Alcohol-related harm in families and alcohol consumption during COVID-19

CFCA PAPER NO. 60

Claire Farrugia and Trina Hinkley

Child Family Community Australia | information exchange
## Contents

Summary ....................................................................................................................... 2

Introduction .................................................................................................................. 3
  Alcohol consumption during and after disasters ......................................................... 3
  Impact of COVID-19 .................................................................................................. 3

Methodology .................................................................................................................. 4

What does the evidence indicate? ................................................................................. 5
  Changes in alcohol consumption during COVID-19 .................................................. 5
  Key factors influencing alcohol consumption ............................................................ 6

Alcohol-related harms ................................................................................................. 8
  Identifying alcohol-related harms .............................................................................. 8
  COVID-19 alcohol-related harms .............................................................................. 9
  Harm minimisation approach to alcohol consumption .............................................. 11
  Actions to minimise alcohol-related harms ............................................................... 12
  Maximising the health and wellbeing of the family .................................................. 14

Conclusion ................................................................................................................... 15

Authors and acknowledgements ................................................................................. 15

Further resources ......................................................................................................... 15

References .................................................................................................................... 16

Appendix A: Study inclusion criteria ......................................................................... 20

Appendix B: Included empirical studies ..................................................................... 21
Summary

This paper explores alcohol-related harm within families and the best available evidence on alcohol consumption during the restrictions related to COVID-19 in Australia, from March to July 2020. Drawing on a scoping review of survey data and established evidence, the paper explores what alcohol-related harm looks like, what we know about alcohol consumption and alcohol-related harm during the early stages of COVID-19, and how practitioners can adopt a harm-minimisation approach when working with clients.

This publication is intended to provide the basis for practitioners without specialist alcohol and other drug training to gain a greater understanding of how alcohol consumption changed during COVID-19, to better understand potential alcohol-related harms, and to develop strategies to support clients who may be experiencing harm themselves or in their families.

Key messages

- Alcohol-related harm in a family can present in a number of ways, from interrupted sleep and difficulty caregiving through to experiencing or perpetrating abuse and violence. While small amounts of alcohol can cause harm, the level of harm can differ according to the circumstances of a family.

- Evidence shows that there can be changes in alcohol consumption during large-scale disasters and this may increase harm in families.

- While a large proportion of people maintained their consumption of alcohol at pre-COVID-19 levels during March–July 2020 in Australia, people reporting higher levels of stress and women were more likely to increase their alcohol consumption.

- During COVID-19, several factors may result in increased alcohol consumption, including greater stress levels, being bored and spending more time at home.

- A short discussion with clients in the form of a ‘brief intervention’ can help identify current or potential alcohol-related harms and appropriate referral pathways when significant harm is present.
Introduction

Drinking alcohol can be a source of pleasure and social connection (Harrison, Kelly, Lindsay, Advocat, & Hickey, 2011; Keane, 2009). However, even low levels of alcohol consumption can contribute to harm. Alcohol can impact physical and cognitive functioning, impair a sense of caring responsibility, reduce time or money available for basic needs or unsettle the attachments children and parents share with each other and with extended family members (Bergmans, Coughlin, Wilson, & Malecki, 2019; Lander, Howsare, & Byrne, 2013; World Health Organization [WHO], 2006). Harms can be immediate, such as those experienced from alcohol-induced family violence, or longer term, such as impacts on young people's alcohol consumption behaviours.

Alcohol-related harms can include a general disruption to the wellbeing of family members. Family wellbeing includes the mental and physical health of parents or caregivers, the ability of a family to meet its own basic needs in terms of housing, food and support, and the resilience of a family unit to manage conflict or stressful situations in a way that supports the growth of adults and children (Newland, 2015). Families can include a variety of caring relationships between people who are, or are not, biologically related and who live in the same house or live separately. High-quality evidence shows children's adjustment to new and stressful situations is related to the strength and cohesion of relationships in a family. As a result, the current paper is focused on the relationship between the parent/carer and the child in the context of alcohol-related harms (Browne, Plamondon, Prime, Puente-Duran, & Wade, 2015; Daniels & Bryan, 2021).

Alcohol consumption during and after disasters

The last decade has seen a global increase in extreme weather conditions and natural disasters. In Australia, much of the population experienced extreme heat, bushfires, floods or cyclones. These events have adversely affected the health and wellbeing of families (Bryant et al., 2017; Molyneaux et al., 2020; Taylor et al., 2010). Experiencing stressful events can increase a person’s alcohol consumption (Keyes, Hatzenbuehler, & Hasin, 2011) to help reduce tension and cope during such times (Blevins, Abrantes, & Stephens, 2016). While there are different aspects to how an infectious disease outbreak and a natural disaster affect wellbeing, they can both involve an abrupt change in daily routine and an increased sense of uncertainty (Esterwood & Saeed, 2020).

However, evidence of how alcohol consumption and alcohol-related harms change after large-scale disasters is limited (Reifels, Mills, Dückers, & O’Donnell, 2019). Evidence from the US points to a reported increase in alcohol consumption after people experience terror events (Boscarino, Adams, & Galea, 2006; Keyes et al., 2011), an increased risk of alcohol use disorder after human-made disasters such as transport accidents, mass shootings or purposely lit fires (Reifels et al., 2019) and higher levels of drinking and more binge drinking following natural disasters (Cerdá, Tracy, & Galea, 2011). Less consistent evidence is available on how long these changes in alcohol consumption last after these events (Keyes et al., 2011).

Changes in alcohol consumption are not uniform across a population exposed to disaster. Pre-existing factors also shape how much people change their alcohol consumption (Collins, 2016; Esterwood & Saeed, 2020). People who experience social and economic adversity, such as those with lower income levels, are likely to experience greater social and financial impact from exposure to natural disasters. This can affect their alcohol use and widen existing health disparities (Cerdá et al., 2011).

Impact of COVID-19

In March 2020, COVID-19 reached the status of global pandemic. Federal and state governments in Australia introduced social distancing measures and ‘lockdowns’ to slow the spread of the virus. This resulted in substantial changes to living arrangements and conditions for many individuals and families. Many parents were required to work from home while others lost their employment and income. With school restrictions in place, children continued schooling from the family home.

By the end of April 2020, 46% of Australians said that they were working from home and approximately a third of Australians (31%) aged 18 years and over reported that their household finances had worsened due to COVID-19 (Australian Bureau of Statistics [ABS], 2020b). Parents and families experienced multiple stressors that continued into mid-2020, the most widespread of which was loneliness (14% of people Australia-wide) (ABS, 2020d). Mental distress increased during this time with two in five Australians (42%) reporting that they felt restless or fidgety at least some of the time (compared with 24% in the 2017-18 National Health Survey) (ABS, 2020b).
One in three Australians (35%) felt nervous at least some of the time (compared with 20% in the 2017–18 National Health Survey).

Alcohol consumption can change in times of mental distress. In the context of COVID-19 and associated lockdowns, assessing the extent of this change and the factors that influence it can help identify potential alcohol-related harms.

This paper presents evidence about alcohol-related harms, alcohol consumption at the beginning of the COVID-19 pandemic in Australia and family health and wellbeing. The aims of the paper are to support non-alcohol specialist practitioners (family violence practitioners, youth workers, child protection caseworkers and so on) who work with families to:

- understand what alcohol-related harm is in the family and how to identify harm
- understand how alcohol use changed at the beginning of the COVID-19 pandemic in Australia
- understand the factors that contributed to changes
- understand the harm minimisation approach to alcohol consumption
- work with families to identify and use appropriate strategies to minimise alcohol-related harms.

**Methodology**

A scoping review was undertaken to assess best available evidence on alcohol-related harm, alcohol consumption during the COVID-19 pandemic in Australia and the health and wellbeing of families. The review followed the steps outlined by Arksey and O’Malley (2005):

1. Identify the research question.
2. Identify relevant studies with comprehensive search strategies that are documented and can be reproduced.
3. Based on an understanding of the literature, establish inclusion/exclusion criteria as the basis for deciding on studies that are credible and will contribute to answering the research question.
4. Analyse the studies to sort and categorise the available evidence and knowledge in a useful way to answer the question.
5. Collate the various findings of the studies and present the results in various forms depending on the type of studies included.
6. Consult and engage with stakeholders as means of checking the validity and utility of the analysis.

The primary research question for the review was: Did alcohol consumption change in families during the COVID-19 pandemic in Australia? The secondary question was: What impact does alcohol-related harm have on family wellbeing?

The search strategy was guided by inclusion criteria (see Appendix A). The databases searched were: Web of Science, APA PsycInfo, Medline, Scopus and Google Scholar. Google was also searched for survey material that had not yet been peer-reviewed. An initial search was conducted with a combination of key words including: ‘alcohol’, ‘alcohol consumption’, ‘drinking behaviour’, ‘alcohol interventions’, ‘risky drinking’, ‘COVID-19 or coronavirus’ and ‘Australia’.

Empirical studies were included if they recorded the prevalence of alcohol consumption, change in consumption over time and factors associated with alcohol consumption during COVID-19 in Australia. Articles were also required to meet the inclusion criteria in Appendix A and were excluded if they focused on the health impacts of alcohol on someone who has contracted COVID-19 or had a focus on, or were published by, the alcohol industry. The database literature search identified 196 publications. After excluding articles that did not fit the criteria and removing duplicates, 25 articles remained on the topic of alcohol consumption during COVID-19. In those articles, 10 sources of Australian alcohol consumption data were identified that were collected in the period from March to May 2020 and one source of data collected in June–July 2020. These 11 studies became the focus of this review (see Appendix B).

Secondary searches were conducted to target the impact on family health and wellbeing, key words included: ‘family’, ‘family wellbeing’ and ‘alcohol consumption’. Due to limited results, the search was expanded to include ‘disaster’, ‘natural disaster’, ‘mental distress’ and ‘stress’ to provide context for changes in alcohol consumption during periods of widespread mental distress. Additional publications were included in the broader discussion in this paper when they provided contextual evidence on alcohol use during and after natural and human disasters.
Further searches were undertaken to identify tools and guidelines that assist practitioners to identify alcohol-related harms and engage in harm minimisation. These searches were conducted in Google. While the included studies on alcohol in Australia were limited to 2020, older literature was included where it provided important context. Publications included peer-reviewed and other publicly available reports from reputable sources.

Of the 11 included surveys, only four were peer-reviewed and the remaining seven were not subject to peer review prior to publication. The sample size ranged from 319 to 14,632. Small sample sizes can limit how much the findings can be generalised to other population groups. While the studies provide useful insights into alcohol consumption during COVID-19, some caution should be exercised in interpreting results as they are limited in their ability to represent changes across the Australian population.

What does the evidence indicate?

Limited research data exist on the prevalence and characteristics associated with parental alcohol use in Australia. Data from the 2007 and 2013 Australian National Drug Strategy Household Survey suggest that parents are more likely to report being moderate drinkers, less likely to report being abstainers and less likely to report being risky drinkers than non-parents (Laslett, Jiang, & Room, 2017). Parents are also less likely to exceed alcohol guidelines than people who are not parents (Bowden, Delfabbro, Room, Miller, & Wilson, 2019; Maloney, Hutchinson, Burns, & Mattick, 2010). Therefore, parents may engage in less harmful alcohol consumption behaviours than adults who do not have children.

Some differences between parental roles are also evident. For instance, some data from the 2007 Australian National Drug Strategy Household Survey suggest that single mothers were more likely to report binge drinking, compared to mothers from couple families (Dawe et al., 2007; Maloney et al., 2010). However, mothers are also more likely to report being abstainers than fathers (Laslett et al., 2017) and fathers are more likely to exceed alcohol guidelines than mothers (Bowden et al., 2019). Overall, parents are more likely to report drinking in the home than non-parents (Bowden et al., 2019).

Changes in alcohol consumption during COVID-19

The evidence included in this review suggests that COVID-19 and its associated stressors changed alcohol consumption in Australia for some people (ABS, 2020a; Biddle, Edwards, Gray, & Sollis, 2020; Callinan et al., 2020; Neill et al., 2020). For many, their frequency and quantity of alcohol consumption either stayed the same or declined compared with pre-pandemic levels (ABS, 2020c; Biddle et al., 2020; Callinan et al., 2020). However, for those reporting higher levels of stress and for women aged 36-50 there was an increase in alcohol consumption. This varied pattern of change is similar to changes in alcohol consumption previously reported in international studies exploring alcohol consumption during times of high collective stress (ABS, 2020a; Biddle et al., 2020; Callinan et al., 2020; Neill et al., 2020; Nordløkken, Pape, Wentzel-Larsen, & Heir, 2013).

<table>
<thead>
<tr>
<th>Decreased alcohol consumption during COVID-19</th>
<th>Increased alcohol consumption during COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Young people aged between 18-25</td>
<td>• Women aged 36-50</td>
</tr>
<tr>
<td>• Young women aged 26-35</td>
<td>• People experiencing high levels of stress</td>
</tr>
<tr>
<td>• Men aged 51-65</td>
<td>• Men with a decrease in hours worked</td>
</tr>
</tbody>
</table>

Stable alcohol consumption: Eleven sources of data explored the potential effect of COVID-19 in Australia on adult alcohol consumption (see Appendix B). Between 38% (Foundation for Alcohol Research and Education [FARE], 2020a) and 47% (ABS, 2020a) of Australian adults maintained stable alcohol consumption. The ABS reported differences between men and women, with more men (54%) than women (40%) reporting stable alcohol consumption levels (ABS, 2020a).

Decreases in alcohol consumption: The Centre for Alcohol Policy Research at La Trobe University asked 1,684 Australians about how their alcohol intake during May 2020, two months into social distancing, compared to levels before the COVID-19 outbreak (Callinan et al., 2020). All groups of people except men aged 26-35 decreased their risky drinking frequency. Further, the following three groups of adults decreased their overall alcohol consumption (Callinan et al., 2020):

- • young people aged 18-25
- • young women aged 26-35
- • men aged 51-65.
A decrease in alcohol consumption was also reported by the Centre for Social Research Methods at the Australian National University in their 34th ANU Poll of 3,219 people (Biddle et al., 2020). In May 2020, around two months after the introduction of the first COVID-19 lockdown in Australia, 27% of people reported drinking less (Biddle et al., 2020).

The proportion of men (27.5%) and women (26.7%) reporting decreases was similar. A smaller survey of 319 commissioned by Hello Sunday Morning showed that, during the March lockdown, the biggest overall change in drinking patterns was an increase in the number of people drinking less. After the first two weeks of lockdown, 22% of people were drinking less, and this figure rose to 29% after seven weeks in lockdown (Hello Sunday Morning, 2020). Assessing a later period of time, the ABS reported a similar trend with 1,022 adults: 9.5% of those surveyed in April/May 2020 reported decreased alcohol consumption (ABS, 2020a). Overall, Roy Morgan (2020) reported that 66.3% (13,073,000) of Australians aged 18+ in the year to March 2020 had consumed alcohol in an average four-week period, a slight decrease from 67.5% (13,102,000) from 12 months previous.

In June–July, the Gambling in Australia during COVID-19 study conducted by the Australian Gambling Research Centre, Australian Institute of Family Studies, surveyed 2,019 participants and reported decreases in people drinking four or more times a week (Jenkinson, Sakata, Khokhar, Tajin, & Jatkar, 2020). Despite higher levels of alcohol consumption overall, decreases in drinking were also observed among men and young people aged 18–34 years and there was an increase of people reporting that they ‘never’ consumed alcohol from before COVID-19 to June 2020 (Jenkinson et al., 2020).

Increases in alcohol consumption: Across studies, the proportion of people who reported increasing their alcohol consumption ranged from 14% (ABS, 2020a) through to 20% (Biddle et al., 2020) in May 2020. Some differences between population groups, and different types of drinking behaviours, were also evident.

For instance:

- Three times more people (14%) reported drinking daily in April–May 2020 compared to January 2020 (5%) (FARE, 2020a).
- Eighteen per cent of women and 10% of men reported increasing alcohol consumption in May 2020 (ABS, 2020a).
- Women aged 36–50 reported an increase in both the frequency and quantity of consumption between April and May 2020 (Callinan et al., 2020).
- People experiencing high levels of stress reported relatively higher levels of consumption than those with lower levels of stress between April and May 2020 (Callinan et al., 2020).

In the FARE poll, one in five (20%) households reported buying more alcohol than usual since the COVID-19 outbreak in Australia. In households where more alcohol was purchased than usual (n = 202), 70% reported drinking more alcohol than usual since the COVID-19 outbreak in Australia (FARE, 2020a). Patterns in alcohol consumption also changed from May 2019 to May 2020. In comparison to previous years (30.3% in 2017-18), 33.8% of men reported drinking on three or more days per week. The increase was more substantial for women, increasing from 16.2% in 2017-18 to 21.9% in the year up to May 2020 (Biddle et al., 2020).

Key factors influencing alcohol consumption

A number of factors may have influenced changes in alcohol consumption during COVID-19. These include gender and carer status, employment status and income, age, mental health, and pre-COVID consumption patterns. However, the selected surveys asked different questions and used different methods to assess what factors were associated with alcohol consumption. Differences between surveys limit the evidence on why these factors are associated with an increase or decrease in alcohol consumption.

Gender and carer status

Women were more likely to have increased, and slightly less likely to report having decreased, their alcohol consumption than men during COVID-19 (ABS, 2020a). Evidence suggests that women, rather than men, increase their alcohol consumption when confronted with conflicting work and family duties (Kuntsche & Kuntsche, 2020). By May 2020, 76% of Australians with children in their household kept them home from school or child care (ABS, 2020a). Women were almost three times as likely as men to look after children full-time.
and on their own during May 2020 (ABS, 2020a). Of women who were primary carers, 28% reported increased alcohol consumption compared with 21% who were not primary carers (Biddle et al., 2020). This difference is not statistically significant but may represent a trend that could be better accounted for with a larger sample size. The relationship between hours worked and alcohol consumption appears to be different according to gender. Men who decreased their number of hours worked or lost their job between March and May 2020 increased their alcohol consumption (Biddle et al., 2020). Women reported an increase in alcohol consumption regardless of whether their work hours remained stable or decreased (Biddle et al., 2020).

**Employment status and income**

Employment status and income do not have a consistent relationship with changes in alcohol consumption. Studies on natural and terror disasters have found lower income is associated with increased drinking (Cerdá et al., 2011). Conversely, studies on public health emergencies, such as exposure to the epidemic severe acute respiratory syndrome (SARS), reported that higher income levels was associated with increased alcohol use (Wu et al., 2008).

In the COVID-19 and you: mental health in Australia now survey (COLLATE) project of 4,462 adults, an average or higher income was associated with increased alcohol use in May 2020, after the onset of the pandemic (Neill et al., 2020). This finding may suggest that people who were able to afford to drink more alcohol increased their consumption. However, the 34th ANU Poll suggests that a decrease in hours worked is also related to an increase in alcohol consumption.

Among men who worked fewer hours over February–April, 27.2% reported that their alcohol consumption increased, with a similarly large increase (but large standard errors) for those who stopped working between February and April (27.6%). For men whose work hours stayed the same or increased between February and April 2020, there was an increase in alcohol consumption by 15.8% and 16.5% respectively (Biddle et al., 2020). For women, on the other hand, those who had a decrease in hours worked had roughly the same level of increased alcohol consumption as those whose hours stayed the same (30.0% and 31.1%).

**Age**

Young Australians aged 18–25 reported a decrease in alcohol consumption during April–May 2020 (Callinan et al., 2021). While Callinan and colleagues (2021) were not drawing on a representative sample of the Australian population, the data provide an insight into a trend that may be related to COVID-19. Several factors may have influenced this change. Under lockdown, parents spent more time at home and may have been able to supervise children and young people in a way that they were not normally able to. Parental supervision has previously been associated with lower levels of alcohol consumption in adolescents (Wood, Read, Mitchell, & Brand, 2004).

Opportunities to consume alcohol outside the home were also limited as alcohol outlets such as pubs and clubs were closed or restricted the number of patrons (Callinan et al., 2021). Additionally, states that experienced severe lockdowns, such as Victoria, restricted young people’s opportunity to visit friends and be away from home after enforced curfew times. This would have restricted opportunities to consume alcohol outside the home in social settings.

Older age groups may have found it easier to access alcohol. Women aged 36–50 showed the highest increase in both their frequency and quantity of consumption during mid-April and May 2020 (Callinan et al., 2020).

**Mental health**

Multiple studies indicated that higher levels of stress during 2020 were associated with reported increases in alcohol use (ABS, 2020a; Callinan et al., 2020; Neill et al., 2020). For those who did increase their alcohol consumption in May 2020, the most common reason for both men (67%) and women (63%) was spending more time at home (Biddle et al., 2020). The next most common reason for women to increase their drinking was increased stress (42%). For men, the second most common reason was boredom (49%) (Biddle et al., 2020).

While reports of being bored began to decrease after the first seven weeks of the April lockdown, reports of anxiety and stress as factors influencing alcohol consumption started to rise (Hello Sunday Morning, 2020). Anxiety was not as closely related to increased alcohol consumption as depression and stress (Neill et al., 2020; Stanton et al., 2020). Drinking to cope with stress was most apparent in the 18–49 age groups (10–13%) and less a concern for those aged over 50 (5%) (FARE, 2020a).
Pre-COVID drinking patterns

While pre-COVID drinking patterns were not a factor reported in all surveys, previous studies on alcohol consumption after large-scale disasters have found that people who drank heavily before the disaster were more likely to increase their drinking following the disaster (Heslin et al., 2013). This includes people who may have had pre-existing alcohol disorders (such as dependence) and were most likely to report increased drinking after such events (North, Ringwalt, Downs, Derzon, & Galvin, 2010).

The June–July Gambling in Australia during COVID-19 survey found that around one in seven participants (15.3%) did not drink alcohol in either period (classified as ‘non-drinkers’), while 4.8% drank before COVID-19 but not during, and 2.4% drank during COVID-19 but not before (Jenkinson et al., 2020). On the other hand, people who reported heavy drinking (10 or more standard drinks per week) prior to COVID-19 were more likely than those who were not heavy drinkers to report an increase in alcohol consumption during 2020 (Neill et al., 2020). This may have been context-dependent, however, as Callinan and colleagues (2021) found that high-risk drinkers who had a low level of home-based drinking in 2019 decreased their drinking during the pandemic. This finding suggests that reduced options for consumption outside of the home may change the behaviour of high-risk drinkers.

Drawing conclusions

The available data suggest that a large proportion of the Australian population decreased or maintained their level of alcohol consumption in the early stages of COVID-19. A decrease in alcohol consumption could have been influenced by the lack of social outlets to drink, mental distress or difficulty reaching alcohol outlets (Callinan et al., 2020). For those who maintained previous consumption levels, a rise in stress, loneliness and a decrease in socialising did not contribute to a change in drinking patterns.

For the one in five people who increased their consumption, COVID-19 changes could have played a role. Increases in alcohol consumption may have been driven by gender, older age, employment status or income level, pre-COVID-19 drinking patterns and mental health. There could also be factors at play that were not asked about in the current surveys. For example, housing and household composition such as living alone or living in a share house, cultural norms around drinking, the location where people drank alcohol and so on. There is a significant gap in the data relating to Aboriginal and Torres Strait Islander people’s experiences of alcohol consumption during COVID-19. A gap in data also exists for the experiences of culturally and linguistically diverse communities and LGBTIQA+ communities.

Regardless of which factors have contributed to potential increases in alcohol consumption, or the level of consumption, harm may be experienced by people and their families. There can be alcohol-related harm from even low levels of alcohol consumption, regardless of whether consumption occurs during stable times or those of disaster. The following section explores the types of harms that may result from alcohol consumption.

Alcohol-related harms

The previous sections have explored how Australians’ alcohol consumption was influenced by COVID-19. This section provides suggestions for practitioners to help identify and minimise alcohol-related harms.

Identifying alcohol-related harms

The last 20 years has seen a significant shift in how alcohol consumption is perceived in global public health research and policy. The traditional model of ‘alcoholism’ versus ‘normal drinking’ has been replaced by an understanding that alcohol consumption can range from no use or abstinence through forms of social use to alcohol dependence (Australia’s National Research Centre on Alcohol and Other Drugs Workforce Development, 2021; Nicholas, Roche, Lee, Bright, & Watsh, 2015). The experience of alcohol-related harms can differ between individuals, and the amount of alcohol consumed does not automatically relate to the same alcohol-related harms for all drinkers. Similarly, alcohol might be harmful for one family in a way that it is not for another family.

Working collaboratively with parents and children can help identify what alcohol-related harm looks like for a particular family (Shaw, Johnston, Gilligan, McBride, & Thomas, 2018). Further to harms mentioned above, adverse outcomes associated with alcohol use can relate to the:
Alcohol-related harm in families and alcohol consumption during COVID-19

- mental and general health and wellbeing of parents
- social and emotional wellbeing of children
- the ability of parents and carers to nurture the social, emotional and material needs of children
- type and impact of family violence.

An introductory discussion about family circumstance – including reasons for alcohol consumption, environmental factors such as loss of employment, pre-existing alcohol-related harms, and family violence – may help to identify potential risk factors that make someone more prone to alcohol-related harms, including hazardous or high-risk drinking (Charlet & Heinz, 2017). Unstable situations and circumstances may foster more immediate risks of alcohol-related harms.

In light of the increased stress that families are facing during COVID-19, early identification of potential or existing harm will help maximise family health and wellbeing. The aim of identifying current alcohol consumption behaviour and potential harms through screening is to:

- identify high-risk people and high-risk situations where an immediate response is necessary
- identify if someone may require further support
- obtain a baseline understanding of alcohol-related harms that can be assessed over time to see if it changes or escalates (Knott, Bell, & Britton, 2018).

COVID-19 alcohol-related harms

The included 2020–21 data are substantially limited in what they say about the relationship between changing alcohol consumption and alcohol-related harm during COVID-19. The FARE YouGov survey (FARE, 2020a) found that 13% of Australian drinkers were concerned about the amount of alcohol they or someone in their household was drinking during the April lockdown (FARE, 2020a) but context for this concern is lacking. Without population-level data showing an association between increased drinking rates during COVID-19 and harms, other sources of data provide insight. For example, of 53 frontline specialist domestic and family violence workers surveyed in New South Wales during May 2020, 51% reported that they perceived alcohol was increasingly involved in family violence. However, 40% reported no perceived change (FARE, 2020b). No indication was given in that report as to what might explain differences (e.g. geographical location, family circumstances).

Psychological factors influencing alcohol consumption levels, such as stress, anxiety and loneliness, are also associated with harms to family wellbeing (Esterwood & Saeed, 2020). There is some evidence that parents have been adversely affected during COVID-19. The Alcohol and Drug Foundation (ADF) YouGov survey of 1,007 people found 14% of parents reported drinking alcohol on a daily basis in May 2020 (ADF, 2020). During a similar period of time, the Gambling in Australia during COVID-19 survey found that young men (aged 18–34 years) were the subpopulation most likely to sign up for new online gambling accounts and to increase their frequency and monthly spending on gambling (Jenkinson et al., 2020). This is the same age group that also had a higher alcohol intake, despite seeing a decrease in their consumption during the June–July COVID-19 period. While it is complex and difficult to draw any direct links between alcohol consumption and gambling, further research can be done to understand co-occurring and potentially harmful behaviours for individuals in times of high stress and isolation (Jenkinson et al., 2020).

Further data on harms from parental alcohol consumption during COVID-19 are not available yet. However, there are particular harms related to parents or those who are the primary caregivers of children. Box 1 outlines some of the potential impacts parental alcohol consumption can have on children when combined with social, financial and mental strain.
In times of mental distress parents face greater challenges attending to the wellbeing of their children. Alcohol consumption is one of a number of factors that can contribute to harms during high stress and can be compounded by, or compound, other factors such as unstable housing, unemployment and family violence. There is some evidence that when parents or carers regularly consume alcohol, their emotional responsiveness can decline due to mood shifts (Lander et al., 2013).

If parents consume alcohol as a way to cope with the impact of adverse large-scale events or lifestyle changes, as with COVID-19, long-term outcomes for children may become less favourable. For instance, parents play an important role in helping children understand and cope with big events such as natural disasters (Powell & Leytham, 2014). Parents who consume alcohol may become less emotionally available to support their children during the disaster, an outcome that may be relevant to the COVID-19 period.

Parental alcohol consumption can also influence children’s and young people’s consumption (Homel & Warren, 2017). For instance, parental drinking is associated with the frequency of drinking in their children (Rossow, Keating, Felix, & McCambridge, 2016). Children who live with parents or carers who have alcohol dependence, or a pattern of heavy consumption, are prone to poorer health and higher levels of substance use (Manning, Best, Faulkner, & Titherington, 2009). Parental use of alcohol can shape adolescents’ expectancies of alcohol use, which can shape future drinking behaviour and alcohol-related harms in children (Rossow et al., 2016; Smit et al., 2018; Waddell, Blake, Sternberg, Ruof, & Chassin, 2020). Alcohol expectancies are personal beliefs that a particular behavioural, emotional and/or cognitive effect will occur from drinking alcohol (Rossow et al., 2016; Smit et al., 2018; Waddell et al., 2020).

In Australia, parental heavy drinking is associated with around one-third of child protection cases and half of family physical violence cases (Laslett et al., 2015). Multiple factors contribute to the possibility of family violence taking place, such as parental age and education and unequal power dynamics (Black, Heyman, & Smith Slep, 2001; Flood & Webster, 2015). An increase in alcohol use in an already abusive home can increase the risk of someone, including children, being physically injured (Curtis et al., 2019). The alcohol consumption of caregivers can also increase the chances of a family being involved with child protection (Canfield, Radcliffe, Marlow, Boreham, & Gilchrist, 2017).

Questions for practitioners

- Do you have evidence that alcohol is related to current family harms, such as family violence, financial hardship or neglect?
- Is alcohol affecting the physical, cognitive or emotional functioning of the parent or carer in a way that is causing harm?
- Are there particular social, economic or family circumstances that could affect the likelihood of alcohol consumption being translated into alcohol-related harm?
- Has alcohol contributed to medical emergencies?
- Is alcohol reducing the amount of time or money available to spend on the family’s/child’s basic needs in a way that is causing harm?
- What other factors may be involved in harms the family is experiencing?
- What factors/strengths does the family possess to protect against harms?

If there is an indication of alcohol-related difficulties and/or difficulty caring for children, there are screening tools that can help non-specialist practitioners to support intervention and better outcomes, and to assess if the amount of alcohol use may be problematic for a family. Screening can help identify a person’s level of risk for harm and determine appropriate management and treatment pathways. One evaluated tool, the Alcohol Use Disorders Identification Test (AUDIT) is outlined in Box 2.
Box 2: Using the Alcohol Use Disorders Identification Test (AUDIT) to help identify potential for alcohol-related harm

Understanding how much alcohol is consumed, and the frequency of use, can help to identify potential for harm; however, as mentioned above, the volume of alcohol consumed is not the only indicator of harm. Some tools also include a preliminary assessment of whether current alcohol consumption may already be causing harm or have recently caused harm.

The AUDIT, developed by WHO, is widely accessible and has been internationally validated as a reliable method of screening for alcohol consumption patterns, hazardous drinking and dependence. It has been used in a range of countries, including with a range of populations in Australia (Bryce, Spitz, & Ponsford, 2015; Reinert & Allen, 2007; Saunders, Aasland, Amundsen, & Grant, 1993). The AUDIT is a free instrument to use and includes the longer AUDIT-10 and a shorter version, AUDIT-C for brief screening when time constraints are a factor. Additionally, the AUDIT helps identify some potential harms including failing to do what is normally expected of the person, feeling guilty or remorseful after drinking, being unable to remember what happened while they were drinking, or causing or incurring injuries as a result of their drinking (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001).

It is necessary to provide an explanation to people of the content of the questions, the purpose for asking them, and the need for accurate answers when undertaking an AUDIT assessment (Babor et al., 2001). Most online versions of the AUDIT provide this information and guidance on the potential level of harm people may be exposed to based on their reported alcohol consumption. Practitioners may then choose to provide guidance, intervention or referral as required (see the section below on minimising alcohol-related harms).

Harm minimisation approach to alcohol consumption

Adopting a harm minimisation approach to supporting people who use alcohol means working to minimise the negative consequences of alcohol, regardless of whether consumption occurs during a large-scale disaster or not. Decreasing alcohol consumption can be one strategy for minimising harms but it is not the only strategy. A harm minimisation approach is based on the following premises (Department of Health, 2004):

- Alcohol and drug use is an inevitable part of society.
- Alcohol and drug use may change over time due to various factors.
- A range of harms are associated with different types and patterns of use.
- A range of evidence-based approaches can be used to prevent and minimise harms.

Goals and strategies for harm minimisation are wide ranging and are not generally intended to stop people from consuming alcohol. The level of alcohol an individual can consume before causing harm is different from person to person and will differ depending on the social context and setting. With no set level of alcohol consumption that contributes to alcohol-related harms within the family, even a small amount of alcohol consumption matters if it is contributing to harm.

A harm minimisation approach is broad enough so that continued drinking, moderated drinking or abstinence could all be accommodated according to the needs and capacities of clients. There are a number of ways that practitioners can help identify potential alcohol-related harms and minimise the impact on individuals and families. Part of minimising impacts is also about minimising exposure to judgement and stigma related to alcohol use. The relationship between stigma and alcohol is outlined in Box 3.

Critical reflections for practitioners

- What open questions could you ask a person about how they feel their alcohol consumption may be causing harm to them or their family?
- Under what circumstances does alcohol consumption become harmful for the family?
- Under what circumstances is alcohol consumption not harmful for a family?
- From the options for interventions and in relation to a specific case:
  - How could you use AUDIT and/or a brief intervention to help initial identification and response to alcohol-related harms?
  - What referral pathways are open to you and best suit the particular needs of clients facing alcohol-related harms?
Box 3: Stigma and alcohol

Stigma and resulting discrimination can cause substantial harm to people who consume alcohol. Stigma is a social process through which one person or group of people determine that another person or group displays a trait, behaviour or status that makes them less acceptable (Goffman, 1963). Stigma comes from a set of attitudes, beliefs, behaviours and structures that create prejudice and discrimination towards people who consume alcohol.

For some people who use alcohol, stigma is a real problem. Other people’s actions and language can make them feel unwelcome and unsafe. People who experience stigma may feel disapproved of, condemned, ignored and dismissed (Fraser, Moore, Farrugia, Edwards, & Madden, 2020). Stigma can lead to social segregation (Blendon & Young, 1998), poorer mental and physical health (Lancaster, Santana, Madden, & Ritter, 2015) and poorer relationships (Tamutiene & Laslett, 2017), resulting in further isolation. People who experience stigma may delay seeking help as stigma can act as a barrier to seeking treatment (Mojtabai & Crum, 2013), lead to reduced access to accurate health assessments (Thornicroft, Rose, Kassam, & Sartorius, 2007), and result in poor treatment (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013) and unempathetic counselling practices (Gray, 2010).

Language is a key driver of stigma. As such, a number of anti-stigma language guidelines now exist in Australia (International Network of People who Use Drugs, 2018). These guidelines target health care professionals (ADF, 2020), media (AOD Media Watch, 2017) and clinicians (Mindframe, 2019), among others. The language guidelines recognise that alcohol use is a health and social issue (ADF, 2020). They promote taking a strengths-based and person-first/person-centred approach (ADF, 2019). Body language and tone are also important in helping people who consume alcohol to feel included and supported.

Choosing words and body language that focus on people rather than the amount of alcohol they consume helps to engage people in a conversation about potential alcohol-related harms (VicHealth, 2019). Other considerations may be avoiding judging or overly attributing blame for harms to a family member who consumes alcohol, checking in with family members to see how being identified as ‘high risk’ or ‘problematic’ on screening tools makes them feel, and asking family members about their concerns, needs or desires regarding next steps and what terminology can be used to speak about alcohol use.

Actions to minimise alcohol-related harms

If alcohol-related harms are identified, interventions to address and minimise harms can help improve the health and wellbeing of families.

These can include brief interventions, education, and referral to a specialist alcohol and other drugs (AOD) related provider. The level of intervention recommended could be guided by AUDIT scores and recommended actions:\footnote{There are a number of considerations to take into account when interpreting AUDIT scores. The AUDIT scores can vary slightly depending on the country’s drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Judgement can be exercised in cases where the client’s score is not consistent with other evidence, or if the client has a prior history of alcohol dependence.}

- 0–7 Brief Intervention: alcohol education
- 8–15 Brief Intervention: simple advice
- 6–19 Brief Intervention: simple advice plus brief counselling and continued monitoring
- 20–40 Referral to specialist for diagnostic evaluation and treatment.

Brief interventions

One common way to help reduce harm from alcohol consumption is for a practitioner to have a short conversation – a ‘brief intervention’ – with a client. Brief interventions can be efficient as they require minimal time and can be delivered in as little as 15 minutes on each occasion (Álvarez-Bueno, Rodríguez-Martín, García-Ortiz, Gómez-Marcos, & Martínez-Vizcaíno, 2015). They have been shown to be effective when they are delivered multiple times over a six-month period or longer (Beyer et al., 2019). Additionally, evidence suggests they can have positive outcomes for people who use alcohol in harmful ways (Joseph & Basu, 2017).
Modalities used can include motivational interviewing or goal setting (Haber, Lintzeris, Proude, & Lopatko, 2009; Tanner-Smith & Lipsey, 2015).

Motivational interviewing is not about giving advice but about helping clients to accept and potentially change their behaviour through self-motivation. This form of interviewing can use empathy through reflective listening, avoid confrontations and support clients to achieve their goals by noticing when current behaviour is at odds with those goals (Miller & Rollnick, 2002). Motivational interviewing and goal setting require a degree of rapport with the patient to begin and an agreement about the value of exploring behaviour change (Rollnick, Heather, & Bell, 2009). The aim of these interventions is that the identification of any problem areas is self-directed, as is any subsequent goal setting (Saitz et al., 2010).

Recommendations from the Department of Health, based on three frameworks for delivery of brief interventions, suggest that these interventions should at least include feedback on personal risk and advice about changing behaviours (Saitz et al., 2010). Additional elements that can be included in brief interventions are (Haber et al., 2009):

- providing options for change
- ensuring the practitioner displays empathy for the client
- supporting and facilitating self-efficacy
- goal setting
- assistance and/or support, including making arrangements, for the client to implement change.

These additional discussion points could be included in a brief intervention:

- Discuss what a standard drink is, how many drinks are considered risky and other aspects of safe alcohol consumption (National Health and Medical Research Council [NHMRC], 2020).
- Goal setting could include supporting the client to move towards reducing their consumption to align with current safe-drinking recommendations (Haber et al., 2009).
- Explore results from a screening instrument like AUDIT. Often people are unaware of the extent of some of their behaviours and tend to underestimate behaviours such as alcohol consumption that can cause harm (Gual et al., 2017).
- Screening results can be coupled with individualised feedback about risks associated with continued drinking and potential health problems (Haber et al., 2009).
- Provide self-help materials, such as printed information or reputable websites, which provide information about potential harms (Haber et al., 2009).
- Support the client to develop strategies that work for them and their situation. Options could include specific limits to alcohol consumption, recognising the antecedents of drinking, or developing skills to avoid or minimise drinking in high-risk situations (Haber et al., 2009).

These interventions can be used to help clients understand their current alcohol consumption patterns and potential associated risks. Providing information on the health risks of alcohol is also important as risky drinkers are more likely to believe they can consume excess alcohol without putting their health at risk (Australian Institute of Health and Welfare [AIHW], 2017). Interventions that aim at alcohol reduction are associated with positive effects in harmful, hazardous or alcohol-dependent drinkers (Charlet & Heinz, 2017).

The following guiding questions are adapted from brief motivational strategies in a medical setting (Rollnick et al., 2009):

1. Opening strategy: Talk generally about lifestyle, stresses and question ‘Where does alcohol use fit in to this broad life picture?’
2. Further unpack a typical day and where alcohol may or may not fit in.
3. Provide information about alcohol consumption and alcohol-related harms based on the readiness of the patient to receive information. Provide information in a neutral and non-personal way and with the use of open questions.
4. Have a ‘future’ and ‘present’ conversation that asks, ‘How would you like things to be different in the future?’ and unpacks what the barriers in the present are to making this change.
5. Explore concerns (if there are any) about alcohol or about changing the type or level of alcohol consumption.
6. Help with decision making and goal setting if a client wishes to make changes.
Referrals

Brief interventions may be most effective in supporting people who are not experiencing alcohol dependence. For parents who experience alcohol dependence, referral services should be considered and differ in New South Wales, Queensland, Tasmania, Victoria, Western Australia, South Australia, Australian Capital Territory and the Northern Territory. Australian guidelines and screening tools such as AUDIT can help practitioners assess a client’s relationship with alcohol. For parents or carers showing clear signs of alcohol-related harms to themselves or their children, referral to a specialist service is the critical next step.

In Victoria, Tasmania and the Northern Territory, practitioners can contact the Drug and Alcohol Clinical Advisory Service (DACAS) to speak to an alcohol and other drug specialist for advice on how to work with clients. There is no ‘one-size-fits-all’ approach to minimising alcohol-related harms. The data reported in 2020 do not allow direct comparison to Australian alcohol guidelines. For more information on the guidelines see Box 4. Further work with a specialist alcohol service is essential to ensure the best outcomes for families impacted by alcohol consumption.

Box 4: Australian guidelines to reduce health risks from drinking alcohol

The Australian guidelines to reduce health risks from drinking alcohol provide health professionals, policy makers and the Australian community with evidence-based advice on the health effects of drinking alcohol. The guidelines aim to help people make informed decisions about drinking alcohol (NHMRC, 2020). To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day. Consuming more alcohol than this is associated with a risk of a number of health and wellbeing harms.

These guidelines present a starting place to identify different levels of risky alcohol use. They are applicable to the general adult population in Australia. However, some groups of the population may be at greater risk and therefore may benefit from even lower levels of consumption. These include pregnant women, children and people under 18 years of age, young adults aged 18–25 years, people aged over 60 years, people with mental or physical health conditions, people with a family history of alcohol dependence, and people who use illicit drugs or take medications that interact with alcohol (NHMRC, 2020).

Maximising the health and wellbeing of the family

COVID-19 lockdowns and social distancing measures disrupted family wellbeing. Together with an increase in stress, loneliness and isolation (ABS, 2020a), COVID-19 disrupted valuable sources of support. Social connection with friends and family members is associated with reduced stress in parents and can support children and parents to feel more connected (Mikocka-Walus, Stokes, Evans, Olive, & Westrupp, 2020). For children, evidence suggests that schools also play a critical role in both protecting children from present dangers and nurturing their future resilience (Masten & Barnes, 2018; Ungar et al., 2019).

In a time when these kinds of informal and formal sources of support are restricted, child, family and welfare services can reduce the risk factors for increased alcohol-related harm by connecting families with relevant programs. Selected examples are discussed below.

Parent support programs

Parent support programs can be run by local councils, and child, community and welfare services. Alcohol and drug professionals also provide specific support programs to help families respond effectively to an increase in alcohol consumption or alcohol consumption that is stable but high.

Family counselling programs

These services are provided to families who seek help, counselling and support for their family member. They can be general counselling programs or more specific alcohol-related programs.

---

2 These guides are generally based on cisgendered men and women and are not inclusive of transgender clients.
Specialist family violence supports

Collaboration and communication between alcohol and other drugs services and domestic and family violence services can help identify and prevent alcohol-related abuse and neglect. In the case of serious domestic violence injury and death, police, legal and social services can also be involved (FARE, 2020b).

Conclusion

This publication is intended to provide the basis for non-specialist alcohol and drug practitioners to gain a greater understanding of how alcohol consumption changed during COVID-19. The results of this review show that some groups of Australians experienced increased levels of stress, loneliness and isolation during COVID-19, which may have resulted in higher levels of alcohol consumption. Further, some groups, such as women with carer responsibilities, are at greater risk of increasing alcohol consumption and alcohol-related harm. Practitioners can use this evidence to prepare for those groups of people experiencing harm and requiring support.

Although evidence is available about changes in alcohol consumption due to COVID-19 in Australia, there is, as yet, no evidence about harms to parents or children specifically as a consequence of these changes. However, this review highlights evidence about the nature of alcohol-related harms that may be experienced by families and individuals. Strategies that raise awareness of the risk and nature of alcohol-related harm or referral in higher risk situations can form part of a response. Other strategies could involve assisting families in addressing factors that may lead to increased alcohol consumption.

Authors and acknowledgements

All authors are employed by the Australian Institute of Family Studies. Dr Claire Farrugia is a Senior Research Officer and Dr Trina Hinkley is a Research Fellow in the Knowledge Translation and Impact Lab. The authors wish to thank Dr Nerida Joss for her guidance in producing this paper and thank Dr Brendan Quinn, Australian Institute of Family Studies and Dr Michael Savic, Monash University, for their review and feedback on the paper.

Further resources

- Parental Substance Use and Child-Aware Practice: podcast. This Emerging Minds podcast supports practitioners to develop an understanding of the importance of a trauma-informed approach, about child-focused and other practices in the alcohol and other drug sector, and the challenge of strengthening parent-child relationship when shame and stigma are present.
- Working with Mothers Affected by Substance Use: Keeping Children in Mind: online resource. This written resource by Emerging Minds highlights how mothers often experience co-existing issues besides alcohol consumption and showcases engagement strategies that support mothers and their children.
- Turning Point is Australia’s leading national addiction treatment, training and research centre focusing on alcohol and other drugs. It hosts a number of online learning modules to help practitioners use standard adult alcohol and drug screening and assessment tools.
- The power of words is a resource to support health and other practitioners to identify potential instances of stigma-inducing language and behaviour. It provides information about alternative language and behaviour to help minimise the impact of stigma on people who use alcohol and other drugs.
- CFCA has produced a resource that includes case studies aimed at prompting readers to consider options when responding to client needs and what quality practice looks like when working with clients who use alcohol and other drugs, and/or their children. The case studies are available here: Working together to support families where a parent uses alcohol and/or other drugs.
- Drug and Alcohol Clinical Advisory Service (DACAS) offers a free 24/7 telephone advisory service that assists health and welfare professionals in Victoria, Tasmania and the Northern Territory to respond effectively to individuals with alcohol or other drug use problems.
References


Mojtabai, R., & Crum, R. M. (2013). Perceived unmet need for alcohol and drug use treatments and future use of services: Results from a longitudinal study. Drug and Alcohol Dependence, 127(1), 59-64. doi.org/10.1016/j.drugalcdep.2012.06.012


## Appendix A: Study inclusion criteria

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Inclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Australia</td>
</tr>
<tr>
<td>Language</td>
<td>English</td>
</tr>
<tr>
<td>Publication date</td>
<td>March 2020–October 2020</td>
</tr>
<tr>
<td>Publication type</td>
<td>Journal article, report, media release of findings</td>
</tr>
<tr>
<td>Study primary focus</td>
<td>Original research or secondary data analysis of quantitative and/or qualitative findings</td>
</tr>
</tbody>
</table>
### Appendix B: Included empirical studies

<table>
<thead>
<tr>
<th>First Author (Year)</th>
<th>Publication type</th>
<th>Study design*</th>
<th>Aim</th>
<th>Collection dates</th>
<th>Sample characteristics</th>
<th>Prevalence</th>
<th>Change</th>
<th>Findings</th>
<th>Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS (2020)</td>
<td>Data release (not peer-reviewed)</td>
<td>Longitudinal survey using telephone interview</td>
<td>Insights into the prevalence and nature of impacts from COVID-19 on households in Australia</td>
<td>Late April–early May 2020</td>
<td>1,022 adults 18+</td>
<td>N/R⁴</td>
<td>Stable alcohol consumption (47.1%), usually abstained (28.9%), increase consumption (14.4%; 18% females; 10.8% males), decreased consumption (9.5%). 18% of females, and 10.8% of males, increased consumption.</td>
<td>N/R</td>
<td></td>
</tr>
</tbody>
</table>

---

⁴ Not directly reported
<table>
<thead>
<tr>
<th>First Author (Year)</th>
<th>Publication type</th>
<th>Study design*</th>
<th>Aim</th>
<th>Collection dates</th>
<th>Sample characteristics</th>
<th>Prevalence</th>
<th>Findings</th>
<th>Association</th>
</tr>
</thead>
</table>
| Biddle et al. (2020)      | Report (not peer-reviewed) | Survey comparison of 34th ANU Poll, NDSHS 2016, Standardised NHS 2017/18 | Analyse changes in alcohol consumption since the spread of the COVID-19 pandemic | 2017/18: May 2020 | 34th ANU Poll: 3,219 aged 18+ NHS (2017/18): 21,315 aged 18+ including selected 15-17 NDSHS (2016): 23,772 aged 12+ | N/A | NHS and NDSHS benchmark: Alcohol consumption frequency increased 3.5% overall (5.5% females and by 3.5% for males). NHS benchmark: Females who drank less than once a month (including never) decreased from 44.8% to 37.7%. Males decreased from 25.9% to 25.1%. Self-reported changes since the spread of COVID-19: 20.2% increased consumption; 27% decreased consumption. | Reasons for changes in alcohol consumption
Person is spending more time at home (67.3% for males and 63.7% for females). Boredom: males 49.0%; females 38.4% (p-value = 0.10). Increased stress: males 28.5%; females 41.9% (p-value = 0.041). 28.3% of females with caring role increased consumption; 21.4% of females with no caring responsibilities increased (p-value = 0.07). 20.7% of male carers increased consumption; 17.8% of males with no caring responsibilities increased (difference not statistically significant). Employment
Males: increased or stable work hours led to 16.5% and 15.8% of males increasing alcohol consumption, respectively; decreased work hours led to 27.2% increasing alcohol consumption. Females: decreased hours resulted in 31.1% increasing alcohol consumption; no change in work hours resulted in 30.0% increasing consumption. In other groups of women alcohol consumption increased by: 19.5% with increased work hours, 18.1% with unemployment, and 20.8% for those who lost their job Feb–April 2020. |
<table>
<thead>
<tr>
<th>First Author (Year)</th>
<th>Publication type</th>
<th>Study design*</th>
<th>Collection dates</th>
<th>Sample characteristics</th>
<th>Prevalence</th>
<th>Findings</th>
<th>Change</th>
<th>Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Callinan et al. (2020)</td>
<td>Peer-reviewed journal article</td>
<td>Online survey and audit and stress subscale</td>
<td>Mid-April–mid-May 2020</td>
<td>1,684 adults 18–65 years old who drink at least monthly</td>
<td>N/A</td>
<td>Decrease in harmful drinking [2019 score = 8.2, 95% confidence interval (CI) = 7.9, 8.4; during the pandemic = 7.3, 95% CI = 7.1, 7.6]. Women aged 36–50 increased both their frequency and quantity of consumption.</td>
<td>N/A</td>
<td>Those experiencing high levels of stress had relatively higher shifts in scores than those who reported low levels of stress. However, the estimated marginal means for those in the high stress group (-0.77, 95% CI = -1.06, -0.49) were still significantly below zero, indicating an overall decrease.</td>
</tr>
<tr>
<td>Callinan et al. (2021)</td>
<td>Peer-reviewed journal article</td>
<td>Survey</td>
<td>2019; April–May 2020</td>
<td>2,307 adults 18+</td>
<td>N/A</td>
<td>Reports of average consumption before (3.53 drinks per day [3.36, 3.71 95% confidence interval]) and during (3.52 [3.34, 3.69]) the pandemic were stable. 15.4% became lower risk; 15.0% higher risk.</td>
<td>Decreased consumption in young men; those who drank more outside the home in 2019. Increase in consumption associated with high levels of stress and bulk-bought alcohol.</td>
<td></td>
</tr>
<tr>
<td>Hall &amp; Partners reported by Hello Sunday (2020)</td>
<td>Media release (not peer-reviewed)</td>
<td>Telephone survey</td>
<td>April 2020</td>
<td>319 adults aged 18+</td>
<td>N/R</td>
<td>Reports of drinking less increased from 22% (2nd week of lockdown) to 29% (7th week of lockdown). Reports of drinking more increased from 17% (2nd week of lockdown) to 20% (7th week of lockdown).</td>
<td>Reasons for increased alcohol consumption: boredom (53% at 2nd week of lockdown down to 39% at 7th week); anxiety and stress (41% for 30–59 year olds at 2nd week of lockdown and 57% at 7th week).</td>
<td></td>
</tr>
<tr>
<td>First Author (Year)</td>
<td>Publication type</td>
<td>Study design</td>
<td>Aim</td>
<td>Collection dates</td>
<td>Sample characteristics</td>
<td>Prevalence</td>
<td>Change</td>
<td>Findings</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td>--------------</td>
<td>-----</td>
<td>------------------</td>
<td>------------------------</td>
<td>------------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>Jenkinson et al. (2020)</td>
<td>Report (not peer reviewed)</td>
<td>Survey</td>
<td>To learn more about how people’s gambling participation, alcohol consumption and health and wellbeing were affected during COVID-19 pandemic</td>
<td>June–July 2020</td>
<td>2,019 adults 18+ who had gambled in the last 12 months</td>
<td>15.3% (n = 309) no consumption during COVID-19, 4.8% (n = 97) drank before COVID-19 but not during, and 2.4% (n = 49) drank during COVID-19 but not before. Consumption stable between the two time periods (mean AUDIT-C score 5.91 before and 5.86 during COVID-19); consumption higher for males compared to females (mean AUDIT-C scores around 6.2 compared to 4.6) and young people aged 18–34 years compared to older age groups (mean AUDIT-C scores around 6.4 compared to 5.3 among those aged 35–54 years and 4.8 among those aged 55+ years).</td>
<td>Significant decreases in drinking were observed among men and young people aged 18–34 years.</td>
<td>N/R</td>
</tr>
</tbody>
</table>

<p>| Neill et al. (2020) | Peer-reviewed journal article | Longitudinal survey | Examine what predisposing (distal) and pandemic-related (proximal) factors were associated with increased drinking in the wake of the COVID-19 pandemic | April 2020 | 4,462 adults 18+ | Non-drinkers prior to COVID-19 (28%); drinking &gt;10 standard drinks a week (10.5%); &lt;10 standard drinks a week (61.3%). | Reported reduced or no change to alcohol (69.2%); drinking a lot more than usual (30.8%). | Increased drinking associated with higher levels of depression and stress; heavy drinking pre-pandemic; higher income; gender; with females overrepresented in the sample drinking a lot more than usual; age, with those aged 25–49 years drinking more. |</p>
<table>
<thead>
<tr>
<th>First Author (Year)</th>
<th>Publication type</th>
<th>Study design*</th>
<th>Aim</th>
<th>Collection dates</th>
<th>Sample characteristics</th>
<th>Prevalence</th>
<th>Change</th>
<th>Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roy Morgan (2020)</td>
<td>Media release (not peer-reviewed)</td>
<td>Telephone interviews</td>
<td>Overview of alcohol consumption in Australia</td>
<td>March 2020</td>
<td>Apr 2018–Mar 2019, (n = 16,276), Apr 2019–Mar 2020, (n = 14,632) adults aged 18+</td>
<td>N/R</td>
<td>A total of 66.3% (13,073,000) of Australians aged 18+ in the year to March 2020 consumed alcohol in an average four-week period, down from 67.5% (13,102,000) 12 months previous.</td>
<td>N/R</td>
</tr>
<tr>
<td>Stanton et al. (2020)</td>
<td>Peer-reviewed journal article</td>
<td>Online survey</td>
<td>Examine the associations between psychological distress and changes in selected health behaviours since the onset of COVID-19 in Australia</td>
<td>April 2020</td>
<td>1,491 adults 18+</td>
<td>22.3% ((n = 332)) consumed alcohol on four or more occasions per week.</td>
<td>Just over half ((n = 825), 55.3%) reported no change in alcohol consumption.</td>
<td>Negative change in alcohol associated with higher depression (adjusted OR = 1.07, 95% CI = 1.04, 1.10), anxiety (adjusted OR = 1.08, 95% CI = 1.04, 1.12), and stress (adjusted OR = 1.10, 95% CI = 1.07, 1.13) symptoms</td>
</tr>
<tr>
<td>YouGov Galaxy (commissioned by FARE) (2020)</td>
<td>Report</td>
<td>Telephone poll</td>
<td>14% report they have been drinking daily, a near threefold increase when compared to a January 2020 YouGov survey (5% drinking daily).</td>
<td>April 2020</td>
<td>1,045</td>
<td>Drinking more alcohol during COVID-19 (18%); drinking less (17%).</td>
<td>Drinking on their own more (12%); drinking to cope with anxiety and stress (11%). Drinking to cope with anxiety and stress (10% for 18–24 years, 13% for 25–34 years and 10% for 35–49 years). Aged over 50 (5%).</td>
<td></td>
</tr>
<tr>
<td>YouGov Galaxy (commissioned by the Alcohol and Drug Foundation) (2020)</td>
<td>Media release</td>
<td>Telephone Poll</td>
<td>29% report increased alcohol consumption during COVID-19 lockdowns.</td>
<td>May 2020</td>
<td>1,007 parents of school-aged children</td>
<td>n/a</td>
<td>Reasons for increased alcohol consumption: feelings of anxiety and stress (38%); stress of home schooling (25%); extra video socialising (1 in 5 for all parents and 1 in 3 for parents aged 18–34).</td>
<td></td>
</tr>
</tbody>
</table>