's Drug Strategy Program aims to reduce harm to individuals and communities from harmful use of AOD. Regrettably, the Budget for the Program was reduced by $98.25 million from $258.8 million in 2013-14 to $160.55 million in 2014-15. These cuts to AOD sector funding have occurred at a time when demand for AOD services has increased. There has been a six per cent increase in the number of treatment episodes across Australia since 2011-12.[205] Waiting lists are also long and act as a barrier to those seeking treatment and support.[206]

There is also significant funding uncertainty, with many services unsure if their funding will be extended beyond the end of the 2014-15 financial year. This uncertainty affects the financial viability of services, constrains an organisation's ability to plan and offer services currently provided and leads to weakened staff retention and 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.[207]



[c] 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 three months and there is a change in the main treatment type, principal drug of concern or delivery setting.

Policy proposals

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

Family violence and AOD services need security of funding through sustained commitments over five year periods. This is important for both the planning and availability of services, building service capacity and development of new services. Lack of funding security ultimately threatens the quality and quantity of services provided which ultimately has an impact on client outcomes. It also makes it difficult to recruit and retain staff which affects not just to the organisation but the sector as a whole.[208]

Family violence funding needs to be adequate, long-term and responsive to demand for family violence support services to ensure continuity of care to clients of these services. If the Australian Government intends on funding family violence services through partnerships with the states and territories, the whole package of funding for this sector from all levels of government needs to be transparent and certain. Demand for family violence services should be consistently measured to identify where funding and resources are needed most.

More funding is needed to enable AOD services to meet client demand. The National Drug and Alcohol Research Centre has estimated that $2.4 billion in funding is required to adequately support those who need help with their AOD use.[209] Yet in 2012-2013, funding by all health departments in Australia was $1.26 billion, with the Australian Government providing 31 per cent of this amount.[210] Alcohol and illicit drugs are responsible for 1.9 per cent[211] of the burden of disease but the percentage of the total health care Budget (estimated at $140.2 billion) spent on AOD services is just 0.9 per cent.[212]

In 2013, the Australian Government commenced a review of the AOD treatment services sector. The final report of the *Review of the drug and alcohol prevention and treatment services sector* included an exploration of funding models to inform robust and sustainable funding for AOD services in the future. The Australian Government has commenced work with state and territory governments to progress further analysis of the review's findings.[213,214] Based on this review, governments should work to develop a longer term funding plan for the AOD sector to allow the sector to plan and deliver services.

Actions	Government responsible
15. Develop a longer term funding plan for family violence services (including Women's Legal Centres) to allow the sector to plan and deliver services.	Australian, State and Territory Governments
16. Develop a longer term funding plan for alcohol and other drug services to allow the sector to plan and deliver services, based on the Australian Government's *Review of the drug and alcohol prevention and treatment services sector*.	Australian, State and Territory Governments

3.3 Ensure that perpetrator programs adequately address the use of alcohol and pilot innovative perpetrator programs

When a perpetrator of family violence is consuming alcohol, they are less likely to be aware of the physical force they are using, and less concerned about consequences. 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.[215] Perpetrators may deliberately get drunk to instigate a fight, or use alcohol to signal to the victim that violence is imminent.[216]

The reduction or cessation of alcohol use has been demonstrated to reduce family violence and improve family relations and functioning. A survey of Australians in recovery from substance addiction (alcohol was the primary drug of concern for 66 per cent of participants) found reported improvement in life outcomes following recovery compared to those in the active addiction phase. Half of participants reported being a victim or perpetrator of family violence in the active addiction phase, compared to less than ten per cent in the recovered or recovery phase. Furthermore, there were marked improvements in other life outcomes that are often risk factors for family violence. This includes improved financial situation, more proactive healthcare behaviours, fewer legal problems, higher participation in education and the workforce, and regaining custody of children.[217]

The link between alcohol use and risk of perpetration is increasingly being recognised in treatment and legal systems. In NSW, under Section 35 of the *Crimes (Domestic and Personal Violence) Act 2007*, Apprehended Violence Orders can stipulate restrictions on the defendant's behaviour including prohibiting them from approaching the protected person within 12 hours of consuming alcohol or drugs.[218]

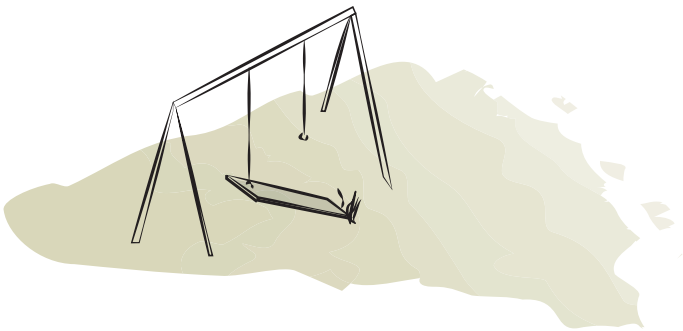
In the USA, the 24/7 Sobriety Program, first introduced in 2004 in parts of South Dakota, required people arrested or convicted for alcohol-related offences to take two alcohol breath tests a day or wear a continuous alcohol monitoring bracelet with immediate, consistent yet modest sanctions. The program originally targeted repeat drink drivers but has been modified to include other alcohol-related crimes (including family violence) and adopted in more jurisdictions across the USA.[219] This project found a nine per cent reduction in intimate partner violence arrests following the implementation of the program.[220] This occurred despite the fact that the program initially targeted drink driving reoffenders before expanding to perpetrators of broader types of alcohol-related crimes.

There are also programs that specifically aim to change the behaviour of men who are perpetrators of family violence. Perpetrator counselling programs began to appear in the late 1970s and early 1980s 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. Some programs involve group sessions, others focus on the individual and many use a combination of these approaches depending on organisational principles, the availability of resources and the needs of the clients.[221]

Men's behaviour change programs also vary in how they approach the alcohol use of their clients. Men presenting to a program intoxicated will often be excluded from participation until they are able to attend sober. Most programs will refer a participant to an AOD service and only resume communication with him if or when he returns to the behaviour change programs sober. Other programs will integrate a man's AOD treatment alongside their progress in the behaviour change program. A small number of behaviour change programs will also provide preventive AOD intervention to men with past problems with alcohol or drugs. This is because participation in the behaviour change program may trigger feelings of shame and guilt, making them vulnerable to relapse.[222,223]

The effectiveness of men's behaviour change programs in Australia have not been formally evaluated. Internationally, *Project Mirabal* evaluated the efficacy of programs targeting perpetrators of family violence in the UK. It found that 12 months after commencing a program, most men had completely ceased using physical or sexual violence as well as other threatening or harassing behaviours. Women and children were more likely to feel safer after the perpetrator completed the program.[224] [225]

Currently, there is no formalised and unified approach employed across men's behaviour change programs in Australia when dealing with a perpetrators use of alcohol. This need, to improve interventions for perpetrators of family violence, has been recognised in the *Second Action Plan* of the National Plan. The Australian Government is providing $4 million in funding to support states and territories to update and align their standards for perpetrator interventions with national outcome standards for perpetrator interventions. To support the development of these national standards, Australia's National Research Organisation on Women's Safety has been funded to implement a specific research stream on perpetrator interventions to investigate what factors will optimise their success.[226] The extent to which alcohol will be considered in these national outcome standards for is unclear.



Minimum standards for men's behaviour change programs vary across states and territories. The NSW Government's minimum standards for men's behaviour change programs stipulate that program providers must provide appropriate referrals to men who have additional needs such as alcohol treatment.[227] Victoria's *Men's behaviour change group work: Minimum standards and quality practice* provides further recommendations for alcohol. These minimum standards were funded by the Victorian Government and produced in 2005 by No To Violence, the Victorian statewide peak body of organisations and individuals working with men to end their violence and abuse against family members. The Victorian minimum standards recommend that screening of men for substance issues takes place prior to their participation in the program. Once established, there also needs to be formal intra/inter-provider communication in relation to their substance abuse.[228]

Policy proposals

National outcomes standards for perpetrator interventions must include strategies to address alcohol misuse. These strategies include a common risk assessment framework, referral pathways, and cross-sectoral training and collaboration. Perpetrator programs must comply with these standards when managing clients with alcohol issues. As acknowledged in the Senate Finance and Public Administration Committee *Interim Report into Domestic Violence in Australia*, perpetrator programs need to be supported by adequate funding in order to achieve effective service delivery. Formal evaluations of perpetrator programs in Australia, particularly in relation to addressing alcohol, are needed in order to determine what works and inform progress.

The 24/7 Sobriety Program should be piloted in an Australian jurisdiction targeting perpetrators of alcohol-related crimes. The pilot should be formally evaluated with the aim of improving the process before it is rolled out in other jurisdictions across the country. It is important to note that, as with all interventions designed to decrease or cease the perpetrator's alcohol consumption, the safety of family members is the priority. Treatment for alcohol problems can increase the risk for violence due to the discomfort of physiological or psychological withdrawal heightening a perpetrator's anxieties and irritability.[229] Implementation of the 24/7 Sobriety Program is best where the victim and perpetrator are not living together, or where the perpetrator has already undergone a period of sobriety (e.g. after release from prison or remand) such that physical withdrawal from alcohol will not be an issue.

The 24/7 Sobriety Program must be complemented by a long-term multifaceted approach that addresses the social and health environment of the individual and acknowledges the increased risk of further violence. Men's behaviour change programs aim to change the deeply entrenched attitudes and behaviours that lead to violence. 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 individuals that relate to treatment, and being responsive and flexible to the learning styles and motivations of the perpetrator.[230] In situations where family violence is alcohol-related, integration and/or collaboration between AOD treatment services and family violence services will increase program effectiveness.[231]

Actions	Government responsible
17. Ensure that national outcomes standards for perpetrator interventions include strategies to address alcohol misuse.	Australian, State and Territory Governments
18. Pilot a court-based sobriety program, based on the South Dakota 24/7 model for alcohol-related offences.	Australian, State and Territory Governments

Priority Area 4:

Continue to build the evidence-base by investing in data collection and evaluation

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Continue to build the evidence-base by investing in data collection and evaluation

This priority area aims to support all levels of prevention by informing policy makers about the incidence of family violence and the impact that various interventions have on reducing this violence.

The collection and surveillance of data is important as it provides information on the extent of family violence 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 in comparing between one time period and another. Surveillance of trends over time is important not only for policy development but also service planning.

4.1 Invest in data collection and public reporting of alcohol's involvement in family violence

Current health and alcohol consumption data are integral in conceptualising the impact of alcohol on the Australian community, including family violence. Data on alcohol-related family violence 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 family violence being a largely 'invisible' problem, self-reporting is considered a more reliable gauge of the nature and extent of alcohol-related family violence.

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 complemented 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. As many as half of intimate partner violence occurrences are unreported and not all Australian jurisdictions collect this data consistently.[232]

As part of the National Plan, all jurisdictions have committed to a national data collection and reporting framework. It aims to create nationally consistent data definitions and collection methods. It is intended that the national data collection and reporting framework will be operational by 2022.[233] The collection and reporting of alcohol-related family violence incidents should be included as part of this work. At present, NSW,[234] Victoria,[235] NT[236] and WA[237] collect and report on statistical data on alcohol's involvement in intimate partner violence.

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 alcohol-related child maltreatment incidents separately to intimate partner violence incidents would provide greater detail on child maltreatment and the prevalence of children affected by alcohol-related family violence. Considerable improvement is also needed in the recording of alcohol involvement in incidents in police reports, child protection investigations, and in schools and hospitals records. A combination is needed of a mandatory check-box on whether and to what extent alcohol is involved in the situation or incident. To guide this, there needs to be clear 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 family violence.

There is also limited data available on the extent of alcohol's involvement in intimate partner violence deaths and child maltreatment deaths. Governments in NSW, Queensland, Victoria, WA and ACT have formed review bodies for cases of individual deaths related to intimate partner violence and family violence, and child deaths.

In May 2015, the Victorian Government announced *Measuring the toll: The family violence index.*[238] This document declares the government's intention to launch a world-first family violence index to better understand the scale of family violence in Victoria.[239] The index would use data collected from the fields of crime, justice, health, education and the community sector. While it is encouraging to see plans to develop such a tool for tracking and monitoring family violence, the proposal neglects to recognise the involvement of alcohol in family violence.

Policy proposals

Ensuring data is collected in a consistent manner is a crucial to understanding the prevalence of alcohol-related family violence. 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, data on AOD treatment, hospitalisations and child protection should be collected, to build a complete picture of alcohol's involvement in alcohol-related family violence.

The amount of alcohol consumed in Australia is estimated by the ABS through the apparent per capita consumption of alcohol. Until 1996 this data was based on state and territory alcohol sales data, which is when most states and territories stopped collecting alcohol sales data. In WA, the NT and Queensland, the *National Alcohol Sales Data Project* continues to report on per capita consumption based on alcohol sales data,[240] which provides more accurate estimates of consumption. It is important that alcohol sales data is collected consistently across the country.

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

Researchers and service providers 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.

The Australian Government should develop a national family violence index, modelled on Victoria's proposed family violence index, which also includes alcohol-related family violence data. Alcohol harms data must be included in any index of family violence given the significant involvement of alcohol in family violence.[241] Inclusion of alcohol-related family violence information would ensure that the involvement of alcohol in family violence and efforts to prevent it are accounted for and monitored.

Agencies responsible for collecting alcohol-related family violence data should ensure that policies are in place that clearly outline the requirements for data collection. This includes requiring the examination of alcohol involvement in deaths brought before review bodies for family violence, intimate partner violence and child deaths. This will assist agencies to collect consistent and comparable data.

Actions	Government responsible
19. Improve data collection on alcohol and family violence by consistently collecting alcohol sales data and data on alcohol's involvement in police incidents, ambulance and emergency hospital presentations and child protection cases. Ensure that Domestic and Family Violence Death Reviews and Child Death Review Committees in each state and territory account for the use of alcohol in the reviews.	Australian, State and Territory Governments

4.2 Consistently and systematically invest in the evaluation of policies and programs to prevent alcohol-related family violence

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. To ensure that initiatives to prevent alcohol-related family violence are effectively implemented, adequate resourcing needs to be provided to evaluating the outcomes of these initiatives.

A range of evaluation activities are being undertaken to assess how the Australian Government is progressing against the National Plan. These activities include:

- Reviews of three-yearly Action Plans: these will reflect on the success of the previous Action Plan to inform the development of the next Action Plan.
- Annual progress reporting: these are a key monitoring, accountability and communication activity under the National Plan.
- Evaluation of flagship activities: this involves the evaluation of key national initiatives under the National Plan.
- Underpinning evaluation activities: this includes analysis of the considerable and increasing amount of data available to measure women's safety, including the *Personal Safety Survey* and *National Survey on Community Attitudes towards Violence against Women*.[242]

The Evaluation Plan for the National Plan states that the following high-level indicators of change will be used to assess progress:

- Reduced prevalence of intimate partner violence and sexual assault.
- Increased proportion of women who feel safe in their communities.
- Reduced deaths related to intimate partner violence and sexual assault.
- Reduced proportion of children exposed to their mother's or carer's experience of intimate partner violence. [243]

The Evaluation Plan for the National Plan does not address the contribution of alcohol to family violence in Australia. This is a serious short-coming of the Evaluation Plan, given the extent to which alcohol contributes to family violence in Australia. References to alcohol in the Evaluation Plan are limited to equipping the mainstream workforce to undertake early identification and intervention or referral for women experiencing violence. The Evaluation Plan notes that evaluations of government initiatives and other data reports regarding alcohol (among other related areas) could also inform the monitoring and evaluation of the National Plan. What is imperative is that evaluations of the National Plan are not an exercise to be treated as an end in itself. According to the National Commission of Audit, 'Across government, the quality of evaluations is variable, with evaluation activity [taking place] on an ad hoc rather than systematic basis'.[244] The National Commission of Audit further cautioned that: 'While evaluations are useful for ongoing programme management, the limited visibility of evaluation at the centre of government decision-making, the Budget process, indicates that even the evaluation currently being undertaken is not being used to its potential.'[245]

Evaluations of the National Plan need to be used as a vital means of informing government decision-making pursuant to the prevention of intimate partner violence. Without systematic evaluations, there is poor visibility of how the system has supported, and how it should evolve to continue supporting victims and perpetrators to move beyond their experiences of family violence.

Policy proposals

Evaluation processes should form an integral part of the implementation of any alcohol-related family violence 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. Jurisdictions in Australia that have well-established evaluation frameworks in place include NSW (the *NSW Government Evaluation Framework)*[246] and the ACT (*Strengthening Performance and Accountability: A framework for the ACT Government*).[247]

Evaluations of the National Plan should serve to inform key decision-makers as to:

- The current state of the issue being addressed.
- How the situation has changed over time.
- How initiatives underway and planned for implementation should evolve to better meet the needs of victims and perpetrators of family violence.
- The cost of initiatives to date against the outcomes achieved.
- The distribution of funds between frontline services and bureaucratic oversight.

The evaluation should seek to examine the following high-level indicators of change to assess progress in preventing alcohol-related family violence:

- Reduced prevalence of alcohol involvement in intimate partner violence and sexual assault.
- Increased proportion of women who complete AOD treatment programs in tandem with their family violence support programs.
- Reduced deaths from alcohol-related family violence.
- Reduced the number of children exposed to alcohol-related family violence.[248]

Any evaluation framework needs to be developed in consultation with a range of experts including researchers and the agencies that are collecting and reporting the data.

Actions	Government responsible
20. Fund the evaluation of policies and programs to prevent alcohol-related family violence, and disseminate and translate the findings of these evaluations.	Australian, State and Territory Governments

Actions to reduce alcohol-related family violence

Priority Area	Actions	Government responsible
Primary prevention ***Introduce whole of community action to prevent family violence.***	**1.1 Reduce the physical availability of alcohol.** 1. Task the Council of Australian Governments to implement uniform minimum principles for liquor licensing legislation across states and territories to limit the excessive availability of alcohol which is leading to increased violence. The consistent principles should address three priority areas: • Preventing areas from becoming saturated with liquor licenses, by: - Introducing time-limited liquor licences, which are reviewed at least every five years. - Elevating harm minimisation as the only primary Object of liquor licensing legislation. - Reforming licence application processes to include as primary considerations the density of liquor licences in an area, the socio-economic status of the area, the existing levels of alcohol-related violence, and community views. • Reducing the excessive availability of alcohol in areas saturated with liquor licences, by: - Undertaking assessments of existing liquor licence density and levels of alcohol-related violence to determine whether areas are 'saturated' with liquor licences. - Where an area is deemed to be saturated, a licence freeze should be imposed and licence buy backs undertaken. • Introducing restrictions to reduce the excessive availability of alcohol, by: - Introducing a closing time of no later than 3am for on-licence venues (pubs, clubs or bars) and a 1am lockout. - Limiting off-licence (packaged liquor) trading hours to between 10am and 10pm. - Terminating all 24 hour liquor licences. - Introducing precinct-wide measures including restrictions to days or hours of trading.	State and Territory Governments
	1.2 Reduce the economic availability of alcohol. 2. Reform the alcohol taxation system to allow alcohol to be priced according to the volume of alcohol within a product and the potential of the product to cause harm, by: • Abolishing the Wine Equalisation Tax and replacing it with a volumetric tax rate for all alcohol. The rate for wine should be transitioned to a differentiated rate that is based on the alcohol content of wine. • Applying a levy through the alcohol taxation system to pay for the costs incurred by Government in responding to family violence.	Australian Government
	1.3 Regulate the promotion of alcohol. 3. Introduce national legislation modelled on Tobacco Advertising Prohibition Act 1992 (Cth) to phase out alcohol advertising from print, films, videos, television, radio, the internet, tickets, sponsorship, and outdoor advertising on billboards. 4. Strengthen state and territory regulation of alcohol advertising and promotions by: • Prohibiting alcohol advertising from taking place on public property. • Applying alcohol promotion regulations to both on- (bars, pubs and clubs) and off-licence (packaged liquor) premises.	Australian, State and Territory Governments

Priority Area	Actions	Government responsible
	1.4 Conduct sustained social marketing campaigns and school-based education on preventing family violence and ensure that the role of alcohol is adequately featured. 5. Include information on the role of alcohol in family violence in the $30 million Council of Australian Governments' awareness raising campaign to reduce family violence. 6. Require all school-based respectful relationships programs to include information on the role of alcohol in family violence.	Australian, State and Territory Governments
Secondary prevention ***Assist people most at risk of family violence through early identification and support***	**2.1 Support family-centred programs for people with alcohol and other drug problems.** 7. Fund alcohol and other drug services to adopt child and family sensitive practice in all their programs. 8. Fund residential alcohol and other drug services for families, including culturally-sensitive residential services for Aboriginal and Torres Strait Islander families. 9. Extend funding for positive parenting programs, such as *Parents Under Pressure* and *Kids in Focus*, for children and families identified as being affected by, or at risk due to parental alcohol misuse.	Australian, State and Territory Governments
	2.2 Conduct screening programs for alcohol in healthcare settings. 10. Implement a screening and brief intervention program for risky alcohol use in health settings, which includes: • Training for health professionals on how to administer screening tools and the advice to provide. • Developing clear referral pathways between healthcare, alcohol and other drug and family support services.	State and Territory Governments
	2.3 Identify and support children and young people at risk of child maltreatment. 11. Require health professionals and educators to be trained in the early identification and referral processes for child maltreatment.	State and Territory Governments
	2.4 Close the gap on the higher prevalence of alcohol-related family violence among Aboriginal and Torres Strait Islander peoples. 12. Support policies and programs targeting the reduction of alcohol-related family violence in Aboriginal and Torres Strait Islander communities. Ensure that these policies and programs are community driven, culturally-sensitive, use existing local resources and structures and engage with community leaders including Elders. 13. Fund and implement community-led Alcohol Management Plans in communities where a need has been identified and agreed upon and according to the following principles: • That plans clearly articulate who within the community is responsible for the establishment plan. • That stakeholders implementing the plan include community representatives as well as local government, health and education authorities, relevant law enforcement, criminal justice agencies, alcohol and other drug services and service users and representatives from local liquor outlets, licensees and businesses. • That clear goals are set to measure change and establish the local evidence-base for the measures to be achieved. • That funding is required for at least five years, including funding for treatment services, to enable communities to undertake and implement these plans. • That funding be allocated to the creation of community development positions to coordinate the work of implementing and evaluating the plans.	Australian, State and Territory Governments

Priority Area	Actions	Government responsible
Tertiary prevention ***Provide support for people affected by family violence and protect them from future harm***	**3.1 Facilitate collaboration between alcohol and other drug services and family violence services to ensure a 'no wrong doors' approach.** 14. Fund and develop Models of Care between alcohol and other drug services, mental health services, intimate partner violence services, perpetrator programs and child protection services, which incorporate: • Common risk assessment frameworks with a shared understanding of alcohol and family violence. • Inter-sectoral and joint training between sectors. • Joint guidelines and systems that facilitate information sharing about the wellbeing and safety of clients' children between alcohol and other drugs service and child protection services.	State and Territory Governments
	3.2 Support and develop viable alcohol and other drug services and family violence services sectors. 15. Develop a longer term funding plan for family violence services (including Women's Legal Centres) to allow the sector to plan and deliver services. 16. Develop a longer term funding plan for alcohol and other drug services to allow the sector to plan and deliver services, based on the Australian Government's *Review of the drug and alcohol prevention and treatment services sector*.	Australian, State and Territory Governments
	3.3 Ensure that perpetrator programs adequately address the use of alcohol and pilot innovative perpetrator programs. 17. Ensure that national outcomes standards for perpetrator interventions include strategies to address alcohol misuse. 18. Pilot a court-based sobriety program, based on the South Dakota 24/7 model for alcohol-related offences.	Australian, State and Territory Governments
Research and evaluation ***Continue to build the evidence-base by investing in data collection and evaluation***	**4.1 Invest in data collection and public reporting of alcohol's involvement in family violence.** 19. Improve data collection on alcohol and family violence by consistently collecting alcohol sales data and data on alcohol's involvement in police incidents, ambulance and emergency hospital presentations, child protection. Ensure that Domestic and Family Violence Death Reviews and Child Death Review Committees in each state and territory account for the use of alcohol in the reviews.	Australian, State and Territory Governments
	4.2 Consistently and systematically invest in the evaluation of policies and programs to prevent alcohol-related family violence. 20. Fund the evaluation of policies and programs to prevent alcohol-related family violence, and disseminate and translate the findings of these evaluations.	Australian, State and Territory Governments

Definitions

The following definitions and terms are used in this Framework.

Family violence refers to violence between family members (including parents, step-parents or guardians, siblings, cousins, aunts/uncles, and grandparents).[249] It may be perpetrated between adults, by adults on children or by children on parents. References to family violence in the Framework should be interpreted to incorporate both intimate partner violence and child maltreatment.

Intimate partner violence refers to acts of abuse that occur between people who have, or have had, an intimate relationship. While there is no single definition, intimate partner 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 used 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.[250]

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).[251] Other psychological threats include threatening to hurt children, family members or pets. Intimate partner 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.[252]

This Framework uses the terminology of intimate partner violence rather than domestic violence.

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).[253] The responsibility for child maltreatment or abuse always rests with the perpetrator and never with the child.

WHO defines child maltreatment as including: physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.[254] 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[255]), 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).[256]

Children can also directly witness or overhear physical or psychological violence between adults as it occurs, or see 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.[257]

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