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Scoping response system management of alcohol's harm to others in lower middle income countries

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ABSTRACT

AIMS – As part of the WHO Harm from others' drinking project, Thailand, Sri Lanka, India, Chile, Nigeria and Vietnam undertook scoping studies to examine: which service agencies in low and middle income countries responded to people affected by others' drinking; how commonly key informants from these agencies indicated alcohol was part of the problems they managed; and whether any routine reporting systems collected information on alcohol's harm to others (AHTO) and the types and examples of harms experienced across the six countries. METHODS – Researchers synthetised within country peer-review literature, reports, news and agency website information. Additionally, researchers interviewed key informants to investigate current structures, functions and practices of service agencies, and in particular their recording practices surrounding cases involving others' drinking. RESULTS – 111 key informants agreed to participate from 91 purposively selected agencies from health, social protection, justice and police, and 'other' sectors. National and provincial level data, as well as state-run and civil society agency data were collected. Diverse service response systems managed AHTO in the different countries. A large range in the percentage of all cases attributed to AHTO was identified. Case story examples from each country illustrate the different responses to, and the nature of, many severe problems experienced because of others' drinking. CONCLUSIONS – AHTO was a major issue for service systems in LMIC, and significantly contributed to their workload, yet, very few recording systems routinely collected AHTO data. Recommendations are outlined to improve AHTO data collection across multiple sectors and enable LMIC to better identify and respond to AHTO.

KEYWORDS – alcohol, harm to others, response systems, cross-national

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Background

Alcohol consumption is predicted to increase particularly in developing countries; and countries with fewer financial resources are at greater risk of health and other problems per litre of pure alcohol consumed (compared to high income countries) (World Health Organization, 2014). Moreover, research and program response priorities have largely targeted drinkers (Room et al., 2010). These priorities largely reflect the health harms to drinkers themselves, and do not count social harms or harms to others from drinking. Given the effects of harmful alcohol use on others by drinkers in low- and middle-income countries (LMIC) are likely to be substantial and to increase, it is important that harm to others from drinking and institutional re-

sponses to it be studied and analysed in a wider range of countries, as a basis for new policy initiatives.

In 2011 the World Health Organization (WHO) and the Thai Health Promotion Foundation (ThaiHealth) collaborated in supporting the development of a research protocol, and building on the harm to others (AHTO) studies which had been implemented in Australia and New Zealand (Casswell, Harding, You, & Huckle, 2011; Laslett, Catalano, et al., 2010), funded the "Harm from others' drinking project[1]" in six LMICs, namely Thailand, Sri Lanka, India, Chile, Nigeria and Vietnam. The study included scoping and assessment studies, as well as general population surveys in Phase I (Callinan et al., early view). Drawing on Phase I data and recent papers, estimates of the magnitude of alcohol's harm to others in different regions of the world using surveys have begun to emerge. These indicate that substantial proportions of the population in LMICs, as well as in high income countries, experience harms from others' drinking (Casswell, You, & Huckle, 2011; Esser et al., 2015; Greenfield et al., 2009; Laslett et al., 2011; Obot et al., 2014).

In the last decade, survey research on alcohol's harm to others has burgeoned (Callinan et al., early view; Laslett, Callinan, & Pennay, 2013; Ramstedt et al., 2015; Seid, Grittner, Greenfield, & Bloomfield, 2015), with substantial proportions of general populations in many high-income countries reporting that alcohol is involved in a range of harms to others of differing *types* [e.g. littering, noise, fear (Laslett et al., 2011), work-related harms (Dale & Livingston, 2010), road crash injuries (Laslett, Catalano, et al., 2010), family violence (Laslett, Jiang, & Room, in press) and child abuse (Laslett, Ferris, Dietze, & Room, 2010)], *severity* [e.g., annoyance (Wilkinson & Livingston, 2012), physical assault (Connor, You, & Casswell, 2009), injuries and deaths (Laslett, Catalano, et al., 2010)] and *duration* (e.g., single incident or ongoing harms (Laslett, Callinan, Jiang, Mugavin, & Room, 2015)]. Young adults appear to be near universally at greater risk, with men experiencing more street-based harms and women more harm, including intimate partner violence, from family members (Laslett, Catalano, et al., 2010; Ramstedt et al., 2015; Seid et al., 2015). Greater variability in findings is evident around the association between social disadvantage and harm to others (Seid et al., 2015).

In a separate body of literature, harms from others' drinking as measured in registry or routine data bases suggest that more severe harms such as deaths, interpersonal violence and child maltreatment may be more apparent in more disadvantaged groups (Herttua, Mäkelä, & Martikainen, 2008; Herttua, Mäkelä, Martikainen, & Siren, 2008; Laslett, Catalano, et al., 2010; Laslett, Dietze, & Room, 2013). This phenomenon has led to coining of the two worlds of alcohol problems addressing drinkers' problems (Storbjörk & Room, 2008) and two windows of alcohol problems in relation to others' drinking (Laslett, 2013).

1 Harm to others (AHTO) draws attention to alcohol's role in the harm. However, the WHO project was titled "The harm from others' drinking" and consequentially emphasises the behaviours of drinkers. The two terms however, essentially refer to the same concept.

There has been less research attention focussed on routine data base analyses of alcohol's harm to others. There are two main reasons why such data is not routinely collected: (1) to some extent in social agencies, and particularly in health agencies, the main attention is on the cases to be treated; information on a patient's level of intoxication may affect the immediate treatment proffered and the prognosis of the patient in the health system and hence there is a strong rationale for collecting that information in particular. Secondly, information on someone else's level of intoxication who may no longer be at the scene is less reliable and more difficult to collect, although this has been more recently begun to be taken into account for instance in emergency rooms (Cherpitel, 2012) and sporadically in more developed systems elsewhere, e.g., ambulance data (Lloyd & Livingston, 2009), and child protection and police data in Australia (Laslett, Catalano, et al., 2010), and in Finland where data linkage links previous alcohol treatment and subsequent harms to others (Raitasalo, Holmila, Autti-Rämö, Notkola, & Tapanainen, 2015). Thus investigation of others' drinking is more commonly investigated by police only in serious criminal cases. The lack of data in the health system on others' drinking in injury cases, for example, has resulted in only limited understanding of alcohol's harm to others in burden of disease studies (World Health Organization, 2014).

Analysis of routine data bases are important because they illustrate the magnitude of the serious cases that come to the attention of government (and non-government) agencies, and also because they simultaneously describe how problems associated with others' drinking are being managed. Whether harms from others drinking are reported in low and middle income countries and how they are dealt with has not been studied.

The general capacity of public sector programmes to respond to harms caused by others' drinking and provide a range of services is likely to be constrained by the resources available in different countries. Gross National Income (GNI) is one indicator of this and varies per capita between US$1890 in Vietnam and US$14,900 in Chile (World Bank, 2015). Thus, underlying resource capacities of countries and to a lesser extent spending priorities contribute to different levels of per capita spending on different programs. Examining per capita health expenditure, India spent $61, Sri Lanka $102, Vietnam $111, Nigeria $115, Thailand $355 and Chile $1,204 (and for comparison this was $6,110 in Australia) in 2013 US dollars (World Bank, 2013).

Spending on health welfare, policing and education sectors also diverges substantially, with, for instance, higher income countries such as Chile providing welfare transfers, family assistance, poverty pensions (Kurtz, 2002) and a well-developed child protection system (Muñoz-Guzmán, Fischer, Chia, & LaBrenz, 2015), while a number of low income Asian countries have more limited public investment in state welfare services and functions (ECPAT International, Plan International, Save the Children, UNICEF, & World Vision, 2014; Köhler, 2014). Consequently many low income countries have emergency response systems, such as police and hospitals that attend often only to the most severe cases. Other welfare programs

have been much more reliant on aid from international donors for specific, often child-centred programs, e.g., orphanages.

This paper draws on the six WHO/ThaiHealth Harm from others' drinking scoping studies undertaken in Phase I and aims to gather information about the notice given to and the handling of drinking by others in cases dealt with by a range of agencies from each country. The scoping studies provide information on how different societies currently manage and record AHTO problems as they become apparent in their health, social, criminal justice, police and other sectors. The scoping studies also describe specific examples of responses to particular types of alcohol's harm to others experienced in these countries and seek to develop a descriptive picture of alcohol's harm to others for each society as a whole. The scoping studies also inform Phase II of the project.

The research questions in the study were

- How much understanding is there of how other peoples' drinking contributes to problems managed in a range of response agencies?
- How commonly did key informants from the selected agencies indicate alcohol was part of the problems they managed?
- Are there systematic reporting systems in place to document alcohol's harm to others?
- What types of problems linked to others' drinking were identified?
- What were the common themes and apparent differences in the agency responses and reporting systems?
- Were there notable differences or similarities between countries?
- What recommendations stem from the findings regarding development of future reporting and response systems for alcohol's harms to others?

Methods

Thailand, Sri Lanka, India, Chile, Nigeria and Vietnam followed the WHO/ThaiHealth Harm from others' drinking study protocol for the scoping study component, using the key informant (KI) questions as a guide for qualitative interviews and the information and consent forms specified. The protocol was approved by the WHO Research Ethics Committee and the relevant national/institutional ethics committee in each country. The six country–level work teams selected key informants from four overarching sectors: health, social services (women's, family and child welfare), police, traffic and justice, and "other" (e.g. educational, private hospitality). In each country agencies were mainly selected from urban areas, but provincial centres were also visited, where possible. Key informants were selected from a range of positions and organisations including high level officials from within the national ministries, managers of regional emergency and mental health departments within large teaching hospitals, as well as local workers within non-government funded support agencies (e.g., orphanages). Some countries mainly interviewed policy makers, while others interviewed a mix of personnel from a hierarchy of community and government organisations. The key informant questions in the protocol as a guide for the interviewers are displayed in Table 1.

In this qualitative research, primary attention was on eliciting substantive an-

Table 1. Key informant question guide

1. How many people do you/does the organisation/centre see each day?
2. What proportion of cases would involve others' drinking?
3. What information do you record on their problems and harms?
4. Does others' drinking contribute to these injuries, assaults, attendances or problems? In a small number of, some, many or most cases?
5. Whose drinking causes these problems? Strangers, people they know?
6. Describe the effects of drinking on their families, friendships, income, work, roles in the home?
7. Describe a typical situation or story about how others' drinking affects a person who attends your organisation e.g. What types of problems they experience, how often it happens, who else is affected besides the person in attendance, is the problem ongoing?
8. Does your clients' or patients' drinking contribute to others' problems?
9. How do you/does your agency record this information? Paper records? Notes or set forms, computer entries? Do you tick a box or record information on alcohol use, drug use? Do you always get time to complete these forms?
10. May we please have a copy of a blank form, a print out of an uncompleted screen that you would usually use to collect this information?

swers to the research questions, and the bilingual principal investigator at each site took responsibility for reporting the substantive findings in English. These 10 questions were used as an interview guideline and interpreted broadly, with for example, national agencies being questioned about national data trends and local level agencies being asked about more detailed service information, including typical case histories. Not all agencies were asked all questions.

A total of 111 key informant (KI) interviews were conducted with staff from 91 government and non-government, national, state and local organisations or departments from Thailand (Waleewong, Jankhotkaew, & Thamarangsi, 2015), Sri Lanka (Hettige, de Silva, & Suganthika, 2014), India (Benegal, Girish, Gururaj, & Murthy, 2014), Chile (Florenzano, 2015), Nigeria (Obot, 2014) and Vietnam (Hanh & Hanh, 2015). The interviews were conducted in the local language. Summaries of the situation in a particular agency quoted in this paper are based on these interviews, as reported in the national scoping study report in English for the country named.

Results

The results section is structured to present information on the awareness of harms to others from drinking in different countries and sectors. Reference is made to estimates of caseloads apportioned to others' drinking and whether reporting systems exist to record data on AHTO, along with an assessment of their capacity to do so. Finally cases studies are presented on different harms to others and how they are managed in different countries by different sectors.

Awareness of harms caused by others' drinking and service responses in low, middle and high income countries

Table 2 summarises the KIs' awareness of AHTO and presents this along with additional information on the percentage of

cases that KIs estimate involve alcohol's harm to others. KIs also make comment on the systems used to collect and store information as well as the quality of data collected. The information is presented for each sector, and country-level differences are highlighted where relevant.

Most KIs from sectors and organisations within each country reported the involvement of the drinking of others in many of the cases they responded to. In all countries it was noted by KIs from health, social welfare (families and children's services), police and justice and other sectors that others' drinking problems were a source of a range of harms to clients. Only two health organisations (in Nigeria and Sri Lanka) of a total of 91 organisations from across all sectors and countries reported that AHTO was not a problem, as far as they knew. A significant minority of organisations across all countries reported that AHTO was involved in very few or less than 5% of their cases (e.g., Police, Thailand; Police, Nigeria; National Department of Probation and Child Care Services, Sri Lanka; Mediation Board, Sri Lanka).

Health sector agencies: Key informants were interviewed from many agencies in the health sector, including major teaching hospitals, regional hospitals, mental hospitals, emergency and mental health departments of hospitals, alcohol and other drug (AOD) agencies (including Alcoholics Anonymous and detoxification centres), primary health care regional managers and community mental health clinics. KIs from Government Health Ministries and Health Departments were also interviewed.

In all countries (Thailand, India, Sri Lanka, Nigeria, Chile and Vietnam) the health sector appeared to be the main sector taking care of those affected and AHTO was perceived as an issue for the health sector, although this was more consistently evident from KIs in mental health and AOD treatment organisations than those from emergency wards. Whilst AHTO was acknowledged, the AOD treatment systems and trauma units within hospitals were focused on managing the problems of the patients at hand. For instance, KIs from India estimated that 10-30% of emergency and trauma cases were linked to alcohol, but it was not clear whether this was linked either to the patients' drinking or to drinking by others. Treatment organisations commonly reported impact on families and sought to manage the problems of these families, but were limited by available resources. In reality most services were directed to drinkers, and few services were provided to family members. For example, in an Indian health organisation, it was reported that –

> the agency does see cases of effect of one's own and other people's drinking. The common issues are road traffic accidents, accidental deaths, assaults, domestic violence, suicide and poisoning with alcohol. The proportions [of cases involving harm from others' drinking] range between 20 to 25% and the numbers have increased in the last 5 years. Case notes provide the information related to alcohol's harm to others. There is no mandatory recording of alcohol use in the formats routinely used. The staff do not enquire about the 'impact of a client's drinking on others' or 'impact of others' drinking on the client'. However, whenever, there is a case related to harm from al-

> cohol use either in self or family, they are referred to a de-addiction centre in the public sector hospitals. (Benegal et al., 2014).

Police, Traffic and Justice agencies: National Road and Traffic Safety authorities, Ministry of Transport officials, National, Provincial, District and Local level police station representatives and officers, Security and Civil Defence Corps members, as well as Ministry of Justice High Court, Probation offices, Family Court, and Juvenile Justice Board representatives were all interviewed as part of the scoping exercise across the six countries.

Police KIs in Thailand only saw AHTO problems present in a minority of cases (<5%). In Nigeria KIs also perceived that AHTO was a rare phenomenon, although higher proportions of criminal cases (10-25%), and traffic cases (30-50%) were reported as being linked to drinkers in India. However, whether these incidents involved property or other people was not always clear. A number of organisations reported that while they did manage AHTO cases they did refer clients on to other services – for instance, police referred women to domestic violence response services where they were available in most countries. The range in magnitude of the reporting of cases involving alcohol was marked in the traffic, police and justice sectors, both within and across countries.

Social welfare agencies – women's and children's services: The organisations responding to family crises or violence that key informants interviewed could generally be divided into two groups, those that focussed on women and those that addressed children's needs. These organisations are either state or NGO managed, with for example, NGOs quite dominant in taking care of victims and managing this kind of violence in Thailand. Services for women included local domestic violence crisis or intervention centres, including women's shelters; regional and local women's centres; family health centres; family welfare services; social welfare offices; and women's legal federations, women's foundations, national agencies for family protection, national centres for violence prevention and general charitable organisations. Women's domestic violence organisations consistently acknowledged alcohol's contribution to domestic violence, with organisations in different countries estimating involvement of others' drinking in high percentages of cases, e.g., in Thailand 30-55% of cases, and 40% in Sri Lanka. For instance, in the recorded data from a crisis centre in Thailand –

> there were 1,068 patients in 2012. Women and children are identified as the main victimized clients. There are about 4 to 5 new cases every day, or about 70 to 80 cases per month, transferring to this centre. It is estimated by the staff that about half of female client cases were related to alcohol drinking and drunkenness of husbands or partners. About 50% of female cases were physically abused, and about 40% sexually abused. Cases of male drinkers physically assaulting their mothers were also found in the records. (Waleewong et al., 2015)

In a service centre for women in Sri Lanka, the

> main agenda lies with active participation in protection of women from domestic and all forms of violence, they are not directly involved with the prevention of alcohol abuse or at any form of alcohol related issue. However they have witnessed that 40% of abuse of women occurs as a result of alcohol abuse. Alcohol remains among the top five reasons for family problems. However as the organization does not specialize in this particular area, they direct cases involving alcohol abuse to other non-profit or government organizations which specialize in rehabilitation of alcohol abusers. The Head Counsellor of the organization stated that many women who have alcohol abusive husbands are forced to find money for their husbands and are abused if they fail. (Hettige et al., 2014)

For children, children's protection centres, children's homes (orphanages and street-child rescue centres), pre-school child support centres, Child Protection Societies, Children's Rights Foundations and National Child Protection Authorities responded specifically to their needs. The family based organisations that were referred to above also benefit children. There was greater variation in the estimated percentages of cases that involved another's drinking in the child protection sector: Thailand (60-70%), India (15-20% in Family Court) and Sri Lanka (very few). For instance, in a boys' home in India,

> the agency does see cases of effect of other people's drinking on the boys. The common issues are family problems, financial problems, domestic violence and child neglect. The proportions range around 80% and the numbers have remained the same in the last 5 years. The agency routinely collects information/data relating to alcohol harm to others through set forms 'alcohol: yes/no/don't know' as related to only the father. Case notes provide the information/data related to alcohol's harm to others. There is no mandatory recording of alcohol use in the formats routinely used. The staff do not enquire about 'impact of a client's drinking on others' or 'impact of other's drinking on the client'. However, the agency's staff to date have reportedly not come across any case where the effects of others' drinking has had a negative effect on children. The agency has collected very limited information on family economical changes and social status of the boys. (Benegal et al., 2014)

Other agencies and sectors: The principal investigators in each country chose to interview key informants from sectors additional to those mentioned above. For instance, a number of projects interviewed key informants from religious organisations and charities (a Buddhist AOD treatment organisation, the Catholic National Bishop's conference, a Lutheran regional church, a Jewish collectivity), the education sector (Department representatives and a private school), a mediation board and private organisations (a private trucking company, and private hospitality providers).

The problems from others' drinking reported by key informants in this group were varied and sometimes unusual, although despite coming from a different perspective, often concerned by similar themes. The KI from the trucking company (Nigeria) received complaints about their drivers' drink-driving, spousal stress and fights. Mediation centres – an initiative of the Family Court (India) – commonly address matters concerning marriage breakdown, dowries, family problems, legal problems, child custody and maintenance. In 40 specific cases discussed with a key informant, an estimated 8 to 10 concerned alcohol use. KIs from the hospitality/entertainment industry were concerned about non-settlement of bills after drinking and debt repayment, and less concerned about other harms to themselves or others because of drinking (Nigeria).

Routine reporting systems collecting information on alcohol's harm to others

Data quality. In general very little information was recorded in any data sets on AHTO, and often recording of alcohol's involvement in cases of any kind was rare.

Table 2. Awareness[1], management, case involvement and data quality as estimated by sector key informants[2]

Category	Aware that HTO is involved	Manage HTO cases	Range:% HTO cases/ all cases	Data quality
Chile (n=31 with 32 KIs)	**Y/N**	**Y/N**	**Range in % cases**	
Health Based Organization (n=10)	Y	Y (75% of orgs do)	0-75%	Poor
Social Welfare Agency (n =11)	Y	Y overloaded	0-50%	Poor
Police/Justice/Traffic (n=6)	Y	Y	0-20%	Poor
Other: 3 religious organisations and 1 school (n=4)	Y	Y	0-100%	Fair
Thailand (n=12)	**Y/N**	**Y/N**	**Range in % cases**	
Health Based Organization (n=4)	Y	Y	<5-80%	Poor
Social Welfare Agency (n=4)	Y	Y	30-70%	Poor
Police/Justice/Traffic (n=3)	Y	Y	<5%	Poor
Other: Religious Treatment Centre (n=1)	Y			
Nigeria (n=16)				
Health Based Organization (n=4)	3/4	2/4	10-30%	Poor
Social Welfare Agency (n =4)	4/4	4/4	10-30%	Poor
Police/Justice/Traffic (n=5)	5/5	4/5	10-30%	Poor
Other: Hospitality Outfit (n=3)	3/3	3/3	10-30%	Poor

[1] Awareness is categorised by whether key informants reported or not in the interviews that HTO was involved in the caseload of the agency.

[2] Nigeria collected this information as a percentage of organisations interviewed within that sector. So for example, three of the four KIs from health organisations reported that they were aware that alcohol was a factor in the patients they responded to but only two of these organisations reported that they treated them per se. Thailand, Sri Lanka and India reported awareness of HTO and provided for each organisation an estimated percentage of cases that involved HTO where this was possible. India took this process a step further and accessed small numbers of case files from the agencies that agreed to participate and analysed them to see whether alcohol was documented in case notes (thereby gaining an indication of congruence between the KI estimates and the documented records held by the agencies involved). →→→

	Aware that HTO is involved Y/N	Manage HTO cases Y/N	Range:% HTO cases/ all cases	Data Quality
Sri Lanka (n=13 with 26 KIs)				
Health Based Organization (n=5, 11 KIs)	Y	Y		Confused individual alcohol problems with HTO
Social Welfare Agency (n =3, 7KIs)	Y (but some N)	Few	40% (Women in need cases)	
Police/Justice/Traffic (n=4, 8KIs)	Y (but some N)	Y		Managing alcohol per se or risk but not actually HTO
Other: Mediation Board (n=1)	Y	N	rare	Interesting example of HTO from neighbours
India (n=11, 17 KIs)	**Y/N**	**Y/N**	**Range in % cases**	
Health Based Organization (n=3, 5 KIs)	Y		10-30%	Poor
Social Welfare Agency (n=5, 6KIs)	Y		10-90%	Poor
Police/Justice/Traffic (n=3, 6KIs)	Y		15-25%	Poor
Vietnam (n=8) (Departments of ministries or local units)	**Aware that HTO is involved Y/N**	**Orgs managing HTO Y/N**	**Range in % cases**	**Data quality**
Health sector (n=3)	Y	N		Only drinking status of "patients of traffic injuries at emergency units" of some hospitals. HTO data not in surveillance form. Recognized connection between domestic violence experienced by women and children and alcohol use.
Culture- Sport- Tourism Sector (n =1) – monitoring data on domestic violence	Y	N		HTO data not in surveillance form. Written case data may be available.
Police sector (n=3) Road traffic injury Crime	Y	N		Only drinking status of perpetrator of road traffic injuries Written case data may be available. Recognise forms and recoding may be useful from criminal and road traffic data.
Other – education (n=1)	Y	N		
Total (n=91 with 111 KIs)				

Only for the most serious cases, where legal agencies were involved, was there more extensive recording of alcohol's harm to others. In contrast, household survey data from most countries shows the prevalence of AHTO in many domains. This low level of recording by agencies might be due to the low level of awareness of alcohol's role in harms to others.

The Nigerian national report highlights concerns about data quality seen in Table 3.

Despite the high level of awareness of alcohol-related harms in general and harms to others from alcohol consumption in particular among the agencies surveyed, it was observed that systems for record-

Table 3. Magnitude of cases across agencies about alcohol's harm to others, India

	Name of the Organization	*Total magnitude of cases*	*Link with alcohol*	
			Estimate of KI	*Documented in records*
1. Trauma Care services				
1.	Emergency Service (police, fire, medical) management	Approximately 2000 cases / day in the whole city	20–30%	28%
2. The Department of Women and Child Development				
2a	Juvenile Justice Agency	Approximately 5–8 cases / day	10%	12%
2b.	Charitable organisation for children	Approximately 25–30Cases / day	90%	32%
2c.	Government reception centre for girls	Approximately 8-10 cases / day	60–70%	23%
2d.	Government centre for boys	Approximately 100 cases / day	90%	8%
2e.	Government home for girls	Approximately more than 10 cases / day	90%	9%
3. Emergency and causality services				
3a.	Teaching Hospital	Approximately 550–600 cases every day	10%	4%
3b.	Trauma and Orthopaedic Institute	Approximately 60 cases every day	10%	0%
4. Police and justice				
4a.	Law & Order	Approximately 2 or 3 cases every day in 1 police station limit 400 cases / day within the city	10–25%	1%
4b.	Traffic	Approximately 300–500 cases / day	30–50%	2%
5.	Family Court	Approximately 40 cases / day	15–20%	10%

ing such information were generally inadequate. Few of the agencies surveyed had institutionalized systems for recording cases of alcohol harm to others, such as case notes, set forms, computer entries and other methods for tracking such data. The few who had such systems were mainly the women and child service agency, a national drug law enforcement agency and the mental health unit of a major teaching hospital.

Underestimating Alcohol's Harm to Others. The Indian data below in Table 3 (Benegal et al., 2014) provide an excellent example of the consistency between estimates reported by KIs and documented cases within systems, especially in terms of under-reporting in the records as compared to estimates. In only one organisation was there high congruence between estimated and documented alcohol links, and the KI acknowledged that this question related more to the intoxication of the patient (which was critical information in such serious cases) than to whether the patient had been harmed by others' drinking.

In all of the other organisations KIs reported much higher levels of alcohol involvement than was documented in the formal reporting systems.

Case study examples of alcohol's harm to others

The following cases provide in depth examples of the types of harm to others identified across different countries as well as provide indications of how such data is recorded in these countries.

In this first example, the AHTO from drinking was a key feature of the complaint brought to the attention of the Medi-

ation Board. Neighbours and police are to be involved in documenting the problem and hopefully in resolution. However, this information will be unlikely to be taken further unless complaints of this kind are tallied, either manually or electronically in a database.

> AHTO from neighbours (Sri Lanka): The KI mentioned that recently a case was brought forward to the board where the neighbour complained about the disorderly conduct of his fellow neighbour who shouts at night after drinking, which has turned in to a public nuisance. Several other neighbours too have confirmed the complaint. Thus the Board has called upon this individual and has warned him about the possible legal penalties which could be taken against him and have advised him to behave in an appropriate manner. The neighbours were also asked to monitor and report the particular individual's behaviour so that necessary measures could be taken if he behaves improperly. (Hettige et al., 2014)

It seems this woman affected by harm from others' drinking will be brought to the attention of a home for young women, but not the hospital in this case, nor the police. The agency takes case notes, but information on this crime is unlikely to be recorded by police or health agencies.

> AHTO from strangers (India): Ms. S is a young college student aged about 18 years who had to discontinue college due to poverty and started working in a garment factory. One day, on her way back home, a group of boys on the street makes lewd comments. They are drunk and are not in their normal senses. They molest her one after the other. While protecting herself, she stabs one of them with a sharp knife and injures him. Seeing one of their friends bleeding, the boys run away and escape from the scene and also from the police. In the melee S has had minor injuries and is lying bleeding on the road. A passerby informs the women's help line, rescues her and brings her to the institution. [Government Reception Centre for Girls] (Benegal et al., 2014)

In this third example, police and health systems are intensively involved in managing a rape and assault. Justice systems also come into play to assist the victim and discipline the perpetrator of the crimes.

> AHTO and intimate partner violence (Thailand): Miss A, aged 18, graduated from secondary school in north-eastern Thailand. She migrated to work in a factory in Bangkok and met Mr B. who also came from the same region. They fell in love and shortly decided to live together without parental recognition. Before staying together, Mr B drank only occasionally. After only a short period together, the behaviour of Mr B changed. He became a regular drinker, more jealous and often abused Miss A. He was often violent towards Miss A after drinking, and often accused Miss A of adultery. Miss A later decided to separate, and live on her own nearby because she could not tolerate any more abuse and pain from Mr B. The day that changed Miss A's life forever

> is the day that Mr B. was again drunk with his friends. Mr B dragged Miss A to his room and abused her with all of his force, finally he spilled petrol over her body and then burned her. Her neighbour came to help, but that was too late. Now, Mr B was penalized with 17 years' imprisonment and left Miss A. in pain and sorrow [(KI, Women's NGO and Thairath, 2010)]. (Waleewong et al., 2015)

In a final and serious example (see below), hospital and child protection services are required to manage the harm to a young boy from others' drinking. At the hospital, the handwritten medical case history may or may not describe the circumstances of the boy's injury, depending on whether the staff consider it relevant to the boy's immediate treatment plan. It is the action of the passerby, effectively acting as a case manager (transferring information and the boy) that ensures the child's health and child protection needs are met. It is likely that the ongoing problem of his father's drinking is considered a factor relevant to decisions about the boy's future. However, whether the passerby called the police is not noted. It is apparent that the key informant at the boys' home was acutely aware of the consequences of harm from others' drinking. Although multiple systems are substantially involved in this instance it is possible that alcohol has not been detailed as involved in the case at all (with the only record being the passing on of the story orally by the passerby and the boy to the key informant), let alone in a systematised way. That the boy was working underage may also be related to the inability of the father (and mother) to provide for the family given the fathers' spending on alcohol.

> Harm to children (India): Mr. Z is an aspiring student aged about 8 years. He left school and was working in a tobacco factory. His father is an alcoholic and drinks every day at home both at day and night. Returning home, after the day's work, Z saw his father on the way. His father repeatedly pestered him for money to buy liquor and repeatedly the boy refused. His father, who was under the influence of alcohol, stabs him with a beer bottle and injures him. In the situation, the boy has had major injuries to his stomach and there was loss of blood. A passerby rescued and hospitalized him and brought him to the Boys' Home. (Benegal et al., 2014)

In summary a number of issues are common to all of the case examples: Often it seems that the actions of neighbours and "passers-by" are integral to the reporting and management of the harm. It is evident that serious cases often involve multiple systems in the responses required to respond to problems associated with others' drinking. There is little evidence of systematic reporting of the role of others' drinking in cases.

Discussion

While a number of studies in Australia, the United Kingdom, Europe and the United States (Manton & Maclean, 2015; Manton, MacLean, Laslett, & Room, 2014; Orford, Velleman, Copello, Templeton, & Ibanga, 2010; Velleman, Templeton, Reuber, Klein, & Moesgen, 2008; Young & Timko,

2015) have studied qualitatively and summarised the harms experienced because of others' drinking, few studies have examined these harms as they occur within systems at the micro-level. Rarely have studies examined the costs to systems of alcohol-related harms to others (Laslett, Catalano, et al., 2010) and to the family (Copello, Templeton, & Powell, 2010); this has only been undertaken in a small number of high income countries with well developed systems for record management. The need for better estimates of and systems to record and manage alcohol-related harms to others is apparent globally (World Health Organization, 2014), and particularly in LMIC. Uniformly it was found in this study that recording systems did not routinely collect AHTO data, yet case stories from the countries provided examples of the nature of many severe problems, illustrating the links between them and others' heavy drinking. Interest in proper documentation of cases of harm to others from alcohol use in these agencies is clear and arises because of the centrality of substance abuse to the everyday workload in these agencies.

Nearly all agencies surveyed acknowledged seeing clients who were negatively impacted by other people's drinking. In many sectors, the 'other' whose drinking caused harm to the client was usually a spouse or family member, and more rarely a co-worker or neighbour. In the health sector, the patients seem to have been more likely to have been affected by a stranger's drinking in car crashes or street assaults. Physical harms included road traffic accidents, assaults, quarrels, fights, injuries, harassment, and domestic violence. Child battery by alcohol-using parents, especially fathers, was reported, as were economic harms to others, including indebtedness by drinkers, inability to provide for their family, loss of property and stealing from family members. The cost of treatment for an injured alcohol user or for injuries caused to a family member was also included in this category of harms. Social harms included divorce or marital dissolution, discontinuation of children's education, abandonment of family and illegal and criminal acts. Occupational harms to others included unemployment and poor productivity, arising from hangovers and hospitalization due to alcohol-related health problems.

Alcohol's involvement in domestic violence was a prominent issue in all countries, with all women's agencies approached concerned about alcohol's role. The harms to children were highlighted also, particularly in India. In Thailand, health and social service systems emphasised that most of the violence against women and children cases was registered as physical and sexual assaults. Many of these victims were the more severe cases, and were frequently brought to service agencies by someone else rather than walking in by themselves. These findings have synchronicity with recent UNICEF report findings that indicate that, while there is progress in development of child protection systems in East Asia, there has not yet been implementation of structural reforms to enable holistic and integrated service provision (United Nations Children's Fund, 2015). Thus, many low-income countries have national legislation and a national body responsible but not as yet comprehensive child protection systems, and responses were still recent-

ly summarised as "ad hoc" by UNICEF (United Nations Children's Fund, 2015). It should however be noted that some countries covered by the scoping study (namely Chile, Thailand and Sri Lanka) have enacted comprehensive child protection legislation and established national institutions to address child protection issues like abuse and exploitation of children.

Health care systems, especially hospital emergency departments, become the most common front line system for victims of others' drinking in LMICs. Thai crisis management services provide an excellent model for multi-sectoral management in such circumstances. For instance, One Stop Crisis Centers (OSCC) were set up in 2000 under the Ministry of Social Development and Human Security as a government policy response to family violence. The OSCCs are located in all provincial hospitals, normally close to the emergency room. Only a minority of cases present at other social welfare services or to the judicial system.

A majority of the agencies, when probed more deeply about cases of alcohol's harm to others in their agencies, indicated that they did not possess a comprehensive system for tracking emerging information. The key informants from the many institutions involved expressed willingness to document phenomena related to AHTO, a promising sign for any effort to develop systems for this. The Nigerian scoping study report summarised,

> "Some [organisations], especially Civil Society Organizations (CSOs) and hospitals, expressed the view that such systems will be put in place because they've now realized the need to collect such data for the purpose of understanding the problem and developing appropriate intervention strategies." (Obot et al., 2014)

It is apparent that most systems still focus on the person at hand, with reporting on harms from others systematically absent. The health system is perhaps most obviously tied to a focus just on managing the individual patient. Systems and services that take responsibility for children are arguably better positioned to be concerned about harms from the actions of others and do take such factors into consideration. There is variation between countries and between organisations providing services for women in describing the role of alcohol in domestic violence, with some countries, e.g., Nigeria, judging alcohol's role as negligible, while substantial proportions of such harms are attributed to alcohol in Thailand. This contrast mirrors that found in the population surveys in these countries, in terms of respondents' reports of harms from others which they attribute to the others' drinking. In Thailand it was noted that "most clients/victims who used services were identified as severe cases (such as with physical injuries)". These clients represent the tip of the AHTO iceberg; the health sector (and particularly the emergency departments) may be particularly useful functioning as frontline services for AHTO victims. This model has been employed in crisis management services for women.

Police force and health services key informants across all countries did not mention alcohol's role in violence between men and traffic crashes as much as its role in family violence, perhaps because these

issues are viewed predominantly as concerns which affect drinkers, ignoring the externalities and effects upon others. Although alcohol-related road traffic crashes (World Health Organization, 2013) and assaults (World Health Organisation, 2011) are recognised as substantial issues in LMIC (Patel, Chisholm, Dua, Laxminarayan, & Medina-Mora, 2016), this was not in focus for the key informants. A recent WHO report noted that almost half of all countries world-wide do not have data on alcohol-related road deaths (World Health Organization, 2013). In 2016 the WHO emphasised that LMICs have a high burden of alcohol-related problems (without even effectively factoring in alcohol's harms to others) and a medium to low level of policy interventions that target alcohol-related problems (Patel et al., 2016).

Widespread, systematic reporting of alcohol's harm to others in response agency data sets is also not uniform in higher income countries, such as Australia and the US. While data on some social and health consequences are captured at state and national levels, the presence of drinking or intoxication leading to these consequences is often only fitfully recorded in case notes (Cherpitel, 2012; Laslett, Catalano, et al., 2010). Individual state electronic databases do record alcohol's involvement via a computerised tick box system in family violence cases attended to by police and in some child protection data systems in Australia, but in other cases the data is less reliable, with police in many Australian states reluctant to routinely record intoxication as an element in assaults (Laslett, Mugavin, et al., 2015). In Canada a census of child protection agencies is used to record alcohol's involvement in child protection cases (Trocme et al., 2005). Alcohol is reported upon routinely in child protection systems only in a small number of states in the US, although it is nearly universally regarded as a risk factor (Centers for Disease Control and Prevention, 2008). Such examples illustrate how AHTO can be integrated in current routine records and foreshadow the potential introduction of such systems in LMIC. However, given the sporadic reporting of AHTO in high income countries, recommendations for how best AHTO might be reported have been included here and are relevant globally.

Key recommendations for recording alcohol's harm to others

Health systems do not routinely assess whether the patient, let alone the person they were harmed by, was intoxicated. For unconscious and other patients unable or unwilling to discuss their own drinking patterns, objective signs of intoxication (e.g., breath or blood alcohol content) should be recorded. A marker of intoxication of patients should record patient intoxication as: a) yes, b) probably, c) no, and d) unknown. Assessment of others' drinking is only possible via interviewing the patient (or other family members, bystanders or agency personnel involved in bringing the patient to the attention of the health service)

This should be reported as a) yes, one or more person held responsible was intoxicated, b) probably one or more persons held responsible were intoxicated, c) no he/she/they were not intoxicated, or d) this is unknown.

Police systems commonly collect breath and blood alcohol content as part of roadside testing after traffic crashes. This practice should be expanded and results routinely incorporated into case reports and electronic data collection requirements for road traffic incidents. This practice could be expanded to include blood or breath alcohol content testing of persons arrested for assaults. Where impractical, markers of intoxication (see above) as assessed by police could be routinely recorded in case notes and electronic data records. This information is commonly not linked to ambulance, hospitalisation or death records of patients affected in these crashes or assaults. Transfers between systems should be traceable via unique identifiers or included in documentation handed on.

Child protection agencies often collect information on the risk factors in the family that are relevant to the welfare of the child and that are taken into account when interventions are determined. This commonly includes whether the parents and carers of the child have alcohol-related problems, and this is typically recorded in Europe, the US and Australia as 'alcohol abuse' and in the UK as 'alcohol misuse'. This information should be consistently included in casenotes and electronic databases, again as a) yes, b) probably, c) no, and d) not known. Ideally this field should compulsorily be completed.

Women's services and family violence response agencies Routine recording and estimates of whether men held responsible for family violence have alcohol abuse problems in these services were not identified in the studies drawn upon by the authors in this paper. Again this information should be consistently included in casenotes and electronic databases: whether alcohol abuse or misuse by the person held responsible is involved in the harm: a) yes, b) probably, c) no, and d) not known. Ideally this field should again compulsorily be completed.

Conclusion

The scoping studies undertaken in the six WHO/ThaiHealth describe the most serious forms of harm from others' drinking and the diverse array of services that respond to harms to children, women, accident victims and other community members from others' drinking. If the focus is only on the welfare of individual clients, with little or no recognition of the role of others' drinking in their victimization the potential for change is limited. While many organisations are replete with examples of harm and aware that AHTO contributes to a substantial proportion of their caseloads, there are virtually no systems for reporting or routinely collecting information on alcohol's harm to others. Recognition by NGOs and government organisations of harm from other's drinking is likely to initiate responses. Consequentially, the information gathered in these scoping studies is critical for informing policy makers, NGOs and governments about the extent and impact of harm associated with heavy drinking evident across multiple government, non-government and private service sectors. The recommendations outlined identify important steps that will improve data collection across multiple sectors and enable LMIC to better identify and respond to alcohol's harm to others.

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