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## CONCEPTUAL AND METHODOLOGICAL ISSUES IN STUDYING ALCOHOL'S HARM TO OTHERS<sup>1</sup>

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**Abstract.** While there is a longer history of concern about alcohol's harm to others, researchers' interest has intensified in the last few years. The background of variation in concern over time in different societies is outlined. Three main traditions of research have emerged: population survey studies of such harm from the perspective of the 'other'; analysis of register or case-record data which includes information on the involvement of another's drinking in the case; and qualitative studies of interactions and experiences involved in particular harms from others' drinking. In the course of the new spate of studies, many conceptual and methodological issues have arisen, some of which are considered in the paper. The diverse types of harms which have been studied are discussed. The social and personal nature of many of the harms means they do not fit easily into a disability or costing model, raising questions about how they might best be counted and aggregated. Harm from others' drinking is inherently interactional, and subject to varying definitions of what counts as harm. The attribution to drinking, in the usual situation of conditional causation, is also subject to variation, with moral politics potentially coming into play. For measurement and comparison, account needs to be taken of cultural and individual variations in perceptions and thresholds of what counts as a harm, and attribution to alcohol. The view from the windows of a population survey and of a response agency case register are often starkly different, and research is needed, as an input and spur to policy initiatives, on what influences this difference and whether and how the views might be reconciled.

### Introduction

Alcohol consumption is a leading cause of social and health harms, and a substantial part of the harms are a result of someone else's drinking. In recent years, there has been growing attention in a number of countries to harm from others' drinking. This paper draws on this experience in recent years of detailed studies of harms from others' drinking. Starting from a brief history of attention to the topic, it considers the types of problems that have been studied as harms from others' drinking, noting not only the variety of such problems, but also the different levels – individual, interactional, and collective – at which they exist, and their variation from being highly tangible to being highly subject to perception and interpretation. The main frames for data collection and analysis in the field are then considered -- population surveys, studies of case registers of social and health agencies and systems, and qualitative studies – with attention to characteristic

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categories of data gathered and analysed in each. Issues in the interpretation of data gathered in these frames are discussed: the potential role of cultural, institutional and individual differences in perceptions and thresholds of noticing and problematizing, and the issues involved in attribution of a harm to alcohol, whether by a respondent or by the analyst – epistemological, procedural, and to some extent also ethical. Lastly, the contrast is discussed between what is observed through the window of population surveys – with harms from others’ drinking broadly spread in the population -- and through the window of response agency case registers – with the harms often concentrated among the poor and marginalised. Studying explanations for the discrepancies and exploring means of bringing the views into a common focus are proposed as agendas for future research and as guides to policy.

### **The rediscovery of harm from others’ drinking**

That one person’s drinking can cause harm to others has long been well recognised. Hogarth’s ‘Gin Lane’ from 1751 shows a baby falling from the arms of a mother too drunk to hold the baby safely. A major theme in the international temperance movement by the latter part of the 19<sup>th</sup> century was “home protection”, reflecting the Women’s Christian Temperance Union’s analysis that men’s drinking together in taverns adversely affected the interests of their wives and families (Levine, 1980; Gifford & Slagell, 2007). Though the temperance movement was initiated in English-speaking countries, it spread widely in the late 19<sup>th</sup> century, and in a number of societies, notably including the Nordic countries, was second only to worker’s/labour movements as a grassroots social movement (Schrader, 2010). Shifts in thought under the impetus of the temperance movement played a large role in the recognition in the 19<sup>th</sup> century of the role of alcohol in traffic and other injuries (e.g., Levine, 1983 concerning the U.S.).

In a global perspective, concern about alcohol and its interpersonal effects long predated western temperance movements, most notably in Islamic societies, but also in Buddhist and some other traditions (Room & Hall, in press). Temperance thinking also spread beyond Europe and North America through Anglophone (and to a lesser extent other European) colonial empires and settler societies (Room et al., 2002, pp. 23-27).

Particularly where the temperance movement had been strongest, and its more radical wing had succeeded in its push for total prohibition of alcohol, there was a substantial societal reaction against its ideas, with those becoming adult at the time of the strongest reaction in the particular society in the forefront (for the U.S., see Fass, 1977; for Finland, see Sulkunen, 1979). In the reaction against temperance, the levels and even the existence of problems resulting from alcohol were systematically downplayed. For instance, the medical and public health literature pointed to other causes of liver cirrhosis than heavy drinking (Herd, 1992). More specifically, and particularly in Anglophone societies, as little attention as possible was paid to the idea that alcohol consumption might cause problems for others. To the extent problems from drinking were acknowledged at all, the focus narrowed to the alcoholic: the drinker him- or herself became the primary victim, and the drama concerning drinking narrowed to an internal struggle within the alcoholic (Cook & Lewington, 1979; Herd, 1986; Room, 1989a). Alcoholics Anonymous was just for the alcoholics themselves, and other members of the family, to the extent they sought to be involved, were relegated to AlAnon or Alateen. In the same period, officially-collected statistics often stopped recording the involvement of drinking patterns or problems in social issues or problems. No-fault divorce meant no statistics any more on drunkenness as a reason for divorce; offering a discount on life insurance for

abstinence went out of favour, so insurance companies lost interest in data on drinking habits and mortality (Room, 1996).

The constriction of the frame to focusing on effects on the drinker was carried through as population surveys began to measure “alcohol problems” in the general population. That there were social or interactional problems from the drinking might be recognised, but they were thought of primarily as symptoms of the disease of alcoholism or as problems for the drinker. Thus in the population surveys conducted by the California social research group of which the first author was a junior member, the list of ‘drinking problems’ asked about included ‘trouble with spouse’, ‘trouble with friends’, ‘job trouble’ and ‘trouble with police’ (Knupfer, 1967). That such problems were in fact problems in social interactions was recognised (Room, 1980), but the group tended to frame them as problems for the individual drinker, under the heading of ‘social consequences’ or ‘disturbance of social and economic functioning’ (Clark, 1966), and to focus on the role of others as responding to the ‘problems’ (Room, 1989b), rather than the potential involvement of others as an intrinsic element in the problem.

In the alternative framing in population studies of alcohol problems, the tradition of psychiatric epidemiological studies, the interactional nature of many harms from drinking was further hidden, since the focus of this tradition was on developing measures of psychiatric diagnostic conditions, notably ‘alcoholism’ and later ‘alcohol dependence’ (Caetano, 1991). The indicators (later criteria) for arriving at an alcoholism or dependence diagnosis included an indicator pointing to a social interactional dimension (“important social, occupational, or recreational activities are given up or reduced because of alcohol use”) -- but this was regarded as simply a sign or symptom of the phenomenon of interest, which was whether the drinker qualified for a diagnosis of alcoholism or alcohol dependence.

While these trends were strong in Anglophone societies, Hauge (1999) has argued that a policy framing with a focus on the harms of alcohol to others persisted in Norway until the 1960s. In Hauge’s view, it was the advent of the public health perspective, with its focus on the “total consumption model” of levels of drinking in the population as a whole, which paved the way for a weakening of Norwegian policies on alcohol availability, by diverting attention away from alcohol’s harm to others, which had provided a stronger rationale for governmental restrictions of the alcohol market. Underlying Hauge’s analysis, we can also discern the longer persistence of temperance influence on alcohol policies in Nordic countries (except Denmark) than in Anglophone societies.

From a global perspective, these trends in popular and professional thinking about potential adverse effects of drinking alcohol have been specific to particular societies, and strongest in the societies where the temperance movement had been strongest -- the “temperance cultures”, as Levine termed them (Levine, 1993). But on the other hand, these societies have been in the forefront of medical, social and public health research. And in particular, research on alcohol and its problems has been strongest in these societies (Savic & Room, 2014). As Room (1990) noted, in this sense “alcohol research is the residual legatee of a formerly strong temperance movement”.

The rediscovery of harm from others’ drinking in the research literature was a gradual and uneven process. In some specific fields, notably drink-driving, the idea that a major part of the harm from drinking happened to others became established in Anglophone societies by the 1960s. But a more general revision in researchers’ conceptualisations to a more social and interactional view of the nature of many problems from drinking did not begin to be manifested until late in the 20<sup>th</sup> century. In some ways, the first manifestation was in terms of economic cost studies, as the ‘cost-of-illness’ methodology developed by Dorothy Rice was applied to ‘alcohol abuse’ (Berry and Boland,

1977). In principle, such studies are looking at costs to the society as a whole attributable to the 'illness' in question. The initial focus tended to be on governmental costs, for instance the enforcement and incarceration costs associated with alcohol-related crime, and the health system costs of alcohol-related injuries. But it was recognised that as the costs were measured, from whatever data the economists and others involved in the study were able to uncover, they included many costs borne neither by the government nor by the drinker, but by others around the drinker – for instance, the costs of repairing a car crashed into by a drink-driver. However, the societal perspective of the cost-of-illness studies meant that there was little emphasis on harm to particular others (Navarro et al., 2011) – and, for reasons of ideology<sup>2</sup> or of lack of data, harm to other household members was often explicitly excluded.

In terms of population survey questioning about harm at the interactional level from drinking, the beginnings of the turn can be dated to the 1985 analysis by Fillmore (1985) of questions about harms from others' drinking. Fillmore's analysis was based on questions which had been designed to measure effects on the neighbourhood in a study of the effects of a change in law which allowed liquor stores to be located in previously 'dry' areas in university towns (Wittman, 1980). Given this focus, more of the questions were oriented to trouble from strangers than from family or friends. The first modern cross-national report of findings on harms from others' drinking was included in a four-country Nordic study reported in 1999 (Mäkelä et al., 1999). Again, the focus was on problems coming from drinkers who were strangers on the street. At about the same time the issue of measuring harms from others' drinking began to be covered in discussions of drinking survey methodology (e.g., Room, 2000).

For 'register studies' and other studies based on case records of social and health agencies, there had been various studies of the alcohol dimension in specific problems of harms to others -- notably in studies of alcohol in traffic injuries. Marvin Wolfgang (1958) had initiated a tradition of studies of alcohol involvement in criminal events, drawing on detailed police investigations of such crimes as homicide (Wolfgang, 1958; Aarens et al., 1977:322). Such disparate fields were to some extent drawn together in studies of alcohol's role in "casualties and crime" (Aarens et al., 1977). But the book edited by Klingemann and Gmel (2001) at the turn of the millenium can be seen as marking the advent of an explicit recognition of a "forgotten dimension" of alcohol's "social consequences" (Klingemann, 2001) reaching across a variety of types of harm.

Following a meeting in Stockholm in 2008, the World Health Organization took on the issue of alcohol's harm to others as one of four major streams of investigation for its global alcohol program to be pursued in low- and middle-income countries. WHO included in its 2011 Global Status Report on Alcohol and Health (WHO, 2011:34-37) attention to "harm to other people" and "to society at large". The idea of studying a range of harms from others' drinking in a common frame has now proved appealing in a number of countries (e.g., Callinan et al., 2016).

## **What kind of problems are involved?**

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<sup>2</sup> The assumption was sometimes made that choices about drinking made by any member of the family were a choice by the family as a whole, and thus costs incurred by family members from this choice were elective costs and should not be counted as an externality. Thus Crampton et al. (2011, p. 6) argue that "the costs ... of legal activities occurring within families [should] be counted as internalised by that family", and thus not counted. Another important reason such costs have not been included is that economic data is often available only at the household level.

*Injury, mental harm, property damage, defective or defaulted role performance.* Harms to others from drinking are of many types. They can result from a particular intoxicated event, or from a recurrence or cumulation of drinking occasions. They include physical injury and emotional or mental hurt to the person, damage to or loss of property or social standing. Many of the harms happen with respect to major social roles which are common in our everyday life – a role as a spouse, as a parent, as a housemate, as a family member, as a friend, as a worker, and in terms of public comportment. Drinking on a particular occasion can adversely affect the drinker's performance in a role, or result in the role not being performed when expected. Role performance – and the evaluation and acceptance by others of that performance -- can also be adversely affected by a pattern of drinking over time. If a drinker fails once to pick up a child from kindergarten when expected to, there may be remonstrance and an argument; if it happens repeatedly, the parents' relationship (and the roles it involves) may be permanently damaged.

*Collective harm as well as harm to individuals.* The terms used above to discuss harms to others from drinking are implicitly in terms of interaction with and response from other individuals. Harms can also occur at the collective level – for instance, to a family, a friendship group, a workplace or club, or a whole society. A company running a factory where many workers are underperforming heavy drinkers may go bankrupt, with loss to all the shareholders, as well as to the workforce. Problems at a societal level are often most visible when the society is small (Room et al., 2002, pp. 152-154). Sackett (1977) describes how, when alcohol became easily available to an Aboriginal tribal group in Wiluna, Western Australia, the result was not only “a decline in general health among heavy drinkers and the lack of proper care and attention shown to a number of children by habitually intoxicated parents”, but also harm to central elements in the culture as a whole -- to the practice of the traditional tribal belief system known as ‘the Law’ and “deleterious effects ... on ritual activities generally” (Sackett, 1977).

*Neighbourhood amenity harms.* Litter and vomit in the front yard, and noise from late-night pubs and clubs can be disturbing to individuals, but also potentially have a collective effect on the livability of a neighbourhood and on municipal cleanup costs. Australian planners describe such harms as impairment of ‘neighbourhood amenity’. It should be recognised, however, that there is a perception element, as well as concrete events, in these ‘amenity harms’, as discussed below. Prohibition of drinking in public places, for instance, may involve some element of social prejudice, and enforcement is often tied to disputes over control of public space (Pennay et al., 2016).

*Fear of harm as well as direct experience of harm.* So far, we have discussed harms where there is a direct effect of the drinking behaviour on others in such terms as loss of property, injury, emotional hurt, or failure in role performance. There are also harms where drinking behaviour has an effect, but the effect is mediated through the fears or discomfort of others. Fear of what others may do while intoxicated has much the same relationship to the experience of harm from drinking that ‘fear of crime’ has to being a victim of crime. As criminologists have noted, the fear of crime can be at least as debilitating at a community level as the direct effects of crimes in themselves (Warr, 2000). Among Australian adults, 18% reported that in the past twelve months they had “felt unsafe waiting for or using public transport because of someone’s drinking”, 23% had “felt unsafe in any other public place”, and 43% had “gone out of [their] way to avoid drunk people or places where drinkers are known to hang out” (Laslett et al., 2010:148). Positive answers to these questions were more common among women than among men, and more common among younger than older adults. A comparison of responses by Australian 16-24-year-olds concerning harms from alcohol and from “drugs” found that, while tangible harms were commoner from alcohol than from drugs, fears

and amenity harms were more evenly spread between drugs and alcohol (Callinan & Room, 2014). For this population, tangible harms were thus a more dominant part of harms from alcohol than of harms from drugs. Again, as discussed below, fears of harm can easily involve elements such as social prejudice, which should be recognised in interpreting responses in this area.

### **Frames/windows for measuring and analysing harms from others' drinking**

*General population samples.* As already mentioned, surveys of harms from others' drinking are rapidly multiplying. Harms in such studies can be measured from several perspectives: from the perspective of the drinker, from the perspective of the affected other, or from the perspective of an observer. As already noted, traditional 'alcohol problems surveys', for instance from the 1960s, were often measuring what others would consider to be harms to the others, although it was the drinker's perspective -- whether the drinking had resulted in problems for the drinker -- which was being ascertained. Nevertheless, if I tell you that my drinking has caused problems in my family life, there is likely to be at least one other member of my family who would agree.

The alternative, currently burgeoning tradition is to ask about the harms from the perspective of the 'other'. Here, there are currently several main traditions of questioning and analysis. They have in common that the respondent usually gets to define what constitutes harm, and to attribute the harm to someone's drinking.

Specific instances of harm. One approach is in terms of a series of items inquiring about particular situations or events of harm, commonly specified as having occurred during the last year. Follow-up questions are sometimes asked about the frequency of occurrence, and about out-of-pocket costs or time spent where appropriate (e.g., Wilkinson et al., 2009).

Analysis of such items may take several directions. A common summary procedure is to treat all harms from others' drinking in a common frame, putting them together into a score or giving the proportion of the sample reporting any of the harms. Particularly when items on fears of drunken strangers or amenity harms from their presence or actions are included, it is common to find that a majority of the adult population reports one or more harms in the past year (e.g., Laslett et al., 2010, p. 41). Quite commonly, the different harm items are treated as of equal severity, although this is unlikely to be how the respondent would see them. For harms from strangers, there has been some differentiation between what were initially described as 'more serious' versus less serious harms (Laslett et al., 2010, p. 42), but with a division which is now tending to be recast in terms of tangible harms versus amenity harms and fears (Callinan & Room, 2014). But as yet, as far as we are aware, there have been no analyses which have attempted to establish a metric for relative seriousness of the items, for instance on the basis of survey questions on ratings of seriousness. And analyses taking account of frequency of occurrence of specific items are as yet rare.

Another procedure in analysing the specific harm items is in terms of types of harm. Fillmore (1985) set the precedent of classifying the items in her analysis into six scales, apparently on the basis of the face value of the items: Obnoxious behaviour; Property damage; Family and friend problems; Violence; Accidents; and Employment threatened. A more recent analysis, on the Australian data, used multiple correspondence analysis to define four 'domains' of items: psychological, physical, and social harm, and a residual pair of items labelled 'practical harm' (Berends et al., 2014).

Domains of relationship. A second approach divides harms into domains in terms of the relationship between the drinker and the other. A common division is in terms of 'strangers' and

‘known drinkers’, with the latter category subdivided into household members, other family members, friends and workmates. Implicitly, this subdivision is in terms of major social roles: a relationship in which the drinker is in the role of household member, of family member, of co-worker, of friend, etc. The relationships can be further subdivided, for instance in terms of the exact family relationship – parent, spouse, ex-spouse, etc. (e.g., Berends et al., 2012). There are potential overlaps in categories to be dealt with – most obviously between household and family members. And the implication of a particular relationship may change with the social circumstances. Thus, for instance, in a village a neighbour a few houses away is likely to be a ‘known drinker’, but in a big city may be a ‘stranger’.

One further relationship often asked about in current surveys is harms from adults to the respondent’s children. But in this case, the perspective has somewhat changed: the respondent is taking on the role of a third-party observer reporting on harm to another (even if the respondent may often take the harm caused to the child quite personally). Although the emphasis in analyses tends to have been on harm to the child from other family members, over one-quarter of those whose drinking harmed respondents’ children in the Australian survey were outside the family -- a ‘family friend’ or ‘other’ (Laslett et al., 2015b, p. 42).

A family relationship category which has been largely neglected so far in alcohol harm survey analyses is siblings. Harm between siblings has long been recognised as a common occurrence in the general family violence literature (e.g., Gelles & Straus, 1979), but has not received much attention concerning harms from drinking, although the alcohol dimension in harms is potentially present for teenage siblings.

Ratings of degree of harm. A third approach is to ask the respondent to rate the degree of harm experienced from others’ drinking. This has been asked about in two main ways: in terms of ‘a lot’, ‘a little’ or no harm, and in terms of a scale ranging from 1 to 10 (or, where those with ‘no harm’ have not already been filtered out, 0 to 10). Ratings of degree of harm have often been made separately for each of the main domains of relationship, e.g. “how much negatively affected by the drinking of a household member, relative or friend”, “... of a coworker”, “... of strangers or people you don’t know well”, and how much a child was negatively affected by others’ drinking (Laslett et al., 2010, p. 43).

Titration of the scales against each other, Callinan (2014) has shown that for Australians, those answering ‘a little’ respond on the scale at an average of about 3½, and those answering ‘a lot’ at about 8. Another study has found the values for Swedes are about 3 and 8, respectively (Ramstedt et al., 2014, p. 35). An Australian qualitative follow-up study comparing those answering ‘a little’ with those answering ‘a lot’ for harm from an adult’s drinking to their children found there were indeed marked differences in the intrinsic severity of the harms implied by the respondents’ detailed descriptions (Manton et al., 2014).

Correlates of harm from others’ drinking in population surveys. Probably the most common variables used in survey analyses of correlates of harm from others’ drinking are demographic variables. Other variables included in analyses have included the respondent’s own drinking pattern, and the existence or number of heavy drinkers in the respondents’ circles (e.g., Laslett et al., 2015a, pp. 40, 42). Having a heavy drinker in one’s family or among one’s friends is obviously a precondition for experiencing harm from a known drinker, but the longitudinal finding that whether or not a respondent experiences harm from others’ drinking is affected by changes in the number of heavy drinkers around the respondent suggests that the relationship is still important (Laslett et al., 2015a, pp. 24, 40, 67). An article analysing Danish data explores the overlap between those who

report harm to themselves from others' drinking and those reporting that their own drinking has harmed others, and demographic differences between those reporting both and those reporting each direction of harm (Seid et al., 2015)

Another line of analysis has pursued the relationship of harm from others' drinking to quality of life (Livingston et al., 2010; Casswell et al., 2011; Dussaillant & Fernandez, 2015). In general, cross-sectional analyses find an association with lower quality of life, particularly when the harmful drinker is in the same household (Johansson et al., 2006, pp. 67-69). But the meaning of these cross-sectional findings was put in doubt by the only longitudinal analysis so far, which found no significant relationship of change in harm from others' drinking and change in quality of life measures (Laslett et al., 2015a, pp. 53-59).

In a related line of work, an analysis of Australian data comparing those caring for others as a result of another's drinking with those not doing such care, though affected by the drinking, found a lower quality of life for the carers (Jiang et al., 2015). There have also been initial efforts to bring survey data on harms from others' drinking (externalities, in economists' language) to bear in benefit/cost analysis of alcohol prevention measures such as taxation (Marsden Jacob, 2012).

Research has begun to look at correlates of variation in the level of harm reported from family members' drinking (Berends et al., 2012) and at overlaps in harm, for instance between harm to the respondent and to the respondent's children (Laslett et al., 2015b, pp. 43-44). Analysis of US data found that having experienced harm from others' drinking is associated with favouring greater controls on alcohol availability (Greenfield et al., 2014). But analyses in the general harm from others survey studies has not yet proceeded much further in charting individual- or relationship-level correlates of harm from others' drinking. One problem for population analysts is that including a full inventory of questions about harms from others' drinking in a questionnaire does not leave much space for asking about potential correlates.

Apart from the early Nordic comparison (Mäkelä et al., 1999), analyses comparing rates of reported harm from others' drinking in different societies have begun to appear only recently (e.g., Dussaillant & Fernandez, 2015; Ramstedt et al., 2015; Synnøve Moan et al., 2015; Bellis et al, 2015). The analyses are considerable steps forward, but their findings so far tend to pose questions more than to answer them, since there are so many varying elements underlying the described harms and their relation to drinking, as well as in the social construction of the harms and the responses to them, which could be affecting the comparisons.

*Register data, and sampling and coding caseloads.* By its nature, register data is assembled from particular 'windows' on human problems, reflecting the health, social and legal agencies that respond to the problems in their own particular frame of reference. Reflecting the nature of their response and work, the agencies typically differ in their focus, and in particular in the extent to which they are focused on the individual case they are treating or responding to, or are oriented to the situation in which the case arises. In general, health agencies are quite narrowly focused on the individual case, and collect relatively little data beyond the purview of the case's body and mind. Emergency departments will collect and code the nature of an injury, and secondarily may code the 'external cause'. They may record intoxication in the case at the time when the case is triaged, but they are unlikely to collect data on whether another person involved in the incident has been drinking. There have been substantial efforts to collect further data on the case's drinking in special studies (Cherpitel et al., 2009), but there have been very few efforts to expand the routine questions



and procedures of emergency medicine to collect data on the drinking of others involved in an injury (Cherpitel et al., 2012).

In a global perspective, less has been published on alcohol recording in system registers for service systems other than health, so the discussion here relies primarily on CAPR's investigation of the situation in Australia (Laslett et al., 2010). By the nature of their mandate, child and family service agencies are far more likely than health agencies to collect data about the social environment of their cases, and their caseworkers are clearly well aware of the potential adverse effects in family life associated with a family member's drinking. But this does not necessarily mean that they systematically collect and aggregate data on this. For instance, only one Australian jurisdiction has ever systematically collected specific data on problematic alcohol use by a parent or carer as a factor in child protection cases, and this data was collected only for a few years, up till 2006 (Laslett et al., 2015b, pp. 82-86).

Other registers which potentially could record the involvement of someone else's drinking in a case include police and traffic incident records and ambulance records. There has been a pioneer move in Australia towards regular coding of alcohol involvement in ambulance cases (e.g., Lloyd et al., 2013; Lloyd, 2013), but it is not clear how well this could be extended to recording the involvement of others' drinking. Some Australian traffic crash datasets can be used to measure harm from others' drinking (Laslett et al., 2010, pp. 191-204), but such data is not regularly available. Police data on alcohol involvement in assaults – in Victoria, particularly in domestic violence – is perhaps the most consistent register data in Australia in recording drinking by perpetrators (People, 2005; Laslett et al., 2010, pp. 68-73, 88-92), but has limited availability for research purposes.

Perhaps the best opportunities for analyses of register data concerning harm to others from drinking would come from data linkage between case registers of societal agencies. But data linkage studies involving harm from others' drinking do not seem to exist. At this point, this remains a matter for further thought, discussion and exploration.

In the absence of routine recording of data related to effects of drinking on another in register data, an alternative view of the issues through the 'windows' of societal agencies can be gained by systematic new data collection on samples of the caseloads. The 6-country WHO/ThaiHealth study undertook a 'scoping study' on this in the course of Phase I of the study, and some summary results of that study have been analysed (Laslett et al., 2015c). For each country which is able to take part in Phase II of this study, the plan is to undertake systematic collection of data on samples of cases in up to three agency systems, to pilot how such information might be routinely collected, and to build a base of knowledge for policy planning and action to reduce harms from alcohol.

*Qualitative studies.* As discussed below, there is a need to expand the horizon of studies of harms from others' drinking beyond descriptive surveys documenting the rates, patterns and distributions of occurrence, and to move in various ways to gain a better understanding of the relationships, interactions and social processes which influence the occurrence and aftermath of the harm. One part of this should be, in my view, a substantial program of qualitative studies, planned and operating in interaction with epidemiological and explanatory quantitative studies.

One potentially fruitful way of linking qualitative and quantitative studies is by using a quantitative survey sample as the frame from which to recruit informants for a qualitative study. Such a procedure potentially has several advantages over snowball sampling or other common recruiting methods for qualitative informants. (1) The qualitative informants can be chosen

systematically to overrepresent interesting subgroups. (2) The sample of qualitative informants has a known relationship to the underlying population sampled in the survey. (3) The informant's responses on the prior survey can be used in the analysis of the qualitative data. (4) The survey responses are potential guides to followup discussion in the qualitative study. Thus, for the followup study already mentioned concerning harms from adult drinking to children for whom the respondent was responsible (Manton et al., 2014), equal numbers were interviewed (ten each) of respondents who had said their children were harmed "a lot" by another's drinking, and respondents where the harm was "a little". The qualitative sample, although derived from a general population sample, was thus structured to include only respondents who reported their children had been harmed at least a little, and included more whose children had been harmed "a lot" than could easily have been recruited by other means.

No matter how they are framed and however the sample is drawn, qualitative studies in this field need to draw and build on relevant prior work. It is likely that there is a wealth of data in existing qualitative studies, conducted with other research agendas in mind, which would be relevant to the circumstances of harm from others' drinking. There is a need for creative thinking and searching to find and analyse relevant prior material.

### **Perceptions, thresholds, attribution, causality**

*Perceptions and thresholds.* Questions about harm from drinking, no matter whether asked of a person harmed, of the drinker, or of a bystander or official, usually involve at least two aspects: a characterisation of a situation or event or of a reaction to a situation or event, and an attribution of the involvement of someone's drinking in the occurrence of harm in the situation or event. Concerning perceptions and thresholds, consider, for instance, the following items from the 2008 Australian survey:

- E.1.e. Did you have to stop seeing them because of their drinking?
- E.1.i. Did they fail to do something they were being counted on to do because of their drinking?
- E.1.j. Did they break or damage something that mattered to you because of their drinking?
- G.3.a. [Was a child] left in an unsupervised or unsafe situation because of some else's drinking?
- I.1.a. [Were you] kept awake at night or disturbed because of someone's drinking?
- I.1.c. [Have you] been physically abused because of someone's drinking?
- I.1.g. [Have you] felt unsafe while waiting for or using public transport because of someone's drinking? (Wilkinson et al., 2009)

Each of these items involves a judgement or perception about an event or situation – the respondent is telling us that s/he regards the event or situation as negatively affecting her/him. Presumably this judgement has a lower threshold – a level below which the event or circumstance would not be noticed, or would not be judged harmful. Some items are fairly concrete – "break or damage something" – while others may be taken to refer to something concrete, but are stated in a way which is abstract and subject to definition – "fail to do something they were being counted on to do".

The perceptions and thresholds involved may well vary from person to person, reflecting their social situation and life experience. They are also very likely to vary between sociocultural groups (Room & Paglia, 2000) – and between cultures. Considerations of social desirability, in some societies, may mean that respondents are more or less likely to report risky drinking by others and its consequences. Role expectations in the culture may also affect whether or not a drinking behaviour is accepted as normal, and whether a family member's response to it is regarded as an

insufferable burden or just as a routine part of their role. For instance, in some Asian cultures, wives generally are willing to look after their drunken husbands and humour their excessive drinking behaviour. Thus, in a study of wives of men treated for alcoholism in Japan, one wife commented that her husband “wasn’t violent or verbally abusive when drunk, so I didn’t have a strong sense of victimization”. The anthropologist conducting the study reported that “drinking to the point of passing out could be normalized within the context of daily family life. The fact that the husband had consumed enough alcohol to pass out was not seen as worrisome or unusual. Nor did it seem to create a major disruption. Without growing violent or obnoxious, he quietly drank himself into a stupor.... Eventually the problem was managed by his wife, who deftly escorted him from the scene.” (Borovoy, 2005: 44, 48). In another culture, the wife might well have very different expectations and interpretations of the situation.

The cultural and other variation in perceptions and thresholds may be reduced – but not eliminated – for items which are more concrete. But the more concrete the items, the more chance there is that there will be harmful events or situations which will not be picked up by any of the questions. “Something they were being counted on to do” can cover a multitude of omissions, and to try to spell out the possibilities would become an endless task. When cross-national comparisons are contemplated, the best strategy may be a combination – concrete items, which at least reduce the level of cultural construction, but backed up by wider-ranging general items, to cover the broader territory.

Issues of cultural variation in perceptions and thresholds of harm could be fruitfully explored with parallel and coordinated qualitative studies in different cultures, as have now been conducted concerning variations in drinking norms between southern and northern European cultures (e.g., Rolando et al., 2014).

*Attribution and causality.* Very few events or conditions are solely caused by alcohol. In some adverse events where there has been drinking, the alcohol plays no causal role. Where the drinking does play a role in the occurrence of the event, the causality is usually conditional – in principle, the event would not have happened without the drinking; but there were also other factors involved, and removing one of them would also have prevented the event. At least in English, language patterns do not readily recognise this conditionality: we talk of X happening ‘due to’ Y or ‘because of’ Y. This habit of speech means that the role of alcohol in an event can easily be inflated, since customary language does not recognise the conditionality. But, by the same token, it can just as easily be deflated. “The violence was due to his macho drive for dominance” can become a framing which rules out any role for alcohol in the event.

In cross-cultural comparisons, cultural variations in style of drinking may affect the extent to which adding alcohol to a situation affects whether harm will occur. For instance, drinking in northern European societies is considerably more likely than drinking in southern Europe to be in the form of relatively infrequent heavy drinking. Accordingly, though overall homicide rates are lower in northern than southern Europe, the same increase in per-capita alcohol consumption pushes up the homicide rate in northern Europe two or three times as much as it does in southern Europe (Room & Rossow, 2001).

Another source of variation in rates of alcohol-attributed harm is differences in the likelihood of noticing an alcohol connection to the harm, and in willingness to attribute the harm to the influence of drinking. The attribution may itself become a source of contention. Much of the harm to others from drinking is a social rather than (or as well as) a health harm. Such harms have

an inherently interactional character: there is a behaviour defined as problematic, but there is also someone whom the behaviour impinges upon. The attribution to drinking often also has an interactional flavour: the drinker's own attribution may be the result of someone else's attribution, or a dispute concerning the attribution may become part of the problem. (Room, 2000)

Survey questions about the harms from drinking have taken several approaches to asking respondents about the connection between the drinking and the event or condition (Room, 2000). Sometimes the respondent is simply asked about temporal association: e.g., "Has someone who had been drinking) pushed or shoved you?" (Eliany et al., 1989). Sometimes the causal connection is worded weakly: e.g., "My drinking was involved in my losing a friendship" (Cahalan & Room, 1974). And sometimes wording concerning the causal connection is strong: e.g., "have you had family problems or marriage difficulties due to someone else's drinking?" (Eliany et al., 1989). Or the harm may potentially be directly about the drinking: "Has someone who had been drinking made you afraid when you encountered them on the street?" (Mäkelä et al., 1999).

In the Australian survey and the version in English of the WHO/Thai Health survey questionnaire, the causal attribution tended to be quite direct: as can be seen from the items quoted above, the wording was generally in terms of "because of" their drinking. Respondents are thus unambiguously being asked to make a causal attribution.

But the tendency to make such causal attributions, and the threshold for when it is made, are very likely to vary cross-culturally (Room et al., 1996), and there can also be substantial variation over time within a given culture (e.g., Herd, 1992; Levine, 1983). There is scattered evidence, too, that attribution can vary with one's vantage point. An old U.S. study found that police called to domestic disputes did not necessarily agree with the complainant or the other party on whether a party was drunk, and were relatively sparing in attributing a causal role to the drunkenness (Bard & Zacker, 1974). In an analysis of multinational emergency department data on injury cases resulting from violence, a smaller proportion of cases attributed causality to drinking by the assailant or themselves than the proportion which would have been assigned on the basis of case-control or case-crossover studies (Cherpitel et al., 2012). On the other hand, analysing U.S. survey data on drinkers' reports of specific problems in their life and of similar problems "in connection with drinking", Gmel et al. (2000) found that 30%-60% of those who reported the consequences in connection with their drinking did not report a similar problem at a general level.

Such findings suggest the substantial issues which persist around issues of assigning a causal role in harmful events and conditions to drinking or intoxication – and around the relation of such 'alcohol attributable fractions' to assignments of causality by participants in and bystanders to such an event. In principle, public health estimations and calculations concerning alcohol's role as a risk factor, for instance in burden of disease calculations, seek to define an 'attributable fraction' of the end-point disease or disabling condition which results from drinking in the conditional sense that the disease or condition would not have occurred in the absence of the alcohol (the 'counterfactual' comparison – Murray et al., 2003). But for some conditions -- notably for violent injuries (Graham et al., 1998) – the potential causal pathways for alcohol are multiple, and there is strong ethnographic and epidemiological evidence (Room & Rossow, 2001) that comportment while drunk varies between cultures in ways that influence the likelihood of violence at a given level of drinking.

Researchers need also to recognise that, as illustrated by the historical summary with which this paper started, there is a moral politics in most societies around whether and how alcohol is attributed a role in the occurrence of a harm. It is rare for any adverse event or condition to be

solely attributable to someone's drinking; drinking is at best a conditional cause, in the sense that the harm would not have occurred if it had not been an element in the situation (Room, 2006). This means that there are also other conditional causes involved in the situation. The moral politics of a social movement, of a subculture, or of a society at a given moment will tend to make choices between factors involved concerning which are favoured for an attribution. Nineteenth-century American temperance-movement writers gave priority to the alcohol element if it was present in the situation, commonly attributing that "three-fourths of all the crimes of the land result from the use of intoxicating liquor" (Dickinson, 1830; cited in Levine, 1983, p. 137). Conversely, in 1950s America, priority was assigned elsewhere, for instance by epidemiologists who looked to urbanisation and industrial toxins as prime causal factors in cirrhosis (Lilienfeld & Korn, 1950; Herd, 1992). Nowadays, an Australian state has decided that a deadly blow delivered when the assailant has a high blood-alcohol level should be punished twice as severely as a deadly blow delivered while sober (Quilter, 2014). Conversely, many who argue for the cause of victimised women in domestic violence are resistant to any mention of intoxication in connection with the violence (e.g., Murphy, 2009), fearing that it will serve to excuse the man involved. Alcohol intoxication is a quite heavily moralised field in many societies, and in most societies there will be a moral loading around many harms to others. Those involved in studying and reporting on alcohol's harm to others need to recognise the potential moral politics surrounding their findings. In my view, they need to do their best to steer a dispassionate path in reporting their findings, discussing potential implications in a balanced way.

These difficulties do not mean we should dismiss or set aside the idea of causal connections of alcohol with violence or other harms. And we should not assume that cultural biases about alcohol as a cause go only in one direction – as the history summarised in the first section of this paper suggests, 'problem deflation' can be as much an issue as 'problem amplification' (Room, 1984). Neither do they mean that we should abandon questions which include causal attribution. But the difficulties do pose a number of questions for further research. When and in what circumstances are causal attributions made to drinking or intoxication in a given cultural situation? How do such attributions compare with social psychological experimental evidence, and with attributable fractions based on relative-risk results? Can ways be found to collect testimony and other evidence about potential causal effects which are less subject to cultural perceptions and assumptions?

### **Harm to others from drinking in burden of disease or cost studies**

An issue which is currently on the table, which gives urgency to addressing issues of conceptualising and measuring causation, is the questions of how to integrate data on the burden of harm from others' drinking into quantifications of the social costs or the burden of disease attributable to drinking. As noted above, social cost of alcohol studies have primarily measured costs borne at aggregate levels in the society – in the health system, by the police and court agencies, and lost productivity as a societal cost – along with (more controversially) some costs for at least some of the drinkers. Largely missing from the calculations have been costs for individuals impacted by someone else's drinking. The Australian 2008 survey included questions on out-of-pocket costs and on time spent because of someone else's drinking. When potential double-counting is excluded, estimates based on these questions amount to the same order of magnitude as the other costs traditionally included in social cost of alcohol studies (Laslett et al., 2010, pp. 176-178; Marsden Jacob Associates, 2012). The harms from 'second hand drinking' costs thus seem to be a considerably higher fraction of the total harms from alcohol than the harms from 'second-hand

smoking' are of harms from cigarette smoking (see also Nutt et al., 2010). Yet the metrication even of most health harms from others' drinking has not reached the stage where they are accepted for inclusion in calculations of the contribution of risk factors to the Global Burden of Disease (GBD Risk Factors Collaborators, 2015), while the estimates of harms from 'second-hand smoking' are included.

The path which has been followed for measuring health harms to the drinker from alcohol is of using meta-analyses of prospective and case-control epidemiological studies to derive 'alcohol-attributable fractions' for different diseases and disorders. As implied by the discussion above, we are a very long way from such measurements for harm from others' drinking and, because of the nature of health systems' primary focus, it is going to be very hard to get good data from them on this form of risk. Also, much of the harm to others from drinking does not qualify easily for a code in the International Classification of Diseases, and is dealt with outside health systems. We need to be inventive about measuring harms from others' drinking, and to consider ways of taking account of data from population survey analyses and other non-register sources.

These issues also have implications for governmental advice about drinking, such as the Australian 'low-risk guidelines' (NHMRC, 2009). At the moment, these guidelines are framed only in terms of risks to the health of the drinker. While it can be seen as appropriate for governments to offer such health advice, there is even more justification, in terms of the responsibilities of government, for advising on the risk levels for harm to others from drinking, and guidelines on drinking which will minimise them. The 2009 Australian guidelines noted specifically that this area remains to be tackled, and there are already some brief discussions of some of the issues which will be involved (Room & Rehm, 2012).

### **Getting binocular (multiocular?) in our vision of harms from others' drinking**

As described above, one of the main quantitative 'windows' we have for examining alcohol's harm to others has been through register and other data for the societal response agencies which deal with health, social and legal problems in our societies. The evidence is becoming clear that, in societies where a substantial amount of alcohol is consumed, drinking or intoxication is a factor in many of the problems dealt with by an assortment of agencies (Laslett et al., 2015b). The other window with quantitative data, from which we have rapidly growing evidence, is population surveys which ask about harms from others' drinking and about social harms from drinking. Again, the evidence from this window is of a high prevalence of reported harms from others' drinking in societies consuming a substantial amount of alcohol (e.g., Laslett et al., 2010).

At this juncture, we have difficulty fitting the pictures from these two windows together. Take the case of child abuse or neglect, as studied in the second author's dissertation (Laslett, 2013). The picture from the case records of Victorian Child Protection Services (CPS) is that drinking by someone with responsibility for the child is a problematic factor 33% of the time in the problems which have brought the case to the service's attention. These children with a carer's drinking as a factor amount to 0.2% of all Victorian children (Laslett et al., 2015b, pp. 87, 101). When adult survey respondents are asked about drinking-related harms or dangers in the last year to children they are responsible for, the proportion answering in one way or another that there has been a problem is 22%. This is two orders of magnitude higher than the 0.2% of the general child population with such problems who are in the CPS caseload (Laslett et al., 2015b, p. 38). Apart from this huge discrepancy in prevalence, the nature and mix of the problems from drinking viewed through these windows, as well as the situation of the children involved, is very different. The families in the caseload of the

Child Protection Services are largely poor and marginalised, while survey respondents reporting their children were adversely affected are pretty much a cross-section of the parental population. The discrepancy in prevalence is reduced to one order of magnitude when a parent in the population survey reports a child was harmed 'a lot' by someone's drinking (3% of the parents). At this level, the adverse effects of the drinking begin to sound close to the severity of Child Protection cases (Manton et al., 2014); but at this level, the difference in social class distribution between the two windows, though somewhat lessened, remains stark. Part of this remaining discrepancy is likely to be a result of poorer and more marginalised families being more subject to social surveillance (Henman & Marston, 2008), through welfare, police and public housing, health and education services.

The disjunction between general-population and case-record pictures of harm from others' drinking, illustrated by this example of alcohol's role in harm to children, exists also for other forms of harm from others' drinking. We need to think about ways in which we can build a three-dimensional picture of alcohol's harm to others in a population perspective, bringing these two very different perspectives on harms from others' drinking together, and learning more about the circumstances and correlates which predict moving from one frame to the other – that is, becoming a case for action by emergency and social services. To do this, we are going to require a variety of study methodologies, including more qualitative and multimethod studies, and substantial linkage projects to enable analysis of data from the different windows in a common frame. Studying what contributes to the discrepancy between what is seen in the two windows, and what should and can be done to bring the pictures together, are important agendas not only for research, but for policy action.

## **Conclusion**

It is now almost a decade since the turn began towards taking the whole range of alcohol's harms to others seriously and studying them across the board. In greater or lesser detail, such studies have now been carried out in dozens of countries, and reports from these studies, and comparative analyses across many of them, will be appearing in increasing numbers in the next few years. While there were already substantial literatures on a few particular harms – fetal alcohol syndrome, drink-driving casualties, and injuries from violence – the picture of alcohol's harm to others is now being filled in with details of other harms, often more mundane and continuing or recurrent, and often at the level of personal interactions and relationships. We have described here some of the contours of this new literature, and some conceptual and methodological issues which it has brought to the fore.

Apart from their implications for future research, many of these issues are also substantial challenges to policy. The lack of attention to the role of someone else's drinking in what brings a case to a hospital emergency department, for instance, is not only an issue for researchers; it also raises policy questions, not only of whether the first responders should pay attention to that aspect of the situation, but also of what can be done to head off a recurrence. Beyond the level of the individual case, the lack of evidence on alcohol's role in harming others around the drinker also hinders rational policymaking about control of alcohol availability and other more general policy measures.

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