Alcohol and child maltreatment in Australia through the windows of child protection and a national survey

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Abstract

This thesis describes the adverse effects of others’ drinking on children as viewed through two different windows. The first focuses on children in the Victorian child protection system. It examines how many, and in what ways children have been affected by the drinking of their carers as recorded by child protection workers between 2001 and 2005 in routine electronic databases. In the second window, national survey data are used to estimate the prevalence of households where children have been affected by someone else’s drinking in the last year, using questions that stem from key definitions of types of child maltreatment.

This research

i) documents the extent of alcohol involvement in child protection cases in Victoria,

ii) explores and defines risk factors for child protection outcomes, including the role of alcohol, comorbidities and socio-economic factors,

iii) assesses the number of Australian households where children have been affected by someone else’s drinking, and

iv) compares the size and social location of alcohol-related harms to children in the child protection system and the general population.

Carer alcohol abuse was reported in a third of all substantiated child protection cases across Victoria. Alcohol was implicated in 27% of physical, 12% of sexual, 39% of emotional and 35% of neglect cases. As further intervention was required, the percentage of cases that involved alcohol increased – from 25% of cases that were substantiated but required no further intervention, to 42% of cases that involved court orders.

Alcohol abuse and multiple other “risk factors”, including likely other drug abuse, carer mental ill-health, unstable housing, low income levels and single parent family composition, were associated with the greater likelihood of receipt of more serious child protection interventions and repeated experiences of child maltreatment.

Alcohol-related harm to children in the general population was also measured. One in five (22%) respondents or Australian families reported that their children had been affected in at least some way by others’ drinking in the past year. One per cent reported a child being physically hurt, 9% reported verbal abuse, 3% reported exposure to domestic violence and
3% reported a child being left alone or unsupervised because of others’ drinking. These alcohol-related harms to children were prevalent across the socio-economic strata examined.

A greater proportion of alcohol-related harm to children in the community exists in middle and high income groups, although there was a higher prevalence of more severe community harm to children in the lower income group. The vast majority of cases in the child protection system were from disadvantaged groups. This suggests there is underestimation of the risks of others’ drinking for children in the general population, and that government child protection service responses are driven by closer scrutiny of low income groups as well as greater need.

The two windows of the study indicate that alcohol-related harms to children from others’ drinking are prevalent. To prevent and minimise further harm to children from their carers’ and others’ heavy drinking, alcohol and child protection policy responses are required.
Declaration

This is to certify that:

(i) the thesis comprises only my original work towards the PhD, except where indicated in the Preface,

(ii) due acknowledgement has been made in the text to all other material used,

(iii) the thesis is fewer than 100,000 words in length, exclusive of tables, maps and bibliographies.
Preface

Four papers have been published that relate in part or substantially to the contents of this thesis. The relationships between the chapters of the thesis and the papers, and the extent of the advice and assistance I received in writing these pieces are detailed below.

Chapter 5 includes aspects of the methodology detailed in

However, Chapters 5 and 9 of this thesis examine child maltreatment outcomes that were not included in the above paper.

Chapter 7 is based on

The candidate was responsible for the generation of the concept, the majority of the writing and undertook all analyses. Advice on statistical analysis and editing of drafts was provided by Room and Dietze.

Chapter 8 draws heavily upon

The candidate was responsible for the generation of the concept, the majority of the writing and undertook all analyses. Advice on statistical analysis was obtained from Ferris and Dietze and editing of drafts was provided by Room and Dietze.
Chapter 9 is based on


The conception of the project, including question development was undertaken in conjunction with Room. The candidate was responsible for the majority of the writing and conducted all analyses. Advice on statistical techniques and interpretation was obtained from Ferris and Dietze. Editing of drafts was provided by Room and Dietze.

No work was submitted for other ‘qualifications’, or carried out prior to PhD candidature enrolment.
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The Child Protection Unit of the Victorian Department of Human Services, deserves a particular mention for not only providing me with access to de-identified data on the clients in their care but also for answering my many queries about the nature of the data and child protection work in Victoria more generally.

In an era where the public are becoming increasingly impatient with telephone surveys I thank the many people who gave of their valuable time to answer our survey questions.

My fantastic colleagues at the Centre for Alcohol Policy Research assisted me in countless minor and major ways on a daily basis – they have made working and studying a collaborative joy. On those odd occasions that have been not so joyful they have been supportive and understanding. Thank you! In particular Robin Room, our leader, has brought
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Chapter 1 Drinking and parenting

The kids are finally asleep. Or you're cooking dinner after a stressful day at work, listening to your darlings fighting over whose turn it is on the computer or which TV show to watch. No matter, a glass of wine is at the ready. This is downtime, decompression time, kick-back time. This is wine o'clock, when one glass becomes two or sometimes three, when parenting's endless Groundhog Day feels a little easier to endure when accompanied by mummy's little helper.

And

Social drinking is woven into the very fabric of parental life: school fundraising events and sports events, barbecues and picnics, where there's one Esky for the kids and one for the adults.

(Johnson, 2013, pp. 1-2)

1.1 Introduction

Alcohol is widely used in Australia, not always responsibly, and mostly in "leisure time" (Room, 1988). For families with children, most "leisure time" is also "family time" (Bittman & Wajcman, 2000). Families with young children tend to have relatively young adults as parents, and heavy drinking is common at this life-stage (Australian Institute of Health and Welfare, 2011). Although most adults consider it unseemly for an intoxicated adult to be in charge of young children (NSW Department of Community Services, 2006), many Australian parents drink (Dawe et al., 2007). Recently, in a poll of Australians, 79% of drinkers with children under 18 years living in their home reported consuming alcohol around their children (FARE, 2013).

This thesis is about problematic drinking and parenting, in the general population, and how this may result in harms to children. This view of alcohol-related maltreatment forms the first research “window” of the dissertation. In a second window the child protection system’s view is examined. The thesis considers how formal child protection systems record and manage a range of alcohol-related harms and examines what the outcomes for children are when their carers drink heavily. After analysing how alcohol abuse of carers is linked to protective interventions and recurrence of child abuse and neglect, and examining alcohol-related harms
to children in the general population via the national survey of alcohol’s harm to others, the size of these problems are compared, and which groups in society are affected by these problems is examined. The implications of the findings for parenting, the child protection system, and alcohol policy will also be examined.

However, prior to this it is important to consider how drinking-related harms to children are defined and present in the general population, and in the child protection systems that have developed to respond to these problems. This chapter considers the range of ways in which drinking of parents and carers may affect children.

There are situations where drinking by adult carers appears to be more acceptable; for example, if only one or two drinks are consumed – and there is no evidence that drinking at this level whilst caring for children presents an immediate risk to children. In unpublished data from a survey of gender, alcohol and culture, including adults’ attitudes to parents’ drinking around small children in Victoria, Australia, 49% of respondents felt no drinking (49%) or consumption of only one or two drinks (45%) was considered acceptable (Matthews, 2012). Only 6% thought it was OK to drink “enough to feel the effects” around them. But while these answers tell us what is normative, there is evidence that in practice children are exposed to a range of different drinking patterns of their parents and others at social occasions (Adamson & Templeton, 2012; Allan, Clifford, Ball, Alston, & Meister, 2012; Cook, 2005; Jayne, Valentine, & Holloway, 2011; Velleman & Templeton, 2007).

In Finland, drinking to intoxication was also unanimously disapproved of around small children. However, if someone else was in charge of the children (e.g., the mother, whilst the father drinks), 40% of respondents regarded this as acceptable (Raitasalo, 2011). Respondents in this study reported that children were present at 12% of their drinking occasions, and that 24% of all drinking occasions were heavy drinking occasions (calculated to be at the BAC level of .05 or greater), suggesting that while respondents may disapprove of drinking around children, many still do so. Women’s attitudes and drinking behaviours were significantly correlated with each other in this study, whereas men’s were not (Raitasalo, 2011), suggesting that men were more likely to drink around children regardless of their reported general disapproval of drinking to intoxication around children. Of course, the lack of correlation may also mean that some men are not drinking around children although approving of it.
In the United States it has been estimated that one in four children is exposed to the effects of alcohol abuse or dependence of a family member (Grant, 2000). In the United Kingdom an estimated 30% of children (or 3.3-3.5 million children) live with at least one “binge drinking” parent (the United Kingdom the definition of binge drinking is greater than 6 standard drinks [equivalent to 8gm of pure alcohol in the United Kingdom] on the one occasion for women in the last year, and greater than 8 drinks for men) (Manning, Best, Faulkner, & Titherington, 2009). Indeed the estimates of the proportion of children living with problematic drinkers vary widely between countries: in 2006 in Lithuania a reported 3% of children aged 0-18 years grew up with a parent who misused alcohol, whereas in Finland and Poland the corresponding figures were around 10% and 19% respectively (Harwin, Madge, & Heath, 2010).

Like parents in other countries, whilst Australians do not approve of drinking too much when parenting, those of child-bearing and child-raising age do quite a bit of drinking. Dawe et al. (2007) estimated that 13% of children are at risk of exposure to short-term risky drinking in Australian households by at least one adult. Further analysis suggested that around 25% of fathers and 10% of mothers (in couple-plus-children families) had “binge drunk”, i.e., had drunk at short-term risky levels (>5/7 drinks for women/men on an occasion), two or more times a month in the past year (Dawe et al., 2007). When compared to the broader population (Australian Institute of Health and Welfare, 2008c), these figures suggest that Australian mothers are less likely to binge-drink than women in their age group overall, whilst fathers are slightly less likely to binge-drink than other men their own age, but not as much less as mothers. In a more recent analysis of Australian national survey data, which has been adjusted to better gather this information, Maloney et al. (Maloney, Hutchinson, Burns, & Mattick, 2010) reported that fathers were more likely than mothers to report problematic drinking patterns. However, these parents may choose only to drink riskily when their children are not with them. Whether the drinking occasions of parents were in the presence or absence of their children was not specified in the Dawe et al. study. This is a common feature of national drinking surveys and polls, which often do not ask whether children were present for the parent’s drinking, or whether children were harmed because of a carers’ or others’ drinking.
1.2 The range of effects of carers’ drinking on children

There is evidence from numerous sources that outcomes for children can be affected by their carers’ drinking (Adamson & Templeton, 2012; Dawe et al., 2007; Forrester & Harwin, 2008; Orford, Velleman, Copello, Templeton, & Ibanga, 2010; Velleman & Templeton, 2007), and that these effects vary in prevalence and severity. A hangover may mean parents are impatient with their children when they ask them for something or want to tell them something on a Sunday morning. Or intoxication may affect parents and others who are already struggling to cope with children, and repeatedly result in incidents of verbal or physical abuse or neglect. Parents may also be less able to protect their children from others in various situations if they are intoxicated. Heavy drinking by multiple members within households, including adult children or other underage children or other relatives, may mean that children are at greater risk of experiencing adverse effects in family environments that allow or support heavy drinking. Velleman and Templeton (2007) summarise years of work and report a range of ways in which families have been affected, including by disruptions to rituals, parent-child roles, routines, communication, social connectedness, finances and relationships. Children’s experiences of such problems may be one-off, intermittent or chronic, and both short-lived and ongoing problems may have long-term effects (Kroll & Taylor, 2003).

Children can be affected by the drinking of their carers or parents in a range of different ways that occur along a spectrum of severity. At one end of the spectrum, parental drinking may mean parents model poor drinking behaviours. Research suggests that parental drinking patterns, of both mothers and fathers, can contribute to increased problematic drinking patterns for their children (Raitasalo, 2011; Smith, Miller et al., 1999; Wilks et al., 2006; Yu, 2003). Parents may also find it difficult to maintain routines and be unable to take children to organised early morning sports matches because they are hung over occasionally or more often (Velleman & Templeton, 2007).

At the other extreme, parental drinking may play a role in accidental child deaths, infanticide, assault, and extreme cases of neglect and child abuse (Victorian Child Death Review Committee, 2009). Problems because of a parent’s drinking may be limited or ongoing, for example affecting supervision at one-off social functions, or at the other end of the spectrum hindering a child’s development over many years if the child is inadequately fed, clothed and looked after (Laslett et al., 2010).
Perceptions about how children are harmed may also differ depending on whether it is the perspective of the drinker, the other parent or carer in the relationship, or the child that is asked. In an Australian survey of children who called the phone help service, “Childline,” parental alcohol misuse was identified by children as connected to a broad range of problems, including running away, violence in the home, physical abuse, sexual abuse, neglect and poor family relationships (Tomison, 1996). In the United Kingdom, focus groups with children and reviews of the literature revealed that children of alcohol misusing parents were neglected and physically hurt, felt that their families did not function as they should have, felt ashamed, considered that they had missed out on childhood, and had normalised awful situations, and felt they were not prioritised in their parents’ lives (Adamson & Templeton, 2012).

A body of research examining how children have been affected by others’ drinking comes from child protection system sources. Carer alcohol abuse (and other drug abuse) has been linked to confirmed cases of child abuse in many studies from different countries in the “World report on violence” (Gilbert, 2009; Krug, Dahlberg, Mercy, Zwu, & Lozano, 2002), in the United Kingdom (Forrester & Harwin, 2008) and in North America (Fluke & Shusterman, 2005; Trocme et al., 2005). In these studies it is usually child protection workers’ reports that form the basis of the dataset that is examined, describing the contributing factors and family situations as well as the outcomes for children. Whilst taking into account the perspectives of all involved parties in their investigations, and considering the child’s needs as paramount, child protection workers determine and record whether abuse has occurred, whether the threshold for intervention has been breached or not, and whether parental drinking played a role. Alcohol-related child maltreatment, as managed by child protection systems, is discussed in Chapter 2.

However, where cut-offs are set between good, adequate, and neglectful or abusive parenting is arbitrary and the subject of broader public debate (Adamson & Templeton, 2012; Bita, 2012; Tucci, Mitchell, & Goddard, 2008; Wake, 2012). The media highlights stories of heavy drinking parents and the consequences of child abuse in Australia (Murphy & McArthur, 2012), and overseas (Smith, 2013). For example, in Australia a child’s understanding of alcohol problems in Western Australia became a news headline, “Go and take the grog away, and then we will have mum and dad back” (Taylor, 2009). These stories are commonly about alcohol abuse in disadvantaged families and less often about single incidents of intoxication,
but in the Algarve in Portugal, three British children were taken into custody after their parents drank so much they both passed out, in what was described as an ‘out-of-character’ incident (Batty & Adetunji, 2008). Incidents and on-going problems have for decades been reported in families, for example affecting Christmases and other rituals (Cork, 1969; Orford & Harwin, 1982). What is ‘good enough’ parenting is also the subject of numerous child-rearing books (Biddulph, 2013; Wake, 2012), but alcohol’s involvement in parenting problems, aside from the effects of parental behavioural modeling in subsequent development of teenage drinking patterns (e.g., Green, Macintyre, West, & Ecob, 1991; Vermeulen-Smit et al., 2012), has been more commonly researched in marginalised heavy drinkers than in general population samples (Adamson & Templeton, 2012), and analyses have often underlined the most serious effects from the perspective of informing treatment responses.

There are a range of parenting and family situations that involve problematic alcohol use, as well as reasons why drinking can be problematic and push the situation over the threshold for poor parenting. Given that there is evidence that drinking increases the severity of domestic violence between spouses (Fals-Stewart, 2003; Graham et al., 2008; Graham, Plant, & Plant, 2004), it is likely that this effect may also be seen in child maltreatment. Thinking about alcohol’s involvement in aggression, alcohol intoxication may diminish a parent’s ability to react to stimuli that are more peripheral and filter out inhibitory impulses and reactions (Gustafson, 1994). For example, the primary response to a child breaking something may be an angry one. Intoxication may filter out secondary responses such as: “but he/she didn’t mean to, maybe it doesn’t matter so much, the punishment I feel like inflicting is too harsh, or maybe I won’t say what I was going to”. Alcohol may also remove some of the more peripheral cues regarding others’ needs as compared to one’s own needs (Steele & Josephs, 1990), thereby impacting on role performance. Neglect of children can also be associated with inadequate social role performance (Garbarino, 1977), and can occur when parents are unable to prioritise the child’s needs above their own, including their wishes to drink socially or heavily. Purchasing alcohol may divert family finances, which matters particularly in families with fewer resources (Velleman & Templeton, 2007). On the other hand, parents in employment may have more problematic drinking patterns than those who are unemployed, if their work environments encourage heavy drinking (Ames & Janes, 1987). This may result in situations where children are neglected or hurt when a parent drinks heavily after work, either because they are absent or because they return home intoxicated (Zajdow, 2002).
Children may also suffer a range of ill effects because of the drinking of others aside from their carers, including that of other family members or relatives, of their own friends, siblings and schoolmates, or of strangers (Velleman & Templeton, 2007). There has been very little attention paid, aside from police and legal attention in severe cases, to relationships where there is no expectation that there should be a duty of care. Thus fights with siblings and friends, or verbal abuse from other relatives when they are intoxicated, although common, are less examined (Eriksen & Jensen, 2006). Police reports on domestic violence incidents identify a much wider range of relationships involved in alcohol-related violence than spousal domestic violence and child abuse alone (Victoria Police, 2010).

Serious effects upon children from carers’ and others’ drinking include disease and disability outcomes, as well as broader emotional, psychological and social effects of carers’ and others’ drinking on children. Often the most serious cases end up in crisis response systems – still other problems are managed in treatment systems, and arguably the bulk of incidents lie below such thresholds for intervention, yet may have substantial impacts upon children (Creighton, 2004).

**Physical and health effects upon children of carers’ drinking**

Parents and other carers are responsible for children and, as part of their responsibility, typically seek to protect their children from injury and disease, and maintain their health and wellbeing. Alcohol consumption can result in decreased response times and judgement errors, along with decreased alertness, increased relaxation and loss of consciousness (Babor et al., 2010). Such effects limit parents’ and others’ ability to supervise children or prevent a range of injury types and indeed other diseases (e.g., lack of adequate care resulting in more serious pneumonia). Thus, carer drinking is potentially involved in child deaths from various injuries – from fire, drowning, traffic crashes and falls. Drinking by parents and carers may also be associated with intentional child injuries in child maltreatment, as will be discussed further in this section, and in Chapter 2. Foetal Alcohol Syndrome (FAS), Foetal Alcohol Effects (FAE) and Foetal Alcohol Spectrum Disorder (FASD) although rare in Australia are more common in indigenous populations (Elliott and Bower, 2004), and contribute to serious long term health and social problems (Alati et al., 2006; Allen et al., 2007), including learning difficulties and intergenerational problems, often particularly in combination with other forms of social disadvantage (Allen et al., 2007).
However, alcohol-related harm to children because of their parents’ and/or others’ drinking is not routinely measured in health and other data systems. Alcohol involvement in injury is often ascertained in clinical settings – it will affect the way the patient is managed clinically. However, when the injury or problem is experienced by someone else, intoxication of the person causing the injury is not routinely captured. For example, in Australian data sets such as the National Coroner’s Information System or the Australian Bureau of Statistics cause of death data, the blood alcohol content of the victim at the time of death is likely to be measured, but the blood alcohol content of a carer or other involved party is not routinely included in reports. Thus, a child who drowns in a bathtub or falls from a height may not have been adequately supervised at the time of the incident because the carer was intoxicated, but this may not be recorded.

When investigations of child deaths are undertaken in Australia, carer alcohol problems are a common finding. In 2003 in New South Wales (NSW), 68 assault and neglect deaths of children aged 0-17 years were investigated, and in 19% of these cases carers with a history of alcohol abuse were identified (NSW Child Death Review Team, 2003). In these types of investigations, questions about the usual drinking pattern of carers are asked, although often in non-standard ways. In Victoria a similar review panel exists that investigates all child deaths where the child was a client of Protective Services Victoria (Victorian Child Death Review Committee, 2009). Of the 28 children who died in the financial year 2010-2011, parental alcohol problems were identified in 14 (50%). Intoxication at the time of the event will often be crucial, as may recent patterns of episodic or routine drinking behaviours of parents which may also put children at risk in a range of ways. But it is usually not possible to ascertain whether the carer was intoxicated at the time of the event.

In Australian analyses of how children suffer road traffic injuries from others’ (often their carers’ or parents’) drinking, attributable fractions are used to apportion responsibility for a fraction of all cases of children aged 0-14 years to alcohol (English et al., 1995; Ridolfo & Stevenson, 2001). It is the drinking of the adult in charge (and not the child) that is held responsible for the case and attributed as a causal percentage of cases in that type of injury, based on past evidence. Thus, an estimated 33% of male child deaths, 11% of female child deaths, 25% of male child hospitalisations and 11% of female child hospitalisations for road traffic injuries in Australia are attributed to the drinking of others, although the drink-driver is not necessarily the parent (Collins & Lapsley, 2008; Ridolfo & Stevenson, 2001). In the same
manner 41% of all fire injuries of children aged 1-14 years are also currently attributed to alcohol (Ridolfo & Stevenson, 2001). These studies also link alcohol with violence and child abuse hospitalisations and deaths, generally apportioning 16% of child abuse hospitalisations and child abuse deaths to alcohol (English et al., 1995; Ridolfo & Stevenson, 2001; Single, Robson, Xie, & Rehm, 1998). Whilst alcohol attributable fractions are useful, they are calculated indirectly and based on assumptions that the proportion of these deaths and hospitalisations attributable to the drinking of others is the same as that identified in past research in diverse populations. In the case of child maltreatment, the fraction (16%) is based on old United States studies from the 1970s (English, 1995). Thus these attributable fractions assume similar patterns of causality and relative prevalence across countries and decades.

A few studies have investigated links between parental drinking and injury to children more closely. Recently in Norway, increased reporting of patterns of parental drinking to the point of intoxication by students in school surveys (prior to the child’s suicide or suicide attempt) was associated with later matched health record data on adolescent suicide and suicide attempts (Rossow & Moan, 2012). This suggests that something about the pattern of heavy drinking by parents (or other factors linked to this) was associated with increased risky behaviour and mental health deterioration for their children. This effect remained after adjusting for the adolescent’s own drinking patterns. Other studies of children of heavy drinkers have shown a range of negative effects on children of problem drinkers, including depression and reduced intellectual development (Dawe et al., 1997; Strausser, 1994; Barber and Crisp, 1994), which may explain the association between parental heavy drinking and adolescent suicidality reported by Rossow and Moan (2012).

*Emotional, psychological and social effects of others’ drinking on children in families with heavy drinkers (often in treatment)*

Where one member of a family has an alcohol problem there may be a range of negative outcomes for other family members, including children. Drinkers in treatment describe financial problems, separations and divorces, stress, and poor health which often have obvious flow-on effects on their families (Orford, 1990; 2005). Families where both parents drink heavily have been found to be at even greater risk of disruption of routines and rituals (Haugland, 2005). Given that the lack of a protective adult is a feature of child maltreatment (Department of Human Services, 1999), if both parents are incapacitated, or their parenting ability is diminished by heavy drinking, the risks to the child are likely to be greater (Dube et
al., 2001), whether from the parents themselves or other people and hazards they cannot protect the child from.

A small mixed-methods action research study of children whose parents were in treatment for their drug or alcohol dependencies in Australia showed that intoxication and withdrawal could impair parents’ ability to prepare meals, maintain household cleaning, keep school routines, respond to children’s emotional needs, and supervise and manage risk of injury, including neglect or harm of their children by others (Gruenert, Ratnam, & Tsantefski, 2004). Parents in this study of substance users, who were in a variety of treatment programs at a large in- and out-patient treatment institution (Odyssey House), reported that during times of active drug use they themselves were more irritable, intolerant or impatient toward their children, that they used harsher discipline, were less responsive to their children’s needs, yelled more and let go of routines, including getting their children to school. They also reported that they let their children take on adult roles, including caring for younger siblings.

Dawe et al. (2007) also reviewed and summarised case control studies comparing children of alcoholics (mostly in treatment samples) with children of non-alcoholic parents, and reported that these studies provide some evidence that higher levels of internalising (e.g., anxiety and depression) and externalising (e.g., conduct disorder and aggression) disorders (Johnson & Leff, 1999; West & Prinz, 1987) were more common in children of alcoholic parents than non-alcoholic parents, but that only a minority of children of alcoholic parents were negatively affected (West & Prinz, 1987).

Research suggests that drinking patterns of both mothers and fathers can contribute to increased problematic drinking patterns for their children (Raitasalo, 2011; Smith, Miller et al., 1999; Wilks et al., 2006; Yu, 2003). The children of heavy drinkers have been shown to be more likely to be heavy drinkers themselves (Barber & Crisp, 1994; Raitasalo, 2011), though the mechanisms by which this could happen are various and could be indirect (e.g., that both generations are in the same heavy drinking cultural group). In their review, Barber and Crisp (1994), reported mixed effects at different ages upon children of heavy drinkers, finding in general that social and emotional developmental problems were more prevalent in children of heavy drinking parents, but that there were only small or no differences in cognitive problems between these children and children in the control groups, and that there was less evidence to suggest that these effects were long lasting.
Holmila et al. (2011) describe how children aged 12-18 years of problem drinkers (not necessarily in treatment), recruited for the study via web advertisements, reported direct and intended forms of harm, as well as more commonly unintended harms. Although this study extends beyond treatment groups to children of problem drinkers calling a helpline, this study is still not likely to be representative of the experiences of children from a general population sample, particularly as this helpline is advertised to children of parents in treatment and other target groups. The authors did note a range of problems in this difficult-to-access group. These children were upset by incidents of quarreling and violence when their parents drank, and described having to take on increased household responsibilities, caring for and protecting younger siblings, and having reduced time for school and sleep. They also described poverty, lower social status, shame and discrimination associated with their parents’ drinking. Importantly, however, the authors noted that many of these children had developed methods for coping with some of these problems and had suggestions about what might help other children in the same situations.

There has been a small amount of qualitative Australian work on the impact of alcohol consumption on problem drinkers’ families, undertaken in the Northern Territory in indigenous communities (Orford, 2005). In this research verbal and physical aggression was linked to drinking by spouses. Family members told interviewers that they could not rely on these heavy drinking family members, that they worried about these drinkers, and that sometimes children were caught up in the drunken violence, protecting one parent from the other. The physical environment in the home was also damaged by drinking parties and the family atmosphere was one where shame and sometimes chaos did not support regular family activities.

The narrative of the family split apart by drinking and domestic violence is also present in Australian research with members of Al-Anon (Zajdow, 2002). In this study, children and their mothers were hurt by violent and drunken fathers, and financially disadvantaged and isolated, although the primary focus of this work was on how spouses of alcoholic men had been affected and coped. Interviews with women in other countries who live with heavy drinking men provide moving insights to the many problems they and their children experience, including physical violence, verbal abuse and destruction of their belongings (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962), although this literature largely on spousal violence will not be further explored in this thesis.
There is also a body of research that asks adults about their childhood experiences and focuses on the adult children of alcoholics (e.g., De Bortoli, Coles, & Dolan, 2012; Velleman & Orford, 2000). However, research on the opinions of children about their parents’ drinking or other drug use more broadly is rare in Australia (Gruenert et al., 2004). The only Australian studies found of the impact upon children of others’ drinking were in treatment samples (Dawe et al., 2007; Gruenert et al., 2004) and amongst children who were in child protection systems (see Chapter 2). However, reports from children overseas indicate that they may be anxious about their own safety or embarrassed, as well as being concerned for their parents about the effects of their drinking (Raitasalo, 2011).

Research concerning the harmful effects of parents’ drinking upon children in the general population

While there is data on the prevalence of parental alcohol misuse in many countries, as well as smaller-scale studies about alcohol-related child deaths and hospitalisations and how children are affected by parents’ dependent and heavy drinking patterns, there is limited quantitative data on how drinking patterns of parents may directly affect children along a continuum of harm. In this thesis the focus is on quantitatively examining recent harms associated with carers’ drinking that have been reported in general populations, and upon harm that is recorded contemporaneously, as in child protection systems data.

The dearth of data regarding the prevalence of the direct effects of carers’ drinking upon children in general population samples has also been noted by others (e.g., Adamson & Templeton, 2012) and will be addressed in this thesis. Only a small number of studies report upon these problems: for example, Straus et al. (1998) asked respondents in a general population survey in the United States whether they had been so drunk or high in the last year they had a problem taking care of their child; 2% of respondents reported that they had. In one study, using older data from the United States, Berger (2005) reported that increased maternal, but not paternal, occasions of drunkenness were associated with self-reported violence towards children. Manning et al. (2009), using Scottish personal safety survey data, reported that 1% of children had witnessed partner-to-partner domestic violence in the household when the adult held responsible had been drinking.

Drinking has been linked to lack of surveillance of children and increased risk of injuries in three large scale studies in the United States. In a large sample of United States families, Bijur (1992) found that children of mothers categorised as problem drinkers had twice the
risk of serious injury as children of mothers who were nondrinkers, although other measures of mothers’ alcohol consumption were unrelated to child injuries, as were all measures of fathers’ drinking. In the second study, Crandall (2006) surveyed 5000 “fragile” families and found that maternal alcohol use in the past month was associated with injury to children under 12 months old. In the largest study in this area, Chaffin, Kelleher and Hollenberg (1996) analysed a large randomly selected sample (from 5 sites across the United States) prospectively and found that parental substance use (including both alcohol and other drugs) was a significant and strong predictor of physical abuse and neglect, providing longitudinal evidence of the association between substance misuse, as recorded using DSM-III criteria, and child abuse and neglect, as measured in the antisocial personality section of the Diagnostic Interview Schedule (DIS) (Robins, Helzer, Croughan, & Ratcliff, 1981). The presence of parental substance abuse tripled the risk of experiencing child abuse or neglect. The incidences (new cases, excluding cases that were prevalent, i.e., previously identified at baseline) of physical abuse and neglect identified were low within the one year period – 0.8% and 1% respectively. The 3% prevalence identified at baseline was also low, which they explained by the nature of the questions, and sampling of not current but “lifetime” parents (Templeton, 2013). However, given that only a proportion of the reported rates of child abuse and neglect related to substance abuse, the prevalence of alcohol-specific harm to children identified was very low indeed.

Only one meta-analytic study was identified. Stith et al. (2009) conducted a meta-analysis of 39 risk factors for individual forms of child abuse and neglect. The exclusion criteria effectively excluded all studies of child welfare populations and studies that did not differentiate between forms of abuse and neglect. Thus Stith et al. incorporated only three studies that examined the association between alcohol abuse and child physical abuse or neglect. The meta-analysis was largely influenced by Chaffin et al. (1996) discussed above. They reported that the effect size was small (0.17) and significant at the P<0.001 level but that other more proximal factors had greater effect sizes. The literature on the effects of carer drinking on children as measured using child protection system data is examined in the following chapter and briefly in Chapters 7 and 8.

1.3 In conclusion

Whilst there is well-developed evidence regarding how children have been seriously affected by very heavy drinking parents and carers, there is only a scattering of studies that extends
into the privacy of the home. There is a critical need for more, well designed, population-level studies and meta-analyses upon which to base new attributable fractions and build the basis for policy interventions.

There is a dissonance evident between the attitudes and behaviours of Australian parents regarding their drinking and caring for children, particularly from the point of view of the child’s safety, but also from the point of view of being role models. Being drunk is seen by the society as inherently risky around small children, and evidence backs this up: a range of problems are associated with alcohol misuse by parents and other carers. Thus, physical, psychological and social effects of parental or carer drinking upon children are commonly reported in families that include heavy drinkers, although the prevalence of these problems in the wider population is little measured. Whilst societal and most individual attitudes towards drinking around children indicate that carers *should not* drink to the point of intoxication around children, the reality is that the majority of parents and carers do drink, and probably in many contexts in the presence of their own and others’ children. Parents are expected to remain in control of their own and their children’s lives, and to manage the risks associated with drinking. Where parents and carers are seen to have failed to do so (and their actions or inactions are reported), Child Protective Services are given the task of making decisions on drinking-as-a-risk-factor and its ability to affect parenting capacity.

Concerns about parental roles have a considerable history in Australia (as in other countries). The main institutional embodiment of this has been in the systems set up to deal with the whole spectrum of problems of "child endangerment" and child abuse. These systems exercise state power to ensure as best they can that children are safe and flourish within the private sphere of the family. The role of child protection practice in Australia and its connection with monitoring of parental behaviours, including drinking, is covered in the following chapter. The development of child protection systems and their institutional responses to alcohol-related child maltreatment are also examined.
Chapter 2 Alcohol-related harm to children as identified in the child protection system

Leslie was the public image of the neglected child. Unkempt, dishevelled, his swollen belly protruding from his unbuttoned clothing, he appealed to the benevolent for rescue. The full photograph appears in the Annual Report of the VSPCC [Victorian Society for the Prevention of Cruelty to Children] and shows Leslie accompanied by the uniformed figure of the Society’s inspector, William Noble, with the text assuring readers that justice has been done. Leslie and his sisters are safely in care and their drunken stepmother has been gaoled for her cruelty.


2.1 Introduction

The previous chapter outlined the attitudes to and patterns of drinking of parents and began to examine which harms were associated with parents’ drinking. It also began to explore difficult questions about where the threshold between good-enough parenting and child abuse and neglect lies and noted that child protection workers and systems were primarily put in charge of understanding and responding to these thresholds. This chapter, in examining the literature and data developed from within child protection services, provides the second window of this dissertation, on alcohol-related child maltreatment recorded by child protection systems. This chapter examines practices within child protection systems more closely, introduces definitions of child maltreatment, and describes how different forms of child abuse and neglect have come to be defined over time. It also discusses the role of child protection and the development of responses to child protection concerns. There is some comparison of these definitions and systems of response across countries, and description of how carer drinking patterns are recorded within systems. The processes of the child protection systems in Australia that relate to carers’ drinking and outcomes for children are described. These understandings inform the findings presented and discussed in later chapters.

The Convention on the Rights of the Child ... spells out the basic human rights that children have everywhere: the right to survival; to develop to the fullest; to protection
from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. (UNICEF, 1989, p.1).

Whilst the United Nations Convention on the Rights of the Child (UNICEF, 1989) details the basic human rights of children (see quote above), definitions of child abuse and neglect are commonly constructed in terms of minimum standards that define the level of suffering that children should be protected from. In contrast to generally held notions of parenthood, and the expansive language of the Convention, Saunders and Goddard (1998) argue that in Australian child protection systems, workers are seeking to determine minimum acceptable standards, and in fact are not actually asking what is adequate:

*Every day [they] are confronted with family situations that demand an answer to the question: What degree of abuse is acceptable?* (p.13)

Whilst Saunders and Goddard criticise both families and child protection systems for failing children, they also acknowledge that it is not just individual carers, families and child protection workers that contribute to a child’s upbringing and ensure that the rights of children are upheld, but broader social and political systems (Saunders & Goddard, 1998). Definitions of child abuse and neglect are narrow and tend to focus attention on how individuals fail rather than on how support systems do. This is the case within child protection systems, where parents and carers are the primary focus of social workers’ attention, whether they are birth or step-fathers, mothers or other guardians. Child abuse is viewed as involving situations where the child is harmed directly by one or both carers or parents, and situations where these carers fail to protect the child from harm from others. This political decision to focus on individual failure detracts attention from a broader system view (Cashmore, Scott, & Calvert, 2008), and yet this individual focus at the same time has often (currently and even more in the past) been constrained by laissez-fare positions that the state has little business in private spaces (Scott & Swain, 2002).

In Australia, definitions and judgements of child abuse and neglect are required, first by those reporting an incident or ongoing problem, then by child protection workers who assess the situation, and in serious cases by courts. Thus citizens, professional bodies and the law assess the way a child has been, should be and/or is likely to be cared for and protected, and determine whether and how a case should be handled in the child protection system (Australian Institute of Health and Welfare, 2008b). This involves judgement of the adequacy
of parenting capacity and of what constitutes harm. Inevitably the lines drawn by individuals, professionals and communities reflect individual and collective expectations and experiences – norms, mores, qualifiers, and accepted levels of deviance from these notions. Ideally, anything less than provision of the basic human rights of children might be considered child maltreatment. In reality, how does any parent ensure they have really enabled their child to develop to their fullest and protected them from harmful influence? Ultimately the representative of the state must, with as much relevant information as is available, pragmatically and fairly, taking into account whatever might be the alternatives, decide which situations breach ill-defined thresholds. Many cases below the thresholds of child protection investigations and interventions are nonetheless cause for concern. Definitions of child abuse and neglect are discussed in Section 2.3.

2.2 Child protection: A history of concern about risks and harms to children, including those related to parental and carer drinking in Australia

Child protection is the responsibility of Australian state governments, and services (hereafter Child Protective Services) have been established in all states and territories to protect children from harm (Australian Institute of Health and Welfare, 2008b). In considering whether there is a need for intervention, Child Protective Services describe their role, for example in Victoria, as to “assess the capacity of the parents to protect the child in the future and meet their safety, stability and developmental needs,” and to arrange for “intensive work with families to provide them with the widest possible assistance to address the impacts of harm and demonstrate parenting capacity to prevent future harm without the need for further statutory intervention” (Department of Human Services - Victoria, 2007b). The practitioner should “engage the family in developing and implementing a best interests plan to address identified protective concerns, monitor the progress of the plan, continue the risk and needs assessment and make a determination to assign the levels of risk,” as well as to “manage collaborative working relationships with the family, community-based agencies and other professionals” (Department of Human Services - Victoria, 2007b). The current role of Australian Child Protective Services is broadly similar in all states.

Child protection systems have not always been in existence. Whilst basic health and education systems have developed progressively in Australia since the mid-1800s (Hancock, 1989), government child protection-specific policies and services have developed more sporadically in that time (Scott & Swain, 2002). Soon after the arrival of The First Fleet,
abandoned and neglected children were boarded out, and the first orphanage was established in 1795 on Norfolk Island (Tomison, 1996). In the subsequent century, protection of children continued to be taken on voluntarily, predominantly by church organisations and concerned individuals (Tomison, 1996). In general, Australian governments have been reluctant to interfere in private family life, although during 1864-1874 legislation was enacted across all Australian colonies to enable removal of children from “negligent parents” and placement of these children in orphanages or industrial and reformatory schools (Scott & Swain, 2002). Whether this was to protect children or society was unclear. Governments of the time were fearful of child vagrancy and street crime, state concerns that it was felt could be managed by the police, who were permitted to remove such children from their parents and intern them (Scott & Swain, 2002). In Victoria in 1887, an additional law was enacted that gave powers parallel to those which police already had to remove children to “private child rescuers,” who could bring parents before the courts and take on the guardianship of neglected children (Scott & Swain, 2002). In the colonies of South Australia and New South Wales statutory child welfare systems were established as early as the 1880s and comprised boards that included individual child rescuers, church organizations and government representatives (Scott and Swain, 2002). In Queensland, records kept between 1900 and 1971 showed that “Chief Aboriginal Protectors” and “Local Aboriginal Protectors,” usually members of the police force, were employed to manage removal of large numbers of Aboriginal children and adults (Copland, 2005).

Around the end of the 19th Century Children’s Courts were established in the colonies (Tomison, 2001). At the same time more organised non-government child protection systems came into existence. For example, the Victorian Society for the Prevention of Cruelty to Children was established in 1896 (Scott & Swain, 2002). Protection of children was taken on voluntarily by the Societies for the Prevention of Cruelty to Children across Australia (although legitimised by Government power and legislation) (Scott & Swain, 2002) and commonly these societies employed “inspectors” to visit families where child abuse or neglect was suspected.

These various Australian state Societies for the Prevention to Cruelty to Children were concerned about the needs of desperate and neglected children, including children of parents with drinking problems (Scott & Swain, 2002). Indeed, these early societies operated at a time of strong social concern about adverse effects of drinking, particularly on the family, so
the systems have always paid some attention to the alcohol dimension in child endangerment and abuse (Scott & Swain, 2002). For example, Smith (1916), advocating for six o’ clock closing of Australian pubs and bars, described the problems for families associated with men’s heavy drinking in Victoria in the early 20th Century:

Unhappy mothers, mourning for their drunken sons; haggard wives listening for the staggering steps of drunken husbands; frightened children cowering from the fury of their drunken fathers.

(Quoted in the column “A Day in the Life of Australia” by Dunstan (1988), p.2 [describing the end to six o’ clock closing, and the original reasons for its introduction])

There were strong links between the Temperance societies, women’s movements advocating for suffrage and the Societies for the Prevention of Cruelty to Children around the end of the 19th Century (Room, 1988; Scott & Swain, 2002). Although these children’s societies, where possible, sought to improve the situations for children within their families by seeking changes to living conditions and parent behaviours, the removal of children from their families was an omnipresent threat, and in fact, the primary response delivered between 1891 and 1907 (Scott and Swain, 2002).

These societies and organisations, although focused on individual cases, were also active in seeking changes to legislation that would protect children, primarily by enabling intervention to “rescue” them from their families. However, they also took on causes that had broader societal effects. The work of many of these child rescue and child welfare organisations and the Temperance movement, coupled with pressures to abstain from drinking to help the war effort, led to the limiting of hotel bar opening hours across all of the Australian states between 1915 and 1923 (Phillips, 1980). This was in part a strong reaction to the perceived risks of heavy drinking to families and children (Room, 1988).

Assessing risks for children

Child protection practice has always been linked with risk assessment, assessing in particular whether parents harm their children directly or are unable adequately to protect their children from harm from others. Over the last one hundred years or so, governments and a range of institutions involved in care have varied in their emphasis on different risk factors – emphasising “risks” as disparate as aboriginality, unmarried motherhood, corporal
punishment, emotional abuse, drug use and parental drinking (Tomison, 2001). The aim of child protection is in conflict with the strong cultural value on family privacy, so that these systems, in Australia as elsewhere, are a perpetual site of cultural-political conflict (Australian Law Reform Commission & New South Wales Law Reform Commission, 2010). Given the cultural ambiguity about drinking and parental roles, this issue is often involved in these conflicts (Scott and Swain, 2002).

Alcohol abuse by carers was perceived as a “risk” for negligent parenting even in the very earliest cases brought to the attention of the courts. In Victoria in the late 1800s, a young boy, “Leslie”, was removed from the care of his parents partly because of the drinking of his stepmother (Scott & Swain, 2002). In the 1960s, thousands of children were placed in Victorian state institutions or “Children’s homes” because of carer alcohol abuse, illness and family breakdown (Cummins, Scott, & Scales, 2012).

Assessments of risk by governments and child protection organisations, as evidenced in child protection practice and policy, have differed starkly at times, and have been critically influenced by divergent forces. Indigenous Australians have been most obviously affected by child protection responses; children were forcibly removed and placed in Missions and other children’s institutions across Australian jurisdictions from the mid-19th Century onwards, and then later fostered or adopted out in placements until the 1970s (Cummins et al., 2012). The Industrial and Reformatory Schools Act (1865) explicitly mentioned Aboriginal children, stating that “any child born of an aboriginal or ‘half-caste’ mother could be deemed to be neglected” (Copland, 2005). It was not officially accepted until 1966 that Aboriginal children should stay with their parents if possible (Cummins et al., 2012). Aboriginal children were removed across Australia simply because of the race of their mother or because their parents were of different races (Copland, 2005). The removal of Aboriginal children led to immense suffering and disempowerment (Copland, 2005). Whilst there is a perception that alcohol has been a problem for Aboriginal parents, this is a recent problem. Alcohol was prohibited for Aborigines until about 1960, although the abolition of this prohibition varied across different states (Lewis, 1992). Copland reports upon both the removal of Aboriginal adults and children from their land, and estimates that around 13,000 children were removed from their families in Queensland between 1897 and 1971. Of thousands of Aborigines removed from their land, in only one was alcohol use given as the primary reason (Copland, 2005). In contrast, in contemporary South Australia substance abuse was a factor in all child protection
removals from aboriginal families and 61% of removals from non-aboriginal families in 2006 (Jeffreys, Hirte, Rogers, & Wilson, 2009).

**Historical and contemporary responses to risk**

Across the colonies (and the states after Federation) the influence of the Societies for the Prevention of Cruelty to Children waxed and waned, but there were gradual moves to greater governmental control of services in the late 19th and 20th Centuries, particularly in Queensland, South Australia and New South Wales. However, in Victoria the state did not take primary responsibility for Child Protective Services until the 1980s (Cummins et al., 2012). A number of high profile child abuse cases, the emphasis by non-government agencies on removal of children from families, and concerns regarding non-government agency control, led to the transfer of child protection practice out of the non-government sector in Victoria in 1983 to within the Department of Human Services and its predecessors (Cummins et al., 2012). There was substantial public and organisational pressure, and a number of fundamental reviews that pushed governments, whilst generally averse to taking on political risk, to take primary responsibility for Child Protective Services in all Australian states in the latter half of the 20th Century. These kinds of pressures have meant that these governments, like other governments across the globe, have struggled to manage the risk of child abuse and neglect. In attempts to do so, many countries have introduced mandatory reporting of child abuse (Gilbert, 2009; Mathews & Kenny, 2008). Mandatory reporting is the compulsory reporting of suspected child abuse or neglect by prescribed groups, e.g., certain professionals, or even all citizens, to the state protective agency (Mathews & Kenny, 2008). Whilst there is still ambivalence about the state’s role in managing child abuse and neglect in the private domestic sphere (Cummins et al., 2012), mandatory reporting was introduced as a response to high profile child abuse cases, and seen as an additional way to protect children within their families. However, mandatory reporting is perceived by some to push limited financial resources for child welfare towards more protective and punitive responses, also discouraging some at-risk families from seeking help for fear of being reported.

Mandatory reporting, combined with continuously evolving attitudes to child discipline and child rights, saw the number of reported cases in Australia increase in the 1990s and then plateau in the mid-2000s in most states apart from Victoria (Australian Institute of Health and Welfare, 2012; Zhou & Chilvers, 2007). This plateau may be connected to the counterforce of movements for parents’ rights. In Victoria the number of reported cases has continued to
increase between 2000 and 2011, although the number of “substantiated” or investigated and confirmed cases has not (Cummins et al., 2012). The continuing increases in Victoria may be partly explained by increased publicity and a number of reviews of Child Protective Services, or may reflect destigmatisation of reporting when the outcome is known to be more likely to be provision of family support services than referral to Child Protection, or may be because of other unknown reasons. The ongoing discrepancy between reports and substantiations may be partly explained by mandatory reporting (Mathews & Kenny, 2008). There have also been deliberate attempts to channel children and families into broader family-based support services, as is for example the model in Scandinavia and other high-income European countries (Gilbert, 1997), rather than into Child Protective Services. Another factor is that there is a limit to the number of cases that can be managed within a finite government-funded system with a limited workforce (Cummins et al., 2012), thus while reports increase, child protection cases and interventions are more stable.

In general, Australian governments have oscillated between more and less interventionist phases, for example emphasising the rights of families to remain together, as a counter-reaction to earlier zealous child removal policies (Cummins et al., 2012). This balance is elusive, and the tension continues; for example, the Australian Childhood Foundation talks of a philosophical problem where “we don’t get involved when we should and the system has swung too far towards parents’ rights” (Overington, 2007, p. 13). On the other hand, it is argued that “the rise of the foetus” with the backing of modern medicine stigmatizes and subjugates the rights of disadvantaged mothers (who use substances) (Leppo, 2010).

Alcohol’s role is apparent in the Australian history of child abuse and neglect and the private and government responses that have emerged to manage these concerns, but has often been mentioned in passing, rather than focused upon. The following sections of this chapter define terms used to describe child abuse and neglect in contemporary practice. Using these definitions, the prevalence of these problems that involve alcohol is described in different Australian states and internationally.

2.3 Defining child abuse and neglect

Legal battles have tested previously held notions that children are simply the “property” of their parents – that parents can treat (and discipline) their children as they like and fundamentally defined child abuse and neglect in the 19th Century (Tomison, 2001).
Definitions of child maltreatment are thus relative to the accepted mores and laws, culturally bound by time and place: the contexts and societies in which children develop fundamentally affect their lives. For example, the majority of children in Australia grow up in relative affluence (Australian Institute of Health and Welfare, 1993; UNICEF, 2012). In stark contrast, children from low income countries may live with their families in poverty-stricken, disaster-ravaged and war-torn regions (Machel, 2003; UNICEF, 2012). Within Australia, the level of family welfare provided and the size of welfare safety nets and the priority allocated to meeting children’s needs has varied historically, impacting on the definition and management of child abuse.

Despite economic, cultural and historical differences across countries, there is some consensus in western English-speaking countries that child abuse involves failure of carers to protect children from harm, and definitions of child abuse and neglect are similar (See Table 2.1). In Australia, as in the United States and Canada, each state or provincial child welfare

| Table 2.1 Statements defining child abuse |
|-------------------------------|----------------------------------|
| **Country**       | **Statements defining child abuse**                                   |
| Australia         | A substantiation of child abuse occurs when a child has been, is being or, is likely to be abused, neglected or otherwise harmed (Australian Institute of Health and Welfare, 2008b) |
| Canada            | A case is deemed to be substantiated if the balance of evidence indicates that abuse or neglect has occurred (Trocme et al., 2005). However, definitions of abuse types include “or is at substantial risk of suffering [e.g., physical harm]”. (Trocme et al., 2005) |
| United Kingdom    | ‘Harm’ [to children] means ill-treatment or the impairment of health or development (including, for example, impairment suffered from seeing or hearing the ill-treatment of another), [where] ‘development’ means physical, intellectual, emotional, social or behavioural development; ‘health’ means physical or mental health; and ‘ill-treatment’ includes sexual abuse and forms of ill-treatment which are not physical. ‘Significant harm’ is determined relative to the health and development of that which could be reasonably expected for a similar child (Children Act 1989 - as amended by the Adoption and Children Act, 2002). |
| United States     | Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm. (Keeping Children and Families Safe Act, 2003) |
| United States     | Any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child (Centers for Disease Control and Prevention, 2008). |
department has its own definition of child maltreatment and system for investigation and recording that focuses on proving or substantiating claims that a child has been abused or neglected. However, in English practice, a child is assessed to determine whether they are “in need,” and this need may be because of a range of developmental, family or community problems. Where the child is “in need of protection” because they have been significantly harmed or are at risk of significant harm they are referred to Social Care Services (Newcastle Safeguarding Children Board, 2013). There is not such a focus on substantiation but rather attention to how a child should be managed in practice if harm is determined to be significant. Whether harm (including ill treatment or the impairment of health or development) suffered by a child is deemed significant is ascertained by comparison of the health and development with that which could reasonably be expected of a similar child (Children Act 1989 - as amended by the Adoption and Children Act).

There is general acknowledgement that definitions of child maltreatment have expanded over time to include, for example, cases of emotional abuse and exposure to domestic violence. Attitudes to physical punishment have also been modified over time (Holzer & Lamont, 2010). The definition of physical abuse has expanded, with corporal punishment now illegal in schools but not homes in Australia, although in Sweden all forms of corporal punishment are illegal (Holzer & Lamont, 2010). On the other hand, there have been attempts to ensure that poverty per se is more commonly managed not as a child protection issue but through family support services (Tomison, 2001), and, more recently there have been (partially successful) attempts made in some Australian states to reduce the number of notifications (by providing families and children with family services) to ensure that cases are not unnecessarily managed by Child Protective Services (Cummins et al., 2012).

There are a number of terms that deserve close attention in the definitions in Table 2.1. “Significant harm” is the term used in the United Kingdom (Para 5.18, HM Government, 2010) and in Victorian (Australia) child protection practice, and specifically the Victorian Risk Framework (Department of Human Services, 1999). The Victorian Risk Framework was a key document that described how risks to children should be assessed and responded to by Child Protective Services in the period studied in this dissertation, between 1999 and 2005. In the Victorian Risk Framework, significant harm is described as “extreme, serious or concerning”. This definition of “significant” was formed in a Supreme Court of Victoria decision in 1992: “More than trivial or insignificant but need not be as high as ‘serious and
important’ or ‘of consequence’ to the child’s ... development and it is irrelevant that the evidence may not prove some long lasting permanent effect or that the condition could be treated” (Department of Human Services, 1999, p. 11). In the Australian definition “is likely to be” is much more inclusive than “has occurred” in the Canadian definition of substantiation (Trocme et al., 2005, p. 121). Of the statements in Table 2.1, only the Canadian definition does not include “risk” or “likely to be”, although variations in definitions occur across Canadian provinces, where responsibility for child protection is held, as in Australia for the states.

The definitions for abuse and different types of abuse are similar across the Australian states. In Australia, abuse includes physical, sexual, emotional or psychological harm or medical or physical neglect. According to Australian definitions (Australian Institute of Health and Welfare, 2008b, p. 96):

- **Physical abuse** is any non-accidental physical act inflicted upon a child by a person having the care of a child.

- **Sexual abuse** is any act by a person having the care of the child which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards.

- **Emotional abuse** is any act by a person having the care of a child that results in the child suffering any kind of significant emotional deprivation or trauma.

- **Neglect** is any serious omissions or commissions by a person having the care of a child which, within the bounds of cultural tradition, constitute a failure to provide conditions which are essential for the healthy, physical and emotional development of a child.

The Victorian definitions (Victorian Department of Human Services, 2007, pp. 3-4) are similar but more expansive:

- **Emotional abuse** occurs when a child is repeatedly rejected, isolated or frightened by threats or the witnessing of family violence. It also includes hostility, derogatory
name-calling and putdowns, or persistent coldness from a person, to the extent where the behaviour of the child is disturbed or their emotional development is at serious risk of being impaired.

Neglect includes a failure to provide the child with an adequate standard of nutrition, medical care, clothing, shelter or supervision to the extent where the health or development of the child is significantly impaired or placed at serious risk. A child is neglected if they are left uncared for over long periods of time or abandoned.

Physical abuse consists of any non-accidental form of injury or serious physical harm inflicted on a child by any person. Physical abuse does not mean reasonable discipline though it may result from excessive or inappropriate discipline.

A child is sexually abused when any person uses their authority over the child to involve the child in sexual activity.

In some countries, emotional harm does not constitute child abuse, and it has only been included in western English speaking countries gradually over time. In Canada, exposure to family violence is considered a fifth primary type of child abuse (Trocme et al., 2005). It is not considered a distinct type of primary abuse in Victoria, but is included in the definition of the primary abuse type of emotional abuse, and also as a risk factor if present in a case (Victorian Department of Human Services, 2007).

Differences in definitions and practice

There are numerous reasons why definitions of child abuse in different countries and between states differ. Social and cultural values regarding child rearing practices, including attitudes towards corporal punishment and drinking around children, will also affect what is perceived as child maltreatment in different societies. The main variations in reporting practices and definitions have been well documented by Trocme et al. (2005), and include variation in the definitions of substantial risk or significant harm, inclusion of different types of abuse, and legal mandates regarding whether all persons or specified professions are required to report.

Mandatory reporting of child abuse was first introduced across different states in the United States between 1963 and 1967 (Mathews & Kenny, 2008), but has never been introduced in
the United Kingdom (Mathews & Kenny, 2008). In Canada, reporting is mandatory by all citizens (Mathews & Kenny, 2008). Mandatory reporting was introduced earliest in Australia in the state of South Australia in 1972, and the remaining states incrementally introduced a range of different acts mandating reporting of different abuse types by various professions, although Queensland and Western Australia did not introduce mandatory reporting until the mid 2000s. Mandatory reporting was not introduced in Victoria until 1993, as a response to the high profile child abuse case of Daniel Valerio (Cummins et al., 2012). In Victoria, reporting of serious physical and sexual abuse by medical professionals, police and nurses was mandated in 1993 and by teachers and school principals in 1994 (Higgins, Bromfield, Richardson, Holzer, & Berlyn, 2010).

Another key variation between states and countries is around which system or systems have responsibility to manage the welfare of children. Professional practices differ across countries, and different emphases are placed upon provision of welfare and protective roles. The Victorian and other Australian state systems are considered, along with the United States, Canadian, and United Kingdom systems, to be more bureaucratic and legalistic, and less welfare-based than Scandinavian, German and Dutch child protection systems (Cashmore et al., 2008; Gilbert, 1997). In the United Kingdom, where reporting of child abuse is not mandatory, there is a greater emphasis on handling only those cases requiring specialist child protection intervention within the system (Cashmore et al., 2008).

There have been recent moves in Victoria to adopt a more preventive system, streaming families and children to family support agencies, if suitable, prior to the point of notification to Child Protective Services (Australian Institute of Health and Welfare, 2008b; Cummins et al., 2012). Family services provide more holistic financial and support services to the whole family, whilst the child protection systems in each state have the primary legal function of protecting children (Australian Institute of Health and Welfare, 2008b).

Continuingly evolving attitudes to child discipline and child rights, and changes in understandings of what constitutes child abuse and neglect (Cummins et al., 2012; Tomison, 2001), combined with the introduction of mandatory reporting of child abuse in many countries (Mathews & Kenny, 2008) have led to changes in practice around (and increased) reporting of cases to child protection in Victoria (Gilbert, Kemp et al., 2009; Mathews & Kenny, 2008), although the management of “substantiated” or confirmed cases appears to have changed less in terms of the numbers of cases managed (Cummins et al., 2012). Thus
whilst reports have increased in number substantiations have remained stable. This discrepancy may be partly explained by the finite capacity of the system to respond to these reports, and provision of supportive family services rather than more punitive child protection responses as discussed earlier in this chapter.

2.4 Stages in the child protection process

Despite the complexity of defining child abuse, the key stages of the child protection process in all Australian states and territories appear similar. The four stages are: reporting or notification, investigation and substantiation, continued involvement and protective intervention, and care and protection orders, including court orders.

Reporting, reports and notifications

Suspected child abuse or neglect (or welfare concerns such as financial difficulties or social isolation) is reported to child protection authorities or other family services or welfare services by someone in the community, a professional mandated to report child abuse and neglect, by an organisation that that has contact with the child or family, a family member or the child him- or herself (Australian Institute of Health and Welfare, 2008b). The report is assessed by an intake worker (sometimes a person from Family Services, at other times a Child Protective Services worker and in some cases staff trained specifically for this task) (Australian Institute of Health and Welfare, 2008b; Cummins et al., 2012). At this first stage, reporting of the suspected abuse or neglect, the matter can be screened in or out at what is called “intake”. This can lead to the report being dealt with as a “family support issue”, or as a child protection notification (although in Tasmania all reports are recorded as notifications) (Australian Institute of Health and Welfare, 2008b).

Child welfare departments must then determine whether a report or a notification requires an investigation. In those cases where the worker finds that the reporter has a belief that child is in need of protection and has grounds to support that belief, the case will proceed to the investigation stage (Australian Institute of Health and Welfare, 2008b).

Re-notifications are those cases that are notified a second or further time, after the file for an earlier notification has been closed.
Investigation and substantiation

An investigation “is the process whereby the relevant department obtains more detailed information about a child who is the subject of a notification, and the aim of an investigation is to make an assessment of the degree of harm or risk to the child” (Australian Institute of Health and Welfare, 2008b, p. 2). In Australian states the outcome of an investigation is either substantiated or unsubstantiated child abuse or neglect (a two-option system). Substantiations conclude that “a child has been, is being, or is likely to be, abused, neglected or otherwise harmed” (Australian Institute of Health and Welfare, 2008b, p. ix).

Substantiations can lead (but do not always lead) to further actions such as a child being placed on a care and protection order or in out-of-home care (Australian Institute of Health and Welfare, 2008b).

Continuing Child Protective Services involvement (“protective interventions” but not “orders”)

Where cases are substantiated the relevant departments “generally attempt to protect the child through the provision of appropriate support services to the child and family” (Australian Institute of Health and Welfare, 2008b, p. 35). This stage of the process is not reported upon at the national level.

Care and protection orders

The relevant departments responsible for child protection in each state may apply to the relevant court at any stage in the process to place the child on a care and protection order.

Recourse to the court is usually a last resort and is used in situations where supervision and counseling are resisted by the family, where other avenues for the resolution of the situation have been exhausted, or where removal of a child from home into out-of-home care requires legal authorisation. (Australian Institute of Health and Welfare, 2008b, p. 4).
Family services

At any point in the child protection process Child Protective Services may choose to refer the child’s family to family support services. These family support services may be provided instead of child protection interventions or in addition to such services. Education, skill development, mediation and therapy, residential and in-home support and advocacy services may be provided at varying intensity, and may be provided to prevent separation of children from the primary carers or to facilitate reunification (Australian Institute of Health and Welfare, 2008b).

2.5 Alcohol recording within child protection systems

As indicated, alcohol has long been linked with child maltreatment internationally (Gilbert, Widom et al., 2009) and in Australia (Scott & Swain, 2002), yet it has been only inconsistently included in recording systems. Alcohol involvement is recorded in a variety of different ways in different child protection databases, limiting easy comparisons across studies and simple synthesis of previous research. In particular, alcohol involvement in child abuse and neglect is variously recorded in different Australian jurisdictions (see Table 2.2).

There is a national minimum dataset for child protection case records in Australia, but it does not collect data on alcohol involvement (Australian Institute of Health and Welfare, 2008a). It cannot do so without changes in the procedures and recording in the states and territories, since there are major differences in the way in which alcohol abuse is recorded. In New South Wales alcohol involvement is recorded at the reporting stage (Hopkins & Smoothy, 2007). In Queensland alcohol and other drug use is not distinguished, that is, their presence is recorded in the same field (Queensland Government Department of Communities, 2008). In other states alcohol involvement has largely been assessed post-hoc via analysis of case notes in specific research projects, rather than as part of ongoing operations. Only in Victoria was there routine recording of alcohol involvement, although this collection ceased in 2006 when the system changed from CASIS to CRIS (for reasons unknown to the author).
Table 2.2 Comparison of alcohol recording within child protection data systems in Australia

<table>
<thead>
<tr>
<th>Recording of alcohol involvement routine in state and national databases</th>
<th>Australia</th>
<th>Victoria – yes, at substantiation between 2001 and 2006, not routine thereafter</th>
<th>NSW – yes, at initial report stage</th>
<th>Queensland – recorded together with other drugs at substantiation</th>
<th>Western Australia, South Australia, Northern Territory, Tasmania – no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form of alcohol involvement recorded</td>
<td>Varies, not standardised, e.g., in Victoria alcohol and other drug abuse are recorded separately as risk factors for one or more carers and then in an additional field for children – although only one field is used, ‘substance abuse’, that does not differentiate between alcohol and other drugs for the latter (Department of Human Services, 1999); NSW records primary, secondary and tertiary reasons for reporting (New South Wales Department of Community Services, 2008)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recording of alcohol involvement generally

Alcohol abuse is a term that is commonly used by child protection workers and systems to describe drinking behaviours of carers that have been or may be considered to put a child at risk. In a child protection system context, the term is used quite broadly and without specific definition. On the other hand, alcohol abuse is also a technical diagnostic term, and usage may be influenced by this. In the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) alcohol abuse is “a maladaptive pattern of substance [alcohol] use leading to clinically significant impairment or distress within a 12-month period”. This impairment includes failure to fulfil major role obligations at home such as “neglect of children or household” (American Psychiatric Association Taskforce on DSM-IV, 1994). Lay concepts surrounding drinking centre upon drunkenness and addiction, sometimes referring to abuse but more often featuring images of addiction that include loss of control and craving (Room, 1998). Whether social workers and child protection workers use clinical or lay terminology, or have their own specific understandings of alcohol abuse in the context of child protection, has not been studied. It is likely that individual workers within Child Protection systems hold a variety of understandings of what alcohol abuse, addiction and more “normal” drinking may mean. In the United Kingdom, Forrester and Harwood (2010) were highly skeptical of child protection workers’ understandings of alcohol and drug problems:
In general, there appeared to be a strong institutional tendency towards underresponding to alcohol and drug misuse......a pervasive sense that social workers did not know how to work with parental alcohol or drug problems.....[they had] minimal training and often had limited supervision and support.....a toxic cocktail that is almost certain to produce poor practice. (p. 116)

2.6 Alcohol and child maltreatment in child protection caseloads

Alcohol is commonly associated with child protection issues, but the extent of its causal impact in child protection cases remains contentious. Recent Australian data (see Table 2.3) suggests that alcohol is implicated in a large but varying percentage (15-54%) of child abuse cases across Australian states, although these statistics are obtained at various stages of the child protection process depending on the state. In New South Wales (NSW) 21% of all reports involved alcohol and other drugs and 11% included alcohol alone (NSW, Department of Community Services, 2008), although the majority of reports in NSW do not go on to be substantiated. Approximately half of all substantiated child abuse and neglect cases investigated by Child Protection in Victoria involved some degree of problematic alcohol or other drug use by the child’s parents and 31% of cases between 1996/97 and 2000/01 involved alcohol (Department of Human Services, 2002). In Western Australia, 47% of protective applications (where it is requested via the children’s Court that guardianship be transferred from the parents/carers to the Department of Community Development) in 2000 involved alcohol (Farate, 2001), whilst alcohol was involved in 54% of cases entering alternative care (i.e., temporary foster care or more permanent placements outside the home) (Jeffreys et al., 2009) in South Australia and 78% of foster care cases in Victoria (Victorian Department of Human Services, 2003). Comparison across states is thus made difficult by the lack of comparable or reliable recording methods, and in these Australian studies alcohol was recorded at different stages of the child protection process.

Internationally, estimates of the rates of involvement of alcohol in reported and substantiated child protection cases vary widely, ranging from 13 to 70% (Rossow, 2000). Dore, Doris and Wright (1995) reported that between one- and two-thirds of maltreatment cases in the United States involved parental alcohol and other drug abuse. Canadian studies found that 18% of female caregivers and 30% of male caregivers had confirmed diagnoses of alcohol abuse in substantiated cases of child maltreatment (Trocme et al., 2005). Recent alcohol or drug use
### Table 2.3 Current state estimates of alcohol in child protection cases

<table>
<thead>
<tr>
<th>State</th>
<th>Current estimate of alcohol’s involved in cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital</td>
<td>Substantiated cases: 56% of cases in a study of 150 children from 110 families involved alcohol and drugs (Murray, 2004)</td>
</tr>
<tr>
<td>Territory</td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>Substantiated cases: 15% involved alcohol (Hopkins &amp; Smoothy, 2007) Court applications: 38% of cases involved alcohol (McConnell, Llewellyn, &amp; Ferronato, 2000)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Parental/caregiver substance misuse cited as a significant factor in child protection (Bamblett, Bath, &amp; Roseby, 2010)</td>
</tr>
<tr>
<td>Queensland</td>
<td>Substantiated cases: 47% (both alcohol &amp; drug), 51% of these (i.e. 23% of all) involved alcohol only. Parental/carer alcohol misuse was most commonly found in neglect cases (Queensland Government Department of Communities, 2008)</td>
</tr>
<tr>
<td>South Australia</td>
<td>Alternative care: approximately 70% of cases involved parental substance misuse, with alcohol involved in 77% of these parental substance use cases (Jeffreys et al., 2009) (i.e., 54% of all involved alcohol)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>No estimates identified</td>
</tr>
<tr>
<td>Victoria</td>
<td>Substantiated cases: 31% involved alcohol between 1996/97 and 2000/01 (Department of Human Services, 2002) Out of home care (foster care): 42% involved substance abuse (alcohol or other drugs), and a further 37% involved alcohol abuse (Victorian Department of Human Services, 2003)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Applications to Children’s Court for care and protection orders: 47% involve alcohol (Farate, 2001)</td>
</tr>
</tbody>
</table>

was identified as the primary concern in zero to 24% of families with welfare concerns across different counties in Ireland (Hope, 2011).

Child maltreatment studies invariably include multiple types of child maltreatment, averaging together relationships between alcohol and quite different types of child maltreatment outcomes, for example sexual abuse, emotional abuse and neglect. Although relatively few studies report carer alcohol problems by type of abuse, the proportion of cases that involve alcohol does appear to vary by the type of primary abuse. Comparing data from the Canadian national survey of child protection agencies undertaken every three years (Trocme et al., 2005) and a sample of Victorian cases from 1993-94 (Victorian Department of Human Services, 2001), alcohol involvement was most commonly implicated in neglect and emotional abuse cases in both countries, and less commonly identified in physical and sexual abuse cases.
2.7 In conclusion

Whilst there has been a long history of concern about parenting and drinking, and a range of child protection responses, it is only since the 1990s that there have been organised systems of recording problems and risk factors associated with them. This chapter examined the emergence of non-government and state responses to such concerns and presented definitions of child abuse and neglect. The involvement of carers’ drinking in the child protection process in different states and different types of child abuse was summarised, and there is evidence that a large proportion of child protection cases are associated with carers’ drinking. There are considerable data that are routinely collected in child protection systems, but these data are usually not analysed in order to understand the extent of alcohol’s involvement in child protection cases.

The major problem with previous analyses of the child protection system data is that very few studies follow children prospectively and record whether they end up in the child protection system. This thesis does not address this problem, but does examine whether alcohol is associated with more intensive outcomes and repeated entry into the system. The next chapter conceptualises how alcohol may be linked to the risk of child maltreatment.
Chapter 3 Understanding alcohol-related child maltreatment

Almost no one is immune to the role of child abuser if the discrepancy between situational demands (e.g., difficulty of the child, emotional stress on the caregiver, etc.) is great enough, although people vary in the degree to which they are prone to act in an abusive manner.

(Garbarino, 1977, p.723).

This chapter situates the dissertation in terms of the various theoretical understandings of how parental drinking might result in child maltreatment. Instances of alcohol-related child harm are explained at the most proximal level by largely individual actions or deficits of carers, yet these individual behaviours are moderated and defined by the public supports and social contexts within which individual carers and families act, and drink. Finally, after examination of a number of approaches to understanding child abuse and neglect, a hybrid model for understanding and responding to children affected by their carers’ drinking is presented and discussed.

3.1 Individual-level understandings of the relation of alcohol and child maltreatment

Alcohol is a central nervous system depressant that when consumed results in effects similar to those of the body’s naturally occurring endorphins which control pain and mood, in moderate doses creating feelings of relaxation and euphoria in suitable situational contexts (Gilman, Ramchandani, Davis, Bjork, & Hommer, 2008; Hamilton, Kellahear, & Rumbold, 1998; Heather, 2001). In larger doses alcohol leads to suppression of reflexes, decreased coordination, impaired decision-making and eventually unconsciousness (Galanter & Kleber, 2008; Knight, 2001). If carers become intoxicated, their ability to supervise and respond to a child’s needs may be diminished. For example, decreased coordination means that a parent may not be able to drive, walk straight, or hold their child. Slurring of words and inability to think clearly compromises parent-child communication, and if a carer becomes unconscious they are unable to care for their child.

Biomedical models of drinking describe how consumption of alcohol can result in intoxication and when repeated over time can result in the development of tolerance – the need to increase the dose to achieve the same effect – and a withdrawal syndrome, where cessation of intake results in withdrawal symptoms if the person has become physically
“dependent” on the drug (Famularo, Kinscherff, & Fenton; Koob, 2006). Dependence comprises more than tolerance or withdrawal – often including the behavioural and cognitive cravings or desires to continue using, impaired control of use, use despite harmful consequences and prioritisation of use over other activities and responsibilities (Famularo, et al.; Hamilton et al., 1998; Koob, 2006). Dependence, often used as a term interchangeably with “addiction,” tends to be a chronic relapsing condition (Koob, 2006). Parents may become dependent on alcohol to a varying degree and be unavailable for their children for more extended periods of time.

Alcohol has well recognised effects on cognition (Simons, Downs, Hurster, & Archer, 1966) and Steele and Josephs (1990) argue that it is alcohol’s effects causing reduced awareness of and diminished ability to interpret cues when intoxicated that may lead to aggression. They describe how “alcohol myopia” impairs perception and thought by blocking responses to conflicting impulses, and amplifies or channels the more immediate and strongest responses to the stimuli in any given situation, resulting in aggression and violence that might otherwise have been avoided.

Miller, Maguin and Downs (1997) theorise specifically how parenting can also be affected by “cognitive disorganisation” and posit that “alcohol abuse increases the likelihood of violence, because it interferes with communication among family members and results in misinterpretation of social cues, overestimation of perceived threats, and underestimation of the consequences of violence” (Widom & Hiller-Sturmhöfel, 2001, p. 53). That alcohol impairs judgement is widely recognised (Babor et al., 2010) and that it likely compromises rational responses to problems and may result in domestic violence and physical child abuse is commonly understood.

According to the alcohol disinhibition theory, alcohol affects the ability to control one’s immediate, and aggressive, responses (Widom & Hiller-Sturmhöfel, 2001). This would explain why, when there are tensions within families, and family members attempt to exert control over one another, the introduction of alcohol may diminish the threshold at which violence is introduced. Disinhibition has been put forward as a reason for why socially unacceptable behaviours such as physical abuse may be more likely to be perpetrated where drinking acts to loosen normal behavioural controls (Widom & Hiller-Sturmhöfel, 2001).
Bandura (1978) posited that behaviours are learned, and that social learning of aggressive behaviour consists of three components: learning of the origin of aggression; learning of (situational) instigators of aggression; and learning of the reinforcements of aggression (or what makes a person continue to be aggressive). Alcohol could feasibly be involved in any of the three. For example, a parent may have learned as a child that intoxication was associated with aggression; that alcohol is present in subsequent aggressive encounters and that originally learned aggressive behaviours are carried out under its influence; and that alcohol is sometimes perceived as an excuse in the society and situations within which the parent operates.

MacAndrew and Egerton (1969) and Kallmen and Gustafson (2013) agree that social norms are important, and dispute that pharmacological disinhibition is universal. They argue that although alcohol alters behaviour, there are strong differences between cultures in the extent and nature of alcohol-related drunken behaviours, so that disinhibition appears to be far from uniform – suggesting that the way in which one is expected to behave when drunk in a particular culture has a stronger role than biomedical effects. They suggest that drunken behaviour or “comportment” is learned through socialisation with peers and within families. They put forward that in some societies and situations the behaviours expected when people are intoxicated differ more from sober behaviour and that alcohol is used in such cultures as a “time out” when normal social rules are relaxed (MacAndrew & Edgerton, 1969). “Drunken comportment” suggests that learned situational behaviours may explain incidents where children are put at greater risk when their parents are intoxicated and less is expected of them, perhaps resulting in less control of their discipline, what they say, or how much attention they should be paying to what their children are doing. However, the rules for drunken behaviour are applied “within limits” (Room, 2001), and arguably especially so when children are involved.

In summary, intoxication impairs physical and cognitive functioning and increases the risk of child abuse and neglect (Knight, 2001). Along with pharmacological effects, learned behavioural strategies for parenting, drinking and dealing with conflicts may contribute to how children are affected. Where cultures of acceptance of problematic responses exist, and few strategies and supports exist to manage stressful situations, child abuse and neglect become more likely under the influence of alcohol.
3.2 Social-level understandings of child maltreatment and the role of alcohol: an ecological model

Sociological explanations of child maltreatment start from an acknowledgement of the complex situated human reactions to the demands of parenthood, and the proposition that almost anyone is capable of child abuse given certain conditions and stressful situations (Garbarino, 1977). Garbarino adds,

_In contrast to psychiatrically–oriented researchers who seek to understand maltreatment as a personality malfunction, a sociologically-oriented approach focuses on maltreatment as a role malfunction._ (p. 723)

In this approach, individuals develop over their life course, are socialised, and transition through various roles. “[Child] abuse perpetrated by ‘normal’ individuals may be described as a form of situationally defined incompetence in the role of caregiver” (Garbarino, 1977, p. 723). This incompetence can result in excessive use of force (physical abuse), verbal abuse, or inadequate attention to a child’s basic needs (neglect). Garbarino argues more generally that child abuse arises when parents do not adapt to carer roles, when they do not reorder their own needs in relation to their children’s, when substantial stress is experienced, and more generally when there is evidence that “lives are out of control” in families. For example, where no parent takes responsibility for decisions, parents see themselves as impotent, and families move from one crisis to another (Garbarino, 1977). Garbarino surmises that two conditions are necessary for physical child abuse: a cultural acceptance of physical violence in child-caregiver relations, and a lack of family, service, community and organisational support for the carer. The lack of these conditions may equally be necessary for other forms of abuse, such as emotional abuse and neglect, these being generated where verbal abuse and limited supervision are the norm and support systems are weak or non-existent. In these social conditions, alcohol may contribute via previously discussed biological and psychological mechanisms and affect parenting roles.

In an ecological model for understanding child maltreatment, Garbarino (1977) and Bronfenbrenner (1979) identify numerous correlates of child development and child abuse that potentially act as causes. Garbarino (1977) puts forward a model of child maltreatment that includes: the broader societal context (socio-economic factors, demographic factors, ideological and historical factors); neighbourhood or community support systems (availability of family services, feedback and monitoring for families in trouble,
neighbourhood connections); family characteristics, including stresses in the life course (events, special needs, socio-economic and demographically problematic factors, timing of major events in the life course and family career); and local systems of social support for the child and the family (including their social networks and social involvement in organisations).

In Garbarino’s model, the factors mentioned above are important determinants of child maltreatment. Whilst Garbarino does not explicitly discuss the effects of alcohol and other drug use on each of the key groups of factors in this model, it is argued here that problematic drinking (an extension of non-risky drinking patterns) has the potential to act upon many of the factors correlated with child maltreatment.

Societal and cultural contexts affect how people (and parents) drink. For example, heavy drinking cultures evident amongst young people may be shared by young parents, although others suggest parenthood may be a catalyst for diminished drinking (Maloney et al., 2010). Alcohol-free entertainment options are rare, and alcohol is promoted as a social lubricant at sporting clubs and local school fundraisers (Duff & Munro, 2007; Johnson, 2013; Rowland, Allen, & Toumbourou, 2012). In extreme circumstances heavy drinking may turn some locations into no-go zones for others, including authorities, particularly at certain times (Robins et al., 1981). Cultures of expected heavy alcohol consumption in different countries and regions, communities, workplaces and other groups support drinking patterns that may not be very compatible with family life (e.g., Ames & Janes, 1987).

Some communities have fewer local resources and less access to a range of services, including alcohol and drug services, than others (Whitehead, 1992) – which affects how parents are supported if they drink heavily. Drug and alcohol treatment services may be limited, untargeted and inaccessible to individuals who have young children or are working (Harwin et al., 2011), meaning little help is available for parents and their children. This means that something of a “postcode lottery” may exist in which some children and families are less disadvantaged and better supported than others (Kelleher, Chaffin, Hollenberg, & Fischer, 1994; Swan, 2005). Some communities will be better able to mobilise forces to maintain local parks, playgrounds, schools, services and to manage entertainment precincts where alcohol is consumed, including their size, composition and regulation (König & Segura, 2011).
Alcohol consumption within the family unit by one of the family members may result in financial stresses upon the household and family (Velleman & Templeton, 2007). For some carers, problematic drinking may be inconsistent with, delay or hinder transitions into parenting roles (Umberson, 1987). Problematic intoxication and dependence can act as major life stresses for those around the drinker – the other parent or carer and other family members – as well as for the drinker, complicating parenting, and sometimes, if family members feel embarrassed or ashamed, isolating the family from support networks such as extended family, friends, school communities and clubs (Velleman & Templeton, 2007).

Social disadvantage and drinking

Social disadvantage (sometimes as a result of a carer’s alcohol problems) may act independently at all of these levels to make life difficult for societies, communities and families in many ways, and numerous authors describe the links between child maltreatment and social disadvantage (Garbarino, 1977; Gilbert, 1997; Gilbert, Widom et al., 2009). Berger (2005) describes how poverty can be associated with increases in child maltreatment cases but also notes that it is not possible to determine whether higher observed and reported maltreatment rates in lower socio-economic groups are because of biases introduced by their increased contact with welfare agencies or whether these rates represent a higher incidence per se. However, in their study using 1984 data they found mixed results— that lower income was associated with child physical violence in single parent families but not in two-parent families. Sidebotham et al. (2002) looked at social deprivation more broadly, and identified financial security, housing situation, material benefits of the family, the job situation of the parents and the stability and quality of social networks as determinants of child maltreatment. Examining the association of deprivation and drinking from the opposite direction, drinking may cause loss of social position, and unemployment may be seen as a precipitator of commencement of a heavy drinking career (Mäkelä & Paljärvi, 2008). The influence of both a heavy drinking parent and social disadvantage on child maltreatment is most likely cumulative, regardless of the direction of the origin of the problem.

Although the volume of alcohol consumption is often greater in higher social classes (Marmot, 1997), the class distribution of more problematic drinking patterns and outcomes is often in the opposite direction, although this may at least in part be because of the way these outcomes are more likely to come to the attention of authorities amongst less advantaged groups (Room, 2005).
Locating and managing heavy drinking parents

Sociological theories also contribute to our understanding of how, in the context of parenting and child maltreatment, drinkers are perceived and managed. Role theory and labeling discuss how and when parenting and drinker roles are perceived to have moved beyond social norms towards deviance (Garbarino, 1977; Sargent, 1973). The deviance tradition tends to focus on subgroups which are in contact with, and form much of the caseload of, social handling institutions which deal with “trouble” – police and courts, emergency departments, alcohol and drug services, welfare services and, particularly in the present context, Child Protective Services. Many of these institutions deal differentially with different parts of the population, and particularly the poor and marginalized are much more likely than those with more social and economic resources to come to police and court attention, and to show up in other services as well (Weatherburn & Lind, 1997).

There is Australian evidence that, whilst parents who were investigated by child protection authorities felt respected by child protection workers as parents, they felt stigmatised and strongly disapproved of by society in general; they “felt they would be judged forever because of the [Child Protection] report” (Harris & Gosnell, 2012). Theories of “social location” describe how it is less powerful subjects (for example heavy drinkers and families seeking welfare) that are scrutinised more than others (Bacchi, 1999; Weatherburn & Lind, 1997). There are likely to be inequalities in labeling of parents who drink heavily enough to affect their children. Sargent (1973) describes how the most socially visible are much more likely to be labeled as “alcoholics,” whilst people with high prestige are reluctant to label those within their own status groups as deviant in this way, meaning their behavior may be more likely to be called “heavy drinking”.

There is overseas evidence about how heavy drinking groups are managed differently, and that there exists a more “extreme” or captured group who both needs and accesses, or is provided compulsorily with, alcohol and drug services. Storbjörk and Room (2008), in describing the Swedish alcohol and drug treatment population, note that most people in the general population surveyed never enter treatment, whilst the clinical group experienced multiple problems because of their drinking in many areas of their lives.

These “two worlds” of alcohol problems appear to co-exist with few interconnections. There is evidence that there is a hidden group within the general population which have severe problems but do not enter treatment, and the size of this group has been estimated to be
between 3 and 13 in the general population to 1 in treatment (Sobell, Sobell, & Toneatto, 1992). Storbjörk and Room’s (2008) study found stark differences between the general population and the alcohol and drug clinic population: the clinical group was more likely to be male, older, poorer, less educated, drink more and have no other place to go.

It is plausible also for parents and carers with alcohol problems that two such groups exist: the first that have children who are managed within the child protection system, and a second, larger group where parents also drink problematically (either occasionally or often) but are not handled by the child protection system. In fact a majority of those handled by Child Protective Services will not need intensive management, although some will, whilst others will not need any assistance at all. Within the group not known to Child Protective Services will be children who are harmed by their parents’ drinking (to a greater or lesser degree, and more and less often), as well as children whose parents drink problematically but do not harm their children. We know almost nothing about the groups that are not in contact with the welfare and treatment systems.

It is convenient for policy makers and governments, and particularly for the alcohol industry, to marginalise the problem and demarcate alcohol-related child abuse as confined to a minority of heavily disadvantaged parents, when there is evidence that the problem may be more widespread (Meredith & Price-Robertson, 2011).

**3.3 Public health understandings of child maltreatment and alcohol-related child maltreatment**

The vast majority of Australians drink, and a substantial minority (35%) have done so at risky levels in the past year (Australian Institute of Health and Welfare, 2008c). If there are strong links between intoxication and a range of forms of child maltreatment of varying levels of severity, it is likely that many children have been affected by the drinking of parents and carers, or by mistreatment by others whilst their parents or carers have been affected by alcohol. The current child protection system in Australia is a service system that manages over 300,000 reports and approximately 50,000 substantiated (or confirmed) cases of child maltreatment a year (Australian Institute of Health and Welfare, 2008b; Child Family Community Australia, 2012). There is evidence from across Australia that alcohol is involved in a substantial proportion of these cases (see Chapter 2). That so many children are affected, and an even greater proportion potentially affected, suggests that the problem should be considered at a more general societal level, and not just in terms of individual cases. Recent
reviews have suggested a public health approach to child maltreatment that enables the problem to be viewed in terms of how it can be reduced overall, via different preventive strategies (Cummins et al., 2012; Hunter, 2011; O'Donnell, Scott, & Stanley, 2008).

Figure 3.1 depicts an expanded ecological model (based on that described by Cummins, et al. (2012), adapted from Bronfenbrenner (1979) and Garbarino (1977)). Placing the child at the centre, it shows how individual children are situated within the family and thus can be affected by the problematic drinking of their parents and other family members. The social and cultural circumstances, including conditions that result in problematic alcohol and other drug use within societies, set up the conditions of these children’s and families’ lives, and how they are managed or not by these systems are also referred to in Figure 3.1. The expanded ecological model, by displaying individual, family, and broader community and societal aspects, highlights different relationships and risk factors which can addressed to initiate change. There is evidence that children who are exposed to multiple risk factors and fewer protective factors are more likely to experience child abuse and neglect (Cummins et al., 2012; Fluke, Shusterman, Hollinshead, & Yuan, 2008; Gilbert, Widom et al., 2009).

Figure 3.1 Expanded ecological model, adapted by the author from Cummins et al (2012) and the “Ecological model of child development” by Garbarino (1977)
More recently a public health approach to managing child abuse and neglect has been advocated (O’Donnell et al., 2008). The attraction of a newer, public health approach is its ability to describe public policies and emphasise prevention as well as management of cases already within Child Protective Services. In the model, a whole-of-population approach is applied to managing child protection issues, moving emphasis away from “forensic-investigative driven” approaches to broader strategies that focus on identifying community and population level risk factors rather than individual and family level deficits (Cummins et al., 2012).

The public health model acknowledges that both individual and community strengths and deficits are important, but focuses particularly on the risk factors and responses for the child, the family, and the community, and enables the development of matching primary, secondary and tertiary management strategies (O’Donnell et al., 2008). Focusing here on the general and alcohol-related examples of these strategies, primary prevention includes universal programs that focus on community and societal level factors such as social inequality, community attitudes to corporal punishment, and community levels of drunkenness. Secondary or targeted prevention involves providing for high risk groups who need a range of services, such as those who may already be drinking heavily but not harming their children, and individual or tertiary level strategies seek to prevent further harm by managing those cases that have already been affected.

In a six-layered pyramidal, public health model, O’Donnell et al. (2008) describe how the child and family welfare, health and child protection systems should seek to respond to and prevent child abuse and neglect, defining the base layer of the pyramid as one where universal prevention is delivered by supporting all children and families. The second layer up describes targeted or secondary prevention by delivering services and programs to vulnerable families and children, whereas the layers above this in their pyramid all provide different levels of management of incidents where there is evidence of child abuse or neglect already.

### 3.4 A hybrid pyramidal model for understanding alcohol-related harm to children

The hybrid pyramidal model of alcohol-related harm to children used in this thesis is described in Figure 3.2. It has been adapted from numerous pyramidal models: Creighton’s (2004) model, in which it was used to describe the number of cases that were hidden from Child Protective Services; Hope’s (2011) model, that described more specifically increasing risk of severe outcomes for children associated with other people’s (primarily carers’ and
parents’) drinking; and the public health model of O’Donnell et al. (2008) which describes the responses required to prevent and manage child abuse and neglect. Figure 3.2 depicts all confirmed cases of child maltreatment in the top layer – including children in out-of-home care and children who are receiving protective interventions because of others’ drinking (Layer 1). This top layer is focused on the individual families and children that have been harmed who have been identified and managed in the child protection system. The aim of government social systems or the public health model at this level is a tertiary preventive one – that is, to manage children whilst they are in crisis, and prevent further harm to these children, in this way assisting their departure from and preventing their return to the system (O’Donnell et al., 2008).

Figure 3.2 Pyramidal model of alcohol-related harm to children
[Adapted from the pyramids of Creighton (2004), Hope (2011) and O’Donnell et al. (2008)]

The second layer down includes children with incidents of child maltreatment which have been confirmed or substantiated, but who do not need to be handled further within the child protection system. This may be because the case could be handled by family support services, or because, whilst the incident was confirmed, the child is no longer at risk. It may be the case that the alcohol problem of the parent did not warrant intervention or that the family was
better managed by alcohol and drug services, and child protection responses were not appropriate.

The third layer includes children in families where welfare concerns have been identified and are the target of intervention because drinking within the family is a risk factor. However, there may not be any evidence of child abuse and neglect. These families and children in their care may be the subject of notifications (but not substantiations) or may seek or be offered additional support independently (via a range of welfare mechanisms), either wholly or partially because of alcohol problems. In Australia these families would include those families referred to family support services and perhaps alcohol and drug treatment services but not substantiated by Child Protective Services, and those families where the drinking of the carer or carers may be having financial or emotional impacts, but the child is at not deemed to be at significant risk. The purpose of providing these targeted social supports is to prevent these children from being significantly harmed and to assist them without their entry into the child protection system (O'Donnell et al., 2008). These families ideally receive targeted individual family-level secondary preventive services because of their at-risk status. In theory all families with heavy drinking family members might be targeted in this layer of the pyramid. In reality it is families with multiple problems, and heavy drinking carers, that form the subset of families in Australia that receive such services. So intervention is provided because some families are deemed in “need” and at “risk”. Families with heavy drinking carers and few other risk factors may sit lower than this in the pyramid.

Children experiencing neglect and abuse as a result of someone else’s drinking which has not been reported, and who have no contact with welfare systems, appear in Layer 4. Very little has been known about these families, the harms they experience and the drinking patterns of their carers. The children and carers in this layer are highly likely to avoid the gaze of social agencies (Sargent, 1973).

The difference between the second and third layers from the top may be only that, for children in the second layer, the incident has been confirmed and the child and family are known to Child Protective Services, whereas in the third layer there is less information, and only potential situations that may be problematic for children and linked to alcohol. The difference between the second and third layers from the top and the fourth layer is that children and families in the second and third layers are in contact with welfare services, whilst children in the fourth are not. This may be similar to the two worlds characterised by
Störbjork and Room (2008) study – one composed primarily of heavily disadvantaged families, visible to the authorities, and another more privileged world where there are problems but they are more hidden and less likely to be managed by Child Protective Services or other support services.

In Layer 5, children are perceived to be at some risk because they live in households where hazardous drinking occurs. The base of the model (Layer 6), includes all children, who are put at some risk simply by virtue of the fact that they live in a culture where adults drink hazardedously and are perceived to model and perpetuate a heavy drinking culture (Hope, 2011).

Figure 3.2’s population pyramid places the harm and risk of harm to children associated with drinking in perspective. It suggests on the one hand how children in care are fewer in number but are more severely affected by carers’ drinking at the peak of the pyramid, and on the other hand, the increasing prevalence of these problems as they are constructed more broadly. This pyramid of risk characterises the alcohol-related dimensions of child maltreatment.

The public health model and the hybrid pyramidal model for alcohol-related harm to children discussed here acknowledge the need to prevent further harm and provide targeted services via secondary and tertiary prevention strategies, but suggest that the most effective way of managing alcohol-related harm to children may be through primary prevention (O'Donnell et al., 2008). There is a strong public health argument that suggests it may be more effective to target children and families whose complex problems and situations are not quite so intractable, although crisis systems still need to be maintained for the most vulnerable (O'Donnell et al., 2008). To prevent there being large numbers of severely affected children at the apex of the pyramid, services should be targeted at preventing problems earlier, in the broader populations in the lower levels of the pyramid.

Whilst a public health approach is used to frame the research in this dissertation, there is tension between individual and public health approaches – there are arguments about the sensitivity and specificity of child protection practices, and in providing services to all. If tertiary approaches dominate, and funding is directed only to those most devastated (who may be harder to help), there is less funding for the larger population of children in need and more children may be left unassisted, although their problems may be less severe (Littlechild, 2008).
The reality is that there will always be a need for emergency response systems that focus primarily on individual and family problems and individual deficits, and that public health approaches are also critical. Indeed, how much leeway or risk should be entertained when consuming alcohol around children is not only an individual question but a social and public policy one. How best to manage the risks of parental and carer drinking to children is a contentious question, as is the question of when should governments intervene and at what level to protect and support children individually and more broadly.

In public health approaches to decreasing alcohol-related harm, primarily by reducing harms to drinkers, increased price, decreased availability and restrictions on advertising have been demonstrated to decrease the number of drinkers and heavy drinkers (Babor et al., 2010). These interventions would theoretically impact on all levels of the pyramid by acting to reduce drinking by parents and carers and hence drinking-related problems.

There is less evidence that suggests that the most severely affected children (towards the apex of the pyramid) would benefit from the policy interventions described above. However, evidence from small community studies has shown, for example, decreased admissions to hospital of aboriginal women as victims of domestic violence when alcohol availability restrictions have been implemented (Douglas, 1998). Further studies are needed to examine whether these policy interventions are effective with other larger communities with high concentrations of children known to child protection.

3.5 The plurality of understandings about the harms and risks of carer drinking to children

This chapter details how individual, sociological and public health models understand child abuse and neglect. The model developed in this chapter highlights the potential alcohol-related links to child maltreatment and ultimately, taking into account other explanations of the problem, situates this problem in a public health frame. Importantly this chapter presents a model for understanding alcohol-related child maltreatment – the “Pyramidal model of alcohol-related harm to children” that informs how children are harmed or put at risk because of their carers’ drinking – and illuminates ways in which alcohol-related child maltreatment might be managed within a public health frame. It also alludes to the reasons why some groups are more likely to found in certain layers than others.
In this thesis the focus is on Layer 1 of the pyramid – children who have been substantiated in Child Protective Services and Layer 4 – children who have been harmed but we know little about.
Chapter 4 Research questions and aims

4.1 Introduction

Whilst there is a long history of concern about how children can be affected by their carers’ drinking and a considerable body of international research undertaken within child protection systems, the study of the involvement of carers’ drinking in child abuse in Australia is relatively underdeveloped. Whilst carer drinking is recognised as a factor in child abuse, there is limited knowledge of the range of ways in which alcohol problems appear in the child protection population. Alcohol’s involvement has not been ascertained in different types of child maltreatment in Australia, or in cases at different stages of the child protection process within the one system. Many analyses of child protection data have been purely descriptive and have not taken multiple factors into account at the same time, using multivariate techniques. The pathways through child protection systems of cases that do and do not involve alcohol have not been tracked and compared. How much cases where there is carer alcohol abuse reappear in the system has not been examined in Australia.

A number of large North American studies of child protection cases have identified alcohol and other drug use as key factors in renotifications and resubstantiations (Fluke & Shusterman, 2005; Fluke et al., 2008; Trocmé et al., 2005), although findings on the relative importance of the effect of alcohol versus other drug use are inconsistent. Substance use, sometimes including alcohol and drug use separately and at other times not, is usually incorporated in these studies as one of many important factors that have been shown to predict child maltreatment (see the introduction to Chapter 8). English work has focused on more severe outcomes, including entry into out-of-home care, and found that parental drinking is a predictor of poorer outcomes (Forrester & Harwin, 2008). However, as child protection practice has focused on establishing who should enter the system, management of children in the system and prevention of recurrence, there has been little substantial attention paid to primary prevention (see the discussion in the previous chapter). Individual risk factors, and particularly alcohol misuse as a risk factor, have been viewed as deficits of individual parents and families. How substantially these factors contribute to the problem, and how a public health approach (compared with individual child and family based approaches) might be utilised to reduce the problem by primary prevention, have been conceptualised but little investigated (Hunter, 2011; O’Donnell et al., 2008).
One reason that there has been resistance to public health approaches is that there has been a tendency to marginalise child abuse as a problem that is presumed to occur only, or largely, in “other,” and usually less affluent families (Luthar, 2003). As discussed in Chapter 2, studies of child maltreatment have mostly focused on cases that have been identified and handled in the child protection and other systems dealing with cases singled out for attention, and there has been a long history of intervention in individual families to remove children in order to protect them (Nelson, 1986; Scott & Swain, 2002). Studies of child maltreatment in the general population are extremely limited (Adamson & Templeton, 2012). Likewise there is only limited understanding of how alcohol-related child maltreatment might be defined and described in the general population (O'Donnell et al., 2008). Parenting capacity has been addressed in some recent longitudinal studies of the family in Australia (Australian Government Department of Families, 2011), although alcohol involvement has not been well recorded or fully analysed in these studies. Indeed, the prevalence of alcohol-related child maltreatment (even by self-report) in general population samples has not been described to date, except in one United States study via one question in 1995 (Straus et al., 1998).

With few studies of the general population, it has not been possible to compare the social location of alcohol-related child maltreatment cases in the child protection system and the general population. To address the gaps in our knowledge, a number of questions have been identified, and answering these is the primary function of the research presented here.

4.2 Research aims

In this thesis harms to children because of others’ drinking are examined through two different windows which offer different perspectives on how children may be affected by their carers’ drinking. The first window is that of the child protection system, the window through which child protection workers see how children are affected by their parents’ and others’ drinking. The second window asks adult respondents in a general population survey how their children have been affected by others’ drinking. The study aims to determine the size of the problem according to different definitions and describe and compare those affected in both these windows.

The first window examines the issues through the child protection system data, making a number of further analyses possible that aim to examine the relationship between carer alcohol “abuse” as a risk factor and more severe child protection case outcomes and repeated instances of confirmed child maltreatment.
The second window examines the issues through a general population survey in which respondents are asked to attribute cause and describe instances of alcohol-related harm to children. This study aims to describe the distribution and the frequency of this harm in society, including more and less serious instances of harm to children. Together these perspectives aim to provide a comprehensive picture of alcohol-related child maltreatment. Consequently this research aims to:

i) document the extent of alcohol involvement in child protection cases in Victoria,

ii) analyse the demography of cases to determine the social location of alcohol-related child protection cases,

iii) explore alcohol in relation to a range of other risk factors for child protection outcomes,

iv) estimate the number of Australian families where children have been affected by someone else’s drinking, using questions that stem from key definitions of types of child maltreatment used in the child protection system,

v) assess the severity of alcohol-related child maltreatment in the general population,

vi) compare the rate of alcohol-related child maltreatment in the child protection system and the general population, and

vii) compare the social location of alcohol-related child maltreatment in the child protection system with that of alcohol-related child maltreatment in the general population.

4.3 Importance of this research

This dissertation will provide an improved understanding of the role of alcohol in different types of cases of child maltreatment, as well as cases at different stages of the child protection process. The national survey will provide important initial information about how the alcohol consumption of others affects children more broadly, including an initial estimate of the extent of this problem. The social location of alcohol-related child maltreatment in families identified in the child protection system and in the general population will be compared, and the results discussed in the context of various explanations of how carers’ and
others’ drinking may result in child maltreatment and may, or may not be, reported and substantiated within the child protection system.

The value of this study also lies in its ability to enable comparison of the two windows discussed. A number of questions arise when the findings about alcohol-related child maltreatment that emerge from the two windows are compared. These include:

- What are the relative estimates in the Child Protective Services and the general population of the numbers of children who have been affected by their carers’ drinking in different ways?

- How do social class and other demographic factors predict alcohol-related child maltreatment in the child protection system compared with the general population?

- What can we say about how alcohol-related child maltreatment is managed in the general population as compared with how it is identified and managed in the child protection system?

This work will fill gaps in knowledge about the relationship between alcohol and child abuse and neglect in both the case-register and the general population windows. Perhaps most importantly, the study will provide results and inform public policy decisions around parental risky drinking and general alcohol harm minimisation strategies, potentially contributing to the prevention of child abuse. The following chapter details the methods through which these research aims will be addressed in order to better understand the relationship between alcohol and child maltreatment.
Chapter 5 Methods and datasets

5.1 Introduction

This chapter provides an overview of the methods used in the thesis and is divided into two main sections. The first focuses on children, cases and carers in the Victorian Child Protection system. It defines the data and describes the methods used to record information about child protection cases, including carers’ drinking in these cases. It then goes on to describe the five years of Victorian Department of Human Services Child Protection data examined in this research, as well as the techniques employed to analyse these electronic case files retrospectively.

The second section provides details on a national survey that was used to identify and analyse patterns in households where children have been affected by someone else’s drinking. Statistical techniques used for these analyses are also detailed.

In this thesis both data sources have been used to measure various adverse effects attributable to the alcohol consumption of others on children and describe the demographic and other characteristics of those households where children have been affected by child maltreatment. A number of definitions have been applied in both data sources. Child abuse and neglect are similarly defined by the Victorian Department of Human Services (2007) and the Australian Institute of Health and Welfare (2008b). In the survey the questions about the types of harms experienced are based on these child abuse and neglect definitions. Respondents are asked whether their children have experienced the instances of harm discussed, and they bring their personal understandings, and not necessarily any professional training, into their understanding of the problem and the nature and seriousness of the incident, as well as whether alcohol was causal in the incident. Similarly, the opinions of child protection workers as to whether alcohol was implicated in the case, and whether there is evidence of child abuse and neglect, are based on an individual protective worker’s perceptions and judgements, although after having been trained and with varying levels of experience.

An overview of the methods employed will be included in this chapter, although more detail will be provided alongside the results and discussion chapters in the thesis.
5.2 Child protection data system methods

Setting: The child protection system within Victoria

Victoria is the second most populous state in Australia, and the most urban, with around three-quarters of its population of 5.4 million people living in Melbourne, the state capital. It reports similar or slightly lower substantiated child abuse rates than the other states (Australian Institute of Health and Welfare, 2008b). Victoria is fairly close to the Australian average on dimensions of drinking, although its per capita consumption level is lower than Australia’s overall level (Australian Institute of Health and Welfare, 2008d).

The system studied in this thesis is the Victorian Child Protective Services system, a division of the Victorian Department of Human Services (DHS). Family Services is a separate but linked state government unit, also within DHS, that works closely together with Victorian Child Protective Services. Family Services in Victoria provides a range of support services to Victorian families (State Government of Victoria, 2011), and in particular to those families perceived to be vulnerable or at risk, including parents dealing with alcohol and drug problems, e.g., to improve the family’s community connections and access to community resources (Centre for Excellence in Child and Family Welfare, 2012). Victorian Child Protective Services have statutory responsibility to determine whether children in Victoria are being harmed or at risk of harm, and to determine whether children are “in need of protection” (Department of Human Services, 1999).

Thus, in Victoria, in instances where families appear limited in their ability to keep children safe, Child Protective Services investigates and intervenes. These interventions are not undertaken lightly; they are deemed necessary for a range of reasons defined by type of harm, the seriousness of the harm and the parents’ ability to protect the child from further harm. Any person who believes on reasonable grounds that a child is in need of protection may contact a “protective intervener” who is then required as soon as practicable to investigate the claim (Victorian Department of Human Services, 2002). Between 2001 and 2005, the period of the dataset used in this study, all calls regarding concerns relating to children’s safety and wellbeing were managed by Child Protective Services intake workers. Whilst any person may contact Child Protective Services to report suspected abuse, teachers, members of the police force, medical practitioners, nurses and midwives are mandated in Victoria by law to report situations where they believe a child is in need of protection from physical and/or
sexual abuse, and to provide grounds for this belief (Cummins et al., 2012). At the first point of contact with Victorian Child Protective Services, decisions are made regarding whether the case (family and child) requires no further action, should be referred for support services or be formally investigated. Whether the child and family are best provided for by Family Services or Child Protection is decided at this point, although exit points in the system enable referral to Family Services later within each pathway, and Family Services may commonly refer to Victorian Child Protective Services in a kind of a feedback loop – see Figure 5.1 (Victorian Department of Human Services, 2002). The stages in the Victorian Child Protection process, including notification, investigation, intervention and court order phases, are similar to those outlined above for all Australian states (Australian Institute of Health and Welfare, 2008b).

Intake workers receive calls from persons reporting their concerns to Child Protective Services. These workers triage these reports. In the “Intake phase”, following the report, information provided by the person or agency making the report and third parties, such as schools who may also have information relevant to the child’s case, as well as any information already on the database, is assessed. The Intake outcome decision (to close, refer or investigate the case) triggers the investigation phase. In this phase assessment is undertaken of the parents’ or carers’ responses to the allegations, of the child’s wellbeing, views and wishes, and of any information provided by third parties obtained during the

![Figure 5.1 Progression through Child Protection, Victoria, Australia, 2001-2005](image-url)
course of the investigation (including specialist assessments if necessary). Those cases not considered to require an investigation may be dismissed or referred to Family Services without further Child Protective Services involvement. Very little information on alcohol involvement is recorded about notifications that are dismissed at this point.

The investigation outcome decisions include: not substantiated; substantiated and no further action required; substantiated and further protective intervention needed; and in a small number of cases, a recording that there was insufficient information to base an investigation on. Again, a large percentage of notifications are dismissed at the investigation stage, because the case is not substantiated or there is insufficient evidence. After substantiation cases may also be dismissed because, although substantiated, no further action is required. Cases may be referred back to Family Services at this point.

The purpose of the investigation is for the child protection worker to judge whether the child is “in need of protection”. This is defined in the relevant Victorian Act (Children and Young Persons Act 1989, pp. 75-76):

For the purposes of this Act a child is in need of protection if any of the following grounds exist—

(a) the child has been abandoned by his or her parents and after reasonable inquiries—
   (i) the parents cannot be found; and
   (ii) no other suitable person can be found who is willing and able to care for the child;

(b) the child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child;

(c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;

(d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
(e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;

(f) the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

In summary, as is noted by the Australian Institute of Health and Welfare (2008b, p. ix), this means the child protection worker must ascertain whether there is sufficient evidence to form a belief that a child is being harmed, has been harmed or is at risk of significant harm and “conclude that the child has been, is being, or is likely to be, abused, neglected or otherwise harmed”. The Victorian criteria are essentially similar to the general Australian definition. If the child protection worker determines that any of the above criteria are met, the case is “substantiated”. The involvement of alcohol and other risk factors in Victorian child protection cases was recorded between 2001-2005 for all individual cases as part of the substantiation process (Bounden, 2009). This thesis focuses on substantiated cases.

Following substantiation, Child Protective Services determine whether a child protection intervention is required. This protective intervention stage is intermediate between substantiation and care and protection court orders and involves provision of support and monitoring of the family’s and child’s situations. Child Protection interventions usually involve implementation of a plan (commonly involving other services, sometimes just involving extended family) to address the issues identified. Where possible the intervention is decided on by agreement with the family. The intervention also reflects an assessment of the plan’s viability. Interventions (or service dispositions) following substantiation include provision of ongoing child welfare services; referrals to other services; and sometimes placement of children in out-of-home care (when in agreement with, and when placement is with, other family members, without a court order) (Department of Human Services - Victoria, 2007b).

The court order phase involves supervision of a number of types of court orders, the majority of which include temporary or permanent removal of the child, although may include closely
supervised orders with a number of conditions (e.g., alcohol and other drug treatment, testing for compliance with alcohol and drug treatment) imposed by the Children’s Court. Progression through to these later stages is indicative that a child has been significantly and seriously harmed or is at risk of significant harm that requires Child Protection to intervene. Court orders commonly but do not always involve removal of the child from the custodial carer/s. They also include court supervised conditions (De Bortoli et al., 2013; Department of Human Services - Victoria, 2007a).

Assessing risk

Much of the Child Protective Services process depends on the assessment of risk. Advice regarding determination of risk during the period of data collection is provided in the Victorian Risk Framework (VRF) (Department of Human Services, 1999).

The Victorian Risk Framework (VRF) is an assessment tool that was introduced in 1999-2000 (Department of Human Services, 1999; Victorian Department of Human Services, 2002). It makes clearer how child abuse and neglect cases are defined and the judgement that is involved in arriving at decisions in each of the stages of the child protection process. The VRF examines “the relationship between the degree of harm and the probability of the believed harm occurring” (Department of Human Services, 1999, p. 3) and involves evaluation of harm which has occurred, and in addition assesses the probability of future harm. The “risk assessment process” involves gathering information, analysis of information and judgement of risk for the purpose of “risk management” – including information on the child, parents, opportunities for harm, sources of harm and formal and informal support networks. Analysis involves examining the severity of harm, the vulnerability of the child per se and in situ, and the likelihood of harm, given patterns, beliefs and complicating factors and safety or protective factors (Western Suburbs Legal Service, 2008), including alcohol and other substance abuse (Department of Human Services, 1999).

Recording of carer alcohol abuse by Victorian Child Protective Services

In Victoria alcohol abuse by parents and carers was compulsorily recorded as a “likely” risk factor in 2001-2005, once a case was substantiated (Department of Human Services, 1999). It is recorded as a risk factor by workers as it relates to consumption by any parent, carer or adult in the household, or by more than one or all of those in the household (Department of Human Services, 1999, Appendix 5, p. 24; Victorian Department of Human Services, 2005a).
The incorporation of likely acknowledges the reality that confirming alcohol abuse in diagnostic (and even lay) terms is difficult in contexts where protective workers operate (e.g., families may try to conceal alcohol problems).

Whilst there is a modus operandi for reporting likely parental or carer alcohol abuse, i.e., a simple tick box that must be ticked before passing to the next question, there are only hints on how this should be determined in practice. One such way is documented in “The Victorian Protocol between Drug Treatment Services and Child Protection” (Department of Human Services, 2002). This document informs alcohol and drug workers (and child protection workers) that “Approximately half of all child abuse and neglect cases investigated by Child Protection in Victoria involve some degree of problematic alcohol or other drug use by the child’s parents,” and one third of cases involve alcohol (Department of Human Services, 2002). The protocol describes a range of ways that children in these families may be affected, and is described on p. 75.

The protocol explicitly states that an example of a situation where a notification should be made by an alcohol and drug worker is

if a parent presents as seriously affected by alcohol or other drugs and has the sole care of a child whose safety would be compromised in the care of that adult. (p. 1)

This may make intuitive sense, but the implication in the protocol is that alcohol intoxication per se may be unequivocally and almost inevitably linked with child maltreatment. If this is the case, as can be seen from Chapter 1, it implies a far greater prevalence of child maltreatment in the general community that is unrecognised and in need of attention.

Child protection workers have been given guidelines about when alcohol or other drugs are cause for concern in the Victorian Risk Framework (VRF), although most of this document pertains to general risk assessment (see below). The VRF was developed in 1997 (Department of Human Services, 1999) and is widely used in Victoria (Bamblett et al., 2010).

Substance abuse (including either or both alcohol and other drug use) is first mentioned in the VRF in a section entitled “complicating factors” (p.8) and then in the section under Risk Assessment (p. 16) and Risk Analysis (p. 19). Using the VRF, child protection workers are expected to assess and judge consequences as “extreme”, “serious” or “concerning.” Substance abuse is noted as an example of “extreme harm” (Department of Human Services, 1999), and where harm is “concerning” (p. 22). However, whilst these references to
substance abuse are clear in the VRF, the text then proceeds to describe what it is the child protection workers should be assessing, judging both the consequences of harm and the probability of harm and how this can be used to assess future risk, which child protection workers must then categorise as high, medium or low, whilst considering the immediate and longer-term safety of the child (Department of Human Services, 1999). So, in this definition risk is clearly based on severity, vulnerability and likelihood, and this likelihood of harm must be carried forward into the future, suggesting that the risk should be more than likely. The VRF states that “behaviour which has been consistent in the past through a series of scenarios will probably re-occur in the future” (p. 8). Moreover this likelihood should be assessed, according to the VRF, given previous patterns, in the absence of effective interventions, given the beliefs of the carer about their actions and capacities and in the light of complicating factors. The importance of these complicating factors is gauged by the “extent to which they, singularly or in combination, diminish capacity to provide sufficient care and protection to the child or young person” (p. 8).

Later in the document the assessment of these types of factors are again referred to in “the risk profile” and include initial screening questions, risk factors and comprehensive assessment questions. A specialist assessment tool indicated for parents with potential substance abuse issues was also included within the VRF. In summary, the VRF indicates that where alcohol abuse is “extreme”, “serious” and “concerning” it is likely to recur, but should not stand alone as a reason for intervention. However on these matters the VRF, although widely used in Victoria at the time of data collection period (Bamblett et al., 2010), is somewhat contradictory and unclear.

Thus, child protection workers should be focused on functionally defining alcohol as problematic in the specific context of child abuse and neglect – and whether the behaviour does cause a problem for the child or place them at risk. Whether the alcohol problem is dependence or abuse, as defined in formal diagnostic systems, is largely irrelevant. In this thesis the term “carer alcohol abuse” is used throughout with the meaning it has in the Victorian context. Nevertheless, the limitations of this terminology are recognised; carer alcohol abuse will probably include some cases where the level of alcohol involvement is unclear. Another factor which bears on the validity of this category, is that in South Australia, where the presence of alcohol was compared in electronic and case-note data, there was
evidence that electronic systems severely under-reported alcohol problems by carers (Jeffreys et al., 2009).

Data used in the analysis

The Victorian child protection data collection system was originally designed to enable recording of essential elements of hand-written case-notes. It was developed primarily for case work but was also developed to enable statistical or socio-epidemiological research. The Child and Services Information System (CASIS) was introduced in 1993 (Prent, 1995). Data were collected on reports, notifications, substantiations and more serious outcomes in the protection system, including protective interventions and court orders. Once cases were deemed appropriate to be managed in the Child Protective Services system, information on these cases was entered into CASIS by child protection workers at each stage of the process. The system collected important characteristics, including alcohol problems of carers, compulsorily.

This component of the study will use five years of Victorian child protection data from the CASIS in a retrospective case review. Over 300,000 de-identified case records on children notified to Child Protection between 2001 and 2005 were obtained. Data were provided for use in this study in three separate files: one each on the demographic details, risk factors, and case outcomes for each case. These were cleaned, and then merged on the basis of a unique client code to enable analysis by both case and child. Linkage between children in the same family was not possible, so analysis by family was not possible.

In the years 2001-2006, according to the CASIS Regional Download Information (Victorian Department of Human Services, 2005a), “parental alcohol abuse” was mandatorily recorded as a “family characteristic” in CASIS at the substantiation phase of the child protection process. Child protection workers coded parental alcohol abuse as “yes – likely”, “no – not likely” or “unknown”. “Parental substance abuse” and “Child substance abuse” were separately and similarly coded. Whilst the terminology makes it clear that parental alcohol abuse was most often assessed, alcohol abuse by other carers was also recorded in this field. We use the term “carer alcohol abuse” throughout this study, acknowledging that the field may refer to alcohol abuse of one or both parents or carers, or combinations of parents and carers, and that the electronic field notation does not distinguish between whether the child was threatened or harmed by the person (or persons) with alcohol abuse, or whether the carer
was unable to prevent risks or harms from others (i.e., whether the carer was the “protective” or “perpetrating” carer).

From 2006 onwards CASIS has been replaced progressively by the Client Related Information System (CRIS) database. In the CRIS database, carer alcohol abuse is no longer compulsorily recorded as a family characteristic, although it is still possible to record “alcohol abuse” and “other substance abuse” as family risk factors, although Victorian Department of Human Services personnel indicated that this was no longer completed as reliably as previously, now that completion of the field is not compulsory (Bounden, 2009).

**Key outcome and explanatory variables**

The outcome variables in this thesis have been selected from within CASIS. Alcohol-related substantiated cases are those cases where carer alcohol abuse and a substantiation have been recorded. Alcohol abuse is compulsorily recorded for one or both carers or other family members who may have been held responsible. The variable “carer alcohol abuse” discussed earlier has been coded: “yes” = 1 and “no” or “unknown” = 0.

In this dissertation, carer alcohol abuse has been used as an outcome and an explanatory variable in different situations as different analyses have warranted. It has been assumed that where carer alcohol abuse has not been recorded that alcohol was not involved, although there is likely to be under-reporting of this, as carers may seek to conceal this from child protection workers, and workers may not perceive heavy drinking or alcohol abuse as a problem, particularly in relation to other drug abuse.

In Chapter 6 carer alcohol abuse substantiated cases are used as the outcome variable for descriptive analyses. In Chapters 7 and 8 more serious stages in the Child Protective Services system and repeated experiences of child maltreatment have been used as outcome variables, and carer alcohol abuse has been used as a predictor variable. Construction of the child protection stage and repeat cases variables are detailed in Chapters 7 and 8 respectively.

**Explanatory variables: socio-demographic factors, family characteristics and risk factors**

The full list of family characteristics or risk factors, child factors and socio-demographic variables are listed in Table 5.1. As the carer alcohol abuse variable was, the other “risk factors” or “family characteristics” listed below were coded “Unknown”, “No” or “Yes” by Victorian Child Protective Services workers, with coding mandatory at the completion of the
investigative stage (moving on to the next field was not possible unless a code was assigned). The other drug, use and domestic violence variables also included “likely” (as discussed on the previous page), whilst other risk factor variables did not. These risk factors were provided in a dichotomised format to the researchers: “1” indicated a child protection worker recorded the presence of a risk factor, and “0” that a worker indicated that a risk factor was not present or that they did not know whether the risk factor was present or not. All of the “parental” or family risk factors may have referred to any adult within the household, including the alleged maltreating parent, the other potentially protective parent, both parents, or non-biological caregivers (Department of Human Services, 1999). A number of terms have been simplified or clarified, and the terms used throughout the thesis are presented in column 1 of Table 5.1. For example, in the alcohol and drug field “substance abuse” is commonly used to describe abuse of alcohol or other drugs, thus “Parental substance abuse – yes, likely” has been replaced with “carer other drug abuse” to avoid confusion.

A range of social and demographic characteristics and contextual factors important for different child protection outcomes have been included because (a) they have been identified as correlates or causal conditions in previous research, and (b) they are available for analysis within the existing CASIS data set.

Child’s gender and age were used in the majority of analyses, with age grouped into 0-3 years, 4-11 years, and 12+ years. Family type was also recorded in CASIS and was coded as: “intact” where two biological parents were present; “extended family” where additional relatives (a couple or one other) had care of the child, or were present in addition to biological parents; “step” which included stepfather or stepmother families; “blended” which included a non-biological parent and in addition included children from different relationships; “sole parent,” which included sole father and sole mother families; and “other” families which include a couple or one person without these connections and children.

Accommodation status was coded as “own/buying,” “renting – other,” “renting – public housing” and “caravan/ no fixed abode” and “other”. Family income type coded was coded as “pension”, “wage/salary low”, “wage/salary medium” and “wage/salary high.” This income type variable was based on Victorian Child Protective Services workers’ assessments of the family’s situation during the interviews in the investigation stage. There are no set criteria for income levels associated with these categories. Thus the low, middle and high income
categories in the Child Protective services data do not correspond to exact income bands and working families are simply classified as being on low, middle or high incomes.

Table 5.1 Table of variables: Family characteristics, child characteristics and socio-demographic variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Wording in form completed by child protection worker</th>
<th>Variable responses: record categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk factors or family characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer alcohol abuse</td>
<td>Likely parental alcohol abuse</td>
<td>0, 1</td>
</tr>
<tr>
<td>Carer other drug abuse</td>
<td>Likely parental substance abuse</td>
<td>0, 1</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>Likely parental domestic violence</td>
<td>0, 1</td>
</tr>
<tr>
<td>Carer history of child abuse as a child</td>
<td>Parent previous client</td>
<td>0, 1</td>
</tr>
<tr>
<td>Carer mental illness</td>
<td>Parental mental illness</td>
<td>0, 1</td>
</tr>
<tr>
<td><strong>Child characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child age</td>
<td>[Continuous]</td>
<td>0-3 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4-11 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12+ years</td>
</tr>
<tr>
<td>Child gender</td>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td><strong>Socio-demographic characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family type</td>
<td>Intact</td>
<td>Intact</td>
</tr>
<tr>
<td></td>
<td>Extended</td>
<td>Extended</td>
</tr>
<tr>
<td></td>
<td>Step-mother + carer; and</td>
<td>Step</td>
</tr>
<tr>
<td></td>
<td>Step-father + carer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blended</td>
<td>Blended</td>
</tr>
<tr>
<td></td>
<td>Sole father and sole mother</td>
<td>Sole parent</td>
</tr>
<tr>
<td></td>
<td>Foster care and institutional</td>
<td>Other</td>
</tr>
<tr>
<td>Accommodation status</td>
<td>Own/buying</td>
<td>Own/buying</td>
</tr>
<tr>
<td></td>
<td>Renting – other</td>
<td>Renting – other</td>
</tr>
<tr>
<td></td>
<td>Renting– public housing</td>
<td>Renting– public housing</td>
</tr>
<tr>
<td></td>
<td>Caravan/ No fixed abode</td>
<td>Caravan/ No fixed abode</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>Family income type</td>
<td>Sole Parent Pension</td>
<td>Benefit or Pension</td>
</tr>
<tr>
<td></td>
<td>Unemployment Benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Pension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wage/Salary High</td>
<td>Wage/Salary High</td>
</tr>
<tr>
<td></td>
<td>Wage/Salary Low</td>
<td>Wage/Salary Low</td>
</tr>
<tr>
<td></td>
<td>Wage/Salary Medium</td>
<td>Wage/Salary Medium</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

*Although Child Protective Services call these variables family characteristics, in the main these variables relate to the parent’s or caregiver’s conditions. Child characteristics are recorded separately.

Analyses

In the following results chapters a number of different statistical techniques, each appropriate to the particular research question being addressed, have been employed. In Chapter 6
patterns of child maltreatment substantiations that involve carer alcohol abuse are described and presented according to a range of demographic and socioeconomic characteristics.

Chapter 7 focuses on progression through to increasingly serious stages of the child protection process and Chapter 8 focuses on repeat cases of substantiated child abuse and neglect. Whilst the outcome variables differ in these chapters, the risk factor investigated in each chapter is carer alcohol abuse (see the discussion on the following page for a discussion of this variable). In addition, in many of the analyses a range of social and demographic characteristics and contextual factors important for different child protection outcomes described above have been included or adjusted for in the analyses.

Data analysis has made use of a variety of methods appropriate to the nature of the data. For example, analyses have included: crude numbers of and rates per 1,000 children affected by carer alcohol abuse, and percentages of children at different stages within the protective services process who are affected by carer alcohol abuse. The social and demographic characteristics of these clients and their families (such as family income type and housing) have also been described. Bivariate Chi-square, t-tests and logistic regression have been used to examine data for significant associations between exposure and outcome variables. Confidence intervals have also been calculated and reported. Social and demographic variables have then been employed as explanatory variables and used to examine a range of different outcome variables. Multivariate analyses, such as multivariable logistic regression, have been used to examine the relationship between alcohol and the outcome variables, after adjusting for other factors. These also enable determination of which factors are most strongly associated with the outcome variables, including substantiation, protective intervention and protective order placement and repeat cases. Where variables were not significant at the bivariate level they were excluded in subsequent multivariate analyses, unless theoretical reasons for inclusion were strong.

5.3 General population study methods

The thesis utilised items from the survey included in the “Range and magnitude of alcohol’s harm to others study,” described here summarily as the “Harm to Others” project (Laslett et al., 2010). The Harm to Others project examined the harm from others’ drinking using secondary data analysis of existing surveys and public service registry data as well as a new national survey of the effects of others’ drinking. Combining multiple datasets, the findings described the prevalence of problems associated with others’ drinking that ranged from
minor nuisances to road and child abuse deaths due to the drinking of others. I directed this project and used this opportunity to access a national sample in the Harm to Others survey (Laslett et al., 2010; Wilkinson et al., 2009). Alcohol-related child maltreatment questions were added to the survey for the purposes of this dissertation and to address a research area where there were few general population-based findings. These data provide a second window through which to view alcohol-related child maltreatment, as perceived by a randomly selected sample of the general population. These questions, along with others from the Harm to Others survey, have been used subsequently by researchers in New Zealand (Casswell, You and Huckle, 2011), Ireland (Hope, 2011), and incorporated into the World Health Organisation Harm to Others from Drinking Protocol: A WHO/Thai Health International Collaborative Research Project (World Health Organisation, 2012).

Sample characteristics and data used in the analysis

The “Range and magnitude of alcohol’s harm to others’ survey” was conducted between October and December 2008, and involved a national landline telephone survey of 2,646 randomly selected Australians aged 18 years or older. The distribution of respondents across the Australian states and territories is shown in Figure 5.2.

![Figure 5.2 Number of survey participants by state](image)

Participants were selected by random digit dialing, stratified by geographic location, using rural and urban strata from each state and territory. Eligibility was restricted to persons living in private households and able to be interviewed in English, with the specific respondent in
the household selected by the next-birthday method (Wilkinson et al., 2009). The co-
operation rate was 50% and the response rate was 35%, based on the standards of the
American Association of Public Opinion Research (2006), including non-contacts estimated
to be eligible in the denominator. The sample was generally representative of the national
population in income type and level (Wilkinson et al., 2009), although men, young people,
less formally educated and overseas-born Australians were under-represented compared with
the general Australian population.

The Harm to Others Survey

Participants completed a computer-assisted telephone interview (CATI). A full description of
the survey instrument is provided in the technical report (Wilkinson et al., 2009). Briefly, the
Harm to Others survey instrument requested information on heavy and episodic drinkers who
were family members, household members, friends and work colleagues, and the degree to
which the drinking behaviour of these individuals had negatively impacted upon the
respondent. The section of the questionnaire used in this paper included questions regarding
how many children were living with the respondent (and children of respondents not living
with them, e.g., step-parents) and whether this child or these children had been affected by
the drinking of others. Other sections of the instrument requested information on the
respondent’s own socio-demographic information and drinking patterns.

Key outcome variables

Respondents with children living in the same house or for whom they have some parental
responsibility were asked a number of questions about harms experienced by their children
related to others’ alcohol consumption. These respondents were asked the four specific
questions in Table 5.2 that loosely mirrored the definitions of the types of primary harm,
excluding sexual harm, used by Victorian Child Protective Services, and child protection
workers more generally in Australia (Australian Institute of Health and Welfare, 2008b).
Participants were subsequently asked whether alcohol-related incidents were reported to
child protection or family services. This set of questions concluded with an overall question:
“How much has the drinking of other people negatively affected (this child/these children) in
the last 12 months?” The response options to this general question were a lot, a little or not at
all.
<table>
<thead>
<tr>
<th>Abuse type</th>
<th>Statements defining child abuse (Australian Institute of Health and Welfare, 2008b)</th>
<th>Survey question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional abuse</td>
<td>Emotional abuse occurs when a child is repeatedly rejected, isolated or frightened by threats or the witnessing of family violence. It also includes hostility, derogatory name-calling and putdowns, or persistent coldness from a person, to the extent where the behaviour of the child is disturbed or their emotional development is at serious risk of being impaired.</td>
<td>How many times was/were the child/ren yelled at, criticised or otherwise verbally abused because of someone else’s drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many times did the child/ren witness serious violence in the home because of someone else’s drinking?</td>
</tr>
<tr>
<td>Neglect</td>
<td>Neglect includes a failure to provide the child with an adequate standard of nutrition, medical care, clothing, shelter or supervision to the extent where the health or development of the child is significantly impaired or placed at serious risk. A child is neglected if they are left uncared for over long periods of time or abandoned.</td>
<td>How many times was/were the child/ren left in an unsupervised or unsafe situation because of someone else’s drinking?</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>Physical abuse consists of any non-accidental form of injury or serious physical harm inflicted on a child by any person. Physical abuse does not mean reasonable discipline though it may result from excessive or inappropriate discipline.</td>
<td>How many times was/were the child/ren physically hurt because of someone else’s drinking?</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>A child is sexually abused when any person uses their authority over the child to involve the child in sexual activity.</td>
<td>Not asked</td>
</tr>
</tbody>
</table>
Respondents who reported any of the specific items were asked “What was the relationship to the children” of the person/or persons whose drinking adversely affected them. The response categories for these identified persons were: caregiver (parent, step-parent or and/or guardian); sibling; another relative; family friend; or person with whom the child comes into contact such as a sports coach, teacher, priest; or someone else. Respondents were not asked about adverse effects on the children due to the respondent’s own drinking. To this extent, the maltreatment rates reported in the survey are an underestimate of total rates.

Prevalence rates of alcohol-related child maltreatment in the general population were calculated per respondent with children for whom they were responsible, and additional prevalence rates were also estimated per child (see Chapter 9 for further details).

Explanatory variables

Demographic data on the respondent’s gender (male, female), age (18-29, 30-59, 60-99 years), educational background (less than secondary, secondary or post-secondary), work status (paid work, other) and family income (less than $50,000, $50,000 to $74,999, $75,000 or more) were collected and summarised. A neighbourhood socio-economic status variable was constructed on the basis of the postcode of the respondent, using the Australian Bureau of Statistics Socio-Economic Indexes for Areas (Australian Bureau of Statistics, 2006a) measure, with participant postcodes grouped into quintiles according to SEIFA score. Household family structure was coded as “two carers with children”, “single carer with children”, and “other”. Respondent’s current drinking status was categorized as drinking five or more drinks weekly or more often, monthly, or not at all in the previous year.

Analyses

A weighted sample was used for analysis, with sampling weights set to reproduce the age, sex and geographic composition of the Australian adult population in the 2006 census. Weights were assigned as an inverse of sample selection probability. The weighted total number in the sample was set equal to the unweighted sample size. Stata S/E v11 was used for all analyses.

The results of survey questions will be used as outcome variables and analysed by a range of demographic, social and other explanatory variables cross-sectionally. As described earlier for the analysis of Child Protective Services data, statistical techniques appropriate to the
particular research questions have been employed. In Chapter 9, raw numbers and weighted percentages with confidence intervals have been used to obtain national estimates of the percentages of families where children have been affected by others’ drinking. Descriptive statistics, including mean, mode and range values, describe the frequency with which carers report children have experienced different types of specific harm. Bivariate (unadjusted) and multiple-variable (adjusted) logistic regression have been employed for outcome variables that are dichotomous to explore the relationship between explanatory variables and alcohol-related harm to children.

5.4 Ethics

Ethics approval for the overall project was obtained for the general population survey and access to Child Protective Services data from the Victorian Department of Human Services Health Research Ethics Committee (HREC), as well as the University of Melbourne HREC. Additional approval for access to the Child Protective Services data was obtained from the Victorian Department of Human Services Child Protection Research Coordinating Committee. Partway through the study, as Turning Point Alcohol and Drug Centre merged with a large state government health service provider (Eastern Health), the Victorian Department of Human Services HREC approval was transferred to the Eastern Health HREC.
Chapter 6 Prevalence of alcohol-related child abuse in the Victorian child protection system

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

(Department of Human Services, 2002, p. 1)

6.1 Introduction and scope

This chapter provides an initial description of the number of child protection cases in the CASIS sample between 2001 and 2005. The descriptive analyses focus on annual rates of overall child protection cases, type of abuse and the key socio-demographic characteristics outlined in Chapter 5. The numbers of cases that move through the pathways of the Victorian Child Protective Services system, and crucially for the purposes of this thesis, the percentage of cases that involve carer alcohol abuse in different types of child maltreatment (abuse, neglect or otherwise harmed) are presented. Whilst basic prevalence data are presented in this chapter, specific outcomes are examined more closely in Chapters 7 and 8.

6.2 Methods

As described in Chapter 5, this study involved a retrospective case review from routinely-collected electronic records completed by statutory child protection workers in Victoria, Australia between 2001 and 2005. The numbers of cases that enter the system at each stage are described, but this chapter focuses attention on the substantiated cases that involved carer alcohol abuse. These cases are described and compared with cases that do not have any such record of carer alcohol abuse. Descriptive statistics on alcohol involvement were generated.
for the 38,487 cases of child maltreatment substantiated between 2001 and 2005. These cases were analysed by the family, social and demographic variables described in Chapter 5.

6.3 Child protection system numbers, rates and pathways

Information was available on 188,063 cases managed in the system over the period 2001-2005. This represented 97,684 children, meaning that children were recorded as cases on average 1.3 (CI: 1.29, 1.32) times across this five-year period. The pathways of these cases are depicted in Figure 6.1 (derived from Figure 5.1). Of the total number of notified cases, 38,487 or 21% were substantiated. Of those cases that were substantiated, 28% were substantiated but no further action was taken, 50% received a protective intervention but not a court order, and 22% went on to receive a court order.

Figure 6.1 Pathways through the Child Protective Services system in Victoria, Australia, 2001-2005 (ns processed at each stage in this period)

6.4 Alcohol involvement in substantiated cases over time

Figure 6.2 depicts the annual rate over the five-year period of overall substantiated cases of child abuse and the rate of substantiated cases that involve alcohol per 1,000 children. In 2001 the average annual rate of substantiated child protection cases was 7.1 per 1,000 children; in 2005 this figure had decreased slightly to 6.7 substantiated cases per 1,000. There was little change over time from the rate of 2.4 to 2.3 per 1,000 children in substantiated
cases with reported carer alcohol involvement. The percentage of substantiated cases that involved carer alcohol abuse also changed little over this time period, with 34% (2.4/7.1) cases in 2001 involving carer alcohol abuse and 34% (2.3/6.7) cases doing so in 2005.

**Figure 6.2 Child protection cases per 1,000 aged 0-16 years in Victoria, Australia, 2001-2005**

*17 year olds have been excluded from this figure because of small numbers and comparability with existing published rates for Victoria, Australia

### 6.5 Alcohol involvement in substantiated cases by type of abuse

Table 6.1 shows that carer alcohol abuse was most commonly identified among parents or caregivers in the small number of families where parents were deceased or incapacitated. Compared to the percentage of total cases where carer alcohol abuse was identified, carer alcohol abuse was also more commonly found in cases where there was emotional or psychological harm, and was slightly more prevalent in neglect cases. Carer alcohol abuse was less commonly identified in cases of substantiated sexual abuse and physical abuse than in the remaining categories of child abuse.
Table 6.1 Alcohol involvement in substantiated cases by type of primary harm, 2001-2005

<table>
<thead>
<tr>
<th>Alcohol involvement</th>
<th>Child abandoned</th>
<th>Deceased or incapacitated</th>
<th>Physical harm</th>
<th>Sexual abuse</th>
<th>Emotional or psychological harm</th>
<th>Neglect</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>245</td>
<td>245</td>
<td>2,554</td>
<td>385</td>
<td>6,661</td>
<td>2,681</td>
<td>12,771</td>
</tr>
<tr>
<td>%</td>
<td>37.9</td>
<td>55.4</td>
<td>27.0</td>
<td>12.3</td>
<td>38.9</td>
<td>35.0</td>
<td>33.2</td>
</tr>
<tr>
<td>Total</td>
<td>647</td>
<td>442</td>
<td>9,478</td>
<td>3,121</td>
<td>17,144</td>
<td>7,655</td>
<td>38,487</td>
</tr>
</tbody>
</table>

6.6 Comparison of alcohol and non-alcohol families by socio-demographic and other risk factors

Table 6.2 indicates that a greater proportion of children from families where carer alcohol abuse was identified were in the younger two age groups, compared with families where alcohol was not a carer risk factor.

Those families where carer alcohol abuse was recorded were more likely to have a range of other problems and were more likely to be socially disadvantaged. For example, families where carer alcohol abuse was recorded were more likely to be in public housing and less likely to own or be buying their home, and were more likely to be receiving single parent pensions and much less likely to be earning a medium-level wage. A greater percentage of families where alcohol abuse was identified was also likely to be unemployed. Very few people in the data set were earning a high wage. Whilst these families with alcohol abuse recorded were of a similar composition to families without, they were more likely to co-present with carer other drug abuse, domestic violence, mental illness and history of child abuse as a child.

6.7 Alcohol involvement in child protection cases in a wider perspective: Victoria in the early 2000s compared with other places and times

In Victoria, over the period 2001-2005, carer alcohol abuse was recorded as a parental or carer risk factor in the family in a third (33.2%) of all substantiated cases of child abuse. The findings for Victoria are not unusually high, in comparison to studies elsewhere. Murphy, Jellinek and Quinn et al. (1991), summarising data on alcohol abuse in reported child abuse
<table>
<thead>
<tr>
<th>Child case data</th>
<th>Total n</th>
<th>Non-alcohol families (%)</th>
<th>Alcohol families (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>19,238</td>
<td>49.5</td>
<td>51.0</td>
</tr>
<tr>
<td>Female</td>
<td>19,249</td>
<td>50.5</td>
<td>49.0</td>
</tr>
<tr>
<td><strong>Age</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>11,266</td>
<td>28.4</td>
<td>31.1</td>
</tr>
<tr>
<td>4-11</td>
<td>17,153</td>
<td>43.1</td>
<td>47.5</td>
</tr>
<tr>
<td>12-17</td>
<td>10,068</td>
<td>28.5</td>
<td>21.4</td>
</tr>
<tr>
<td><strong>Family type</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blended Family</td>
<td>5,171</td>
<td>12.9</td>
<td>14.6</td>
</tr>
<tr>
<td>Extended Family – Couple or one person</td>
<td>1,098</td>
<td>3.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Intact Family</td>
<td>10,805</td>
<td>28.4</td>
<td>27.5</td>
</tr>
<tr>
<td>Sole Parent – Father or mother</td>
<td>18,360</td>
<td>47.5</td>
<td>48.2</td>
</tr>
<tr>
<td>Stepfather or Stepmother Family</td>
<td>2,226</td>
<td>6.0</td>
<td>5.4</td>
</tr>
<tr>
<td>Other adults - Couple or two others</td>
<td>827</td>
<td>2.3</td>
<td>1.8</td>
</tr>
<tr>
<td>**Accommodation status *****</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own/buying</td>
<td>8,763</td>
<td>26.7</td>
<td>14.8</td>
</tr>
<tr>
<td>Renting – public housing</td>
<td>14,140</td>
<td>33.0</td>
<td>44.3</td>
</tr>
<tr>
<td>Renting – other</td>
<td>12,120</td>
<td>32.4</td>
<td>29.7</td>
</tr>
<tr>
<td>Caravan</td>
<td>450</td>
<td>0.9</td>
<td>1.8</td>
</tr>
<tr>
<td>No fixed abode</td>
<td>1,268</td>
<td>2.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>1,746</td>
<td>4.6</td>
<td>4.3</td>
</tr>
<tr>
<td>**Family income type *****</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sole parent pension</td>
<td>16,359</td>
<td>40.2</td>
<td>47.3</td>
</tr>
<tr>
<td>Unemployment benefit</td>
<td>3,702</td>
<td>8.1</td>
<td>12.7</td>
</tr>
<tr>
<td>Wage/salary high</td>
<td>537</td>
<td>1.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Wage/salary medium</td>
<td>6,548</td>
<td>20.2</td>
<td>10.5</td>
</tr>
<tr>
<td>Wage/salary low</td>
<td>5,260</td>
<td>14.4</td>
<td>12.2</td>
</tr>
<tr>
<td>Other benefit or pension</td>
<td>6,081</td>
<td>15.5</td>
<td>16.4</td>
</tr>
<tr>
<td>Domestic violence ***</td>
<td>20,498</td>
<td>41.8</td>
<td>76.4</td>
</tr>
<tr>
<td>Carer mental illness***</td>
<td>8,559</td>
<td>21.2</td>
<td>24.4</td>
</tr>
<tr>
<td>Carer history of abuse or neglect as child***</td>
<td>8,190</td>
<td>18.7</td>
<td>26.5</td>
</tr>
<tr>
<td>Other drug abuse ***</td>
<td>13,579</td>
<td>23.8</td>
<td>58.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38,487</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***Chi-square tests significant at the p<.001 level
cases from a court in Boston in the United States, reported that approximately half of all parents who had maltreated their children drank heavily or were intoxicated at the time of the abuse. In Canada, alcohol or drug abuse involvement was 40% in 2001 (Trocme & Wolfe, 2001). Recent Australian studies (as summarised in Table 2.3, Chapter 2) also show rates of alcohol involvement in the higher range. In New South Wales, 31% of initial reports (Cashmore et al., 2008) and in South Australia 54% of cases entering care (Jeffreys et al., 2009) involved alcohol.

Burden of disease estimates in Australia (English et al., 1995) and globally (Gutjahr & Gmel, 2001) of the contribution that problematic alcohol makes to child abuse and neglect have used the figure of 16%, derived from United States studies from the 1970s. This figure should be updated; on the basis of our findings, a figure of 31% could be included as a relatively conservative figure in future alcohol-attributable burden of disease estimates for Australia.

_Alcohol-related patterns of child maltreatment over time_

The Victorian data in this thesis are from a relatively short period of child protection history but show a relatively stable pattern of overall and alcohol-related cases. This stability is consistent with Cummins et al. (2012), who describe a general increase in reporting rates of child abuse and neglect, but relatively steady substantiated rates of child protection cases between 2001 and 2011 in Victoria.

Examining previous alcohol-related child protection prevalence figures, there is a considerable difference between 1993/94 findings and the findings reported on in this chapter. In 1993-94, in 21% of child abuse cases in Victoria alcohol was recorded as a family characteristic.

It is possible that in the early 1990s that alcohol was not perceived as such a problem by social workers, and thus was not recorded in case history notes, so that this increase is about perception rather than a real increase. The differences in the child maltreatment rates may be fundamentally due to methodological differences, in particular because case-notes in the early 1990s were paper-based and it was not compulsory to record whether carer alcohol abuse was a risk factor. Furthermore, the study was not specifically seeking information on carer alcohol and other drug use (Prent, 1995). Since 1993/94 there has been a greater emphasis on the importance of recording of all aspects of casework, as child protection practice has become, like much of the health system, more focused on evidence-based practice, more subject to
scrutiny from both management within the system and outside from the media, and many would argue increasingly defensive (Goddard, Saunders, Stanley, & Tucci, 1999). Perhaps these changes affect reporting as well as recording of child protection incidents.

In support of the contention that there may be real evidence of an increase, other alcohol-related harms such as hospitalisation, domestic violence and assaults have also increased in Victoria in this period (Livingston, 2008, 2009, 2011). Given that there is evidence that child protection reports are increasing, future research on the association of child maltreatment with alcohol sales (particularly of packaged liquor which is largely consumed at home), availability of alcohol, and with problematic drinking patterns of parents should be further explored over time and geographically.

*Alcohol’s involvement in different types of abuse and neglect*

As shown in Figure 6.2, in the early 2000s in Victoria carer alcohol abuse was more commonly identified in neglect and emotional abuse than in physical and sexual abuse. This is consistent with patterns of alcohol involvement in Canada, where alcohol abuse was also more likely to be reported in neglect and emotional abuse cases than in cases of physical and sexual abuse (Trocme et al., 2005). In a study of court cases in Boston, Famularo, Kinscerf and Fenton (1992) found that alcohol abuse was associated more with physical maltreatment and less with sexual abuse.

*Child age*

The international evidence suggests that younger children are at greater risk of neglect whilst older (and particularly female) children are at risk of sexual abuse (Jordan & Sketchley, 2009). In Victoria there were relatively small differences by age across the child protection report data for all types of abuse, although neglect cases in Victoria are also more common for younger children (Cummins et al., 2012). Victorian child protection data, recently made available on substantiated reports for the financial year 2009/10, shows that the age at first substantiation is fairly evenly spread, with slightly more children substantiated at 0-12 months, 7-8 years and 10-14 years of age than at other ages (Cummins et al., 2012). These findings are consistent with those in this study that show that a greater proportion of children from families where carer alcohol abuse was identified were in the younger two age groups, compared with families where alcohol was not a carer risk factor.
Given the dependency of children in this age group and their vulnerability (Jordan & Sketchley, 2009), Child Protective Services may be particularly worried about the capacity of carers of children in this age group. These concerns may extend to how problematic alcohol abuse affects the behavior of, and in particular supervision by, parents and carers, and thus the difference in age distribution between the carer alcohol-abuse and non-alcohol-abuse groups.

*Child maltreatment, socio-economic disadvantage and carer alcohol abuse*

The majority of families reported to and managed within the Child Protective Services system are disadvantaged and appear to be a highly skewed selection of families. (The socio-economic disadvantage of the sample in comparison to the general population survey results is discussed in more detail in Chapters 9 and 10.) Consistent with the findings in this chapter, child protection cases have commonly been reported to be located particularly in socio-economically disadvantaged families (Berger, 2005; Cummins et al., 2012; Gilbert, Widom et al., 2009; Sidebotham, Heron, & Golding, 2002). However most of this research is from within-system analyses of Child Protective cases.

The data from the current chapter show that within the child protection system, carer alcohol abuse cases were more disadvantaged than non-alcohol cases in a variety of ways. This dimension has not been reported upon elsewhere. Perhaps alcohol-related problems in the family exacerbate family disadvantage. Alternatively socio-economic disadvantage may lead to carer alcohol abuse. A third alternative is that more disadvantaged drinkers may be more likely to be exposed to Child Protective Services. These questions are addressed further in later chapters.

6.8 Conclusion

Caregiver “alcohol abuse” is identified as involved in a significant proportion of child maltreatment cases in Victoria and internationally. Thirty-one percent of cases involve alcohol abuse. The alcohol-attributable fractions used to inform the global burden of disease estimates should be updated using the findings presented here. Secondly, the findings suggest that families where carer alcohol abuse is present are even more marginalised than other families within the Child Protective Services system. This suggests that their children may need considerable financial and social support. While there is substantial consensus that co-occurrence of caregiver alcohol abuse or alcohol problems and child maltreatment is
common, gaps in our understanding of the relationship between drinking and child maltreatment remain. In the next chapters, more detailed analyses fill in the picture further.
Chapter 7  Carer drinking and more serious child protection outcomes

Go and take the grog away, and then we will have mum and dad back.

(Taylor, 2009, p. 3)

7.1 Introduction

Murphy et al. (1991) summarised the evidence and reported wide variation in the prevalence of parental alcohol involvement across different stages of child protection interventions and court outcomes. Their study in the United States of children brought before a Massachusetts Court found that children of substance users were more likely to experience poorer court outcomes and to have their children removed, with children removed in 91% of cases where the parent abused “hard drugs,” 61% of serious cases where the parent abused alcohol, and in 58% of cases where parental substance abuse was not identified. In a study of 100 families in the United Kingdom, parental substance misuse cases were more likely to be identified at the “heavy end” of the child abuse intervention spectrum, with substance misuse identified in 62% of cases involving care proceedings, 40% of cases involving listing on a child protection register, and 34% of all cases examined that were being considered for allocation (Forrester & Harwin, 2006). Forrester and Harwin (2006) suggested that alcohol cases were less likely to picked up early. Following up alcohol and other drug abuse cases after two years, Forrester and Harwin (2006) reported that carer alcohol misuse was associated with the child remaining cared for at home for longer than if other drug concerns were identified. Furthermore, they reported that worse child outcomes, and ultimately greater chance of removal, were identified in alcohol misuse cases, compared with cases where either carer heroin or crack cocaine misuse were identified (Forrester & Harwin, 2008). Similarly, Murphy et al. (1991) underlined that cases involving parents who abused alcohol were likely to have similar if not worse prognoses than those involving illicit drugs but that cultural biases may mean that alcohol abuse is more accepted and hence more likely to be overlooked or managed less intensely.

In rare child protection cases, children die, from a range of different causes. Reports on child death reviews (see Chapter 1) suggest that a large proportion of child deaths occur in families where there is a history of parental alcohol misuse (NSW Child Death Review Team, 2003; Victorian Child Death Review Committee, 2009). Aside from in these types of studies, alcohol’s role in increasingly serious child protection outcomes has rarely been examined
quantitatively, particularly within the one data set (Burke, Schmied, & Montrose, 2006; Vanderploeg et al., 2007). The previous estimates of alcohol’s involvement in different states (see Chapter 2) may have varied in part because of the stage at which alcohol involvement was recorded. Although this variation may also reflect, among other factors, differences in recording practices and coding standards or in drinking patterns in different geographic locations, this variation by level of intervention may also suggest that alcohol involvement was greater in more serious cases..

There do not seem to be any other studies that examine alcohol involvement in a range of different stages within the one study. This chapter examines whether caregiver “alcohol abuse” is related to increasing intensity of child protective interventions, using CASIS.

7.2 Method

Design & Setting
This chapter involves a retrospective case review of routinely-collected electronic records completed by statutory child protection workers in Victoria, Australia between 2001 and 2005. Substantiated cases were categorised according to their progression across different stages of the child protection system, with the prevalence of recorded carer alcohol abuse noted and described at the investigation stage for substantiated cases (as it was not compulsory earlier). In this study the carer’s drinking problems are thus recorded during the initial investigation of a particular reporting instance, and this coding remains with the child and family as they are tracked through the system. The extent to which recorded carer alcohol abuse was associated with progression to more serious stages of the child protection system was then assessed through two different analyses involving measures of outcome severity, after adjusting for a range of other variables recorded in the data system.

The first analysis considered, among substantiated cases (n=38,487), the extent to which carer alcohol abuse, along with other risk factors, predicted which cases received further processing, involving either a protective intervention or a court order. The second analysis considered, among cases that received protective interventions (n=27,765), which cases went further and were issued court orders. The same independent variables were included in both analyses for comparison.
**Outcome variables**

The intensity of the eventual intervention is analysed in terms of the three main phases in the child protection system, linked to key decisions made as part of the process: substantiation, protective intervention, and seeking a court order. Each case in the analysis was assigned the most intensive stage it reached in the child protection process (e.g., if maltreatment of a child within the family has been substantiated but the case has not needed a protective intervention or court order, “substantiation” will be the stage assigned).

The intensity of the eventual intervention was summarised as two outcome variables: (1) transition to the Protective Intervention phase and receipt of a protective intervention (yes), compared with those cases which were substantiated but did not go further (no); and (2) cases that received a court order (yes) compared with those with a protective intervention but no court order (no).

**Independent variables**

Child’s age, child’s gender, family type, family accommodation category, income type, and the various risk factors were all recorded on the CASIS database by Victorian Child Protective Services workers and obtained for analysis. Risk factors included in this analysis were carer alcohol abuse, carer other drug abuse, domestic violence, carer history of child abuse as a child and carer mental illness (see Chapter 5 for details). These independent variables were also recorded during the initial investigation and substantiation of a child’s case, and this coding remains with the child and family as they are tracked through the system.

**Analysis**

Descriptive statistics on alcohol involvement by stage of intervention were generated for the 38,487 cases of child maltreatment substantiated between 2001 and 2005. Family social and demographic variables were then included in the analysis. Associations between the two system transition outcomes and the independent variables were examined using bivariate and then multivariable logistic regression. Independent variables significant (p<0.05) at the bivariate level were entered into a multivariable logistic regression to determine whether carer alcohol abuse significantly affected child protection outcomes after taking into account
the other socio-demographic and risk factors. Model fit was tested using the Hosmer-Lemeshow test, and likelihood ratio tests were used to compare the full models with and without the alcohol predictor (Hosmer & Lemeshow, 2000).

7.3 Findings

Alcohol and progression through the Victorian Child Protection System

As has already been discussed, of the 38,487 cases that were substantiated over the period 2001-2005, carer alcohol abuse was recorded as a risk factor in the family in a third (33.2%) of all substantiated cases of child abuse. Partitioning these cases by the level of intervention reached, carer alcohol abuse was recorded in one quarter (25.3%) of substantiated cases that did not receive further intervention. In cases where the most serious intervention was a protective intervention (but no court order), 34% of cases were identified with carer alcohol abuse. Of those cases involving an order from the Children’s Court, 42% involved alcohol. Thus, cases that received further and more serious interventions were progressively more likely to involve alcohol. These results are presented in Table 7.1.

Table 7.1 Alcohol involvement by most serious stage in Child Protection Process 2001-2005

<table>
<thead>
<tr>
<th>Cases with most serious stage</th>
<th>Substantiated investigations</th>
<th>Protective Interventions</th>
<th>Protective Orders</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>10,722</td>
<td>19,297</td>
<td>8,468</td>
<td>38,487</td>
</tr>
<tr>
<td>n with alcohol involvement</td>
<td>2,717</td>
<td>6,523</td>
<td>3,531</td>
<td>12,771</td>
</tr>
<tr>
<td>% with alcohol involvement</td>
<td>25.3%</td>
<td>33.8%</td>
<td>41.7%</td>
<td>33.2%</td>
</tr>
</tbody>
</table>

Alcohol among other risk factors in intensification from substantiation to protective intervention

Table 7.2 presents an overview of the relationships between alcohol, other risk factors and socio-demographic factors, and the odds of a case receiving a protective intervention outcome.

The bivariate analyses indicate that all of the independent variables in the model were significantly associated with the likelihood of receiving a child protection intervention. Carer alcohol abuse was strongly associated (p<.001) with the increased likelihood of receiving a protective intervention. The odds of a child receiving a protective intervention if they lived in
a family where there was carer alcohol abuse case were 1.67 times that of the odds for a child living in a family where there was no such alcohol problem. Male children were more likely to receive a protective intervention than female children, although only 1.07 times more likely than for females, suggesting that difference was not of great clinical significance, particularly given the power of the sample to distinguish even small differences. Young children in the 0-3 year old age group were much more likely to receive protective interventions than children in the 4-11 and 12 years and older age groups. The accommodation status of the family was also correlated with the likelihood of protective intervention: children from families who owned their own homes were least likely to receive such an intervention, and those who were homeless or lived in a caravan or public housing were most likely. Income type was also predictive of protective intervention, with wage earning groups all less likely to receive interventions, and those on unemployment benefits or other benefits and pensions more likely than families on sole parent pensions to receive protective intervention. Interestingly, step-parent and extended families were less likely than intact families to receive protective intervention. Other risk factors included in the model all were strongly significantly associated with protective intervention, with parental other drug use having the highest odds ratio.

After adjusting for all of the variables in the multivariate model (last three columns), cases with carer alcohol abuse identified as a risk factor were 1.23 times as likely to receive a protective intervention as those without. This figure, whilst still statistically significant, was reduced in comparison to the bivariate result. Bivariate findings were, in the majority of cases, also evident at the multivariate level: the likelihood of intervention was higher in cases involving younger children and in those families where other risk factors such as caregiver other drug abuse, domestic violence, a caregiver history of abuse, and a caregiver history of mental ill health were identified, after taking into account all of the factors in the model. Compared with people who lived in a home they owned or were buying, cases where children were living in all accommodation categories except “other” were more likely to receive an intervention, particularly those with no fixed abode. In those cases where families were earning a wage, the odds of intervention were lower than for those on a sole parent pension, and the odds were higher for those with unemployment benefits or a pension.
### Table 7.2 Factors affecting the likelihood of child protection intervention among substantiated cases

<table>
<thead>
<tr>
<th>Factor</th>
<th>% of sample</th>
<th>Bivariate Odds Ratio</th>
<th>Multivariate Odds Ratio</th>
<th>Multivariate OR 95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer alcohol abuse</td>
<td>33.2</td>
<td>1.67***</td>
<td>1.23***</td>
<td>(1.16, 1.30)</td>
</tr>
<tr>
<td>Male child</td>
<td>50.0</td>
<td>1.07**</td>
<td>1.06*</td>
<td>(1.01, 1.11)</td>
</tr>
<tr>
<td>Age of child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3 (ref)</td>
<td>29.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-11</td>
<td>44.6</td>
<td>0.66***</td>
<td>0.76***</td>
<td>(0.72, 0.81)</td>
</tr>
<tr>
<td>12+</td>
<td>26.2</td>
<td>0.64***</td>
<td>0.90**</td>
<td>(0.84, 0.96)</td>
</tr>
<tr>
<td>Accommodation status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own/buying (ref)</td>
<td>22.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renting</td>
<td>31.5</td>
<td>1.33***</td>
<td>1.04</td>
<td>(0.97, 1.11)</td>
</tr>
<tr>
<td>Public Housing</td>
<td>36.7</td>
<td>1.98***</td>
<td>1.33***</td>
<td>(1.23, 1.43)</td>
</tr>
<tr>
<td>Caravan</td>
<td>1.2</td>
<td>2.02***</td>
<td>1.21</td>
<td>(0.95, 1.53)</td>
</tr>
<tr>
<td>No Fixed Abode</td>
<td>3.3</td>
<td>2.96***</td>
<td>1.62***</td>
<td>(1.37, 1.91)</td>
</tr>
<tr>
<td>Other</td>
<td>4.5</td>
<td>1.26***</td>
<td>0.88*</td>
<td>(0.78, 0.99)</td>
</tr>
<tr>
<td>Family income type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sole Parent Pension (ref)</td>
<td>42.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment Benefit</td>
<td>9.6</td>
<td>1.34***</td>
<td>1.23***</td>
<td>(1.12, 1.36)</td>
</tr>
<tr>
<td>Other Benefit</td>
<td>5.1</td>
<td>1.26***</td>
<td>1.26***</td>
<td>(1.11, 1.42)</td>
</tr>
<tr>
<td>Other Pension</td>
<td>9.2</td>
<td>1.25***</td>
<td>1.24***</td>
<td>(1.12, 1.36)</td>
</tr>
<tr>
<td>Wage/Salary High</td>
<td>1.4</td>
<td>0.57***</td>
<td>0.83</td>
<td>(0.68, 1.01)</td>
</tr>
<tr>
<td>Wage/Salary Low</td>
<td>13.7</td>
<td>0.74***</td>
<td>0.94</td>
<td>(0.86, 1.01)</td>
</tr>
<tr>
<td>Wage/Salary Medium</td>
<td>17.0</td>
<td>0.55***</td>
<td>0.81***</td>
<td>(0.75, 0.88)</td>
</tr>
<tr>
<td>Other</td>
<td>1.5</td>
<td>0.73***</td>
<td>0.93</td>
<td>(0.77, 1.12)</td>
</tr>
<tr>
<td>Family type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intact Family (ref)</td>
<td>28.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blended Family</td>
<td>13.4</td>
<td>1.04</td>
<td>1.05</td>
<td>(0.90, 1.22)</td>
</tr>
<tr>
<td>Extended Family – Couple or one person</td>
<td>2.9</td>
<td>0.90**</td>
<td>0.94</td>
<td>(0.87, 1.01)</td>
</tr>
<tr>
<td>Sole Parent – Father or mother</td>
<td>47.7</td>
<td>0.96</td>
<td>0.90*</td>
<td>(0.84, 0.98)</td>
</tr>
<tr>
<td>Stepfather or Stepmother Family</td>
<td>5.8</td>
<td>0.79***</td>
<td>0.87*</td>
<td>(0.78, 0.97)</td>
</tr>
<tr>
<td>Other adults - Couple or one person and other</td>
<td>2.2</td>
<td>0.96</td>
<td>1.09</td>
<td>(0.92, 1.30)</td>
</tr>
<tr>
<td>Carer history of Abuse as child</td>
<td>21.3</td>
<td>1.66***</td>
<td>1.31***</td>
<td>(1.23, 1.39)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>53.3</td>
<td>1.46***</td>
<td>1.10***</td>
<td>(1.04, 1.15)</td>
</tr>
<tr>
<td>Other drug abuse</td>
<td>35.3</td>
<td>2.36***</td>
<td>1.74***</td>
<td>(1.64, 1.85)</td>
</tr>
<tr>
<td>Mental illness</td>
<td>22.2</td>
<td>1.69***</td>
<td>1.49***</td>
<td>(1.41, 1.59)</td>
</tr>
</tbody>
</table>

***Significant at the p<.001 level and ** p<.01 level and *p<.05 level for odds ratios presented n=38,487

**Intensification from protective intervention to court order**

The prediction of a court order being issued in the case, among those receiving protective intervention, was then analysed. The bivariate analyses (Table 7.3) indicate that boys were more likely to receive court orders than girls, as was the youngest age group in comparison to the middle and the older aged groups of children. Children who were homeless or lived in a caravan or public housing were more likely to receive court orders than those living in forms
of housing that had been bought or were being purchased. Children from families where the sole parent pension was the form of income received were also more likely to receive a court order than children living in families receiving a wage or salaried income. In contrast, children from families receiving other benefits and pensions were more likely to receive court orders than children where their families received sole parent pensions. Children from blended and “other” family types were more likely to be the subjects of court orders than children from intact families. Children from sole parent families, and step-families were as likely as intact families to receive court orders. Carer history of alcohol abuse, domestic violence, other drug abuse and mental ill health were also all significantly associated with receipt of court orders. Carer other drug abuse had the largest odds ratio, indicating that other drug abuse was most strongly associated with court ordered care, including removal from the family and other court orders.

The last three columns of Table 7.3 show that carer alcohol abuse was associated with an increased likelihood of receiving a court order following a protective intervention, after taking into account all other variables in the model. While many of the patterns of effects seen for the other independent variables in Table 7.2 were similar in Table 7.3, there were some important differences. Examining the alcohol risk factor variable, it is evident that although the results indicate that alcohol predicts both outcomes (ORs =1.23 and 1.13), the size of this effect was slightly less for the court order outcome. This was also true for carer other drug abuse. For other variables the effects were more accentuated for court orders. Families who had no fixed accommodation were more likely to receive protective interventions (Table 7.2, OR=1.62), and this association was even stronger in relation to the court order phase (Table 7.3, OR=2.00). This was also true for those families living in caravans. In general families receiving some form of government benefit were more likely to receive protective interventions, and again even more likely to receive court orders. In contrast, families earning an income (whether it was low, medium or high) were less likely to receive a protective order, and even less likely to receive a court order; meaning that the effect of this income variable diminished as the outcomes increased in severity. The fit of each of the models presented in Table 7.2 ($\chi^2_8 =12.94$, $p=0.11$) and Table 7.3 ($\chi^2_8 =7.53$, $p=0.48$), was satisfactory. The inclusion of carer alcohol abuse added significantly to each of the full models (Table 7.2: $\chi^2 =52.64$, $p<.001$ and Table 7.3: $\chi^2_1 =19.15$, $p<.001$). The removal of carer alcohol abuse from the model left the model significantly less able to predict these more serious child protection outcomes.
### Table 7.3 Factors affecting the likelihood of progression to court order phase amongst cases receiving protection interventions

<table>
<thead>
<tr>
<th></th>
<th>Bivariate % sample</th>
<th>Bivariate Odds Ratio (OR)</th>
<th>Multivariate Odds Ratio (OR)</th>
<th>Multivariate OR 95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carer alcohol abuse</strong></td>
<td>36.2</td>
<td>1.40***</td>
<td>1.14***</td>
<td>(1.08, 1.21)</td>
</tr>
<tr>
<td>Male children</td>
<td>50.5</td>
<td>1.04</td>
<td>1.03</td>
<td>(0.98, 1.09)</td>
</tr>
<tr>
<td><strong>Age of child</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3 (ref)</td>
<td>31.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-11</td>
<td>43.3</td>
<td>0.69***</td>
<td>0.77***</td>
<td>(0.72, 0.82)</td>
</tr>
<tr>
<td>12+</td>
<td>25.1</td>
<td>0.71***</td>
<td>0.93</td>
<td>(0.87, 1.01)</td>
</tr>
<tr>
<td><strong>Accommodation status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own/buying (ref)</td>
<td>20.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renting</td>
<td>30.7</td>
<td>1.41***</td>
<td>1.07</td>
<td>(0.98, 1.17)</td>
</tr>
<tr>
<td>Public Housing</td>
<td>39.7</td>
<td>2.05***</td>
<td>1.38***</td>
<td>(1.26, 1.51)</td>
</tr>
<tr>
<td>Caravan</td>
<td>1.3</td>
<td>2.39***</td>
<td>1.54***</td>
<td>(1.22, 1.94)</td>
</tr>
<tr>
<td>No Fixed Abode</td>
<td>3.8</td>
<td>3.43***</td>
<td>2.00***</td>
<td>(1.72, 2.32)</td>
</tr>
<tr>
<td>Other</td>
<td>4.4</td>
<td>2.02***</td>
<td>1.29**</td>
<td>(1.12, 1.50)</td>
</tr>
<tr>
<td><strong>Family income type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sole Parent Pension (ref)</td>
<td>43.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment Benefit</td>
<td>10.6</td>
<td>1.15**</td>
<td>1.15**</td>
<td>(1.04, 1.27)</td>
</tr>
<tr>
<td>Other Benefit</td>
<td>5.6</td>
<td>1.28***</td>
<td>1.33**</td>
<td>(1.18, 1.50)</td>
</tr>
<tr>
<td>Other Pension</td>
<td>10.0</td>
<td>1.14**</td>
<td>1.16**</td>
<td>(1.05, 1.27)</td>
</tr>
<tr>
<td>Wage/Salary High</td>
<td>1.2</td>
<td>0.31***</td>
<td>0.46***</td>
<td>(0.33, 0.64)</td>
</tr>
<tr>
<td>Wage/Salary Low</td>
<td>12.9</td>
<td>0.69***</td>
<td>0.88*</td>
<td>(0.80, 0.97)</td>
</tr>
<tr>
<td>Wage/Salary Medium</td>
<td>14.5</td>
<td>0.47***</td>
<td>0.70***</td>
<td>(0.62, 0.78)</td>
</tr>
<tr>
<td>Other</td>
<td>1.4</td>
<td>1.31*</td>
<td>1.41**</td>
<td>(1.13, 1.75)</td>
</tr>
<tr>
<td><strong>Family type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intact Family (ref)</td>
<td>27.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blended Family</td>
<td>13.7</td>
<td>1.35***</td>
<td>1.37***</td>
<td>(1.16, 1.62)</td>
</tr>
<tr>
<td>Extended Family – Couple or one person</td>
<td>2.9</td>
<td>0.89**</td>
<td>0.90*</td>
<td>(0.82, 0.98)</td>
</tr>
<tr>
<td>Sole Parent – Father or mother</td>
<td>48.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepfather or Stepmother Family</td>
<td>5.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other adults - Couple or 2.2 one person and other</td>
<td>1.44***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parental history of Abuse as child</strong></td>
<td>23.5</td>
<td>1.62***</td>
<td>1.35***</td>
<td>(1.27, 1.43)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>55.9</td>
<td>1.20***</td>
<td>0.95</td>
<td>(0.90, 1.01)</td>
</tr>
<tr>
<td>Other drug abuse</td>
<td>40.3</td>
<td>1.85***</td>
<td>1.44***</td>
<td>(1.35, 1.52)</td>
</tr>
<tr>
<td>Mental ill health</td>
<td>24.6</td>
<td>1.32***</td>
<td>1.23**</td>
<td>(1.15, 1.30)</td>
</tr>
</tbody>
</table>

***Significant at the p<.001 level and ** p<.01 level and *p<.05 level for odds ratios presented

n=27,765

### 7.4 Discussion

Whilst the relationship between alcohol reporting and substantiation has been the subject of considerable research, the association of alcohol with what happens next has not been previously studied. This study shows that a large proportion of 12,780 alcohol-related cases
studied go on to receive more intensive attention – 51% to protective interventions and 28% to court orders – and that alcohol involvement is predictive of this further progression through the system.

Carer alcohol abuse was thus significantly associated with intensification of handling through to the more serious stages of child protection actions, after taking into account a range of other factors. These findings are consistent with the high prevalence rate of carer alcohol abuse reported in court-involved cases (Murphy et al., 1991), and support analyses that implicate problematic drinking as strongly associated with transition through the system, and worse outcomes. Carer alcohol abuse may have played a causal role in numerous cases, but could also, in turn, be a consequence of maltreatment in others. For example, some research suggests that women victimised by an intimate partner may turn to alcohol to cope (Wingood, DiClemente, & Raj, 2000), and it is plausible that a parent may turn to alcohol because they cannot cope with the fact that they themselves or others maltreat the child. Even so, this is only likely to worsen the situation for the child. Problematic drinking may also interfere with caregivers’ ability to successfully follow a Victorian Child Protective Services plan for remediation, and thus make more serious intervention from the Victorian Child Protective Services system more likely. If a parent continues to drink alcohol problematically the drinking may well play a causal role for more serious outcomes.

The models showed the odds of more serious outcomes were also increased for cases involving younger children, families that were not intact, and families in worse living conditions and who were unemployed or on other benefits, suggesting disadvantage was important. The results in Tables 7.2 and 7.3 suggest the youngest age group of children is more likely than older age groups to be the subject of more serious interventions, after adjusting for all other factors. This is consistent with the international and Victorian evidence discussed in the previous chapter. The higher odds of younger children experiencing a more serious outcomes is consistent with knowledge that infants aged 0-4 years are at a higher risk of more severe outcomes than other age groups (Jordan & Sketchley, 2009).

Child protection workers may be particularly concerned about combinations of child and carer risk factors. Indeed, that alcohol use, age group and other factors all remain significant in the model suggests that child protection workers do take these factors into consideration in their decisions regarding interventions. Other drug abuse, histories of parental abuse as a child, and caregiver mental ill-health were linked even more strongly than carer alcohol abuse
to higher odds of cases requiring further protective interventions and court orders. These findings of independent effects of these variables suggest that numerous factors are part of the causal chain and are taken into account when interventions are undertaken and court orders implemented. Carer risk factors appear to play a strong role in the decisions child protection workers make.

Regarding the relationships identified between predictor and outcome variables, there are two alternate possibilities. It is possible that the Child Protective Services worker’s coding of these variables, for example, carer alcohol abuse, influences the handling of the case in a way which results in a more severe outcome. Alternately, the carer’s drinking may directly influence the child in a more serious way.

7.5 Conclusion

Predictors of child protection outcomes were examined in 38,487 Victorian Child Protective Services cases. Carer alcohol abuse was involved in a third of all substantiated child maltreatment cases in Victoria, and was identified in 25% of cases where the most serious outcome was substantiation, 36% where responses were limited to protective interventions and 42% of cases where court orders were applied. Consistent with these findings, carer alcohol abuse was a significant predictor of more intensive official responses – protective interventions and court orders – after adjusting for a range of other risk factors and other socio-demographic variables. While carer alcohol abuse remained an independent predictor of the two outcomes considered, after adjustment for these other variables, the multi-factorial aetiology of child abuse has also been underscored in this chapter.
Chapter 8  Alcohol’s involvement in recurrent child abuse and neglect cases

There is good reason for the Government to panic. In 2001-02, 62 per cent of children reported to child-protection agencies had been reported before (in 1993-94, the figure was 36 per cent). It gets worse. Another 6 per cent were children who had a sibling previously reported. The increased workload that the department so often complains about is apparently largely made up of children being reported again. And again. And again.

(Goddard and Tucci, 2003, p. 1)

8.1 Introduction

Children who repetitively experience child abuse and neglect have been shown to experience poorer behavioural, educational and mental health outcomes (Higgins, 2004). Many international studies have examined recurrent child abuse and neglect and the involvement of a number of risk factors, including alcohol (Connell, Bergeron, Katz, Saunders, & Tebes, 2007; DePanfilis & Zuravin, 1999; Forrester & Harwin, 2008; Trocme et al., 2005). In this light it is important to determine whether carer alcohol abuse is an important factor in the likelihood of repeat cases of child abuse and neglect.

Fluke and Shusterman (2005) found that recurrence of substantiation occurred more frequently for younger children, and in those cases where services were provided after the first substantiation. Hindley et al. (2006) reported that parental conflict and parental mental health problems were associated with recurrence of child abuse.

Forrester (2007) notes the lack of British data on re-referrals but pointed out that in every study that examined substance use as a variable it was significantly associated with re-referrals. A number of studies have identified substance use as a significant predictor (English, Marshall, Brummel, & Orme, 1999; Forrester, 2007), but do not differentiate between alcohol and other drug concerns. A smaller number of studies have found that recurrence of substantiated child maltreatment occurred more frequently in cases where

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1 As noted earlier in this study, “substantiation” has a specific meaning that refers to a caseworker’s determination of abuse or neglect, or risk of such child maltreatment. A re-substantiated case in this study involves new notification and substantiation of abuse or neglect of the child, after the case has been closed with respect to the earlier notification and substantiation.
carer alcohol abuse was identified (Fluke & Shusterman, 2005; 2008; Swanston et al., 2002).

In Queensland (Australia), Indigenous households and single-parent households were more likely to have had a history of contact with Child Protective Services (prior to the index case), and recurrence was more prevalent in cases for which carer drug and/or alcohol abuse (these two factors were not separated), domestic violence, mental health issues, history of abuse as a child or a criminal history were present, and where multiple risk factors were identified. These repeat cases were also more likely to receive further interventions (Queensland Government, 2008).

One mechanism that might be linked to this higher rate of recurrence of substance-related child maltreatment is “relapse”. Relapse is common amongst drinkers seeking to control their drinking or to abstain, and can be viewed as a normal part of the recovery process (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). Despite a willingness to change drinking behaviours, change is difficult. Furthermore, stress is associated with alcohol and drug use relapse (Brownell et al., 1986), and parenting is inherently stressful for many. Although not discussing repeat child protection cases, Moos and Billings (1982) demonstrated in the United States that the children of relapsed “alcoholics” had more emotional difficulties in comparison with the children of recovered “alcoholics” and controls. However, in the same study, there was little difference in the well-being of children when those with recovered “alcoholic” parent/s were compared with neighbourhood controls.

As mentioned previously, studies have found that substance abuse (drugs and/or alcohol) was associated with re-reporting (Connell et al., 2007; Wolock & Magura, 1996), although in some of these studies it is not possible to distinguish between child maltreatment with alcohol involvement and child maltreatment with other drugs noted as being involved. However, Fluke et al. (2005) found that while alcohol abuse was a significant predictor of re-substantiation, “drug abuse” was not.

In Chapter 7 the roles of alcohol and other drug abuse in predicting more serious outcomes was examined and both factors were shown to be associated with poorer outcomes, after controlling for a range of variables. While the findings of Fluke et al. (2005) suggest that alcohol abuse may be more important than other drug abuse, in Chapter 7 both carer alcohol abuse and carer other drug abuse were found to be statistically significant in predicting more serious outcomes. But neither Fluke et al. (2005), nor the analysis in Chapter 7 tested for
interactions, that is, the effects of the alcohol and drug variables separately and together. Whether there are differences in the relationships between child abuse recurrence and alcohol abuse and other drug abuse, and whether the presence of both increases the relationship are important questions the present study addresses in this chapter. Overall, little work has quantified the extent of alcohol problems in recurrent child abuse and how these children and families are managed by Child Protective Services.

8.2 Aims

This research aims to estimate whether the recording of carer alcohol abuse at the initial substantiation is predictive of a second or further substantiated incident, in comparison to cases without a record of carer alcohol abuse; and whether any such relation persists, after taking into account the effects of other factors, in particular other drug abuse. It was expected that carer alcohol abuse would predict repeat cases of child abuse, after adjusting for other factors. Secondly, it was expected that, given the relative odds ratios found in Chapter 7, the relationship between carer other drug abuse and repeat outcomes will be stronger than that between carer alcohol abuse and repeat outcomes. Finally, it was expected that there would be synergistic effects such that either alcohol or other drug abuse will result in repeat cases, with the combined effect being the strongest predictor.

8.3 Methods

Data

As in previous chapters, de-identified Child Protective Services data from the Victorian Department of Human Services were obtained for the period 2001-2005. Both case and client (aggregated by unique identifier) level data were used, although this chapter focuses primarily on children (n=29,455) rather than on cases (n=38,487).

Outcome variables

“Substantiated” cases were defined in Chapter 2. Re-substantiation or recurrent abuse or neglect is the second or further occurrence of substantiated child abuse or neglect, and occurs after a new report or notification has come from outside Child Protective Services. New reports that come in whilst a case is open are generally added to that file, without creating a new case. Cases are kept open until it is decided that the child is no longer at risk of harm, at which point the case is closed (Tsantefski, 2012).
Child-level data were used to examine how many times within a five-year period each child was affected by a repeat substantiation, that is, appeared in the data as a repeat case. The child-level outcome variable used was repeat cases, i.e. whether abuse or neglect had been substantiated in a child’s case history more than once in the five-year dataset or not. Multiple notifications of the children in the dataset are available for the present analysis only for the period 2001-2005. Some children may have been notified for child abuse and neglect prior to 2001 and a child may have been renotified after 2005.

Independent variables

The independent variables in the analysis were recorded during the investigation when the child’s case was first substantiated within the data set and have been described in Chapter 5. For this chapter, to investigate the interaction between carer alcohol and other drug abuse, a combined substance abuse variable was constructed to measure the four possibilities: neither alcohol nor drug abuse, alcohol abuse only, other drug abuse only, and both alcohol and other drug abuse. This variable enabled disaggregation of the effects of these drugs in multivariate analyses.

Analysis

Substantiated cases per child and percentages of children affected that involved carer alcohol abuse were calculated and reported in a simple descriptive table. Rates for the five year period were described, and confidence intervals calculated assuming a Poisson distribution. Simple Poisson (bivariate) regression was used to examine the number of recurrences and the percentage of cases where carer alcohol abuse was identified. A chi-square test was used to examine the relationship between the number of substantiations and the presence or not of carer alcohol abuse.

Bivariate and multivariate analysis of carer alcohol abuse and the outcome variable, repeat cases, was undertaken using logistic regression. Binary logistic regression was applied for the binary outcome of repeated experience of maltreatment (single versus repeated) in the final model. The independent variables identified in the literature as associated with recurrence were included in the model and examined for strength of association and statistical significance.
8.4 Recurrent child maltreatment findings

Information was analysed on 29,455 children in 38,487 substantiated cases of child abuse and neglect gathered between 2001 and 2005 in CASIS.

**Table 8.1 Substantiations of child maltreatment with and without caregiver alcohol recorded as a risk factor**, Victoria, 2001-2005

<table>
<thead>
<tr>
<th>Number of substantiations</th>
<th>Children (cases)</th>
<th>All children in files (%)</th>
<th>Among children with alcohol recorded (% of 9,194)</th>
<th>Among children without alcohol recorded (% of 20,261)</th>
<th>Alcohol recorded among children with n substantiations (i.e., % of n children in col.2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22,614</td>
<td>76.9</td>
<td>71.4</td>
<td>79.2</td>
<td>29.0</td>
</tr>
<tr>
<td>2</td>
<td>5,079</td>
<td>17.2</td>
<td>20.7</td>
<td>15.7</td>
<td>37.5</td>
</tr>
<tr>
<td>3</td>
<td>1,412</td>
<td>4.8</td>
<td>6.0</td>
<td>4.2</td>
<td>39.3</td>
</tr>
<tr>
<td>4</td>
<td>278</td>
<td>0.9</td>
<td>1.6</td>
<td>0.7</td>
<td>51.4</td>
</tr>
<tr>
<td>5</td>
<td>65</td>
<td>0.2</td>
<td>0.3</td>
<td>0.2</td>
<td>41.5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>0.0</td>
<td>0.04</td>
<td>0.01</td>
<td>57.1</td>
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<tr>
<td>Total</td>
<td>29,455</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>31.2</td>
</tr>
</tbody>
</table>

*Carer risk factor diagnosed at first substantiation

Table 8.1 presents the distribution of the number of substantiations of child maltreatment per child. The majority of children appeared (77%) in the CASIS data system only once. On average children appeared 1.30 times in the data over the five year period studied. Of the 9,194 children where carer alcohol abuse was identified, 6,561 or 71% experienced only one substantiated incident of child abuse and neglect. Children from families where carer alcohol abuse was identified were less likely to experience a single substantiation, and more likely to experience resubstantiations. Amongst children where carer alcohol abuse was not identified, the percentage of resubstantiations was significantly lower (79%, $\chi^2_{(1)}=219.63$, p<.001). The final column in Table 8.1 describes the percentage of children where caregiver alcohol abuse was identified in the family. In general, using Poisson regression, as the number of recurrences increased, carer alcohol abuse was more likely to be reported (p<.001). Overall, 31% of children (as opposed to 33% of cases) were from families where one or more carers had been identified with alcohol abuse.
Table 8.2 describes the intensity of child protection interventions provided in single and repeat cases for children and families with and without recorded alcohol abuse by carers. Children with carers with alcohol abuse recorded were much more likely than non-alcohol cases to be the subject of a court order (28 vs. 19%) and less likely to receive only substantiation and no further intervention (22 vs. 32%). The Chi-square test of the association between intervention outcome and alcohol involvement among repeat cases was significant (C vs. D: $\chi^2(2) = 67.49, p < .001$) as was the association between alcohol involvement and intervention outcome among single cases (A vs. B: $\chi^2(2) = 371.28, p < .001$). Repeat cases involving carer alcohol abuse were slightly more likely to receive an intervention than single alcohol cases (54 vs. 49%), marginally less likely to receive a court order (27 vs. 28%), and less likely to receive only a substantiation (20 vs. 23%). The Chi-square test of the association between intervention and repeat status among alcohol cases was also significant (B vs. D: $\chi^2(2) = 18.09, p < .001$), although there were only small real differences in the way cases involving recorded alcohol abuse were managed between single and repeat cases, and the direction of difference varied at the different levels of intervention. Finally, the overall model describing intervention outcome by repeat status among non-alcohol cases was also significant (A vs. C: $\chi^2(2) = 84.76, p < .001$).

### Table 8.2 Outcomes for children receiving child protection intervention stages – with and without identified carer alcohol abuse

<table>
<thead>
<tr>
<th></th>
<th>Total (n)</th>
<th>Substantiation (%)</th>
<th>Intervention (%)</th>
<th>Court Order (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single (non-repeat cases)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol not reported (A)</td>
<td>16,053</td>
<td>33.9</td>
<td>47.4</td>
<td>18.7</td>
</tr>
<tr>
<td>Alcohol abuse by caregiver reported (B)</td>
<td>6,561</td>
<td>22.9</td>
<td>49.1</td>
<td>28.0</td>
</tr>
<tr>
<td><strong>Repeat cases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol not reported (C)</td>
<td>4,208</td>
<td>26.5</td>
<td>53.6</td>
<td>19.9</td>
</tr>
<tr>
<td>Alcohol abuse by caregiver reported (D)</td>
<td>2,633</td>
<td>19.6</td>
<td>53.6</td>
<td>26.9</td>
</tr>
<tr>
<td><strong>All cases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol not reported</td>
<td>20,261</td>
<td>32.3</td>
<td>48.7</td>
<td>19.0</td>
</tr>
<tr>
<td>Alcohol abuse by caregiver reported</td>
<td>9,194</td>
<td>22.0</td>
<td>50.4</td>
<td>27.7</td>
</tr>
</tbody>
</table>

* $\chi^2(1)$ tests were conducted for (C vs., B vs. D, A vs. B, A vs. C) – all were significant at the P<.001 level (see text on previous page for $\chi^2$ values)

n=29,455 children
Overall, only 1,504 (22.9% x 6,561) or 16% of all children with carers with recorded alcohol abuse were not the subject of a repeat substantiation, protective intervention or court order; in comparison, this was the case for 27% (5437/20261) of children whose carers were not identified with alcohol abuse. More optimistically, 72 % (6,651/9,194) of children whose carers were identified with alcohol abuse problems were managed without resort to court orders in a five year period.

Table 8.3 describes the bivariate and adjusted multivariate relationships between repeat cases and selected independent variables. In unadjusted analysis re-substantiation was 1.53 times more likely where carer alcohol abuse was identified than when it was not; this figure declined to 1.22 in the multivariate analysis. The adjusted odds of re-substantiation were a little greater (OR=1.29) if a carer’s other drug abuse was identified. The multivariate model (in which the non-significant variable gender of the child was dropped) also shows that many other factors along with alcohol and other drug abuse were significantly associated with repeated child abuse and neglect in Victoria. Being the child of a recipient of some type of pension compared with families receiving income from employment was predictive of resubstantiation, as was living in public housing compared with other forms of housing. Living within an extended family versus intact families, or being the child of a sole parent compared to intact families was associated with recurrent substantiation. Children where carer mental ill-health, domestic violence and carer history of child abuse as a child were identified were more likely to experience resubstantiation compared to families where these conditions were not present. Children aged 4-11 years were more likely than older or younger children to be to experience repeat substantiations of child abuse and neglect.

Children who received protective interventions were significantly more likely to experience repeated substantiations. The bivariate effect whereby children who received court orders were more likely to experience a repeat substantiation than children who received no further interventions (substantiations only) was not significant in the multivariate model. It seems that being a repeat case has only a limited amount to do with the intervention stage reached, particularly among carer alcohol abuse cases.

Turning to the question of whether recurrence was more strongly related to carer alcohol abuse, carer other drug abuse or both, the interaction was examined – the findings are
### Table 8.3 Factors affecting the likelihood of recurrence of child maltreatment among substantiated cases

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>Unadjusted Odds Ratio</th>
<th>95% Confidence Interval</th>
<th>Adjusted Odds Ratio</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer alcohol abuse</td>
<td>31.2</td>
<td>1.53***</td>
<td>(1.45, 1.62)</td>
<td>1.22***</td>
<td>(1.14, 1.30)</td>
</tr>
<tr>
<td>Carer other drug abuse</td>
<td>33.1</td>
<td>1.71***</td>
<td>(1.62, 1.81)</td>
<td>1.29***</td>
<td>(1.21, 1.38)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (ref)</td>
<td>50.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>49.7</td>
<td>1.05</td>
<td>(0.99, 1.10)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Age of child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3 (ref)</td>
<td>30.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-11</td>
<td>43.1</td>
<td>1.18***</td>
<td>(1.10, 1.25)</td>
<td>1.26***</td>
<td>(1.17, 1.35)</td>
</tr>
<tr>
<td>12+</td>
<td>26.9</td>
<td>0.87***</td>
<td>(0.80, 0.93)</td>
<td>1.08</td>
<td>(1.00, 1.18)</td>
</tr>
<tr>
<td>Accommodation status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own/buying</td>
<td>26.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renting – other</td>
<td>34.1</td>
<td>1.45***</td>
<td>(1.34, 1.57)</td>
<td>1.08</td>
<td>(0.98, 1.18)</td>
</tr>
<tr>
<td>Renting – public housing</td>
<td>35.0</td>
<td>2.59***</td>
<td>(2.40, 2.80)</td>
<td>1.70***</td>
<td>(1.55, 1.87)</td>
</tr>
<tr>
<td>Caravan/ No fixed abode</td>
<td>4.6</td>
<td>1.61***</td>
<td>(1.39, 1.86)</td>
<td>1.00</td>
<td>(0.85, 1.17)</td>
</tr>
<tr>
<td>Family income type</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pension (ref)</td>
<td>65.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wage/Salary Low</td>
<td>14.2</td>
<td>0.69***</td>
<td>(0.64, 0.75)</td>
<td>0.91*</td>
<td>(0.83, 0.99)</td>
</tr>
<tr>
<td>Wage/Salary Medium</td>
<td>18.9</td>
<td>0.42***</td>
<td>(0.39, 0.46)</td>
<td>0.68***</td>
<td>(0.61, 0.75)</td>
</tr>
<tr>
<td>Wage/Salary High</td>
<td>1.6</td>
<td>0.33***</td>
<td>(0.24, 0.44)</td>
<td>0.51***</td>
<td>(0.37, 0.71)</td>
</tr>
<tr>
<td>Family type</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intact Family (ref)</td>
<td>30.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blended/step family</td>
<td>19.6</td>
<td>1.24*</td>
<td>(1.04, 1.48)</td>
<td>1.17</td>
<td>(0.98, 1.41)</td>
</tr>
<tr>
<td>Extended</td>
<td>2.9</td>
<td>1.53***</td>
<td>(1.41, 1.66)</td>
<td>1.40***</td>
<td>(1.29, 1.53)</td>
</tr>
<tr>
<td>Sole parent</td>
<td>47.3</td>
<td>1.63***</td>
<td>(1.52, 1.74)</td>
<td>1.32***</td>
<td>(1.22, 1.42)</td>
</tr>
<tr>
<td>Carer history of Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>as child</td>
<td>20.2</td>
<td>1.33***</td>
<td>(1.25, 1.42)</td>
<td>1.12**</td>
<td>(1.04, 1.20)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>51.9</td>
<td>1.35***</td>
<td>(1.27, 1.42)</td>
<td>1.11***</td>
<td>(1.04, 1.18)</td>
</tr>
<tr>
<td>Mental illness</td>
<td>21.5</td>
<td>1.36***</td>
<td>(1.28, 1.45)</td>
<td>1.25***</td>
<td>(1.17, 1.34)</td>
</tr>
<tr>
<td>Protective intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substantiation only (ref)</td>
<td>29.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protective intervention</td>
<td>49.2</td>
<td>1.44***</td>
<td>(1.35, 1.54)</td>
<td>1.26***</td>
<td>(1.17, 1.35)</td>
</tr>
<tr>
<td>Court order</td>
<td>21.7</td>
<td>1.36***</td>
<td>(1.26, 1.47)</td>
<td>1.02</td>
<td>(0.94, 1.11)</td>
</tr>
</tbody>
</table>

***Significant at the p<.001 level and ** p<.01 level and *p<.05 level for odds ratios presented

Descriptive percentages are on full sample of n=29,455 with the exception of family type (n=28,797) and family accommodation (n= 28,067) variables where missing data were evident

depicted in Figure 8.1. The probability of recurrence was smallest when neither alcohol nor drug abuse was reported for the care-giver (see point at left hand side of solid line), but did not vary much between those with alcohol abuse only (left hand side of dashed line), with other drug abuse (right hand side of solid line), or with both reported (right hand side of dashed line). Thus, the recording of both alcohol and drug abuse added very little to the prediction of recurrence from having either alcohol abuse or other drug abuse recorded alone.
8.5 Discussion

The majority of children in the data set experienced substantiated child abuse or neglect only once in the five year period examined. However, 23% of Victorian children were the subject of a substantiated child protection record of abuse or neglect a second or further time. This figure is similar to the 26% of cases that were re-substantiated in a study in Queensland, in which three months of cases were examined retrospectively, including all available history for each case held by the department (Queensland Government, 2008).

Fluke and Shusterman (2005) found that 17% of carers were involved repeatedly in a two-year period. In their United States study, the odds of a child being involved in the Child Protective Services system repeatedly increased by just over 20% where carer alcohol abuse was identified. The current results are consistent with this finding. However, the current study extends these findings by showing that both carer alcohol abuse and other drug abuse are equally important factors in predicting recurrence. In contrast to Fluke et al. (2008), in Victoria, at least, thus we found that a caregiver’s other drug abuse also significantly predicted the likelihood of recurrence. This supports the hypothesis that the independent effect of either alcohol or drugs would significantly predict the likelihood of repeat cases.
However, the presence of both risk factors did not lead to the expected additive effect, over and above the independent effects of each variable.

In relation to other predictors, our results fit with the findings from a systematic review (Hindley et al., 2006) showing that indicators of social deprivation, a child’s younger age, parental conflict, and parental mental health problems were important predictors of child maltreatment recurrence. This finding highlights the fact that recurrence appears more likely in families under a range of pressures associated with socio-economic disadvantage. These results are consonant with, and add to, the results presented in Chapter 6 that suggest more serious Victorian Child Protective Services interventions were predicted by multiple factors, including carer mental ill-health and socioeconomic factors.

Table 8.2 shows that the families were more likely to receive protective interventions but no more likely to receive court orders where repeat cases were identified. Indeed, protective interventions are an expected response by the system to repeat cases, as families are asked to demonstrate their capability to meet conditions, and compliance is measured as part of the protective intervention. Furthermore, repeat cases may be expected where problems or risk factors persist despite intervention (Fluke & Shusterman, 2005). The finding that court orders were not associated with recurrence of cases may reflect practices by which the child will have been removed from carers after the initial notification in some cases, reducing the possibility of recurrence.

Examination of the relationship between alcohol, protective interventions and repeat cases (see Table 8.2) suggests that where carer alcohol abuse was identified, families were more likely to experience court orders regardless of whether the case was a single incident or a repeat case.

The large majority of children in the Victorian Child Protective Services system whose parents were identified with alcohol abuse experienced repeat incidents or were intensively involved with Victorian Child Protective Services. That only 16% of all children whose carers were reported with alcohol abuse were not the subject of a repeat substantiation, protective intervention or court order is of concern. However, it is reassuring that almost three-quarters of children in the system with carers who were identified with alcohol abuse were managed without resort to court orders in the course of a five year period, and that 71% of children with carers reported to have alcohol problems were not re-substantiated in the
system. At face value this is reassuring because this data shows that the majority of children from families with carer alcohol abuse are not resubstantiated and it seems furthermore that they have not been removed from their families, although interventions have been put in place.

It should be noted that this study used the child protection data available for a five year period, so that the period of follow-up for each child averaged 2.5 years, ranging from five years for those cases present in the data set at the beginning of 2001 to zero years for the latest cases towards the end of the data period. As such, these data under-estimate the recurrence rate that would be determined if all children were followed from their time of first substantiation within the system.

8.6 Conclusions

At the beginning of the chapter we saw that as the number of repeat cases increased the percentage of cases that involved carer alcohol abuse correspondingly increased. Next the relationship between recurrence (or not) and carer alcohol abuse was examined, adjusting for numerous other factors. Children from families in the Child Protective Services System where carer alcohol abuse was identified were significantly more likely to experience recurrent child abuse than those where carer alcohol abuse was not noted, after adjusting for a range of socio-demographic factors. Social and demographic variables were also important predictors of child maltreatment recurrence. In particular, carer alcohol abuse and other drug abuse were both independently associated with recurrence. In attempts to differentiate which of these factors was more important, the results indicated that carer alcohol abuse and carer other drug abuse were roughly equal in their ability to predict recurrence.

In assessing how carer alcohol abuse cases were managed by Victorian Child Protective Services, whether a case was an “initial” or a “repeat” substantiation appeared to matter little in what intervention was applied to cases involving carer alcohol abuse. However, the data suggest that the majority of children of carers with alcohol abuse were not resubstantiated in the system. Whether this was because the system works to improve the situation of the child, or because these families subsequently avoid contact with reporting agencies and/or other reporters is difficult to say. It seems that carer alcohol abuse cases are more likely to experience repeat cases and protective interventions but not court outcomes than other cases, suggesting perhaps that the system is focusing intensely on this group, yet not necessarily resorting to the more intrusive strategies imposed in the Children’s Court.
When sensitively interpreted, recurrence rates within systems can act as important performance indicators for government agencies, and provide markers of how many and which families and children need additional help and why. These figures should be used to drive action on risk factors such as alcohol in primary prevention as well as to target those most seriously affected who require intensive interventions.
Chapter 9 Alcohol-related harm to children in the general population in Australia

(Wilcox, Sydney Morning Herald, 21st October, 2008)

9.1 Introduction

The previous chapters have focused on the risks of carers’ drinking associated with child maltreatment that have been managed in the child protection system in Victoria. Whether alcohol-related harms to children are prevalent in the general population has not been widely studied. Chapter 9 provides an overview of the findings from a national survey that pertain to alcohol-related harms to children.

Much of the previous data collected on alcohol problems and child maltreatment assumes that alcohol-related child maltreatment is restricted to the small group of drinkers with serious addiction or dependency problems, or to carers who abuse alcohol and come to the attention of child protection systems. There is less acknowledgement that parents may cause considerable harm to their children in the general population because of a range of heavy drinking patterns, including one-off incidents of intoxication. These other patterns may also be linked to child maltreatment. There is evidence that child maltreatment is underreported (Creighton, 2004) and that only a proportion of child maltreatment is known to authorities. Research on other alcohol problems suggests that the majority of problems at a population level may be in fact attributed to the more prevalent but less frequently intoxicated population (Skog, 2006). This “prevention paradox”, wherein most cases of a disease occur in the
population that is at low or moderate risk, and a minority of the cases occur in the group at highest risk of the disease (Rose, 1981), may also apply to alcohol-related child maltreatment.

Given the extent of parental drinking in Australia (Dawe et al., 2007; Maloney et al., 2010), and our understandings of the range of problems that may result to children (see Chapter 1), it is likely that the heavy drinking of parents and carers may cause problems for children in the general population. However, a number of academics suggest that child protection cases in the general population are likely to differ markedly from “clinical” cases (Gilbert, Widom et al., 2009; Straus et al., 1998), but that those in the general population should be subjected to closer scrutiny.

One could argue that a connection between problematic drinking and child maltreatment in the general population has been exaggerated by child welfare and alcohol researchers when they report on the risks for children associated with simply living with a heavy drinkers (Dawe et al., 2007; Manning et al., 2009). Indeed, simply living with someone who consumes alcohol at risky levels may not relate to harm. There is consensus that there is little evidence to suggest how many children are affected and in what ways they have been affected by the drinking of their parents and carers in the general population (Adamson & Templeton, 2012; Kelleher et al., 1994; Templeton, 2013).

Very few studies of the general population report on the prevalence of child maltreatment, let alone whether or not carer intoxication or problematic drinking was involved. In the United States, Kelleher et al. (1994) found that 3% of their large community sample had perpetrated relatively severe physical injuries or neglect and that 36% of this group were parents diagnosed with alcohol abuse or alcohol dependence using DSM III criteria. In Italy in 1998, self-reported “high” and “average,” compared with “moderate,” parental alcohol consumption, were both associated with severe but not minor physical violence towards children (Bardi & Borgognini-Tarli, 2001). And as discussed in Chapter 1, Straus et al. (1998) found that 2% of a sample of parents in the United States self-reported being so drunk or high in the last year they had a problem taking care of their child. A fourth study, examining the lifetime history of a range of social problems in a large Californian sample (Felitti, 1998), found that 23% of adults reported the presence of a “heavy drinking parent during childhood”. Another 5% reported the use of “street drugs”, meaning a total of 26% reported heavy drinking and/or other drug using parents. Of this group 22% reported psychological abuse, 19% reported physical abuse and 34% reported sexual abuse as a child.
In the overall sample the prevalence of these conditions was 11%, 11% and 22% respectively (Felitti, 1998).

In summary, in Australia and elsewhere, knowledge about the relationship between heavy drinking and child rearing in the general population has been limited to information on the extent of drinking by parents in smaller studies or treatment samples, those that involve specific populations, such as child protection clients, and retrospective studies among adults. These usually focus on the impact of very heavy drinking, and few studies have used large representative community samples. The research presented in this chapter seeks to move beyond these limits, to determine i) the prevalence of alcohol-related harm to children in the population because of someone else’s drinking (not including the respondent’s drinking), and, ii) whether rates of alcohol-related harm to children vary by relationship between the child and the drinker, by the respondent’s drinking and by socio-demographic factors.

9.2 Methods

Data

As described in Chapter 5, the Alcohol’s harm to others survey involved a national random sample of 2,649 Australians aged 18 years or older who completed a computer-assisted telephone interview (CATI) in November and December 2008 (Laslett et al., 2011).

For the purposes of this chapter a “parental” subset of the study population was identified, consisting of all respondents who indicated that they were living with children 17 years of age or younger, and all others with parental responsibility for children 17 years of age or younger. In principle, a child could have been reported on from more than one household; for example, if the mother was living with the child and the father was living elsewhere but also took care of the child. But the probability of such duplicate inclusion is extremely small.

Alcohol-related harms to children variables

The parental subset of respondents were asked five specific questions concerning harm a child or children of theirs had experienced in the past year as the result of someone else’s drinking (see Chapter 5). As described in Table 5.1, these questions, which do not include harm caused by the respondent’s own drinking, were derived from the official definitions of types of primary harm, excluding sexual harm, commonly investigated by Child Protective Services across the Australian states and territories (Australian Institute of Health and
Welfare, 2008b). Each of these questions was asked in terms of how often the harm had occurred in the last 12 months. The respondents were also asked “Because of others’ drinking, how many times was a protection agency or family services called?” and a summative question, “How much has the drinking of other people negatively affected (this child/these children) in the last 12 months?” The response options were “a lot”, “a little” or “not at all”.

The primary outcome or dependent variable used was alcohol-related harm to children due to the drinking of others. This variable was coded as 1 if a positive response was reported to one or more of the five specific questionnaire items in Table 5.1 (regardless of how often it had occurred), or if a lot or a little harm was reported in response to the summative question, and a 0 otherwise. Where participants responded “a lot” to the summative question, then this has been used as an outcome variable termed “substantial harm”.

Additional outcomes examined included the frequency of reports of each of the individual items, e.g., frequency of how many times children were hurt because of others’ drinking. These frequency variables examined the specific number of times alcohol-related harms to children were reported within each abuse category and across categories overall. For overall frequency, incidents reported for each type of specific harm were summed. For example; if two incidents of physical harm and one incident of verbal abuse were reported, the overall frequency of harm would total three incidents.

*Calculating the (unweighted) percentage of children affected in the past year because of others’ drinking*

Two measures of alcohol-related harms to children were derived to develop lower and upper bounds of these estimates. More than one child may have been affected in the household and/or family. A conservative approach to calculating the prevalence of alcohol-related harm to children because of the drinking of others was used whereby it was assumed that each respondent was only referring to one child who was harmed and the percentage of respondents affected by others’ drinking was multiplied by the number of Australian families. The less conservative measure assumed that the respondent was referring to all children the
respondent had responsibility for\(^2\). In the latter scenario the percentage of respondents who reported that their children had been affected by others’ drinking was multiplied by the number of Australian families and the average number of children per Australian family. A mid-point was derived by taking the average of these two figures.

**Independent variables**

Respondents who reported any of the specific items were asked “What was the relationship to the children?” of the person or persons whose drinking had adversely affected the child/ren. The response categories for these identified persons were: caregiver (parent, step-parent or and/or guardian); sibling; another relative; family friend or person with whom the child comes into contact such as a sports coach, teacher, priest; or someone else. As detailed in Chapter 5, demographic data on age, gender, educational background, work status and postcode of the respondent were collected and categorised, along with an area-level socio-economic status variable for each participant, applied on the basis of the quintile score of the Socio-Economic Index for Areas of disadvantage (Australian Bureau of Statistics, 2006a) of the participant’s postcode. Household family structure was coded as “two carers with children”, “single carer with children”, and “other”.

Respondents were asked how often they usually drank 5 or more standard drinks on an occasion. This information was also used as an independent predictor of alcohol-related harm to children.

**Analysis**

Respondents with children, whether in or outside the household, were the unit of analysis. Raw numbers and weighted percentages (see Chapter 5 for an explanation of the weights used) with confidence intervals were calculated for annual prevalence estimates of alcohol-related harm variables. Descriptive statistics were calculated for frequency variables, including mean, mode and range statistics. Weighted bivariate and multivariate logistic regression analyses were undertaken to examine associations between the independent variables and overall alcohol-related harm to children. Bivariate relationships significant at

\(^2\) Children under the age of 18 were assumed to be children of someone within the household. A small number of these may have been the partner of an adult – for example a 17 year-old partner of a 19 year-old.
the p<0.1 level were added to the multi-variable adjusted model predicting alcohol-related harm to children.

9.3 Harm to Others Survey Results

Sample characteristics

There were 1142 respondents in the parental subset, who had parental responsibility for 2,457 children (of which 2,004 lived with the respondent). On average each respondent was associated with 2.1 children and lived with 1.8 children.

Table 9.1 shows that alcohol-related harm to children of any type (reporting either a specific form of alcohol-related harm to children or any negative effect) was identified by 22% of respondents. Respondents most commonly reported that children had been yelled at, criticised or otherwise verbally abused because of someone else’s drinking (9%). Fewer respondents reported that children were left unsupervised or in unsafe situations because of others’ drinking (3%), that children witnessed domestic violence (3%), or that children were physically hurt (1%). Very few reported that child protection or family services were called (<1%). In total, 12% of respondents reported that children had been affected in one or more of these specified ways. Respondents could report on more than one type of specific harm to children due to someone else’s drinking, thus 195 specific different types (not incidents) of harm (including calling a protective services agency) were reported by 135 respondents.

Around one in six (17%) respondents reported that a child/ren had been affected a lot (3%) or a little (14%) by someone else’s drinking. Just under half (123 or 48%) of those who identified a lot or a little negative effect did not report any of the specific effects that were covered by the five questionnaire items covering specific types of harm.

A total of 135 respondents attributed these alcohol-related types of harm specific incidents to 138 people (more than one person may have been alleged to be responsible). Respondents were only asked about who they held responsible for the specific types of alcohol-related harm, and not who had been responsible for the general question on a little or a lot of harm.
Table 9.1 The percentage of respondents (families) reporting alcohol-related harm to children by maltreatment type and level of effect (n=1,142, %)

<table>
<thead>
<tr>
<th>Any positive response</th>
<th>(n)</th>
<th>(%)</th>
<th>95% CI (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Because of someone else’s drinking how many times in the last 12 months.....”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were children left in an unsupervised or unsafe situation?</td>
<td>40</td>
<td>3</td>
<td>(2, 5)</td>
</tr>
<tr>
<td>Were children yelled at, criticised or verbally abused?</td>
<td>97</td>
<td>9</td>
<td>(7, 11)</td>
</tr>
<tr>
<td>Were children physically hurt?</td>
<td>16</td>
<td>1</td>
<td>(1, 2)</td>
</tr>
<tr>
<td>Did children witness serious violence in the home?</td>
<td>34</td>
<td>3</td>
<td>(2, 4)</td>
</tr>
<tr>
<td>Was a protection agency or family services called?</td>
<td>5</td>
<td>0.3</td>
<td>(0.1, 0.8)</td>
</tr>
<tr>
<td>% families reporting one or more of above</td>
<td>135</td>
<td>12</td>
<td>(10, 14)</td>
</tr>
<tr>
<td>“How much has the drinking of other people negatively affected your children/the children you are responsible for?”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>40</td>
<td>3</td>
<td>(2, 4)</td>
</tr>
<tr>
<td>A little</td>
<td>168</td>
<td>14</td>
<td>(12,16)</td>
</tr>
<tr>
<td>% affected a lot or a little</td>
<td>208</td>
<td>17</td>
<td>(15,19)</td>
</tr>
<tr>
<td>Specifically affected in any way or affected a lot or a little</td>
<td>258</td>
<td>22</td>
<td>(19, 24)</td>
</tr>
</tbody>
</table>

1 Total ns and %s for the 5 items do not add to 135 and 12% as respondents may have reported that their children experienced more than one type of abuse.

212 people were excluded from the denominator because they did not report any level of effect (i.e. did not answer a lot, a little or not at all)

Table 9.2 depicts the relationship between the child/children experiencing alcohol-related harm and the identified persons implicated. As can be seen in the final column, around 50% of specified alcohol-related harms to children were forms of verbal abuse, 17% involved exposure to domestic violence, 21% involved lack of supervision and 8% involved physical injury. Similar distributions of harms were noted for all relationship types. The most common harm reported from siblings was verbal abuse (56%), followed by physical harm and poor supervision (both 17%), although alcohol-related harms to children attributed to siblings’ drinking appeared more likely to involve physical injury than harms from respondents overall. Alcohol-related harm to children from other relatives compared with harm from other relationships was more likely to involve an incident of serious violence in the home, and harms involving children being left unsupervised were somewhat more likely to be attributed to a family friend’s drinking. The relationship category most likely to have been responsible for specified alcohol-related harm to children (see bottom row of Table 9.2) was the carer.
(parents, step-parents or guardians) category (52%), followed by siblings and other relatives (21%) and family friends (16%). This distribution of harm across relationship types for each of the individual types of abuse (percentages not shown) was similar to the overall pattern: in around 50% of verbal abuse, exposure to domestic violence and lack of supervision incidents reported, carers were deemed responsible.

Table 9.2 The number of alcohol-related harms to children by relationship of affecting drinker, and percentage of harms attributed to each relationship

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Carer (n=68)</th>
<th>Siblings (n=12)</th>
<th>Other relative (n=19)</th>
<th>Family friend (n=25)</th>
<th>Other (n=14)</th>
<th>Total (n=138)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Because of someone else’s drinking how many times in the last 12 months……”</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Were children yelled at, criticised or verbally abused? (% with harm by relationship)</td>
<td>52</td>
<td>56</td>
<td>48</td>
<td>52</td>
<td>46</td>
<td>51</td>
</tr>
<tr>
<td>Did children witness serious violence in the home?</td>
<td>17</td>
<td>11</td>
<td>30</td>
<td>10</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>Were children left in an unsupervised or unsafe situation?</td>
<td>21</td>
<td>17</td>
<td>17</td>
<td>26</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>Were children physically hurt?</td>
<td>7</td>
<td>17</td>
<td>0</td>
<td>13</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Were child protection/family services called?</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Percent of total harms attributed to persons in that relationship to the child (row %)</td>
<td>52</td>
<td>9</td>
<td>12</td>
<td>16</td>
<td>11</td>
<td>100</td>
</tr>
</tbody>
</table>

#Percentages are calculated using the number of respondents reporting any specific harm from that relationship as the denominator
Column %s in italics and row %s in standard font

These data were also examined in terms of the number of cases reporting harm from each particular relationship source (i.e., by examining the number of harms relative to the number of relationships reported). For example, of the 68 carers held responsible for alcohol-related harm to children, 76% (n=52) of them were reported to have verbally abused the child in their care because of their drinking. A total of 31% of these carers reportedly left children unsupervised, 25% exposed their child/ren to serious domestic violence, and 10% were reported to have physically hurt their children because of their drinking. Types of alcohol-related harm to children reported in relation to other relationship types held responsible were similarly distributed, except that other relatives were more likely to be held responsible for proportionally more children witnessing serious violence (37%); and siblings were held responsible for more alcohol-related physical harms (25%). For all relationship types, verbal abuse was the most commonly identified form of harm.
How many children have been affected in the past year because of others’ drinking?

Low and high estimates of the number of children affected by others’ drinking were generated using the Harm to Others’ survey data under two assumptions:

1) that only one child in the respondent’s family was affected by others’ drinking; and

2) that all children in the respondent’s family were affected by others’ drinking

Under the first assumption only one child per Australian family is included, whereas in the second assumption the first assumption is multiplied by the average number of children per Australian family. For example, the number of respondents who reported that their children had been affected a lot by others’ drinking was 3%. This figure is multiplied by the number of Australian families (0.03 x 2,576,000 = 77,280 children affected). If all children are assumed to be affected within the family then this number is multiplied by 1.845 (the number of children per household) and 142,582 children are estimated to be affected. Similarly, to obtain the number of children affected in any way by others’ drinking the proportion of families affected by others’ drinking (0.22) is used and the sums become 0.22 x 2,576,000 =566,720, where only one child is reported to have been affected children, and 0.22 x 2,576,000 x 1.845 = 1,045,598 children where all children within the family are assumed to have been affected. Midpoints between these two estimates have also been inserted into Table 9.3.

Table 9.3 Low, middle and high estimates of the number (n) of children affected by others’ drinking

<table>
<thead>
<tr>
<th>“How much has the drinking of other people negatively affected your children/the children you are responsible for?”</th>
<th>Low n</th>
<th>Middle n</th>
<th>High n</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>77,280</td>
<td>109,931</td>
<td>142,582</td>
</tr>
<tr>
<td>A little</td>
<td>360,640</td>
<td>513,010</td>
<td>665,380</td>
</tr>
<tr>
<td>A lot or a little</td>
<td>437,920</td>
<td>622,941</td>
<td>807,962</td>
</tr>
<tr>
<td>Specifically affected</td>
<td>309,120</td>
<td>439,723</td>
<td>570,326</td>
</tr>
<tr>
<td>Specifically affected in any way or affected a lot or a little</td>
<td>566,720</td>
<td>806,159</td>
<td>1,045,598</td>
</tr>
</tbody>
</table>
Analyzing relationships between alcohol-related harm to children and family socio-demographic factors

Table 9.4 presents information on the percentage of respondents, across a range of socio-demographic characteristics, who reported that their children had been affected because of others’ drinking in any way. Bivariate analysis revealed that respondents in single-carer households, compared to two-carer households, were over twice as likely to report that

### Table 9.4 Percentage and odds ratios of alcohol-related harm to children by selected socio-demographic characteristics (n=1,142)

<table>
<thead>
<tr>
<th>Independent variable (n)</th>
<th>% reporting specific ARHC</th>
<th>% reporting any ARHC</th>
<th>Unadjusted Odds Ratios (CI)</th>
<th>Adjusted Odds Ratios (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender of respondent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (417)</td>
<td>15</td>
<td>24</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Female (725)</td>
<td>13</td>
<td>25</td>
<td>1.04 (0.76, 1.50)</td>
<td></td>
</tr>
<tr>
<td>Age of respondent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29 (168)</td>
<td>15</td>
<td>21</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>30-59 (920)</td>
<td>14</td>
<td>26</td>
<td>1.28 (0.81, 2.04)</td>
<td></td>
</tr>
<tr>
<td>60-99 (54)</td>
<td>5</td>
<td>14</td>
<td>0.60 (0.26, 1.40)</td>
<td></td>
</tr>
<tr>
<td>Household family structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two carers &amp; children (828)</td>
<td>14</td>
<td>21</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Single carer (198)</td>
<td>24</td>
<td>41</td>
<td>2.67*** (1.79, 3.99)</td>
<td>2.66* (1.63, 4.36)</td>
</tr>
<tr>
<td>Other (116)</td>
<td>14</td>
<td>23</td>
<td>1.10 (1.79, 3.99)</td>
<td>0.92 (0.48, 1.76)</td>
</tr>
<tr>
<td>Education of respondent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;secondary (240)</td>
<td>13</td>
<td>24</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Secondary (452)</td>
<td>17</td>
<td>27</td>
<td>1.13 (0.74, 1.75)</td>
<td></td>
</tr>
<tr>
<td>Post-secondary (436)</td>
<td>9</td>
<td>21</td>
<td>0.81 (0.52, 1.26)</td>
<td></td>
</tr>
<tr>
<td>Family income type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid work (809)</td>
<td>16</td>
<td>27</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Other (332)</td>
<td>10</td>
<td>20</td>
<td>0.70 (0.49, 1.02)</td>
<td></td>
</tr>
<tr>
<td>Family income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $50,000 (224)</td>
<td>19</td>
<td>34</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>$50,000 to $74,999 (189)</td>
<td>11</td>
<td>21</td>
<td>0.52* (0.30, 0.88)</td>
<td>0.66 (0.38, 1.16)</td>
</tr>
<tr>
<td>$75,000 or more (519)</td>
<td>12</td>
<td>23</td>
<td>0.59* (0.39, 0.90)</td>
<td>0.77 (0.47, 1.25)</td>
</tr>
<tr>
<td>SEIFA score of neighbourhood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 low status (157)</td>
<td>11</td>
<td>24</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>2 (185)</td>
<td>15</td>
<td>21</td>
<td>0.86 (0.47, 1.57)</td>
<td></td>
</tr>
<tr>
<td>3 (240)</td>
<td>15</td>
<td>31</td>
<td>1.39 (0.80, 2.39)</td>
<td></td>
</tr>
<tr>
<td>4 (259)</td>
<td>15</td>
<td>25</td>
<td>1.07 (0.60, 1.91)</td>
<td></td>
</tr>
<tr>
<td>5 high status (297)</td>
<td>13</td>
<td>22</td>
<td>0.86 (0.50, 1.48)</td>
<td></td>
</tr>
<tr>
<td>Respondent’s 5+ drinking status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not in previous year (512)</td>
<td>12</td>
<td>23</td>
<td>Ref</td>
<td></td>
</tr>
<tr>
<td>Monthly or last year (504)</td>
<td>15</td>
<td>25</td>
<td>1.12 (0.79, 1.60)</td>
<td>1.21 (0.83, 1.78)</td>
</tr>
<tr>
<td>Weekly (105)</td>
<td>18</td>
<td>33</td>
<td>1.67* (1.00, 2.78)</td>
<td>2.01* (1.13, 3.57)</td>
</tr>
</tbody>
</table>

ARHC: alcohol-related harm to children
* p<.05, ** p<.01
1Total observations for socio-demographics do not add to 1,142 due to missing responses (typically less than 1%)
2Includes sole person and couple only households who reported parental responsibility for, but not living with, children
3Includes respondents who were students, unemployed, employed in home duties, volunteers and others
children had been harmed because of others’ drinking. Respondents who reported weekly drinking of five drinks or more on an occasion were more likely to report alcohol-related harm to children, compared to non-drinkers, whilst middle and higher income respondents were less likely to report alcohol-related harm to children than respondents on low incomes. None of the other socio-demographic variables were significantly associated with alcohol-related harm to children. The multivariate model indicates that, once family type and respondent drinking status were adjusted for, income was no longer significantly associated with alcohol-related harm to children.

*Frequency of incidents of alcohol-related harm to children*

The analyses in this chapter have so far concentrated on dichotomised experiences of harm. However, nine percent of respondents reported more than one specific incident of harm (with respondents reporting between 0 and more than 400 incidents of harm, including five respondents who reported 90 or more incidents of harm to children). Respondents reported on average that children who had experienced any specific harm most commonly experienced 2 incidents (mode), and on average experienced 12.4 incidents of harm in the past 12 months.

**Table 9.5 Specific alcohol-related incidents of harm to children: distribution statistics**

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
<th>n inc</th>
<th>Mean†</th>
<th>Mode**</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsupervised</td>
<td>40</td>
<td>3</td>
<td>255</td>
<td>5.3</td>
<td>2</td>
<td>1-20</td>
</tr>
<tr>
<td>Verbally abused</td>
<td>97</td>
<td>9</td>
<td>1294</td>
<td>13.7</td>
<td>2</td>
<td>1-300</td>
</tr>
<tr>
<td>Physically abused</td>
<td>16</td>
<td>1</td>
<td>70</td>
<td>3.7</td>
<td>1</td>
<td>1-24</td>
</tr>
<tr>
<td>Witness domestic violence</td>
<td>34</td>
<td>3</td>
<td>126</td>
<td>3.2</td>
<td>1</td>
<td>1-28</td>
</tr>
<tr>
<td>Notified to CP/Family services</td>
<td>5</td>
<td>0.3</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1-5</td>
</tr>
<tr>
<td>Overall frequency of harm</td>
<td>135</td>
<td>12</td>
<td>1745</td>
<td>12.9</td>
<td>2</td>
<td>1-400</td>
</tr>
</tbody>
</table>

Figures are actual respondent ns; %s and means are weighted
n inc Number of incidents reported
†The average number of harms reported if any harm was reported
**The most commonly reported number of harms

*The drinking patterns of respondents living with children*

The other variable in Table 9.4 that was associated with alcohol-related harm to children was the respondent’s drinking pattern. The pattern of drinking of the person who had harmed the child was not obtained. In order to estimate the proportion of children living with risky drinkers respondents’ drinking patterns were also asked about. Table 9.6 describes the drinking patterns of respondents living with or responsible for children. Whilst 41% of respondents reported never drinking five (Australian standard) drinks or more on an occasion
in the last year (either because they were abstainers and had not drunk at all in the last year or because they just had not drunk more than 5 drinks in the last year), almost a third (30.9%, CI: 27.8, 34.1%) reported having done so monthly or more frequently in the past year, and 28% (CI: 25.1, 30.8%) reported they had done so in the last year but less often than monthly.

Table 9.6 Drinking patterns of respondents in families living with or responsible for children

<table>
<thead>
<tr>
<th>“How often do you have five drinks or more?”</th>
<th>Total (n)</th>
<th>Total (%)</th>
<th>95% CI (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every day</td>
<td>8</td>
<td>1.1</td>
<td>(0.4, 3.2)</td>
</tr>
<tr>
<td>5 to 6 days a week</td>
<td>7</td>
<td>1.0</td>
<td>(0.4, 2.3)</td>
</tr>
<tr>
<td>3 to 4 days a week</td>
<td>23</td>
<td>2.5</td>
<td>(1.6, 3.8)</td>
</tr>
<tr>
<td>1 to 2 days a week</td>
<td>88</td>
<td>9.2</td>
<td>(7.3, 11.4)</td>
</tr>
<tr>
<td>2 to 3 days a month</td>
<td>69</td>
<td>6.5</td>
<td>(5.0, 8.3)</td>
</tr>
<tr>
<td>About 1 day a month</td>
<td>109</td>
<td>10.6</td>
<td>(8.7, 12.9)</td>
</tr>
<tr>
<td>Less often</td>
<td>326</td>
<td>27.8</td>
<td>(25.0, 30.8)</td>
</tr>
<tr>
<td>Never in last 12 months</td>
<td>371</td>
<td>29.0</td>
<td>(26.3, 31.9)</td>
</tr>
<tr>
<td>Abstainer</td>
<td>139</td>
<td>12.2</td>
<td>(10.2, 14.5)</td>
</tr>
<tr>
<td>Can’t say</td>
<td>2</td>
<td>0.2</td>
<td>(0.04, 0.7)</td>
</tr>
<tr>
<td>Total</td>
<td>1142</td>
<td>100%</td>
<td>-</td>
</tr>
</tbody>
</table>

% respondents in families with children or responsible for children reporting at least monthly drinking of five or more drinks 30.9 (27.8, 34.1)

9.4 Discussion

Analysis showed that 22% of Australian families have one or more children who have experienced alcohol-related harm to children as a result of another’s drinking in some way. Twelve per cent of families reported one or more of the specific harms asked about. In these cases, the majority were reported to have been affected by family members, including 61% by immediate family members, 12% by other relatives, and one quarter by the drinking of friends, neighbours, teachers, coaches, religious leaders or others.

The most commonly reported form of specified alcohol-related harm to children identified in this study was verbal abuse. Verbal abuse can be defined as emotional abuse (Australian Institute of Health and Welfare, 2008b; Victorian Department of Human Services, 2007), although emotional abuse is usually a chronic pattern of behaviours such as yelling, denigrating, humiliating, isolating or terrorising the child to an extent that the behaviour is likely to cause the child significant emotional harm (Victorian Department of Human Services, 2007), meaning that not all instances of verbal abuse captured in this study would be likely to qualify as emotional abuse. But where children experienced verbal abuse frequently, this may indicate that children have been maltreated but most likely not managed
by formal services or agencies. Incidents of verbal abuse because of others’ drinking have been shown in this analysis to be prevalent across a range of relationships.

Respondents reported a total of 1,745 specific incidents of abuse. The most commonly reported number of harms children experienced in the last 12 months was two, although a small proportion of children experience many more.

Reports of potentially more severe harms because of others’ drinking were less common. For example in just 3% of families with children, the children were reportedly exposed to serious domestic violence in the home because of others’ drinking in the last year. These findings are similar to those reported by Manning et al. (2009), who found that 2% of children in Scotland witnessed a violent incident between their carers or parents after the perpetrator had been drinking. However, these small percentages translate into a large number of affected families; 3% equates to over 142,000 families Australia-wide. However these more severe incidents may be linked with future health, mental health and alcohol misuse problems. In the United States the Adverse Childhood Experiences study exposed a high prevalence of retrospectively reported harms during childhood (Bynum, Griffin & Ridings et al., 2009) and a relationship to a range of poorer adult outcomes, particularly where these adverse experiences had been multiple (Felitti, Anda & Nordenberg, 1998; Brown, Anda, Henning et al., 2009; Anda, Felitti & Bremner, 2006).

It would be useful to compare our rate of children’s exposure to alcohol-related domestic violence with other Australian figures and non-alcohol-related domestic violence figures. However, whilst the general population personal safety surveys conducted in Australia show that 1% of all respondents (including those not in families) reported experiencing alcohol-related partner violence (Laslett et al., 2010; Mouzos & Makkai, 2004) and 27% of all reported domestic violence occurred in the presence of children (Australian Bureau of Statistics, 2006b), alcohol-specific figures were not reported. The prevalence of severe and all forms of alcohol-related harms to children are markedly higher than those reported by Kelleher et al. (1994), although their results focused on more severe harms to children self-reported by parents.

Child protection data suggest that in the majority of neglect cases biological parents are held responsible (Australian Institute of Health and Welfare, 2010; Sedlak & McDonald, 2010). Some research suggests that mothers are more often held responsible than fathers, simply
because they more often are the primary carers (Lamont, 2011; May-Chahal & Cawson, 2005). However, in physical abuse cases, surveys such as the Australian personal safety surveys suggest fathers are more likely to be responsible (Australian Bureau of Statistics, 2006b).

In the child protection literature, it is acknowledged that the drinking of either a maltreating or a protective parent could contribute to increased maltreatment of children. If a maltreating parent becomes intoxicated, they may be less inhibited and more likely to cause harm by saying or doing things they would not otherwise. If the protective parent drinks heavily they may be less able to protect the child from a partner’s or other person’s actions (Spatz-Widom & Hiller-Sturmhöfel, 2001). In this study, 31% of respondents reported that they drank at least 5 or more drinks on the one occasion at least monthly, and 14% reported that they did weekly. In the bivariate and multivariate analysis the respondent’s drinking pattern (drinking 5 or more drinks at least weekly) was significantly associated with whether children were more likely to be negatively affected by others’ drinking. This may, in part, reflect the fact that heavier drinkers often associate with other heavy drinkers (Cahalan, 1970).

The current study results produce estimates of the percentage of respondents from families with children in them where respondents report drinking more than five drinks on an occasion monthly, weekly and less often. Twenty-one percent of respondents in our survey reported drinking five or more drinks, two to three times a month or more, although this only includes one adult within the household or respondent reporting responsibility for a child outside their home, so this figure is likely an underestimate. This figure is higher than Dawe et al.’s (2007) figure of 13% of children being exposed to the heavy drinking of at least one parent. However, Dawe et al.’s figures include only children 12 years or under and set a higher threshold for men’s drinking (7 or more drinks on the one occasion). If respondents who drink 5 or more drinks at least monthly are included in the results of the current study the figure rises to 31%, although we do not know whether respondents drink these amounts around children, or whether they moderate their drinking when children are present. Parents and other carers (i.e., respondents) who drank at risky levels (5 or more standard Australian drinks per occasion) at least weekly were statistically significantly associated with more harm than those who had never done so. Perhaps respondents who drank at these levels were also more likely to drink around their children, putting them at greater risk from others’ drinking.
by affecting the level of supervision and protection their children are afforded. However, more research is required to confirm this.

In the present general-population survey frame, alcohol-related harm to children was more common in the low income group, but this association between income and harm diminished and was no longer significant after adjustment for family type and respondent drinking status variables. Respondents from single-parenthood households were more likely to report harms to their children even after adjustment in the multivariate model.

The bivariate relationship between income and alcohol-related harm to children is consistent with the Child Protective Services data findings in previous chapters, but this relationship disappears in the multivariate analysis. Moreover, there is harm recorded across the income spectrum. The distribution of alcohol-related harms to children across socio-economic groups in the general population described in this chapter contrasts sharply with the picture from the Child Protective Services case data, which predominantly identifies victims who are financially disadvantaged. Because the majority of parenting occurs in private spaces that state agencies have little ability to observe or control, those families more exposed to a range of state agencies may be more likely to be notified to state welfare organisations (Baachi, 1999; Straus et al., 1998) – and indeed the majority of child abuse cases substantiated in Child Protective Services in Victoria and Australia are identified in socially and economically disadvantaged and disempowered families. How much this may be because the more severe forms of child abuse and neglect occur less often in more socio-economically advantaged homes, and how much because these homes are less likely to come under state surveillance, is examined further in Chapter 10.

Interestingly, the number of families that reported calling Child Protective Services in the general population survey because of others’ drinking was 0.3%, a percentage very similar to that identified in the Child Protective Services data found to be affected by carer alcohol abuse and substantiated in the system (0.2%). It should be recognised that there is a wide confidence interval for the survey figure. However, that the rates of exposure to child protection responses are similar, suggests some consistency in the findings obtained in the survey and the child protection system.
9.5 Conclusion

These results suggest that the drinking of parents and other adults involved with children does have consequences for children and that these incidents are rarely managed by Child Protection and other Family Services. Alcohol-related harm to children was reported in 22% of families in 2008 and specific alcohol-related harm to children was reported in 12% of families. This is concerning, although arguably not surprising given alcohol’s effects on behaviour are well known and levels of heavy episodic drinking in Australia are high, and chronic heavy drinking is also of concern. A weekly risky drinking pattern by the carer was a significant predictor of alcohol-related harm to children. Children in families from a wide range of social backgrounds experienced harm because of others’ drinking, suggesting that alcohol policies with wide application are indicated, although a special focus may be warranted on single carer households and those families where risky drinking (particularly weekly or more often) is occurring.
Chapter 10  
Comparing alcohol-related child maltreatment in the system data and the general population

William Hogarth, Beer Street and Gin Lane, 1751.

10.1 Introduction

Hogarth’s prints (Hogarth, 1751a, 1751b) contrast the consequences of drinking beer, and its “thriving industry and jollity”, with the “dreadful consequences of gin” (Hogarth quoted in Nicholls, 2009, p. 46). The prints portray Hogarth’s view of how gin affected the lower classes, but that beer did not have such affects, and the beer scene portrays mostly the middle and upper classes (his own). While Hogarth clearly intended to describe the child neglect, urban decay, violence and ill-health associated with intoxication, Hogarth’s intentions in depicting the association between poverty and drunkenness are contested. Charles Dickens, amongst others, believed that it was Hogarth’s intention to portray poverty as both a cause and consequence of drunkenness amongst “the neglected orders of society” (Nicholls, 2009, p. 47). In this dissertation, unlike Hogarth’s depictions of drinking amongst different classes, the data from the previous chapter suggest the reality behind the facade in the general population may also be problematic, although the predominant view of child protection workers may continue to be similarly focussed upon particular disadvantaged groups.
Chapters 6-8 examined substantiated child maltreatment involving carer alcohol abuse cases, as defined by child protection workers, and followed these cases through the electronic data system, providing a view through the first window of alcohol-related child maltreatment. Carer alcohol abuse was associated with increasingly serious intervention and repeated involvement with the child protection system. In contrast, Chapter 9 described experiences of alcohol-related harms to children in the general population as ascertained in a national survey, and provides a second window or view of alcohol-related harm to children. This chapter brings both of these data sets into the same frame and compares measures of alcohol-related child maltreatment in Australian families using survey and system data.

One key difference that is apparent in the two windows examined in this dissertation is the composition of the groups studied in the child protection system and the general population. As discussed in Chapter 9, there was no evidence of association between alcohol-related harm and the majority of social class variables, including education of the respondent, neighbourhood socioeconomic factors (SEIFA) and family income type. However, a statistically significant difference was observed in the prevalence of alcohol-related harm to children by income in the general population, although this dissipated after adjusting for other factors (significant at the bivariate level), such as family type and respondent’s drinking pattern. The single carer family type may also be measuring social class in some ways, as single-parent families in Australia are on average economically disadvantaged (Bradbury & Jäntti, 1999; Hancock, 1989). Nevertheless, the association between socio-economic differences and harm were weak in comparison to the stark differences seen in the child protection system data by social class indicators in Chapters 6 to 8. Moreover, the median social position of families of Child Protective Services cases differs greatly from that of families in the general population, suggesting at face value very different hypotheses regarding the relationship of child maltreatment and social disadvantage. Given the different findings about social class distribution between the two windows of observation, this chapter compares the two samples more carefully, and examines whether the relationship between alcohol-related harm and income can be explained, at least in part, by different severities of harm implicit in the two windows.
10.2 The literature on alcohol, child maltreatment, severity and social location

*How many cases are hidden from the Child Protection system and how severe are these cases?*

Child maltreatment is largely hidden from authorities and those outside the intimate social circle of the family (Adamson & Templeton, 2012; Hope, 2011). How alcohol impacts on adults’ care of their children only rarely surfaces, for example, in high profile child abuse cases where children of dependent drinkers are neglected or injured, or in other instances where children are removed (Deceglie, 2010; Littlechild, 2008). In the main, Child Protection systems and other official agencies have little access to the private spaces within which carers drink and children develop and are cared for. It is difficult to assess how children are treated within families, and in particular, how severely they may be maltreated, and whether alcohol is involved. It is true that Child Protection systems (whether it is via self-admission of perpetrators or from reports from family members, teachers or health workers) do detect, investigate and manage many thousands of child abuse cases that involve alcohol (see Chapters 6-8). But, child abuse and neglect are generally considered to be under-reported, and those cases that appear in national and state data collection systems are considered to be a fraction of the true magnitude of the problem (Creighton, 2004; Gilbert, Widom et al., 2009). Whether this is because these hidden cases are less severe is a critical question. Relevant to this question are the studies by Straus and colleagues (Straus et al., 1998; Straus & Stewart, 1999) that found that self-reported severe forms of child maltreatment are much rarer than milder forms (they did not examine this with reference to drinking variables). Only one general population study has examined severity of child abuse outcomes and drinking: As noted, an Italian study found that higher levels of parental alcohol consumption were associated with severe but not minor physical violence towards children (Bardi & Borgognini-Tarli, 2001).

Sometimes hidden cases are severe and become known to Child Protection tragically too late, although more often it seems that high profile cases are known to the system, but the system fails (as it is likely to do, given no system is infallible) (Scott & Swain, 2002). It is important that hidden and severe cases are examined and responded to more carefully, although not to the extent where entire systems are crisis-driven by extreme cases (there is evidence that this has been the case in the United Kingdom and in Australia [Littlechild, 2008; Scott & Swain, 2002]). The information from respondents to the Harm to Others survey suggests that the
majority of incidents reported in the survey are less severe and are not handled by child protection systems. Nevertheless, this chapter focuses on the proportion of cases in the general population survey that respondents identified were more severe, where children were affected a lot.

Social location

The phenomenon wherein some groups are more likely to be seen to be maltreating their children is not new. Scott and Swain (2002) discuss the work of the Societies for the Prevention of Cruelty to Children in Australia at the end of the 19th and beginning of the 20th Century:

*Physical abuse which took place behind closed doors was seldom brought to the inspector’s attention, whilst children forced into the open by poverty could not help but attract his gaze.*

*On his occasional excursions into middle class suburbs or rural areas, Noble [The VSPCC inspector] did encounter cases of cruelty that did not involve poverty as a factor, but he spent most of his time in houses ‘filthy to the point of offensiveness,’ where any money which did come into the house was spent on alcohol in order to ease the pain.* (Scott and Swain, 2002, p. 51-52)

Socio-economic disadvantage is recognised as an important risk factor, with many Child Protection system clients typically from disadvantaged backgrounds and circumstances (Cappelleri, Eckenrode, & Powers, 1993; Garbarino, 1977; Gilbert, Widom et al., 2009; Jack, 2000; Murphy, et al. 1991). However, these findings may merely reflect an increased likelihood for systems to observe child maltreatment in disadvantaged groups. Straus and Stewart (1999) summarised the evidence from the United States and suggested that health and social work professionals were more likely to report child maltreatment in poor and minority than middle class families. These effects continue to be apparent and it seems there is consensus that both social disadvantage and social bias still operate in the United States and the United Kingdom in relation to reporting of child maltreatment (Berger, 2005; Sidebotham et al., 2002). Likewise, Weatherburn and Lind (1997) report that both social disadvantage and social bias operate in Australian legal and welfare systems and that these affect rates of reported social problems.
Alcohol is one of many risk factors noted in child abuse and neglect. Alcohol problems of carers in treatment often bring the family situations of clients to the attention of counselors and other professionals (Trifonoff, Duraisingam, Roche, & Pidd, 2010), providing one clear path by which this group of clients may be more open to scrutiny. Particularly in situations where alcohol problems are combined with social disadvantage, the likelihood that a range of health professionals report child maltreatment increases.

While alcohol appears to be an important factor in child maltreatment, its relative importance to child maltreatment in different social classes has been under-studied. There is some division between those researchers that emphasise social deprivation and those that emphasise substance abuse and other risk factors. Chaffin et al. (1996) suggest that child maltreatment in the United States cannot be solely understood on the basis of social ecology. They found that after controlling for socio-economic factors alcohol abuse and alcohol dependence were strongly associated with child physical abuse and neglect in their large randomly selected sample from five states. On the other hand, there is a large literature that examines the broader effects of poverty on childhood. This link has been established both across and within countries (Brooks-Gunn & Duncan, 1997; Marmot, 2005), and a number of researchers state that removing substance use problems alone is unlikely to result in major improvements for maltreated children (e.g., Dawe et al., 2007).

Socio-economic advantage may protect children from certain forms of maltreatment in particular (Gilbert, Widom et al., 2009); for example neglect involving inadequate provision of food, clothing and medical care would be expected and has been shown to be less prevalent in higher income families (Cappelleri et al., 1993; Weatherburn & Lind, 1997). The role of alcohol here is unclear, but it will matter more if finances in low income families finances are diverted to pay for the drinking of one or more members (Dawe, Harnett, & Frye, 2008; Velleman & Templeton, 2003). In addition, higher incomes may enable drinking away from home, and pay for child care or babysitting, separating intoxication from parental caring roles, and mitigating harms such as poor supervision. Moreover, advantaged groups may be more able to keep child maltreatment hidden from the “gaze” of state power (Foucault, 1975; Hampton & Newberger, 1985). Middle class and culturally dominant groups are not often in contact with a range of services that assist families in need, many of which are staffed by professionals such as police officers who are commonly mandated to report suspected child abuse (Higgins et al., 2010).
In the main, general population studies of alcohol-related child maltreatment are rare. The few surveys reporting on measures of alcohol-related harms to children in the population have not examined whether a social gradient was evident in this maltreatment. However, more generally, Straus and Stewart (1999) found that low income parents were more likely to self-report child maltreatment, but that the differences in rates across income levels were small, and less than would be expected given the differential rates seen in the child protection systems. This difference according to income level was not analysed for alcohol-related child maltreatment. As discussed earlier, Chaffin et al. (1996) did not find socioeconomic status or education affected reporting of physical child abuse or neglect in their sample, although they found that carer alcohol dependence or abuse did.

Consistent with the findings in this study, in child protection system samples, the clients are usually predominantly poor and disadvantaged. These studies also show that alcohol and other drug use is often involved in these cases (Murphy, et al. (1991); Cappelleri et al., 1993; 1991; Sedlak & McDonald, 2010; Trocmé, Fallon, MacLaurin, Daciuk, Felstiner, Black et al., 2005).

It is a common finding for many health and social problems that the class position and distribution of those “captured” in the treatment or other social handling systems differ greatly from the distribution of those affected by these problems in the general population. For alcohol problems this has been termed “the two worlds of alcohol problems”. For example, Storbjörk and Room (2008) found that, while heavy drinking or alcohol dependence criteria did predict alcohol and drug treatment, this was not the most important factor in predicting who was found within the alcohol and drug treatment system. Instead disadvantage and marginalisation were more important, suggesting that whilst the system catered for this disadvantaged and marginalised group, more advantaged groups continued to carry on their lives without coming into contact with the treatment system. It is possible that the child protection system also functions in this way, largely managing children who have suffered abuse from social circumstances that are also quite poor and disadvantaged, yet leaving many children who suffer abuse in the general population relatively unattended (Straus et al., 1998). Storbjörk and Room’s (2008) analysis poses the question of the extent to which there is a similar split between the “two worlds” for alcohol-related child abuse. Here the question is whether social disadvantage provides as strong or stronger prediction of being a Child Protective Services client as that provided by the extent of abuse.
As discussed in Chapter 1, a small number of international studies report on the general population window (Gilbert, Widom et al., 2009). Because there have been so few studies of the general population, there has been little opportunity to compare findings from the general population window with those from the Child Protection System. More recently, Hope (2011) incorporated identical questions to those included in the Harms to Others survey used in this dissertation into the 2010 National Drinking Survey in Ireland, and examined alcohol involvement in the Irish child protection system. She found that 10% of participants reported one or more specific harms to children from carers’ drinking. In her report she also examined alcohol-related presentations to county child protection agencies across Ireland. Although she found that alcohol-related incidents were often poorly reported, she also found that a substantial proportions (0-30%) of child protection caseloads involved alcohol and/or drug abuse. She did not, however, adjust for other factors in multivariate models.

10.3 Aims

In this chapter the Victorian Child Protective Services data and the Harm to Others general population survey windows are examined side by side. This chapter aims to:

i) compare the size of the prevalence of problems identified in both windows;

ii) focus in particular on more serious cases, as a reason that may explain why different groups appear in the child protection system compared with the general population; and

iii) compare the socio-demographic location of characteristics of the children and families observed in the child protection and general population survey windows as another reason that may explain why some children are more likely to appear in the Child Protection system.

It is expected that alcohol-related harms to children will be more prevalent but less severe in the general population as compared to those harms identified in the analyses of the child protection data. Furthermore, it is expected that a social gradient will be more evident for more severe than less severe cases of alcohol-related harm to children in the general population. That is, economically disadvantaged groups will be more likely to experience severe alcohol-related harms than economically advantaged groups.
10.4 Methods

This chapter draws on the results of Chapters 6-9 and compares and contrasts the findings on child maltreatment cases involving alcohol substantiated in the Victorian Child Protection system with those identified in the general population. Although the basic methods employed in these studies have been detailed in chapter 5-9, the essential aspects of the methods of these studies will be reiterated in order to facilitate comparison of the two data sources. As the more severe harms in the general population survey have not been analysed in the previous chapter, they will be described in more detail.

The following three approaches are used to address the aims mentioned above:

i) The primary alcohol-related harm variables used in each window are defined and compared. In this chapter national figures are extrapolated from the Victorian data to provide estimates of the number of children (and families with children) affected by alcohol-related harms in the general Australian population to enable comparison of national level data from both windows. The independent variables used across all data sets are also detailed.

ii) In order to better understand whether the severity of cases in the general population is markedly different from that seen in the child protection system, the frequency of specific types of abuse and overall frequency data of alcohol-related harms to children in the general population window are examined, along with respondents’ self-rated reports of whether the child was substantially affected (i.e., affected “a lot”) by others’ drinking.

iii) Thirdly, alcohol-related child maltreatment outcomes are examined across measures of social disadvantage in the general population and the Child Protection system.

The main purpose of the next section of the methods is to describe how the outcome and explanatory variables in each data set are, or have been made, comparable as the two sets of data have been brought together for analysis. For example, how the Victorian state Child Protective Services data has been used to produce national estimates is detailed. In the Child Protective Services data it is also critical that estimates analyses are produced per child and family, and that these units match those of the Harm to Others survey. Any assumptions made are also detailed.
Bringing alcohol-related harms into the same frame for comparison

As discussed in Chapter 5, the information on harms to children in the general population comes from the Australian Harm to Others survey (Wilkinson et al., 2009), specifically from the questions regarding harm to children from others’ drinking. These questions were based on definitions of primary abuse categories used by Victorian Child Protective Services workers in Victoria and Australia (see Table 5.1), (Australian Institute of Health and Welfare, 2008b), excluding sexual harm. In this sense, there is already some comparability in the estimates.

The variables have been laid out here again to illustrate how they have been compared and contrasted, and to illustrate how their comparison has been made possible and the assumptions used to do so.

a) **Alcohol-related harm outcome variables in the general population:** The main outcome variables used in this comparative chapter include the any harm variable, as described in Chapter 9, and a measure of more severe harm, a dichotomised variable that differentiates between those who did and did not report more severe alcohol-related harm: i.e., “a lot” versus those who reported “a little” or “not at all” in response to the summative question on harm detailed in Chapters 5 and 9. The respondent’s estimate of “a lot” of harm is also termed “substantial harm” in this and the following chapter. A second dichotomous variable was developed that compared those who had been affected “a little” to those who had not been affected at all, excluding those children who had been affected a lot. Frequency variables examining the number of times each type of specific alcohol-related harm to children occurred have also been used, in addition to an overall frequency variable which sums these numbers across specific harms.

Prevalence rates of alcohol-related child maltreatment in the general population were calculated per respondent from households with children within them (i.e., per family), including respondents who reported they had parental-like responsibility for children but did not live with them (e.g., step-parents). These methods and results have been detailed in Chapter 9.
b) **Extrapolating from Victorian child protection data to produce national estimates of alcohol-related child maltreatment**

As described earlier in Chapters 6 and 8 (Tables 6.1 and 8.1), carer alcohol abuse was identified by child protection workers in 31% of the 29,455 children involved in substantiated cases, and in 33% of the 38,487 substantiated cases themselves, in the Victorian Child Protective Services system between 2001 and 2005.

Whilst the survey data are national, the data from CASIS pertain only to one state – Victoria. It has been assumed here that the percentage of cases that involve carer alcohol abuse will be similar to the percentage that will be found for Australia as a whole. However, as Victoria has one of the lowest per capita alcohol consumption levels, it is likely the Australian figure is an underestimate. To estimate the number of children affected by alcohol-related child abuse in Australia, the proportion of children identified in the Victorian CASIS data child abuse and neglect cases that involved alcohol was multiplied by the estimated number of children (n=32,583) who were the subject of substantiated notifications of child abuse in Child Protective Services across Australia in 2006/07 (Australian Institute of Health and Welfare, 2008b). This figure formed the numerator and the denominator is the number of children in Australia in 2006/07, producing the rate of children affected by alcohol-related child maltreatment per child population aged 0-17 years.

To estimate the population rate of families affected by substantiated alcohol-related child abuse in the general population, the numerator is calculated by dividing the total number of children affected by alcohol-related child abuse obtained above by the average number of children per household (1.845). This figure of 1.845 was obtained by dividing the number of 0-17 year old children, n=4,753,000 (Australian Bureau of Statistics, 2011), by the total number of families with children (the denominator), n=2,576,000, (Australian Bureau of Statistics, 2011). The denominator is the number of families with children in Australia in 2006/07.

c) **Independent variables**

The main independent variables examined in this chapter were income, income type and family type. These three variables were significant predictors of alcohol-related outcomes in both data sets. In order to compare these variables across data sets, these variables were
collapsed into categories to enable comparison with each other and overall population findings from the Australian Bureau of Statistics.

**Income:** The analysis of the socio-economic status of participants in the population survey used summary categories of self-reported annual household income – low (<$50,000), middle ($50,000-$74,999), and high ($75,000+). In the Child Protective Services data, income type was trichotomised and all clients reported to be on low wages or salaries by child protective services workers, or receiving benefits and pensions as their main form of income, were placed in the low income category (<$50,000), including those people who were unemployed, whose main form of income was a benefit or a pension and those who report not being in the workforce. The middle and high income wage categories assessed by the child protection workers were assumed to match the middle and high income categories used in the Harm to Others survey and the Australian Bureau of Statistics (ABS). Income categories used in the ABS 2006 census were: <$52,000, $52,000-$72,748, and $72,800 or more.

**Income type:** this variable was collapsed into working versus all other families. It overlapped with the income variable, but provided a second and simplistic way of examining the data across the data sets. For example, the Australian Bureau of Statistics (ABS) figure for the percentage of the population not working includes the percentage of the population not in the workforce and the unemployment rate. This figure is compared with the percentage in the Harm to Others survey that reported studying, volunteering, being retired, home duties, being unable to work and other.

**Family type:** The limited number of categories in the general population survey (two-carer, single carer and other) meant that the detailed data in the Child Protective Services data was condensed into these same three categories. In the Child Protective Services data intact families were coded as two-carer families; single mother and single father carer families were coded as single parent families; and other families, which comprised all other family types.

1) **Comparison of alcohol-related child maltreatment prevalence figures in the two frames, and by sociodemographic characteristics**

The percentage of survey respondents who reported that their children had been affected by alcohol-related child harm was compared with the percentage of Australian families estimated to have a child within them that has suffered from carer alcohol abuse-related maltreatment substantiated within Child Protective Services. The prevalence of child
maltreatment in the two windows is also examined for the range of alcohol-related harm measures in the Harm to Others survey. The prevalence of different alcohol-related outcomes in the two frames is then examined within different social and demographic groups within the two frames.

**ii) Comparative analyses of severity**

In addition to comparisons of overall prevalence, more severe outcomes and the groups experiencing these outcomes have been compared across the Harm to Others survey data, and compared with the Child Protective Service data and the Australian population statistics. The main outcome examined in the analysis of severity draws upon the data from the 2008 Harms to Others survey data, focusing on the respondents who reported their children were affected a lot as the outcome variable. Raw numbers of respondents who reported children had been affected a lot by others’ drinking in their family and weighted percentages with confidence intervals were reported as annual prevalence estimates. Averages and modal values for specific harms and the overall number of harms were reported if respondents reported any specific harm, and also if they reported that their children had been substantially affected (i.e., harmed a lot).

**iii) Comparative analyses of social location**

Bivariate logistic regression analyses were undertaken to examine associations between overall harm, severity of harm and types of harm measures by income. The odds ratios and statistical significance of confidence intervals around the point estimates are presented for all logistic regression analyses. Simple odds were also calculated to enable comparison of percentages in the child protection system relative to the general population, e.g., for the percentage in each sample that reported harm that was in the low income group.

**10.5 Comparative results**

This section summarises the information on relevant and comparable survey data and child protection system findings regarding carer alcohol-related harms to children, examining the more severe alcohol-related child maltreatment survey findings in more detail, and paying particular attention to how the socio-demographic characteristics (especially the income) of the samples are distributed.
i) Alcohol-related child maltreatment survey and Child Protection system findings

Chapter 9 (and Table 9.1 in particular) presented the findings on alcohol’s harm to children from the Harm to Others survey. In summary, 12% of respondents with parental responsibility reported that their children had been affected by the drinking of others in one or more of the specified ways in the past year, approximately one in six (16.9%) reported that their children had been affected a lot or a little (3.2% for a lot vs. 13.8% for a little) by someone else’s drinking, and 22% reported that their children had been affected in any way (in a specified way, and/or a little or a lot) in the last year.

Carer alcohol abuse was identified as a factor in 33% of substantiated child abuse cases and for 31% of children substantiated in the Victorian Child Protective Services system. To estimate the number of children affected by alcohol-related child abuse in Australia, the proportion of children affected by abuse and neglect that involved alcohol (31.2% from Table 6.1) was multiplied by the number of children (32,583) who suffered abuse that was substantiated in the Child Protective Services system across Australia in 2006/07 (Australian Institute of Health and Welfare, 2008b). This yielded an estimated 10,166 children who were victims of substantiated child abuse that involved alcohol. Thus an estimated 0.21% of children were affected by substantiated alcohol-related child abuse in the general population.

To determine the number of families affected by substantiated alcohol-related child abuse in the general population, the total number of child victims of alcohol-related child abuse in Australia was divided by 1.845, the average number of children per household (Australian Bureau of Statistics, 2011). An estimated 5,510 families were affected across Australia. To determine the percentage of Australian families affected, this figure was divided by the total number of families with children [(5,510/2,576,000) x 100]]. An estimated 0.21% of families in the Australian population have a child or children within them that has been a victim of carer alcohol abuse-related substantiated child maltreatment. This figure may then be compared with the percentage of families that report that a child of theirs was affected by alcohol-related child maltreatment in the Harm to Others study.

Whilst an estimated 0.21% of Australian families care for a child who has been identified by Child Protective Services as a case of alcohol-related child abuse, a much larger proportion of Australian families, 17%, report that their child has been affected by one of the four specified
forms of alcohol-related child maltreatment in the past year and more again (22%) reported that a child has been affected by any alcohol-related harm. By these calculations, for every family in which a child is substantiated as a case in the child protection system there will be 81 families where children are affected by a specific form of alcohol-related child maltreatment in the general population, and 105 families where children are adversely affected in any way by others’ drinking each year.

ii) The severity of alcohol-related harm to children

Reiterating the basic prevalence rates of substantial harm reported in Chapter 9: Of the 1,142 respondents who indicated that they lived with or had parental responsibility for children (under 18 years), a small percentage – 3% (n=40) – reported that their children had been affected a lot (hereafter “substantially”) because of others’ drinking. In the previous chapter the frequency distributions of harms were provided for all children harmed in four specific ways (see Table 9.5). Children who were reported to have experienced any form of specific harm, on average experienced harm 12 times (range 1 to 400, mode 2) in the last year.

Table 10.1 displays how often respondents reported alcohol-related harm to children by type of harm when they reported severe harm, and the mode and mean number of incidents reported by those who reported severe harm. Respondents with children who were reportedly seriously affected and whose children had also experienced any form of specific harm, reported that the children, on average, experienced harm 38 times (range 1 to 400) in the last year. The multimodal distribution (mode 1, 2, 50) suggests that the child/ren were most commonly harmed once or twice a year or around once a week in the past year. Fourteen respondents whose child/ren had experienced substantial harm reported that their child/ren did not experience any of the specific forms of harm listed in Table 10.1. When these fourteen respondents are included in the analysis, in the final row of Table 10.2, children who were affected a lot experienced harm on average 25 times in the last year.

In terms of the relationship of specific harms and substantial harm to children, 65% of respondents who reported that their children had been affected a lot reported one or more specific forms of harm. Sixty-one percent of respondents that reported their children had been substantially affected (and affected in these specific ways) were verbally abused, 29% were left unsupervised, 21% physically abused and 32% exposed to serious domestic violence.
Examining the relationship between substantial and specific harms from a second perspective, 15% of the 135 respondents who reported one or more incidents of specific harm said that harm from others’ drinking had affected the child or children “a lot”.

**Table 10.1 Number of times in last year that substantially affected children experienced specific alcohol-related harms**

<table>
<thead>
<tr>
<th></th>
<th>n*</th>
<th>%*</th>
<th>Mean**</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsupervised</td>
<td>11</td>
<td>28.9</td>
<td>14.7</td>
<td>2</td>
</tr>
<tr>
<td>Verbally abused</td>
<td>22</td>
<td>61.1</td>
<td>31.7</td>
<td>1,2,6</td>
</tr>
<tr>
<td>Physically abused</td>
<td>8</td>
<td>20.5</td>
<td>7.3</td>
<td>1-2</td>
</tr>
<tr>
<td>Domestic violence exposure</td>
<td>12</td>
<td>31.6</td>
<td>3.2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Overall frequency of harm</strong></td>
<td>26</td>
<td>65.0</td>
<td>37.8</td>
<td>1,2,50</td>
</tr>
<tr>
<td><strong>Overall frequency of harm</strong></td>
<td>40</td>
<td>-</td>
<td>24.6</td>
<td>0*</td>
</tr>
</tbody>
</table>

*Figures are actual ns; %s and means are not weighted in this sample of 26
**The average number of harms reported if any harm was reported
*14 respondents did not report any of the specific harms

iii) **Social location of child maltreatment in the general population and substantiated cases of child abuse**

Table 10.2 compares the socio-demographic characteristics of: families in the Harm to Others (HTO) survey sample (results column 1); families where children have been adversely affected by others’ drinking as reported in the HTO survey (columns 2, 3, and 4); and the characteristics of families from the Child Protective Services system where children have been affected by carer alcohol abuse and substantiated in the system (column 5). Column 2 describes the HTO sample composition of those who reported their children were affected in any way, column 3 those who reported their children were affected in one of the four specified ways and column 4 shows the distribution of the respondents who reported that their children were affected a lot. In the last column (column 6) comparable socio-demographic figures available from the Australian census conducted in 2006 (ABS, 2006) are displayed.

Families adversely affected by alcohol-related child harms in the HTO study were less likely to be single parent families and more likely to be two-parent families (whether they were intact, blended or step-families was not specified) than families where carer alcohol abuse-related child maltreatment had been substantiated in the child protection system. Families of carer alcohol abuse child protection cases were also much less likely to report that their main source of income was through employment compared with families in the HTO study.
Table 10.2 The prevalence and socio-demographic location of alcohol-related child maltreatment in the Harm to Others (HTO) survey and substantiated child abuse cases

<table>
<thead>
<tr>
<th></th>
<th>HTO total family sample (n=1142)</th>
<th>HTO survey sample: % affected in any way (n=136)</th>
<th>HTO survey sample: % affected in specific way (n=114)</th>
<th>HTO survey sample: % affected a lot (n=40)</th>
<th>CPS alcohol child abuse cases (n=8,800)</th>
<th>Families in general population (ABS, 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Couple with children</td>
<td>72.5</td>
<td>61.7</td>
<td>64.3</td>
<td>58.2</td>
<td>48.5</td>
<td>72.1</td>
</tr>
<tr>
<td>Single parent</td>
<td>17.3</td>
<td>28.9</td>
<td>16.9</td>
<td>23.0</td>
<td>47.2</td>
<td>25.1</td>
</tr>
<tr>
<td>Other</td>
<td>10.2</td>
<td>9.6</td>
<td>18.9</td>
<td>18.8</td>
<td>4.2</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Income type(^1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>70.9</td>
<td>76.8</td>
<td>77.7</td>
<td>64.6</td>
<td>34.7</td>
<td>61.2</td>
</tr>
<tr>
<td>Other</td>
<td>29.1</td>
<td>23.2</td>
<td>22.3</td>
<td>35.4</td>
<td>65.3</td>
<td>39.3</td>
</tr>
<tr>
<td><strong>Family income(^2)</strong></td>
<td>(n=932)</td>
<td>(n=235)</td>
<td>(n=114)</td>
<td>(n=36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>24.0</td>
<td>32.3</td>
<td>27.3</td>
<td>46.7</td>
<td>79.4</td>
<td>38.4</td>
</tr>
<tr>
<td>Mid</td>
<td>20.3</td>
<td>17.0</td>
<td>16.6</td>
<td>15.4</td>
<td>19.0</td>
<td>21.2</td>
</tr>
<tr>
<td>High</td>
<td>55.7</td>
<td>50.6</td>
<td>56.1</td>
<td>37.9</td>
<td>1.6</td>
<td>40.4</td>
</tr>
</tbody>
</table>

\(^1\)ABS figure for “Income type other” is the % of the population not in the workforce. This may be compared with the % of HTO survey respondents in the Income type other category that includes those studying, volunteering, retired, home duties, unable to work and other.

\(^2\)ABS total figure for low income includes percentage of the population not in the workforce plus the unemployment rate.
population who reported there had been alcohol-related harm, and in comparison to families in the general population (35% vs. 78% vs. 61% respectively).

Families where substantiated carer alcohol abuse-related child abuse was identified were also much more likely to report low incomes (79% vs. 27%) when compared with those who reported alcohol-related child harms in the HTO survey. Child protection families where carer alcohol abuse was identified and child abuse was substantiated were also much more likely to earn low incomes than families in the general population (79% vs. 38%). In the HTO survey those who reported that their children had been substantially affected were more likely to be on lower incomes (47%) than respondents who reported any harm (32%) or specific types of harm (27%). In general, the HTO survey respondents were more likely to be employed and in more highly paid employment than the general population, whilst families in the Child Protection system were much less likely to be living in two-parent families, to be employed and to be earning high wages.

Comparing the columns relating to the HTO survey amongst themselves, a larger proportion of those affected a lot (35%) were not in the workforce and were on lower incomes compared to those in the overall sample, and to those who reported they had been affected in more minor ways. Although the socio-economic difference between the HTO sample that reported their children had been affected a lot and the Child Protective services sample of families where carer alcohol abuse was identified narrowed (in comparison to the difference seen between the Child Protective Services sample and the HTO sample where children were adversely affected in any way), it remained large.

(iv) Associations between socio-economic status and alcohol-related harm to children

Whilst Table 10.2 shows the various samples in terms of a number of socio-economic variables, Tables 10.3a and 10.3b expand on this comparison by using logistic regressions and simple odds to calculate the odds of given outcomes for income levels alone across both data sets. For both the HTO general population survey (Table 10.3a), and the Victorian Child Protective Services System data (Table 10.3b), the tables describe the:

a) percentages of families that report that their children have been affected by the drinking of others across the three income groups (totaling 100% across the three groups in the row);
b) percentages of those respondents that report their children have been affected by others’ drinking in the different income groups as a percentage of all those in that income group (the column percent); and

c) relative odds of living in middle and high income families and experiencing harm compared with families on low incomes (also related to the column percentages).

The second row of Table 10.3a shows that, of the 208 HTO survey respondents who indicated that their children had experienced harm from others’ drinking, the majority who reported problems were from high income families (54%). However, as can be seen in the third row, the percentage of high income families (18%) that reported their children experienced alcohol-related harm was smaller than the percentage of low income families who did so (24%). Unsurprisingly, the odds ratio (OR) of reporting a lot or a little harm was significantly lower for high income families although, as mentioned in Chapter 9, this relationship between income and alcohol-related harm to children weakened once other factors were taken into account.

Splitting the level of overall harm into those families whose children were affected a lot (versus all others), there was evidence of a stronger and statistically significant relationship between substantial harm and lower income (p<0.05). Amongst those families whose children were affected a little (versus those not affected at all, excluding those affected a lot), no significant association between a little harm and income was identified. Examining the different types of alcohol-related child harm reported, there was no evidence of association between income and verbal abuse or income and lack of supervision (neglect) variables. However, in comparison to families on lower incomes, families from middle incomes were less likely to report alcohol-related physical violence (p<0.05) and families with middle and higher incomes were significantly less likely to report exposure to alcohol-related domestic violence (p<0.05).

Table 10.3a shows that more severe alcohol-related harms to children, along with physical harms and the exposure of children to domestic violence, are more commonly reported by families with low incomes. However, there were no statistically significant differences in prevalence by income between respondents who reported that their children were affected a little, verbally abused and left in unsafe situations because of others’ drinking.
Table 10.3a Alcohol-related harm to children in different income groups in the HTO survey

<table>
<thead>
<tr>
<th>Household income group</th>
<th>Low</th>
<th>Middle</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HTO survey data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Of HTO sample in income group (n=924)</td>
<td>20.9</td>
<td>20.9</td>
<td>58.3</td>
</tr>
<tr>
<td><strong>HTO sample affected a lot or a little</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of those harmed (lot or little), % in income group (n=208)</td>
<td>27.8</td>
<td>19.0</td>
<td>53.9</td>
</tr>
<tr>
<td>% of income group affected a lot or a little (Col. %)</td>
<td>23.9</td>
<td>16.7</td>
<td>18.3</td>
</tr>
<tr>
<td>OR, harm (lot or little) by income group (n=924)</td>
<td>Ref</td>
<td>0.52 (0.30, 0.88)*</td>
<td>0.59 (0.39, 0.90)*</td>
</tr>
<tr>
<td><strong>HTO sample affected a lot</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of HTO affected a lot sample in income group (n=36)</td>
<td>46.7</td>
<td>15.4</td>
<td>37.9</td>
</tr>
<tr>
<td>% of income group affected a lot (Col. %)</td>
<td>8.3</td>
<td>2.8</td>
<td>2.4</td>
</tr>
<tr>
<td>OR, substantial harm (a lot) (n=924)</td>
<td>Ref</td>
<td>0.31 (0.10, 0.98)*</td>
<td>0.27 (0.12, 0.61)**</td>
</tr>
<tr>
<td><strong>HTO sample affected a little</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of those harmed (a little) in income group (n=143)</td>
<td>22.0</td>
<td>19.9</td>
<td>58.0</td>
</tr>
<tr>
<td>% of income group affected a little vs. not harmed (n=888, excluding harmed a lot) (Col. %)</td>
<td>15.5</td>
<td>14.0</td>
<td>14.6</td>
</tr>
<tr>
<td>OR, a little harm (n=888)</td>
<td>Ref</td>
<td>0.82 (0.45, 1.51)</td>
<td>0.85 (0.53, 1.38)</td>
</tr>
<tr>
<td><strong>HTO sample affected in specific ways</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR, lack of supervision (n=924)</td>
<td>Ref</td>
<td>0.63 (0.18, 2.15)</td>
<td>1.09 (0.39, 3.00)</td>
</tr>
<tr>
<td>OR, verbal abuse</td>
<td>Ref</td>
<td>0.67 (0.32, 1.40)</td>
<td>0.62 (0.34, 1.12)</td>
</tr>
<tr>
<td>OR, physical abuse</td>
<td>Ref</td>
<td>0.70 (0.01, 0.60)*</td>
<td>0.45 (0.14, 1.45)</td>
</tr>
<tr>
<td>OR, domestic violence</td>
<td>Ref</td>
<td>0.21 (0.05, 0.94)*</td>
<td>0.31 (0.13, 0.74)**</td>
</tr>
</tbody>
</table>

Note: ns in tables 10.2 and 10.3a for family income are not equal because 8 people who reported income level did not report whether their child/ren had been affected a lot or a little.

Table 10.3b presents information similar to that described in the Table 10.3a, but for Child Protective Services data. In this table, among the families where carer alcohol abuse-related maltreatment was substantiated (n=9,194), the majority were on low incomes, pensions or benefits (87%), only 12% were on middle incomes and 1% on high incomes.

Among families where repeated carer alcohol abuse-related child maltreatment was found (n=2,633), the majority of children were from low income families (92%) and only small percentages of children were from families on middle (4%) and high (6%) incomes.
Table 10.3b Alcohol-related harm to children in different household income groups in the HTO sample

<table>
<thead>
<tr>
<th>Household income group</th>
<th>Low</th>
<th>Middle</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Protective Services data (total sample)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Of children where maltreatment substantiated in income group (n=29,455)</td>
<td>79.5</td>
<td>18.9</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Carer alcohol-abuse related substantiations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Children where carer alcohol abuse-related maltreatment substantiated in income group (n=9,194)</td>
<td>86.9</td>
<td>11.9</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Carer alcohol-abuse related re-substantiations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Of income group experiencing carer alcohol-abuse related repeat substantiation (Col. %)</td>
<td>91.6</td>
<td>7.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Odds of repeat substantiation carer alcohol abuse cases (n=29,455)</td>
<td>Ref</td>
<td>0.32 (0.27, 0.37)***</td>
<td>0.52 (0.35, 0.77)***</td>
</tr>
<tr>
<td><strong>Carer alcohol-abuse related protective interventions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Carer alcohol abuse cases receiving protective interventions (n=10,054)</td>
<td>89.9</td>
<td>8.9</td>
<td>1.1</td>
</tr>
<tr>
<td>% of income group experiencing carer-alcohol abuse related protective intervention (Col. %)</td>
<td>27.2</td>
<td>12.9</td>
<td>18.4</td>
</tr>
<tr>
<td>Odds of carer alcohol abuse related protective intervention amongst total sample (n=29,455)</td>
<td>Ref</td>
<td>0.40 (0.37, 0.43)***</td>
<td>0.60 (0.48, 0.76)***</td>
</tr>
<tr>
<td><strong>Carer alcohol-abuse related court orders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Carer alcohol abuse court order cases (n=3,531)</td>
<td>94.0</td>
<td>5.5</td>
<td>0.5</td>
</tr>
<tr>
<td>% of income group experiencing carer-alcohol abuse related court orders (Col. %)</td>
<td>10.2</td>
<td>2.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Odds of a carer alcohol abuse-related court order among total sample</td>
<td>Ref</td>
<td>0.24 (0.20, 0.29)***</td>
<td>0.28 (0.16, 0.47)***</td>
</tr>
</tbody>
</table>

*p<0.05, **p<.01, ***p<.001; (confidence intervals in parentheses)

Col. % = Column percent

The percentage of children from low income families that experienced carer alcohol abuse-related recurrent child maltreatment (10%) is higher than the percentage of children that do so from families on middle (4%) and high (6%) incomes. Similar findings are presented for protective interventions and court orders. The odds ratios for more serious outcomes were significantly higher in the low income group compared with the middle income group. The associations between family low and middle income groups and alcohol-related child maltreatment outcomes as substantiated in the system are strong and statistically significant (p<0.001). These results suggest that the odds that middle and high income groups experienced repeat substantiations, protective interventions and court orders were between one quarter and 60% of those of the low income group.
Comparing the alcohol-related child maltreatment in the system and survey windows: the effects of income

It is the comparison of the findings of alcohol-related child harm in the survey and the system data that makes the link to income clearer in the two halves of Table 10.3. The rows used in these comparisons have been highlighted in pale grey. Strikingly, only 1% of the children where alcohol-related abuse or neglect was substantiated in the Victorian Child Protective Services System data were from families in the high income group. However, 54% of the survey group reporting that their children had been affected a lot or a little by someone else’s drinking were in the high income group. The odds of being in the high income group and showing up in the Victorian Child Protective Services System compared to being in the high income group and affected (a lot or a little) in the survey (1.1/53.9) were very small: 0.02. The odds of being in the high income group and affected in the Victorian Child Protective Services System compared to being in the high income group and affected a lot in the survey (1.1/37.9) were also small: 0.03.

The corollary to the analysis of being in the high income group and affected is the analysis of how the low income group is affected. Whereas 87% of children were from low income families in the alcohol-related substantiated Victorian Child Protective Services System data, 28% of respondents in the survey who reported that their children had been affected a lot or a little by others’ drinking were in the low income group. The odds of earning a low income and being in the child protection system were thus three times (86.9/27.8) the odds of earning a low income and being affected as measured in the general population survey. The odds of earning a low income and being in the child protection system were two times (86.9/46.7) the odds of earning a low income and being affected a lot as measured in the general population survey.

10.6 Discussion

Differences between child protection system and general population figures

This chapter highlights the large number of children who experience carer alcohol abuse-related child maltreatment abuse as substantiated in the system and the far greater number of children that are affected by alcohol-related child harms in the general population. Twenty-two percent of Australian families report that one or more of their children have been affected in the last year in some way by someone else’s drinking. A much smaller percentage, 0.2% of
Australian families, have a child in them that has experienced child abuse that involved carer alcohol abuse as identified as a risk factor by the Child Protection worker.

The problems reported in the general population were probably much less severe problems. Nevertheless, 15 times the number identified in the Child Protective Services data (0.2%) reported that their children were affected a lot in the general population (3%) and 104 times the number of families reported that their children had been affected in any way by others’ drinking. It is of concern that significant percentages of families in the general population reported that their children were verbally abused (9%), witnessed domestic violence (3%), were left unsupervised or in unsafe situations because of others’ drinking (3%) or physically hurt (1%). These figures exclude cases where respondents may have affected their own children and so it is likely that they underestimate the extent of alcohol-related harm to children in the population. The children who were substantially affected in the general population were often affected multiple times.

The large difference between the system and general population rates of child harm supports the fact that a large proportion of alcohol-related child maltreatment goes unreported. Creighton’s (2004) description of the layers of response to, and recognition of, child abuse highlights that whilst some children and incidents are known and responded to by criminological systems (including child protection), that there are others who are reported and affected but do not fit the criteria for eliciting a response (writing in context of the United Kingdom, Creighton is discussing the criteria for “significant harm”). Many other children and families are not reported despite concerns. In further instances child abuse and neglect may not be perceived as such in the family nucleus, yet other members of society, and child protection workers (or different societies) may consider it so if they were aware of it; where families are aware of this, they are unlikely to seek assistance and may resist help despite Child Protective Services perceiving the need to intervene.

At face value, our findings indicate that the majority of cases in the general population are not reported by a family member to be severe, perhaps indicating that the majority of these cases should not be referred to Child Protective Services. Also, given that carer alcohol abuse cases, once within the system, appear to be more likely to receive more intensive interventions and reoccur, it seems that they are more severe, suggesting that the system may be right in intervening and should continue to handle those cases involving carer alcohol abuse. These arguments are, to an extent, circular, and how the child protection system might
best identify those children in need outside the system is a difficult question. Although there is little research that informs such identification, the general population data from the Harm to Others survey suggests that families on low incomes may be slightly more likely to self-report alcohol-related harm and therefore have greater needs for effective interventions. While the needs of this low income group are most likely to be met by acting to intervene using alcohol policy interventions because drinking has caused problems for the children of these families, an alternative approach may be increasing incomes in these families.

Social location of child maltreatment

Only 1% and 12% of children reported to child protection were from families on high and middle incomes respectively. This contrasts with the findings that 38% of substantially affected cases in the general population survey were identified in high income families and 15% in middle income families. This implies that families reported to child protection in Victoria were generally socio-economically disadvantaged, and this was even more likely to be true of those families within the child protection system where alcohol abuse by a carer was reported (see Table 10.3).

In Victoria, 82% of children in families where maltreatment was substantiated in Child Protective Services were from families on low incomes, and 89% of children in families where carer alcohol abuse-related maltreatment was substantiated were on low incomes. In comparison, less than half of substantial harm cases were reported by people on incomes less than $50,000 per annum in the general population survey, suggesting that while the relationship between income and alcohol-related harm to children exists, it is much less strong than the relationship seen within Victorian Child Protective Services. For specific forms of harm, and for any form of harm, even more of the harm (56% and 51%) was found in the highest income group in the general population survey.

Bacchi (1999) argues that policy problems are at least in part constructed in terms of what societies focus on. Thus differences in levels of reported problems between the general population and Victorian Child Protective Services data sets may be explained on these grounds. Social problems become recognised as such because the gaze of more powerful groups falls on those who fail to conform to particular social norms and are less able to deflect critical attention (Sargent, 1973). This may result in higher prevalence of substantiated cases in disadvantaged groups in systems oriented towards these groups such as
Victorian Child Protective Services. Whilst alcohol-related harms, and in particular more serious harms to children, were more common in the low than middle or high income groups, still over half of these cases occurred in middle and high income groups, suggesting that more serious harms are likely to be spread across different social groups in the general population. Bacchi would argue that the problems in middle and higher income groups are not constructed, or are less likely to be constructed, as problems because the gaze of the systems is not equally intense upon more advantaged groups. However, this study can only partly test the plausibility of Bacchi’s perspective, because we have no way of comparing results for equivalent levels of severity.

This study also suggests that, whilst there are differences according to income strata in the prevalence of alcohol-related harm in the general population survey, as well as dramatic effects in the child protection system data, these differences are much less than what might be expected. Indeed the middle and high income groups reported similar levels of verbal abuse and neglect and self-reported specific concerns overall to the low income group, apart from exposure to domestic violence, and in comparison to the middle income category physical harm (Table 10.2). The middle and high income groups also reported a similar prevalence of minor harms and harm overall. However, more severe forms of alcohol-related harm to children appear to be more likely to be reported in disadvantaged populations, consistent with the Child Protective Services findings.

Although the prevalence of substantial alcohol-related harm to children is likely to be lower in high and middle income groups, these findings suggest that there is likely to be many more unreported and possibly serious cases missed in middle and higher income families. This introduces a similar notion to the prevention paradox often discussed by alcohol researchers (and described in the previous chapter), wherein the majority of alcohol-related harm is caused by the majority of population that misuses alcohol less commonly, despite the fact that alcohol problems are more prevalent in the group that is smaller but misuses alcohol more often or more seriously (Skog, 2006). In this instance, despite the fact that alcohol-related child maltreatment is more common in the lowest income category, a greater percentage of the problems overall occur in the higher and middle income groups (simply because of the size of these groups).

*Income*
The results consistently show that income is negatively associated with alcohol-related child maltreatment in both the general population and the child protection service system. This is consistent with other findings that disadvantage is one of the strongest predictors of child abuse and neglect (Berger, 2005; Sidebotham et al., 2002), and that there is a clustering effect of risk factors (Dawe et al., 2007; Fluke et al., 2008).

Living in difficult life circumstances may play a role in exacerbating harmful behaviours (Gilbert, Widom et al., 2009; Jack, 2000; Weatherburn & Lind, 1997). For example, higher levels of heavy drinking may be present amongst the unemployed – unemployed persons have reported more abstinence but more harmful or hazardous drinking patterns (Makkai & McAllister, 1998). However, this pattern does not always hold, with other Australian (Victorian Department of Human Services, 2005b) and international studies showing little difference in patterns of drinking between low, moderate and high income groups (Marmot, 1997). Physical living environments also matter: One factor is simply that poor families live more on top of one another – middle class parents can just as easily quarrel and end up fighting but out of view or ear-shot of children and neighbours, or of welfare professionals and the police. Inadequate housing is associated with increased reporting of child protection concerns (Waldfogel, 1998).

The child protection literature suggests that a number of factors coalesce to cause situations that result in harm to children (Garbarino, 1977; Gilbert, Widom et al., 2009; Jack, 2000). Socio-cultural drinking norms of low income families may be focused on heavier drinking patterns or in situations that result in more harm – for example, drinking at home may be the only option when finances are limited (Jayne et al., 2011). This could result in more exposure of children to carer drinking patterns and this may increase the opportunity for children to experience alcohol-related harms. Alternatively, higher income may be protective in some way. Different cultural norms or greater availability of funds that enable drinking away from home, babysitters and taxis may be relevant, as richer parents can pay to protect their children and remove themselves from the family home to drink and then catch a taxi home.

This difference in prevalence rates according to income may also occur in part because the social acceptability of reporting alcohol-related harm to children may differ between income groups. Affluent respondents may be more empowered and feel better able to report on someone else’s behavior without fear of retribution or concern for the financial consequences. On the other hand, affluent carers may be more inclined to hide alcohol-
related harm to children to avoid social stigma, which may also be more potent if the phenomenon is perceived to be less common within their own social class. It is not possible to rule out social desirability biases by class. In the Harm to Others survey respondents are asked to report on others’ behaviours and not their own behaviours when intoxicated, and it is possible that some groups may better hide child abuse and defend others close to them when responding, whilst others may be quicker to reveal them. Class loyalties may come into play, particularly when the “system” is perceived to be run by those from “other” classes.

10.7 Conclusion

This is the first time in Australia that alcohol-related child maltreatment has been compared in two frames. Despite the limitations of this comparison, this chapter adds to the literature on alcohol-related child maltreatment in Australia and begins to define the dimensions of the layers of alcohol-related child maltreatment discussed in Chapter 4. It appears that 0.2% of children are affected by carer alcohol abuse-related maltreatment that comes to the notice of authorities and is recorded in welfare/criminal statistics, whilst an estimated 17% of families have one or more children that has been negatively affected by specific alcohol-related maltreatment, and 22% have been negatively affected in a general or a specified way. The disparity illustrates that most instances go unreported, at least in part because they may be less serious events.

This chapter has compared the socio-demographic location of alcohol-involved cases in the two data sets. The social location of the families involved with child protection system is much more disadvantaged than that identified in the Harm to Others study. Whether this is because disadvantaged families have a limited ability to evade “the system” or because of the multi-factorial nature of child abuse, influenced by poverty, social support, education and family make-up, is difficult to determine.

A small proportion of children in the general population appear to be substantially affected by others’ drinking. It appears that these children may be more likely to be affected by multiple forms of harm, to be frequently affected and in particular to experience physical abuse or verbal abuse or being left unsupervised because of others’ drinking. Many of these children are also from families that are on low incomes and very few of the children identified appear to have been in contact with family services or Child Protective Services.
The evidence in both windows, that economic support and problematic drinking patterns by carers within families are risk factors for child maltreatment is consistent with these things playing a causal role in child maltreatment. That is, alcohol could play a role in child abuse (as mentioned in Chapters 1 and 2), and poverty may lead to this as well, and both may result in greater likelihood of both the problem occurring and that it will be detected. Interventions that improve economic support for families and that intervene to impact upon problematic drinking patterns may synergistically work to prevent child maltreatment.

Examining the more serious cases in the general population survey suggests that the more severe cases may be more likely to be reported by respondents from families with lower incomes. However the absolute rates of more severe alcohol-related child maltreatment are less different than would be implied by the findings from the child protection system. These results provide evidence harms are spread across different income groups more broadly than previously thought.

Returning to Hogarth’s prints (Hogarth, 1751a, 1751b) on page 122: in a sense they illustrate the view of child protective services – there is much attention paid to particular problems in disadvantaged communities in Gin Lane and there is almost no gaze turned upon children in the more affluent Beer Street.
Chapter 11 Summarising and critiquing the evidence about alcohol-related harm to children

Overall, however, there is a dearth of work which has considered the numbers of children who are affected by parental alcohol misuse (and who can be affected at all levels of consumption, not just parents who are dependent drinkers). Tackling this gap is a key first step in understanding the size of the problem and developing the most appropriate practice and policy response to what is believed to be a very significant issue.

(Adamson & Templeton, 2012, p. 33)

11.1 Introduction

In this chapter the main findings of the dissertation are summarised, the limitations of the thesis are outlined and research, policy and practice implications flowing from this work are put forward. The previous chapters have introduced and examined the links between drinking and parenting in Australia, and set out why the links may be problematic, and they have described how commonly different forms of alcohol-related harms to children arise. This chapter uses the child protection data involving alcohol abuse by carers and national data from the Harm to Others survey to fill gaps in the knowledge about the size of the problem in these two windows and estimates the risks to children in different layers of the pyramidal model of alcohol-related harm to children introduced in Chapter 3. The socio-demographic location of alcohol-related child maltreatment observed in these different frames is also critically examined.

11.2 Estimating the number of children who experience of alcohol-related harm from carers and others

The child protection window (and the apex of the pyramid)

System data indicate that 0.2% of all Australian families (see Chapter 10) include one or more children who have been a victim of substantiated child abuse (including, physical, emotional, sexual abuse and neglect cases) each year where one or both carers abuse alcohol. For 31% of children whose cases were substantiated in the Child Protective Services system, alcohol abuse by a carer was identified as a risk factor. Children living in families where carer alcohol abuse was identified were significantly more likely to experience more
intensive protective interventions and experience a recurrent incident (or resubstantiation) than those living in families where carer alcohol abuse was not identified, after adjusting for a range of other risk factors. Nevertheless, the majority (71%) of those cases where carer alcohol abuse was identified did not reappear in the system within the five year period, although three-quarters received some form of intervention which may have played a part in preventing this, including one quarter who were the subjects of a court order.

The general population window (and the middle layers of the pyramid)

In the Australian Alcohol’s Harm to Others survey, 17% of families reported that their children had been verbally abused, left unsupervised, exposed to domestic violence or physically hurt because of someone else’s drinking in the past year. Overall, 22% of respondents reported that a child had been affected in one of these ways or negatively affected at least a little in the past year. There were few differences across income groups in reported rates of problems and alcohol-related harms to children. However, single parents were more likely to report alcohol-related harms to their children. On examining the more serious cases, again relatively small differences by income group were reported, although these harms were more prevalent in poorer families, as was exposure to domestic violence and physical child abuse.

The difference between the windows

The absolute risk for families of being identified in the child protective services system because of alcohol-related carer child abuse was 0.002. The absolute risk of a respondent reporting alcohol-related harm to children from others’ drinking as identified in the general population survey was 0.22; the risk of children in families being affected substantially or “a lot” by others’ drinking in the general population survey was smaller, 0.03.

As can be seen, the rate of any form of alcohol-related child maltreatment reported by families in the general population was 110 times the rate identified in the child protection system for families, and 15 times the rate for the number of families that reported that these effects were substantial. Population rates of harm to children from others’ drinking reported in families thus appear to be substantially higher than the rates of cases in families known to and dealt with by Child Protective Services. That is, children from families in the general population are much more likely to experience some form of harm from others’ drinking than
they are to be one of the families where carer alcohol abuse is identified and enter the Child
Protective Services system.

Defining the layers of the pyramid

The estimates of the numbers of children who have been affected by others’ drinking have
been inserted into the pyramid in Figure 11.1; describing the increasing risk of alcohol-
related harm to children discussed in Chapter 3. The layers in Figure 11.1 correspond roughly
to those described in Figure 3.2. However, in Figure 3.2 the top two layers have been merged
to form Layer 1 in Figure 11.1. Layer 4 in Figure 3.2 has been split to become Layers 3 and 4
in Figure 11.1 to distinguish between those affected in the survey a lot and a little. Thus while
both figures have six layers they are not identical. These figures identify the relative size of
different child populations in Australia affected by carers’ problematic drinking.

This work estimates that over 800,000 children have been adversely affected by other
people’s drinking in the last year, and over 100,000 have been substantially affected. These
figures are substantially greater than the 10,000 children identified as abused or neglected in
the child protection system who have one or more carers who abuse alcohol. Using the
figures generated from the Harm to Others survey, almost 1.5 million children live with at
least one adult who drinks in a risky way at least monthly, and 655,000 live with at least one
carer who does so weekly. These figures are higher than those of Dawe et al. (2007), who
using different criteria found that over 600,000 children live with at least one adult who has
drunk 7 or more drinks on the one occasion in the last month. Beyond this, almost a quarter
of all Australian adults drink at risky levels at least monthly, and a further percentage do so at
least yearly, so that Australian children are presented with multiple opportunities to see adults
modeling hazardous or risky alcohol consumption patterns, and may be affected by them in a
range of ways.

The data suggest that only a small proportion (1.3%) of children who experience alcohol-
related harm in the general population end up in the child protection system. Furthermore, at
most a total of 9% of those affected a lot by others’ drinking end up in the top section of the
pyramid and are managed by the child protective services system in Australia. These data
suggest that alcohol-related harm to children is common but mostly not managed by the
system. This is the first time that the number of children affected by alcohol-related child
maltreatment in the system has been presented as a percentage of all children who have been affected by alcohol-related maltreatment.

Figure 1.1 Alcohol-related harms to children aged 0-17 years in Australia, 2006/07*

*All estimates of children affected in the general population are based on the Harm to Others survey and applied to the number of children aged 0-17 years; that is 4,753,000 children from 2,576,000 families (based on the 2006-07 Family Characteristics Survey - Australian Bureau of Statistics, 2011). National Child Protection System estimates are based on the 58,563 substantiated child abuse cases identified across Australia (Australian Institute of Health and Welfare, 2008b). Where low and high estimates were obtained for the number of children affected (using assumptions that only one child or all children in the family were affected from the survey data), midpoints were calculated.

Layer 1 (The Apex): The proportion of children substantiated in the child protection system where carer alcohol abuse has been identified as a risk factor (0.31%) is multiplied by the number of children substantiated in child protection systems across Australia (58,563). This provides an estimate of 10,166 children.

Layer 2: Children affected by others’ drinking in a range of other welfare services, e.g., the number of children living in families where carers are clients of alcohol and drug services and family services. This number has not been estimated.

Layer 3: As described in Chapter 9, the midpoint between the low and high estimates of the numbers of children affected a lot by others’ drinking has been used (109,931 children).

Layer 4: The midpoint estimate of the number of children affected in any way by others’ drinking is 806,159 children (from Chapter 9).

Layer 5: To get an estimate of the number of children potentially exposed to others’ heavy drinking within their families, the percentage of respondents who drink in a risky way at least monthly (30.9%) from families with children is simply multiplied by the number of Australian families and the average number of children within families. Thus this estimate becomes: 0.309 x 2,576,000 x 1.845 = 1,468,590 children living with adults who drink in this way. Step-families and other families that reported they had responsibility for children but did not live with them were not included in this estimate.

Layer 6 (The Base): This is simply the Australian child population in 2006/07.
11.3 A causal association between carer alcohol abuse and child maltreatment?

For the general population data, the evidence for the causality of this link relies on the opinions of the respondents, who reported that their child had been affected in a variety of ways “because of others’ drinking”. In the child protection system data the link is framed in weaker terms, as child protection workers are required to record alcohol abuse if they perceive it is “likely” to have had implications for the child. We cannot know, despite the documents available, how workers interpret this relationship. Moreover, it is not possible to determine whether carer alcohol abuse was associated with child maltreatment per se, only whether carer alcohol abuse was linked with more serious child protection cases, once they have entered the system. However, cases have been followed through the system (over time) in order to examine more serious interventions and recurrent cases. Given that carer alcohol abuse (recorded at the beginning of the child’s experience within the system) is consistently and statistically significantly associated with (subsequent) outcomes, after adjusting for a range of other factors, this dissertation does provide evidence that alcohol is a causal factor in more serious child maltreatment, albeit one of many factors important in predicting worse child abuse and neglect outcomes in a range of contexts.

11.4 Social disadvantage and social bias in the layers of the pyramid of alcohol-related risks to children

The evidence from the survey data does suggest that there are differences by income and unemployment status in reported effects of carers’ drinking upon children, so that respondents from low-income groups are more likely to report that their children have been affected, and in particular substantially affected, by others’ drinking than families from middle and high-income groups.

This suggestion of a causal element in the link between disadvantage and alcohol-related child abuse and neglect is also supported by the findings in this study from the child protection system analyses, which indicate that socio-economic disadvantage is associated with more severe and repeat child protection outcomes in alcohol-related cases, consistent with other research (Fluke & Shusterman, 2005; Trocmé et al., 2005).

The differences between those families and children who end up in different layers of the pyramid are also made clear in this dissertation. Families in the general population who reported that their children had been a victim of any alcohol-related harm were on average far more socially advantaged than such families identified in Child Protection System data. One
explanation may be that child abuse and neglect may be occurring at broadly similar rates in the general population, but more economically powerful groups are less likely to be observed by and managed within the child protection system.

This is an indication the social class imbalance in the Child Protective Services caseload is a matter both of the differential reporting by welfare agencies and others who are exposed to domestic situations of families (and sometimes mandated to report), and of social disadvantage. This is consistent with the international (Berger, 2005; Sidebotham et al., 2002) and Australian findings (Weatherburn & Lind, 1997) discussed in Chapter 2, that report that social disadvantage, as well as social bias, is apparent in Australian legal and welfare systems.

In sum, the heavy drinking of others impacts on the relationships and experiences of children within families in the general population, and is implicated in child maltreatment identified amongst families in the child protection system. There is a spectrum of harm, where at one end alcohol is implicated in single incidents with relatively minor consequences, and at the other in incidents where children are neglected and abused repeatedly. Particularly where children live in a disadvantaged family and their carer or carers drink heavily and they are harmed by this drinking, they are much more likely to end up in the child protection system than if they live in a more advantaged family.

11.5 Research limitations

A number of limitations exist in relation to the child protection data collected, the national Harm to Others survey and the comparison of the two sets of data.

Child protection data

Multi-factorial vs. carer heavy drinking causes of child maltreatment: Cases of child maltreatment involving alcohol in child protection systems have not often been the primary focus of published research, with many studies focusing on multiple factors simultaneously (Trocme et al., 2005). Figures specifically for alcohol-related child maltreatment have not been enumerated or described. In part, this is because child abuse cases in the system are not necessarily caused solely by heavy drinking and indeed, are more likely to be the result of numerous interlinking factors.
Labeling of these cases as carer alcohol abuse-related child maltreatment cases may to an extent amplify the role alcohol plays, if the formulation is read to imply a single cause. Heavy or risky drinking may be the primary cause or one of many factors implicated in a range of different health outcomes (Gmel & Rehm, 2009). The crucial question, from a policy perspective, is whether the abuse would have occurred if the drinking were not present. In a public health perspective, it may be regarded as causal if removing the heavy drinking improved the situation, lessened the seriousness of the case, resulted in improved outcomes for the child, or prevented the incident of child abuse. The findings in this thesis from the child protection system show that there is an independent effect of alcohol after adjustment of other factors. Nevertheless there was evidence of effect modification: That is, after adjustment, whilst the association remained statistically significant, the strength of the association between carer alcohol abuse and more serious outcomes and recurrent child abuse decreased.

**Reverse causality:** It is also possible that reverse causality may exist, that is, child maltreatment by the carer substantiated in the system, and the outcomes of the substantiation and intervention process, may cause the carer to drink riskily or heavily. However, as the outcomes are examined after the initial measurement of the carer alcohol abuse, this retrospective analysis precludes this bias.

**Measurement of carer alcohol abuse:** The carer alcohol abuse variable has been used as an outcome variable and as a predictor variable. Thus in Chapters 6 and 10, as well as in the pyramidal model of alcohol-related harm, carer alcohol abuse related child maltreatment has been used as an outcome variable. In Chapters 7 and 8 the carer alcohol abuse variable has been used as a risk factor, and its role in relation to other risk factors assessed in predicting increasingly serious and recurrent child abuse and neglect outcomes. The findings from these chapters suggest that carer alcohol abuse is independently associated with child abuse and neglect outcomes, after adjusting for other factors. In these analyses, it has been assumed that, where carer alcohol abuse was identified in the case by child protection workers, alcohol abuse was a causal element in the outcome, and not only a risk factor in the case-file. The subjective assessment of child protection workers has been taken at face value, yet there may be large subjective variation regarding definition of alcohol’s role in the family by different child protection workers. Whilst carer alcohol abuse by the caregiver was mandatorily recorded (as likely present or not) by Child Protective Services workers, there will be
variations in thresholds that workers use to substantiate child abuse and neglect and record carer alcohol abuse as a risk factor “likely” to be a causal factor in the incident.

It should be kept in mind that it is not clear whether the alcohol abuse was by a protective carer or a carer reported to have harmed the child. It would be useful to analyse more detail about how important the role of carer drinking is for protective parents compared to parents held responsible. However this lack of clarity does not undercut the relationships we have found – rather it means that data collection should be improved in future systems and studies. For example, the drinking of both parents should be recorded in the future. Moreover, standardised systems for recording drinking patterns should be developed to differentiate between heavy episodic and ongoing drinking patterns, and whether this drinking is in the presence of children.

It was not possible to draw conclusions regarding alcohol involvement in the totality of cases which are brought to the attention of the Child Protective Services system, because detailed information on cases that are not substantiated is not collected; that is, alcohol is not recorded consistently in the cases which do not proceed beyond the notification phase nor cases that are investigated but not substantiated.

This lack of information prior to substantiation means it is not possible to determine whether Victorian cases that were not substantiated were more, less, or equally likely to involve parental heavy drinking. Information is completed in the system on substantiated cases only from that point on. This means, it was not possible to examine whether carer alcohol abuse is associated with entry to the system or not at the reporting phase of the process, only whether it is associated with worse outcomes or recurrent incidents. However, more severe outcomes, and repeat problems associated with carer alcohol abuse, once cases have been confirmed or substantiated in the system can be, and were, examined.

General population survey data

The response rate: The response rate of the survey, though comparable with many current Australian surveys (Australian Institute of Health and Welfare, 2008c; Brown et al., 1999; Purdie, Dunne, Boyle, Cook, & Najman, 2002; Roxburgh et al., 2010), is suboptimal. This is a common concern for various health surveys (Curtin, Presser, & Singer, 2005), although findings from different surveys with lower and higher response rates have been similar across a number of different health measures (Serraglio, Carson, & Ansari, 2003). Nevertheless,
these response rates place limits on the confidence with which extrapolations to the general population can be made. However, it is likely that estimates in the general population survey are underestimates, as discussed next.

**Under-reporting:** The data used in the general population survey was slightly under-representative of young men and young women (18-34 years). Young people drink more and report higher rates of harm from others’ drinking than older men and women. Therefore, it is likely that this study under-represents the alcohol-related harms experienced by children within households with younger parents, particularly if the young people not interviewed in the survey were more likely to be heavy drinkers. Furthermore, this study did not include data on whether children have been affected by the respondents’ own drinking. This means that it is likely that estimates provided are under-estimates of the true extent of alcohol-related harms to children. Future studies might consider asking about whether children had been harmed because of “your own or others’ drinking” drinking in the questionnaire. However, care with wording and establishing rapport will be necessary to ensure data are not compromised by respondents who do not wish to reveal potentially self-incriminating information.

Heavy drinkers may also be less likely to recognise that their own drinking may be associated with problems. However, it may also be the case that heavy drinkers in this study may have been less likely to report that others’ heavy drinking patterns causes problems because they have not recognised the harms others’ drinking causes. However, on the other hand, in single parent families they may be the only person in a position able to divulge this information.

**Response bias:** There may be some response bias when respondents attribute drinking behaviours and consequences to someone else in relation to children in their own family, although the direction and extent of bias is difficult to ascertain. Social response bias in the direction of under-reporting is likely to be more significant when information on illegal or socially undesirable behaviours is requested (Clark & Tifft, 1966). The Harm to Others study was designed to circumvent problems of this kind of bias by asking about others’ drinking and not about the respondent’s own behaviours towards their children. However, social response bias may be involved also in asking about others’ behaviours, since respondents may also to wish to protect their family from scrutiny and not wish to disclose harms to children that others in the family may be responsible for. For example, partners might either minimise or exaggerate the effects of domestic violence on their children. Gilbert, Kemp et
al. (2009) reported that the prevalence of child maltreatment as reported by children and by parents was comparable, and that both were more likely to report higher frequencies of child maltreatment than reported to child protection systems.

Sample size and composition: The numbers in the Harm to Others survey are small to examine patterns in more severe or specific types of child abuse, and it would be desirable to repeat the study in larger samples. For example, it was only possible to examine severe outcomes bivariately with independent variables. However, these findings form a sound base for calculation of power estimates for setting the size of future larger samples. An additional limitation is that the sample under-represented respondents from more disadvantaged groups, such as those who were earning lower incomes and younger people. Selective sampling to ensure numbers within defined strata would improve the ability of future surveys to measure outcomes within particular groups.

Problems with wording of the questionnaire: The wording of the questions in the Harm to Others survey wherein “one or more children” were affected means that there cannot be exact calculation of prevalence figures of alcohol-related harms experienced by children. Estimates assuming only one child and assuming all children were affected, as well as a midpoint estimate, have been provided in Chapter 9. Better elicitation of the drinking patterns of those held responsible for harms to children and respondents would provide more detailed insight into how carers and others drink around children and when this drinking becomes harmful.

Defining and comparing harm from others’ drinking: Alcohol-related harm to children has been broadly defined in the survey used in this thesis, and may be only loosely connected with substantiated child abuse and neglect. For example, whilst it may be problematic that a child is left unsupervised because a carer is out drinking, or too intoxicated to supervise a child adequately, as asked about in the Harm to Others survey, this is not the same as a child being substantiated for neglect where their physical health and medical needs are not attended to, often over a longer period of time. Similarly, verbal abuse because of someone else’s drinking is not necessarily akin to emotional abuse wherein a child’s emotional development is put at risk. There is also a need for future qualitative studies to ask open-ended questions about the nature of this harm, when respondents feel thresholds for harm are breached, and when they need assistance.
In the Harm to Others general population survey, alcohol-related child maltreatment was attributed by the respondent. Instances were defined as resulting “because of someone else’s drinking”. However, incidents may have occurred because of, or involve, other factors. The Harm to Others survey relies on the respondent’s capacity to judge whether alcohol was causal in the incident. This has intrinsic variability – the level of severity and how causative the drinking was perceived to be will vary between respondents – but the strength of the questions lies in relying on the judgement of the respondent. This inherently involves an assessment that the carer’s child was perceived to be harmed, and that alcohol caused the problem.

Rebutting these limitations: Despite these limitations, this survey has provided a unique window on child maltreatment caused by others’ drinking in the general population. The alternatives include: surveys of drinkers in the general population about how they have affected others; surveys of children in the general population and/or in school based samples and how they are being, or have been, affected by others’ drinking; and surveys of adults about when they were children and how they were affected. These alternative different approaches all offer different perspectives. But these alternatives have even more problematic methodological issues: Self-reporting by perpetrators can be fraught, questioning children below the age of 18 years is sometimes more difficult to gain ethical approval for, and it is impractical to question very young children. Surveys that ask about lifetime experiences (e.g., Cawson, Wattam, Brooker, & Kelly, 2000) are helpful but subject to recall biases, although significant events can be remembered well. Child protection system data may be used to triangulate findings, but are subject to their own operational limitations, and by their nature are not representative of the general population. The strength of the findings presented in this thesis is that they provide a critical first estimate of alcohol-related harm to children as reported by carers in the general population.

Comparing the two sets of data

There are many reasons why the levels of alcohol-related child maltreatment as reported in these two samples may be different.

Differential definitions: Alcohol’s role in the family may be attributed differentially as a problem by child protection workers and respondents in the general population. The definitions of child maltreatment used by Child Protective Services workers, those implied in
the Harm to Others survey questions, and those assumed by respondents across Australia will most certainly vary, both within and across these three groups. The forms of child maltreatment asked about in the Harm to Others survey, whilst based on types of cases reported on in the Victorian Child Protective Services system, comprise only a sub-set of those types of cases recorded in the Victorian Child Protective Services system (for example, sexual abuse and medical and biological neglect cases were not specifically asked about).

More fundamentally, perhaps the largest concern in comparing the two sets of data is the issue of comparability in judgments about causality. The population survey definitions of alcohol-related harm to children are causally attributed by the respondents, whereas the carer alcohol abuse variable within the Child Protective Services system is labeled in the recording system as a risk factor. However, child protective services workers are directed not to record carer alcohol abuse unless it acts upon the case. These attributions have been treated as equivalent in these analyses, but the validity of this assumption should be tested in future work. The author initially sought permission to interview child protection workers as part of this thesis in order to better understand how, in practice, child protection workers in Victoria recorded carer alcohol abuse and handled those cases where it was involved. However, the author was denied permission to interview these workers, with “existing demands upon their time” as the reason given.

Statistical power: The mismatch in the sample sizes of the Child Protective Services data and the Harm to Others survey data means that there is a much greater likelihood of finding statistically significant differences in the former compared with the latter. Interpretations of the analyses in this dissertation have endeavoured to keep this in mind.

11.6 In conclusion

Research in the child protection field acknowledges the role of individual carer factors, and yet also underscores the effects of the social and environmental conditions that coalesce and result in child maltreatment (Garbarino, 1977). Carer alcohol abuse is associated with almost a third of substantiated cases of child abuse and neglect and its presence predicts protective interventions, court intervention and recurrent child abuse and neglect. The children that experience these poor outcomes at the apex of the pyramid of alcohol-related risks for children comprise those children who are most visibly and most seriously affected by their carers’ heavy drinking. Many more children, eleven times this number, exist in the layers
below who have been substantially affected, and one in six children have been affected by others’ drinking in the last year. This study underlines the proportion of children who experience a range of alcohol-related harms from carers and others, but do not appear in child protection systems. This study also makes plain the relative disadvantage of the children who are managed by Child Protective services because of the heavy drinking problems of one or more of their carers.
Chapter 12  Implications for further research, policies and services

Social workers and other agencies need to take alcohol more seriously if we are to improve outcomes for children (Forrester, 2007, p. 1530).

Implications for further research, including descriptive research, intervention research and surveillance are canvassed in the first section of this chapter. In the next, the implications for service responses to alcohol-related harm to children are discussed, including the public health and public policy implications that flow from the research undertaken during the completion of the dissertation.

12.1 Implications for further research

This thesis has underscored the broad reach of the problems for children that may result from carer alcohol consumption. This section of the dissertation describes a number of research gaps that remain, and suggests areas for future descriptive, service and system evaluation and intervention research.

Descriptive epidemiological research

Carer alcohol involvement in child protection systems and a range of harms to children is not uniformly collected within Australia or in similar western developed countries such as Canada and the United States of America, let alone in a wider range of nations, including low income countries. Recently the World Health Organisation (World Health Organisation, 2010) has identified research into the harm to others from drinking as a priority in its ‘Global Strategy to Reduce the Harmful Use of Alcohol’. This research includes a focus on how children are affected by others’ drinking and uses the methodology of this research. A number of recommendations are listed below about how existing data might be improved upon. In addition, new areas of research that would improve understanding of the effects of carer alcohol problems upon children are listed. This type of research has the potential to act as a strong lever upon governments sensitive to and responsible for managing the second hand effects (or externalities) of heavy drinking upon children.

Defining and screening alcohol problems: Both research and policymaking would benefit from an agreement on standardised recording and reporting of alcohol consumption in child maltreatment cases. Screening, for example using the using the AUDIT tool (Saunders,
Aasland, Babor and Grant, 1993), would enable rapid understanding of how problematic a carer’s drinking may be (Alcohol and Drug Abuse Institute, 2013). The AUDIT tool is useful for both clinical screening in primary healthcare settings, and as standardised form of reporting upon alcohol problems that has been utilised in research (Saunders et al., 1993). However, further research should be undertaken into whether this tool should be adapted to take into account whether children are present, and how ‘safely’ carers drink around children. This would enable more comparable estimates of alcohol involvement in child abuse, inform clinical decisions about whether services should be provided to carers at an individual level, as well as the level of services that would be required to meet the needs of these carers by the treatment system. In addition, where possible, information should be obtained about intoxication at the time of the event/s, usual carer drinking patterns, as well as drinking patterns when children are present.

Utilising hospital child injury data: In Australia, child maltreatment inpatient hospital and emergency department data is collected routinely using International Classification of Disease (ICD) coding. This should allow for some surveillance of child protection concerns, but the incidence of such diagnoses is very low (Laslett et al., 2010), particularly given the levels of alcohol-related physical child abuse and neglect revealed in the child protection system in this dissertation. Instead, or in addition, a broader range of child injury diagnoses within particular age groups could be selected as markers of potential child abuse. It may be possible to follow up families who bring their children to hospitals or emergency departments for these injury conditions and ask about a range of protective and other risk factors associated with parenting, including their usual drinking patterns as well as those surrounding the child’s injury. However, given that difficulties may be expected in obtaining drinking histories from parents, other research strategies that look to examine sales data or liquor licence density, and examine the relationship between the child maltreatment ICD diagnoses (and a larger range of ICD child injury diagnoses) and parental drinking geographically (e.g., by postcode) may be more feasible. Alcohol sales data are available in some Australian states, as are liquor licence density measures across postcodes in all states. These studies could examine these data cross-sectionally and longitudinally.

Population studies and qualitative interviews: More attention is needed to understand how alcohol affects family functioning, including its roles in causing conflicts, social isolation and role reversal by disrupting parenting (Rossow, 2000). This research could involve
interviewing all or selected members of families about how alcohol affects different family members and to what extent, how often and in what ways, and should be undertaken in families where alcohol consumption is both problematic and unproblematic. In Australia, a large general population study of how children have been affected by others’ drinking, as well as by other risk factors is needed to tease out the multifactorial nature of child abuse and neglect in the general population. Alternatively, additional questions should be added to existing longitudinal studies of children and families. These studies would inform our understanding of what children’s needs are, as well as whether they are in contact with other services, and how they are affected and assisted (or not) by services, families and peers. In the United States, parents were surveyed about their own drinking patterns and injuries to their children – more injuries to children were identified where parental histories of alcohol treatment were identified (Bijur et al., 1992; Crandall et al., 2006). These large community studies involving carers reporting upon injuries to their children, and self-reporting their drinking patterns, amongst other risk factors, could be considered in Australia, potentially in intervention and control communities. Existing national health studies and longitudinal studies of children with existing data on carer drinking patterns and child outcomes could be identified through research networks and interrogated further.

Meta-analyses

Once a body of comparable studies has been established, meta-analyses of death, hospitalisation and child protection data with respect to alcohol involvement need to be undertaken to determine new attributable fractions for alcohol in each of these three important sets of health and social service data relating to child abuse and neglect. For example, it should now be possible to undertake a meta-analysis of risk factors for recurrent cases of child maltreatment across countries, although cross-cultural alcohol-attributable relative risks should be only used with caution. In other areas, for example child injuries, there are insufficient studies to draw upon in order to undertake meta-analyses that would provide estimates of the proportion of child injuries in the general population that might be attributable to problematic drinking patterns of carers and others.

Service evaluation and intervention research

Within Child Protective Services, future research should investigate in detail the types of problems that children experience that involve alcohol, how these cases are managed by
workers and systems, and what factors appear to influence how worker decisions are made regarding identification and management of alcohol problems of carers, as well as the outcomes that flow from different decisions and policies.

Evaluations of whether alcohol and other drug screening tools (such as the AUDIT suggested above) are practical and effective within Child Protective Services should be considered for identifying carers who drink problematically. These screens should be followed up with evaluations of service referrals along with evaluations of the effectiveness of these services. Interventions for those affected by others’ drinking have also been relatively recently developed but could be considered. For example, Copello and colleagues (Copello, Templeton, Orford, & Velleman, 2010) have developed a five-step brief intervention that focuses on how family members affected by others’ drinking can be assisted. The program encourages use of strategies that will decrease stress levels of those affected, better enable them to care for themselves and try to ensure they maintain appropriate boundaries. These types of interventions may be effective for older children. Randomised controlled trials for individual treatment interventions could be undertaken.

Randomised controlled community trials, wherein different alcohol-related policies (e.g., minimum pricing of alcohol sold in bottle shops) are implemented and studied, should be undertaken and include analysis of the impacts of these strategies upon children and families. Prospective evaluation of outcomes for children in the child protection system and in community samples under different alcohol policy scenarios, or retrospective examination of outcomes over time with existing alcohol consumption, sales and availability data, would also enable better decision-making around primary alcohol problem prevention policy priorities.

Surveillance systems

There is a need to improve recording about carers’ children within Alcohol and Other Drug treatment systems data. Only recently have screening tools begun to collect information on the number of children of clients in treatment, and still little is known about the age or situations of many children of alcohol and other drug clients (Gruenert et al., 2004).

Inclusion of risk factors in the child protection National Minimum Data set would highlight alcohol and other risk factors as an issue and enable ongoing surveillance via national and state child protection data collection systems.
Research collaboration

Data from Child Protection, Children’s Court, police, and alcohol and other drug services are often difficult to access by researchers outside these sectors. Research collaborations or enabling of greater access to and linkage of de-identified files within and across sectors would shed light on a range of complex legal, police and welfare cases. For example, it is not possible to access de-identified unit-level police data on family violence incidents or access de-identified case-note files of child protection workers. The electronic systems that exist can provide efficient access to large numbers of case-files, but usually have not been designed (even secondarily) with research purposes in mind. Collaborative research in these areas would enable better understanding of the proportion of these police, welfare, alcohol treatment system, hospitalisation and court case data that may involve carer alcohol abuse.

Research on stigma and barriers to care

A concern or side effect of focusing on carers and parents already under pressure is that they will be stigmatised, and problems individualised, creating a climate that may push drinking parents with concerns further away from help, creating further risks to children. In particular, because children are typically recognised as precious (UNICEF, 1989), there is an increased likelihood that perceived risks associated with some behaviours such as risky drinking or illicit drug use may become distorted (Douglas, 1966). Berger et al. (2010) were concerned that Child Protective Services decisions in the United States appeared heavily influenced by caseworker perceptions of carer illicit drug abuse, regardless of more relevant risk and protective factors that may affect parenting, for instance, domestic violence or lack of supports for single parents. In highlighting problems for children associated with carers’ drinking, there is a need to ensure that unintended consequences such as increasing stigmatisation of certain groups are monitored and barriers to care are minimised.

12.2 Implications for prevention and management of alcohol-related child abuse and neglect, informing policy and practice

A range of harms and risks from the child’s family life to the child’s welfare are recognized. But while there is substantial agreement about how problematic carer drinking around children can be, there is a plurality of understandings about how different types of child maltreatment and the risks of such maltreatment should be managed (Beck, 1992; Douglas, 1992; Goddard, 1999; Tomison, 2001). There is some consensus in Australia and elsewhere
that increasing the numbers of children in the child protection system is not the best way to provide care to children who may be at risk, and that keeping families intact as much as possible is preferable (Cummins et al., 2012; Tomison, 2001). However, in the United Kingdom researchers have found, for cases involving substance misuse, and particularly in those cases involving alcohol, that the system was too slow to intervene to remove children, and that children who were removed earlier did better (Forrester & Harwin, 2008). This current study does not address whether removal of children is or is not a better option. Whilst casework is inevitable, and will always be an important element of the service system, this study underlines, in its broad construction of the problem as a pyramid of risk, that universal primary prevention should also be emphasised. Particularly given that the population at risk is so large, universal prevention may serve to reduce casework burdens, although these preventive interventions must also be evaluated, particularly with regard to their effectiveness in more seriously affected populations, e.g., those at the apex of the pyramid. As described in Chapter 3, primary or universal, secondary or targeted and tertiary preventive strategies can be used to address different concerns regarding alcohol-related harms to children.

**Tertiary prevention responses**

Tertiary prevention strategies and programs care for children who have experienced child maltreatment or neglect or are at risk of significant harm, and seek to prevent recurrence and limit long-term implications (Holzer, 2007). These strategies include the provision of intensive child protection, family-based support and alcohol and other drug services to families already involved with the child protection system.

Where there is evidence that children have been harmed or are at risk of significant harm, society has an ethical responsibility to try to address these problems. In these situations, child protection workers are expected to assess and manage risks to children, including drinking-related problems of carers who are held responsible for various forms of child abuse and neglect. This thesis underlines that a large proportion of case work is related to families with carers who drink problematically and also have a range of other risk factors. The evidence in Chapter 8 suggests that children whose carers have alcohol problems are more likely to be repeatedly harmed and re-substantiated in the Victorian Child Protective Services system. This suggests that interventions aimed at reducing alcohol abuse by carers may result in better outcomes for children who are clients of Child Protective Services. Dawe et al. (2007) saw supply reduction and harm minimisation strategies specific to alcohol and other drug use
as likely to result only in short-term gains unless accompanied by strategies that address the underlying multiple causes of child maltreatment, causes that extend beyond alcohol problems alone. These findings support the idea that most interventions should not be undertaken in isolation, but in conjunction with other programs that provide additional supports.

Currently a small number of Australian programs exist wherein vulnerable families are identified on the basis of their substance use, e.g., in the “Parents Under Pressure” program described by Dawe et al. (2008). Dawe et al.’s work focuses on high-risk families and provides intensive support to families in crisis. This strategy incorporates individual level parental education programs about strategies that minimise the harms for their children associated with a range of substances, but is not specific to drinking-related problems. Although some programs are promising (Dawe et al., 2008) amongst families affected by multiple risk factors, there is limited evidence on how effective parenting programs can be and whether they result in sustained parental drinking behavior change, particularly in situations where threats to children are considered more minor (Dawe, Harnett, Rendalls, & Staiger, 2003). Dawe et al. (2007) summarized the policy options and suggested that programs should pay attention to multiple factors, including parental mental health concerns, broader contextual problems such as housing and unemployment, improved social services and community supports, co-occurrence of domestic violence, access to shelters and safe houses, couple- and family-based interventions, reducing marginalisation and stigmatisation of substance-using parents, and providing supports for grandparent and other carers. However, there has been little movement to translate these recommendations into broader public policy responses, and programs like this have not been implemented widely. Incidentally, recent reductions to single-parent pensions in Australia are likely to worsen such problems in already disadvantaged and at-risk families (Australian Council of Social Service, 2013).

In the United Kingdom, Forrester and Harwin (2010) write of their concerns about the ability of the child protection sector to respond to individual and complex alcohol and other drug problems in families:

*In general, there appeared to be a strong institutional tendency towards under-responding to alcohol and drug misuse ...... a pervasive sense that social workers did not know how to work with parental alcohol or drug problems ..... [They had]*
minimal training and often had limited supervision and support .... a toxic cocktail that is almost certain to produce poor practice (p.116).

Australian researchers are also concerned about how the child protection system responds to risk factors, including alcohol, more broadly (Dawe et al., 2007; O'Donnell et al., 2008; Scott, 2009). In Australia there is equal concern that alcohol and drug services in Australia are not well placed to respond to the children of their clients with alcohol and drug problems (Nicholas, White, Gruenert, & Lee, 2012), although there have been recent moves to make alcohol and drug treatment more family-sensitive (Trifonoff et al., 2010), including guidelines for alcohol and drug workers about how to ask about child abuse and neglect and how best to respond.

Secondary or targeted interventions

Secondary intervention strategies focus on risk factors such as alcohol and other drug use. Such strategies target families where additional assistance is required because of these risk factors who have not yet entered the system but are at risk of doing so (Cummins et al., 2012). Interventions in this layer include the provision of alcohol and other drug services to families, regardless of evidence of child maltreatment; the multifactorial nature of child maltreatment indicates that a range of other targeted service should be provided to these families also.

Many organisations, such as government agencies, welfare organisations, schools and churches bear a second layer of responsibility to ensure that families and children are supported, and risks to children are managed, by provision of a range of services, for example mental health services, parenting support groups and financial aid. National, state and local governments fund and support such programs. This means that some communities may have more limited supports and community services, including alcohol and other drug services, than others (Dawe et al., 2007; Gruenert et al., 2004). The role of a range of family and welfare services is critical to creating supportive environments in which children can prosper (Tomison, 2001). The development of a range of secondary services and systems is beyond the scope of this thesis. However, as described above, linkages between agencies, and in particular the linkages between alcohol and drug services and family services, are critical to ensuring children in families at risk of child abuse and neglect are supported. These linkages enable both tertiary and secondary prevention.
Primary or universal prevention strategies

That alcohol is a relevant factor in child abuse and child maltreatment has been long recognised by child protection academics and workers, who despite their position within the system criticise the system strongly for being too focused on individual cases and not active enough at the base level of the pyramid where universal alcohol policy interventions could be applied to prevent child abuse and neglect before it appears in child protection systems. For example, frustration at the relentless and piecemeal nature of child protection casework overall is summed up by child advocate Dorothy Scott, who has seen the effects of alcohol on children on a national scale over the last 40 years. She makes an impassioned plea for action and support of policies that act to shift the focus from case to cause.

Alcohol abuse is involved in every type of child maltreatment, with 50 per cent of children entering state care having at least one parent with alcohol problems, and 13 per cent of Australian children living in a household with at least one adult who regularly binge drinks. The scale of the problem is such that we cannot solve it case by case. We must go from case to cause. (Scott, 2009).

Primary prevention or universal strategies focus on whole communities and include a wide range of fundamental supports such as education and health services but also include other more specific primary prevention strategies (Holzer, 2007). In the case of child abuse, primary prevention strategies include, for example, mass media campaigns intended to change attitudes towards corporal punishment.

In the case of alcohol these universal approaches include interventions that affect price, restrict availability and limit advertising to limit problematic consumption (Babor et al., 2010), as well as programs directed specifically at alcohol in the family, such as mass media campaigns sensitising parents to the role model and supervisory aspects of their parenting that may be compromised by risky and heavy drinking. In theory, reducing risky and heavy alcohol consumption amongst carers across Australia would result in reductions in the numbers of the types of incidents described in the general population survey, e.g., decreased verbal abuse of children and less children left in unsupervised or unsafe situations. Whether such strategies do result in reduced alcohol-related harms to children needs to be tested. Moreover, whether there is a trickle-down (or in this case a trickle-up) effect of general
population based strategies – such as those that decrease harmful drinking overall – for children at the apex of the pyramid needs to be carefully researched.

The potential exposure of children to the risky drinking of their parents or caregivers has been highlighted in studies of the general population (Dawe et al., 2007; Hope, 2011; Manning et al., 2009). A recent report suggests that the vast majority of adult Australians do drink around children (FARE, 2013). Positively, there is some evidence that abstaining rates and lower risk drinking amongst the population overall, and in particular amongst young people aged 14-17 years appear to be increasing (Australian Institute of Health and Welfare, 2011). However, that (older yet still relatively young) carers’ risky and heavy drinking patterns may act as a model for, or influence the drinking of, their children is a cause for concern. That children model their carers’ drinking patterns underpins a recent series of advertising campaigns funded by “Drinkwise” that focus on little children with big round eyes, looking up adoringly at their parents drinking, taking in everything they see (Drinkwise Australia, 2012). How cultural attitudes to drinking and drinking heavily around children may be changed has been little studied, although Casswell and others (Babor et al., 2010; Casswell & Thamarangsi, Sally Casswell & Thamarangsi, 2009) have general concerns that alcohol advertising perpetuating cultural norms is difficult to counteract.

Part of the reason why parents may struggle in their roles may be because heavy drinking patterns are broadly accepted and encouraged in Australian society (Fitzgerald & Jordan, 2009; Roche et al., 2009). For example, heavy drinking by carers at sporting clubs and school-based family functions (where children are in attendance) may model poor drinking patterns. They may also place children at greater risk if their own carers and other children’s carers are intoxicated. Where less problematic attitudes to risky drinking and behaviours are prevalent children are less likely to be put at risk by their carers’ drinking and, later, less likely to be put at risk because of their own drinking patterns.

12.3 Implications for alcohol consumption, parenting, risk awareness and harm minimisation

As part of their role as parents, parents are expected to minimise the risky behaviours and situations their children are exposed to. Parents thus manage risks of harms - such as teaching

3 Drinkwise is an alcohol industry funded agency that promotes and investigates responsible drinking, selectively funding advertising campaigns and research, and not interventions that seek to reduce drinking per se (Miller, Kypri, Chikritzhs, Skov, & Rubin, 2009).
children how to behave in traffic, keeping them out of the sun, supervising them whilst they learn to go up and down stairs, basing their risk management upon their risk perceptions, much like Adams’ (1995) conceptual framework of risk management. For example, parents may not drive while they are intoxicated but may push a pram while they are, or parents may drive their children while they are intoxicated if they do not see it as a risk but rather think they know how to handle driving under the influence. Parents and carers of children who are Child Protective Services clients may not see their alcohol consumption as a risk, although child protection workers may. This disjunction of perceptions may mean that carers are resistant to and resent interference by child protection workers. However, many people do acknowledge risks once they are made aware of them. For example, many women perceive drinking during pregnancy as a risk to the foetus and therefore cut back on their drinking when they know they are pregnant, or even during the time of trying to become pregnant (Callinan & Room, 2012).

Whether parents view their drinking as a risk to their own children has been little studied, and how they manage their drinking if they do see it as a risk is largely unknown. Parents probably do differentiate between taking risks for themselves and taking risks that may impact upon their children. For example, parents may commonly organise which parent will drive home from a party or restaurant as a strategy to reduce risks to their children during the drive home. Such strategies are presumably multiply determined to ensure they do not lose their driving licence, to ameliorate risks of self-injury in a crash, as well as to ensure children are not put at risk in the car on the way home – and in addition, perhaps, to ensure at least one person will be sober enough to parent adequately whilst they are at the event. In fact, there is little research on the particular harm minimisation strategies that parents employ in such situations. Particularly given the findings in the survey that many children are affected in a variety of ways in the general population, remaining sober enough to parent may be the most salient reason.

Parents may adopt various strategies in a range of social situations that could work to reduce risks of their heavy drinking. Qualitative research on how parents behave when they are intoxicated, and what they view as risks would inform individual and community level harm minimisation strategies, and might later evolve into material for social marketing campaigns and/or maternal and child health programs. Once designed, such individual and community level prevention strategies should be tested, and if successful introduced more widely. Indeed
modifying risk perception may be a critical component of primary, secondary and tertiary interventions.

Governments have considerable opportunities and responsibilities to manage risks to children in the broader environment by making sensible policy decisions, including alcohol policy decisions that affect primary, secondary and tertiary prevention priorities. The large numbers of children affected within each window, and at each level of the pyramid, suggest that a public health approach to managing alcohol-related child harms is warranted.

12.4 In conclusion

While disentangling alcohol effects from other problems families face is difficult, it is an important task, as alcohol consumption is a modifiable behaviour both at individual and population levels (Babor et al., 2010). Indeed, alcohol problems may prove more easily modifiable than other issues such as unemployment, mental health and local and social deprivation, although alcohol interventions such as these need to be tested for their effect on reducing harm to children at all levels of the pyramid discussed in Chapters 3 and 11. Interventions to reduce carer alcohol abuse need to be co-ordinated with interventions that address other risk factors, particularly for carers who are single parents and on low incomes, and who experience multiple risk factors.

Whilst child protective services have an integral coordinating role addressing the problems of the children who have been most severely abused and neglected, alcohol and other drug services are critical to the secondary prevention of child abuse and neglect. By targeting families at risk and assisting them, their potential is in their ability to address carers’ alcohol problems and prevent the entry of their children into the child protection system.

It is critical that communities and governments invest in strategies that diminish alcohol-related problems in families and communities in general, and in particular amongst those who are most vulnerable and in need. The Child Protection and the Alcohol and Drug Treatment systems must ensure that effective programs exist and that there is close communication and referral between these systems. However, whilst focusing on alcohol alone is likely to improve the situation for many children and families, a more comprehensive approach, at all levels of prevention, is likely to benefit a larger proportion of children in Child Protective Services, who are often at risk because of a range of factors.
Much larger numbers of children than are seen in the child protection system are affected by the drinking of their parents, carers and other family members. As depicted in the pyramid, over 800,000 children across Australia have been estimated to have been affected by others’ drinking. A focus on population-wide alcohol problems would result in a reduction both in the prevalent alcohol-related harms seen in the population, and potentially also, in reduction or prevention of the problems experienced by the children most seriously affected by their carers’ drinking in the child protection system. That these universal measures need to be provided alongside comprehensive coordinated multi-sectoral services for families with multiple risk factors is supported.

The findings of this study contribute to the overall debate on the externalities and harm to others from alcohol, in this case children.
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