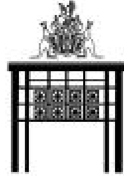

SELECT COMMITTEE ON SUBSTANCE ABUSE IN THE COMMUNITY

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Department of Health and Community Services
Alcohol and Other Drugs Program
ALCOHOL

ALCOHOL AND OTHER DRUGS PROGRAM SUBMISSION

TO THE

SELECT COMMITTEE ON SUBSTANCE ABUSE

IN THE COMMUNITY

JUNE 2002

ALCOHOL

PURPOSE

The Department of Health and Community Services (DHCS) Alcohol and Other Drugs Program has been requested to provide this briefing to the Select Committee On Substance Abuse In The Community.

The briefing has been requested to include information identifying the extent of alcohol use in the Northern Territory, issues of policy, funding and past, present, and future directions.

People engage in the use of alcohol, tobacco and other substances for a variety of reasons. While use of some substances can offer social and health benefits, there are frequently negative outcomes that can accrue in terms of health and wellbeing. These outcomes affect not only the individual user, but they can also impact on family and friends and the broader community. Alcohol and tobacco have the greatest impact.

The primary aim of the Alcohol and Other Drugs Program is to reduce the impact of substance misuse in the Northern Territory.

The mission of the Program is:
To promote individual and community well being by minimising the harm associated with alcohol, tobacco and other drugs through a coordinated range of approaches.

In pursuing this aim, the Program will focus on:

- increasing the knowledge and skills of individuals and the capacity of families, communities and services to address substance issues;
- engaging a range of resources to provide a variety of strategies and an optimum range of care and treatment services appropriate to meet the needs of people experiencing substance misuse problems; and
- supporting an environment, which encourages, enables and reinforces actions taken individually and collectively to minimise substance related harm.

DHCS Commitment:

- commitment to the principle of harm minimisation;
- recognition of a multi-dimensional context of substance use and the need for a comprehensive and integrated array of strategies that address a number of dimensions;
- the use of community development and support methods to secure widespread community participation and generate sustainable change;
- collaboration across program areas;
- broad intersectional collaboration;
- incorporation of research and evaluation activities to continually inform and monitor implementation; and
- commitment to a high level of competence and expertise within the workforce operating from specialist alcohol and drug agencies and an increased capacity among other workers to impact on substance issues.

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1. INTRODUCTION

The Alcohol and Other Drugs Program (AODP) develops, implements and coordinates strategies that address the harmful effects of substance misuse in the Northern Territory (NT). Alcohol, tobacco, petrol, prescription drug misuse and kava are of particular concern in the NT.

The aim of the Program is to promote an integrated range of individual and community strategies that will minimise the harm associated with alcohol and other drugs.

The Living With Alcohol program (LWA) was a Territory initiative to achieve long-term reductions in alcohol-related harm. Between 1991-2001, AODP administered the LWA program. In May 1995, the Minister announced the imposition of a levy of $0.35 on each wine cask sold in the NT. Funds collected by the levy were to be used to fund programs such as the Wine Cask Levy (WCL) to "curb alcohol-related anti-social behaviour in the Territory's large urban centres". The WCL program tended to operate through Ministerial offices in its early years, with administration transferring to THS around 1997. The AODP administered the Wine Cask Levy (WCL) grant scheme to support intervention, diversionary and education/preventative projects throughout the Territory up until 2000/01. During this period fifty-six grants to34 organisations were identified as having received funding from the WCL. Total funding allocated over this time was $3,363,314[1].

On 5 August 1997 as a result of a High Court decision prohibiting the States and Territories from imposing certain kinds of taxes, the levy was abolished.[2] In its place, the Commonwealth Government increased the wholesale sales tax on alcohol and passed this amount onto the NT Government.

Changes to Living With Alcohol

1991 Living With Alcohol established and maintained by Dept of Chief Minister's Office
1992 First collected hypothecated tax levy revenue paid into LWA Trust Account
1993 LWA transferred to Department of Health and Community Services
1995 Minister announces wine cask levy imposition – establishes WCL program
1997 Wine Cask Levy program transferred to THS
1997 High Court Decision rules additional taxation for revenue generation introduced by States and Territories to be unconstitutional. NT Government abolishes alcohol tax in lieu of the Commonwealth Government compensation package of $8m
2000 WCL restructured and name changed to Public Behaviour Program

2. Future Directions

For there to be an impact on the level of substance misuse, factors such as poverty, housing and education (to name a few) need to be taken into account. Such factors are outside the program scope of AODP. The business of responding to alcohol and other drug abuse and misuse is, therefore, a whole of community and government responsibility. Building partnerships between all levels of government, community based organisations, researchers, health professionals, educators, law enforcement authorities, drug users, and the wider community in working together to reduce the harmful social, health and economic effects of drug use is a key strategy for the program.

[1] Evaluation of Wine Cask Levy Funded Project 1995-99, Network Australia, June 2000 (pg; i)
[2] NGO NGO HA and ANOTHER v STATE OF NSW and OTHERS, WALTER HAMMOND $ ASSOCIATES PTY LTD v STATE OF NSW. BRENNAN CJ, DAWSON, TOOHEY, GAUDRON, MCHUGH, GUMMOW and KIRBY JJ. Constitutional Law: 5 Aug 1997

It needs to be recognised that front line workers provide substantial support to people who misuse drugs (eg. G.P.'s and counsellors employed by "mainstream" agencies), using resources that are outside the AODP. The AODP as a DHCS Program has a specific mainstream role to play within the context of the Department's strategic intent "to create and enhance a Territory wide network of services which delivers continuing improvement in the health and well being of all Territorians".

Over the next 3-5 years in the NT it is proposed to refocus and expand AODP servicing to better meet "contemporary need" across the promotion, prevention, early intervention, treatment and continuing care intervention spectrum with particular attention being paid to improving prevention/early intervention, youth and remote area service responses. The process will involve both the use of current "evidence based" information and a process for collaboratively planning services for the future with other key stakeholders.

The term "contemporary need" refers to the ongoing realignment and purchase of service responses required to flexibly meet current and emerging needs arising from changes in:

- population trends,
- drug usage patterns,
- government policy and priorities and
- evidence based best practice approaches

Key NT wide program enhancements have been identified for attention over the next 3-5 years to support the service realignment process, and improve client outcomes, planning and evaluation. These are enhanced standards, assessment processes, care coordination practices and data collection and analysis methods. An ongoing research agenda will also be important to support the Program over time. An updated media plan will also rely on research to indicate what the program needs to be doing to meet the needs of specific target groups with respect to alcohol and other misused drugs.

3. KEY PRIORITIES FOR ACTION

Prevention and Early Intervention

The intent of prevention and early intervention strategies is to stop the onset or escalation of harm. This includes preventing the uptake of illicit drugs. The goal of prevention is to reduce harmful use and encourage "early" individual and collective action on alcohol and other drug issues.

The "National Drug Strategic Framework (NDSF) 1998-2002-03" identifies eight priority areas for action amongst which increased prevention effort including increasing community understanding, supply reduction and use prevention are key initiatives.

Nationally alcohol and other drug abuse prevention activities historically tended to focus on single risk factors or a "just say no" perspective. More recently the focus has shifted to one that emphasises education and information about drugs, their effects and harms, while promoting decisions to not use alcohol and other drugs or to use them in a safer way. This changed emphasis on harm minimisation rather than abstinence per se, has occurred in a context where drugs are increasingly available and, in the case of licit drugs, actively promoted.

Providing opportunities and creating environments that support decisions to not use or misuse drugs, which promote meaningful activities in place of use and approach prevention from a developmental perspective, have been limited and ad hoc.

In the NT prevention activities are in the main developed and implemented by internal service providers with a handful of non government agencies funded for prevention activities as an add on service to treatment.

Budgetary constraints in recent years have reduced the ability of the Program to sustain existing prevention/early intervention efforts and to increase investment in these activities. Whilst appropriate levels of treatment and law enforcement need to be maintained the fact remains that increased prevention and early intervention effort needs to be directed to reducing alcohol and other drug use and its effects on individuals, families and the community.

An analysis of current effort suggests that approx $2.835m or 27.87% of the current budget is targeted specifically towards prevention/promotion type activities with only $0.301m or 2.6% of the budget specifically targeted towards early intervention projects.

Comments from community groups at consultations and through various planning processes over the past few years generally support the need to place a priority on prevention/early intervention• The Government's Tough on Drugs policy clearly identifies the need for "a properly resourced drug prevention strategy requiring inter-sectoral collaboration".

In this context the causal links with other programs such as Mental Health, Health Promotion and Family and Children's Services are significant and such programs could be expected to be key collaborators in the development, resourcing and implementation of appropriate service responses.

A review of prevention efforts needs to be incorporated into any future research and evaluation agenda in the context of ensuring a cost effective and efficient, holistic drug intervention services system•

Family Coping Strategy

The Family Coping Strategy builds on an international collaborative research project (Orford et al 2001) that acknowledges family members suffer the brunt of the abuse and difficulties that arise from others consumption of alcohol. The project aim is to equip people with the knowledge of prevention and early intervention skills and resources needed to effectively intervene with family members affected by the excessive drinking of close relatives.

The key strategic task is to build family capacity to cope with illicit drug use that can be applied at a remote Aboriginal community level. Through selecting and receiving the assistance needed at times of transition and/or crisis, the Family Coping Strategy seeks to meet and support the needs of family members in their own right.

Frontline Training

The AOD Program has retained its strong commitment to training and development of the AOD workforce. The focus is on frontline workers who are most ideally situated to identify and appropriately manage alcohol or other substance problems.

The quality of GP skills in providing 'Brief Interventions' with their clients and their knowledge about 'Alcohol and the New Pharmacotherapies was increased through accredited training, Continuing Medical Education (CME) sessions held in Darwin, Jabiru, Katherine, Tennant, Alice Springs and Kings Canyon.

A consortium comprising TAFE NSW, Next Step Specialist Drug and Alcohol Services (WA) and the Living with Alcohol Program (NT) won the Commonwealth Department of Health and Aged Care tender to develop and trial resources to train Frontline Workers working with youth. Our involvement has been essential towards developing training resources that will be useful in the NT when available nationally in 2002.

Brief Intervention Course

The course in 'Brief Intervention' is a Territory Health Services initiative, identified through the *NT Aboriginal Public Health Strategy and Implementation Guide* in regard to public health training needs for remote Aboriginal community health staff and related support service staff. The original course has been upgraded and now is an accredited short course.

Brief Intervention training continues to be trained as a specialist topic throughout the NT to GP's, Night Patrols, Sobering Up Shelters and others by negotiation.

Training Resources

Workplace safety has been promoted through the launching of the "Taking Care of Business" alcohol and other drug kit in November last year. The kit provides workers and workplace management with accredited education sessions, assistance with policy development and information to assist staff to manage drug and alcohol issues.

Young People

NT Government policy identifies the interests of children as paramount, and a commitment has been made to put in place effective programs to ensure that the next generation gets the best possible start in life.

The DHCS Health Development and Community Services Division is making young people, particularly adolescents, a priority group. The Program is keenly aware of the need to provide adequate services to this group. This is based on input from the community, and the fact that while the ability of young people to meet life challenges is significantly influenced by early childhood development experiences, young people also have unique challenges to face that are shaped by their life stage.

Because of their stage of development and their relative inexperience with substances, adolescents can be particularly vulnerable to substance related harm such as escalation into misuse and abuse, injuries, overdose, school and work disruption, contact with the criminal justice system and family conflict. It is for these reasons that young people have been a specific target of prevention activities. In the Territory, activities have centred on school based drug education, mass media campaigns and diversion activities. In spite of national and NT efforts however, both licit and illicit drug use amongst young people across Australia is increasing and initiation into drug use occurs at a younger age than a decade ago (Spooner et al., 2001)

In the NT anecdotal evidence suggests rates of substance misuse are increasing amongst young people including young people in remote communities with the greatest impact likely on those already health compromised and who have the greatest social and emotional disadvantage.

A paper on Structural Determinants of Youth Drug Use prepared for the Australian National Council on Drugs (2001) highlights the fact "that drug use is as much the result of macro-environmental factors as of individual decisions".

Whilst many of the generic prevention and treatment services purchased by DHCS provide some services for young people only $0.306m or 3% of the AODP funding is spent on services specifically targeted at young people.

It needs to be acknowledged that a range of other programs also have a significant role in supporting young people and their families meet the unique social and emotional challenges young people face in our modern society. Nevertheless the adequacy of services available to support young people requires further investigation, a point made by several Advisory bodies. For example, advice and information from the Supported Accommodation Assistance Program (SAAP) Territory Advisory Committee, has indicated that increasing numbers of young people presenting to SAAP agencies have drug and alcohol issues and to which many service providers feel inadequately equipped to respond appropriately.

Some 270 individuals 20 years and under presented at alcohol and other drug treatment services throughout the NT in 2000/2001 (DHCS statistics). This represented 9% of total clients.

Remote Areas

Across Australia it has been found that those living in rural and remote regions experience poorer health and service differentials. The health of the Aboriginal population has also been shown to decrease with increasing distance from urban centres (Mathers,19994; Strong et al, 1998; Moon et al, 1999;& AIHW, 1998).

Substance misuse, particularly alcohol, tobacco, cannabis and petrol abuse have been identified as major contributing factors to this disproportionate burden of ill health (House of Reps; Health and Aged Care, 2000)

The projected resident population for the Northern Territory in 2001 was 198,943 of which the Aboriginal population comprises 56,371 or 28.3% (DHCS, 2002). While most of the NT population live in the major centres of Darwin, Katherine, Nhulunbuy, Tennant Creek and Alice Springs, the reverse is true for the Aboriginal population, with 63% living in remote communities, out-stations and cattle stations (ABS, 1996). In Darwin and Alice Springs Rural districts, for which statistical information is readily available, in excess of 75% of the population is Aboriginal. If this population ratio is reflected in other districts, as is expected, it means that servicing remote communities in the NT is predominantly an issue of servicing Aboriginal people.

NT Aboriginal populations are located in small, discrete and isolated communities that are separated by large distances. Differences between communities are considerable including social, historical, cultural, geographical and climatic factors. Services in urban settings are not widely accessible to people living in remote Aboriginal communities. In a community setting

this includes prevention, early identification or effective treatment of problems relating to substance misuse (DHAC, 1999; Standing Committee, 2000; LWA, 1998).

Communities have identified a need for supportive community environments where local Aboriginal people are more able to take control of the identification of alcohol problems, pre-empt the emergence of problems and implement innovative local solutions to those problems (DHAC, 1999; Standing Committee, 2000; THS 1999a). This view is supported by NT Government policy that promotes capacity building, ownership of health outcomes and fostering partnerships with Aboriginal people (LWA, 1991; THS, 1999b; NTG, 1999; Weeramanthri et al., 1999).

These communities have also consistently indicated in a range of consultations that meaningful occupation for young people is a key strategy in preventing misuse of drugs and alcohol.

Whilst remote communities in the NT access services in major centres to varying degrees, only $0.512m or 5% (26% of this funding is one off only) of the budget in 200/2001 was spent on local community based servicing. In addition the AODP currently expends $1.16M to foster and support the development of alcohol and other drug strategies in regional centres and surrounding remote communities. This funding, is primarily focussed on intensive "visitor-led" community support, and is spread across a geographical region of 1.337M square Kilometres

4. Alcohol Related Harm

It has been estimated that the harm caused by excessive alcohol consumption accounts for 4.9% of the total disease burden in Australia. In the NT, consumption of 14.0 litres is reported to be twice as high in the Territory as elsewhere in Australia. In addition, the NT has the highest proportion of its population estimated to be drinking at hazardous and harmful levels - 15% of males and 6% of females compared to a national estimate of 7% and 4% respectively. (Trends in Per Capita Alcohol Consumption in Australia, 1990/91, National Drug Strategy, May 2001).

The impact of high-risk alcohol consumption is multifaceted. It includes health concerns such as some cancers, heart disease and stroke, liver disease, pancreatitis, gastritis, epilepsy, cognitive problems and dementia, as well as some psychiatric problems including depression, affective disorders and suicide.

In addition, it is associated with high levels of injury and fatalities associated with motor vehicle accidents, falls, drowning, burns and occupational accidents, as well as high levels of interpersonal violence, particularly domestic violence, assaults and child abuse. In monetary terms it has been estimated that alcohol-related harm alone costs the Northern Territory $477.5M per year [3].

The correlation between excessive alcohol use and violence are significant and pose a considerable cost burden to police, courts and corrections. Some police officers in remote communities estimate that 98% of police resources are used to address excessive drinking. There were 71,721 alcohol-related arrests and 34,607 apprehensions without arrest in 1997/8. Offences where alcohol is most likely to be involved include, damage to property, assault,

[3] Curtain Report 1999

stealing, offences against good order and drink driving offences[3]. Seventy one percent of sentenced prisoners reported committing the offence under the influence of alcohol[3].

Alcohol consumption has been identified as a cause of concern to 57.4% of the NT Aboriginal population surveyed[4]. There is, however, inadequate comparative information about the alcohol consumption patterns of Aboriginal people in remote, rural and urban settings. Regional information lacks quantity or frequency data. Detailed usage patterns are only available for the Aboriginal population in urban settings and at a national level, and there is scant or dated information available at the local community level.

In terms of overall patterns, the National Aboriginal and Torres Strait Islander Survey (NATSIS) reported 44.4% of NT Aboriginal people consumed alcohol within the last 12 months (58.4% of males and 30.7% of females). It is also well recognised that whilst the majority of Aboriginal people do not consume alcohol, the consumption patterns of those who do is a cause for concern. Research has indicated that 11% of the regular Aboriginal drinkers consume alcohol at a hazardous level and 79% at harmful levels. (NDS, 1994)[5]

The recent National Drug Research Institute (April 2002) research 'Alcohol-Related Violence A Major Cause Of Injury In Australia' found that in just one year (1998/99), a total of 8,661 hospitalisations for assault injuries were estimated to have been caused by alcohol - or 167 per week on average. Of these hospital admissions, 74 percent were male, and two-thirds were aged 15 to 34 years of age. The Northern Territory recorded the highest number, with 1 in every 263 adults being admitted to hospital for a serious alcohol-related injury. The ACT recorded the lowest rate (1 in every 5106 adults) of alcohol-caused hospitalisations.

During July 2000 to June 2001, 21.4% of courts or other referrals related to alcohol or other drug misuse to community based organisations for admission.[6]

Figures indicate that consumption of alcohol in NT metropolitan regions has been significantly increasing since 1995/96 whereas as at 1998/99 non-metropolitan regions have shown a decline in alcohol consumption.[7] A possible explanation for the increase in consumption in metropolitan regions may be a result of alcohol restrictions in remote areas.

5. LIVING WITH ALCOHOL PROGRAM

In response to growing public concern about the impact of alcohol misuse and the tabling of the report by the Sessional Committee on Use and Abuse of Alcohol in 1991, the NT Government established the Living With Alcohol Program (LWA). The program operated within a public health framework and had a clear mandate to reduce and report by the year 2000 on four key areas of harm; hospital admissions, consumption, crime and drink driving offences.

While the LWA program is no longer a distinct program a funding line still exists within the AODP policy and program development area and a number of its key underlying principles are maintained:

- an integrated approach to strategies;
- a commitment to harm minimisation; and

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[4] ABS, 1996, NATSIS, Cat no. 4190.7, Aust Gov Pub; Canberra
[5] National Drug Strategy (NDS), 1994. Household Survey; Urban Aboriginal and Torres Strait Islander Peoples Supplement. Canberra: Commonwealth Dept of Human Services & Health
[6] AODS Data Monitoring System
[7] National Drug Strategy, Bulletin Number 4, May 2001

- a strong focus on evaluation.

Description

As a public health program, LWA was a comprehensive and integrated framework targeting both individuals and environments incorporating social culture, drinking culture and alcohol availability. The framework for action addresses three core scenarios that relate to alcohol caused harm:

- Culture - the substance-related knowledge, attitudes and behaviours of the general community and more targeted sections;
- Care - the treatment and intervention services for those who are experiencing problems associated with substance use; and
- Control - the regulatory, legislative or policy aspects involved in the availability, promotion, provision and consumption of substances.

Specific components of the program were:
- community education and research;
- professional training and development;
- delivery of treatment and rehabilitation services; and
- research and evaluation.

The LWA provided for the expansion and enhancement of a range of effective health promotion, early intervention, and treatment and rehabilitation services. The LWA program was reviewed in April 1996 and highlighted achievements:

- Alcohol related fatal accidents reduced by 30%
- Alcohol related deaths reduced by 31%;
- Alcohol related accidents reduced by 29%
- arrests for exceeding the legal blood alcohol level by 29%
- Apparent per capita consumption reduced by 18%
- Light beer consumption 30% of the beer market when in 1992 it was less than 1%

Subsequent research estimated that alcohol related harm alone costs the Northern Territory $477.5m per year in constant values. The Living With Alcohol program contributed significantly to economic, health and safety benefits to NT people with an estimated $31.08m per year saving (Curtin report 1999).

Funding

The LWA program was introduced in November 1991 and was designed and operated as a whole-of-government approach to reducing the cost of alcohol-related harm in the NT.
The LWA program was originally funded by an additional levy on alcohol products containing more than 3% alcohol volume. This levy however, was not implemented until the beginning of April 1992 and funds were first paid into the LWA Trust Account in August of that year. By the end of June 1993 the levy had returned $6,756.670.

Funding collected through this hypothecated tax was quarantined for alcohol specific strategies. The LWA program was initially managed by the Department of the Chief Minister and was transferred to THS in July 1993. This money was allocated exclusively for mass media and targeted education and information campaigns, community development projects,

regulation and law enforcement, professional development and training, treatment and rehabilitation services and research and evaluation activities to reduce levels of alcohol related harm.

The High Court decision on 5 August 1997 ruled it was unconstitutional States and Territories to impose additional taxes on tobacco for revenue generation, thus questioning the legality of the NT alcohol tax. The NT Government opted to remove the additional alcohol tax and accepted a compensation package from the Commonwealth Government totalling $8 million to cover financial shortfalls. Revenue raised in the NT however differed from other States and Territories as alcohol tax raised was quarantined exclusively for projects and activities expected to contribute to reducing alcohol related harm levels whereas the Commonwealth compensation package incorporated an integrated substance approach.

Recent interest has been raised considering options to reintroduce an alcohol levy again in the NT, specifically for minimising alcohol-related harm. Treasury have been approached for their opinion and have indicated that while it could be possible legally to reintroduce an alcohol tax, even possible to introduce the tax in addition to the Commonwealth Government compensatory package. Their opinion is also that it should be well considered as to what really wants to be achieved through revenue raising with other options being considered.

In May 2000, the Treasurer announced that the LWA program would be refocussed. As part of this, government agencies that had received funding from LWA had the funds and responsibility for administration and outcomes transferred directly to them, namely:

- $0.11m to the Police for Alcohol Policy Coordination
- $0.1m to the Education Department for school based drug education
- $0.33m to the NT Licensing Commission for additional liquor inspectors
- $0.25m to NT Corrections for Rehabilitation counselling and education
- $0.125 to Legal Aid to ensure community access to legal services related to domestic violence
- $0.25 Chief Minister's, Office of Women's Policy for domestic violence and education campaigns
- $0.045 Chief Minister's, Office of Youth Affairs for promotion of the biannual youth festival

The Government's refocus of the program also resulted in reductions in AOD Program funding. An additional transfer of $.25m was made recurrently from the LWA program to the Mental Health Unit for Suicide Prevention provided a further reduction

Since funding for community grants was required to be maintained at existing levels, the full reduction in funding ($1.279m) had to be absorbed within the Department.

The amount of funding provided to the Family and Children's Services unit for the Sexual Assault Program, Aboriginal Family Violence Program and Domestic Violence Program was reduced by $439,000 or 34%.

The Government directive was that savings to the LWA program would be from within the internal budget ensuring that no non-government or service provision was effected. The LWA absorbed the remaining $840,000 reduction (constituting a decrease of 27% on the previous year's internal operational budget) by cutting 6 positions and reducing spending on the core operational activities of community education, training and media.

These changes had other consequential impacts on overall AODP operations.

- a refocus of regulatory/legislative responsibilities to the regulation of tobacco and pharmaceuticals and away from other program components eg. alcohol.
- the removal of responsibility for coordination of a whole of government approach to activity in relation to alcohol and other drugs, and
- an increased focus on the specific DHCS AODP public health responsibilities.

The organisational context within which the AODP operates has changed as the Department as a whole has reorientated its business environment through the implementation of a collaborative planning/purchasing framework emphasising increased:

- clarity of roles and responsibilities through implementation of a funder/purchaser/provider framework
- transparency and accountability and
- planning, development and delivery of services based on "evidence".

As the Program evolves over the coming years it will build on the experiences and achievements of the past whilst acknowledging the political, social and economic environment and changing evidence and needs of a new era.

LWA Strategic Approach.

Community Education and Research

The media strategy was strongly supported by the Community Education and Research personnel (CER). Customised health promotion and education strategies were researched, designed and developed that would change individual behaviour and create a supportive environment that facilitated change on an ongoing basis.

Key components:

- raise community awareness,
- community based activities to support media campaigns,
- promote responsible drinking,
- research projects

Specific target areas were:

- work sites

These included the Mining, Defence and Construction industries. Workplace training policy guidelines were developed, promoted, reviewed and catalogued. Peak bodies including the Trades and Labour Council, the Chamber of Commerce and Industry and the Public Service Commission were part of the process.

The Employee Assistance Service (EAS) were funded to incorporated alcohol issues into their regular workplace seminar stream.

Media campaigns and community education activities;

- young people
- Youth education focussed on preventing or delaying uptake of alcohol consumption thereby reducing alcohol-related harm. Media strategies included:
- 'How Will You Feel Tomorrow';
- 'Keep your Head Together'
- 'Lighten Up';

- ‘Choose Yourself‘;
- ‘Rehydrate Before You Celebrate’;and
- ‘Parents Campaign’.

A Youth Grants Program and Youth Worker Training programs were promoted and administered across the NT to encourage youth specific alcohol projects. Process actively encouraged non-alcohol specific services to become involved in addressing alcohol issues with young people connecting with their organisations.

Research into young people and drinking was conducted in 1995 and 1998 with both school and non-school students.

- the alcohol industry.

Coordination and collaboration with the NT Licensing Commission (formally the Liquor Commission) and the Liquor Industry was actively fostered to promote:

- public health policy and legislation;
- responsible serving practises; and
- innovative education programs in licensed premises such as the ‘Operation Drinksense’.

The two positions that promoted the coordination and collaboration with the Liquor Commission were abolished as part of the budget reduction.

Operation Drinksense

Incorporated a cooperative approach between LWA, Police, Non Government Organisation’s and the Liquor Industry. Developing community practices that would maintain initiatives beyond the early stages of the LWA was a crucial component to the program. Local committees were developed to conduct ‘Operation Drinksense’ in Darwin, Nhulunbuy, Alice Springs and Katherine to actively promote responsible drinking habits, responsible attitudes to drink driving among patrons through demonstrating the differing effects of light, mid and regular beers, education on standard drinks, and light beer as a choice promotion.

The Aboriginal Living With Alcohol Program (ALWAP)

The ALWAP comprised of a Director position based in the Policy and Program Development area, and community facilitation and training staff based in Darwin (2) and Alice Springs (3). The focus was to work with communities, individuals and community organisations to raise the awareness of alcohol and towards developing community driven strategies to address local issues of concern. The innovative ‘Storyboard’ was developed together with a training program and was used successfully in remote, rural and some urban communities. The Storyboard was also used as a training tool with Aboriginal Health Workers, Nurses and Allied Health Professionals. Interest was substantial from interstate health areas and the concept has become incorporated into additional educational tools and strategies.

A Handbook for Community Health Teams

In 1998 the ALWAP produced a handbook for Community Health Teams. The idea for the handbook grew out of talking with a group of community health workers at Gunbalanya who asked for some resources about alcohol to help them in their everyday work. Aboriginal Health Workers throughout the Territory also shared their stories about the alcohol related health problems they saw most often in their communities in support of the development of this useful education resource for communities.

Training from the handbook was carried out in the communities across NT by the ALWA staff in Darwin and Alice Springs to health workers and community members. The Handbook material is now included in the Bush Book and reflected in the introductory units of competence of the nationally accredited Certificate in Community Service (Alcohol and Other Drugs Work).

The most recent use of the handbook has been as a resource for the activities being undertaken by the Preventable Chronic Disease Strategy from Alice Springs.

Professional Development & Training

The program has continued a strong commitment to professional development and training.

Informal professional training and development included minimal intervention techniques, improved training for treatment personnel, the availability of group facilitation workshops and the development of a course in responsible serving for bar staff resulted from negotiations between the LWA program and industry service providers.

The "Key Worker Training Program" was developed and delivered to nurses in hospital settings to provide education to enable detection, intervention and referral of patients with alcohol related issues.

The advancement of formal professional training and development was provided through LWA funding to Batchelor College for the Certificate in Primary Health Care (Drug and Substance Abuse) course. Funding was provided for three years and included a requirement that training be upgraded to meet the requirements of the nationally accredited Community Service Training. Limited reported outcomes were considered in future training strategies.

Funding was provided to the Northern Territory University (NTU) to develop and incorporate alcohol education in undergraduate studies. NTU have increased their units to four and continue to provide through their normal student fee structures.

Limited training outcomes were addressed by the training focus being redirected to Front-Line Workers and the commitment to provide nationally accredited alcohol and other drug qualifications by specialised AOD trainers in Darwin, Katherine, Tennant Creek and Alice Springs

In 1999 a restructure of the AOD Professional Training and Development program was undertaken that would align with the national training agendas of the National Alcohol Strategy, National Drug Strategy, and the Australian Framework for Training and Assessment. The new focus provided access to nationally accredited alcohol and other drug training and assessment to those defined as 'Frontline workers'. The NT definition is broader than the national definition to include any persons who, in the course of their work, come into contact with alcohol or other substance issues.

Collaborative training and assessment with other Registered Training Organisations has been undertaken to provide flexible, accessible training opportunities. Partnerships with service providers to enable training and assessment within the workplace have been encouraged.

A consortium comprising TAFE (NSW), Next Step Specialist Drug and Alcohol Services (WA) and the Living with Alcohol Program (NT) won the Commonwealth Department of Health and Aged Care tender to develop and trial training resources for Frontline Workers

working with youth. Quality, accredited training packages that will have NT relevance are being developed and trialing commences in Darwin and Alice Springs in June 2002.

The program has also worked with community-based agencies in the development of the counselling program conducted by CAAPS and the drink-driving course developed by Amity.

Summary Chronological Order:

1	Key Worker Nurse training	aims to up-skill nurses to identify, manage and refer patients will alcohol problems.
2	Out-sourcing of training to Batchelor college	alcohol education training as part of Primary Health Care Certificate
3	Funding to NTU	to develop and deliver AOD training in four AOD courses
4	Frontline Worker Training	Align with National Strategy to develop the capacity of the AOD workforce
5	Consortium-Frontline Worker working with youth	Development and trialing of training resources for frontline workers working with youth. Commonwealth contract.
6.	Training for Frontline Workers	Frontline Workers Specialist topics to also include doctors in Brief Intervention, Alcohol and new pharmacotherapies, Assessment.

Research & Evaluation

Over the lifetime of LWA it was nationally and internationally recognised for its strong commitment to research, evaluation and strategies that are nested within an evidence based, contemporary practice model.

LWAP provided expertise to agencies involved in the delivery of treatment services to assist their evaluation programs and guide future development. This assistance was a necessary prerequisite that enabled agencies to examine the needs of their local community, to work collaboratively, to identify service gaps and to develop solutions.

Research conducted included;

- Illicit Drug Report (IDRS),
- Household Survey of Alcohol Consumption & Related Attitudes (1997),
- school based survey,
- Price and accessibility surveys. Determine consumption trends between full and light beer, soft drink and water and harm indicator data eg road fatalities, hospital admissions,
- Evaluations of LWA media and program activities,
- Harm indicator data.

6. AODP - STRATEGIC DIRECTION for ALCOHOL

The decision of the Hight Court in 1997 that the hypothecated tax was unconstitutional provided an opportunity for the LWA funding to be broadened from a specific focus on alcohol to include other drug program initiatives. The harm minimisation strategic direction of the LWA program remained unchanged. The LWA program remains only as a cost centre within the AOD Policy program. Services are purchased through the DHCS Services Development Division as an integrated approach from one AODP funding stream.

The primary aim of the AODP is to minimise the harm associated with substance misuse in the Northern Territory. The Program Plan provides a framework to actively pursue the broad strategic goal of minimising the incidence and impact of substance misuse on individuals, their families and the community.

The principle of a whole of government and community approach is considered essential and is reflected in the Program Plan together with the need to build and sustain linkages and partnerships with a range of stakeholders including consumers, government and non-government and private sector providers.

The program provides funding for services to respond to the harmful and risky use of alcohol, tobacco, illicit drugs, and inhalants and medications. Strategic responses include policy, regulation and legislation development, community education, community development and capacity building, training and professional development and treatment and care.

The program is underpinned by government legislation, policy and initiatives, Departmental directions and policies, national initiatives and agreements, internationally accepted frameworks and administrative procedures.

In 2001/2002 funding of $12.397m was provided for the AODP through sub program funding sources including the Living With Alcohol program (LWA), the Tobacco Action program (TAP), the Public Behaviour Program (PBP), the Commonwealth National Drug Strategy (NDS) and the National Illicit Drug Strategy (NIDC).

As at March 2002 funding to 39 non-government agencies for AOD services across the NT was provided through the Program. In addition 13 services are provided directly by DHCS ($3.356m or 32% of available funding for services).

7. AOD STRATEGIC APPROACH

Policy and Legislation Development

Development of Legislation and Policy influence behaviours by promoting practices that reduce harmful behaviours and moderate environmental risk factors.

Legislation relevant to the AOD Program;

- *NT Liquor Act* (1978) *Summary Offences Act* (1978) controls the public consumption of alcohol;
- *Private Security Act* (1995) governs behaviour on licensed premises;
- *NT Food Act* (1991) governs the labelling of beverages containing alcohol;
- *Traffic Act* (1987) relates to drink driving; and,
- *Gaming Control Act* (1993) restricts alcohol as a prize for major raffles or lotteries.

The NT Liquor Act is the responsibility of the Liquor Commission. However the Alcohol and Other Drugs Program supports the continuation of licences, which stipulate clear regulatory sanctions including provisions requiring licensees to implement best practice in the responsible sale and supply of alcohol. Also supported are licence conditions that inform the licensee and his/her staff of their responsibilities in a clear and concise way.

In the NT licensing restrictions have resulted in a dramatic reduction in alcohol related violence and injury without affecting the commercial interests of licensees (d'Abbs, Togni

and Crundall, 1997). Dry-area legislation has enabled some remote communities to maintain strong sanctions against drinking (National Alcohol Strategy, 2001). There is clear health and welfare benefits for the majority of people living in alcohol restricted areas. Any review of dry-area legislation needs to be guided by community consultation.

Legislation with regard to permits should be flexible to cater for the diverse needs of Aboriginal communities. It should remain a practice that communities in restricted areas can stipulate limits to the trafficable amount of alcohol that persons can bring into restricted areas. The process for amending or cancelling permits should cater to this need for flexibility.

The NT Government has committed itself to reducing alcohol consumption. Based on the clear relationship between extended trading hours and intoxication and violence, AODP opposed the extension of trading hours on public health and safety grounds.

A substantial number of young people under 18 obtain alcohol from licensed premises, and access takeaway outlets as their usual source of alcohol[13]. Training for staff of licensed premises, particularly in bottle-shops, to be aware of the provisions of the Legislation pertaining serving to minors has been a CER activity in collaboration with the Australian Hotel Association and licensed premises.

Community Education

Raising awareness about substance issues in the community and encouraging changes at both the individual and societal levels are priorities for the AOD Program. Community education seeks to facilitate long-term, sustainable change in the alcohol and other drug culture of the NT.

Community Support Officers (CSO) in East Arnhem (2), Darwin (2), Katherine (2), Tennant Creek (2) and Alice Springs (6) continue to raise issues in remote communities. However a major focus is upon assisting communities to develop strategies that will address substance issues they have identified as a concern for their community. Three Community Education Research positions are funded by AOD to provide community education research and resource development in Darwin and funding is provided to a non-government agency in Alice Springs for 1 position.

The following activities were initiatives of the LWA program and have been delivered within the AOD program:

Resources

Pregnancy Flip Chart

A Pregnancy flip chart to address foetal alcohol syndrome was developed as an effective training resource for remote communities. The original impetus for this resource was from communities of Kalkaringi and Daguragu. The flipchart may be used as a non-endorsed resource to meet some of the underpinning knowledge required in the Community Service Training Package, Certificates 2,3& 4 (AOD) , models CHCAOD2A, 3A, 5A & 8A.

Responsible Retailers Kit

Launched 2001, the kit includes information to retailers about their responsibility towards patrons, recommended alcohol limits, sobering up myths, managing customers, and offences & penalties for drink driving or refusing a breath test. The kit also promotes the roles of other services that work together with licensees, hotel managers and staff to provide information

and support to the community and industry, compliance with Liquor Act, Food Act, Public Health Act and National Food Standards Act and legal operations of business.

Operation Drink Sense
An interesting and entertaining education program held on licensed premises where patrons are shown the effects of low, mid and heavy strength beer through monitored consumption and confirmation of breath alcohol level by breathalyser. Events were promoted in media and a collaborative event between AOD, Police, non-government agencies and licensed premises.

AOD provided funding to DASA for community research and resource development in Alice Springs as part of Operation Drink Sense.

Drink Less, Live More
A responsible drinking alcohol campaign including practical strategies to reduce alcohol consumption. Included TV, radio, newspaper media plus production and dissemination of supportive kits by CER's and other Program staff.

Lighten Up
"lighten up" message, encouraging people to drink beer with a lower alcohol content.

When Worlds Collide
Aimed to reduce incidence of drink driving.

Women & Alcohol
The campaign targeted women who are more likely to consume cocktails. Includes standard drink information relating to cocktails.

Responsible Service of Alcohol (RSA)

Responsibilities of hotel staff towards patrons. Provided at Centralian College, Darwin Skills Development Scheme, Drug & Alcohol Services Association (DASA), NT Training Institute, NTU.

Sober Bob
The major thrust in developing attitude and behaviour shift towards reducing drink driving and associated harms. Licensed premises reward designated drivers with free soft drinks to ensure their friends get home safely. Supporting strategies included media advertisement through television and local newspapers, development and implementation of Pub Card, posters and T-shirts and various other promotional paraphernalia.

Whenever possible dovetailing to national campaigns that are NT relevant has been undertaken to provide value added media opportunity.

Community Development and Capacity Building

Minimising rates of anti-social behaviour, social disorder and offences related to alcohol and other substance use through:

- Community development
- Brokerage funding
- Targeted education
- Frontline Training
- Diversionary activities
- Partnerships/collaborations

An emphasis is placed on communities being increasingly able to identify and address their own substance issues. The Program is committed to building this capacity by supporting and training local community members, facilitating access to specialist assistance and contributing toward the development and maintenance of local action plans. This approach is one of facilitation rather than direction, with the emphasis on communities taking ownership of the processes, the issues and the solutions.

The Program is at a stage where review of media resources available and of community need or relevance is to be undertaken to ensure future media activities are well developed and address Government, Program and emerging priorities.

Family Coping Strategy

The Family Coping Strategy is a cooperative project between the Commonwealth Family and Children's Services, the NT Department of Health and Community Services and the Aboriginal Islander Alcohol Awareness and Family Recovery, a non-Government organisation experienced in providing family programs to Aboriginal families in remote settings.

The strategy builds on an international collaborative research project (Orford et al 2001) that acknowledges family members suffer the brunt of the abuse and difficulties that arise from others consumption of alcohol. Yet it is these family members that are often the ones holding the social fabric together. As a result they suffer significant physical, psychological and social stresses, impacting negatively on their own health.

The project aim is to equip people with the knowledge, skills and resources needed to effectively intervene with family members affected by the excessive drinking of close relatives. The 'stress-coping-support-strain' model is utilised to widen the theoretical and practical understanding of how family members are impacted on by a relative's substance abuse.

The key strategic task is to build family capacity to cope with illicit drug use that can be applied at a remote Aboriginal community level. Through selecting and receiving the assistance needed at times of transition and/or crisis, the Family Coping Strategy seeks to meet and support the needs of family members in their own right.

Public Behaviour Program

The Wine Cask Levy Program was reviewed and restructured in 2000/01 and the name changed to the Public Behaviour Program (PBP). Public awareness of the program and its purpose was increased. The Public Behaviour Program provides funds for initiatives which seek to directly prevent or reduce the incidence os antisocial behaviour in public places that is largely related to alcohol and other drug use. Priority is given to applications that focus on public drinking within the urban setting of Alice Springs, Tennant Creek, Katherine, Nhulunbuy, Palmerston and Darwin. In line with the collaborative planning and purchasing framework the responsibility of managing the funds was transferred to the Services Development Division.

Department of Health and Community Services administers a Public Behaviour Program to address the immediate impact of antisocial behaviour arising from alcohol misuse. Many Aboriginal communities, service providers and others with a large Aboriginal client group have benefited from this program. Supported projects are categorised into:

- Intervention: intervene in the cycle of antisocial behaviour to reduce harm in the community eg Night Patrols and Warden schemes;
- Diversionary: provide alternative activities to groups susceptible to substance misuse. These activities may include cultural, art/craft, sport and recreation; and
- Education: educational or preventative activities to reduce/prevent substance related antisocial behaviour.

Public Behaviour Program grants expenditure for 2001/02 of $996688 for eight grants includes night patrol, warden schemes, youth diversionary activities and youth services coordination throughout the NT.

Program Advancement and Development

The Program has retained its strong commitment to training and development of the AOD workforce.

The direction established during the LWA Professional Training and Development program has been continued striving to ever increase access to training opportunity for Frontline Workers and to ensure quality training is maintained meeting the Australian Framework for Training and Assessment.

In 2001 the AODP was 'show-cased nationally' as an example of flexible training and assessment delivery by Community Services and Health Training Australia.

Collaborative training and assessment with other Registered Training Organisations has been undertaken to provide flexible, accessible training opportunities. Partnerships with service providers to enable training and assessment within the workplace have been encouraged.

The quality of GP skills in providing 'Brief Interventions' with their clients and their knowledge about 'Alcohol and the New Pharmacotherapies was increased through accredited training, Continuing Medical Education (CME) sessions held in Darwin, Jabiru, Katherine, Tennant, Alice Springs and Kings Canyon.

A consortium comprising TAFE NSW, Next Step Specialist Drug and Alcohol Services (WA) and the Living with Alcohol Program (NT) won the Commonwealth Department of Health and Aged Care tender to develop and trial resources to train Frontline Workers working with youth. Our involvement has been essential towards developing training resources that will be useful in the NT when available nationally in 2002.

Frontline Training

NT AOD has a broader definition on frontline workers to include any persons who, in the course of their work, come into contact with alcohol or other substance issues.

The focus is on frontline workers who are most ideally situated to identify and appropriately manage alcohol or other substance problems. During 1999 and 2001 calendar years 762 Frontline Workers from over 35 different workplaces participated in accredited Alcohol and Other Drugs training. This equates to 42,480 hours of individual training opportunity.

Additionally over 150 Aboriginal Health Workers, CDEP workers, Community people received training with the Alcohol Handbook.

Brief Intervention Course

The course in ‘Brief Intervention’ is a Territory Health Services initiative, identified through the *NT Aboriginal Public Health Strategy and Implementation Guide* in regard to public health training needs for remote Aboriginal community health staff and related support service staff. The original course has been upgraded and now is an accredited short course.

Brief Intervention training continues to be trained as a specialist topic throughout the NT to GP’s, Night Patrols, Sobering Up Shelters and others by negotiation.

Negotiations are continuing between Department of Health and Community Services and the Australian Remote and Rural Training Systems towards development of a self-directed learning package, which will be available for Australia wide sale. Negotiations through the review of the Community Service Training Package have resulted in brief intervention being established as a new unit of competence.

Negotiations are continuing for the development distribution of a self directed Brief Intervention training package with Australian Remote and Rural Training Services in South Australia.

Training Resources

Workplace Resources

Workplace safety has been promoted through the launching of the “Taking Care of Business” alcohol and other drug kit in November last year. The kit provides workers and workplace management with accredited education sessions, assistance with policy development and information on managing staff with drug and alcohol issues.

The NT Employee Assistance Service (EAS) were contracted to conduct workplace alcohol and other drug education and training and trial and evaluate the delivery of the workplace kit.

In 2001, 48 people attended the one-day training programs from Darwin and Katherine.

A smaller pamphlet called What Workers Need to Know (this is included in the kit) has been extremely popular with approximately 1500 distributed in response to direct requests from workplaces.

The training package was developed to ensure that it met the competencies, skills and knowledge requirements for accredited training programs such as the Community Services Certificates II, III, Iv, and Diploma and Advance Diploma (Alcohol & Other Drugs Work).

Drink Driving Education

Participation in the drink driver course is required before recidivist and high alcohol level drink drive offenders have their licence restored. Training is provided through accredited training providers throughout the Territory to offenders on a fee for service basis.

Funding has been provided to Amity House to co-ordinate the drink-driving course throughout the NT. The co-ordination method of drink driver education will be reviewed within the 2002/03 year.

Patron Care Course

Section 123A of the *Liquor Act* makes the licensee vicariously liable for the actions of his/her staff. The *Liquor Act* provides motivation for a significant proportion of licensees to train their staff voluntarily, with some licensees making attendance at such training a condition of employment.

The Patron Care Course has received funding previously for development and delivery and co-ordination of training through AHA. As an accredited course it is also trained by other Registered Training Organisations that provide hospitality training.

Treatment and Care

Initially most of the treatment programs were alcohol programs only and funded through LWA. A commitment to a contemporary, integrated model to address substance abuse has enabled a broadening of the range of programs and activities. In 2001/02 the AODP funded $3,804,975 for treatment services.[8]

People who are intoxicated or have substance use problems that lead to antisocial behaviour, have the rights to be cared for in a safe and appropriate setting or manner.

The AOD Program ensures that there are a range of early intervention, treatment, rehabilitation and other intervention services. These are aimed largely at problem substance users, but can also assist the families and close associates of substance users. The emphasis is on providing effective long-term and acute services within culturally responsive environments, which can add significantly to health gains and improved wellbeing. This approach also supports the local accessibility of services wherever possible.

Night Patrols and Warden Schemes

Night Patrols are a community based intervention strategy that usually operates by mediating disputes and disturbances in public places, preventing antisocial behaviour by moving people on, and by providing transport to take intoxicated individuals home, to a safe house or sobering up shelter. The management and operation of the Night Patrols may vary in each community or town. Some communities are managed through local councils, others are grant funded and may employ only Aboriginal staff. Some communities have vehicles whilst others are patrolled by foot. The community shapes the service. For example in some communities the mere presence of Night Patrol Officers is considered valuable. Wardens Schemes are designed to make contact with people who are itinerant or behaving antisocially and ensure that they move to a more appropriate setting or refer them to support agencies that can assist.

The addition of a Top End Remote Area Night Patrol Coordinator will ensure that organisations wishing to establish Night Patrols undertake developmental work as identified by the Office of Aboriginal Development before commencing the service. The Coordinator will assist in identifying appropriate funding sources and provide support and networking for identified services.

Sobering Up Shelters

The PBP supports recommendations in the Muirhead Royal Commission to intervene early and prevent incarceration. Diversion to sobering up shelters has assisted this. Sobering Up Shelters provide support and accommodation to iterants and those affected by alcohol.

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[8] Service Development Unit Budget

Increased security at certain public events has helped eliminate loitering, vandalism and public disorder.

There are 4 Sobering Up Shelters funded by grants to NGO's in the NT: Darwin, Katherine, Tennant Creek and Alice Springs.

A review of Sobering Up Shelters was completed in 2001 and provides an evidence base for purchase of services and standards of care.

Number of admission to NT Sobering Up Shelters 2001/02[9]:

Darwin	4059
Katherine	2015
Tennant Creek	1235
Alice Springs	3,565

Corrections- 23.8% client referrals were to residential treatment services in July to December 2001 six month.

[9] Services Development DHCS database

Northern Territory Government

Department of Health and Community Services

ALCOHOL AND OTHER DRUGS

PROGRAM PLAN

2002 - 2005

Approved by DHCS Executive on ………………………
Endorsed by the Minister for Health and Community Services on ……………
Revision due: May 2005

1. PROGRAM STATEMENT

The primary aim of the Alcohol and Other Drugs Program is to minimise harm associated with substance misuse in the Northern Territory. This Program Plan seeks to provide a framework by which alcohol and other drugs services can actively pursue the broad strategic goal of minimising the incidence and impact of substance misuse on individuals, their families and the community.

The adoption of 'a whole of government and community' approach is essential to achieve these goals. Acknowledging this principle, the Program Plan emphasises the need to build linkages and partnerships with a range of stakeholders including consumers, Government, non-government and private sector providers.

People engage in the use of alcohol, tobacco and other substances for a variety of reasons. While use of some substances can offer social and health benefits, there are frequently negative outcomes that can accrue in terms of health and wellbeing. These outcomes affect not only the individual user, but they can also impact on family and friends and the broader community. Alcohol and tobacco have the greatest impact.

In addition to various acute and chronic health effects that arise from substance use, it is also implicated in a range of social outcomes that include the breakdown of relationships, social disruption, family violence and lost productivity. Along with health risks, these consequences of substance abuse extract significant personal, social and economic costs on the population. In monetary terms it has been estimated that alcohol-related harm alone costs the Northern Territory $477.5M per year. Since 1991, the Living With Alcohol program has contributed significantly to economic, health and safety benefits to the people of the NT. An estimated $31.08M per year saving has been attributed to this program.

Alcohol

Per capita adult consumption in Australia is an important indicator of alcohol related harm in the community. The NT figure of 14.0 litres is highest compared to other jurisdictions. The consumption of alcohol is reported to be twice as high in the Territory as elsewhere in Australia. In addition, the NT has the highest proportion of its population estimated to be drinking at hazardous and harmful levels - 15% of males and 6% of females compared to a national estimates of 7% and 4% respectively.

Alcohol has been involved in around two out of every three road fatalities over the last decade and accounts for 3.6% of hospital separations in the Top End. It has been estimated that the harm caused by excessive alcohol consumption accounts for 4.9% of the total disease burden in Australia. The impact of high-risk alcohol consumption is multifaceted. It includes health concerns such as some cancers, heart disease and stroke, liver disease, pancreatitis, gastritis, epilepsy, cognitive problems and dementia, as well as some psychiatric problems including depression, affective disorders and suicide. In addition, it is associated with high levels of injury and fatalities associated with motor vehicle accidents, falls, drowning, burns and occupational accidents, as well as high levels of interpersonal violence, particularly domestic violence, assaults and child abuse.

Alcohol consumption has been identified as a cause of concern to 57.4% of the NT Aboriginal population surveyed. There is, however, inadequate comparative information about the alcohol consumption patterns of Aboriginal people in remote, rural and urban settings.

Regional information lacks quantity or frequency data. Detailed usage patterns are only available for the Aboriginal population in urban settings and at a national level, and there is scant or dated information available at the local community level.

In terms of overall patterns, the National Aboriginal and Torres Strait Islander Survey reported 44.4% of NT Aboriginal people consumed alcohol within the last 12 months (58.4% of males and 30.7% of females). It is also well recognised that whilst the majority of Aboriginal people do not consume alcohol, the consumption patterns of those who do is a cause for concern. Research has indicated that 11% of the regular Aboriginal drinkers consume alcohol at a hazardous level and 79% at harmful levels.

Tobacco

The Northern Territory has the highest rate of tobacco use in the country. Around one in five adult deaths in the Territory have been attributed to cigarette smoking and 4% of hospital admissions are the result of smoking.

Among NT Aboriginal people, the two leading causes of death and disability are heart disease and respiratory disease. Smoking is recognised worldwide as a significant risk factor for these diseases. In 1996 the Australian Bureau of Statistics reported that Aboriginal men smoke at a higher rate in the NT (59%) than Australia-wide (54%), but Aboriginal women smoke at a lower rate in the NT (36%) than Australia-wide (46%).

Illicit drugs

The use of illicit drugs or the illicit use of other substances is difficult to quantify due to the illegal nature of the activities. Illicit drug use is a concern for public health programs because it causes significant harm to community health and wellbeing, particularly in relation to overdose deaths, infections, blood borne diseases, psychological dependence, mental illness, malnutrition, violent behaviour and criminal activity. However, the Territory is known to have one of the highest rates of morphine use in Australia and amphetamines are of increasing prevalence.

A 1996 survey of secondary school students highlighted widespread use of cannabis among young people in the Northern Territory. In 1994, 21% of NT Aboriginal people listed cannabis as a local problem, a concern that was more common in urban areas (45%) than in rural areas (13%) but tending to be on the increase in remote areas.

Inhalants

Petrol sniffing is a significant health and social problem, particularly for Aboriginal communities. It occurs periodically in relatively small numbers, a review in Central Australia in 1997 suggested that there were 200 sniffers in the region. These figures belie the nature of the problem as it often involves young people and can be extremely disruptive to communities. Petrol sniffing causes a range of serious health and behavioural issues.

Polydrug use

A number of individuals use a variety of drugs concurrently, and those who are dependent on a particular drug will frequently use others when that drug is not available. In line with national trends, reports from a range of service providers including alcohol and other drug agencies, community organisations, Aboriginal community-based workers and Department of Health and Community Services staff indicate that polydrug use patterns are also becoming

more prevalent. Alcohol and cannabis continue to feature regularly in anecdotal reports of polydrug use.

2. PURPOSE

2.1 Vision

The capacity of Territorians to manage inter- related health and wellbeing issues associated with harmful substance use has been enhanced through program and service improvements that reflect, a family focus, locally accessible services, responsiveness to individual needs, best practise evidence and Government priorities.

2.2 Mission

To promote individual and community wellbeing by minimising the harm associated with alcohol, tobacco and other drugs through a coordinated range of approaches.

2.3 Goals

- To increase the knowledge and skills of individuals and the capacity of families, communities and services to address substance issues.
- To engage in a range of resources to provide a variety of strategies and an optimum range of care and treatment services appropriate to meet the needs of people experiencing substance misuse problems.
- To support an environment, which encourages, enables and reinforces actions taken individually and collectively to minimise substance related harm.

3. CONTEXT

3.1 Definition and Scope

(a) Prevention and Early Intervention

The National Drug Strategic Framework identifies demand reduction as a priority for drug policy and practice. Prevention efforts, however, have lagged behind investments in treatment and law enforcement. In an environment where treatment and law enforcement have dominated debate, the fact remains that efforts need to be directed to reducing drug use and its effects on individuals, families and the community.

The intent of prevention and early intervention strategies is to stop the onset or escalation of harm. Prevention is defined (in the National Mental Health Strategy) as interventions that occur before the initial onset of a disorder.

Drug prevention activities to date have tended to focus on single risk factors or a 'just say no' perspective. More recently, the focus has shifted to one that emphasises education and information about drugs, their effects and harms, while promoting decisions to not use drugs or to use them in a safer way. The emphasis on education, rather than prevention per se, has occurred in a context where drugs are increasingly available and, in the case of licit drugs, actively promoted.

Providing opportunities and creating environments that support decisions to not use or misuse drugs, which promote meaningful activities in place of use and approach prevention from a developmental perspective, have been limited and ad hoc.

If the goal of prevention is to reduce harmful use and encourage individual and collective action on drug issues, it follows that opportunities for early intervention and treatment also need consideration. A review of prevention efforts needs to be conducted in light of a cost effective and efficient drug treatment system.
The Program accepts the need for the provision of an appropriate balance of different approaches across a continuum from prevention to treatment.

(b) Youth

NT Government policy identifies the interests of children as paramount, and a commitment has been made to put in place effective programs to ensure that the next generation gets the best possible start in life. Initiatives will be delivered through schools and youth centres, aimed at preventing young people from experimenting with drugs.

The Program is keenly aware of the need to provide adequate services to young people, particularly adolescents. This is based on input from the community, and the fact that while the ability of young people to meet life challenges is significantly influenced by early childhood development experiences, young people also have unique challenges to face that are shaped by their life stage.

Because of their risk taking tendencies and their relative inexperience with substances, adolescents are particularly vulnerable to substance related harm such as escalation into misuse and abuse, injuries, overdose, school and work disruption, contact with the criminal justice system and family conflict. It is for these reasons that young people have been a specific target of prevention activities. NT activities have centred on school based drug education, mass media campaigns and diversion activities. In spite of these efforts, both licit and illicit drug use amongst young people across Australia is increasing (within some age groups) and initiation into drug use occurs at a younger age than a decade ago.

There is a broad consistency between national, international and NT research results. However, NT data suggests that the prevalence of youth drug use is higher. The 1998 National Drug Survey reported 59% of people aged 14 years and over had tried cannabis, with 36% reporting use in the last 12 months.

(c) Remote Areas

The projected resident population for the Northern Territory in 2001 was 197,000 of which the Aboriginal population comprised 28%. While most of the NT population live in the major centres of Darwin, Katherine, Nhulunbuy, Tennant Creek and Alice Springs, the reverse is true for the Aboriginal population, with almost 66% living in remote communities, outstations and cattle stations.

NT Aboriginal populations are located in small, discrete and isolated communities that are separated by large distances. Differences between communities are considerable including social, historical, cultural, geographical and climatic factors. Services in urban settings are not widely accessible to people living in remote Aboriginal communities. In a community setting this includes prevention, early identification or effective treatment of problems relating to substance misuse.

Communities have identified a need for supportive community environments where local Aboriginal people are more able to take control of the identification of alcohol problems, pre-empt the emergence of problems and implement innovative local

solutions to those problems. This view is supported by NT Government policy that promotes capacity building, ownership of health outcomes and fostering partnerships with Aboriginal people.

3.2 Operating Environment

In pursuing its objectives the Program accepts that an appropriate balance of different approaches is needed. Three main areas of action are identified and are considered equally important for meeting the objectives of the program, although different substance issues may require a different emphasis on these individual elements. The three domains of action are:

(1) Culture - which refers to the substance-related knowledge, attitudes and behaviours of the general community and more targeted sections;
(2) Care - which concentrates on treatment and intervention services for those who are experiencing problems associated with substance use; and
(3) Control - which relates to regulatory, legislative or policy aspects involved in the availability, promotion, provision and consumption of substances.

The following strategies are incorporated within these domains.

(a) Policy, Regulation and Legislation

The Program assists Government to develop policies, and has input into the formulation of policies in other Government agencies and jurisdictions. This is achieved via representation on inter-departmental committees, the formation of specific working groups, selective funding and the provision of expert advice and objective and specialist information.

(b) Community Education

Raising awareness about substance issues in the community and encouraging changes at the individual and societal levels are Program priorities. Community education seeks to facilitate long-term, sustainable change in the alcohol and other drug culture of the NT.

(c) Community Development and Capacity Building

An emphasis is placed on communities being increasingly able to identify and address their own substance issues. The Program is committed to building this capacity by supporting and training local community members, facilitating access to specialist assistance and contributing toward the development and maintenance of local action plans. This approach is one of facilitation rather than direction, with the emphasis on communities taking ownership of the processes, the issues and the solutions.

Family members suffer the brunt of the abuse and difficulties that arise from other's consumption and are often the ones holding things together. They suffer significant physical, psychological and social stresses, impacting negatively on their own health.

NT Government policy places a high value on supporting families. In the alcohol and other drug field, attention has been predominantly given to how users can be supported to change their behaviour. Meeting the needs of families, in their own right, has been limited. The Family Coping Strategy aims to shift this focus by enabling practitioners, particularly those within primary care settings, to improve detection, intervention and support skills for relatives of people who misuse substances.

(d) Training and Professional Development

For sustained progress the Program has a commitment to increase the quality and pool of skills of people working in the area. Its focus is on frontline workers who are most ideally situated to identify and appropriately manage substance problems. Frontline workers include any persons who, in the course of their work, come into contact with alcohol or other substance issues. The Program supports primary health care providers and others to develop skills in effectively detecting and managing alcohol issues.

(e) Treatment and Care

The Program ensures there are a range of early intervention, treatment, rehabilitation and other intervention services. These are aimed largely at problem substance users, but can also assist the families and close associates of substance users. The emphasis is on providing effective long-term and acute services within culturally responsive environments which can add significantly to health gains and improved wellbeing. This approach also supports the local accessibility of services wherever possible.

(f) Links with Other Department of Health and Community Services Programs and External Organisations

Effective strategies for addressing alcohol and drug issues demand collaboration between all service providers. The Program expects that its outcomes will be achieved not only by the delivery of alcohol and other drugs specific services, but also by activities delivered or managed by other Department of Health and Community Services programs, other Government agencies, the community-based sector and commercial interests.

The importance of a whole of government approach which includes collaboration and effective working partnerships between Government agencies, is essential to address the complex issues associated with reducing alcohol and other drugs related harm. Partnerships such as with the Commonwealth Department of Family and Community Services are considered essential to the achievement of outcomes The Program must strengthen its pro-active approach in pursuing partnerships.

Close working relationships are needed with Commonwealth bodies such as the Department of Health and Ageing, Aboriginal and Torres Strait Islander Commission and the Office of Aboriginal and Torres Strait Islander Health, and also with local government. Prime stakeholders in the private sector include licensees, tobacco retailers, pharmacists, general practitioners and the like.

It is recognised that local community councils and local workers, who are often volunteers, play a significant role in Aboriginal communities. Fostering and strengthening links with these people is essential if sustained and effective actions to reduce alcohol and other drugs related harm is to occur in remote areas.

Where alcohol and drug services are dealing with young people, additional linkages need to be made with schools, juvenile justice and child protection, police, and recreational services, as well as working with the young people's families.

Linkages need to be developed with other health and welfare professionals, in particular general practitioners, and other services including mental health, housing and accommodation, social support, community health, Aboriginal health services and employment and training agencies.

3.3 Legislative and Strategic Framework

Government legislation and policy that influence and define the operating environment of the Program, and the activities in which it may engage include the:

- *Misuse of Drugs Act* (1994) relates to the supply of petrol for sniffing, the possession and cultivation of cannabis and the possession or consumption of other illegal drugs;
- *Poisons and Dangerous Drugs Act* (1995) regulates the prescription and supply of pharmaceutical drugs;
- *Kava Management Act* (1998) controls the availability of kava; and
- *Tobacco Act* (1992) covers sales and supply of tobacco.

Legislation related to alcohol includes the:

- *Liquor Act* (1978) is the primary legislation governing alcohol availability and the *Summary Offences Act* (1978) relates to the public consumption of alcohol;
- *Private Security Act* (1995) includes provisions about security on licensed premises and the *NT Food Act* (1991) contains regulations regarding the labelling of beverages; and
- *Traffic Act* (1987) relates to drink driving and the *Gaming Control Act* (1993) restricts alcohol as a prize for major raffles or lotteries.

The NT Government's 'Plan to Build A Better Territory: Building a Safer Community - Tough on Drugs' and related commitments have direct implications for the Program. A Taskforce on Illicit Drugs will report in mid-2002. A Select Committee on Substance Abuse was established in January 2002.

Department of Health and Community Services' policies which have particular relevance to the Program include - Preventable Chronic Diseases Strategy, Women's Health Strategy, Aboriginal Health Policy, Aboriginal Employment and Career Development Strategy, Aboriginal Public Health Strategy and Implementation Guide, and Strategy on Petrol and Other Inhalant Substance Abuse.

In addition to local policies and regulations, the Program is also influenced by the National Drug Strategic Plan 1998-2002 and its associated Action Plans, and the National Illicit Drug Strategy to which the NT is a signatory. The environment is impacted by Commonwealth laws relating to the taxation of alcohol and tobacco, the availability of kava and other matters relating to excise and license fees. The Commonwealth Government is a signatory to a number of international treaties and agreements that relate to supply and production and substances.

Internationally accepted frameworks such as Declaration of Alma-Ata, Ottawa Charter and the Jarkata Declaration underpin the strategic approaches of the Program.

4. PRINCIPLES AND PRACTICES

A number of key operating principles and practices underpin the Program.

4.1 Harm Minimisation

This approach aims to reduce the adverse health, social and economic consequences of drug use by minimising the harms of drug use both for the community and the individual without necessarily eliminating use. It is supported by activities that can be divided into three broad categories:

(1) Harm Prevention – activities focusing on the promotion of health and wellbeing within the community and for individuals;
(2) Harm Reduction – activities that aim to reduce the level of existing harm for individuals and the community to cope with them; and
(3) Harm Management – activities aiming to not have harm escalate beyond existing levels and to assist individuals and the community to cope with them.

In dealing with any particular substance it is important that an appropriate balance of these different aspects of harm minimisation is pursued. This recognises that a continuum of harm exists which demands a corresponding range of intervention goals and activities to address varying levels of risk. Abstinence is recognised as part of the continuum, just as some substance use is recognised as beneficial and not requiring any interventions.

4.2 Community participation and development

Maximising community participation is critical for sustainable change. While some situations clearly demand a capacity for reactive measures, the Program also concentrates on establishing and nurturing structures, processes and systems that the community owns and continues to use and evolve to moderate substance-related harm into the future. This includes the community being fully informed about alcohol and other drugs issues in order to effectively assess and generate its own needs, priorities and solutions.

4.3 Multi-dimensional problems and solutions

Problems are multi-faceted, flowing from a mix of personal, social, economic, political and environmental factors. Successful solutions cannot address one dimension in isolation. The Program considers the interplay between factors that contribute to different problems and seeks to modify them in an integrated and complementary fashion. The focus is on the person and setting. It is often unhelpful to consider individual substances.

4.4 Flexible and Varied Strategies

It is accepted that there is no one problem to address, or one client group to satisfy: different people in different locations experience different problems at different times, and different solutions will be required as a result. Flexibility and innovation are required in recognition of the types of problems that exist, the diversity of people who are affected, competing demands, variations in settings and changes over time.

4.5 Collaboration across sectors

People with alcohol and drug related issues and problems present to a wide range of services and providers, eg. primary health care and general practitioners, family counselling, youth services, mental health services. Determinants, risk and protective factors for substance related problems are shared with other social and mental health related problems and issues. The policies and practices of other sectors have significant impacts on alcohol and other drug use and outcomes.

Exposure is maximised, consistency of purpose is ensured and unnecessary duplication is avoided by integrating and focusing the activities of a range of agencies and organisations including Government Departments, regulatory and legislative bodies, community-based organisations, substance-specific agencies, generalist services, the hospitality industry and commercial interests. A collaborative approach also recognises the distinctive skills and knowledge possessed by different groups.

4.6 Research and evaluation

Research and evaluation activities provide critical data, which informs the Program on directions and provides the evidence base for activities undertaken. Research identifies needs and gaps for attention, analyses the relative contribution of different factors in substance-related problems, suggests strategies for implementation and refines interventions adopted from elsewhere to local conditions. Evaluation is critical for assessing the effectiveness of Program initiatives and activities (in terms of both how they are implemented and the outcomes that result) and ensuring that limited resources are being allocated for optimal achievement. It is also essential for monitoring progress over time.

Consequently, the Alcohol and Other Drugs Program is characterised by:

- commitment to the principle of harm minimisation;
- recognition of a multi-dimentional context of substance use and the need for a comprehensive and integrated array of strategies that address a number of dimensions;
- the use of community development and support methods to secure widespread community participation and generate sustainable change;
- collaboration across program areas;
- broad intersectoral collaboration;
- incorporation of research and evaluation activities to continually inform and monitor implementation; and
- commitment to a high level of competence and expertise within the workforce operating from specialist alcohol and drug agencies and an increased capacity among other workers to impact on substance issues.

5. PROGRAM OUTCOMES

By 2005 the Program will have:

(1) minimised the incidence and prevalence of substance misuse;
(2) minimised rates of anti-social behaviour, social disorder and offences related to alcohol and other substance use;
(3) minimised rates of premature death, diseases and injuries resulting from alcohol, tobacco and other substance use; and
(4) increased capacity among individuals, families, communities and services to respond to and cope with substance issues.

These will be achieved through a range of policy, program development and service outputs:

OUTCOME	OUTPUT GROUPS	OUTPUTS (Policy/services/activities)
Minimised incidence and prevalence of substance misuse.	1.1 Policy, Program Development and Services Review	1.1.1 Policy development 1.1.2 Policy review 1.1.3 Service / industry standards
	1.2 Community Education	1.2.1 Incentive grants and sponsorships 1.2.2 Educational resources 1.2.3 Targeted mass media campaigns 1.2.4 Targeted information sessions
	1.3 Controls	1.3.1 Legislative reforms 1.3.2 Healthy public policy 1.3.3 Enforcement 1.3.4 Service and industry standards
Minimised rates of anti-social behaviour, social disorder and offences related to alcohol and other substance use.	2.1 Capacity Building	2.1.1 Community development 2.1.2 Brokerage 2.1.3 Targeted education 2.1.4 Frontline training 2.1.5 Diversionary activities 2.1.6 Partnerships/collabora tions
	2.2 Safety and Care	2.2.1 Sobering Up Shelters 2.2.2 Night Patrols and Wardens Schemes 2.2.3 Respite
Minimised rates of premature death, disease and injury resulting from alcohol, tobacco and other substance use.	3.1 Optimum range of intervention services.	3.1.1 Non-residential assessment, counselling and referral 3.1.2 Brief intervention 3.1.3 Quit Courses 3.1.4 Cannabis cessation programs 3.1.5 Residential programs 3.1.6 Withdrawal and management services 3.1.7 Aftercare services

		3.1.8 Outreach 3.1.9 Screening 3.1.10 Clinical alcohol and drug services 3.1.11 Needle and syringe programs
	3.2 Harm minimisation controls	3.2.1 Legislative reforms 3.2.2 Substance access and availability 3.2.3 Substance related policies (eg. workshop).
Increased capacity among individuals, families, communities and services to respond to and cope with substance issues.	4.1 Workforce Development	4.1.1 Training professionals 4.1.2 Training frontline workers
	4.2 Community engagement and capacity building	4.2.1 Family coping program 4.2.2 Counselling 4.2.3 Brief intervention 4.2.4 Individual social skills training 4.2.5 Community development 4.2.6 Brokerage 4.2.7 Targeted education 4.2.8 Partnerships / collaborations

Department of Health and Community Services AOD Funding 1999-2002

1999/2000	$000	Explanatory Notes
Tobacco Action Project	511	
Living With Alcohol	7,591	• includes $1.29M to Family & Children's Services for Domestic/Family Violence and Sexual Assault activities. • includes $3.9M for community and intrasector grants
Wine Cask Levy	1,147	• full allocation for community grants
National Drug Strategy	651	
Alcohol & Other Drugs – General	4,773	• includes $3.15M for community grants
Total	**$14,673**	

2000/2001	$000	
Tobacco Action Project	516	
Living With Alcohol	4,898	• includes $2.6m for community grants • $.25m Suicide Prevention (Mental Health)
Domestic Violence/SAP	851	
Public Behaviour Program	1,165	• full allocation for community grants
National Drug Strategy	564	
Alcohol & Other Drugs - General	1,584	
Services Development	3,317	• includes $3M for community grants
Total	**$12,895**	

2001/2002	$000	
Tobacco Action Project	524	
Living With Alcohol	2,663	• includes regional staff funding but not grants
Public Behaviour Program	172	• includes allocation for refurbishment of Tennant Creek Sobering Up Shelter
Domestic Violence/SAP	205	
National Drug Strategy	700	
Alcohol & Other Drugs - General	1,583	
Services Development	6,550	• includes $6.36M for community grants (LWA, PBP, AODP)
Total	**$12,397**	