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Developing a Place-based Alcohol Indicators Framework to Monitor and Evaluate Alcohol Management Plans and Other Alcohol Initiatives in the Northern Territory: Final Report

Volume 1: The Framework – Development and Implementation

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List of Acronyms

Acronym	Definition
AAIs	Alcohol Action Initiatives
ACAs	Alcohol Catchment Areas
ADU	Alcohol Data Unit
AMPs	Alcohol Management Plans
AOD	Alcohol and Other Drugs
APAs	Alcohol Protected Areas
APOs	Alcohol Protection Orders
ARG	Alcohol Reference Groups
BDR	Banned Drinkers Register
DoB	Department of Business
CAAPU	Central Australian Alcohol Programme Unit
CDEP	Community Development Employment Projects Programme
ED	Emergency Department
ERP	Estimated resident population
FA	Factor Analysis
FASD	Foetal Alcohol Spectrum Disorder
GEC	Government Engagement Officer
IEO	Indigenous Engagement Officer
NT	Northern Territory
NTG	Northern Territory Government
NTNER	Northern Territory National Emergency Response
PAC	Pure alcohol consumption
PCAC	Per capital alcohol consumption, also known as apparent per capita consumption of alcohol is determined by dividing the total alcohol supplied by an estimate of the population likely to be drinking. National statistics include those people aged 15 years and above as the likely drinking population.
RJCP	Remote Jobs Communities Programme
SA2	Statistical Area 2 (ABS Australian Standard Geographical Classification)
SEWB	Social and emotional wellbeing
SFNT	Stronger Futures in the Northern Territory
SuS	Sobering-Up-Shelter
TAA IP	Tackling Alcohol Abuse Implementation Plan
TBLs	Temporary Beat Locations
The Framework	A place-based framework for monitoring and evaluating AMPs and other alcohol initiatives in the Northern Territory
VSA	Volatile substance abuse

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Glossary

Word or phrase	Definition
Administrative data	Refers to information collected primarily for administrative (not research) purposes. This type of data is collected by government departments and other organisations for the purposes of registration, transaction and record keeping, usually during the delivery of a service. Can be referred to generically as secondary data.
Gunja	Cannabis (other colloquial names include marijuana, grass, green, mary jane, buds, head)
Ice	Methamphetamine or amphetamine
Community sourced data	Survey and key informant data collected for this study to answer specific, locally salient questions. Also known as primary data.

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Executive Summary

Introduction

This report presents findings and recommendations from a project to establish a place-based alcohol indicators framework for monitoring and evaluating Alcohol Management Plans (AMPs) and other alcohol initiatives in the Northern Territory (NT). The task was not to evaluate AMPs and associated programs, but to create a systematic approach to the collection, collation and reporting of a range of alcohol-related and community safety and wellbeing indicators. These indicators will be drawn from government administrative data, but also include indicators and information from community surveys and community key informants. Reporting a set of indicators in a systematic manner over time will assist communities and government in assessing the effectiveness of local programs and policy on reducing alcohol related harms and improving community wellbeing.

This report consists of three volumes:

1. The Framework: Development and Implementation;
2. Key Informant Interviews: Understanding community views on alcohol harms, identifying local community indicators and determining the best approach to feeding back information; and
3. The Community Alcohol and Wellbeing Survey: Measuring alcohol patterns of use, and community strengths and problems.

Volume 1 provides an overview of the study methods and design; presents key findings, including community data reports; makes recommendations regarding implementation and ongoing maintenance of the Framework; and includes a suite of templates and guidelines to assist with the implementation. Volumes 2 and 3 provide a detailed description of the methods and findings relating to the community sourced data (key informant interviews and community survey) used in the development of the Framework.

Background

The pattern of alcohol consumption and the associated harm experienced by Indigenous Territorians is a concern, particularly in the case of remote communities where alcohol problems are amplified by social disadvantage. This has led to a range of policies by both the Northern Territory Government and the Federal Government, which focus on managing alcohol in Indigenous communities. Regional Alcohol Management Plans (AMPs) have existed in the Territory for over a decade and are developed through NT Government processes under provisions in the *NT Liquor Act*. By contrast, AMPs in Indigenous communities come under the jurisdiction of the Federal Government and are governed by provisions in the *Stronger Futures in the Northern Territory Act 2012 (SFNT).*

Under the SFNT Act, community AMPs have required formal approval from the Federal Minister for Indigenous Affairs. However, under new arrangements negotiated between the Federal and the NT Government in 2015, this requirement has been removed in practice,

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although the enabling legislation remains in place. This shift has been accompanied by a focus on developing Alcohol Action Initiatives (AAIs), which will be funded by the Australian Government, and implemented by the NT Government in consultation with communities. AAIs are regarded as a less complex approach to implementing the harm reduction strategies contained in AMPs. One of the requirements arising out of the SFNT AMP program is the development and implementation of a framework to enable communities, governments and other stakeholders to more effectively monitor and evaluate AMPs, and related initiatives, on an ongoing basis.

Currently, the capacity for monitoring and evaluating alcohol-related initiatives is limited, due to: the absence of an efficient system for collecting, analysing and reporting data at regular intervals; inadequate knowledge about what constitutes suitable alcohol-related indicators for local communities; and issues in accessing NTG administrative data in a timely manner, due to the complexity of each department's data release arrangements. In addition, while there is a substantial volume of administrative data, it is not always useful at the community level. Reasons for this include: smaller communities may not have the services that generate administrative data; low numbers of alcohol-related events mean trends often show random variation, rather than meaningful changes; and the quality of administrative data at the community level can vary. Consequently, there is a need to collect additional data from communities through, for example, local surveys and interviews that can provide the information necessary to assess the effectiveness of AMPs and AAIs. The development of a system to provide communities with regular data reports will enable communities to become more engaged in the monitoring and evaluation process, and increase community capacity to self-direct community action in relation to alcohol problems and associated harms.

The present study was initiated in 2014, with Menzies School of Health Research (Menzies) being engaged by the NTG Department of Business (DoB) to develop a place-based framework for monitoring and evaluating AMPs and other alcohol initiatives (The Framework) under the SFNT.

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Framework aims and objectives

The primary aim of The Framework is to provide a coherent and efficient system to enable community AMPs/AAIs to be monitored and evaluated on an ongoing basis. Essentially, The Framework and its elements will provide a sustainable model for collecting, analysing and reporting data over the longer term (noting that *SFNT* is for 10 years). The Framework will effectively be a 'package' of the key elements necessary to achieve this. It will be developed and presented in such a way as to ensure ease of administration by the NTG and to facilitate use by Alcohol Reference Groups, or equivalent committees, in communities whose members may have limited experience interpreting quantitative and qualitative research data. The key elements to be included in the Framework package are:

- A minimum core set of quantitative indicators drawn from health and social data contained in NTG and other administrative datasets.

- A survey instrument and semi-structured interview schedule to enable collection of local data from communities with AMPs.
- A core set of local level quantitative indicators that can be collected by communities.
- A set of guidelines and templates to support the regular and systematic collection of data sourced from communities.
- A reporting framework describing procedures for reporting data to a variety of audiences, including templates and procedures for reporting data.
- Protocols to facilitate timely access to data from NTG departments and other administrative data sources (e.g. Commonwealth, NGOs).

Methods: Development of the Framework

Study design

The study design is comprised of three components:

(1) Identifying, sourcing and assessing usefulness of administrative data;
(2) Community sourced data (community survey and key informant interviews); and
(3) Framework implementation.

The first two components focused on the identification, collection and analysis of alcohol-related indicators, while the third component drew on findings from components (1) and (2) to formulate the final Framework package.

Ethics approval was obtained from the Central Australian Human Research Ethics Committee (CAHREC) and the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health (HREC). Additional permissions were obtained from Aboriginal communities participating in the study and from various Aboriginal organisations as required.

Study sites

The study population is comprised of eight Aboriginal communities, with each community selected from the pool of 29 communities that are being supported to develop and implement AMPs and AAIs under SFNT legislation as at January 2015. The Indigenous population in these 29 communities totals over 13,000, with individual community populations ranging from 108 to 2,034. Each of the eight study sites has a majority Indigenous population. Potential study sites were identified through consultations with staff from the NTG Department of Business who had ‘on the ground’ experience in SFNT AMP communities. The final selection was based on a set of criteria devised to provide a sample that was broadly representative of the 29 SFNT communities, taking into account factors such as: geographic location; population size; alcohol management characteristics; and resources.

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Component 1: Administrative data

Administrative data investigated for The Framework was sourced from the following NTG departments: Police, Attorney General, Health, Education, and Business. Data from the Australian Curriculum, Assessment and Reporting Authority (ACARA) was also investigated, and population counts were sourced from the Australian Bureau of Statistics (ABS). Several data sources that should be considered for future inclusion in The Framework were not included in the final set of indicators, either because data were not made available, or because initial exploratory analyses indicated the data quality to be too poor. These include: child notifications, alcohol-related traffic accidents, night patrol pick-ups, and local health centre data.

Data quality assessment of administrative data

The quality of administrative data sourced from government departments was assessed with reference to the ABS Data Quality Framework which includes the following dimensions: institutional environment; relevance; timeliness; accessibility; accuracy; interpretability; and coherence. A key benefit of The Framework will be the ability to compare a range of data sources over time, allowing for a better understanding of the coherence of the different data indicators. Determining the quality of indicators contained in the administrative data will provide users with the information needed to make informed decisions regarding changes observed in indicators over time, and as importantly, be used to inform processes that lead to improvements in the quality of administrative data.

Component 2: Community sourced data

Component 2 involved interviewing key informants (Phase 1) and collecting survey data from residents (Phase 2) in each of the eight study sites.

In Phase 1, interviews were conducted with between 7 and 15 key informants from each community, totalling 89 interviews across the eight study sites. Key informants were defined as those with extensive local knowledge of alcohol-related issues affecting the community. They included both Indigenous and non-Indigenous individuals who played an active role in the day to day functioning of the community and in determining its social and cultural priorities (e.g. service providers, Elders, community safety committee members). A semi-structured interview schedule was used to collect data through an exploration of the following domains: views on alcohol-related issues in the community; perspectives on community alcohol management; identification of local indicators that could be collected by the community; and preferred methods for reporting data to communities. The method developed by Ritchie and Spencer to facilitate large scale social research, was used to analyse the data and to identify common themes. Information from the key informant interviews also informed the development of the survey instrument for Phase 2. See Volume 2 of this report for more details.

In Phase 2, a Community Alcohol and Wellbeing Survey (CAWS) was conducted in each of the eight study sites, with participants drawn from the Indigenous adult population (18 years

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or more). Participants had to have lived in the community for 12 months or more and quotas on age (less than 35 years/35 years and over) and gender (male/female) were used to ensure the sample was representative of age and gender. In each location, we attempted to sample around 50 people, which was based on sample calculations that would produce estimates with relative standard errors less than 25%, if random sampling had been done. The survey captured information on a range of factors, including: alcohol consumption and patterns of use; problems caused by alcohol; community strengths and problems; perspectives on alcohol management and alcohol support services; and social and emotional wellbeing. A range of statistical techniques were used to analyse data, including simple linear regression models, factor analyses, and Chi-square tests to assess statistical significance. Community scores were produced for per capita pure alcohol consumption, community and household alcohol problems, and community strengths and problems. See Volume 3 of this report for more details.

Results: Indicators identified as suitable for inclusion in The Framework

Component 1: Administrative data for inclusion in The Framework

Indicators for inclusion in The Framework were grouped according to the following domains: Alcohol Consumption Patterns; Community Safety; Community Health and Wellbeing; and Community Education. The following table lists administrative data indicators recommended for inclusion in The Framework and whether they should be reported at a regional or community level or both.

Domain	Indicator	Community or Regional
Alcohol Consumption	Pure alcohol consumption Percentage alcohol type	Regional only
Community Safety	Offence rates for assaults	Both
	Percentage alcohol involvement	Both
	Percentage DV involvement	Both
	Offence rate for stealing, break & enter, theft, & property damage	Both
	Offence rate for driving under influence	Regional only
	Percentage female victims of assault	Both
	Percentage less than 20 years victims of assault	Regional only
	Percentage 50 years or more victims of assault	Regional only
	Percentage Indigenous victims of assault	Regional only
	Admissions to Sober-up Shelter by region	Regional only
Community Health and Wellbeing	Hospital admissions rate for acute alcohol-related diagnoses	Both
	Hospital admissions rate for chronic alcohol-related diagnoses	Regional only
	Emergency department attendance rate of all external injury diagnoses	Both
	Percentage of head, elbow and forearm, wrist and hand external injury diagnoses	Both
	Percentage Mother's drinking alcohol in 1st or 3rd trimester	Regional only
	Percentage Non-term births	Regional only
	Number of births	Regional only
	Average birthweight term births by alcohol use	Regional only
Community Education	School enrolments and percentage average daily attendance	Both
	NAPLAN numeracy and literacy for Years 5 and 7	Community but not regional

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Component 1: Processes for accessing administrative data

Processes for accessing administrative will primarily be governed through Memoranda of Understanding (MoUs) that will be drawn up between the DoB and the relevant government departments. Each MoU will include an agreed record specification that sets out which indicators are required, the years for which data are to be supplied, and the data delivery periods. This will streamline the process and ensure that DoB receive pre-agreed data at regular intervals. MoUs have been drawn up with the following NT Government departments: Health; Attorney-General and Justice (includes police offence data); and Education. A record specification has been developed to facilitate ongoing data requests for NAPLAN (literacy and numeracy) data from ACARA.

Further negotiations will need to be undertaken with the relevant data custodians in relation to the use of night patrol, child notifications, Aboriginal Community Controlled Health Centre data and motor vehicle crash data, as this data was not made available over the course of the study. This would be beneficial, as these data sources are likely to have high relevance for monitoring and evaluating alcohol-related harms, and should be assessed for their inclusion in The Framework.

Component 2: Key informant data for inclusion in The Framework

Key informant data provides a rich source of contextual information that is not available through administrative or survey data. It has the potential to inform the interpretation of findings from administrative and survey data and will also provide a more in-depth understanding of the issues communities face in relation to alcohol management. In addition, key informant data provides a means of identifying structural and resource issues that may affect the success of alcohol-related programs, as well as a means of evaluating the effectiveness of processes used to implement these initiatives. It is recommended that relevant key informant data be included under each domain (alcohol, education, safety, and health and wellbeing) in community data reports, where these data relate to alcohol and the particular domain. Furthermore, information from key informants will become of greater importance, once information on AAIs and other programs are included in the community context section of the Community Data Reports (see below and Chapter 4).

Component 2: Community survey data for inclusion in The Framework

The community survey provided more nuanced information than the administrative data. Of key importance is the ability to use the survey to collect alcohol consumption data at the community level, as this is a central indicator that is not available from any other source. It also provides important information on a range of community problems, education and wellbeing. The table below lists indicators recommended for inclusion in The Framework from the survey.

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Domain	Indicator
Alcohol Consumption	Mean community PAC on last drinking occasion Frequency of alcohol consumption on last drinking occasion Where people consumed alcohol on last drinking occasion Type of alcohol consumed on last drinking occasion Number of types of alcohol consumed
Community Safety	Change in community alcohol problems Mean community score for community alcohol problems Mean community score for household alcohol problems Mean community score for problems factor: Violence and Anti-social Behaviour Mean community score for problems factor: Gambling & Problematic Social Relations Mean community score for problems factor: Poor Community Safety Mean community score for community drug problems
Community Health and Wellbeing	Mean community score for strengths factor: Respectful Relationships Mean community score for strengths factor: Children Cared for & People Attend Ceremony Mean community score for strengths factor: Healthy Social Engagement
Community Education	Highest year of schooling Non-school qualifications

The community strengths listed under the Community Health and Wellbeing domain have been modified since this survey was carried out, and now reflect community participation in a range of activities including: Sporting events, School events and/or programs, Cultural events (e.g. Art, music, healthy living festivals), Traditional or Law Ceremonies, Church, Women's groups, Men's groups, and Art groups/centres.

Other community sourced data for potential inclusion in The Framework

A set of local level indicators, which could be collected by the community, was identified through the key informant interviews. These indicators relate to the everyday life experience of community members and include things like drinking at the social club, children not attending school after parents have been drinking heavily, loud parties keeping people awake at night, and women going to the safe house to avoid violence. The incorporation of indicators that have direct relevance to everyday life, and which would directly involve the community in the selection, collection and reporting processes, has the potential to increase community ownership of alcohol management. These data would be held by the community, but also sent to DoB for inclusion in The Framework Database. There are currently no systems in place for collecting these types of data and AAI officers from the DoB would need to work with the community to set up these systems. Ideally, a community member would be employed on a part-time basis to coordinate collection and entry of these data into The Framework database. Further detail on these proposed indicators can be found in Chapter 3, Section 3.2.2.

Community Data Reports

Chapter 4 contains a detailed data report for each of the eight study sites, with each report including information from administrative, survey and key informant data. These reports organise indicators under Alcohol Consumption Patterns, Community Education, Community Safety, and Community Health and Wellbeing and will provide each participating community with a comprehensive snapshot of the current status of alcohol-related harms in their community. In addition to reporting the indicators under each domain, each data report

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contains a: Highlights summary; Community context; Data sources; Interpretation of graphs and statistical testing for each domain; and Limitations and purpose of the data.

Interpretation and assessing change in indicators

Administrative data is reported in 6-monthly periods from 2008 for education, offences and victims data and from 2005 for hospital admissions and emergency department attendances data. Reporting 6-monthly time trends ensures that seasonal changes in the series can be identified. Statistical tests are carried out on these data to allow users to determine:

1. If a change in an indicator from year to year is significant for each 6-month period (e.g. Jan-Jun 2014 compared with Jan-Jun 2015; and Jul-Dec 2014 compared with Jul-Dec 2015).
2. Whether the indicator is significantly different from the NT wide number.
3. The trend in the indicator (18-month (3-point) moving average trend line).

Community scores from survey data (e.g. average PAC, community problems etc) for each of the eight study sites are reported and allow the user to determine:

1. Where a particular community ranks for each indicator, in relation to the other seven communities surveyed (more if more communities surveyed).
2. Whether the community score for a particular community is significantly different from the average of all eight.

Categorical data from the community survey, where reported, includes the average for all eight communities for that particular indicator (e.g. non-school qualifications).

Key informant data is reported under each of the four domains and provides additional interpretative information to the survey and administrative data. Information from key informant interviews is also included in the community context section of data reports.

Highlights scoresheet

The ‘Highlights’ page at the beginning of each data report summarises how indicators have changed compared with the previous year. This can be used as a score sheet to assess if things have generally improved, stayed the same or declined across the four domains and the community as a whole. Further validation work on the scoresheet is required to assess the relevance and usefulness of changes over time in domain scores.

Feeding data reports back to communities: Suggested format

The format used for the data reports is intended as a template for future community data reports generated through The Framework. These data reports should be made available to the relevant community safety committee, alcohol reference group or other appropriate body at least once per year. They should be in a format such as a Word document or PowerPoint, so relevant sections of the report can be used by groups within the community to develop educational materials and alcohol-related interventions that have direct meaning for the community.

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Composite indicators and assessing relative need

Individual community data reports provide longitudinal data for the community, which is compared to the NT wide measure for each indicator. However, understanding the relationships between different indicators across communities will assist in evaluating the effectiveness of larger-scale policies and programs, and help to identify important community contexts which mediate the effectiveness of alcohol harm reduction programs. Chapter 5 presents a multivariate analysis of cross-sectional data for 2014 to provide an example of how this type of analysis can further value-add to the data collated for The Framework. The multivariate analyses in this chapter include: the development of composite indicators within and across the Community Health and Wellbeing, and Community Safety reporting domains; an approach to identify associations between different indicators that are not apparent when simply viewing individual community data reports; and an approach to assessing the effectiveness of large-scale policy decisions.

Implementing quantitative and qualitative community data collection and reporting

The extensive scope of The Framework poses significant implementation challenges, particularly with respect to the collection of community sourced data and the effective reporting of data to remote communities. Consequently, an integral part of this study has been to develop systems and mechanisms that will streamline processes related to accessing, collecting and reporting data. Over the course of the study, a suite of resources have been developed to assist DoB with the collection of community sourced data. These processes vary considerably according to the data source, and the challenges of collecting community sourced data should not be underestimated, particularly as the intention is to eventually collect these data for all 29 SFNT communities.

If these data are to be of good quality it will be necessary to ensure that: field work is adequately supervised; key informant and survey managers and interviewers are well trained; and field based key informant interviewers and survey administrators are neutral in relation to community politics. Full details on implementing community sourced data collections are in Chapter 6 of Volume 1, with the resources developed for The Framework now summarised for each of the primary data collections.

Resources for administering the Community Alcohol and Wellbeing Survey

- The original Community Alcohol and Wellbeing Survey has been refined, based on the analyses done in Volume 3 of this report, with the updated instrument contained in Appendix 3.
- An alcohol consumption conversion table for group drinking in Appendix 4.
- Visual prompts to assist interviewees in understanding Likert scales used in the survey.
- A training manual for the CAWS has been developed and is in Appendix 10. This includes information on the CAWS, goes through each question in the instrument and has examples of collecting data on alcohol consumption.

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Resources for administering key informant interviews

- An interview schedule in Appendix 11.
- A training manual for key informant interviews has also been developed and can be found in Appendix 10.

Adding additional community sourced data to the community data reports

As noted earlier, the collection of local level indicators by the community would require AAI officers and local community members to work together to develop systems for collecting these data. Chapter 6 includes a table which sets out a range of proposed indicators, and flags actions that may need to be taken to collect and report these data. These include: selecting the indicators that are to be collected; determining who will collect and report the data; developing a template for recording data; developing criteria to ensure that the measurement of indicators is consistent over time; and negotiating permission to access and report data where indicators are already collected by local community groups (e.g. information from the social club, permit club, and safe house). Examples of templates that could be used to collect and report on these types of data are included in Appendices 14 and 15.

Refinements to data reports to communities

Key informants from the eight study sites provided insights as to the best methods for presenting data in ways that are meaningful and relevant to the lay person, and suggested avenues for disseminating information from alcohol-related data reports to community members. Informants emphasised the need to keep graphs simple, to include explanatory text and to increase engagement by employing a creative approach through the use of pictorial effects, or combining graphs with pictures that relate to the information being depicted.

It was generally agreed that a DoB officer should be responsible for presenting data reports to a nominated key stakeholder committee (or committees) and that committee members would then use their networks to disseminate the findings more broadly. Two main methods for disseminating information were put forward: dissemination through service providers; and dissemination through public mediums such as posters, newsletters, video-loops, community meetings/barbeques (public within the community, not the general public).

Public mediums would focus on disseminating information to the community as a whole, and would primarily provide an overview of the key results. Dissemination through service providers, such as the clinic, school, police and safe house, would be targeted at small groups and focus on extracting specific data from the report for use in the development of education and intervention tools.

Many community stakeholder groups have limited resources with which to develop materials for disseminating information through public mediums, and informants expressed a preference for the government to supply these materials with the data report. This would be highly resource intensive, but one option is for the government to employ an Indigenous graphic designer to develop a generic template into which relevant data could be inserted.

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This could be used for all communities and would potentially have a shelf life of several years. Alternatively, communities could apply for funding to develop their own dissemination materials, with one avenue for such an application being the new National Partnership Agreement on Remote Aboriginal Investment that is currently being negotiated with the NT Government. Dissemination through service providers is largely dependent on their interest in developing education and intervention tools and their ability to access the data. Data access should be facilitated by ensuring that the data report is provided to the community in a form such as PowerPoint or Word, so that graphs and text can be easily copied.

Where to from here?

Key elements of The Framework are now in place and a range of resources (Chapter 6) have been developed to support the implementation process. The program of works encompassed by The Framework is extensive, and its successful implementation will require strong central management and a high degree of coordination.

Over the longer term, it is intended that The Framework will expand to include data from up to 30 SFNT communities, which will pose considerable challenges in terms of logistics, staffing, and resources. It will be important, at an operational level, to address these challenges by ensuring that:

1. The Framework is led by an experienced manager;
2. Adequate resources are available to access the statistical and research expertise necessary to undertake the types of analyses recommended for use with Framework data; and
3. Staff undertaking field work are adequately trained and supervised.

The novel design and comprehensive coverage of The Framework means that ongoing maintenance, collection of data and production of resources (e.g. data reports, community survey, key informant interviews and analyses) will be onerous, particularly in the first year or two of implementation.

There would be significant benefits to the NTG in partnering with an external organisation, with relevant technical expertise, to assist in management, collation, collection, analysis, presentation and feedback of data. A partnership would lead to greater accountability, transparency and sustainability of The Framework.

Addressing quality in administrative data will also require resourcing to ensure that a continuous quality improvement approach is taken, whereby data custodians receive regular updates on data quality in order to identify ways to improve it over time. For example, recording alcohol consumption by pregnant women in antenatal care visits varies substantially, with missing data, ranging from 10% to over 30% across communities. Regular feedback to health centre workers, who collect this data, describing how it is used to improve

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outcomes should create greater ownership and, with training, can lead to substantial improvements to data quality over time.

Similarly, ensuring the sustainability of community sourced data collection will require ongoing engagement with remote communities by demonstrating the value of The Framework through the provision of regular reports in appropriate formats. Positioning The Framework to ensure that it receives the ongoing support necessary to its long term sustainability and further development, will require the maintenance and strengthening of relationships with both government data custodians and external stakeholders, as well as a communication strategy that clearly sets out the benefits for both government and remote Indigenous communities.

The Framework has great potential to improve understanding of alcohol problems and their association with community health and wellbeing in Aboriginal communities and regions in the NT. The data reports developed for this project can be used by communities, government and other stakeholders to better understand the effectiveness of alcohol and wellbeing programs operating in communities. Providing the information directly to those people seeking to make change for the better in their community is empowering, and something the project team has witnessed first hand while carrying out this project.

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Recommendations

Recommendations for managing and developing The Framework

- That NTG give consideration to partnering with an external organisation, with relevant technical expertise, to assist in management, collation, collection, analysis, presentation and feedback of data. A partnership with an external organisation would lead to greater accountability, transparency and sustainability of The Framework.
- That staff selected to conduct community surveys and key informant interviews are provided with adequate training as set out in the Community Alcohol and Wellbeing (CAWS): Training manual (Appendix 10) and the Guide for Conducting semi-structured interviews (Appendix 12).
- That further multivariate analysis is carried out for more indicators, particularly with the inclusion of school attendance data and survey data (once more communities are included in the Community Alcohol and Wellbeing Survey).
- That composite indexes be developed for each domain and their relevance and usefulness in relation to assessing change in alcohol-related problems be explored.
- That further investigations be carried out to explore the feasibility and usefulness of producing an annual report which highlights the state of play in SFNT communities, across the indicators included in the Framework.

Recommendations on administrative data

- That regional and community level administrative data indicators identified in Chapter 3, Section 3.1, be included in The Framework.
- That night patrol, child notifications, local health centre, and motor vehicle crash data be followed up and assessed for data quality and indicators added to The Framework if suitable.
- That a system be setup whereby the Department of Business feeds back information to data custodians on the quality of data provided, thereby creating a continuous quality improvement approach to data quality.
- That the NT Department of Health repeat the validation of hospital demographic data carried out in 1998 by Condon et al, or revisit recommendations and implement as required.
- That the ABS Indigenous Location (community) estimated resident population data used for denominators in calculating rates be re-calibrated once 2016 Census population usual resident population counts and estimated undercounts by Indigenous status are available.
- That discussions be held with ACARA regarding the possibility of setting up an MoU to facilitate the automatic release of NAPLAN data. It might be possible to facilitate this through the NTG Department of Education.

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Recommendations on community sourced data

- That community surveys and key informant interviews be conducted annually, or every two years, in each community covered by The Framework.
- That the Department of Business work with communities to set up systems to collect and report on data from relevant local level indicators as set out in Table 16, or other appropriate local indicators that may be developed in the future.
- That in each community, a community member be appointed on a part or full-time basis to work with the AAI officer to coordinate the collection and reporting of these data.

Recommendations on community data reports

- That community data reports be made available to the relevant Community Safety Committee, Alcohol Reference Group, Local Authority Board, or other appropriate body (pending discussions with the community), at least once per year.
- That validation work be undertaken on the Scoresheet on community data reports to assess the relevance and usefulness of changes over time in domain scores.
- That further work be carried out exploring the relevance and usefulness of the community score card in the Highlights section of data reports.
- That DoB explore the feasibility of developing generic, but culturally sensitive materials, to facilitate the presentation of alcohol-related data in a way that is relevant and meaningful to people living in remote communities
- That community data reports be provided in a format such as a Word document or PowerPoint, so relevant sections of the report can be used by community service providers or other stakeholders to develop educational materials and alcohol-related interventions that have direct meaning for the community.
- That information in community data reports is fed back to local residents of communities through a range of mediums to ensure the information is available to as many residents as possible.

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1. Introduction

This report presents findings and recommendations from a study to establish a place-based alcohol indicators framework for monitoring and evaluating Alcohol Management Plans (AMPs) and other alcohol-related initiatives in the Northern Territory. The report consists of three volumes: (1) The Framework - Development and Implementation; (2) The Key Informant Interviews - Understanding community views on alcohol harms, identifying local community indicators and determining best approach to feeding back information; and (3) The Community Alcohol and Wellbeing Survey - Measuring alcohol patterns of consumption, and community strengths and problems.

Volume 1 sets out recommendations regarding the implementation and ongoing maintenance of The Framework; provides an overview of the study methods and design; presents findings from administrative, survey and key informant data in the form of data reports for eight communities; presents findings from the data quality assessment of administrative data; and includes a suite of templates and guidelines to assist with the implementation process in relation to data access, collection, analysis and reporting. It is suitable as a stand-alone document where the interest of the reader is primarily to understand how The Framework was developed and how it could be implemented. Volumes 2 and 3 provide a more detailed description of the methods and findings in relation to the community sourced data used in the development of The Framework. The key informant data presented in Volume 2 includes a detailed analysis which identifies and synthesises themes across all of the communities that participated in the study while in Volume 1, key informant data is simply provided in summary form for each of the communities. Volume 3 includes results from all of the variables generated from the community survey, whereas Volume 1 only includes the results which have specific relevance to The Framework.

1.1 Background

Australia is well known for its drinking culture, with alcohol often treated as a central ingredient of cultural and family celebrations, social and business functions, and recreational and sporting events (Midford 2005). This widespread acceptance of alcohol as a normal part of Australian culture is reflected in comparatively high levels of per capita alcohol consumption (PCAC), with 2010 data ranking Australia 10th out of 34 OECD countries in terms of consumption (Organisation for Economic Development and Cooperation 2015). Alcohol consumption in the Northern Territory (NT) is particularly high, with apparent PCAC of 12.21 litres recorded for 2014 (Northern Territory Government 2015b) compared to 9.71 litres recorded for Australia overall (Australian Bureau of Statistics 2014). The difference in PCAC between the NT and Australia is largely due to the substantially higher proportion of Territorians that drink at risky levels (52.6% compared to 43.6% nationally) (Australian Bureau of Statistics 2012a). The impact of higher consumption is reflected in the disproportionate amount of alcohol-related harm occurring in the NT, with the total social costs associated with these harms estimated at $4,197 per adult for the year 2004-05

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compared to $943 per adult estimated for the nation as a whole (South Australian Centre for Economic Studies 2009, p i).

Alcohol consumption also varies by Indigenous status, with estimates from the 2013 National Drug Survey showing that Indigenous Australians are more likely to abstain from alcohol than non-Indigenous Australians, however, those who do drink are more likely to do so at risky levels (Australian Institute of Health and Welfare 2014). In addition, the majority of Indigenous abstainers are ex-drinkers, many of whom ceased drinking because of their health (Wilson, Stearne, Gray & Saggers 2010). In 2004/5 and 2005/6, Skov, Chikritzhs, Li, Pircher and Whetton (2010) found that non-Aboriginal residents of the NT were twice as likely to die from alcohol-attributable causes as Australians nationally, while Aboriginal residents of the NT were between nine and ten times as likely to die from alcohol-attributable causes. In the 2011-12 NT Annual Crime Statistics Report, alcohol was recorded as a factor in 65 percent of assaults on Indigenous females and 64 percent on Indigenous males, compared to 43 percent on non-Indigenous females and 53 percent on non-Indigenous males, while the alcohol-related victimisation rate for Indigenous females in 2011-12 was 18 times the rate for non-Indigenous females (Department of the Attorney General and Justice 2012, p 15).

1.2 Policy context

The long-standing heavy drinking culture in the NT has generated a number of policy responses since the NT was granted limited self-government by the Australian Government in 1978. These have included provisions in the NT *Liquor Act,* under which local communities can elect to ban or restrict the possession and consumption of liquor; government-imposed bans on consuming liquor in public places; a ten-year public health-based 'Living with Alcohol' program from 1991 to 2000 that yielded a significant decline in alcohol-attributable deaths (Chikritzhs, Stockwell & Pascal 2005, Stockwell, Chikritzhs, Hendrie, Fordham, Ying, Phillips, Cronin & O'Reilly 2001); and a short-lived 'Banned Drinkers Register' in 2011/12. More recently there has been a mix of law-enforcement measures that include mandatory treatment for individuals repeatedly apprehended for public drunkenness; Alcohol Protection Orders that prohibit designated persons from consuming alcohol or entering licensed premises; and 'Point of Sale Interventions', under which police stand outside bottle-shops and stop persons from entering the premises if they are unable to nominate an address where the possession of liquor is legal (d'Abbs 2015). In 2005, the NT Government also announced its intention to support the creation of Alcohol Management Plans (AMPs) in towns and other communities under a new 'Alcohol Framework' (Northern Territory Government 2004).

Concerns about the impact of alcohol on Indigenous communities have also resulted in greater Australian Government involvement in the NT policy making process than occurs in other jurisdictions. Australian Government input was initially shaped by the *Northern Territory National Emergency Response Act 2007* (NTNER) (Commonwealth of Australia 2007) which, among other things, imposed alcohol prohibition, not only on almost all remote Aboriginal communities (thereby over-riding restrictions already in place under the NT Liquor Act), but on all land defined as Aboriginal land under the *Aboriginal Land Rights*

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(Northern Territory) Act 1976, except where specifically exempted. In 2012, the NTNER Act was superseded by the *Stronger Futures in the Northern Territory Act 2012* (SFNT) (Commonwealth of Australia 2012), which continues to give the Australian Government extensive powers with respect to regulating access to alcohol in remote NT communities (Commonwealth of Australia 2012).

Over the last decade, the NT Government has used AMPs as a key strategy for minimising alcohol-related harms (Northern Territory Government 2004), with AMPs being implemented in both regional towns and remote communities. Regional centre AMPs, and AMPs with a primary focus on geographical areas not covered by the SFNT Act, are developed through NT Government processes linked to the NT *Liquor Act*. These AMPs include Alice Springs, Tennant Creek, Katherine, Groote Eylandt, Nhulunbuy/East Arnhem (the Gove Peninsula), and Jabiru/Kakadu Park (Conigrave, Proude & d'Abbs 2007, d'Abbs, Ivory, Senior, Cunningham & Fitz 2010, d'Abbs, McMahon, Cunningham & Fitz 2010, d'Abbs, Shaw, Rigby, Cunningham & Fitz 2011, Senior, Chenhall, Ivory & Stevenson 2009).

AMPs in remote communities are governed by Australian Government legislation, initially under the NTNER, and later the SFNT. Under the SFNT Act, community AMPs have required formal approval from the Australian Government Minister for Indigenous Affairs. However, under new arrangements negotiated between the Australian and NT Governments in 2015, this requirement has been removed in practice, although the enabling legislation remains in place. This shift has been accompanied by a focus on developing Alcohol Action Initiatives (AAIs), which will be funded by the Australian Government and implemented by the NT Government in consultation with communities. AAIs are regarded as a less complex approach to implementing harm reduction strategies contained in AMPs, and in communities which already have an AMP, will take into account the strategic framework provided by the AMP. AAIs will enable communities to select a small number of goals that are directly relevant to their community, and which they perceive as achievable, given the local context and available resources.

1.3 The need for systematic data collation for monitoring and evaluation purposes

The capacity to collect and report on relevant data is essential to the effective monitoring and evaluation of alcohol-related harm reduction strategies. Currently, there is a dearth of capacity in this area due to the absence of an efficient system for facilitating the regular and timely collection, collation and reporting of data; a lack of knowledge about what constitutes suitable alcohol-related indicators for local communities; and a lack of knowledge about the best methods for reporting data to community residents.

Although administrative data held by the NTG includes a wide range of alcohol-related indicators, the ability to utilise this data for monitoring and evaluation purposes is severely hampered by issues related to data access, data quality, and related to data quality, the suitability of the data for smaller population communities. Alcohol-related data is sourced from a number of datasets held across a range of government departments, each of which has

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its own rules for releasing data. This impedes the ability to put together coherent data reports in a timely manner and inhibits effective monitoring and subsequent evaluation. Similarly, there are gaps in knowledge about which alcohol-related indicators yield the best quality data and are most sensitive to change at different levels of analysis. There is a need to address these issues if community level data is to usefully inform understanding and decision making in this area. Evaluation of AMPs has primarily occurred at the regional level and the indicators used to evaluate regional AMPs may not be as effective in remote community settings, due to significant differences in infrastructure, population, and access to alcohol outlets and services. In addition, administrative data, when used in isolation, may not always be the most effective way of monitoring and evaluating alcohol-related initiatives in small communities, as low numbers of alcohol-related events make it unrealistic to expect change to be statistically significant.

One of the requirements arising out of the SFNT AMP program is a framework to enable communities, governments and other stakeholders to more effectively monitor and evaluate AMPs, and other alcohol initiatives, on an ongoing basis. The present study was initiated in 2014 in response to this requirement, with Menzies School of Health Research (Menzies) being engaged by the NTG Department of Business (DoB) to develop a place-based framework for monitoring and evaluating AMPs and other alcohol initiatives under the SFNT.

Development of The Framework sits within the Stronger Futures legislation, and also meets the needs of the NT Government in monitoring alcohol-related indicators of harm that impact on regional and urban community safety and wellbeing. There are five key stakeholders for whom The Framework will be of use. They are:

- Indigenous communities and their corresponding Alcohol Reference Group, Community Safety Committee or other equivalent committee;
- Northern Territory Government;
- Australian Government;
- Researchers; and
- Peak Indigenous organisations (e.g. AMSANT).

The NTG Department of Business will be responsible for maintaining and implementing The Framework.

1.4 Project Aims

The primary aim of this study is to conduct the research necessary to develop a framework that will provide a coherent and efficient system to enable AMPs and related initiatives to be monitored and evaluated on an ongoing basis (noting that SFNT is for 10 years). Both administrative data and locally collected community data will be included in The Framework. Intrinsic to the development of an effective framework is the embedding of data collection and reporting mechanisms within key governance systems, namely: NTG departments; Australian Government departments that collect data from nationally funded alcohol-related

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programmes; NGO service providers; and relevant committees in remote communities such as Alcohol Reference Groups (ARGs), Community Safety Committees or Local Authority Boards.

More specifically, the study aims to:

i. Develop a minimum core set of quantitative indicators drawn from health and social data contained in NTG and other administrative datasets.
ii. Develop a reporting framework to facilitate the timely provision of administrative data on an annual or 6-monthly basis.
iii. Identify indicators of consumption and harm that can be collected at the community level and develop methods and guidelines for the regular and systematic collection and reporting of these indicators, for example, key informant interviews and community surveys.

In addition to the above, the NTG Department of Business has undertaken to develop a database for recording contextual information that may impact on alcohol management, such as community/regional events; services; resources; and changes to regulations e.g. local liquor outlet licences. This database will assist with the interpretation of data by identifying contextual factors that may have influenced trends in alcohol harms and by identifying factors that may have impacted on alcohol-related program outcomes.

1.5 Outline of the Report

This section has provided background to the project and an overview of the supporting policy context.

- Chapter 2 describes the overall study design.
- Chapter 3 discusses the quality and usefulness of data from both community and administrative sources and the extent to which these data can provide useful alcohol indicators for inclusion in The Framework.
- Chapter 4 presents data reports for the eight communities participating in the study, with these reports including administrative, survey and key informant data.
- Chapter 5 examines the potential to use multivariate analyses techniques to explore relationships between all the indicators for all communities simultaneously and to develop composite indexes for each domain.
- Chapter 6 draws on the data quality assessments (Chapter 3) and exploratory analysis of data (Chapter 4, and Volumes 2 and 3 of this report), and provides detailed guidelines, protocols and templates for (a) accessing, collecting and analysing the alcohol-related data that is to be included in The Framework; and (b) for reporting data to identified audiences including: SFNT communities identified by the DoB, and the Alcohol Policy and Strategy Unit, DoB.
- Chapter 7 concludes the report by summarising key findings and making recommendations with respect to the ongoing development, implementation, support and management of The Framework.

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2. Study Design and Methods

The aim of this section is to provide an overview of the study design and a summary of the methods used to develop The Framework. More detailed descriptions of the overall project methodology and of the methods used for individual components of the project are contained in:

- The *Place-based Framework for the Evaluation and Monitoring of Alcohol Management Plans and Other Alcohol Initiatives in the Northern Territory: Methodology* (Stevens, Midford, Buckley & d'Abbs 2015);
- Volume 2: *Key Informant Interviews – Understanding community views on alcohol harms, identifying local community indicators and determining best approach to feeding back information;* and
- Volume 3: *The Community Health and Wellbeing Survey - Measuring alcohol patterns of use, and community strengths and problems.*

2.1 Study Overview

The research design used an integrated, mixed methods approach, in which both quantitative and qualitative data were collected or accessed from a number of different sources. This approach is particularly useful in community settings where an understanding of both the scale and context of the issue being investigated is important (Creswell 2013). As shown in Figure 1, the study design has three components, two of which are focused on research and one which draws on findings from the research to create the actual Framework.

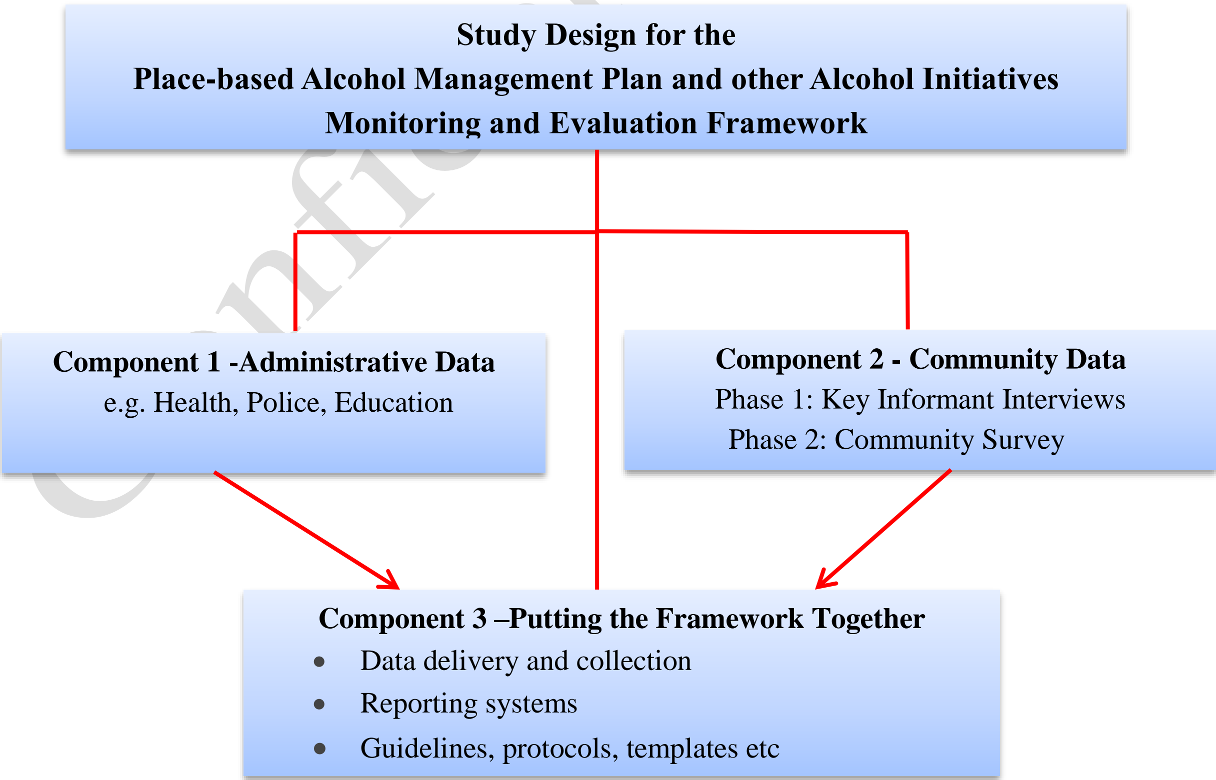

Figure 1: Overview of study design

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The administrative data component includes: exploratory analysis of indicators from a range of administrative datasets to identify their suitability for use at various geographic levels; an assessment of data quality; identification of alcohol catchment areas and linkage of data at the community level; and negotiation of ongoing data access with administrative data custodians in relation to specific alcohol-related datasets. Component 2, community sourced data, includes two phases: Phase 1, key informant interviews; and Phase 2, a community survey. The main purpose of Component 2 is to identify alcohol-related indicators that can be collected locally in each community and to explore the feasibility and usefulness of developing these indicators into a dataset that can be routinely collected as part of The Framework. However, Component 2 has also provided an opportunity for collaboration with communities and has enabled community members to have input into, and greater ownership of, The Framework. The function of Component 3 is to formulate the actual Framework, based on research findings from Components 1 and 2. The Framework includes alcohol-related datasets, and systems, protocols, guidelines and templates for accessing, collecting and reporting data in a sustainable, efficient and timely manner.

2.2 Ethics

As study sites are located across the whole of the Northern Territory, ethics applications were submitted to the Central Australian Human Research Ethics Committee (CAHREC) as well as to the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health (HREC). Full ethics approval was received from CAHREC on 5 May 2015 and from HREC on 6 May 2015. Prior to conducting the research, a range of approvals and permissions were also obtained from other organisations including: Miwatj Health Aboriginal Corporation; Central Land Council; Northern Land Council; and the Tiwi Land Council. As per ethics requirements, participants in the community survey and the key informant interviews were provided with an information sheet about the project and required to sign a consent form acknowledging their agreement to participate in the research.

2.3 Conceptual Framework

A high proportion of harms experienced by Indigenous people are alcohol related and these harms, together with the involvement of services such as police and health, often occur outside of the community where they live. Consequently, an ecological approach has been adopted to ensure that where possible, The Framework takes into account the linkages within the immediate geographic area covered by the community, as well as linkages to surrounding regional areas. Figure 2 illustrates the hierarchical relationship between different geographic levels, with an explanation in Box 1. The levels are: SFNT AMP community and outlying but connected community fringe areas where drinking occurs; alcohol supply catchment areas (ACAs); larger regional areas where there are service and other regional relationships; and the Northern Territory as a whole. The relationships between these geographical areas will differ across communities depending on remoteness; distance to nearest alcohol outlet; the cultural ties between communities and other places of significance; and the types of services and

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programs available in the community (e.g. police station etc.). Because of the hierarchical and multi-factorial relationship between the community and surrounding geographical areas, it is necessary to develop a scalable place-based framework that can be adapted to the particular circumstances of each community and which can also be updated over time.

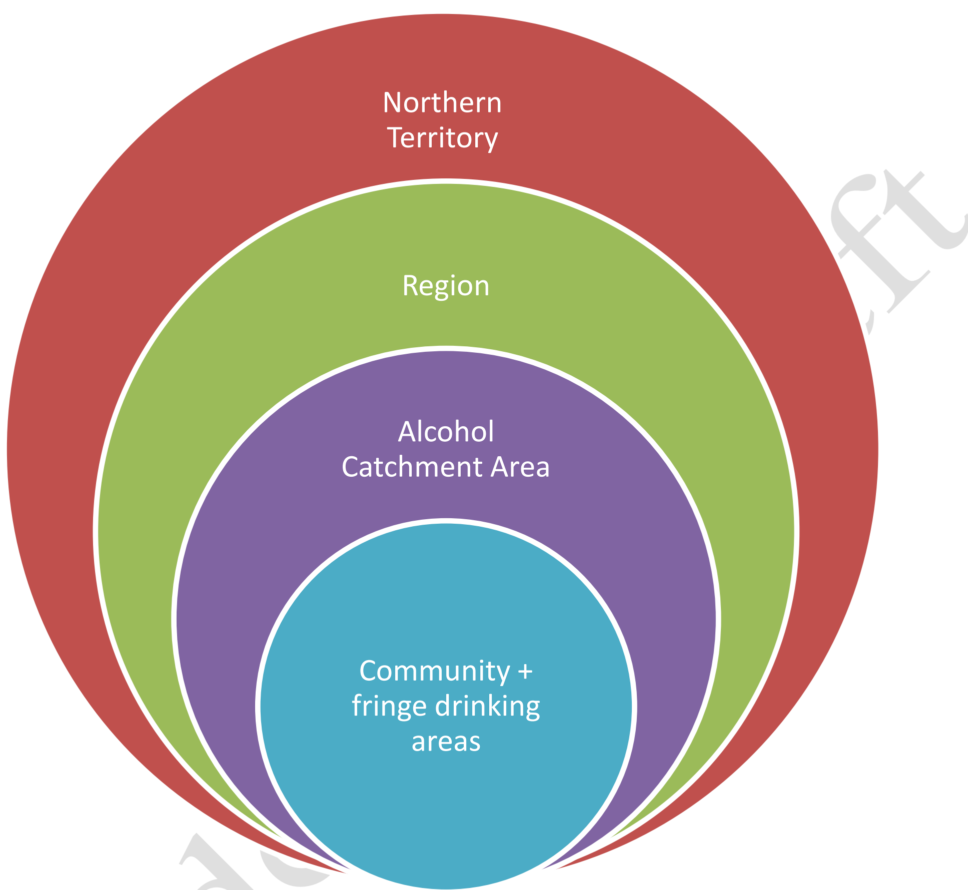

Figure 2: Conceptual diagram of how communities/townships fit within larger geographic levels (see Box 1)

Box 1. Notes on the conceptual diagram of how communities/townships fit within larger geographic levels in the Place-based Framework and AMPs (Figure 1)

1. The geographical area defined by the community boundaries, including fringe areas where drinking occurs.
2. The Alcohol Catchment Area (ACA) relates to accessibility of alcohol. A catchment will need to include two or more commercial alcohol outlets, and may include more than one community (and associated fringe drinking areas).
3. The region comprises a geographic area where there is a functional relationship between its constituent parts. It may include multiple communities (and fringe areas) and ACAs.
4. The Northern Territory completes the hierarchy and reflects that some policies to reduce alcohol-related harms will be large-scale or NT wide (e.g. Banned Drinkers Register), while others will be more locally driven (e.g. Temporary Beat Locations).

One of the major challenges in developing a scalable Framework is to find a way to deal with differences in the geographical boundaries applied by the various government departments that supply the administrative data. These differences in how boundaries are applied mean that the geographic boundaries for data from the first three levels of Figure 2 may not always be hierarchical in nature. That is, regional health service data may follow one set of

boundaries, alcohol supply data may have another set of boundaries, justice system data may follow a third set of boundaries, and so on. AMPs and AAIs implemented under AMPs may relate to parts of one or more geographic areas in different data sets. Therefore, it is expected that community level data will need to be aggregated to match the various hierarchies of geography for which The Framework will need to cater. Aggregation will also be required due to: the small size of the population in some communities; the sensitivity of outcomes to capture trends rather than natural random variations; and to ensure confidentiality of commercial alcohol suppliers.

AMPs have been implemented at different times in different communities, though the influence they have as an intervention can be represented similarly for each community and is shown in Figure 3. AMPs, and the AAIs developed under AMPs, aim to change alcohol consumption patterns and improve community safety, health and wellbeing. The data gathered from continuous monitoring and evaluation can be used to determine the effectiveness of AMPs and AAIs, leading to changes in AAI approaches and implementation in a similar manner to continuous quality improvement (CQI) approaches (Bailie, Si, O'Donoghue & Dowden 2007, One21Seventy 2014).

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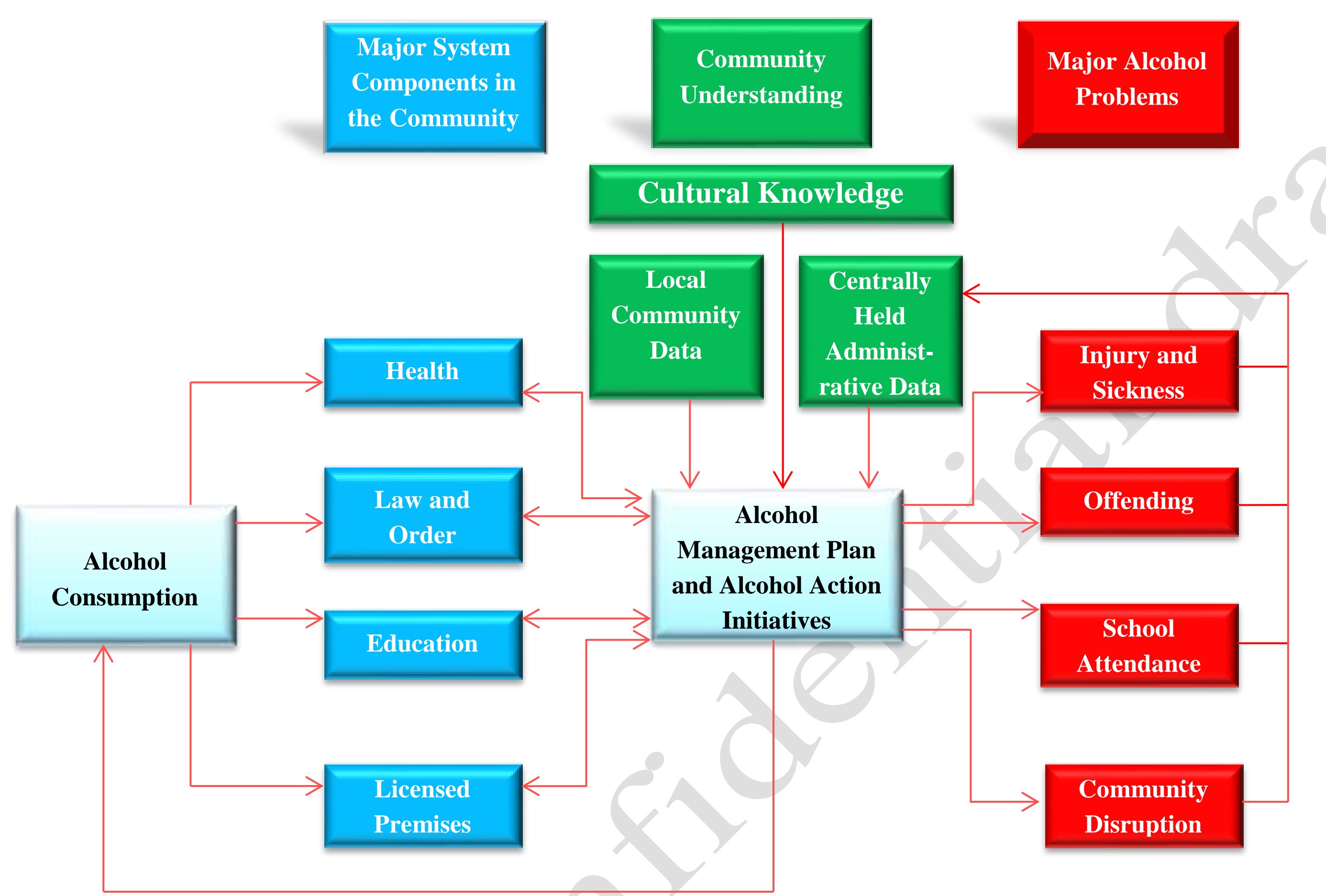

Figure 3: Continuous quality improvement cycle between AMP, AAIs and alcohol-related harms

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Furthermore, it would be expected that regular analysis and feedback of community level data will lead to an improved understanding of the quality of each source of data, which in turn can influence collection procedures leading to improved data quality (e.g. less missing data).

2.4 Study setting and population

The study population consists of eight remote Aboriginal communities that have been selected from the 29 communities that are being supported to develop and implement AMPs and AAIs under SFNT legislation as at January 2015 (Figure 4) (Northern Territory Government 2015a). The Indigenous population in these 29 communities totals over 13000, with populations ranging from 108 to 2,034, with an average of just over 550. Nearly all of these locations are considered very remote according to the ABS remoteness classification, and have a majority Indigenous population. The eight study sites selected for 'in-depth' study were identified through consultations with staff from the NTG Department of Business who had 'on the ground' experience in SFNT AMP communities. These eight communities were selected because, collectively, they provide a broadly representative sample of the 29 SFNT communities. The criteria used in the selection process are set out below:

- The ability to provide a good geographic spread across NT regions and remoteness;
- Size – communities with both small and large populations are represented;
- Regulatory and enforcement characteristics – e.g. representation from communities with and without a police station, permit system, or social club;
- Varying degrees of resources.

Table 1 summarises the key characteristics of each community and shows the extent to which the eight communities, as a whole, met the criteria outlined above. In order to comply with ethics requirements these eight communities have been de-identified. The geographic location of the 29 SFNT AMP communities is shown in Figure 4.

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Table 1: Characteristics of communities selected for in-depth study

Community	Characteristics
Community 1	Approximate population=670 (>90% Indigenous); police station; range of resources; dry, but ready access to nearby alcohol outlets.
Community 2	Approximate population=1480 (>70% Indigenous); unique type of community; proximity to major centre; few resources; dry, but ready access to nearby alcohol outlets.
Community 3	Approximate population=1080 (>80% Indigenous); police station; wide range of resources; mix of Indigenous and non-Indigenous residents.
Community 4	Approximate population=600 (>70% Indigenous); police station; developing a permit system; range of services; several liquor outlets nearby.
Community 5	Approximate population=470 (>90% Indigenous); social club with limited on premise alcohol access; weekly access to off premise alcohol; permit system; police station.
Community 6	Approximate population=220 (>90% Indigenous); dry; no police station; limited resources.
Community 7	Approximate population=600 (>90% Indigenous); dry; social club with limited alcohol access; no police station.
Community 8	Approximate population=980 (>80% Indigenous); proximity to regional centre, dry; permit system; ready access to nearby alcohol outlets; police station.

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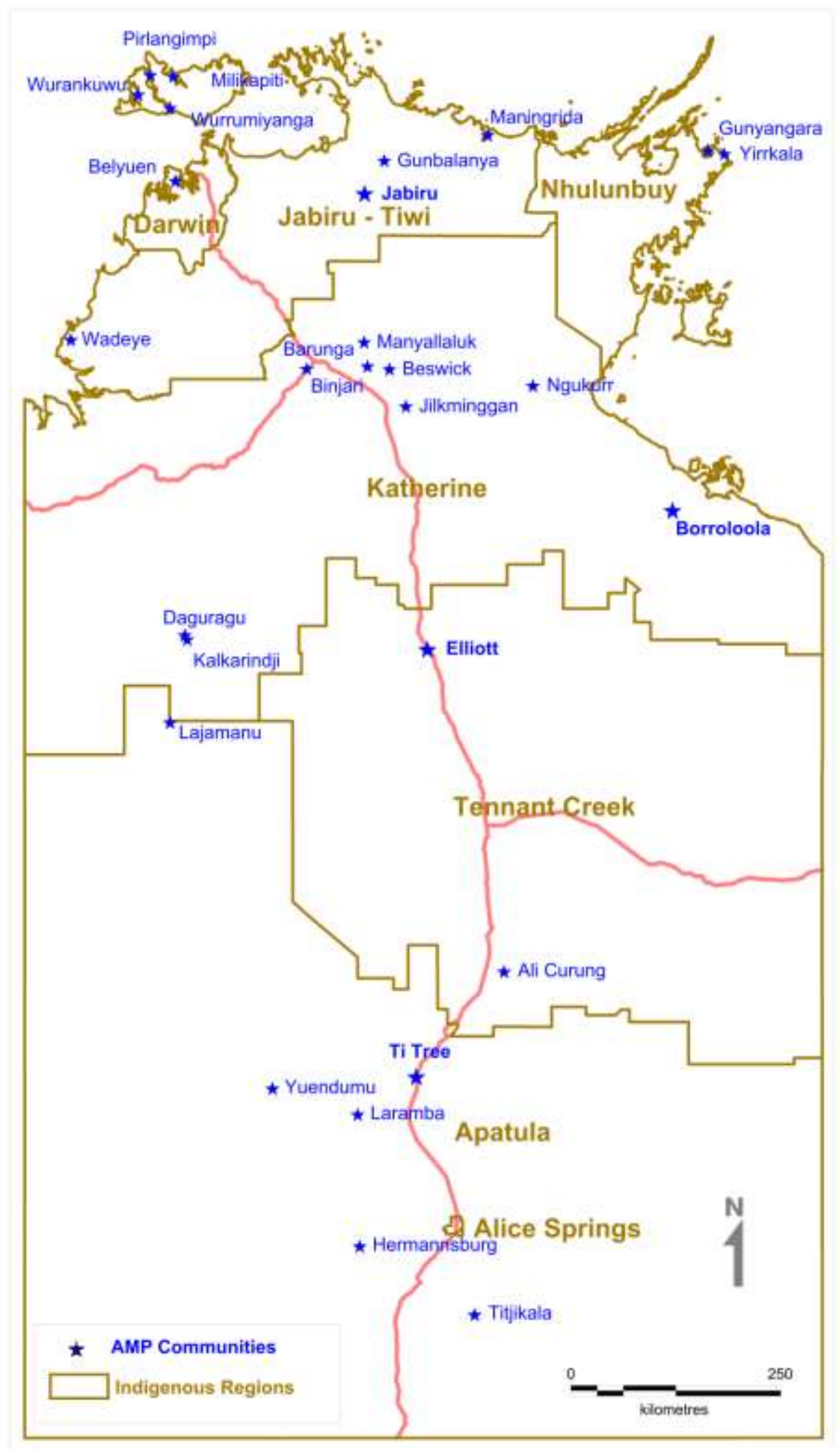

Figure 4: Geographic location of communities with an AMP developed or in development

2.5 Overview of Methods

2.5.1 Component 1 – administrative data

Data Sources and Indicators

The study investigated a range of administrative data sources to identify which indicators are most suitable for measuring the effectiveness of interventions applied at both the regional and the local community level. For administrative data to be considered for inclusion in The Framework, it needs to have geographic coverage at a community level across the NT, be available annually or 6-monthly, and be of sufficient quality. Table 2 lists data sources that were investigated for the study, as well as those which were proposed for investigation but which were not made available.

Table 2: Data sources, custodian, data domain and availability

Domain	Data custodian	Data	Availability
Community safety	NTG Police Dept	Offences (DV, assault, theft etc.)	√
	Attorney General Dept	Incidents	√
		Victims of assault	√
	NTG Dept Children & Families	Child notifications	X
	NTG Dept of Transport	Alcohol-related traffic crashes	X
	NTG Dept of Business	Sober Up Shelter admissions	√
	Dept Prime Minister & Cabinet	Night patrol pick ups	X
Community health and wellbeing	NTG Dept of Health	Hospital separations	√
		Emergency Dept attendances	√
		Local health Centre data	X
		NT Midwives - births	√
Community education	NTG Dept of Education	School attendance	√
		School enrolment	√
	ACARA	NAPLAN numeracy	√
		NAPLAN literacy	√
Alcohol consumption	NTG Dept of Business	Apparent pure alcohol consumption (wholesale data)	√
Demographic	Australian Bureau of Statistics	Population counts	√

Investigation of administrative data at the community level focused on seven of the eight in-depth communities, with one community excluded due to problems with data availability. Definitions of indicators investigated over the course of the study are included in Table 3.

Table 3: Alcohol-related indicators and definitions

Indicator	Indicator definition
Police Offences	Offences relate to the number of charges laid by police. An individual can have multiple offences against them in a single incident. Assault by alcohol involvement, Breach of Violence Order by alcohol involvement, Alcohol Consumption in a Regulated Space, Disorderly conduct and other Public Order offences by alcohol involvement, Driving Under the Influence, Break and Enter with intent to Steal, Motor Vehicle and Other Theft, Drug possession and selling, and Property Damage.

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Indicator	Indicator definition
Police Incidents	Anti-social incidents by alcohol involvement.
Victims of assault	Victim rates are based on counts of victims of assault. Victims of assault by alcohol involvement, age, sex, domestic violence involvement. Alcohol involvement includes the 'offender', 'victim' or 'both'.
Sober-Up-Shelter admissions	Admissions to Sober-Up-Shelters (SuS) by SuS Location and community of person being admitted.
Emergency department services	ICD-10 External causes of morbidity: Injuries to head, neck, thorax; abdomen, lower back, lumbar spine, pelvis and external genitals; shoulder and upper arm; elbow and forearm; wrist, hand and fingers; hip and thigh; knee and lower leg; ankle and foot; multiple body regions; and unspecified region (and total of all).
Hospital admissions	ICD-10 diagnosis codes: Includes acute and chronic conditions where alcohol as an 'attributable fraction' is equal to or greater than 40% (NTG Department of Health, 2015). Acute conditions include: accidental poisoning; mental and behavioural disorders; malnutrition; assault (and sexual); neglect abandonment and maltreatment; intentional self-harm; alcohol chronic pancreatitis; acute pancreatitis unspecified Chronic conditions include: Oropharyngeal Cancer; Laryngeal cancer; Epilepsy & status epilepticus; Alcoholic cardiomyopathy; Oesophageal varices; Gastro-oesophageal laceration-haemorrhage syndrome; Alcoholic liver disease; Unspecified liver cirrhosis; Alcoholic chronic pancreatitis
Health centre episodes of care and child health checks	Episodes of care: Presentation to service clinic involve one or more episodes of care by alcohol involvement Child health check: Positive screens for anaemia, wasting and stunting (and estimated percentage of children screened)
Births	Number of births by alcohol use by Mother; average birthweight; and non-term births
School attendance	Average daily attendance of enrolled students
School enrolment	Number of students enrolled in a school
NAPLAN Numeracy	Percentage of students meeting the numeracy national standard by year
NAPLAN Literacy	Percentage of students meeting the literacy national standard by year
Apparent pure alcohol consumption	Apparent pure alcohol consumption (PAC) is a conversion of percentage alcohol into pure alcohol in litres (allows different beverage types to be compared in total PAC), and comes from wholesale alcohol data.

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Data quality framework

The importance of data quality is widely recognised, with this reflected in the number of national statistical agencies that have developed data quality frameworks to assist data users to understand both the limitations associated with particular data sources and the conclusions that can reasonably be drawn from these sources (for example, see Statistics Canada, 2002). This study draws on the data quality framework used by the ABS, which identifies seven dimensions of data quality as set out below (Australian Bureau of Statistics 2009).

- *Institutional environment* – refers to the institutional and organisational factors which may have a significant influence on the effectiveness and credibility of the agency producing the statistics.

- *Relevance* – does this information relate to my topic of interest, include the variables I am interested in and use concepts and definitions that are consistent with my problem?
- *Accuracy* – If so, are the variables measured with sufficient accuracy for my purposes?
- *Timeliness* – are the data available in time?
- *Accessibility* – can I obtain the data easily in the format I want at a cost I can afford?
- *Interpretability* – having obtained the data, can I understand them; know their reliability and the methodology behind them?
- *Coherence* – do they fit in with other related data, are they consistent over time and can I use them in combination with other data sets?

Brackstone (1999) has noted that six of the data quality dimensions can be arranged in a hierarchical fashion, as shown in Figure 5. This view of data quality stresses that:

- Without relevance, the other five dimensions are unimportant – perfect information on the wrong topics is not useful;
- Given relevance, without timeliness and accessibility the data are not available when they are needed; and so
- Only when relevance, timeliness and accessibility are satisfied do accuracy, interpretability and coherence become important.

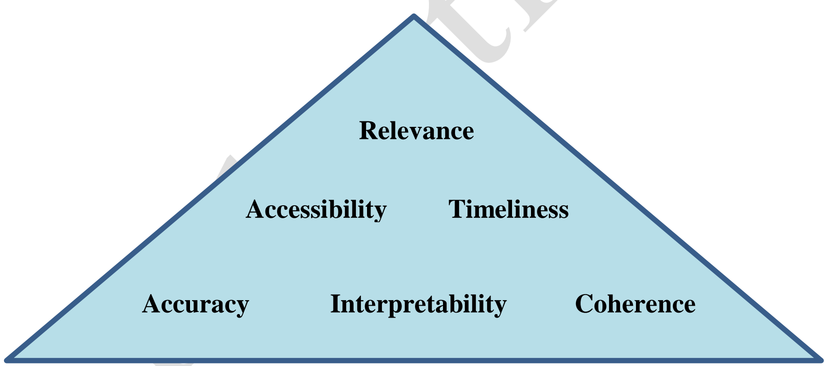

Figure 5: Hierarchical view of the dimensions of data quality used by Statistics Canada

One advantage of setting up The Framework is that a range of data sources can be compared with each other over time (triangulation), allowing for a better understanding of the coherence of the different data indicators. Interpreting time-trends for small communities is confounded by a number of data quality issues. For example, time trends in smaller communities exhibit random variation over time simply due to small numbers of events and, confounding interpretation of change further, community population estimates obtained through the Census are known to undercount both Indigenous and non-Indigenous people (Australian Bureau of Statistics 2012b). Identifying the quality of indicators contained in the administrative data sources will provide users with the information needed to make informed decisions regarding changes observed in indicators over time.

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Exploratory analysis of administrative data

For each data source, 6-monthly and annual time trends were generated to determine whether counts were high enough for reporting data at a community and regional level. Data definitions and classifications were confirmed through discussions with data custodians and the Steering Committee feedback from earlier interim reports. After this process, data requests to the various data custodians were refined. The administrative data presented in the community data reports in Chapter 4 have been through this refining process, with all data reported 6-monthly to the end of 2015, except the hospital admissions and emergency department attendances, for which the data was not available in time for inclusion in this report. Not all data was reported for all communities due to small counts for some indicators.

Chapter 5 presents a cross-sectional multivariate analysis of a range of indicators using 2014 administrative and community survey data. It outlines an approach that can be used to assess relative need across communities, by generating composite indexes using a range of indicators from each domain (community health and wellbeing, community education, community safety, and alcohol consumption patterns). This analysis, if done on annual basis, can be used to assess relative need within the various domains or across all domains simultaneously, and to identify outliers and anomalies in the data.

2.5.2 Component 2 - community sourced data

The community sourced data component included the collection and analysis of data from each of the eight communities, with this contributing to a more comprehensive range of indicators than would be available through administrative data alone. Some of these indicators can also be compared with community level administrative data, with this having the potential to assist in determining the data quality and reliability, and sensitivity to change, of the administrative data.

The community sourced data component also collected information on community perspectives on the effects of alcohol misuse and the strategies employed to minimise harm, thereby providing valuable insights into the relevance and efficacy of current approaches to the implementation of remote community AMPs. Working directly with the community to identify local level alcohol-related indicators, and the most appropriate methods for reporting data back to local communities, is also more likely to elicit community engagement in the ongoing monitoring and evaluation of AMPs than is a top down approach.

Collection of community level data was undertaken in two phases: Phase 1 – Key Informant Interviews; and Phase 2 – the Community Alcohol and Wellbeing Survey.

Phase 1: Key Informant Interviews

Key informants were defined as those with extensive local knowledge of alcohol-related issues affecting the community. They included both Indigenous and non-Indigenous individuals who played an active role in the day to day functioning of the community and in

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determining its social and cultural priorities. Between seven and fifteen people (comprised of both service providers and community members) were interviewed in each community. The following domains were explored, using a semi-structured interview schedule (see Volume 2, Appendix 2 for interview schedule used in the development of The Framework):

- Views on alcohol-related issues in the community;
- Perspectives on community alcohol management;
- Identification and collection of local level measures which capture patterns of alcohol consumption and related harms; and
- Preferred methods for reporting data to communities.

Analysis of the key informant data used the Framework Method, developed by Ritchie and Spencer in the late 1980s to facilitate large-scale social policy research (Gale, Heath, Cameron, Rashid, & Redwood, 2013). This method fits within the broader genre of analysis methods termed thematic analysis, or qualitative content analysis. In applying the Framework Method we first entered the interview notes into NVivo software and then coded text into the pre-selected categories of the analytical framework. These data were then summarised and entered into a matrix for each theme using Microsoft Excel. Themes were clustered around the four domains used to organise the semi-structured interviews and these domains, in turn, were situated under one of two broad categories: community perspectives on alcohol issues and related harms; and mechanisms for monitoring and reporting alcohol-related harms.

<u>Phase 2: Community Alcohol and Wellbeing Survey</u>

Participants for the Community Alcohol and Wellbeing Survey (CAWS) were drawn from the Indigenous adult (18 years or more) population of each of the eight study communities. Residents who had not lived in the community for more than 12 months were not eligible to be surveyed. Quota sampling was used to overcome the difficulties in conducting random sample household surveys in Aboriginal communities. Quotas on age (less than 35 years/35 years and over) and gender (male/female) were used to ensure the sample was representative in terms of both gender and age. Respondents were recruited using a range of methods including holding a community BBQ to publicise the survey, catching people in community meeting places, such as outside the community store. Full details on how respondents were recruited can be found in Volume 3, Section 2.3.

The survey instrument drew on previous surveys used in Indigenous communities (e.g. National Aboriginal and Torres Strait Islander Social Survey), although some questions were developed or amended to suit the current survey, taking into account responses from key informant interviews and consultation with DoB staff and project Steering Committee members. A copy of the instrument is included in Appendix 1 of Volume 3 of this report. The survey captured information on the following topics:

- Alcohol consumption and patterns of use (outcome variable);

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- Problems specifically caused by alcohol in (a) the household and (b) the community, in the last year and change from previous year (outcome variables);
- Perspectives on alcohol management and services in the community (explanatory variable);
- Socio-demographics including age, sex, employment status, and mobility (covariates);
- Community strengths and problems (explanatory/outcome variables); and
- Social and emotional wellbeing (SEWB) (explanatory/outcome variables).

The survey instrument was uploaded to the SurveyGizmo (www.surveygizmo.com) platform, which could be accessed on an iPad/Tablet and used either online or offline. This allowed survey responses to be captured live in the field and minimise errors associated with transcribing paper forms to a database. Data were extracted from the secure SurveyGizmo website and uploaded to Stata v14 (StataCorp 2015) for statistical analysis.

Simple linear regression was used to determine significant associations between pure alcohol consumption on last drinking occasion and explanatory variables and covariates, while Chi-Squared tests were used to determine evidence of a significant association between covariates, explanatory variables and ordinal outcomes.

The purpose of the CAWS, particularly moving into the future, is to provide more nuanced measures on alcohol patterns of use, and community strengths and problems. The survey and sampling approach is not designed to assess individual alcohol risk, but to generate community level indicators that can be tracked over time.

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3. Community and Administrative Data Sources for inclusion in The Framework

A core requirement of this study has been to identify indicators for monitoring and evaluating alcohol-related harms and community safety and wellbeing in the Northern Territory. Although there are a wide range of indicators that can be used for this purpose not all of them are of sufficient data quality to justify their inclusion in The Framework. Similarly, some indicators might work well at regional or NT wide levels of analysis but be less useful at the remote community level. This chapter outlines the findings of the data quality analysis and makes recommendations on an initial set of administrative indicators for The Framework. In addition, it examines the feasibility of including community sourced data in The Framework, and the issues associated with collecting this data from remote communities through surveys, key informant interviews and other methods.

3.1 Assessment of administrative Data Indicators

Indicators from administrative data are reviewed in the tables below and are grouped under the following domains: wholesale pure alcohol consumption; community safety; community health and wellbeing; and community education. The advantages and disadvantages of each indicator are discussed, and recommendations made regarding their inclusion in The Framework at either the regional or community level.

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3.1.1 Alcohol Consumption and Patterns of Use

Wholesale Pure Alcohol Consumption (PAC) Indicators - recommendations

- Propose that the following indicators be sourced 6-monthly/annually and presented 6-monthly for regions and regional towns, and for specified Alcohol Catchment Areas:
  - Pure alcohol consumption in litres;
  - Percentage alcohol type.

Table 4: Alcohol consumption and patterns of use – indicators, advantages and disadvantages

Indicator	Advantages	Disadvantages
Apparent Pure Alcohol Consumption (PAC)	• PAC data is sourced from alcohol wholesalers and is supplied regularly to the NT Department of Business. • Useful measure for regional areas, NT wide and NT Balance.	• PAC Alcohol Supply data is not very accurate at either the community level or at the alcohol catchment area level as: ○ Sly grog running into communities is mostly not captured in this data, depending on what outlet alcohol is purchased from and whether it is captured in an ACA ○ There may be a lag between when alcohol is shown as purchased by an outlet and when it is consumed by the people in an ACA ○ Alcohol may be purchased in one ACA and taken to another ACA to consume. ○ The lack of clear boundaries of ACAs makes it difficult to use population data to create standardised measures of alcohol consumption such as PAC per person per year. ○ PAC data includes alcohol purchased by tourists
Percentage alcohol type	• Provides detailed breakdown of the type of alcohol	• The detailed breakdown of the type of alcohol allows for comparison with the alcohol consumption from the community survey.

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Data quality statement: Wholesale PAC

Dimension of data quality	Statement
Institutional environment	Data provided by wholesalers to the DoB for collation. Limited in what can be released publicly due to commercial in-confidence
Relevance	The wholesale PAC is very relevant to the key aim of The Framework; that being to monitor alcohol-related harms and to understand where alcohol is being accessed.
Accuracy	The data has a number of limitations which will affect its accuracy, though these are inherent in the data (see disadvantages in table above).
Timeliness	Lag time for data is 3-6 months, which is acceptable for use in The Framework.
Accessibility	Data is provided to the DoB, so the data is easily accessible, though commercial in-confidence will limit use in the public arena.
Interpretability	There is limited or no information on who buys the alcohol (i.e. Aboriginal community residents, tourists, non-Indigenous etc). For some more isolated communities, the catchment area may reflect the amount of alcohol being consumed; however, as identified in Table 4 there are a number of disadvantages to using this indicator. If compared to the community survey data on what type of alcohol people drank last time they drank, it may help to identify where there is sly grog running. In one of the communities in this report, the catchment area only showed mid-strength beer being bought through the ACA outlets, yet the community survey found 40% of those surveyed who drank alcohol, had drunk bottled spirits. This is also related to the next dimension of data quality, coherence.
Coherence	The wholesale data fits naturally within The Framework, and can also be aggregated regionally and for the whole of the NT. In conjunction with information obtained from the community survey on patterns of alcohol consumption, emergency department attendances, hospitalisations for alcohol related diagnoses, and assaults with alcohol-involvement, it will provide useful long-term data on the distribution of alcohol sales across the NT.

3.1.2 Community Safety Indicators

Police offences data indicators - recommendations

- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly in The Framework if the community has a police station:
    - Offence rate for assaults;
    - Percentage alcohol involvement;
    - Percentage domestic violence involvement;
    - Offence rate for break & enter/unlawful entry with intent, other theft and related offences, motor vehicle theft, and property damage.
- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at the regional level in The Framework:

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- Offence rate for assaults;
- Percentage alcohol involvement;
- Percentage domestic violence involvement;
- Offence rate for break & enter/unlawful entry with intent, other theft and related offences, motor vehicle theft, and property damage;
- Offence rate for driving under the influence or exceeding prescribed content of alcohol/other substance limit.

Table 5: Community safety: Offences data – indicators, advantages and disadvantages

Offences data indicators	Advantages	Disadvantages
Offences data	• *Indicators available for a range of offences that reflect alcohol related problems in the community, and other problems such as break and enter and stealing.* • *Data available approximately 3 months after offences occur* • *Alcohol involvement for relevant offences (e.g. assaults, breach of violence order etc, see below).*	• *If community is not serviced by a police station (or has none nearby), then data cannot be used due to small numbers and inconsistent trends related to other factors (e.g. police behaviour).* • *No demographic data (e.g. no Indigenous identifier, age, sex)* • *Rate denominator will need to include Indigenous and non-Indigenous population* • *The farther the community is from the police station, the less offences recorded for that community. This reflects distance rather than level of offences occurring.*
Assault	• Includes alcohol involvement • Includes domestic violence involvement • Geography – community, region and SA2 • Usually has large enough numbers to present 6-monthly if serviced by a police station and community population 300+	• No demographic data (e.g. no Indigenous identifier, age, sex) • Rate denominator will need to include Indigenous and non-Indigenous population • Not of use if community is not serviced by police station (or one in close proximity (e.g. <50-60 km) • Not of use for smaller communities
Breach of violence order	• Includes alcohol involvement • Includes domestic violence involvement • Geography – community, region and SA2 • Correlates strongly with 'assault', so could be combined to provide more reliable 6-monthly estimates	• No demographic data (e.g. no Indigenous identifier, age, sex) • Numbers too small on its own even if serviced by police station • Can be biased by police officer charging ('bureaucratic'), so may not be suitable to merge with assault
Breach of community based orders	• Geography – community, region and SA2	• Insufficient numbers if used on its own, even if serviced by police station • Only available from start of 2014

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Offences data indicators	Advantages	Disadvantages
Disorderly conduct	• Includes alcohol involvement • Geography – community, region and SA2 • Correlates strongly with ‘other public order offences’, so can be combined to provide more reliable 6-monthly estimates	• No demographic data (e.g. no Indigenous identifier, age, sex) • Numbers too small on its own, even if serviced by police station
Other public order offences	• Includes alcohol involvement • Geography – community, region and SA2 • Correlates strongly with ‘disorderly conduct’, so can be combined to provide more reliable 6-monthly estimates	• No demographic data (e.g. no Indigenous identifier, age, sex) • Numbers too small on its own, even if serviced by police station
Break & enter/unlawful entry with intent	• Geography – community, region and SA2 • Correlates strongly with ‘MV theft’ and ‘property damage’, so can be combined to provide more reliable 6-monthly estimates • Measure of community safety	• Numbers too small on its own for smaller (<350 population) communities • Not directly related to alcohol
Other theft and related offences	• Geography – community, region and SA2 • Correlates strongly with ‘break and enter with intent’, ‘MV theft’ and ‘property damage’, so can be combined to provide more reliable 6-monthly estimates • Measure of community safety	• Numbers too small on its own for smaller (<350 population) communities • Not directly related to alcohol
MV theft	• Geography – community, region and SA2 • Correlates strongly with ‘break & enter/unlawful entry with intent’ and ‘property damage’, so can be combined to provide more reliable 6-monthly estimates • Measure of community safety	• Numbers too small on its own for smaller (<350 population) communities • Not directly related to alcohol
Property damage	• Geography – community, region and SA2 • Correlates strongly with ‘MV theft’ and ‘break & enter/unlawful entry with intent’, so can be combined to provide more reliable 6-monthly estimates • Measure of community safety	• Numbers too small on its own for smaller (<350 population) communities • Not directly related to alcohol
Possession or use of illicit drugs,	• Geography – community, region and SA2 • Measure of transfer of alcohol to other drug use	• Numbers too small for communities (could use at regional level) • Not directly related to alcohol

Offences data indicators	Advantages	Disadvantages
		• Usually marijuana for personal use, which is decriminalised
Other (supplying) drug offences	• Geography – community, region and SA2 • Measure of organised supply of illicit drugs	• Numbers too small for communities (could use at regional level) • Not directly related to alcohol
Consumption of legal substances in regulated space	• Geography – community, region and SA2 • Directly alcohol related • Some correlation with 'liquor offences', so can be combined to provide more reliable 6-monthly estimates	• Numbers generally too small for communities (could use at regional level)
Liquor offences	• Geography – community, region and SA2 • Directly alcohol related • Correlates strongly with 'MV theft' and 'break & enter/unlawful entry with intent', so can be combined to provide more reliable 6-monthly estimates	• Numbers too small for communities (could use at regional level)
Drive under the influence or exceed prescribed content of alcohol/other substance limit	• Geography – community, region and SA2 • Directly alcohol related • Correlates strongly with 'MV theft' and 'break & enter/unlawful entry with intent', so can be combined to provide more reliable 6-monthly estimates	• Numbers too small for communities (could use at regional level)

Data quality statement: Police offences indicators

Dimension of data quality	Statement
Institutional environment	The Police Department and Attorney General have good quality systems for capturing offences and victims of assaults in the NT.
Relevance	The police offences data provide a good quality set of indicators for The Framework, which can be used at the regional and community level. The capture of alcohol (and domestic violence) involvement in assaults is central to understanding the distribution of alcohol involvement in assaults and domestic violence incidents.
Accuracy	The accuracy of the offences data for communities that have a police station is very good, but as the distance (or travel time) between a community and police station increases, the accuracy of this data in representing offences in a community diminishes. This will also impact on regional level indicators, as the proportion of the population served by a police station will affect regional level offence rates. The assault data

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	does not say anything on the seriousness of the assault. For example, proactive policing may lead to an increase in assault offence rates, but these may be of a less serious nature. Population movements (particularly influxes for large events) may lead to sporadic and sharp increases in assaults. Smaller Aboriginal communities within regional centres were unable to be identified in both the offences and victims data, which means these locations will not be able to have any data reported for them.
Timeliness	Lag time for data is 3-4 months, which is acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access this data. Moving forward, the DoB and the relevant department providing these data will have a Memorandum of Understanding that will specify the data request and the periodicity of data provision.
Interpretability	The offences data have a consistent, reliable approach to measurement over time. However, as mentioned under accuracy, pro-active policing may lead to increases in some offences for short periods of time, which could influence 6-monthly trends presented in The Framework. However, interpretation can be facilitated though communication with local police officers in communities and through recording changes in policing methods on the contextual basis that DoB will be maintaining for each community. Missing data on alcohol and domestic violence involvement in assaults is generally low, but should be monitored for data quality purposes, and to assist in interpretation of alcohol and domestic violence involvement in assaults.
Coherence	While no specific statistical analyses have been carried out to assess coherence of these data, visual inspection between emergency department attendances for external injuries, and assault rates following similar trends (i.e. increase in assaults rate corresponded to an increase in emergency department attendance rate in the same time period). In the future, it will be possible to triangulate the offences data with the community survey data, in addition to emergency department attendance rates.

Victims of assault data indicators - recommendations

- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at community level in The Framework if the community has a police station:
    - Percentage female victims of assault.
- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at the regional level in The Framework:
    - Percentage female victims of assault;
    - Percentage less than 20 years victims of assault;
    - Percentage 50 years or more victims of assault;
    - Percentage Indigenous victims of assault.

Table 6: Community safety: Victims (of assault) data – indicators, advantages and disadvantages

Victims data indicators	Advantages	Disadvantages
Victims of assault	• Includes alcohol involvement for both victim and perpetrator • Includes demographic data (age, sex, Indigenous status) – better measure for sub-population groups (e.g. women, young and old people) • Geography – community, region and SA2	• Only available for victims of assault offences - not available for stealing, break and enter or property offences
Victims of assault by alcohol involvement	• Includes alcohol involvement for both victim and perpetrator	• As above
Victims of assault by domestic violence and alcohol involvement	• Includes alcohol involvement for both victim and perpetrator • Includes whether assault was domestic violence	• As above
Victims of assault by Indigenous status	• More targeted population group • Can present percentage Indigenous for specific changes in Indigenous population of the community	
Victims of assault by gender	• More targeted population group • Can present percentage female	• As above
Victims of assault by age	• More targeted population group • Can present percentage young (20 years) and old (55+ years)	• As above

Data quality statement: Victims of Assault data

Dimension of data quality	Statement
Institutional environment	The Police Department and Attorney General have good quality systems for capturing offences and victims of assault in the NT.
Relevance	The victims of assault data provide a good quality set of indicators for The Framework, which can be used at the regional and community level. The capture of alcohol (and domestic violence) involvement, gender, and age in the victims data is central to understanding the distribution of victims of assaults across the NT.

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Dimension of data quality	Statement
Accuracy	The accuracy of the victims of assault data is very good, but as the distance (or travel time) between a community and police station increases, the accuracy of victims of assault data in representing offences in a community diminishes. This will also impact on regional level indicators, as the proportion of the population served by a police station will affect regional level offence rates. The victim of assault data does not say anything on the seriousness of the assault. For example, proactive policing may lead to an increase in victim of assault rates, but these may be of a less serious nature. Population movements (particularly influxes for large events) may lead to sporadic and sharp increases in victims of assault. Smaller Aboriginal communities within regional centres were unable to be identified in both the offences and victims data, which means these locations will not be able to have any data reported for them.
Timeliness	Lag time for data is 3-4 months, which is acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access this data. Moving forward, the DoB and the department providing these data will have a Memorandum of Understanding that will specify the data request and the periodicity of data provision.
Interpretability	The victims of assault data have a consistent, reliable approach to measurement over time. However, as mentioned under accuracy, pro-active policing may lead to increases in some offences for short periods of time, which could influence 6-monthly trends presented in The Framework. However, interpretation can be facilitated though communication with local police officers in communities. Missing data on alcohol and domestic violence involvement in victims of assault is generally low, but should be monitored for data quality purposes and to assist in interpretation of alcohol and domestic violence involvement in the victims of assault data.
Coherence	While no specific statistical analyses have been carried out to assess coherence of these data, visual inspection between emergency department attendances for external injuries and assault rates showed that as expected but indicators are following similar trends (i.e. increase in assaults rate corresponded to an increase in emergency department attendance rate in the same time period. In the future it will be possible to triangulate the offences data with the community survey data, in addition to emergency department attendance rates.

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Police incidents data indicator - recommendation

- Propose the NO indicators be presented in The Framework.

Table 7: Community safety: Police Incidents data – indicators, advantages and disadvantages

Incident data indicators	Advantages	Disadvantages
Antisocial incidents	• Includes alcohol involvement • Geography – community, region and SA2	• No demographic data (e.g. no Indigenous identifier, age, sex) • Will sometimes change depending on proactive policing • May have different standards in different locations making it difficult to compare across communities, and regions, and also within a community if there is a change in personnel
Antisocial incidents by alcohol involvement	• Includes alcohol involvement • Can plot as rate if population denominator data available • Geography – community, region and SA2	• As above
Antisocial incidents – percentage alcohol involved	• If population denominator data is considered too unreliable, then can monitor percentage alcohol involvement	• Need to monitor unknown alcohol involvement as may increase or decrease depending on percentage missing
Antisocial incidents – Unknown alcohol involvement	• May be useful for monitoring data quality (missing data) • Geography – community, region and SA2	• As above

Data quality statement: Police incidents data

Dimension of data quality	Statement
Institutional environment	The Police Department have good quality systems for capturing (antisocial) incidents in the NT.
Relevance	The incidents data, while being quite relevant to the objectives of The Framework, will be of limited value due to issues with accuracy, interpretability and coherence.
Accuracy	The accuracy of the incidents data is variable due to differing approaches to recording and proactive policing. As with offence and victims data, it is also affected by the community's distance to the nearest police station; so, as the distance (or travel time) between a community and police station increases the accuracy of the incidents data in representing such incidents in a community diminishes. This will also impact on regional level indicators, as the proportion of the population served by a police station will affect regional level offence rates.
Timeliness	Lag time for data is 3-4 months, which is acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source

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Dimension of data quality	Statement
	to access this data. Moving forward, the DoB and the department providing these data will have a Memorandum of Understanding that will specify the data request and the periodicity of data provision.
Interpretability	Interpreting the incidents data would require input from the local community police station. The use of these data for comparison between communities is limited because of accuracy and measurement issues.
Coherence	There was limited coherence between incidents and other data sources (e.g. assaults), and this is likely due to the issues identified under accuracy and interpretability.

Sober-Up-Shelter data indicators - recommendations

- Propose **no** indicators be presented annually at community level in The Framework.
- Propose the following indicator be sourced 6-monthly/annually and presented 6-monthly at the regional level in The Framework.
  - Admissions to SuS by region (for regions that have a SuS)

Table 8: Community safety: Sober-Up-Shelter – indicators, advantages and disadvantages

Sober-Up-Shelter indicators	Advantages	Disadvantages
Admissions by location of SuS	• Geography – community, region and SA2 • A measure of public drinking for towns and cities with a Sober-Up-Shelter	• Limited to towns and regions with a SuS
Admissions by location of SuS by the community that the person identified as coming from	• Geography – community, region and SA2 • Can trace person back to community from where they said they come from	• Difficult to interpret the "home" community, as many people may not have lived in their "home" community for some time (e.g. 6-24 months), but may still identify it as where they live (or are from)

Data quality statement: Sober-Up-Shelter data

Dimension of data quality	Statement
Institutional environment	The SuS is collected by NTG Department of Health and captures all people admitted to a SuSs in the NT.
Relevance	The SuS data, while being relevant to the objectives of The Framework, will be of limited value for communities due to issues with accuracy, interpretability and coherence, but for regional centres will provide a useful relevant measure.

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Dimension of data quality	Statement
Accuracy	The community identifier in the SuS data is of unknown data quality, and for this reason, cannot be seen as a reliable measure of whether someone from a particular community has been picked up drinking in one of the regional towns where SuS's operate. For the regional centres where SuS's operate, this data will provide a useful measure on the number of people drinking in public places. Could improve accuracy by standardising the way people admitted are asked about the usual place of residence (e.g. ask where they have lived the most over the last 6 months, and do this consistently).
Timeliness	Lag time for data is 3-4 months, which is acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access this data. Currently, DoB simply email DoH and ask for these data, however moving forward, the DoB and DoH could set up a Memorandum of Understanding that will specify the data request and the regularity of providing the data to DoB for collation into The Framework.
Interpretability	Interpreting the SuS data for regional centres where they exist is straightforward, with changes reflecting changes in the number of people drinking in public places, though more active patrolling (or increased resourcing could lead to increases (and conversely, decreases).
Coherence	There was limited coherence between SuS and other data sources (e.g. assaults), though investigation at the regional level was not carried out.

3.1.3 Community health indicators

Hospital admissions data indicators - recommendations

- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at community level in The Framework:
  - Hospital admissions rate for acute alcohol-related diagnoses.
- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at regional level in The Framework:
  - Hospital admissions rate for acute alcohol-related diagnoses;
  - Hospital admissions rate for chronic alcohol-related diagnoses.

Table 9: Community safety: Hospital admissions for alcohol related diagnoses – indicators, advantages and disadvantages

Hospital admissions indicators	Advantages	Disadvantages
Admission rate for acute alcohol-related diagnoses (Alcohol Attributable Fraction (AAF) of 40% or more)	• Geography – community, region and SA2 • Geographic coverage of all communities with standardised naming (though not always for Community 2).	• Some admissions will be incorrectly coded geographically, with previous research suggesting this is more of a problem in central Australia (Condon, Williams, Pearce & Moss 1998)

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Hospital admissions indicators	Advantages	Disadvantages
		• Small numbers mean that all diagnoses will need to be grouped together to enable 6-monthly or annual reporting at the community level. • The naming convention used in relation Community 2 was changed in 2010, with this making it difficult to link data from this community to pre-2010 data.
Admission rate for chronic alcohol-related diagnoses (Alcohol Attributable Fraction (AAF) of 40% or more)	• Geography – community, region and SA2 • Geographic coverage of all communities with standardised naming (though not always for Community 2). • Long term indicator of alcohol related hospital diagnoses.	• Some admission will be incorrectly coded geographically, with previous research suggesting this is more of a problem in central Australia (Condon et al. 1998, Sicilliano, Stevens, Condon & Bailie 2006) • Cannot be reported for communities due to small numbers. • The naming convention used in relation to Community 2 was changed in 2010 with this making it difficult to link data from this community to pre-2010 data.

Data quality statement: Hospital admissions

Dimension of data quality	Statement
Institutional environment	The hospital admission data is collected by the NT Department of Health, and records admissions to all hospitals in the NT. The DoH has good systems for collecting information relating to the health of people who attend a hospital in the NT.
Relevance	Admissions to hospital for acute and chronic alcohol-related diagnoses are highly relevant to the key objectives of The Framework.
Accuracy	The accuracy of recording diagnoses for the selected alcohol-related conditions may vary from doctor to doctor and hospital to hospital, though in most instances these diagnoses will be recorded in a consistent manner. Less is known about the accuracy of the recording of the geographic identifier used to place admissions back to a community or suburb. This could be improved through training to front line staff to standardise the way this information is captured and coded and to provide regular feedback to these staff as to the purpose of the data collection and any changes associated with data quality. See disadvantages in the above table for more information on accuracy.
Timeliness	Lag time for data is 3-4 months, which is acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access this data. Moving forward, the DoB and the department providing these data will have a Memorandum of Understanding that will

Dimension of data quality	Statement
	specify the data request and the periodicity of data provision.
Interpretability	The hospital admissions data are collected in a consistent and reliable way, but with some doctor to doctor and hospital to hospital variation. The measure for chronic alcohol-related diagnoses was not reliable at the community level because numbers were to small.
Coherence	Data for hospital admissions for acute-alcohol related diagnoses showed generally consistent trends for communities. Community rates for chronic alcohol related diagnoses were too low to report (annually), however would recommend reporting rates for regions and larger towns. They use the same geography as the emergency department attendances data (see next).

Emergency Department attendances data indicators - recommendations

- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at community level in The Framework:
  - Emergency department attendance rate of all external injury diagnoses;
  - Percentage of Head, elbow and forearm, wrist and hand external injury diagnoses.
- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at regional level in The Framework:
  - Emergency department attendance rate of all external injury diagnoses;
  - Percentage head, elbow and forearm, wrist and hand external injury diagnoses.

Table 10: Community health: Emergency Department admissions for external injuries – indicators, advantages and disadvantages

ED indicators	Advantages	Disadvantages
All external injuries rates	• Geography – community, region and SA2 • Geographic coverage of all communities with standardised naming (though not always for Community 2). • Grouping head, elbow, forearm, wrist and hand injuries (more indicative of alcohol injury), separately from total external injury codes.	• Some admissions will be incorrectly coded geographically, with previous research suggesting this is more of a problem in central Australia (Condon et al. 1998, Sicilliano et al. 2006) • Small numbers mean that all injury codes will need to be grouped together to enable 6-monthly or annual reporting at the community level. • The naming convention used in relation to Community 2 was changed in 2010, with this making it difficult to link data from this community to pre-2010 data.
Percentage head, elbow and forearm, wrist and hand external injury diagnoses	• These injuries are the most common type of injury associated with assaults.	• As above

ED indicators	Advantages	Disadvantages
	• Provides a comparison data source to the police offence assault data	

Data quality statement: Emergency department attendances

Dimension of data quality	Statement
Institutional environment	The emergency department attendance data is collected by the NT Department of Health, and records attendances to emergency departments in all hospitals in the NT. In addition to patient demographic data, all attendances are given one or more diagnoses.
Relevance	Emergency department attendances for external injuries are highly relevant to the key objectives of The Framework.
Accuracy	The recording of external injuries is consistent. Less is known about the accuracy of the recording of the geographic identifier used to place attendances back to a community or suburb. This could be improved through training to front line staff to standardise the way this information is captured and coded and to provide regular feedback to these staff as to the purpose of the data collection and any changes associated with data quality. See disadvantages in the above table for more information on accuracy.
Timeliness	Lag time for data is 3-4 months, which is acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access this data. Moving forward, the DoB and the department providing these data will have a Memorandum of Understanding that will specify the data request and the periodicity of data provision.
Interpretability	The emergency department attendance data are collected in a consistent and reliable way.
Coherence	Data for emergency department attendance showed generally consistent trends for communities. They use the same geography as the hospital admissions data (see previous).

Northern Territory Midwives (perinatal) data indicators - recommendations

- Propose no indicators be presented at community level in The Framework.
- Propose the following indicators be sourced annually and presented annually at the regional level in The Framework:
  - % Mother's drinking alcohol in 1st or 3rd trimester;
  - % Non-term births;
  - Number of births;
  - Average birthweight term births.

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Table 11: Community health: Northern Territory Midwives (perinatal) Collection – indicators, advantages and disadvantages

Perinatal indicators	Advantages	Disadvantages
Indicators from the Northern Territory Midwives data collection (Mothers and babies)	• *Geography – community, region and SA2* • *Geographic coverage of all communities with standardised naming (though not for Community 2).*	• *Some births will be incorrectly coded geographically, with previous research suggesting this is more of a problem in central Australia* (Condon et al. 1998, Sicilliano et al. 2006) • *Naming conventions in Community 2 were changed in 2010 which has made it difficult to link data from this community to pre-2010 data.* • *There is a 1-2 year lag time in the supply of the data*
Number of births	• Need to contextualise meaning of other perinatal indicators	• Small numbers in many communities • Some Mother's will move to have birth and may be incorrectly coded.
% Mothers drinking alcohol in 1st or 3rd trimester	• Directly related to alcohol	• Missing data varies significantly by community (generally between 10% and 30%, though has improved over time).
% Non-term births	• Need to contextualise meaning of other perinatal indicators	• Small numbers in many communities
Average birthweight of term births	• Need to contextualise meaning of other perinatal indicators	• Small numbers in many communities

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Data quality statement: Northern Territory Midwives (perinatal) data

Dimension of data quality	Statement
Institutional environment	The Northern Territory midwives data collection is collated by the NT Department of Health from hospital data, and records births and birth related indicators that are part of the national minimum standard.
Relevance	The indicators contained in this data set are highly relevant to The Framework. It can provide information on alcohol consumption during pregnancy, one of the essential criteria used to diagnose foetal alcohol syndrome (FASD).
Accuracy	The accuracy of the recording of the geographic identifier used to place births back to a community or suburb is unknown. The same problems with community coding that emerged for Community 2 also apply to this data set, as much of the information is sourced via the hospital data. Missing data on alcohol use in pregnancy is variable across regions and communities.

Dimension of data quality	Statement
Timeliness	Lag time for data is 1-2 years, which is not acceptable for use in The Framework. However, further investigation is required as these data may be able to be sourced through the hospital admissions data, which would mean data is available within an acceptable time frame for The Framework. Also, given the relevance of this data source, it is strongly recommended to follow up these indicators in the future.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access this data. Moving forward, the DoB and the department providing these data will have a Memorandum of Understanding that will specify the data request and the regularity of providing the data to DoB for collation into The Framework.
Interpretability	The midwives data are collected in a consistent and reliable way, though the level of missing data for alcohol use amongst pregnant women has improved over the last 5 years, is still of variable quality from community to community, with some community health centres recording alcohol use (and smoking) with less missing than others. Training of the front line staff that collects this information and feedback on how the data is used along with missing data would lead to improvements in collection of alcohol use in pregnancy. Further, a less coarse measure of alcohol use would be beneficial; for example, how often and how much alcohol the person drinks.
Coherence	Data on births showed generally consistent trends for communities. This data set uses the same geography as the hospital admissions data (see previous).

3.1.4 Community education indicators

Attendance and enrolments (NTG) indicators - recommendations

- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at community level in The Framework:
  - School enrolments and percentage average daily attendance.
- Propose the following indicators be sourced 6-monthly/annually and presented 6-monthly at the regional level in The Framework:
  - School enrolments and percentage average daily attendance.

Table 12: Community education: NTG School enrolments and attendance – indicators, advantages and disadvantages

NT Education indicators	Advantages	Disadvantages
School enrolments	• Geography – school, community, NTG DoE region and remoteness • Geographic coverage of all communities with standardised naming. • Standard collection over time	• Some inaccuracies due to movement of school children between schools and communities

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NT Education indicators	Advantages	Disadvantages
School percentage daily attendance	• Geography – school, community, NTG DoE region and remoteness • Geographic coverage of all communities with standardised naming. • Standard collection over time	• Some inaccuracies due to movement of school children between schools and communities

Data quality statement: School attendance and enrolments

Dimension of data quality	Statement
Institutional environment	The school attendance and enrolment data is collected by the NT Department of Education.
Relevance	School attendance and enrolment data are highly relevant to the key objectives of The Framework. In the research associated with developing this Framework, key informants in all communities noted an association between school attendance and parental alcohol use.
Accuracy	These data are collected in a consistent way, though mobility of children between schools will affect the accuracy of average daily attendance. Further investigation in to other measures of attendance is warranted. For example, it has been suggested that the percentage of children attending school at least 90% of the time might be a better measure than percentage average daily attendance.
Timeliness	Lag time for data is 3-4 months, which is acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access this data. Moving forward, the DoB and the department providing these data will have a Memorandum of Understanding that will specify the data request and the periodicity of data provision.
Interpretability	The attendance and enrolment data are understandable and use a consistent methodology for collection and reporting, but with limitations. The issue of movement of children between schools can affect accuracy of attendance rates, which could be biased in a positive or negative direction depending on the net movement of children in or out of the school (particularly post enrolment).
Coherence	These data fit well within The Framework and, in conjunction with NAPLAN data, provide local communities and government with information on education outcomes (literacy and numeracy) and inputs (attendance). Key informant interviews in all communities noted the link between school attendance and alcohol use in the community.

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NAPLAN numeracy and literacy indicators - recommendations

- Propose the following indicators be presented annually at community level in the Framework:
  - Year 5 school score for literacy;
  - Year 5 school score for numeracy;
  - Year 7 school score for literacy;
  - Year 7 school score for numeracy.
- Propose NO indicators be presented annually at regional level in The Framework.

Table 13: Community education: NAPLAN literacy and numeracy – indicators, advantages and disadvantages

NAPLAN indicators	Advantages	Disadvantages
Years 3, 5, 7 and 9 literacy – percentage students meeting national standard	• Geography – school, community, NTG DoE region and remoteness • Geographic coverage of all communities with standardised naming. • Standard collection over time	• Often no data available due to small numbers of children completing NAPLAN tests • Will need to be requested annually from ACARA • Less reliable for smaller schools
Years 3, 5, 7 and 9 literacy – school score and National average	• Geography – school, community, NTG DoE region and remoteness • Geographic coverage of all communities with standardised naming. • Standard collection over time	• Often no data available due to small numbers of children completing NAPLAN tests • Will need to be requested annually from ACARA • Less reliable for smaller schools
Years 3, 5, 7 and 9 numeracy – percentage students meeting national standard	• Geography – school, community, NTG DoE region and remoteness • Geographic coverage of all communities with standardised naming. • Standard collection over time	• Often no data available due to small numbers of children completing NAPLAN tests • Will need to be requested annually from ACARA • Less reliable for smaller schools
Years 3, 5, 7 and 9 numeracy – school score and national average	• Geography – school, community, NTG DoE region and remoteness • Geographic coverage of all communities with standardised naming. • Standard collection over time	• Often no data available due to small numbers of children completing NAPLAN tests • Will need to be requested annually from ACARA • Less reliable for smaller schools

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Data quality statement: NAPLAN literacy and numeracy

Dimension of data quality	Statement
Institutional environment	The National Assessment Program – Literacy and Numeracy (NAPLAN) data is collected and collated by The Australian Curriculum, Assessment and Reporting Authority (ACARA), which is an independent statutory authority of the Commonwealth. Data is available to the public for individual schools via a website, while researchers and government who wish to obtain specific data need to first submit a formal data application setting out how they intend to use the data, and then sign a Data Licence Agreement.
Relevance	NAPLAN data are relevant to the key objectives of The Framework and were seen as a good indicator by local community people when the first wave of data was being feedback to communities. Communities preferred school data over student data.
Accuracy	These data are collected in a consistent way throughout all schools in Australia. However, poor school attendance in remote communities will affect the reliability of school level data, which can lead to large jumps from year to year, as well as missing data for some years. Smaller schools usually have more missing data.
Timeliness	Lag time for data is 6-12 months, which is just acceptable for use in The Framework.
Accessibility	In developing The Framework, Menzies was required to gain ethics approval, in addition to approval by the data custodians of each data source to access these data. Moving forward, the DoB will need to liaise with ACARA to determine if an MoU can be drawn up, or whether data will need to be applied for on an annual basis.
Interpretability	The NAPLAN is relatively easy to interpret, with the school score and the national average score providing a measure of where the school sits relative to the national average. Data is cross-sectional, though possibly in the future, if numbers permit, a cohort of students from each community could be followed and this information used.
Coherence	These data fit well within The Framework, and in conjunction with school attendance and enrolment data, provide local communities and government with information on education outcomes (literacy and numeracy) and inputs (attendance).

Recommendation

That regional and community level administrative data indicators identified in Section 3.1, be included in the Framework.

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3.2 Community Sourced Data

Menzies has examined a range of options for collecting data from remote communities, including: (a) community surveys; (b) key informant interviews; and (c) local community data that is, or can be, recorded by community based service organisations such as schools, night patrol, safe houses and social club committees. The type of data provided by each of these data collection methods varies (some is quantitative and some is qualitative) and each data type fulfils a different function. The advantages and disadvantages of options (a) and (b) are summarised below.

3.2.1 Community survey and key informant interviews: advantages and disadvantages

Table 14: Advantages and disadvantages of carrying out a survey

Advantages / strengths	• Collection of community specific indicators on alcohol consumption and patterns of alcohol use not available in any other data source. • Collection of indicators on community strengths not available in other data sources, which can be used to develop different community strengths indexes. • Collection of indicators on community problems not available in other data sources, which can be used to develop different community strengths indexes. • Provides a more nuanced measure of community problems and strengths compared with administrative data and enables community perceptions of problems and strengths to be measured. • Provides an external data source which can be triangulated with administrative data to assess sensitivity to change and data quality. • Has potential to build community capacity by providing casual employment to local community members. • Captures the view of the 'person on the street' and provided the sample is adequate will provide an objective measure of alcohol consumption, patterns of use, community strengths and problems.
Disadvantages /risks	• Difficulties associated with managing the complex logistics of conducting a survey across multiple Aboriginal communities in the NT. • Related to survey management, is maintaining the quality of data collected over time. • Too frequent collection of survey data may result in communities being 'over-researched', and lead to poor quality data and less representative samples. • Requires training of interviewers and specialist skills for analysis and interpretation of the data. • Achieving recommended sample size can be difficult, particularly if unforeseen community events occur (e.g. death of someone).

Table 15: Advantages and disadvantages of carrying out a key informant interviews

Advantages /strengths	• Can assist with identifying broad structural and resource issues that influence effective implementation of Alcohol Action Initiatives or related social and emotional wellbeing programs. • Can explore the overall impact of programs and identify areas for future program development.

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	• Can be used to provide a process evaluation of individual Alcohol Action Initiatives or related social and emotional wellbeing programs and thereby inform future program development and implementation. • Can provide perspectives on community alcohol-related problems from people with extensive local knowledge of the broader issues facing the community. • Can inform interpretation of survey and administrative data results. • Can provide feedback on the effectiveness of the processes used to report findings to communities. • Has potential to build community capacity by providing casual employment to local community members. • Can help to explain why things are occurring not just that they are occurring.
Disadvantages /risks	• Does not provide specific data on alcohol consumption. • Cannot measure long-term outcomes. • Requires staff with interviewing and note-taking skills and the ability to analyse the data effectively. • Will require training of staff to ensure collection and interpretation of information is reliable

Both community surveys and key informant interviews would add considerable value to The Framework because they enable the collection of data not available through administrative datasets and provide a richer context for the interpretation of trends, as well as a more in-depth understanding of the issues communities face in the management of alcohol problems. Consequently, both of these data sources should be incorporated into the ongoing Framework.

Recommendation

That community surveys and key informant interviews be conducted annually, or every two years, in each community covered by The Framework.

3.2.2 Local level indicators that could be collected in communities

A system in which indicators of alcohol-related harm are collected by the local community has the potential to provide information that is more directly and personally meaningful than that provided through administrative data. This is because locally collected indicators relate to everyday life experiences, such as drinking at the social club, children not attending school after parents have been drinking heavily, loud parties keeping people awake at night, and women going to the safe house to avoid violence. In addition, these indicators will measure a single item and can be described in plain language which is easier to understand than the more abstract terminology used for administrative indicators, for example, 'loud parties keeping people awake at night' is likely to have more meaning to individuals than 'anti-social incidents'. The incorporation of local level indicators into The Framework has the potential to empower the community and increase community ownership of alcohol management by:

- Enabling the community to select the indicators they consider to be most useful;
- Placing responsibility for collection and reporting of data directly onto the community;

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- Facilitating more frequent reporting (e.g. quarterly rather than annually);
- Providing an environment where there is potential for community members to work together on alcohol problems.

Table 16 sets out local level community indicators that were identified in consultation with key informants from the eight study sites. It is not necessary for communities to collect data on every one of the indicators; rather, they form a set from which communities can select those most suitable for their community, based on relevance and their capacity to collect the data consistently and accurately. Benefits accruing from collecting this data, and challenges associated with its collection, are similar for all indicators and are included in the table.

Table 16: Local level indicators strengths and challenges

<table>
<tr><th>Domain</th><th>Indicator</th><th>Strengths and Challenges</th></tr>
<tr><td>Alcohol consumption</td><td>• Record of social club sales;
• Record of people banned from club and reason for the ban;
• Record of people seeking admittance to social club who were over breathalyser limit (if breathalyser used);
• Number of people with permits;
• Number of people who have had permits rescinded.</td><td rowspan="3">Benefits
• Data that is collected locally has the potential to be reported quarterly to the community ARG or equivalent committee, thus providing the community with more frequent feedback than would be feasible for administrative, survey, or key informant data.
• Collection of these data will involve some members of the community on a regular basis and, through the relevant frequency of collection and reporting, is likely to encourage greater engagement with alcohol management processes.
• There is the potential to employ a local community member to work with an AAI officer to coordinate collection and reporting, with this providing an opportunity for capacity building.
• Local level data can be reported to DoB on a regular basis and incorporated into the larger Framework database.

Challenges
• There are currently no systems in place for collecting and reporting this type of data, so it will be necessary for DoB to assist the community in setting up systems to do this.</td></tr>
<tr><td>Community education</td><td>• Number of parents involved in children’s education through engagement with school activities;
• Incidents of disruptive behaviour in the classroom;
• Increased school attendance on days when non-attendance is typically high;
• Number of children who are tired or sleepy at school;
• Number of students who are late to school.</td></tr>
<tr><td>Community health and wellbeing</td><td>• Record the number of families needing special support;
• Record the number of people of employable age and how many of these are in regular work.</td></tr>
</table>

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Domain	Indicator	Strengths and Challenges
Community safety	• Number of times night patrol issued warnings to people having noisy parties, and number of times they reported failure to stop noise to the police • Number of young people taken home by night patrol • Record number of clients taken to safe house as a result of violence or due to fear of violence	• It may be difficult to sustain collection of these indicators over the longer term due to changes in personnel and extra work for some service providers.

Recommendation

That the Department of Business work with communities to set up systems to collect and report on data from relevant local level indicators as set out in Table 16, or other appropriate local indicators that may be developed in the future.

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4. Community Data Reports

This section provides a data report containing key research findings from all data sources for each of the eight in-depth communities and then integrates the findings to identify factors that appear to contribute to different outcomes across individual communities. In order to comply with ethics requirements each community has been de-identified.

4.1 Limitations and how to interpret the graphs in this data report

4.1.1 Data sources

Data sets and owners of the data in this report include:

- 2008-2015 Wholesale pure alcohol consumption (NT Department of Business)
- 2005-2015 Hospital separations (NT Department of Health)
- Emergency department admissions (NT Department of Health)
- 2008-2015 Police Offences and Victims of assault (NT Police Department & Attorney General)
- 2008-2015 School attendance and enrolments (NT Department of Education)
- 2008-2015 School NAPLAN test results for Reading and Numeracy (Australian Curriculum, Assessment and Reporting Authority)
- 2015 (Sep-Nov) The Community Alcohol and Wellbeing Survey (Menzies School of Health Research, Northern Territory DoB)
- 2014 (May- Jun) Key Informant interviews (Menzies School of Health Research, Northern Territory DoB)

4.1.2 Interpretation of graphs on Alcohol consumption and patterns of use

- The Department of Business collates wholesale alcohol sales for the NT, which is then converted to Pure Alcohol Consumption (PAC) in litres. Where possible alcohol catchment areas were derived from outlets within driving distance from the community. Not all communities could be reliably linked with local alcohol outlets, and no data is presented where this is the case.
- Data from the Community Alcohol and Wellbeing Survey (CAWS) provides baseline (2015) information on drinking patterns of residents in this community (amount, type, frequency, location). Into the future, changes in patterns of alcohol use over time will be presented and where possible significant changes assessed using statistical testing.

4.1.3 Interpretation of graphs relating to community education

- The school attendance and enrolments data comes from the NT Department of Education. The graphs in this section show 6-monthly trends in attendance for your community school(s) (bars) and for the NT. The bars represent the percentage average daily attendance for children enrolled in the school, while the green line shows the NT average. The first period of the second last and last years is coloured light blue and the second period coloured red to assist in making comparisons. Statistically significant changes between these periods are denoted by either * ($p<0.05$), ** ($p<0.01$), or *** ($p<0.001$) under the rate in the 2015 period. A trend line for the community is also included on graphs (black line) and is the 3-point moving average for the community which gives the trend taking into account the previous two time periods. Statistical differences between the last year for the community and the NT are denoted in the legend next to the community name using the same statistical notation.

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- NAPLAN reading and numeracy school test results are obtained from The Australian Curriculum, Assessment and Reporting Authority (ACARA), and are presented for Years 5 and 7. The graphs for numeracy and literacy show the school score (Blue bars), a comparison with schools identified as similar according to the Index of Community Socio-Educational Advantage (maroon line), and the national average (green line). No statistical tests are carried out to determine significant changes. Ideally, the school score (blue bars) should be approaching the national average (green line) over time, and the school score should be equivalent to or higher than the similar schools (maroon line). The legend of each graph also contains a percentage next to the school name reflecting the schools score as a percentage of the national average.
- Data from the CAWS is only providing baseline information in this data report.

4.1.4 Interpretation of graphs relating to community safety

- The data in this section come from the NT Police Department and the Attorney General's office. Offence rates per 100 persons for the community (blue bars) and the NT (green line) are presented for (i) assaults, and (ii) theft, break and enter and property damage for 6-monthly periods. The percentage alcohol involvement, domestic violence and percentage female victims of assault are also presented. The first period of the second last and last years is coloured light blue and the second period coloured red to assist in making comparisons. Statistically significant changes between these periods are denoted by either * ($p<0.05$), ** ($p<0.01$), or *** ($p<0.001$) under the rate in the 2015 period. A trend line for the community is also included on graphs (black line) and is the 3-point moving average for the community which gives the trend taking into account the previous two time periods. Statistical differences between the last year for the community and the NT are denoted in the legend next to the community name using the same statistical notation.
- Changes in assault rates and the percentage domestic violence related may be influenced by changing reporting behaviours of victims. For example, Project Respect has been implemented since November 2013, and initially this program may lead to an increase in reporting of assaults and DV involvement in communities.
- Data from the CAWS is only providing baseline information in this data report.

4.1.5 Interpretation of graphs relating to community health and wellbeing

- The data in this section come from the NT Department of Health. Rates per 100 persons for the community (blue bars) and the NT (green line) are presented for (i) acute alcohol-related hospital separations, and (ii) Emergency Department admissions for external injuries, and (iv) Percentage Emergency Department admissions for hand, wrist, forearm and head (grouped) injuries for 6-monthly periods. The first period of the second last and last years is coloured light blue and the second period coloured red to assist in making comparisons. Statistically significant changes between these periods are denoted by either * ($p<0.05$), ** ($p<0.01$), or *** ($p<0.001$) under the rate in the 2015 period. A trend line for the community is also included on graphs (black line) and is the 3-point moving average for the community which gives the trend taking into account the previous two time periods. Statistical differences between the last year for the community and the NT are denoted in the legend next to the community name using the same statistical notation.
- Data from the CAWS is only providing baseline information in this data report.

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4.1.6 Limitations and purpose of data

This data report is for use by communities, government and approved external users (e.g. researchers) as a tool to assist in monitoring and evaluating community safety and wellbeing initiatives, with a focus on alcohol related harms. On its own and at one point in time the information contained in this report, is unlikely to provide the detail necessary to evaluate community or regional level programs and policy. However, in conjunction with other evaluative approaches, this information provides a rich source of contextual and observational information over an extended period of time. Statistical testing in this data report is limited to comparison with the previous year (same time period), which does not capture longer term trends. Furthermore, no statistical analysis is presented to identify causal or correlational associations between indicators contained in this report. Although alcohol is a key factor in many of the indicators presented in this report, other factors, such as, gambling, unemployment, and overcrowding will also influence trends in these indicators.

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4.2 Community 1 Data Report

Highlights: 2014 to 2015

- '↑↑' large or significant improvement; '↑' small or non-significant <u>improvement</u>; '=' no change or small change; and '-' not applicable
- '↓↓' large or significant worsening; '↓' small or non-significant <u>worsening</u>; '=' no change or small change; and '-' not applicable

Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-6 to 6)		**-**	**-50% (-3)**
Wholesale PAC in catchment	Peak in 2013-2 but now in upward trend	↓	-1
Community average PAC	Just below average of 8 communities	=	0
Frequency of drinking	More likely to drink weekly or fortnightly	-	-
Number types of alcohol drank	More likely to drink 3 or more alcohol types	↓↓	-2
Community Education (-10 to 10)			**30% (3)**
School attendance	Steady at 50%	=	0
Year 5 reading	Improvement & just above similar schools	↑	1
Year 5 numeracy	Improvement & just above similar schools	↑	1
Year 7 reading	Steady & just above similar schools	=	0
Year 7 numeracy	Improvement & just above similar schools	↑	1
Adult year 12 completion	Similar to average of 8 communities	-	-
Adult other qualifications	More likely to have Certificate 1 to IV	-	-
Community Problems & Safety (-24 to 24)			**-4% (-1)**
Assaults offences	Improving trend over last 2 years	↑	1
Alcohol % in assaults	Steady trend over last 2 years	=	0
Family violence % in assaults	Steady trend over last 2 years	=	0
Females % in assaults	Worsening trend over last 2 years	↓	-1
Theft, stealing, break & enter	Significant improving trend over last 2 years	↑↑	2
Change in community alcohol problems	Most people said about the same	=	0
Community alcohol problems	Just above average of 8 communities	=	0
Household alcohol problems	Highest of 8 communities	↓↓	-2
Violence & Anti-Social behaviour	Just above the average of 8 communities	=	0
Gambling & Problematic Social Relations	Just above the average of 8 communities	=	0
Poor Community Safety	Above the average of 8 communities	↓	-1
Community Drug problems	Just below the average of 8 communities	=	0
Community Strengths, Health & Wellbeing (-12 to 12)			**8% (1)**
Emergency Department attendances	Significant improving trend over last 2 years	↑↑	2
% head, elbow, forearm, wrist & hand	Small worsening trend over last 2 years	↓	-1
Acute alcohol hospitalisations	Improving trend over last 2 years	↑	1
Respectful relationships	Above the average of 8 communities	↑	1
Attend Ceremony & Children Cared for	Similar to the average of 8 communities	=	0
Healthy Social Engagement	Lowest of the 8 communities	↓↓	-2
Total score			**-4%**

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Key informant interviews: Highlights

Alcohol was considered a major issue in the community, with one informant commenting that at least 40% of people had significant alcohol problems. Alcohol misuse was perceived as having an adverse effect on community safety; educational outcomes; and health and wellbeing. Key informants put forward a range of demand factors that contributed to community alcohol problems, such as unemployment, family problems, stress, and low self-

esteem; however, supply factors were also regarded as a major factor, with alcohol seen to be readily available through both legal and illegal channels. In terms of reducing supply, there was a strong focus on reducing opening hours at local liquor outlets and providing regulated drinking areas in or near the community through, for example, a social club, beer gardens at the local liquor outlets, or a properly serviced drinking camp close to the community. Although most informants thought it important to reduce liquor licensing hours, there was less agreement regarding the benefits of having a social club, drinking camp or permit system. Effective policing and electronic ID systems were regarded as important harm reduction strategies, with several informants praising a new police officer for adopting a stricter approach to enforcing consequences for alcohol-related infringements.

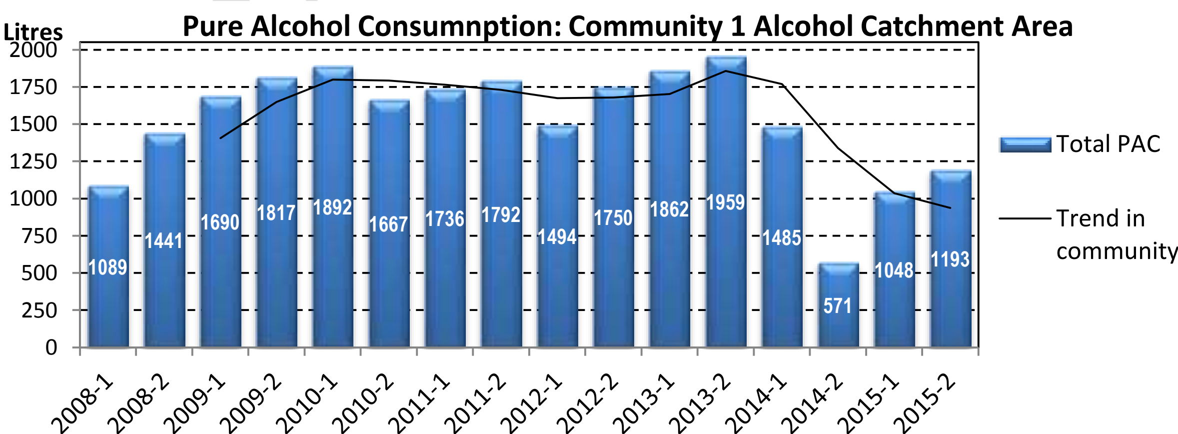
Community context

This community has an Indigenous population of around 485 people, is located in the central region of Australia near a main highway and is around 170 km from the nearest regional town. Key services include a police station, women's centre, and an art centre. There is no social club or permit system. There are two nearby liquor outlets, one of which is 60 km distant and the other 40 km. One of these has no restrictions on purchases, while at the other, purchases are restricted to 6 x 375 ml full-strength beer or 6 x 375 ml RTDs or 8 x 375 mls mid-strength beer or 12 x 375 mls light beer per person per day.

Alcohol consumption patterns

Administrative data

- PAC in litres by alcohol type for Community 1 alcohol catchment area (ACA - two outlets within driving distance) is shown in the graph below and represents the amount of pure alcohol consumed per 6-monthly period.
- Since the second half of 2014 the amount of PAC in Community 1 ACA has doubled from 571 litres per 6-months to 1,047 litres in 2015-1 and 1,193 litres in 2015-2, though this is lower than what was being consumed compared with all previous years going back to 2009.



- Full-strength and mid-strength beer increased as a proportion of alcohol consumed from 2014 to 2015, making up around 77% of PAC in 2015, while pre-mixed spirits also

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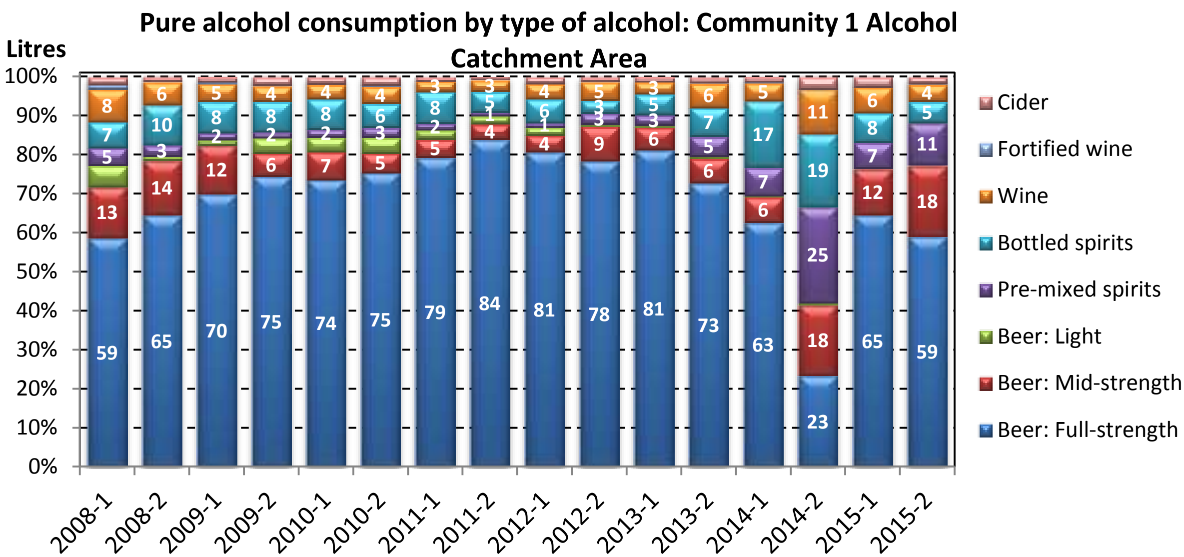
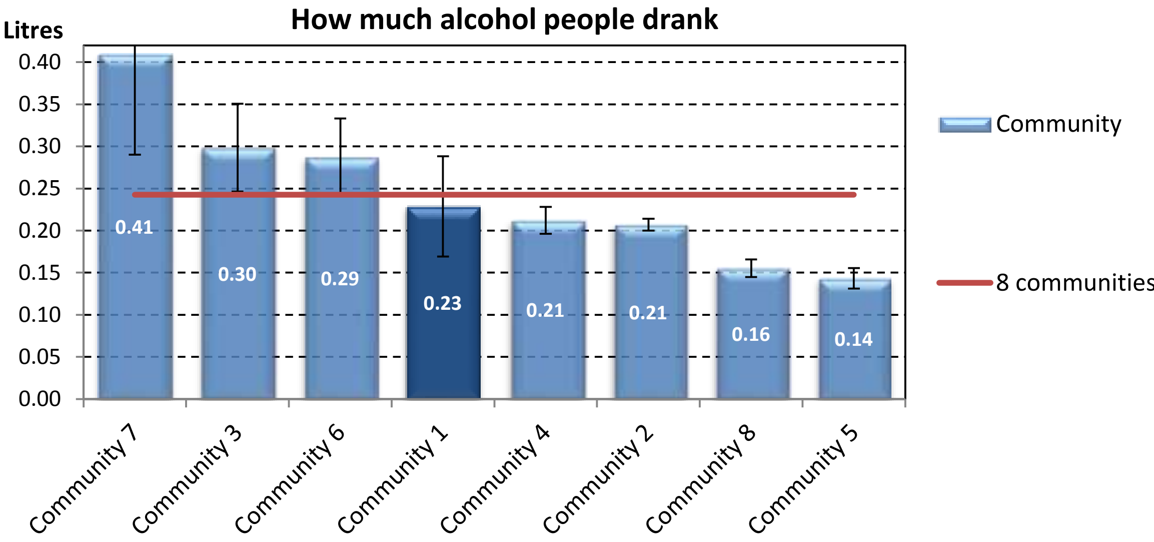
increased as a proportion of total PAC from 7% in the first half of 2015 to 11% in the second half.



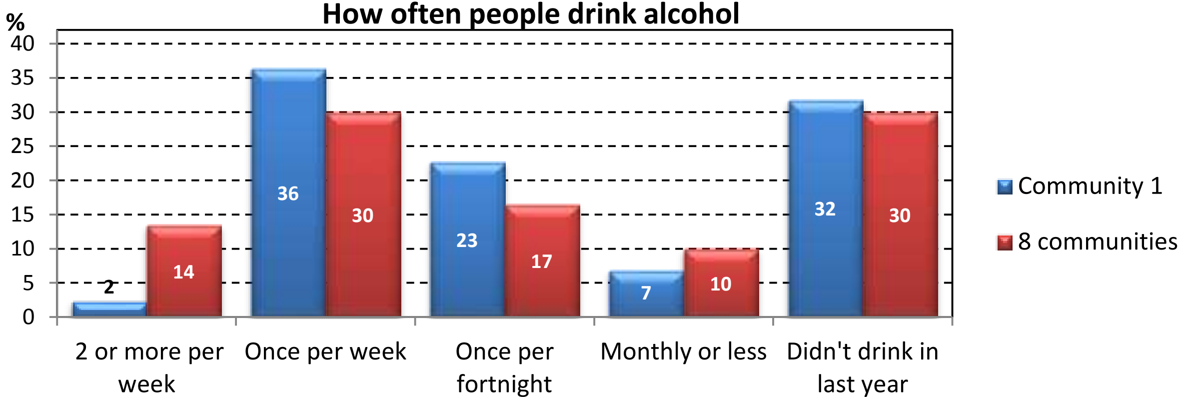
Community Survey

PAC Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

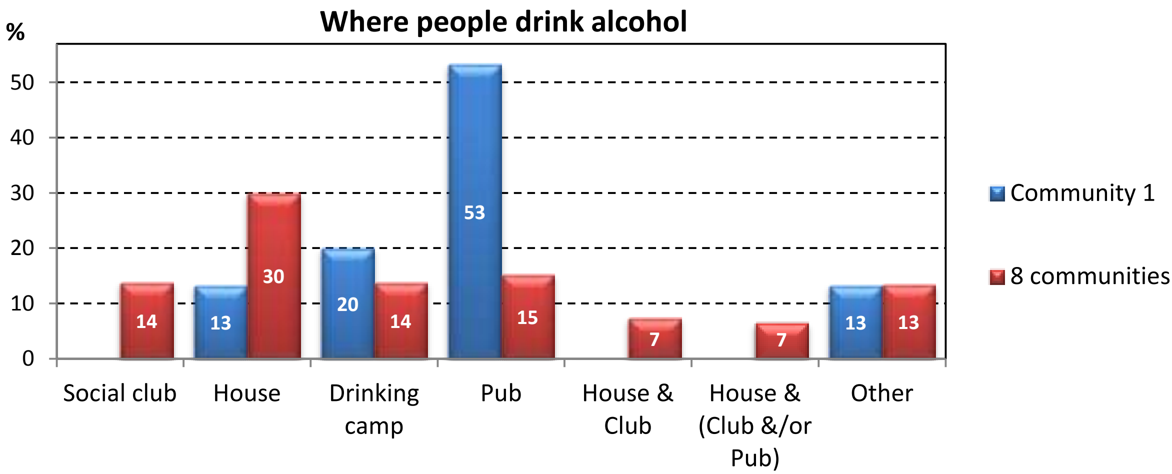
- The average PAC for Community 1 residents last drinking session was 0.23 litres (approximately 18 standard drinks or 13 full strength beers), which was slightly lower than for the average for the eight communities surveyed.



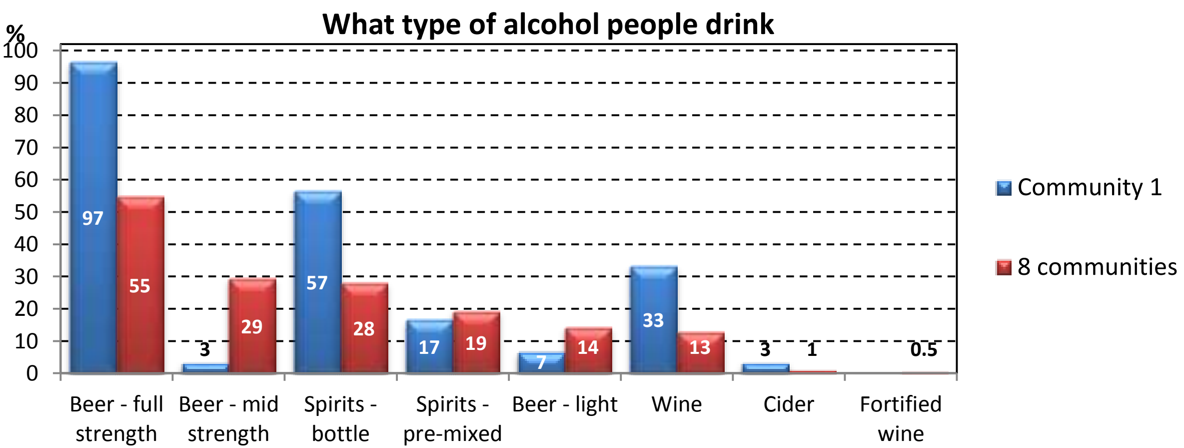
- Thirty-six percent of Community 1 residents drank alcohol around once per week, and a further 23% once per fortnight, which was slightly higher than for all eight communities, where a higher percentage drank two or more times per week.



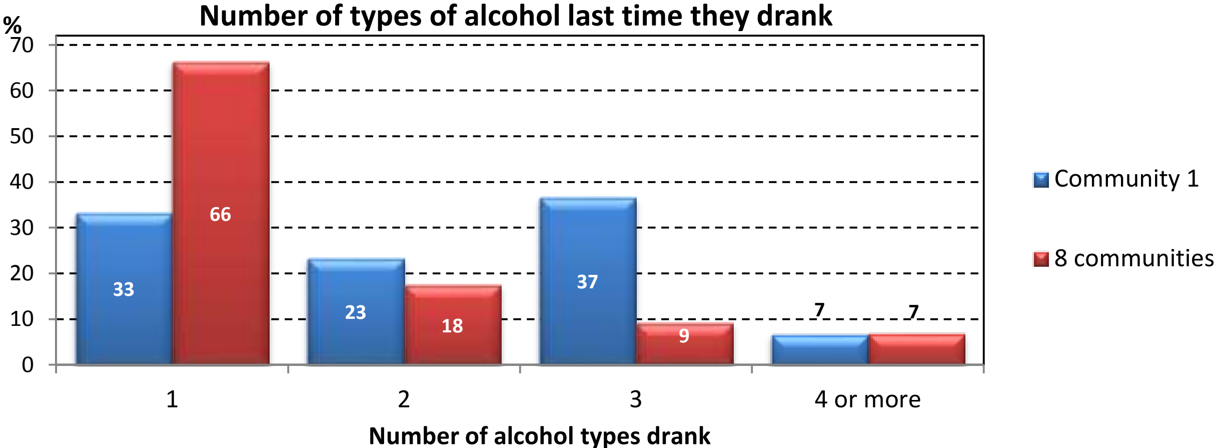
- The next figure shows where people drank and this varied depending on access to alcohol outlets. More than half (53%) of residents in Community 1 who drank, did so in the pub, followed by drinking camp (20%), and in a house (13%).



- Full-strength beer was the most commonly drank alcohol type (97%), followed by bottled spirits (57%), with both of these higher than what was observed across all eight communities.



- Last time people drank, 37% drank three different types of alcohol, which was higher than across all eight communities (9%).



Key informant interviews

Excess alcohol consumption was regarded by most key informants as a major problem in the community, with one key informant commenting that at least 40% of people in this community have significant alcohol problems, while another noted that around 95% of school children are affected by parental drinking. One person commented that Community 1 *is like a pub*, that *sly grog is an issue,* and that alcohol is very accessible, with people drinking at home, on the boundary and near the purchase point.

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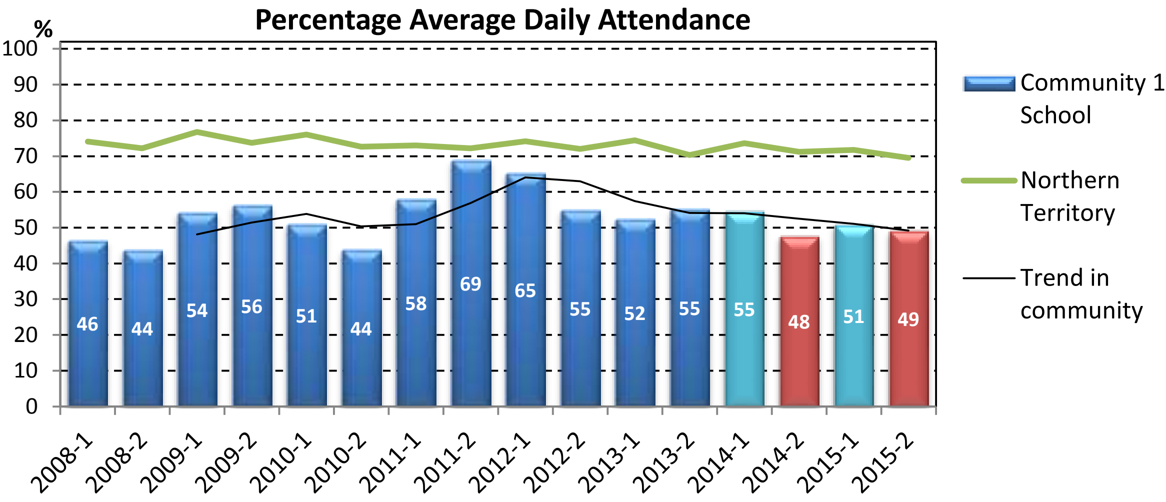
Community education

Administrative data

School attendance and enrolments

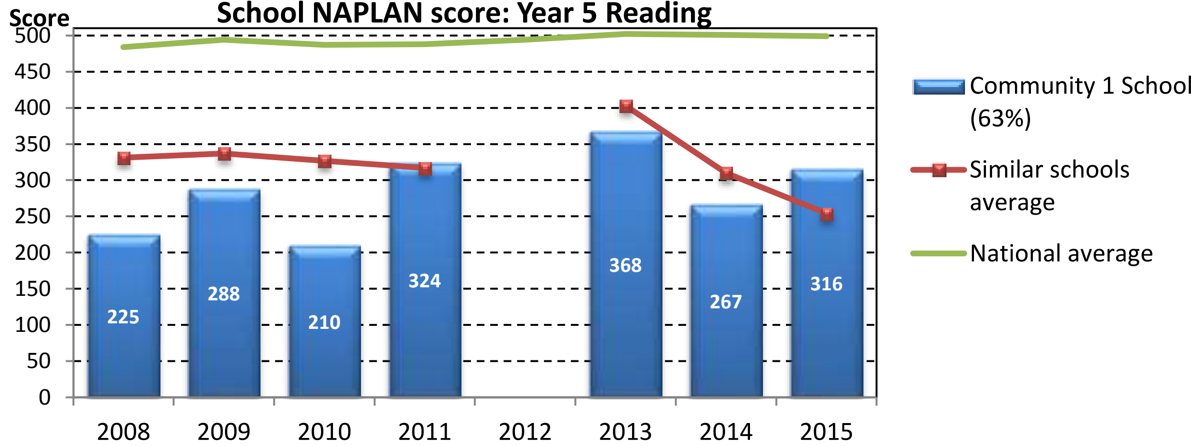
Community 1 School	2008-1	2008-2	2009-1	2009-2	2010-1	2010-2	2011-1	2011-2	2012-1	2012-2	2013-1	2013-2	2014-1	2014-2	2015-1	2015-2
Number enrolled for semester	155	146	138	130	116	105	107	119	121	143	141	129	128	135	130	141

- The last four 6 month periods has seen attendance between 55% and 48%, with no significant changes. The NT average attendance from 2014-2015 was 72% (green line).



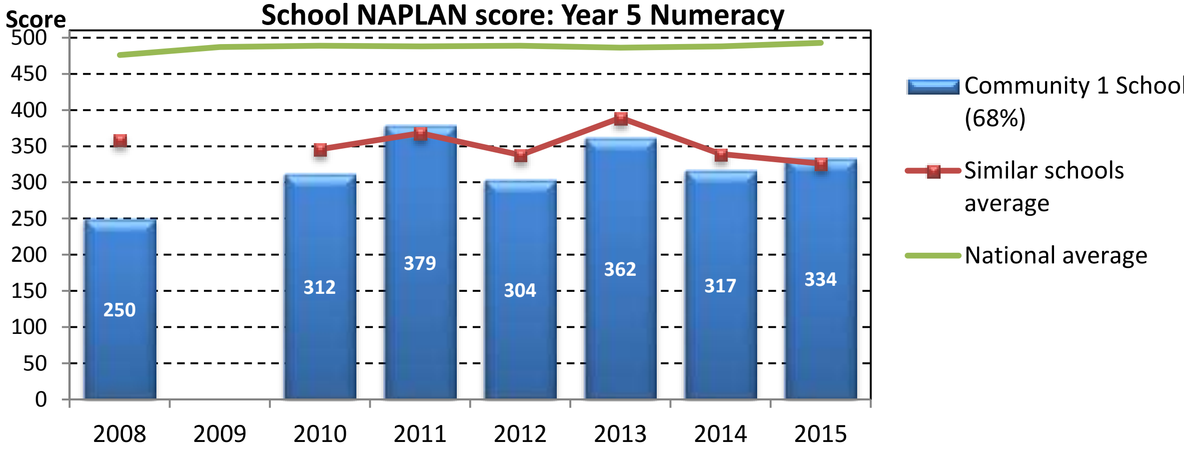
Literacy and numeracy of school students

- The school score for Year 5 reading increased from 267 to 316, with this improvement taking the school score to above the average of similar schools.
- The 2015 school score of 316 was 63% of the national average (499).

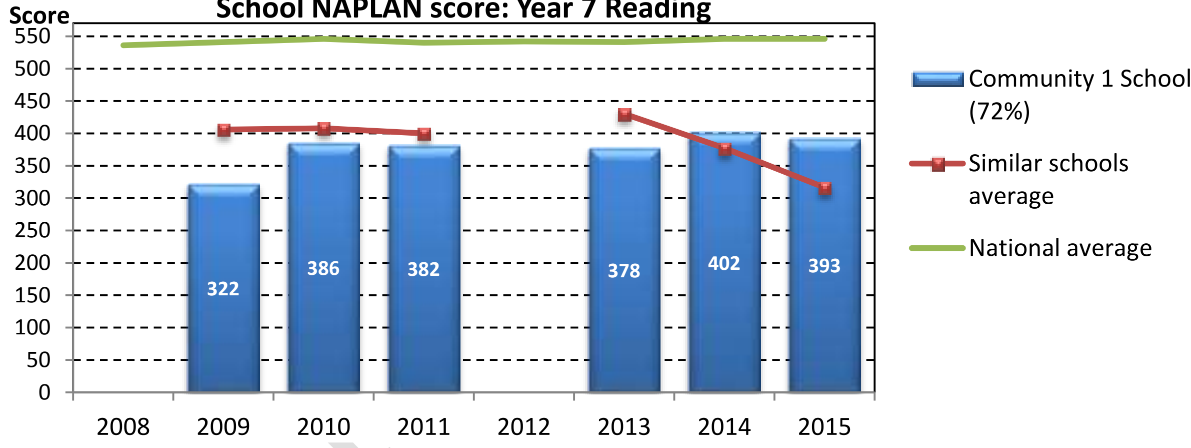


- The school score for Year 5 numeracy increased from 317 to 334, with this improvement taking the school score to a little above the average of similar schools.

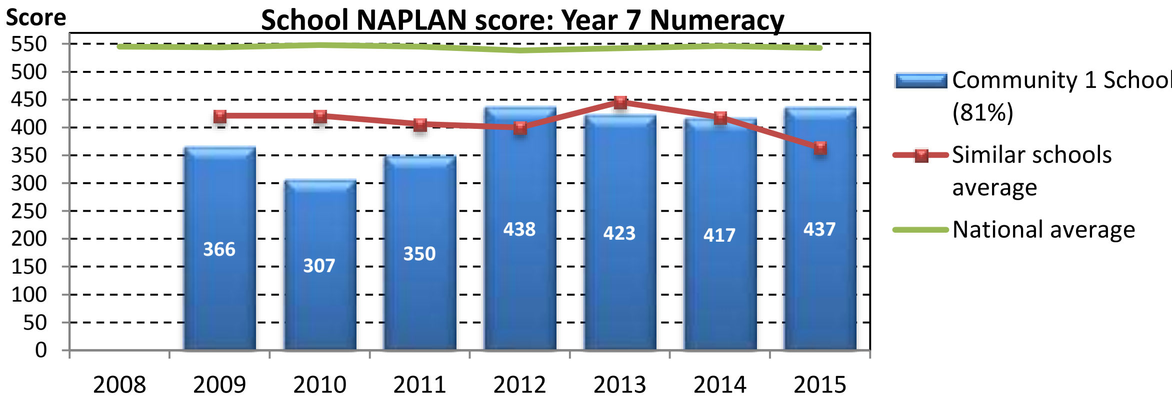
- The 2015 school score of 334 was 68% of the national average (493).



- The school score for Year 7 reading decreased from 402 to 393, though the school score was above the average of similar schools.
- The 2015 school score of 393 was 72% of the national average (546).



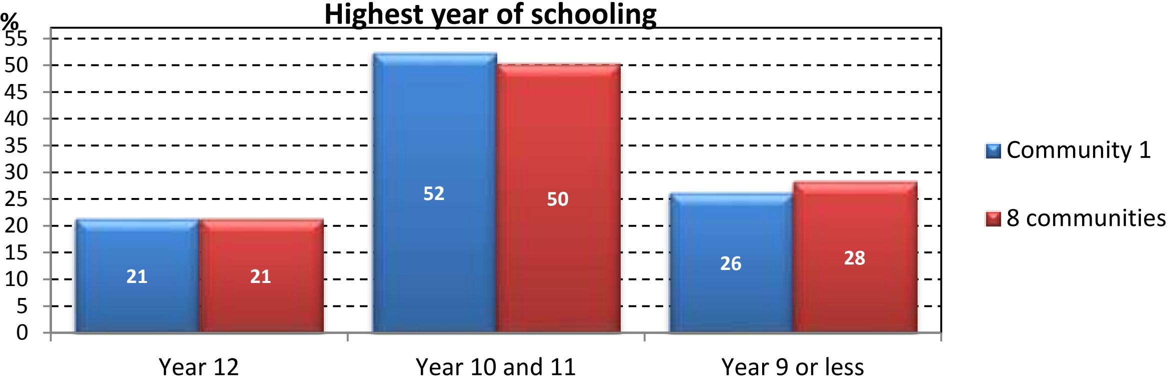
- The school score for Year 7 numeracy increased from 417 to 437, with this improvement taking the school score to above the average of similar schools.
- The 2015 school score of 334 was 68% of the national average (543).



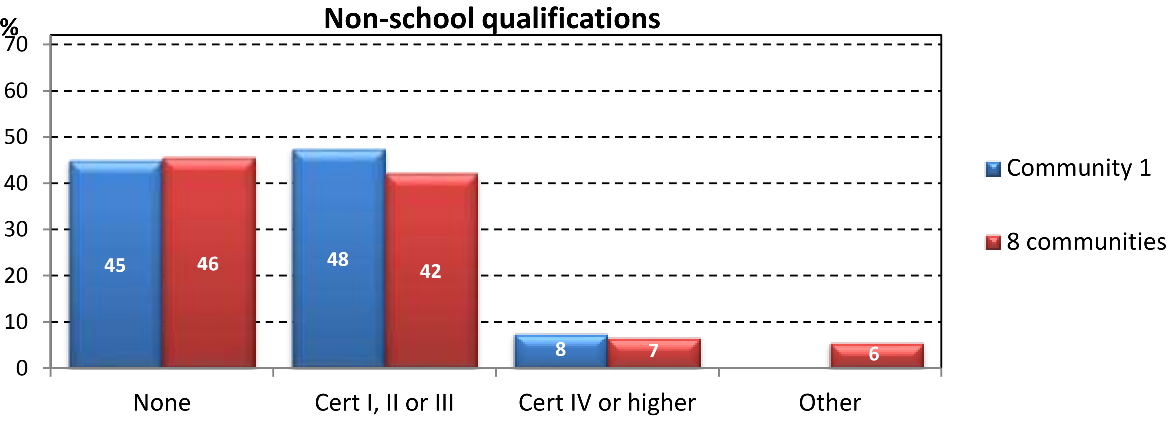
Community Survey

Adult education

- Around 21% of adults completed year 12 in Community 1, which was similar to that observed across all eight communities.



- Nearly half (45%) of adults in Community 1 did not have any non-school qualifications, which was similar to that observed for all eight communities.
- Forty-eight percent of adults had completed a Certificate I, II or III, compared with 42% across all eight communities.



Key informant interviews

Alcohol misuse in parents was considered to contribute to low levels of school attendance and behavioural problems at school. Several key informants noted that levels of literacy and education were low, with this making it difficult for community members to gain employment. Key informants linked unemployment to a range of social issues and mental health problems such as low self-esteem, boredom, family problems and stress, with these being perceived as major reasons for why community members misused alcohol. Passive welfare, combined with people having 'time on their hands', was also seen as problematic, with better outcomes more likely to occur when people were employed, whether this be

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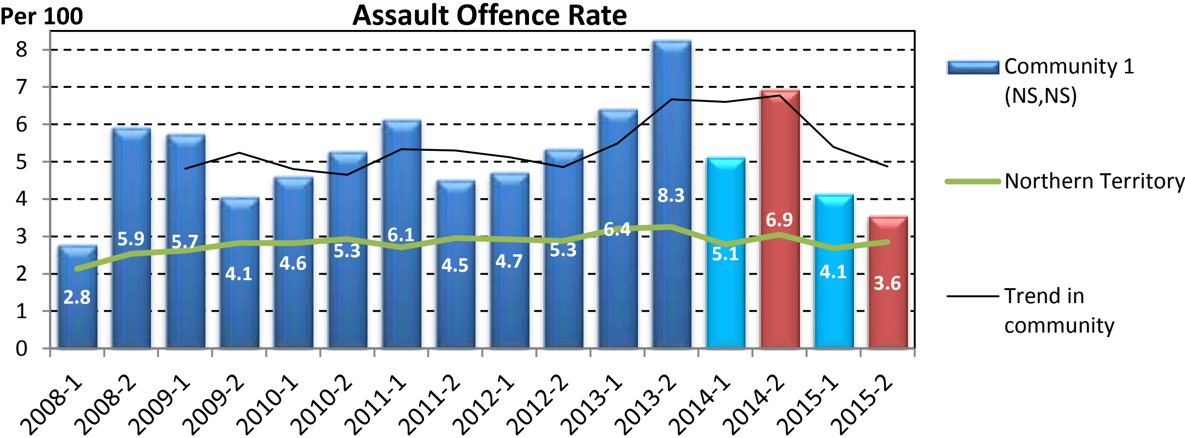
through regular employment or part of a strategy such as the Community Development Programme (CDP).

Community safety

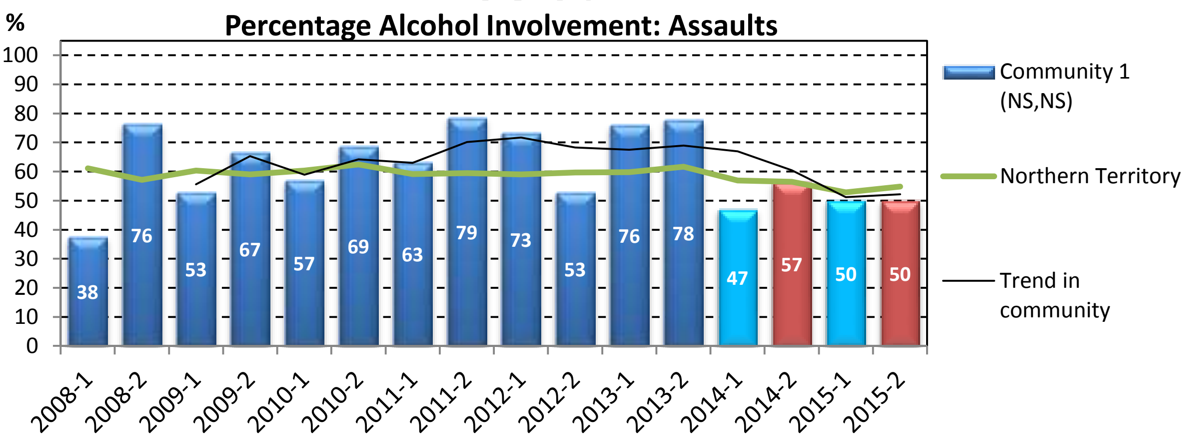
<u>Administrative data</u>

Assault offences

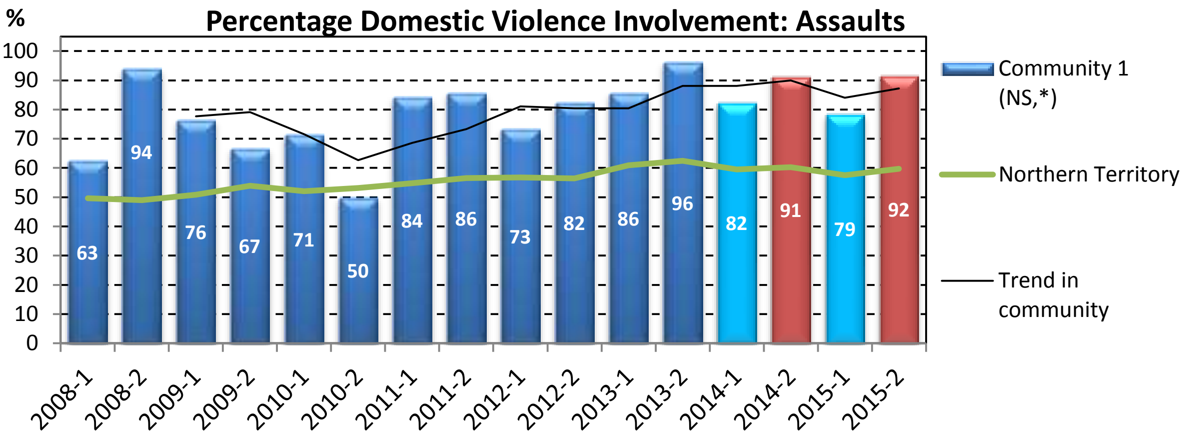
- There was a marginally non-significant decrease (p=0.06) in the rate of assaults in Community 1 from 6.9 per 100 people in 2014-2 to 3.6 per 100 in 2015-2.
- The assault rate in Community 1 was a little higher than the NT rate, which was 2.7 and 2.9 per 100 in 2015-1/2, but this difference was not significant.



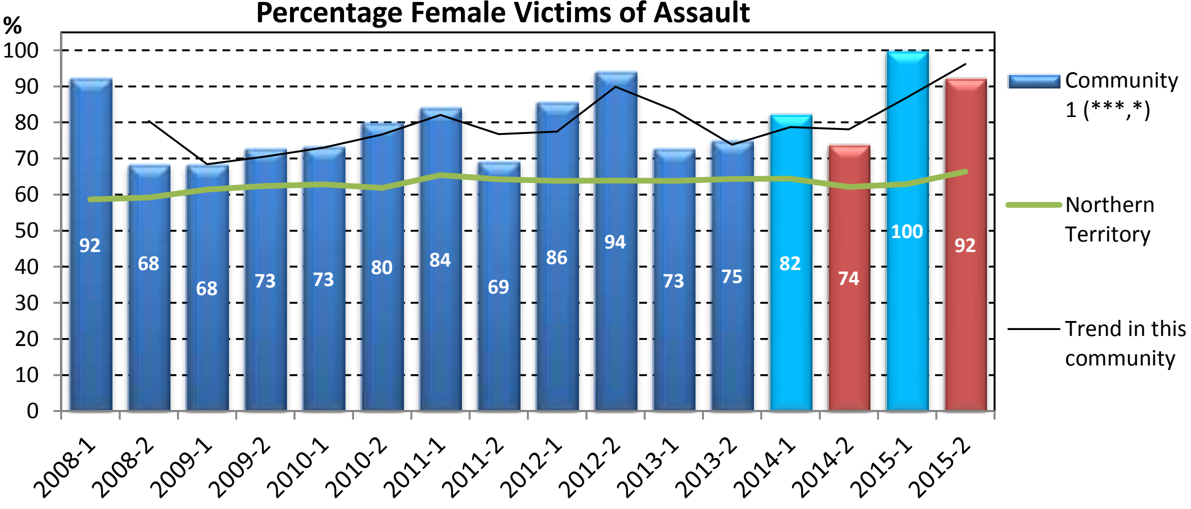
- The change in percentage alcohol involvement for assaults between 2014 and 2015 was not significant, and was similar to percentage alcohol involvement in assaults for the entire NT.



- The percentage of assaults where domestic/family violence was involved in Community 1 was steady between 2014 (82% and 91%) and 2015 (79% and 92%).
- The percentage of domestic violence related assaults in Community 1 (92%) was significantly higher than that observed for the NT (60%).

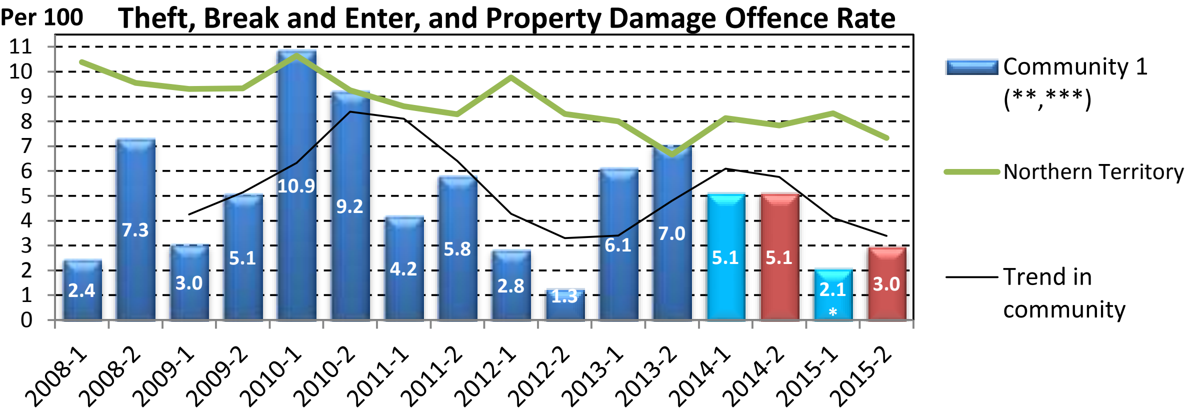


- The change in percentage female victims of assault between 2014 and 2015 was not significant, though it did increase from 82% to 100% and from 74% to 92% between corresponding periods in 2014 and 2015 respectively.
- The percentage of victims of assault who were female was significantly higher than that observed for the NT in both periods of 2015 (63% and 66%).



Theft, break and enter and property damage

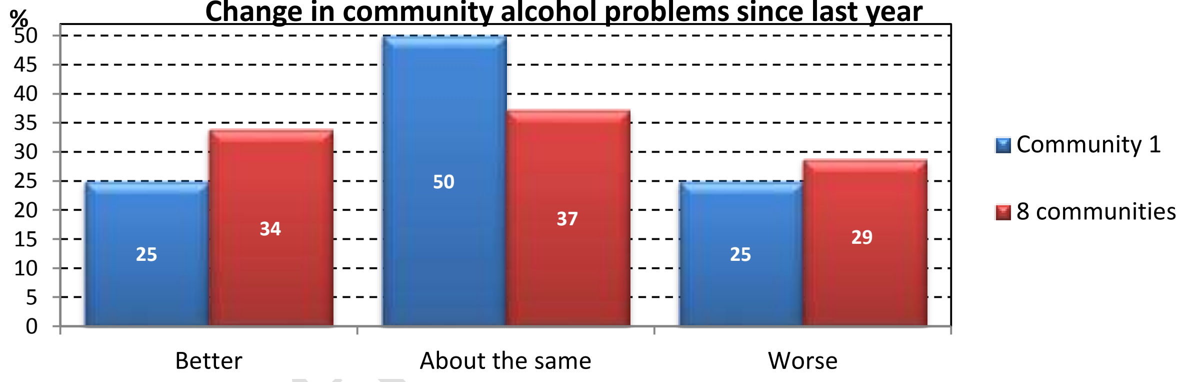
- There was a significant decrease in the theft, break and enter and property damage offence rate from 2014-1 to 2015-1 (5.1 per 100 to 2.1 per 100 people).
- The offence rate in 2015 for theft, break and enter and property damage was lower in Community 1 (2.1-3.0 per 100) compared with the entire Northern Territory (8.3-7.3 per 100).



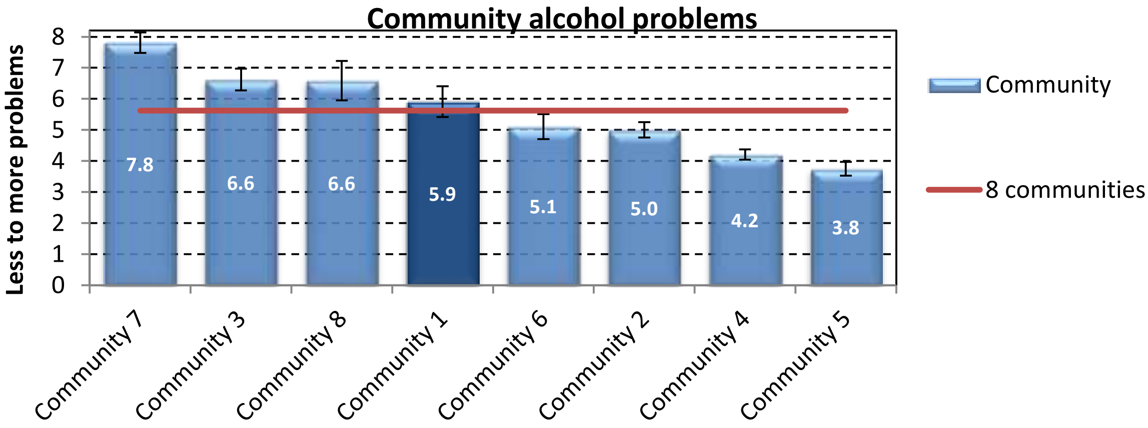
Community survey

Community and household alcohol problems

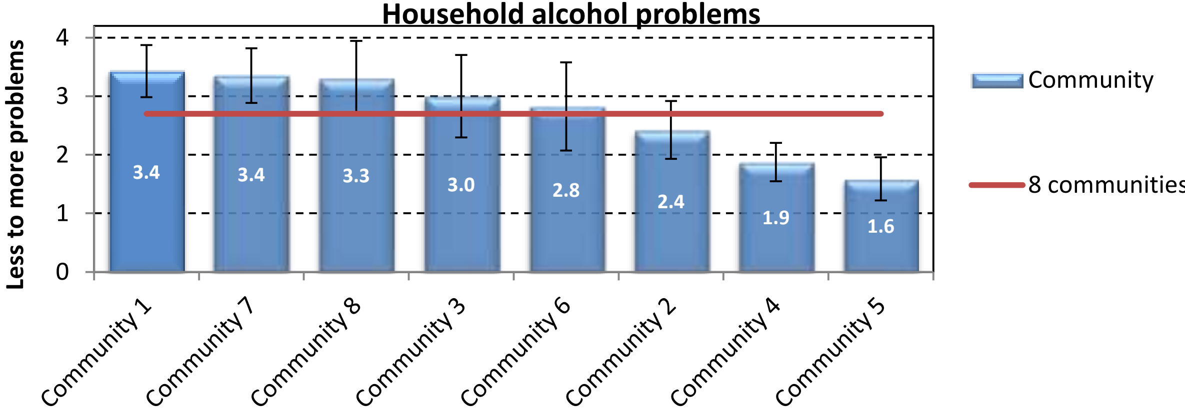
- A quarter (25%) of Community 1 people surveyed said that community alcohol problems were better compared with the previous year, which was a little lower than for all eight communities (34%). Fifty percent said they were about the same and 25% said they got worse.



- When asked about community alcohol problems and how often they occur, Community 1 was a little above the average compared with the eight communities.



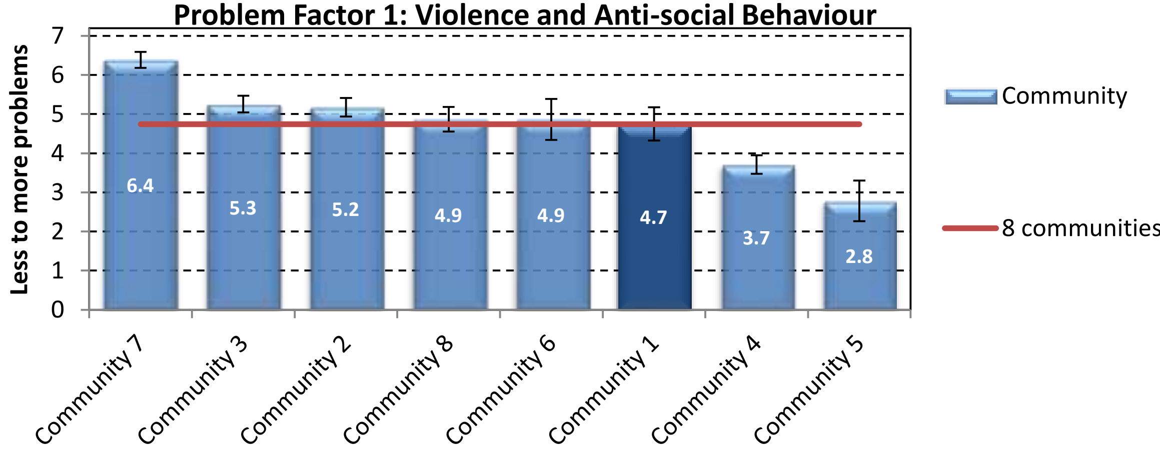
- When asked about household alcohol problems and how often they occur, Community 1 scored the highest, meaning people in Community 1 said that household alcohol problems occur more often compared with the other communities included in the survey.



Community problems

- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
    2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
    3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.

- Community 1 scored a little bit above the average of the eight communities for *Violence and Anti-Social Behaviour Problems* in the community. That is, things are a little worse than the average in Community 1.



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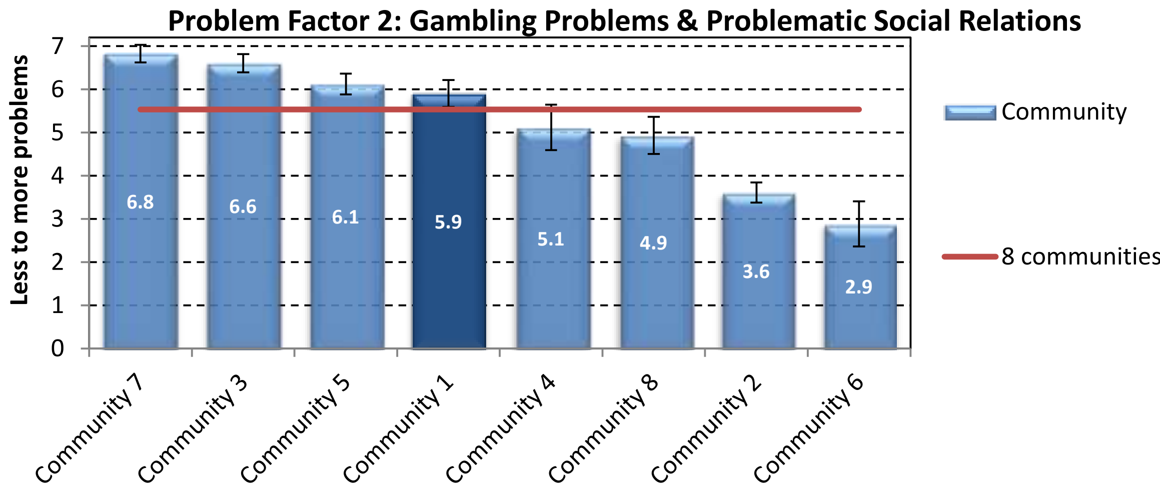
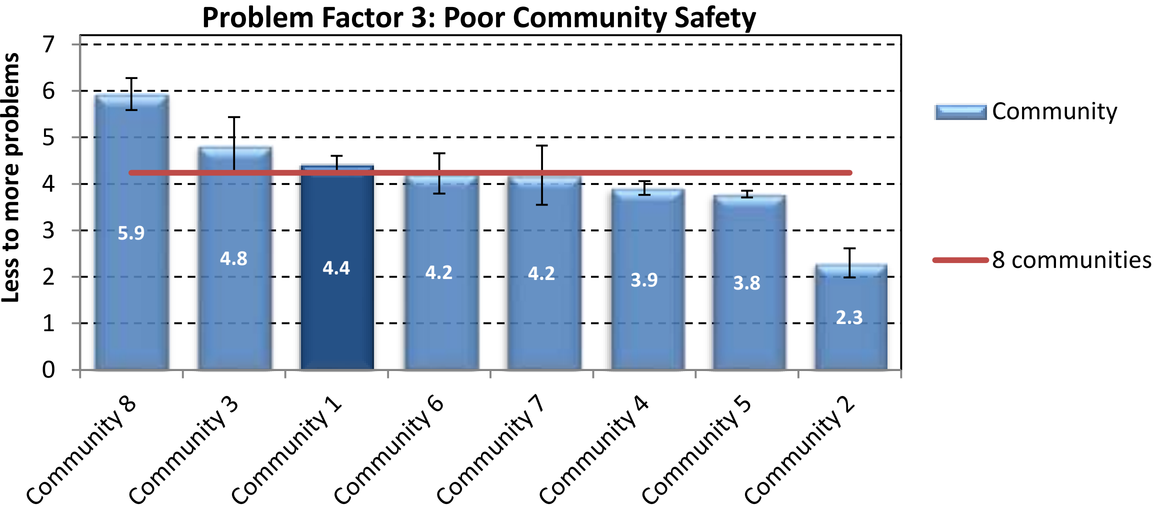
- Community 1 scored just a little bit above the average of the eight communities for *Gambling Problems and Problematic Social Relations* in the community. That is, things are a little worse than the average in Community 1.

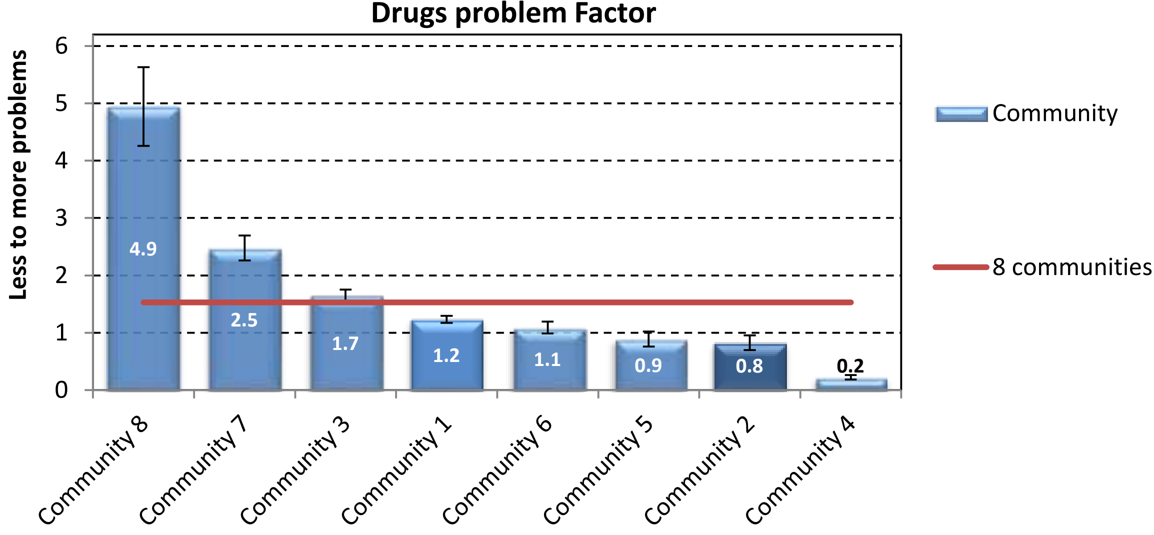


- Community 1 scored a little bit above the average of the eight communities for *Poor Community Safety* in the community. That is, things are a little worse in Community 1 than the average.



Community drug problems

- The Community Survey also asked residents about drug problems (marijuana, sniffing, kava and ecstasy) and how much of the time over the last year they were a problem. The figure below shows Community 1 scored below the average of the eight communities in how much of the time drugs were a problem. Some other communities had more problems with sniffing and kava.



Key informant interviews

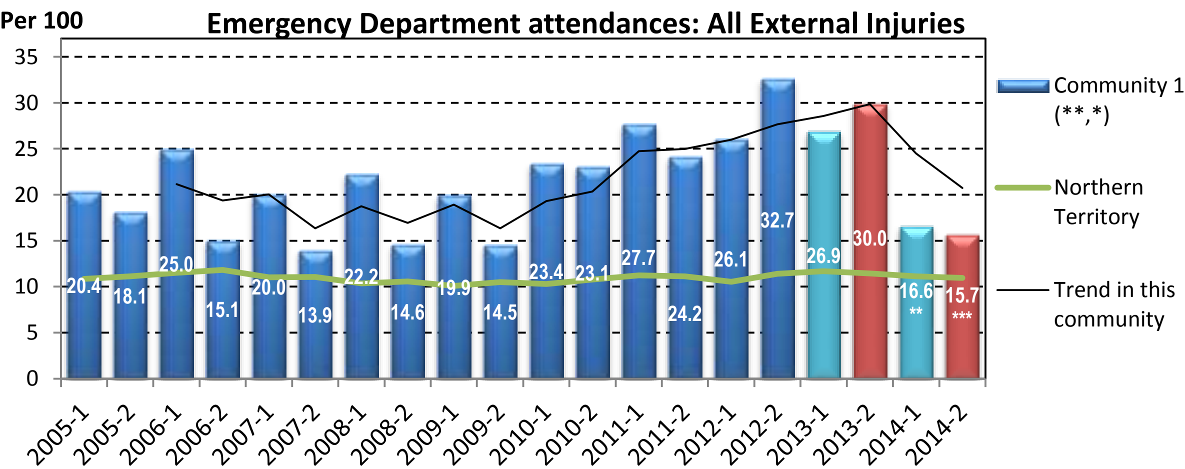
Key informants noted that alcohol had a range of adverse effects on community safety including: domestic violence; assaults; and noise and disruption at night. Several informants commented that effective policing and electronic ID systems could help to reduce these harms.

Community health and wellbeing

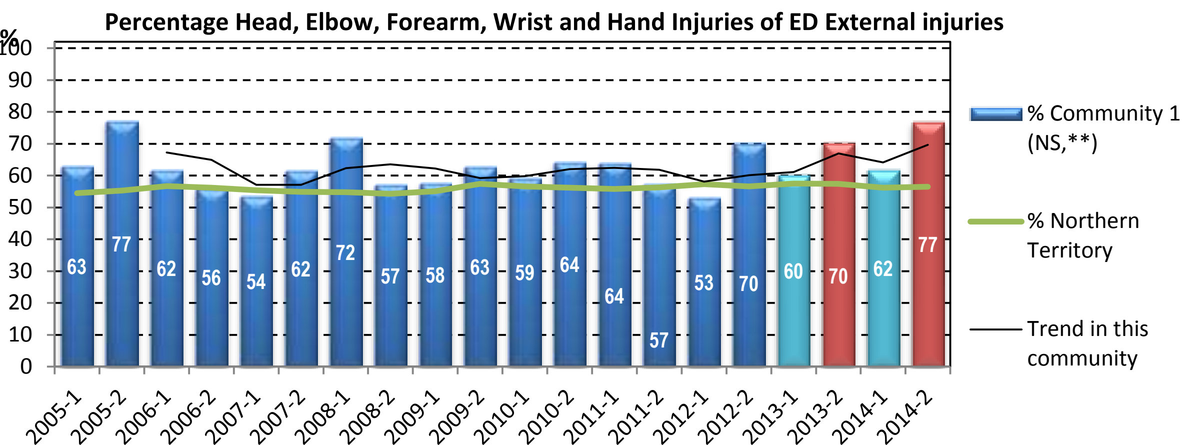
Administrative data

Emergency Department admissions for external injuries

- The following graph shows admissions to the Emergency Department (ED) for all external injuries (e.g. broken bones, cuts etc).
- There were significant declines between 2013 and 2014 in both halves of the year from 26.9 to 16.6 per 100 people in the first half and from 30 to 15.7 per 100 people in the second half.

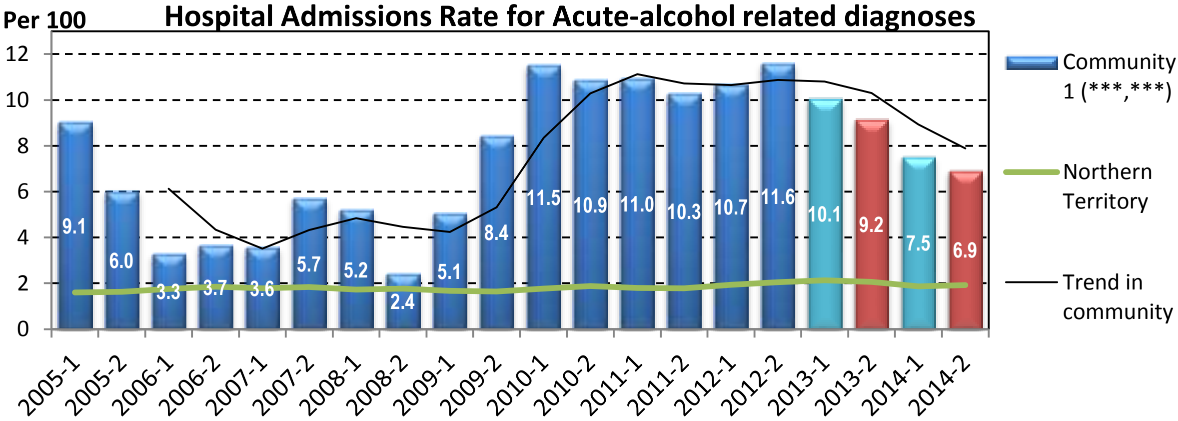


- Head, elbow, forearm, wrist and hand injuries as a percentage of all external injuries increased between 2013-1 (60%) and 2014-1 (62%), and between 2013-2 (70%) and 2014-2 (77%), though neither increase was statistically significant.
- The percentage head, elbow, forearm, wrist and hand injuries were significantly higher in Community 1 in 2014-2 (77%) compared with the NT percentage (57%).



Hospitalisation for alcohol-related conditions

- For Community 1, hospital admission rates per 100 people for alcohol-related diagnoses increased quite dramatically from 2008-2 through to 2011, before levelling off and declining again from 2012-2 (11 per 100 people) through to 2014-1 (6 per 100 people).
- None of the recent decreases were significantly different from the corresponding previous period, though the rate in Community 1 (7.5 and 6.9 per 100 people) was significantly higher than the NT rate (1.9 and 1.9 per 100 people) in both 2014-1 and 2014-2.



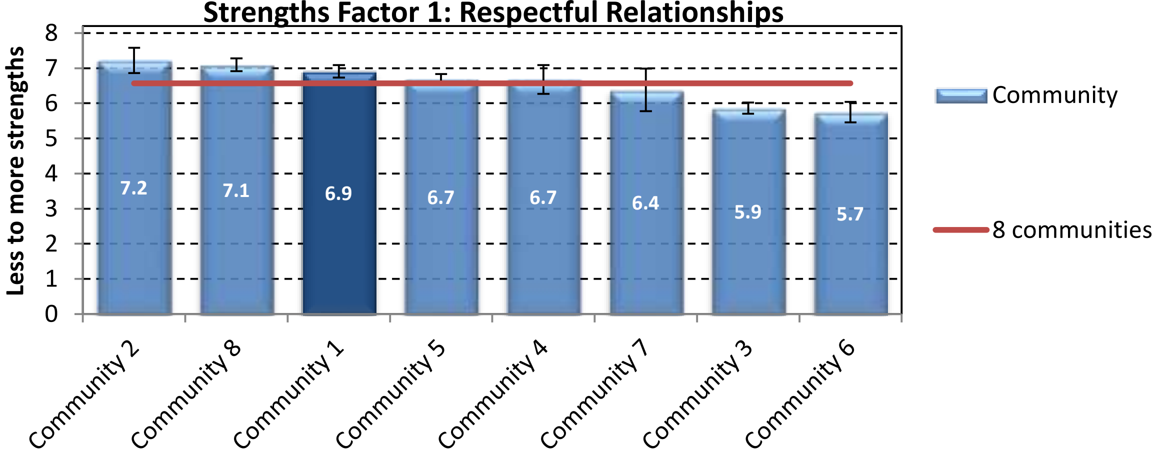
Community survey

Community strengths

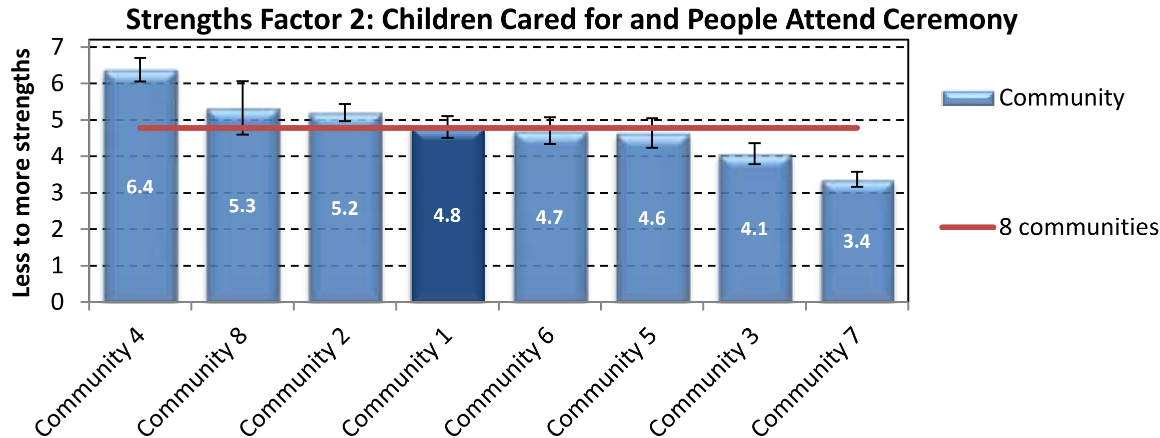
- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:

1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) people respect Elders, (ii) people respect other community members, and (iii) people help each other.
2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
3. Strengths Factor 3: *Healthy Social Engagement* which includes three community strengths: (i) people go out for bush tucker, (ii) people do organised sports and other activities and (iii) people say no to humbug.

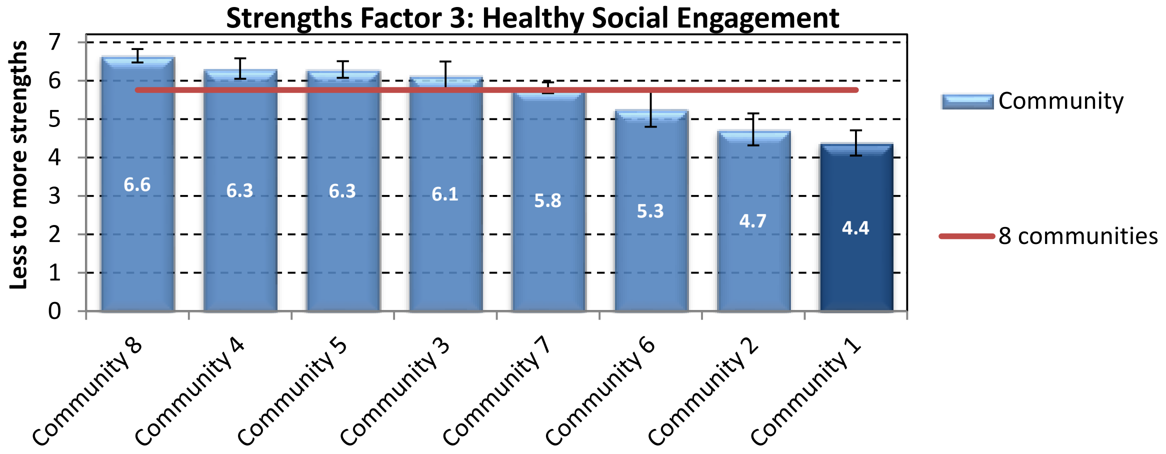
- Community 1 scored above the average of the eight communities in *Respectful Relationships*.



- Community 1 scored on the average of the eight communities in *Children Cared for and People Attend Ceremony*.



- Community 1 scored below the average of the eight communities in *Healthy Social Engagement*. Some communities had less access to bush tucker (e.g. access to water) which may have affected their score for this measure.



<u>Key informant interviews</u>

Alcohol was perceived as having adverse effects on community health and wellbeing because it contributed to: a lack of motivation; feelings of hopelessness; child neglect; and pressures on extended family members to care for children of parents with alcohol problems, with these pressures particularly affecting older women. Key informants canvassed a range of demand reduction strategies that would help to improve community wellbeing. These included: community development; infrastructure development; alcohol-related education programmes; education and training programmes; more sport and recreation opportunities; appropriate employment opportunities; and mentoring and capacity building at the individual level to … *encourage people to take ownership, to care, to take pride in themselves and their community*. One key informant commented on the need for a 24 hour drop-in centre as this would help to build relationships between community members and health staff and, in doing so, would create a space for intervention.

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4.3 Community 2 Data Report

Highlights: 2014 to 2015

- ↑↑ large or significant improvement; ↑ small or non-significant <u>improvement</u>; = no change or small change
- ↓↓ large or significant worsening; ↓ small or non-significant <u>worsening</u>; = no change or small change
- NOTE: The survey sample in this community was small (n=33) and less representative of the whole community.

Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-6 to 6)			**33% (2)**
Wholesale PAC in catchment	NA	-	-
Community average PAC last drink	Below the average of 8 communities	↑	1
Frequency of drinking	Similar to the average of 8 communities	=	0
Number types of alcohol drank	Less likely to drink 3 or 4 types of alcohol	↑	1
Community Education (-0 to 0)			**NA**
School attendance	NA	-	-
Year 5 reading	NA	-	-
Year 5 numeracy	NA	-	-
Year 7 reading	NA	-	-
Year 7 numeracy	NA	-	-
Adult year 12 completion	Lower than average of 8 communities	-	-
Adult other qualifications	About the same as average of 8 communities	-	-
Community Problems & Safety (-24 to 24)			**-38% (-9)**
Assaults offences	Significant worsening trend over last 2 years	↓	-1
Alcohol % in assaults	No substantial change over last 2 years	=	0
Domestic violence % in assaults	No substantial change over last 2 years	=	0
Female % in assaults	No substantial change over last 2 years	=	0
Theft, stealing, break & enter	Significant worsening trend over last 2 years	↑	1
Change in community alcohol problems	Most people (58%) said better than last year	↑↑	2
Community alcohol problems	Below the average of 8 communities	↑	1
Household alcohol problems	Just below the average of 8 communities	↑	1
Violence & Anti-Social behaviour	Just above the average of 8 communities	↓	-1
Gambling & Problematic Social Relations	Second lowest of 8 communities	↑↑	2
Poor Community Safety	Lowest of 8 communities	↑↑	2
Community Drug problems	Second lowest of 8 communities	↑↑	2
Community Strengths, Health & Wellbeing (-6 to 6)			**17% (1)**
Emergency Department attendances	NA	-	-
% head, elbow, forearm, wrist & hand	NA	-	-
Acute alcohol hospitalisations	NA	-	-
Respectful Relationships	Highest of 8 communities	↑↑	2
Children Cared for &Attend Ceremony	Above the average of 8 communities	↑	1
Healthy Social Engagement	Second lowest of 8 communities	↓↓	-2
Total standardised score (-60 to 60)			**4%**

Key informant interviews: Highlights

Alcohol is seen as a significant issue in this community. Factors regarded as contributing to alcohol related problems include poverty, unemployment, over-crowding and poor infrastructure. However, the ready availability of alcohol, through numerous liquor outlets in the nearby town, in conjunction with a lack of responsible service is also regarded as a

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contributing factor. Although alcohol harms are experienced broadly across the community, informants repeatedly focused on the negative impacts on children and young people. A range of strategies to reduce harms were suggested, including: supply reduction; community development; more recreational, employment and educational opportunities; and employment programmes linked to unemployment payments. One key informant noted that alcohol harm reduction measures are most likely to work when there is strong community ownership – buy-in. However, the community finds this difficult to achieve, for while there may be a core group of elders who take ownership, there is a strong and mobile periphery of visitors that don't have any buy-in.

Community context

This is a large community consisting of a number of constituent components. There is no social club or permit system but residents have easy access to alcohol through a range of liquor outlets situated in the nearby town.

Administrative data

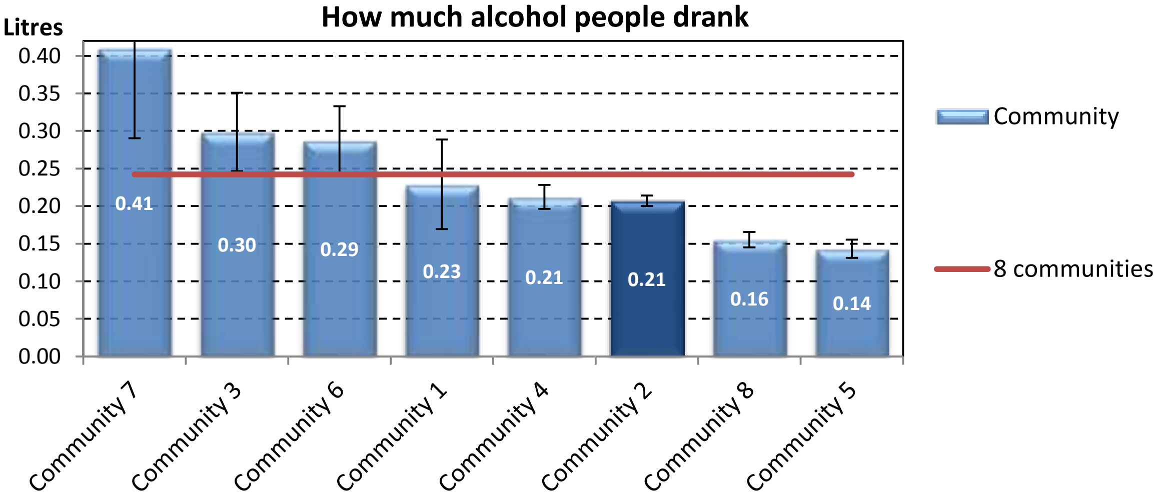
Administrative data was not available for Community 2, consequently, the data report for this community is limited to survey and key informant data.

Alcohol consumption patterns

Community Survey

Pure Alcohol Consumed (PAC) Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

- The average PAC for Community 2 residents' last drinking session was 0.21 litres (approximately 16 standard drinks or 11 full strength beers), which was less than for the average for the eight communities surveyed (0.24 litres).



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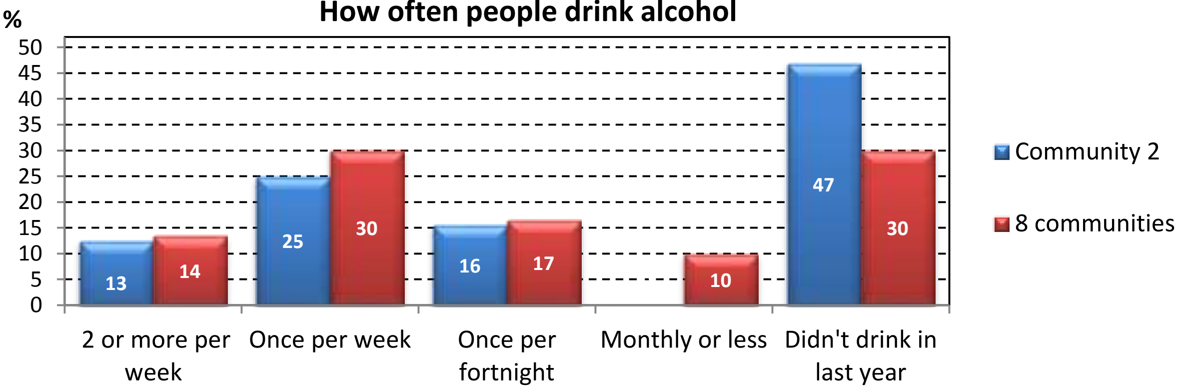
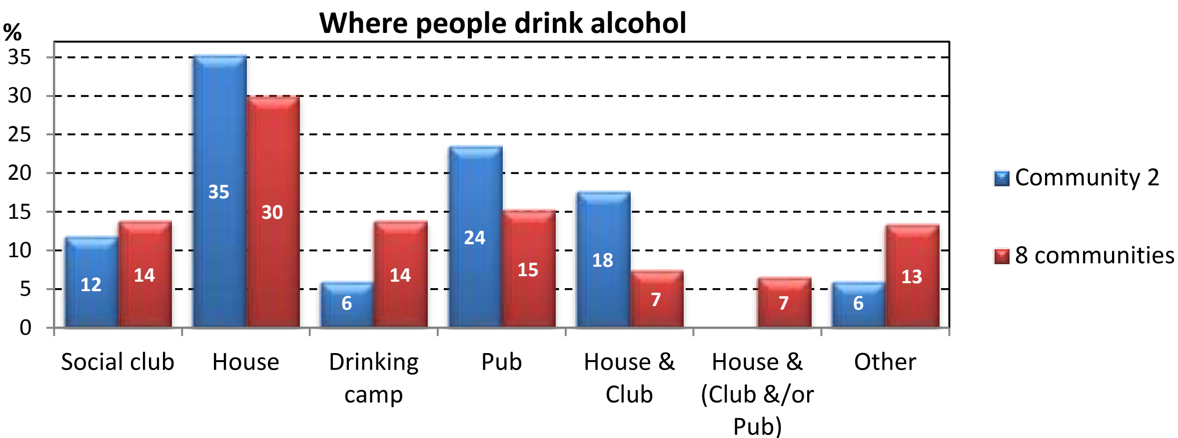
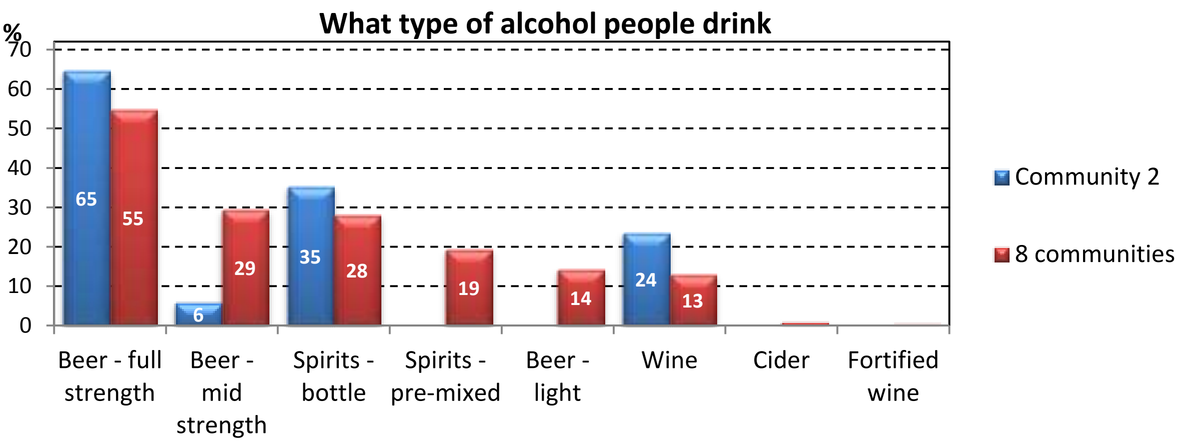
- Most people surveyed in Community 2 who drank alcohol in the last year, drank once a week (25%) or twice a week (13%). A higher percentage of Community 2 residents surveyed did not drink alcohol in the last year (47%), compared with the average of the eight communities (30%).



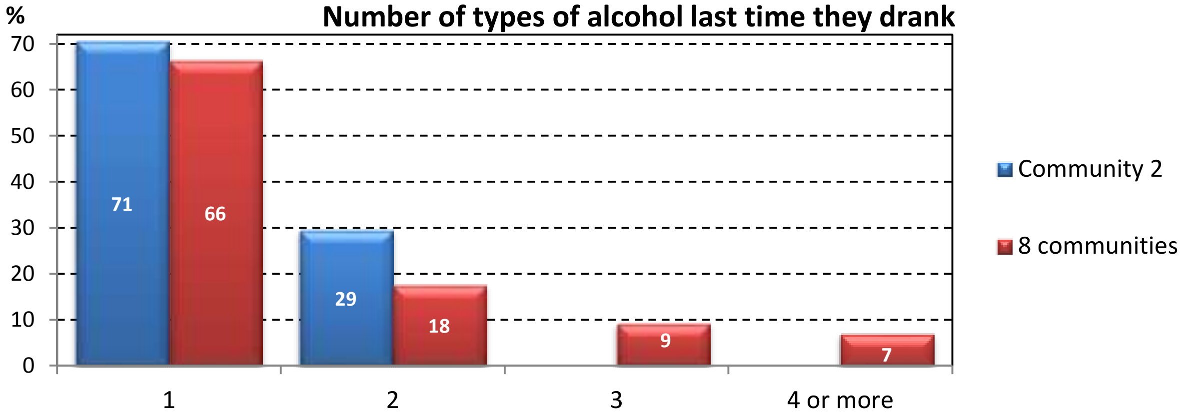
- Most people surveyed in Community 2 drank in their own or a friend's house (35%), followed by drinking in the pub (24%), in a house and club (18%), then social club (12%).



- Last time they drank, most people surveyed from Community 2 drank full-strength beer (65%), while 35% drank bottled spirits and 24% drank wine.



- Most people drank only one type of alcohol (71%) last time they drank, while the remainder drank two types.



Key informant interviews

Alcohol problems are regarded as widespread in Community 2, with strong peer pressure to drink. Drinking occurs regularly in most areas of the community and there is an extensive black market supply of alcohol. Although Temporary Beat Locations (TBLs), based in the nearby town, appear to have had a positive impact in some areas (one informant noted that since their introduction alcohol-related emergency department presentations have reduced by 30%), many Aboriginal people regard them as racist and as increasing black market activity. In addition, licensed premises in the adjacent town make it difficult to manage takeaway outlets effectively. Consumption of alcohol, and related problems, tend to increase during royalty payment periods and on public holidays. One Indigenous key informant commented that everyone in Community 2 was an alcoholic and that the only time people give up is when they run out of money.

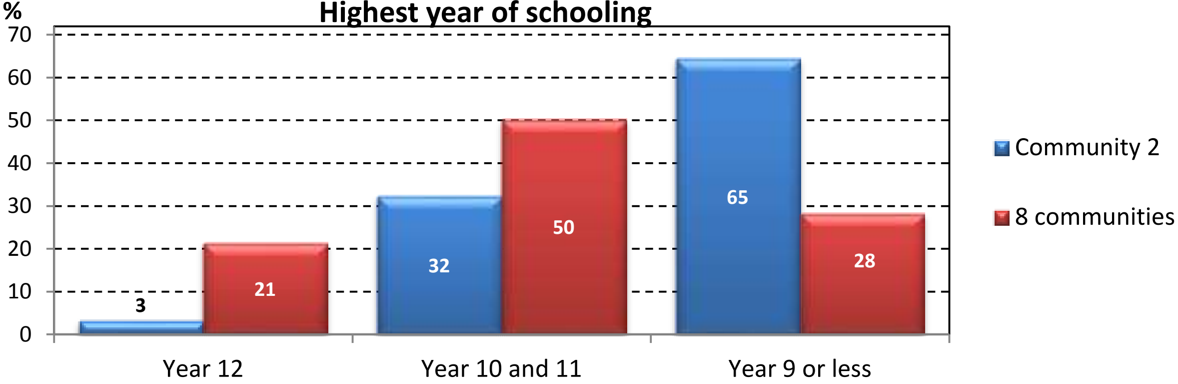
Confidential draft

Community education

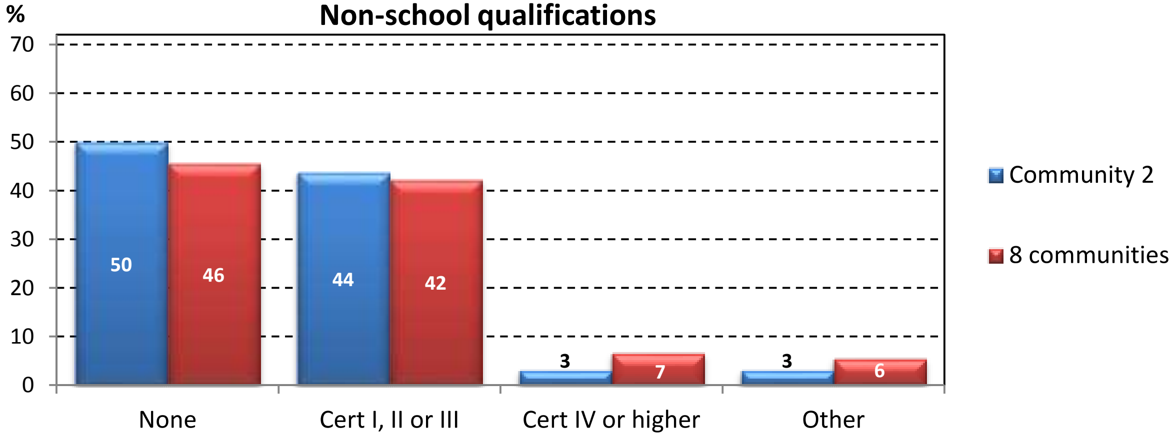
Community survey

Adult education

- Around 3% of adults from Community 2 had completed year 12, which was lower than that observed across all eight communities (21%). Most people surveyed (65%) in Community 2 had completed Year 9 or less, compared with 28% across all eight communities.



- Half (50%) of surveyed adults in Community 2 did not have any non-school qualifications, which was similar to that observed for all eight communities.
- Forty-four percent of surveyed adults had completed a Certificate I, II or III, compared with 42% across all eight communities.



Key informant interviews

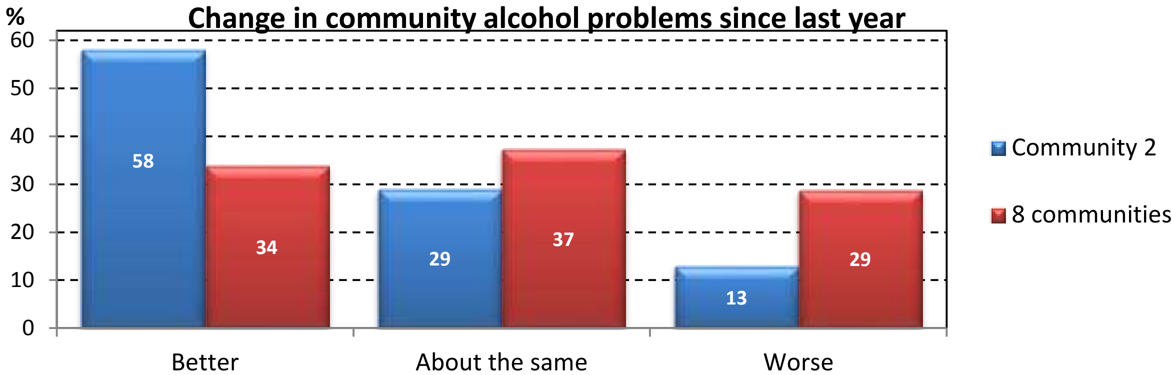
Alcohol is regarded as having a big impact on children and on school attendance. One key informant noted that drinking in the home prevents many children from getting enough sleep and impacts on food availability, consequently, even if these children attend school they are not 'ready to learn'. The principal of one school (which had a high proportion of children from Community 2) noted that parent volunteering was low, and difficult to encourage, and around 40% of the responsible carers were grandparents while another 10% were extended family members.

Community safety

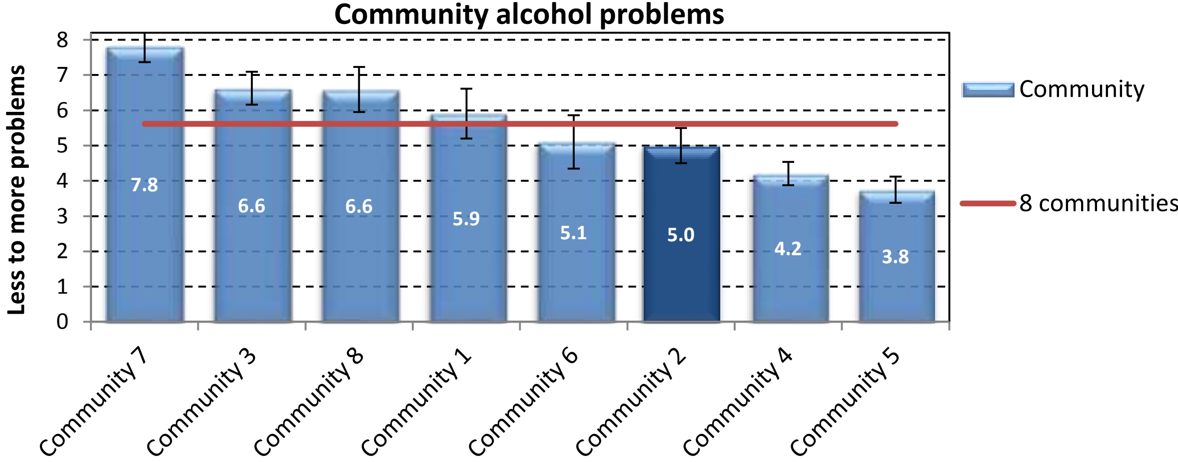
<u>Community survey</u>

Community and household alcohol problems

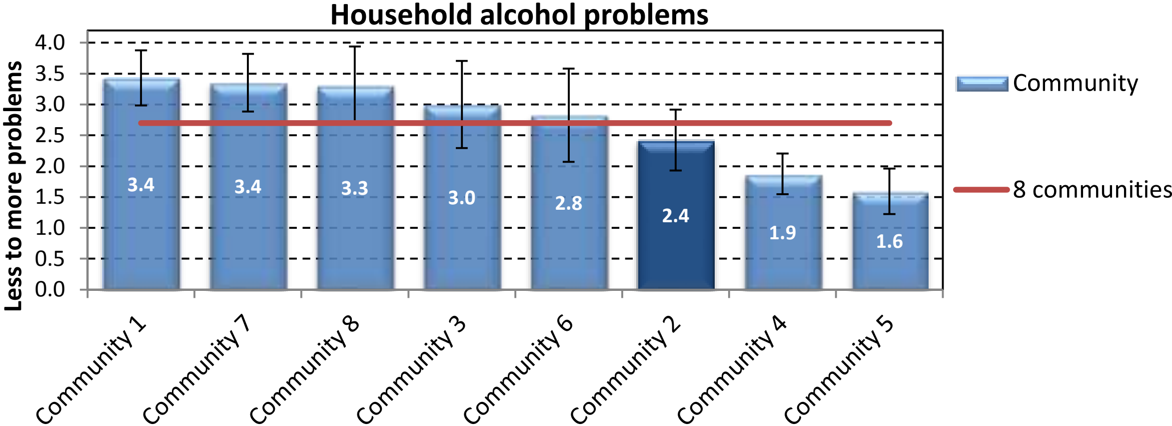
- More than half (58%) of people surveyed in Community 2 thought that community problems with alcohol had got better since the previous year, which was higher compared with all eight communities (34%).



- Community 2 scored below the average of the eight communities included in the survey.

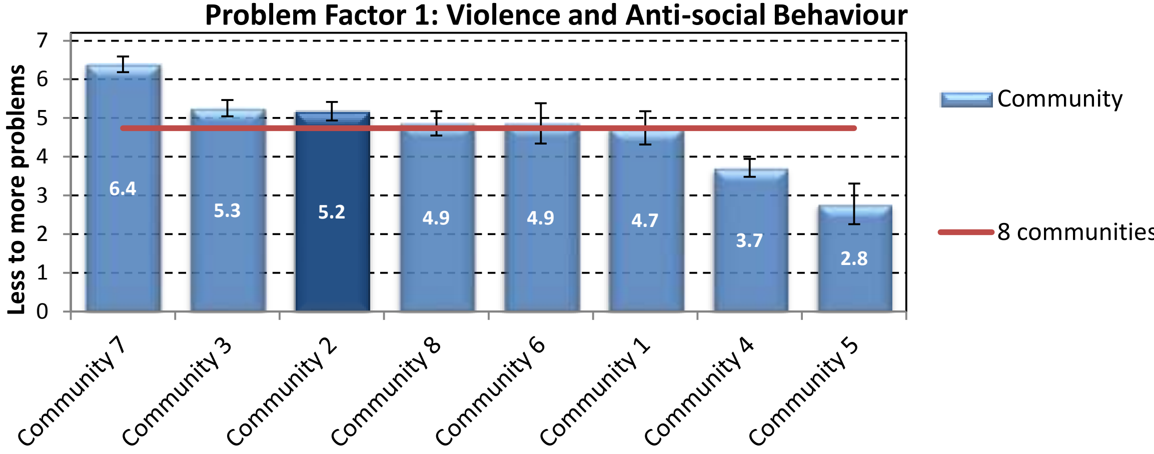


- When asked about household alcohol problems and how often they occur, this community scored just below the average of the eight communities surveyed.

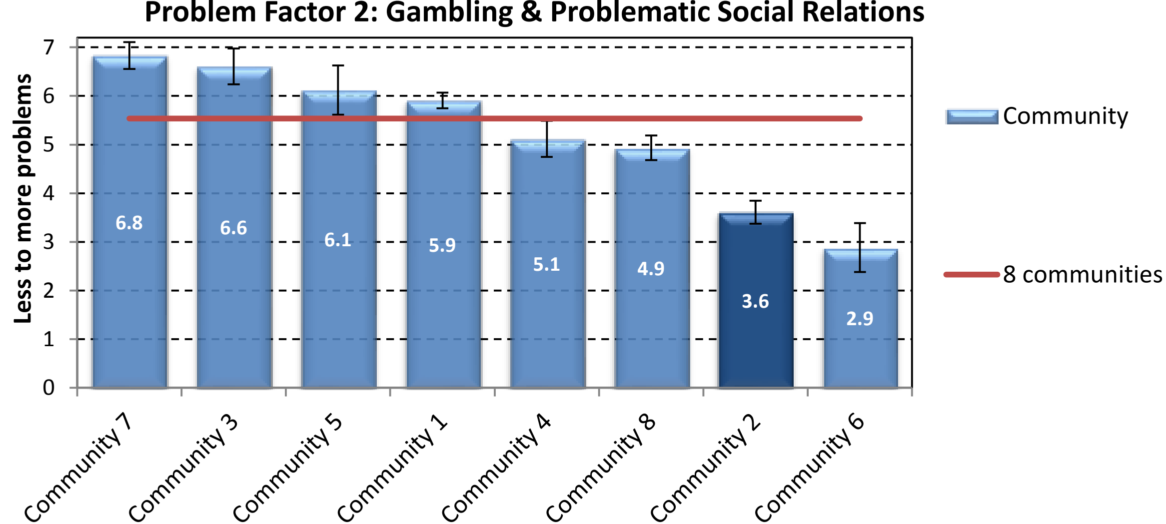


Community problems

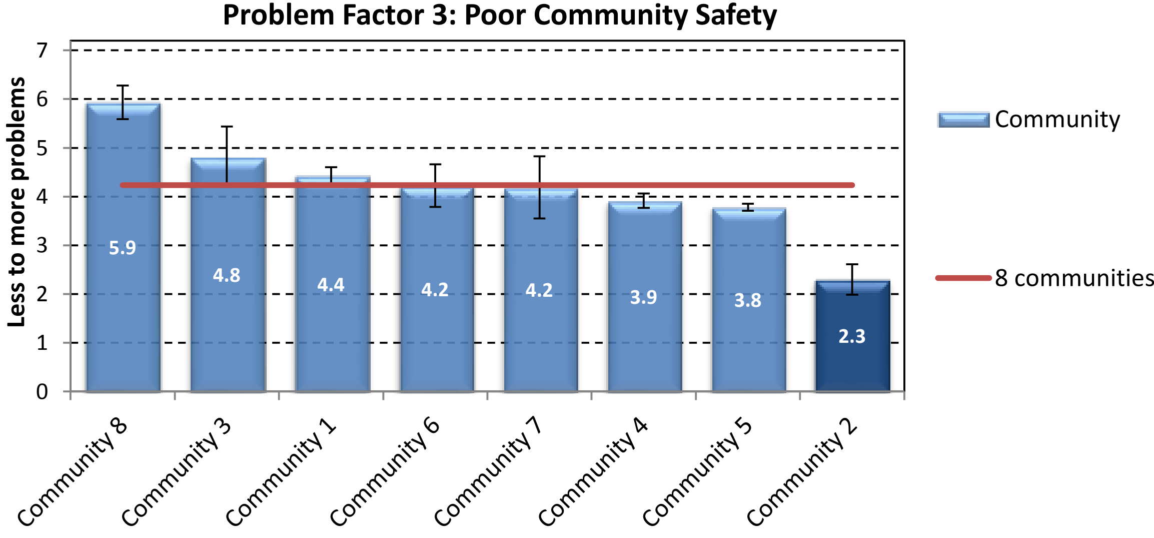
- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
    2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
    3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.
- For *Violence and Anti-Social Behaviour Problems* in the community, Community 2 scored above the average of the eight communities.



- Community 2 scored below the average of the eight communities for *Gambling Problems and Problematic Social Relations* in the community, meaning things were a little better in Community 2 compared with the other communities surveyed.

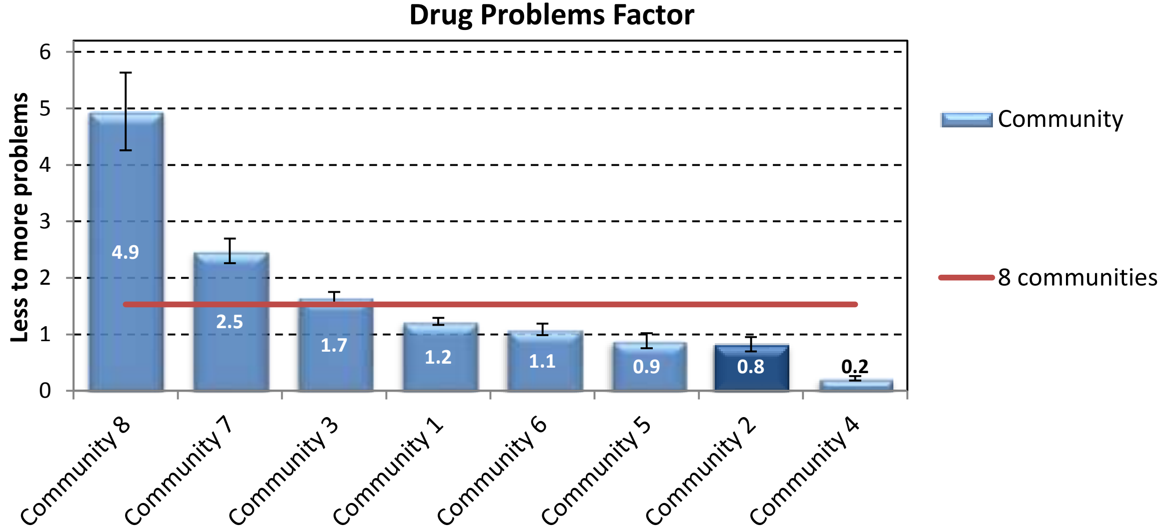


- For *Poor Community Safety*, Community 2 scored the lowest of the eight communities, meaning people in Community 2 said poor community safety was occurring less of the time than what people said in other communities.



Community drug problems

- For *community drug problems*, Community 2 scored second lowest of the eight communities. Some communities had more problems with petrol sniffing and kava, compared with other places.



<u>Key informant interviews</u>

Alcohol is perceived as contributing to a wide range of community safety issues including: domestic violence, violence in general, disorderly conduct, theft, hooning, excess noise, fighting, and teenage delinquency. One informant noted that Community 2 residents were ... *clearly disruptive, very up and down,* and were sensitive to a range of events such as royalty payments, welfare and work payment dates, frequent visitors, and things occurring in other people's lives, with all of these having the capacity to exacerbate alcohol misuse. Both housing allocation practices and the frequent influxes of visitors were regarded as contributing to social disruption which in turn contributed to alcohol misuse and related community safety issues. The community has quite a lot of visitors and this is seen as an issue for Community 2 residents as it contributes to housing and other social problems, which they have little power to resolve. Similarly, it was noted that housing allocation practices did not give enough consideration to whether or not there was a good 'fit' between the particular location in the community and the person or family assigned housing in that location, with one informant commenting that if potential social issues are to be avoided, consideration should be given to the applicant's criminal history, whether or not they were a drinker, and their relationship to others in the community. Most police effort is spent on responding to alcohol incidents in Community 2 and to incidents involving Community 2 residents in public spaces, with one informant noting that *The anti-social behaviour is really confronting* and creates a negative perception of the town. Although TBLs are regarded as having reduced some alcohol-related community safety problems, they are also perceived as concentrating problems in the Community 2 - *Things have gotten better on the surface (less hospital admissions and assaults) but there still is a hidden roller coaster of things because it's pushed back to town camps in a different way.*

Confidential draft

Community health and wellbeing

Administrative data

Emergency Department admissions for external injuries

No data available.

Hospitalisation for alcohol-related conditions

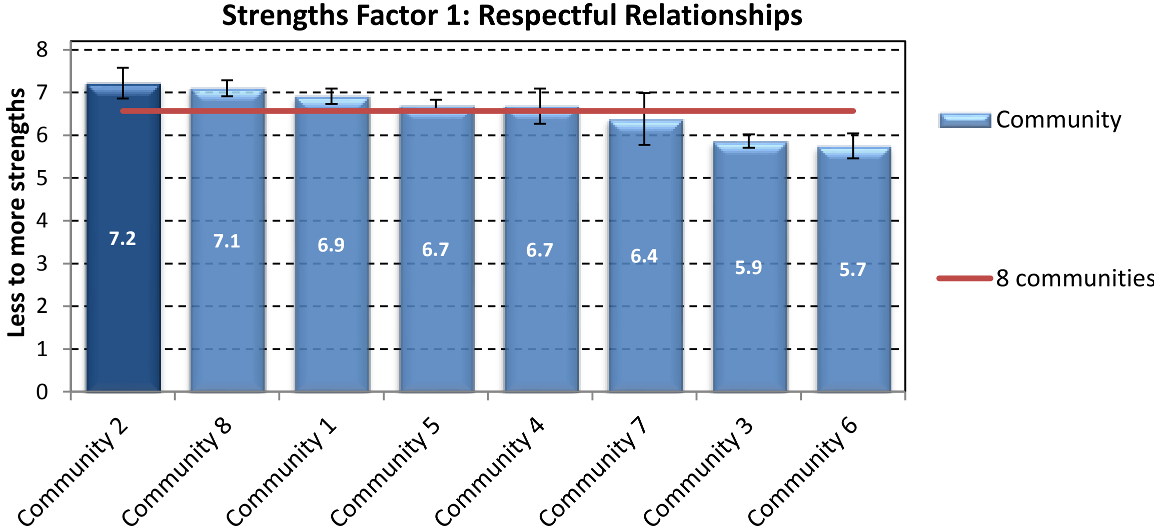
No data available.

Community survey

Community strengths

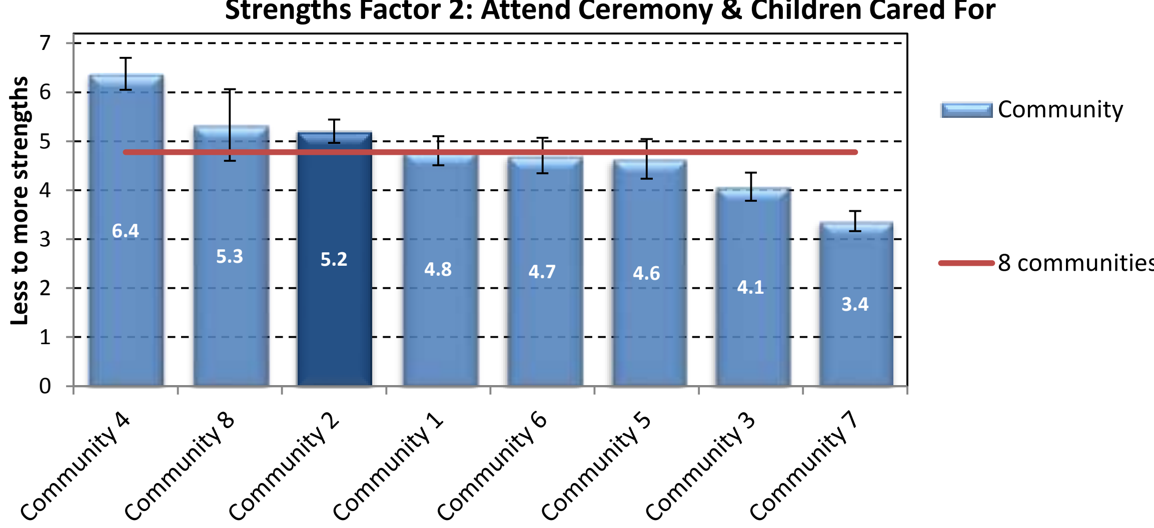
- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) people respect Elders, (ii) people respect other community members, and (iii) people help each other.
    2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
    3. Strengths Factor 3: *Health Social Engagement* which includes three community strengths: (i) people go out for bush tucker, (ii) people do organised sports and other activities and (iii) people say no to humbug.

- In *Respectful Relationships* Community 2 scored the best of the eight communities surveyed.

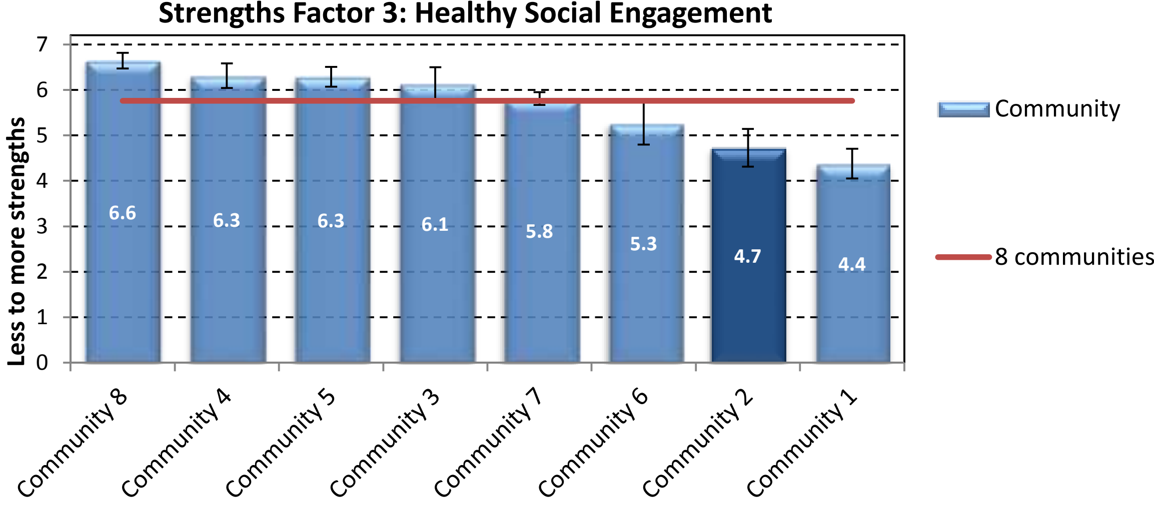


- For *Children cared for and People Attend Ceremony*, Community 2 scored just above the average of the eight communities surveyed.

Confidential draft



- For *Healthy Social Engagement*, Community 2 scored second lowest of the eight communities surveyed.



Key informant interviews

Alcohol was regarded as having a significant impact on family and as destroying traditional life and culture. Misuse of alcohol was often regarded as having the biggest impact on children by contributing to a lack of basic care, poor nutrition, and lack of sleep. Exposure to excessive drinking by parents was regarded as affecting children's attitude to school and employment. As one informant noted:

> *A lot of the kids haven't been to school and some don't want to go to school - kids look at their parents drinking and want to model that - rather than go to school. This causes problems for them later when they want to get a job - kids need a reference from the school if they want to get work and they won't get a reference if they haven't been so this means they have very little chance of getting a job when they leave school.* (community Elder)

Alcohol problems have also resulted in children being taken into care while others are looked after by grandparents, many of whom are not really capable of caring for children and find it a burden. Children who are not adequately cared for are more likely to engage with the justice system at a young age, for example, through activities such as breaking and entering and involvement with gangs. One informant noted that when some children are exposed to alcohol-related family violence, they suffer from post-traumatic stress disorder.

4.4 Community 3 Data Report

Highlights: 2014 to 2015

- ↑↑ large or significant improvement; ↑ small or non-significant improvement; = no change or small change
- ↓↓ large or significant worsening; ↓ small or non-significant worsening; = no change or small change

Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-6 to 6)			**-33% (-2)**
Wholesale PAC in catchment	Steady over last 2 years	=	0
Community average PAC	Second highest of 8 communities	↓↓	-2
Frequency of drinking	About the same as average of 8 communities	-	-
Number types of alcohol drank	About the same as average of 8 communities	=	0
Community Education (-10 to 10)			**30% (3)**
School attendance	Mostly steady over last 2 years	=	0
Year 5 reading	Improvement & same as similar schools	↑	1
Year 5 numeracy	Improvement & same as similar schools	↑	1
Year 7 reading	Improvement & just above similar schools	↑	1
Year 7 numeracy	Small worsening & same as similar schools	=	0
Adult year 12 completion	Below the average of eight communities	-	-
Adult other qualifications	Less likely to have Certificate 1 to IV	-	-
Community Problems & Safety (-24 to 24)			**-50% (-12)**
Assaults offences	No substantial change over last 2 years	=	0
Alcohol % in assaults	No substantial change over last 2 years	=	0
Family violence % in assaults	No substantial change over last 2 years	=	0
Female % in assaults	Significant worsening trend over last 1 year	↓↓	-2
Theft, stealing, break & enter	Significant worsening trend over last 1 year	↓↓	-2
Change in community alcohol problems	Similar to average of 8 communities	=	0
Community alcohol problems	Second highest of 8 communities	↓↓	-2
Household alcohol problems	Just above the average of 8 communities	=	0
Violence & Anti-Social behaviour	Second highest of 8 communities	↓↓	-2
Gambling & Problematic Social Relations	Second highest of 8 communities	↓↓	-2
Poor Community Safety	Second highest of 8 communities	↓↓	-2
Community Drug problems	Similar to average of 8 communities	=	0
Community Strengths, Health & Wellbeing (-12 to 12)			**-33% (-4)**
Emergency Department admissions	No substantial change over last 2 years	=	0
% head, elbow, forearm, wrist & hand	Significant worsening trend over last 1 year	↓	-1
Acute alcohol hospitalisations	Improving trend over last two years	↑	1
Respectful relationships	Second lowest of 8 communities	↓↓	-2
Attend Ceremony & Children Cared for	Second lowest of 8 communities	↓↓	-2
Healthy Social Engagement	Just above the average of 8 communities	=	0
Total change in score			**-22%**

Confidential draft

Key informant interviews: Highlights

Key informants considered alcohol to have a major impact on community safety and health and wellbeing. However, its normative status in the community, and its connection with peer acceptance and socialising, mean that it may be more difficult to achieve concerted

community action on alcohol than it would be on ice or ganga, which are not considered normative. Informants suggested the following strategies to reduce demand: provide more structured recreational opportunities; capacity building to facilitate community leadership; increase adult literacy; provide more job opportunities; reduce overcrowding; and provide a range of social and emotional wellbeing programs. Strategies to address current inconsistencies in where people drink ranged from a permit system; a social club; and the rescindment of dry areas accompanied by strict enforcement of the law. Drinking camps were generally regarded as unsafe and unsatisfactory. Overcrowding was perceived as exacerbating many of the demand factors and as a potential obstacle to the success of a permit system which is one of the favoured strategies for managing alcohol.

Community context

This community comprises several town camps, which are APAs, and a township which is not a restricted area. It has a comparatively large population and is located in the north-eastern region of the Territory.

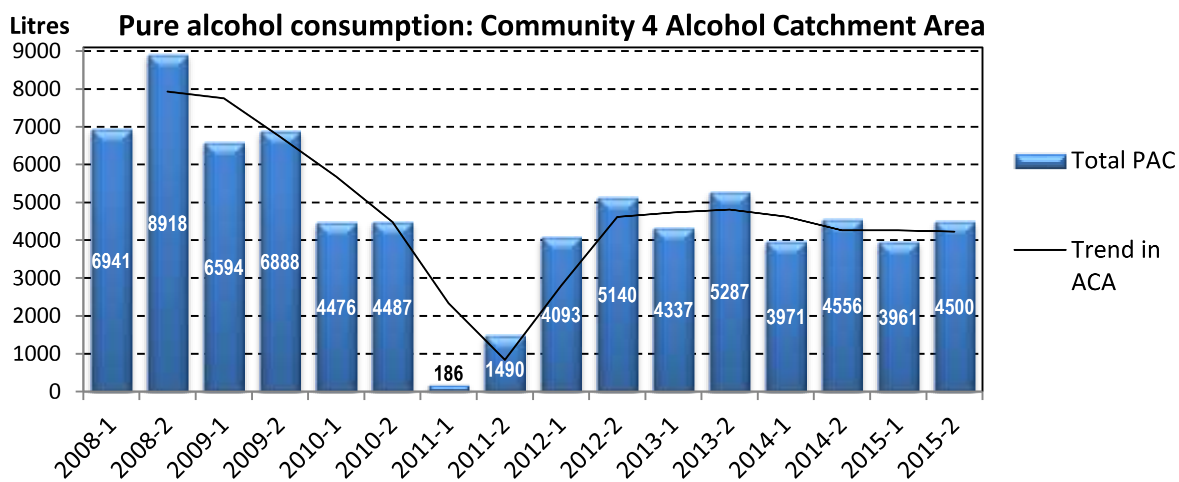
Key services include a police station, health clinic, school, safe house, fuel outlets, supermarkets, community owned store, caravan-park, motel, hotel (currently closed), adult education centre, a non-government organisation, and an art centre. Although there is no permit system or social club, the community has been working towards establishing a permit system from at least 2012. There is one off-licence outlet in the township which restricts sales to residents to 18 cans of mid-strength beer per day. In addition, residents purchase alcohol from two liquor outlets in the alcohol catchment area. The first of these is 110 km from the township and restricts sales to community residents to 18 cans of mid-strength beer per day while the other outlet is 380 km distant and has no restrictions on the licence. Community residents also purchase alcohol on-line and through phone orders, with the latter being delivered twice weekly.

Alcohol consumption patterns

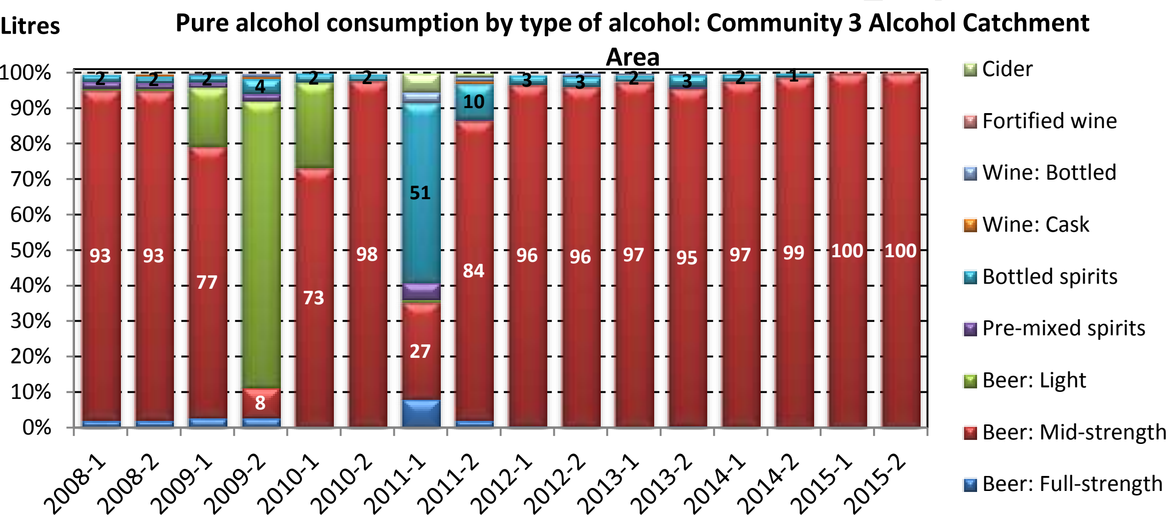
<u>Administrative data</u>

- PAC in litres by alcohol type for the Community 3 alcohol catchment area (ACA - two outlets in the community and one within driving distance) is shown in the graph below and represents the amount of pure alcohol consumed per 6-monthly period.
- The amount of PAC in the Community 3 ACA has remained stable over the 2014 and 2015 periods, with slightly more PAC in the second half of the year.

Confidential draft



- All PAC in 2015 was from the consumption of mid-strength beer, while in 2014 there was a small amount of bottled spirits drank also.



Community survey

Pure Alcohol Consumed (PAC) Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

- The average PAC for Community 3 residents' last drinking session was 0.30 litres (approximately 24 standard drinks or 17 full strength beers), which was higher than the average for the eight communities surveyed.

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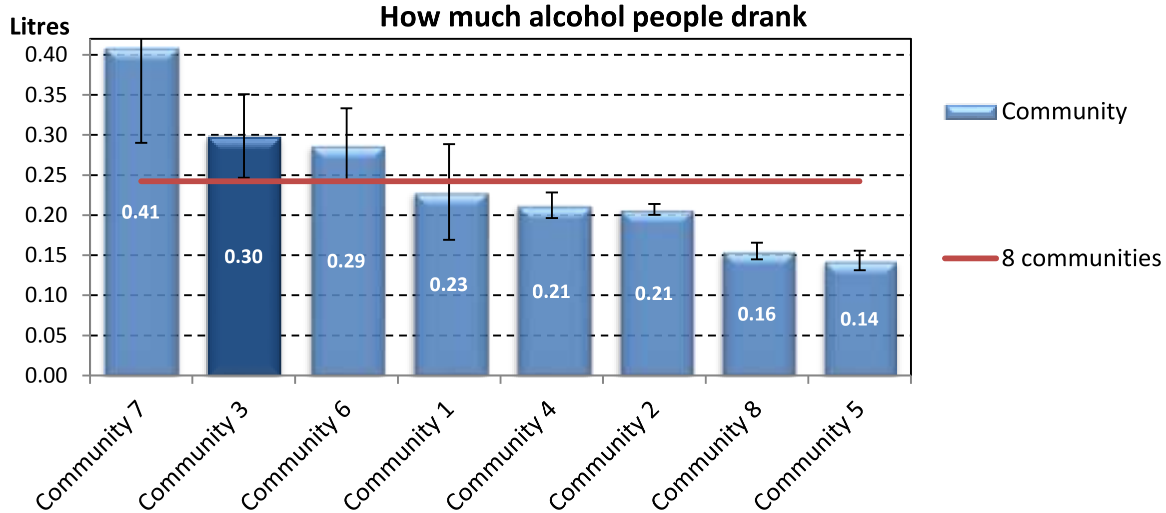
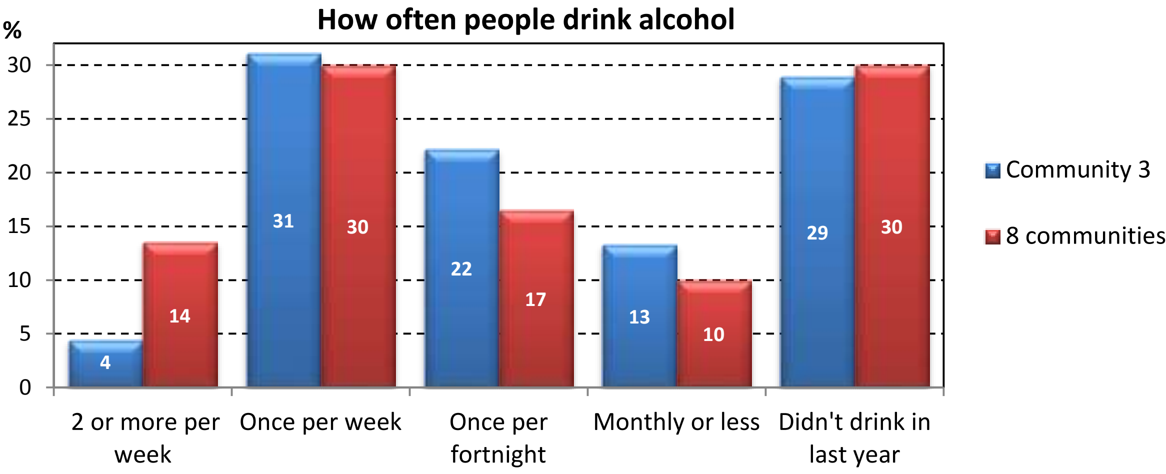
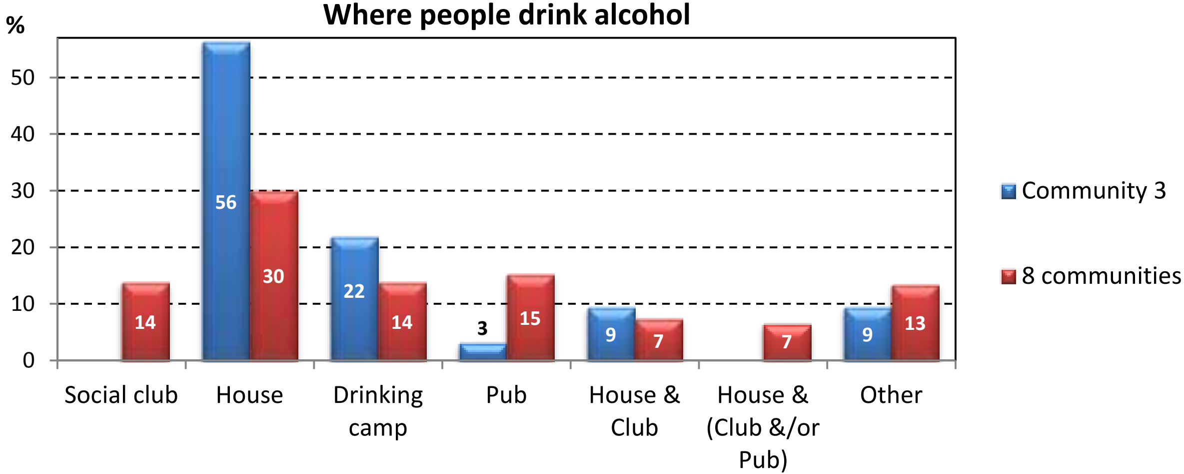


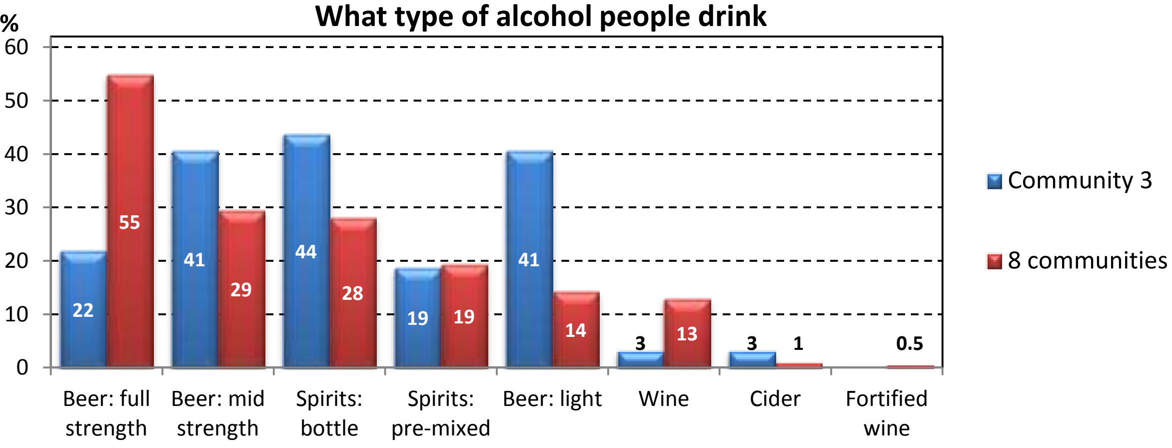
- Thirty-one percent of Community 3 residents drank alcohol once per week, and a further 22% once per fortnight, with the latter slightly higher than for all eight communities, where a higher percentage drank two or more times per week compared with Community 3 residents.



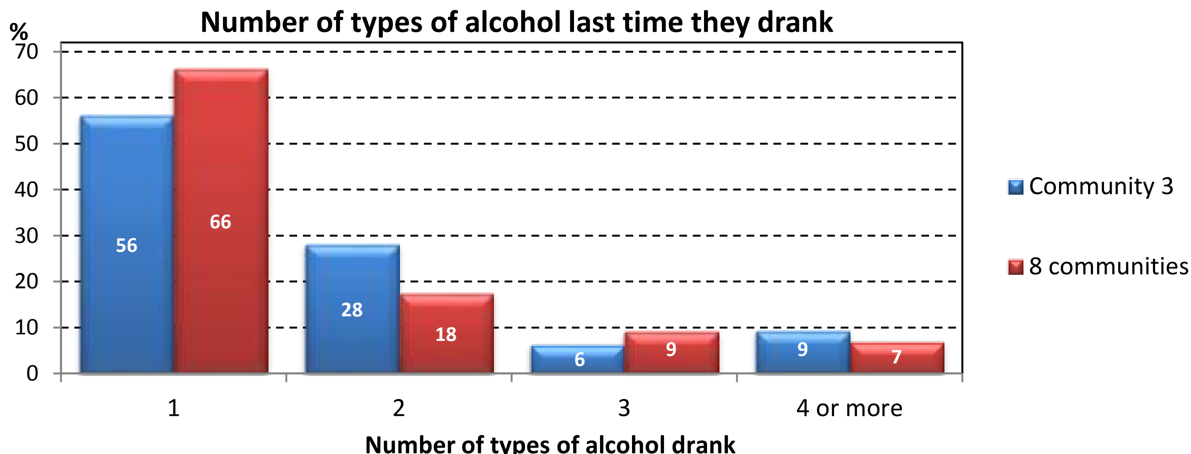
- The next figure shows where people drank with this varying depending on access to alcohol outlets. More than half (56%) of Community 3 residents on their last drinking occasion, did so in house (family or friends), followed by drinking camp (22%). Only 3% of people from Community 3 drank in a pub, compared with 15% across all eight communities.



- Forty-four percent of people drank bottled spirits, 41% drank mid-strength beer, and 41% also drank light beer on the last drinking occasion, which was higher compared with all eight communities. The high percentage of people in Community 3 drinking bottled spirits would indicate that the Community 3 ACA data is not capturing all alcohol being consumed in the community.
- A smaller percentage of people drank full-strength beer in Community 3 compared with the eight community average.



- Most (56%) people drank one type of alcohol last time they drank, while 28% drank two types compared with the eight community average of 18%.



Confidential draft

<u>Key informant interviews</u>

Most key informants considered this community to have significant alcohol problems, with one noting that people ... *drink like there is no tomorrow* (Indigenous resident) and another commenting that the number of after-hours alcohol-related presentations is much higher in this community than in other dry communities (mental health nurse). Binge drinking is common but there are also moderate to heavy drinkers who maintain a job and chronic heavy drinkers with life problems. Alcohol is seen as normative and as helping people to have a sense of belonging. There is considerable peer pressure to drink and, in the absence of alternative forms of socialising, alcohol has become a way of life. This normalisation of alcohol consumption is probably one of the key factors making it difficult to address alcohol-related problems, as one informant noted: *Alcohol is the biggest problem in the community rather than ice or ganga but ice or ganga will be seen by the community as the bigger problem* (clinic). Factors perceived as influencing consumption include: easy access to alcohol; overcrowding; poor literacy and education; lack of employment, sporting and recreational opportunities; low coping strategies; poor communication and relationship skills; modelling of dysfunctional drinking patterns; and loss of culture, with this connected to a history of trauma, exclusion, and massacre. Although the town camps are dry, and there are limits on how much alcohol can be purchased per day, restrictions can still be by-passed through sly grogging, on-line and phone orders, and purchases made from other outlets.

A range of strategies for managing alcohol were canvassed, with a permit system receiving the strongest support. However, some informants felt that a social club would be more effective, at least initially, because it provides a more controlled and regulated drinking environment in which people could learn to drink responsibly. One informant felt that a permit system had greater risk, as it assumes a capacity for restraint which may yet to be developed. In addition, while some informants felt that drinking in private homes was better for family interaction, others thought this wasn't a good option due to conditions of severe overcrowding. Allowing alcohol in such an environment was seen as problematic because it could well exacerbate existing social pressures. Drinking camps were not popular due to their negative impact on amenity, lack of supervision, and safety issues.

Confidential draft

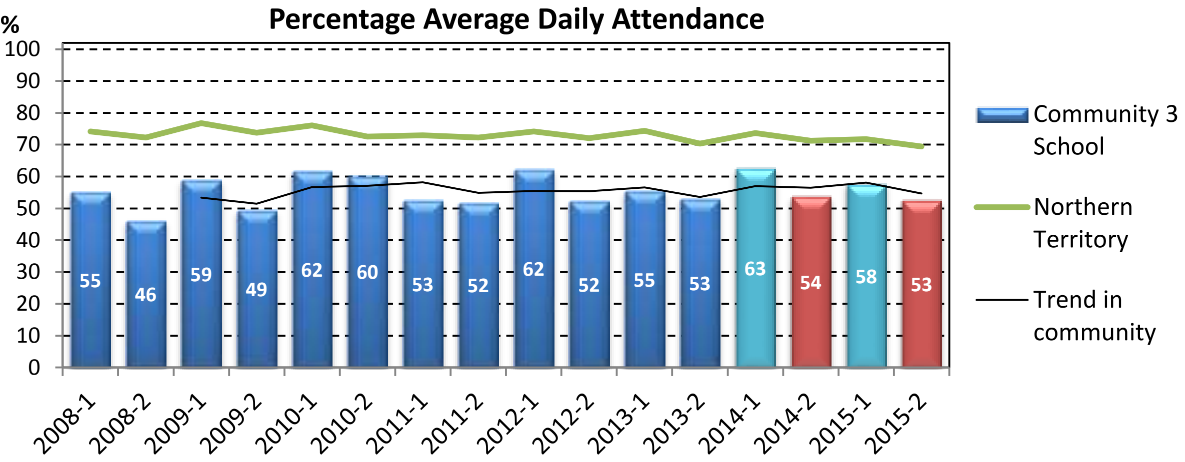
Community education

Administrative data

School attendance and enrolments

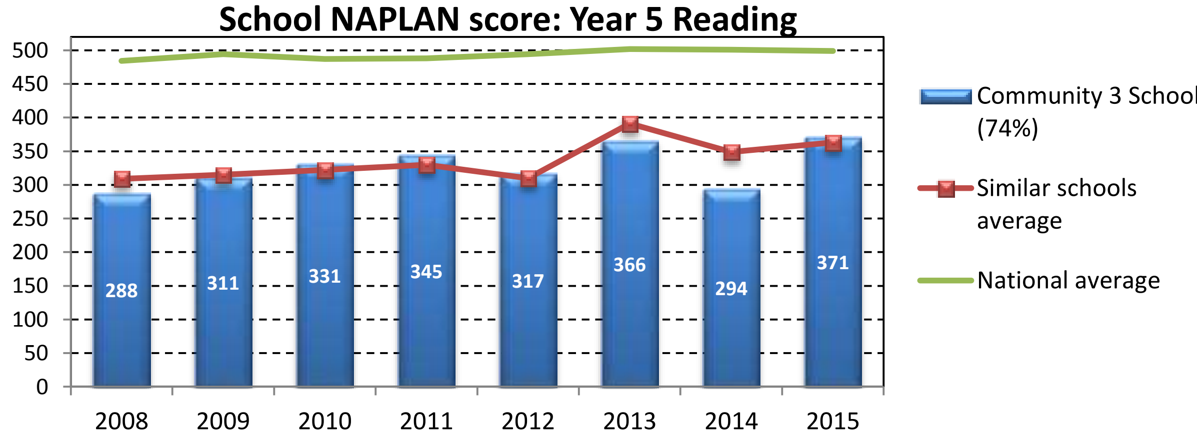
Community 3 School	2008-1	2008-2	2009-1	2009-2	2010-1	2010-2	2011-1	2011-2	2012-1	2012-2	2013-1	2013-2	2014-1	2014-2	2015-1	2015-2
Number enrolled for semester	229	236	227	229	225	213	275	258	270	279	264	253	306	286	257	250

- There was no significant change in attendance rates at Community 3 school between 2014 and 2015. Attendance is usually lower in the second semester compared with the first, and was lower than the NT average in 2015 (72%).

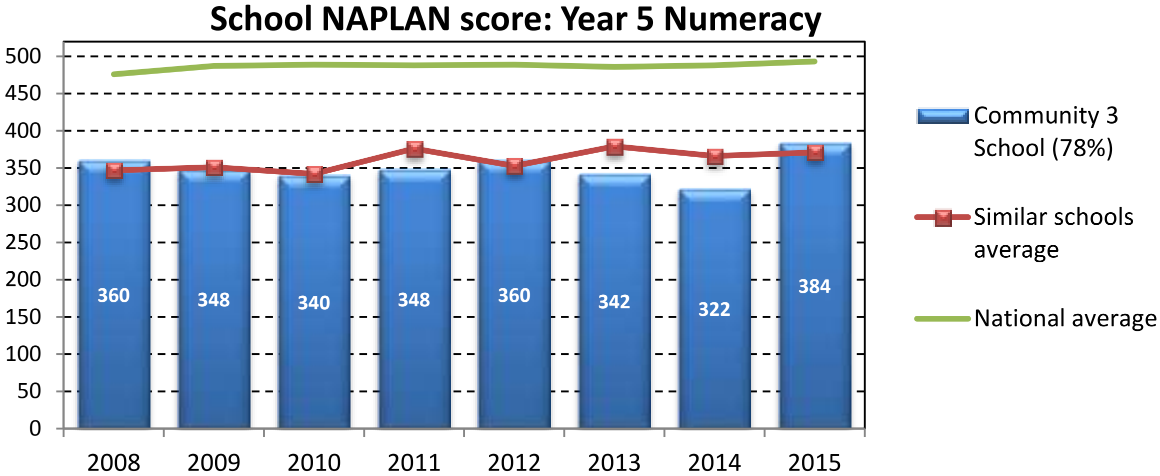


Literacy and numeracy of students

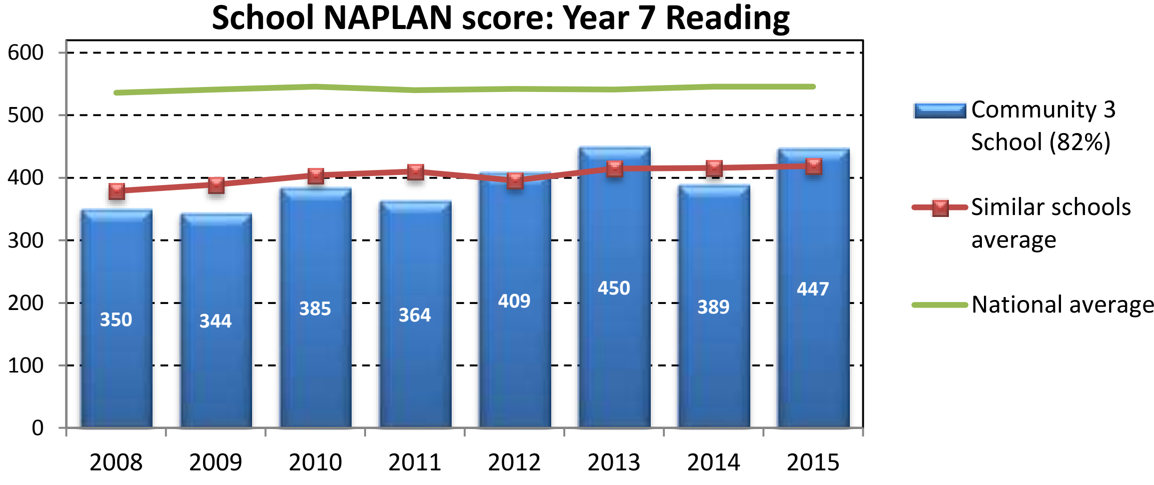
- The school score for Community 3 Year 5 reading increased from 294 to 371, with this improvement taking the school score to about level with the average of similar schools.
- The 2015 school score of 371 was 74% of the national average for Year 5 reading (499).



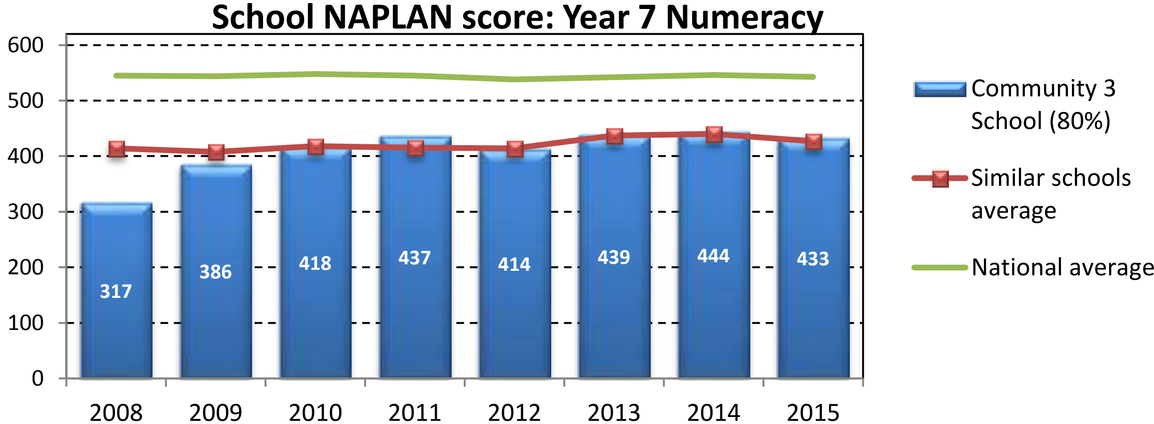
- The school score for Year 5 numeracy increased from 322 to 384, with this improvement taking the school score to just above the average of similar schools.
- The 2015 school score of 384 was 78% of the national average (493).



- The school score for Year 7 reading increased from 389 to 447, taking the school score to above the average of similar schools.
- The 2015 school score of 447 was 82% of the national average (546).



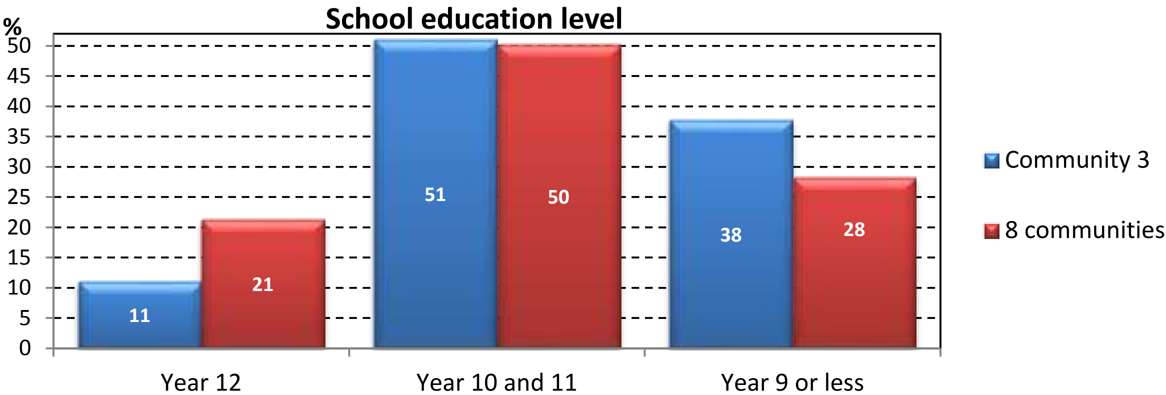
- The school score for Year 7 numeracy decreased slightly from 444 to 433, with the school score similar the average of similar schools.
- The 2015 school score of 433 was 80% of the national average (543).



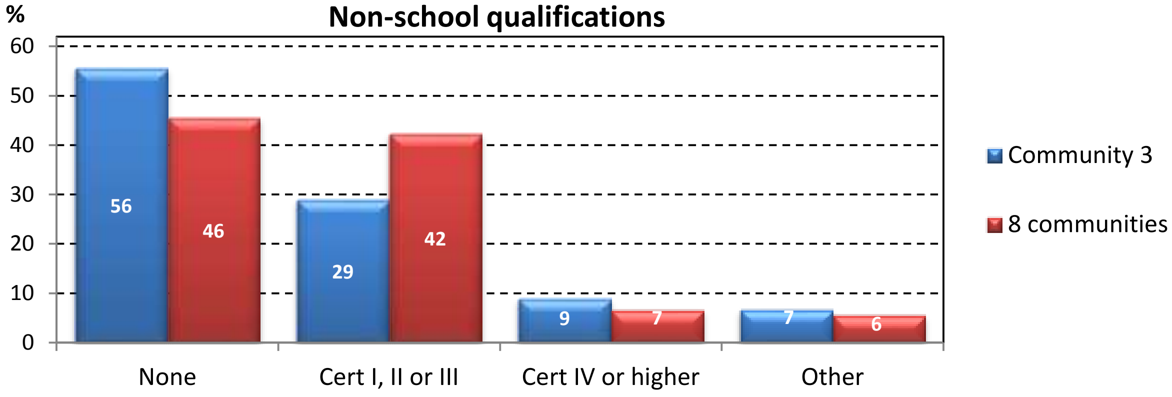
Community survey

Adult education

- Around 11% of adults surveyed in Community 3 completed year 12, which was lower to that observed across all eight communities (21%). A higher percentage of adults surveyed in Community 4 had Year 9 or less as their highest school year completed.



- Fifty-six percent of adults surveyed did not have any post-school qualification in Community 4, compared with 46% for all eight communities, and 29% had a Certificate I, II or III, compared with 42% across all eight communities surveyed.



Key informant interviews

Compared with other communities, fewer informants expressed concerns about school attendance. However, alcohol was regarded as adversely affecting school education through its effect on family life and through children being at increased risk of neglect, as demonstrated through late nights, children being on the street at night, and some sleeping rough on the oval because they didn't feel safe at home. Some children go to school but leave after they've had something to eat.

In general, key informants appeared to be less concerned about school education and more interested in highlighting the need for a range of community based education programmes. A number of informants commented on the need for AOD education to be implemented in both the school curriculum and in community settings and of the importance of running a range of programs related to social and emotional wellbeing issues (SEWB). Programs related to SEWB included education about alcohol and domestic violence, anger management, parenting, self-esteem, and communication and relationships. This type of education was seen as a way of addressing the gaps arising from a lack of positive parental role modelling. In addition to AOD and SEWB programs, there was a focus on the need to improve adult literacy due to the impact of poor literacy on both self-esteem and confidence and on the ability to obtain work.

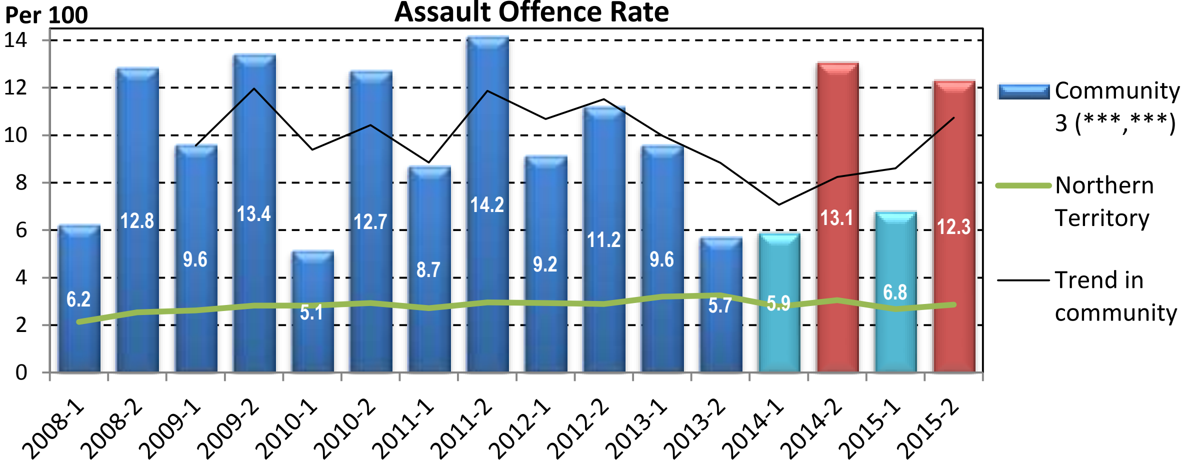
Confidential draft

Community safety

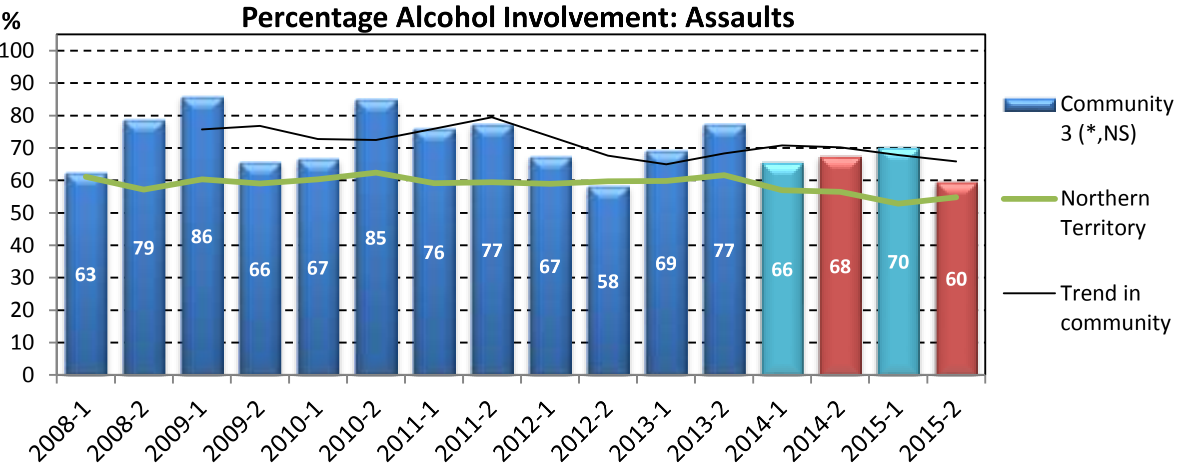
Administrative data

Assault offences

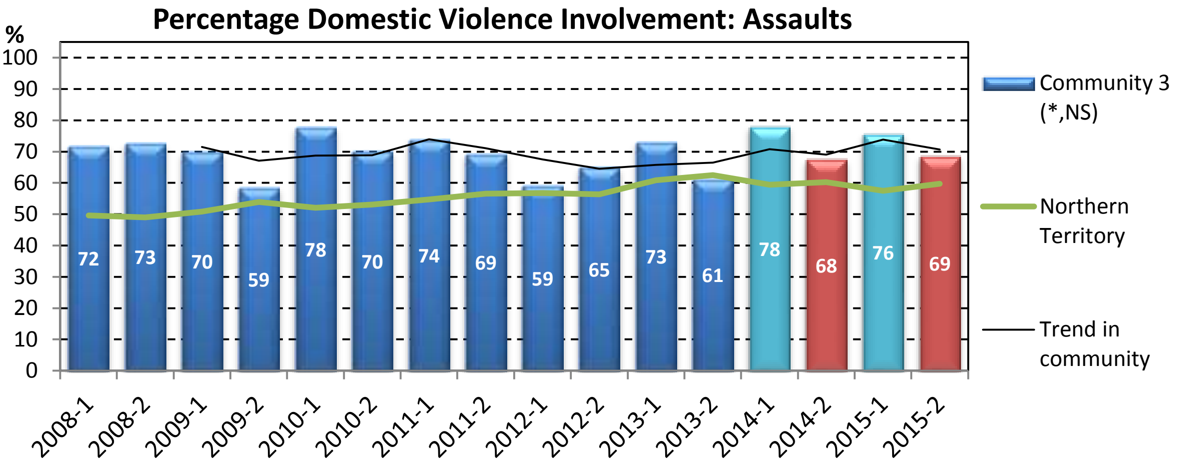
- The rate of assaults in Community 3 was stable between 2014 (5.9-13.1 per 100 people) and 2015 (6.8-12.3 per 100 people), but is on an increasing trend.
- The assault rate in Community 3 was significantly higher than the NT rate in 2015 (both periods), with the NT rate being 2.7 and 2.9 per 100 people across the year.



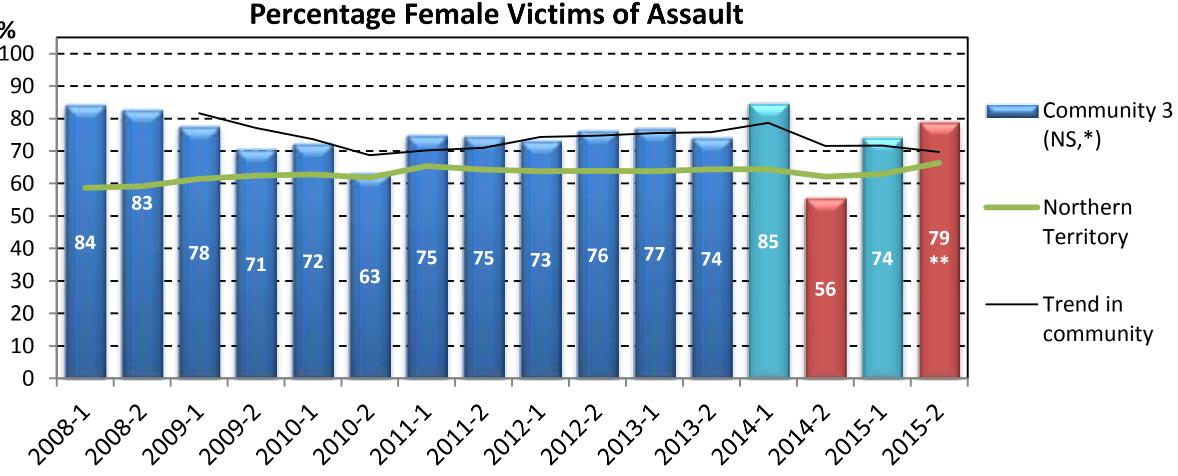
- Percentage alcohol involvement in assaults was mostly stable between 2014 and 2015, with a slight increase from 66% to 70% in the first half of the year, and a slight decrease in the second half of the year from 68% to 60%.
- In 2015-1, there was a significantly ($p<0.05$) higher percentage of alcohol involvement in assaults in Community 3 (70%) compared with NT (53%).



- Percentage domestic violence involvement in assaults was stable between 2014 and 2015.
- There was a significantly ($p<0.01$) higher percentage of domestic violence involvement in assaults in Community 3 (76%) compared with Northern Territory (58%) in 2015-1.



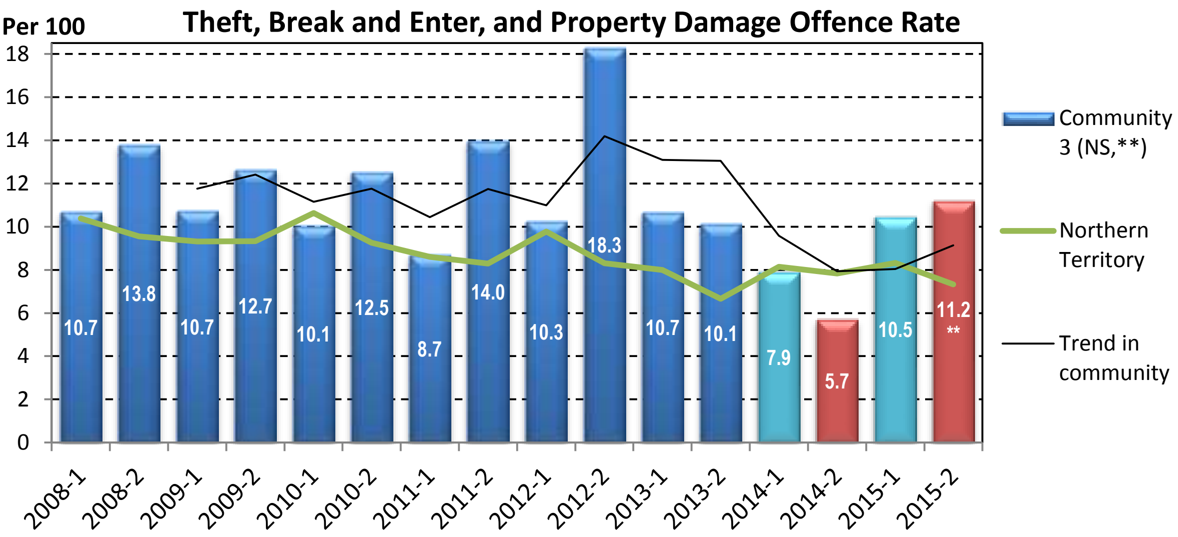
- There was a significant increase in the percentage of female victims of assault in Community 3 between 2014-2 (56%) and 2015-2 (79%).
- Community 3 had a significantly ($p<0.05$) higher percentage of female victims of assault (79%) compared with the Northern Territory (66%) in 2015-2.



Theft, break and enter and property damage

- There was a significant increase in the rate of theft, break and enter and property damage offences from 2014-2 (5.7 per 100 people) to 2015-2 (11.2 per 100 people).
- The property crime rate in Community 3 (11.2 per 100 people) was significant ($p<0.01$) higher than the NT rate in 2015-2 (7.3 per 100 people).

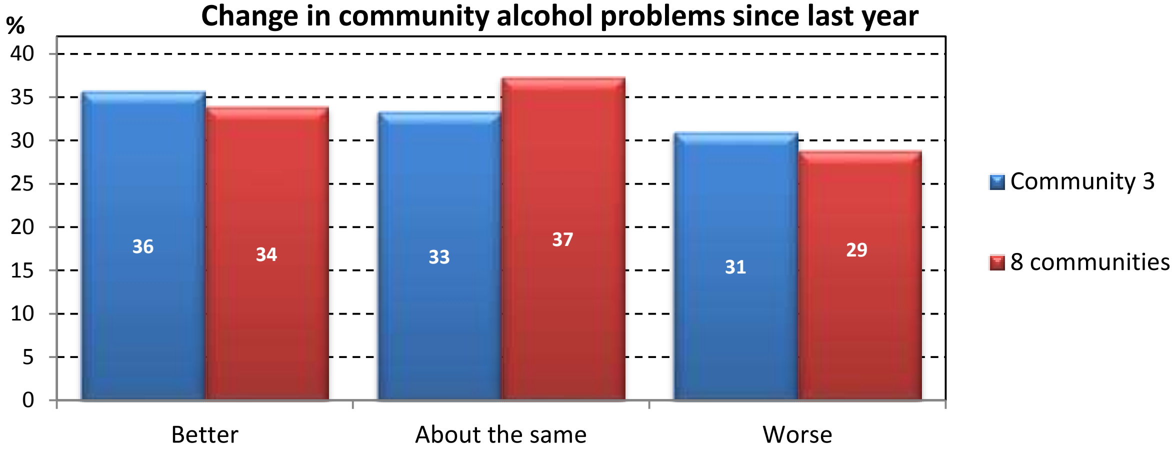
Confidential draft



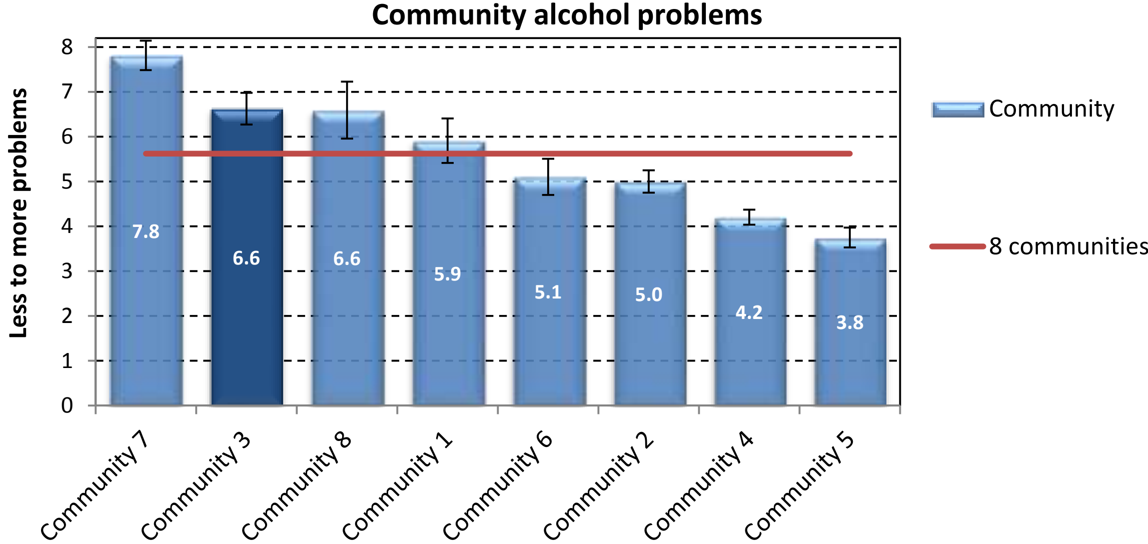
Community survey

Community and household alcohol problems

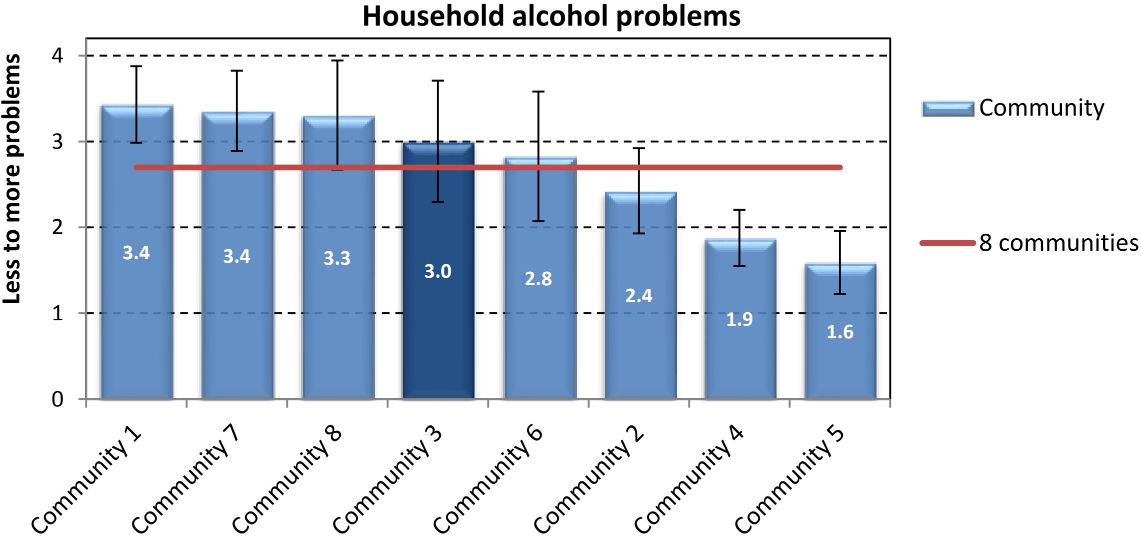
- Thirty-six percent of Community 3 residents surveyed said community alcohol problems were better compared with the previous year, which was a little higher than for all eight communities (34%). Thirty-three percent said they were about the same and 31% said they got worse.



- When asked about community alcohol problems and how often they occur, Community 3 was above the average compared with the average of all eight communities surveyed.



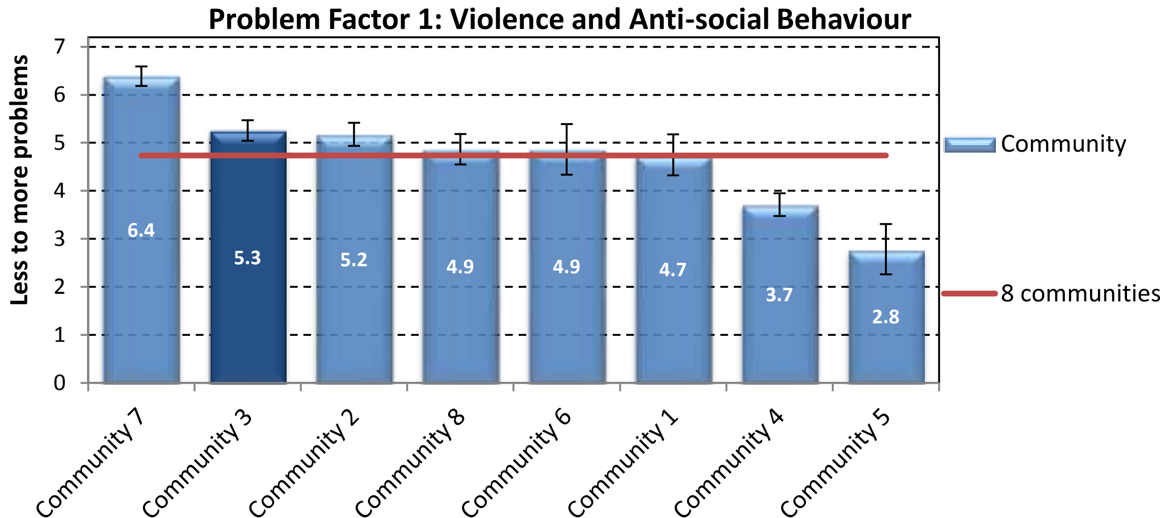
- When asked about household alcohol problems and how often they occur, Community 3 scored midway, and a little above the average of all eight communities together.



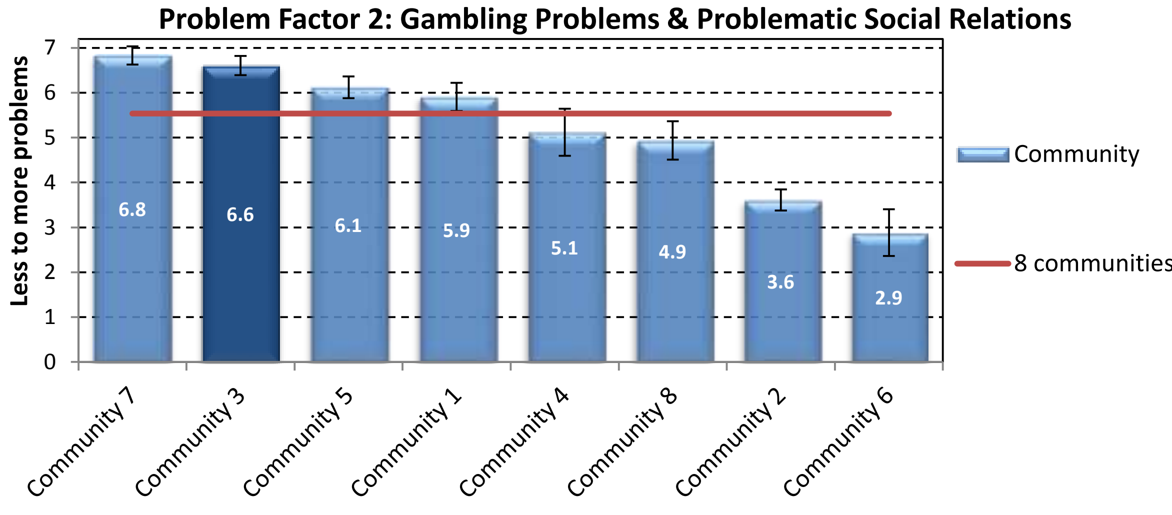
Community problems

- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
  1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
  2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
  3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.

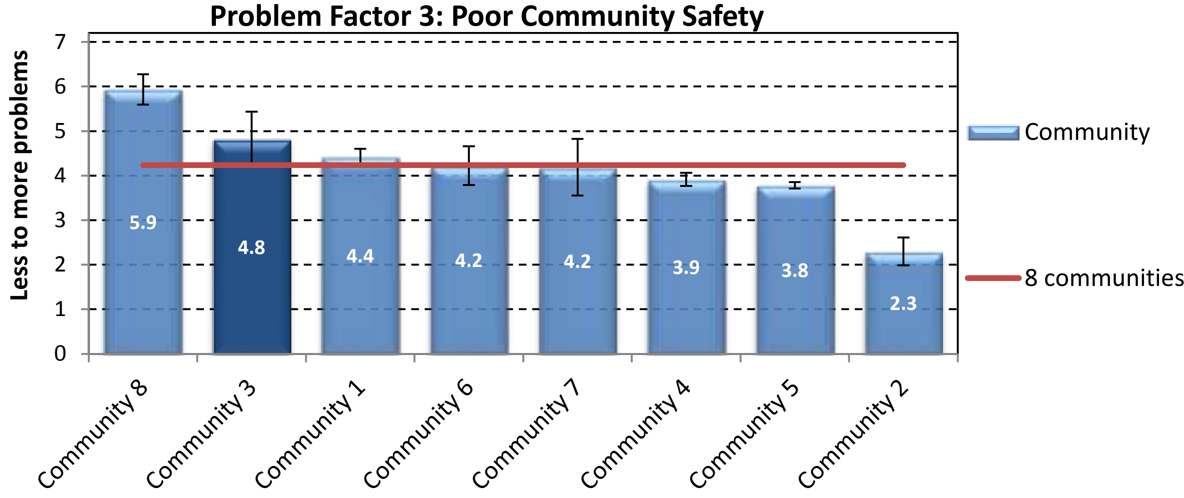
- Community 3 scored just a little bit above the average of the eight communities for *Violence and Anti-Social Behaviour Problems* in the community. That is, things are a little worse in Community 3 compared the average of all eight communities together.



- Community 3 scored above the average of the eight communities for *Gambling Problems and Problematic Social Relations* in the community. That is, things are worse in Community 3 compared with the average of all eight communities.

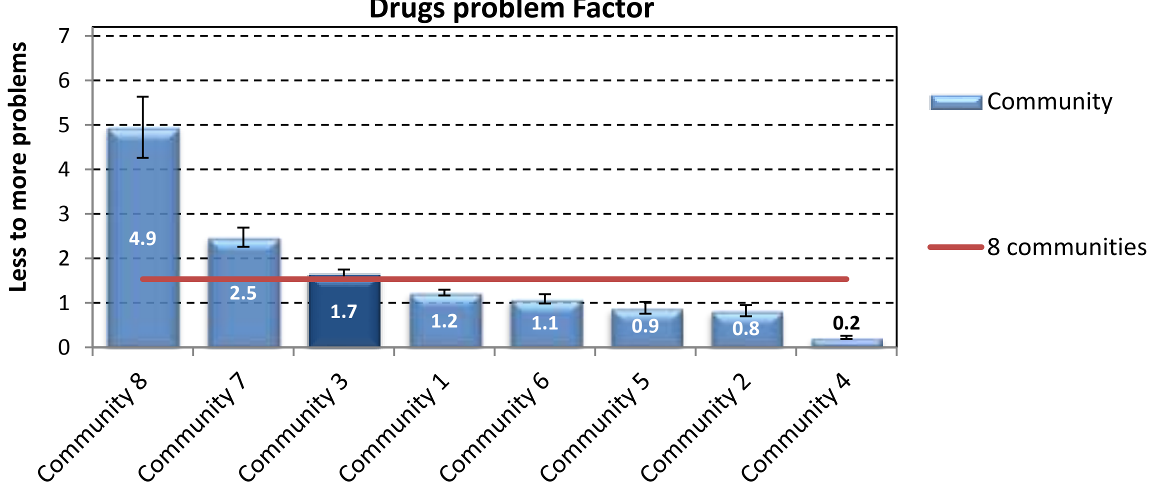


- Community 3 scored a little bit above the average of the eight communities for *Poor Community Safety* in the community. That is, things are a little worse in Community 3 compared with the average of all eight communities.



Community drug problems

- The Community Survey also asked residents about drug problems (marijuana, sniffing, kava and ecstasy) and how much of the time over the last year they were a problem.
- The figure below shows Community 3 scored on the average of the eight communities in how much of the time drugs were a problem. Some communities had more problems with sniffing and kava.



Key informant interviews

According to key informants, alcohol is a primary factor in community safety issues, with one informant noting that it ... *would be very quiet after hours if there was no alcohol in the community*. Although clan conflict is also considered to be a factor, one informant commented that … *only when they are drinking they are fighting*. Most domestic violence, and virtually all police work, is considered to be alcohol-related. In general, alcohol was perceived as contributing to excessive noise, fighting, screaming, loud music and children breaking in to shops and being on the streets at night. Drinking camps are considered unsafe because they: lack basic amenities such as toilets and running water; provide an environment conducive to

fighting (unsupervised and people have to drink together); and some are near a main road. Alcohol is seen as creating an unsafe environment for children, particularly those who are taken to the drinking camps, with one informant suggesting that there is a need for a safe house for kids. Community safety problems were regarded as worse in the town camps (dry areas) than in the town sub-division (not a dry area), with one informant noting that *Really bad stuff happens in town camps.* Police were perceived as concentrating their efforts during daytime hours despite the fact that critical safety risks occur at night-time - this is ... *when it all happens*. In addition, response time to incidents was considered to be too slow. Night patrol has limited powers and primarily picks up vulnerable adults and children; notifies police if people refuse to reduce noise; and breaks up arguments, often by taking one of the parties to another location.

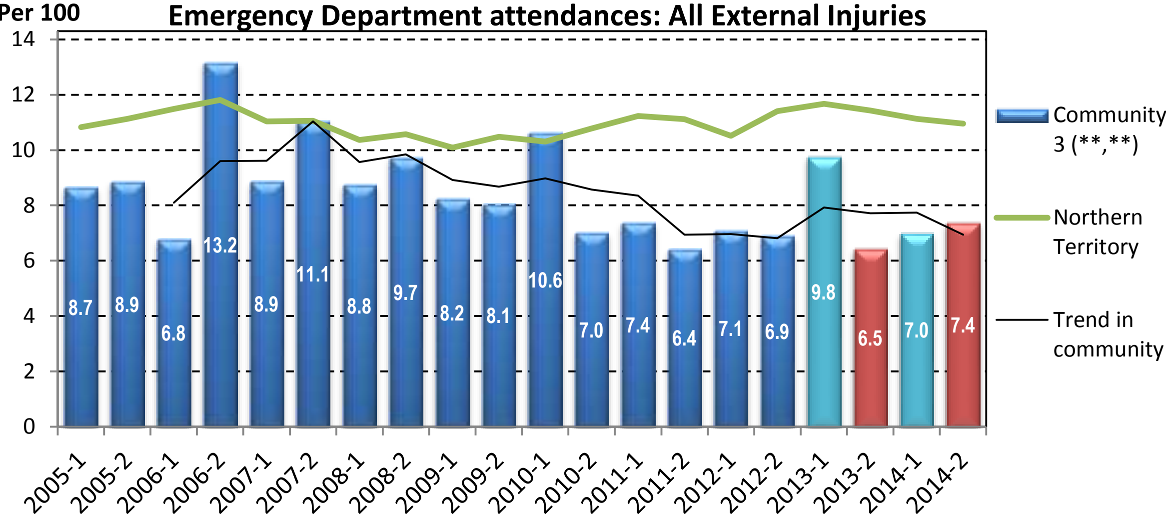
Confidential draft

Community health and wellbeing

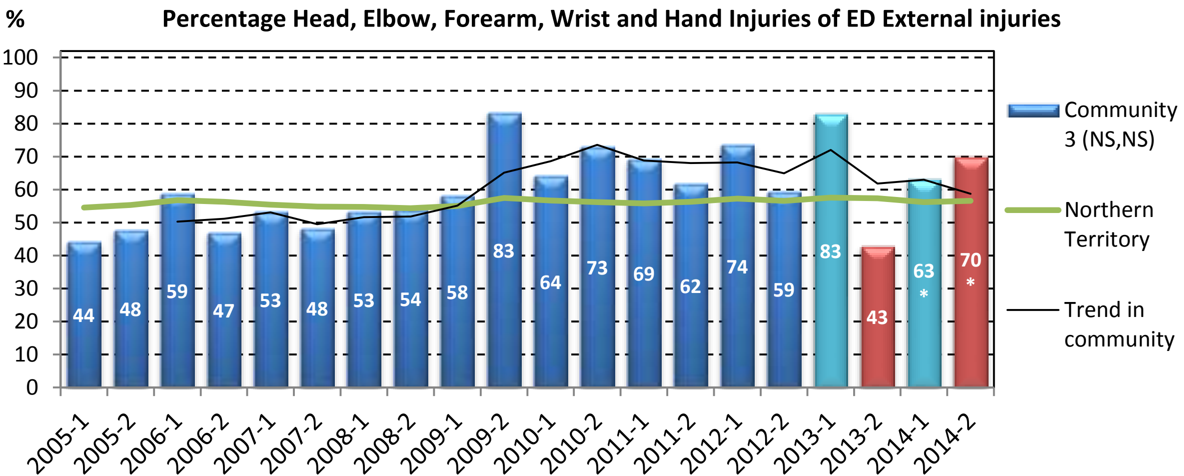
<u>Administrative data</u>

Emergency Department admissions for external injuries

- There was a non-significant decline in emergency department attendances from 2013-1 (9.8 per 100) to 2014-1 (7 per 100).
- Emergency department attendances were significantly ($p<0.05$) lower than the NT in both halves of 2014.



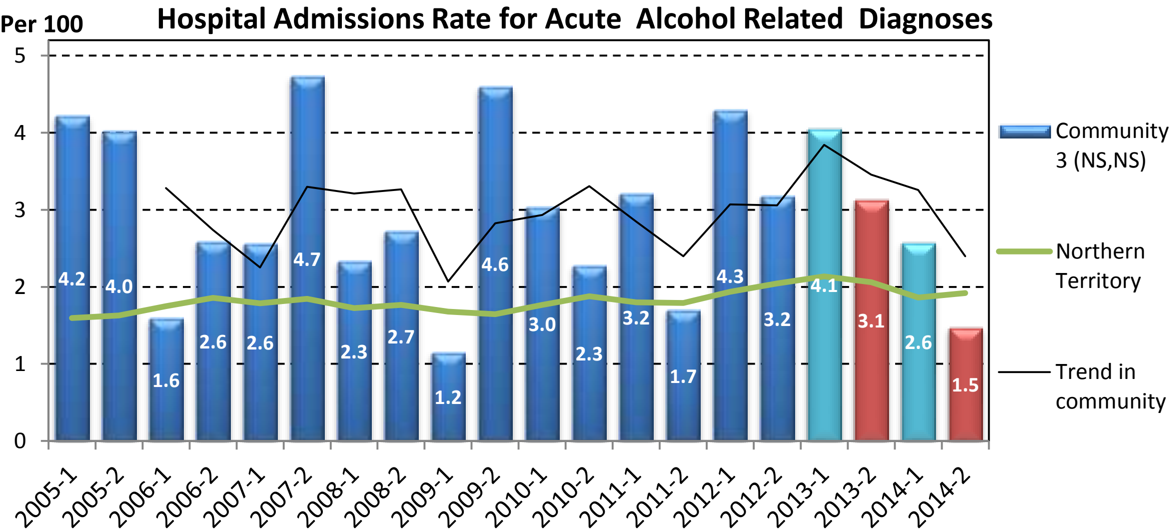
- There was a significant decline in the percentage of ED attendances for external injury that were head, elbow and forearm, and hand and wrist injuries from 2013-1 (83%) to 2014-1 (63%), while it significantly increased from 2013-2 (43%) to 2014-2 (70%).
- There was no significant difference between Community 3 and the NT for percentage head, elbow and forearm, and hand and wrist injuries.



Hospitalisation for alcohol-related conditions

- Marginally non-significant ($p=0.076$) drop in hospital admissions for alcohol alcohol-related diagnoses from 2013-2 (3.1 per 100) to 2014-2 (1.5 per 100), with a decreasing trend over the last two years.

- The rate for hospital admissions for alcohol alcohol-related diagnoses was not significantly different between Community 3 and the NT.



<u>Community survey</u>

Community strengths

- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) people respect Elders, (ii) people respect other community members, and (iii) people help each other.
    2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
    3. Strengths Factor 3: *Healthy Social Engagement* which includes three community strengths: (i) people go out for bush tucker, (ii) people do organised sports and other activities and (iii) people say ‘no’ to humbug.

- Community 3 scored below the average of the eight communities in *Respectful Relationships*. That is, Community 3 residents who were surveyed said respectful relationships occurred less of the time compared with other communities.

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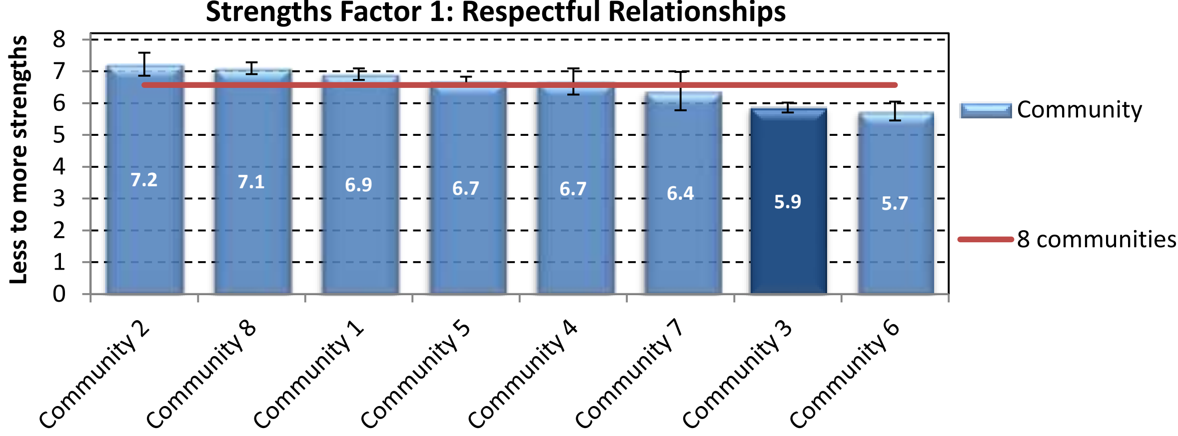
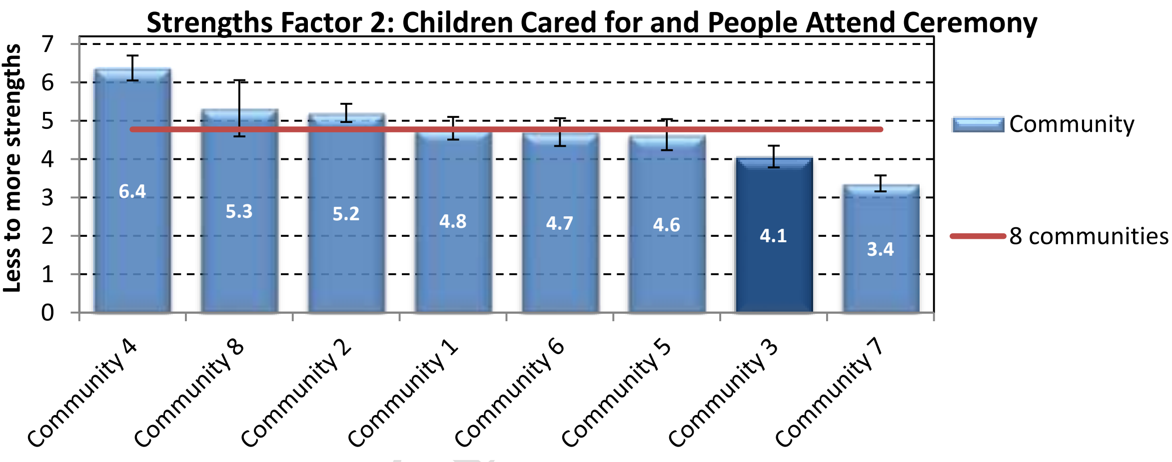
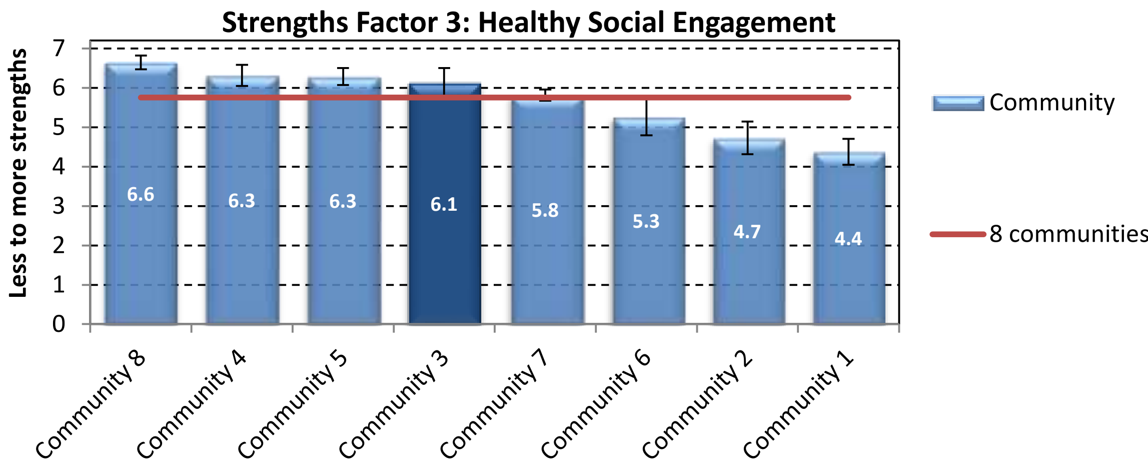


- Community 3 scored below the average of the eight communities in *Children Cared for and People Attend Ceremony*.



- Community 3 scored just above the average of the eight communities in *Healthy Social Engagement*. Communities further away from water scored worse on this due to less hunting and gathering generally occurring.



Key informant interviews

Alcohol was considered to have a major impact on the health and wellbeing of the whole community, affecting child development, food security, sleep, relationships, and mental health. It was regarded as contributing to family breakdowns and to the emergence of a 'missing generation' in which individuals are culturally disconnected and lack basic parenting and life skills. Alcohol problems also deplete clinic resources and adversely affect the day-to-day functioning of the clinic because program work has to give way to acute problems. Clinic staff noted that the absence of a social club and a pub make it difficult for the clinic to take a proactive approach to alcohol support, as drinking tends to be 'hidden' - *There would be lots of people drinking whom we don't know about*.

Around a third to a half of women drink in pregnancy and it is likely that FASD is under-reported. Alcohol misuse means that children are at increased risk of neglect and abuse through: poor nutrition; feeling unsafe at home; being on the street at night; exposure to violence; and modelling of dysfunctional behaviours. As one informant noted: *Kids are experiencing a very unstructured existence, dinner is not on the table at night - nothing to go home for.*

A wide range of strategies for reducing harms and improving health and wellbeing were put forward. Many key informants commented on the need to provide a wider range of social and recreational activities so that people had an alternative to drinking, with the absence of such activities in this community being contrasted to the comparative wealth of opportunities available to people in mainstream urban environments. Alternative activities should be structured and organised, not simply additional infrastructure. In this respect, capacity building was seen as an essential element as this would enable community members to be actively engaged in leading recreational and social programs. Similarly, there was a perceived need to create more employment opportunities and job programs and also to address adult literacy issues so that more people can take advantage of these opportunities. Many informants mentioned the need to improve housing supply and quality and noted how the stress created by overcrowding was an important trigger for alcohol-related problems and violence. Community programs that focus on: building confidence and self-esteem; helping people to re-connect to culture; mental health; and improving general social and emotional wellbeing were high on the list of priorities, with several informants noting the benefits accruing from the current men's group and another noting the need for a healing centre. As one key informant noted: *We have to find ways to engage people in a routine and way of life ... in which alcohol is not the main focus ... and for some people they probably need some really strong help because it has become an addiction.*

Confidential draft

4.5 Community 4 Data Report

Highlights: 2014 to 2015

- ↑↑ large or significant improvement; ↑ small or non-significant improvement; = no change or small change
- ↓↓ large or significant worsening; ↓ small or non-significant worsening; = no change or small change

• Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-6 to 6)		**-**	**33% (2)**
Wholesale PAC in catchment	Large decrease in second half 2015	-	-
Community average PAC last drink	Below average of 8 communities	=	0
Frequency of drinking	More likely to drink once or more per week	-	-
Number types of alcohol drank	More likely to drink only one type of alcohol	↑↑	2
Community Education (-10 to 10)			**-10% (-1)**
School attendance	About the same as NT average (72%-79%)	=	0
Year 5 reading	Worsening & just below similar type schools	↓	-1
Year 5 numeracy	Improvement & same as similar type schools	↑	1
Year 7 reading	Small worsening & below similar type schools	↓	-1
Year 7 numeracy	Tiny improvement & same as similar type schools	=	0
Adult year 12 completion	Less than average of 8 communities	-	-
Adult other qualifications	Similar as the average of 8 communities	-	-
Community Problems & Safety (-24 to 24)			**50% (12)**
Assaults offences	Significant improving trend over last 2 years	↑↑	2
Alcohol % in assaults	Small improving trend over last 2 years	↑	1
Family violence % in assaults	No substantial change over last 2 years	=	0
Female % in assaults	No substantial change over last 2 years	=	0
Theft, stealing, break & enter	Small improving trend over last 2 years	↑	1
Change in community alcohol problems	93% said about the same or better	-	-
Community alcohol problems	Second lowest of 8 communities	↑↑	2
Household alcohol problems	Second lowest of 8 communities	↑↑	2
Violence & Anti-Social behaviour	Second lowest of 8 communities	↑↑	2
Gambling & Problematic Social Relations	Just below average of 8 communities	=	0
Poor Community Safety	Just below average of 8 communities	=	0
Community Drug problems	Lowest of 8 communities	↑↑	2
Community Strengths, Health & Wellbeing (-12 to 12)			**33% (4)**
Emergency Department attendances	Significant worsening trend over last 2 years	↓↓	-2
% head, elbow, forearm, wrist & hand	Small improving trend over last 2 years	↑	1
Acute alcohol hospitalisations	Small improving trend over last 2 years	↑	1
Respectful Relationships	Similar to average of 8 communities	=	0
Children Cared for &Attend Ceremony	Highest of the 8 communities	↑↑	2
Healthy Social Engagement	Second highest of 8 communities	↑↑	2
Total score standardised (-52 to 52)			**27%**

Confidential draft

Key informant interviews: Highlights

Community 4 residents would prefer to drink in their own homes and there is strong support for a permit system. Although there is a drinking area nearby, it isn't regarded as comfortable or relaxing and some informants commented that fighting or arguments are more likely to occur because different families have no choice but to drink in the same place. Although

alcohol-related violence clearly occurs, views on its prevalence vary, however, in comparison with other communities it is probably at the lower end of the scale. Many of the informants indicated that a men's shed would be beneficial. Although there was a general consensus regarding the need for more early intervention, treatment and rehabilitation programs, it was also noted that people are often reluctant to visit the clinic for treatment. Proactive policing methods have had a positive impact on the community, with police building good relationships and endeavouring to encourage a culture change which will enable community members to feel comfortable assisting the police to reduce illegal behaviours, rather than protecting those who put themselves and others at risk. There is a strong emphasis on the importance of Ceremony and its role in guiding and mentoring younger community members. However, some feel that loss of culture, combined with government intervention in community management (the NTNER and also the shift from community councils to super shires), has led to a loss of leadership from Elders with this reflected in Elders being given less respect and less power to manage alcohol problems effectively.

Community context

Community 4 (including one outstation) has an Indigenous population of around 620 people. Key services include a police station, school, health clinic, safe house, and women's centre. There is no social club or permit system. There are two liquor outlets in Community 4 both of which have restrictions on the amount that residents can buy. Purchases from the Community 4 store are restricted to 6 cans of full strength beer per day while daily restrictions for the Community 4 hotel include: 6 cans of full-strength beer or RTDs; or 8 cans of mid-strength beer; or 12 cans of light beer. Community members also purchase alcohol from two other outlets, one of which has the same restrictions as the Community 4 Hotel and is 89 km distant, while the other has the same restrictions as the Community 4 store and is 104 km distant.

Alcohol consumption patterns

Administrative data

- PAC in litres by alcohol type for the Community 4 alcohol catchment area (ACA - two outlets in the community and two within driving distance) is shown in the graph below and represents the amount of pure alcohol consumed per 6-month period.
- Since 2013 there has been considerable change in both the amount and mix of alcohol types bought in the Community 4 ACA. The amount of PAC in the Community 4 ACA increased slightly (7.5%) between 2014-1 (2049 litres) and 2015-1 (2204 litres), and had a large decrease (70%) between 2014-2 (693 litres) and 2015-2 (208 litres).

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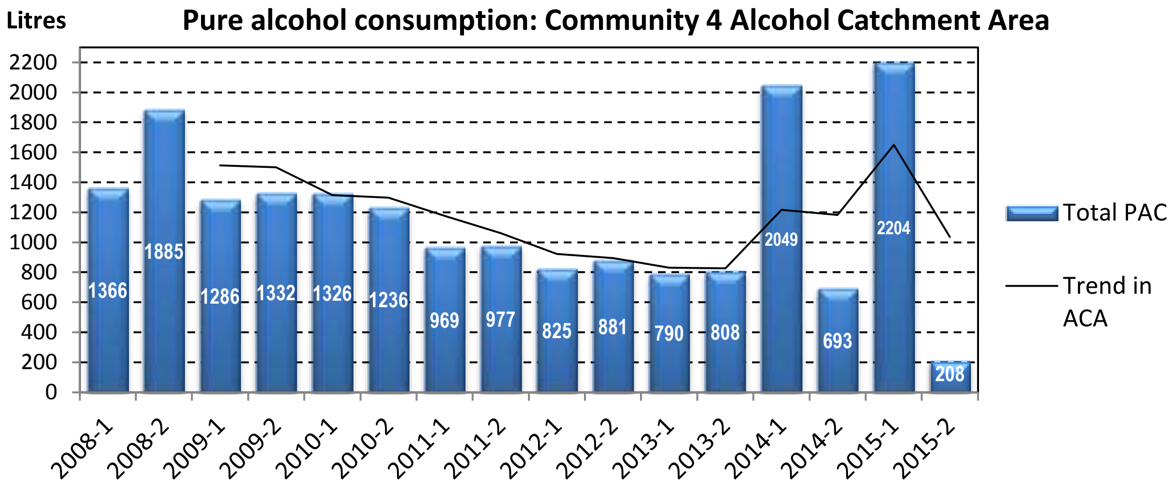
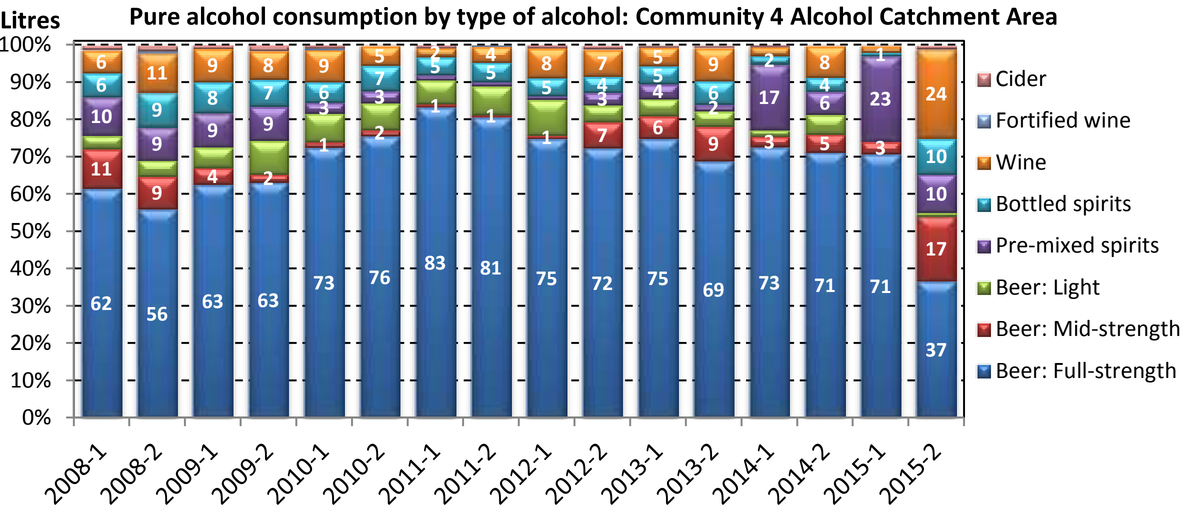


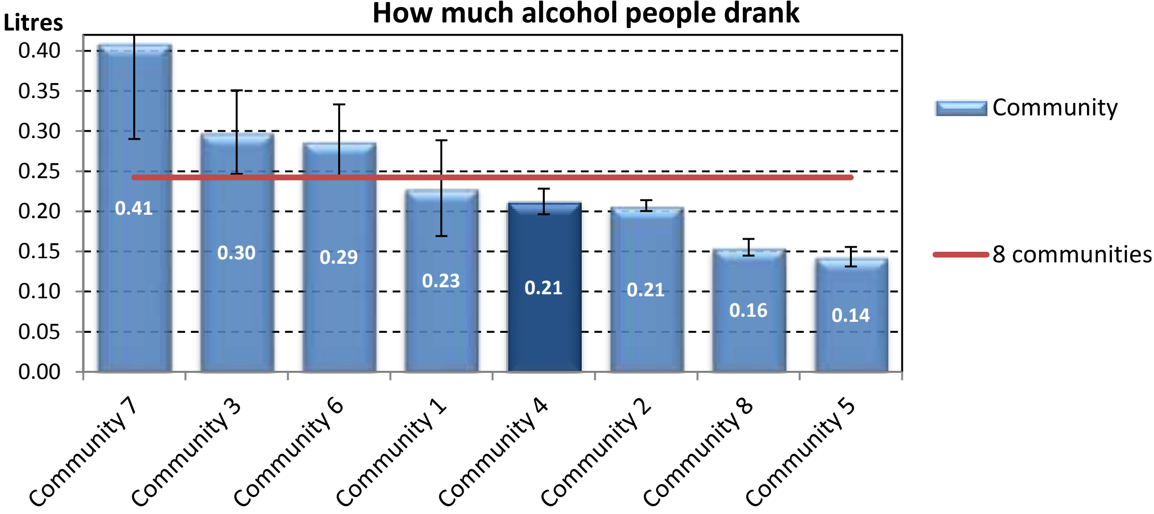
- Between 2014-1 and 2015-1 there was a considerable change in the mix of alcohol types consumed in the Community 4 ACA., with more mid-strength and bottles spirits consumed, as a percentage of the total PAC (though total PAC was lower than in previous periods).



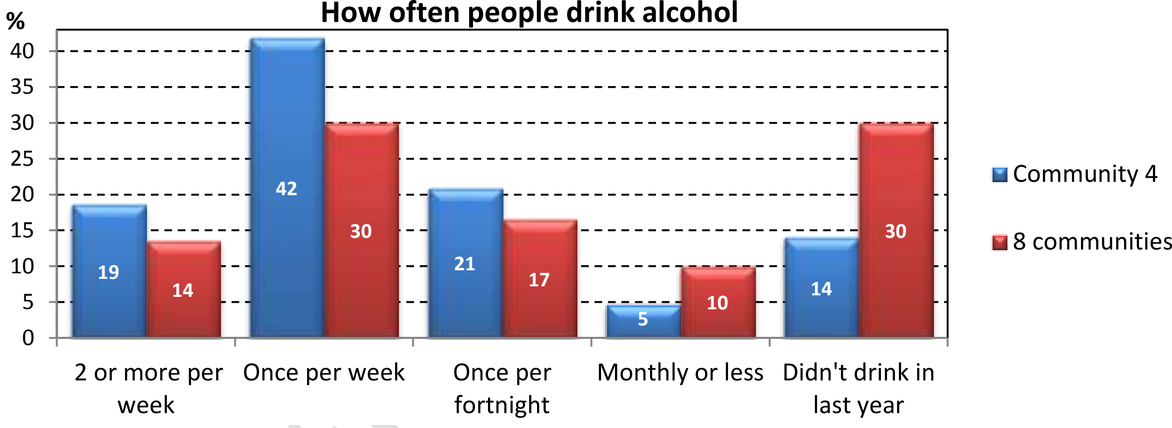
Community Survey

Pure Alcohol Consumed (PAC) Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

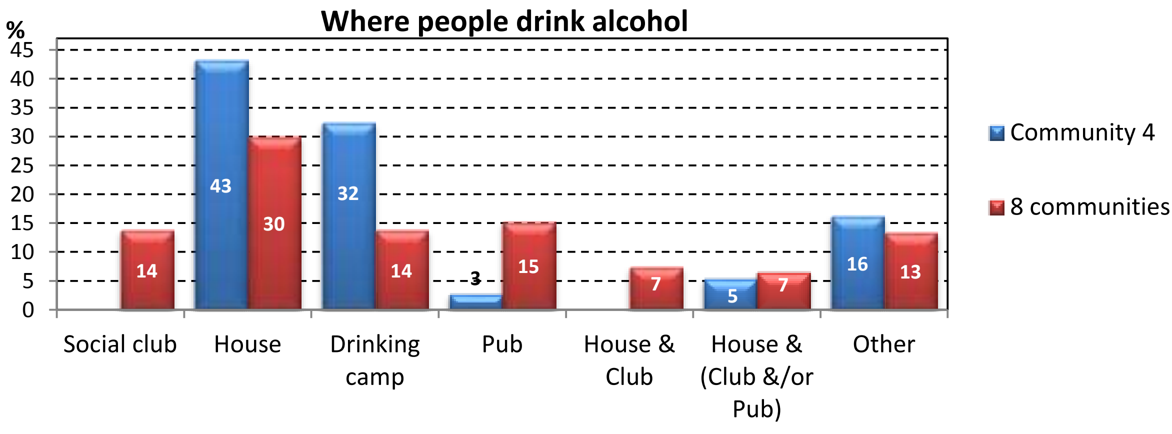
- The average PAC for Community 4 residents last drinking session was 0.21 litres (approximately 17 standard drinks or 12 full strength beers), which was slightly lower than for the average for the eight communities surveyed.



- Forty-two percent of Community 4 residents drank alcohol once per week, and a further 19% twice or more per week, which was higher than for all eight communities, where a smaller percentage drank two or more times per week (14%) and once per week (30%).

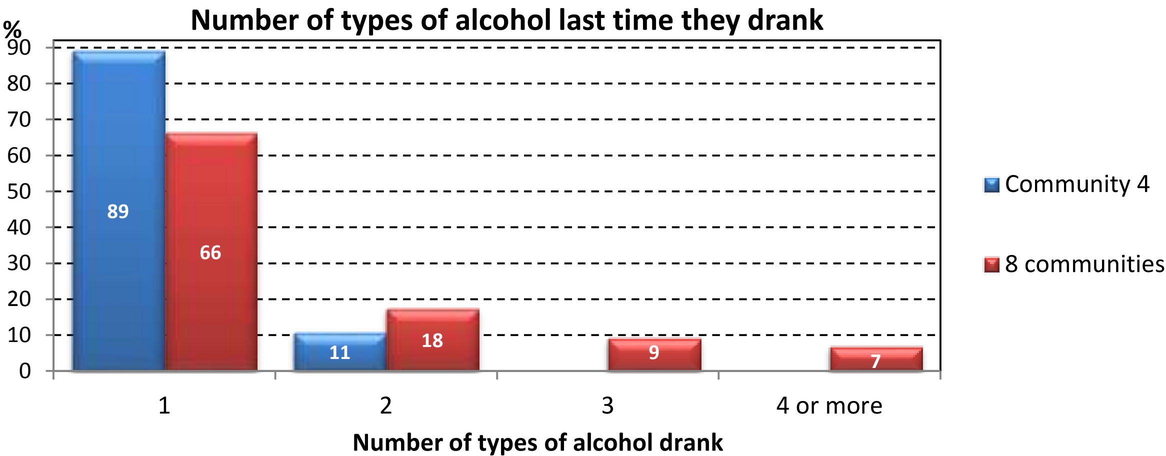


- The next figure shows where people drank and this varied depending on access to alcohol outlets. In Community 4, 43% of those surveyed who drank, did so in their homes, followed by drinking camp (32%), and a combination of a house and pub/club (5%). The 'other' mostly included drinking in a larger regional town or city.



- Full-strength beer was the most commonly drank alcohol type (78%), followed by pre-mixed spirits (27%), and with both of these higher than all eight communities combined. Less people drank mid-strength and bottle spirits in Community 4 than other communities surveyed.

- Most people in Community 4 only drank one type of alcohol last time they drank, which was higher than across all eight communities (66%).



<u>Key informant interviews</u>

Drinking is a popular social pastime in Community 4; however, one informant noted that it is only a core group that drinks to excess. Problem drinking occurs across age groups and binge drinking is common on weekends, particularly among the employed, while those who are unemployed are more likely to drink anytime. Although there are restrictions on liquor outlets both in and near Community 4, some residents bypass these restrictions by bringing in alcohol from Katherine, Tennant Creek, Highway Inn and Daly Waters and by purchasing sly grog. The cost of alcohol from outlets within Community 4 is high in comparison with those further afield, with this encouraging bulk purchases and grog running. This tends to lead to binge drinking to reduce the chance of alcohol being stolen. One suggestion put forward to manage the harms resulting from external purchases of alcohol is to require outlets within Community 4 to breathalyse people before they buy so that sales are not made to those who are already

intoxicated. Several informants commented that illegal drinking by banned drinkers would be easier to control if the BDR was re-introduced. There is strong support for a permit system, with this being perceived as: providing a better and safer drinking environment; helping people to learn to drink responsibly; enabling parents to spend more time with children; and reducing the potential for alcohol-related violence. Under a permit system, more power would be vested in police, through their monitoring and enforcement of the banning list. Some informants perceive this as reflecting a shift from community management of alcohol to management by an external authority and suggest that such a shift is accepted by the community because leadership from Elders has weakened due to loss of culture and government interventions.

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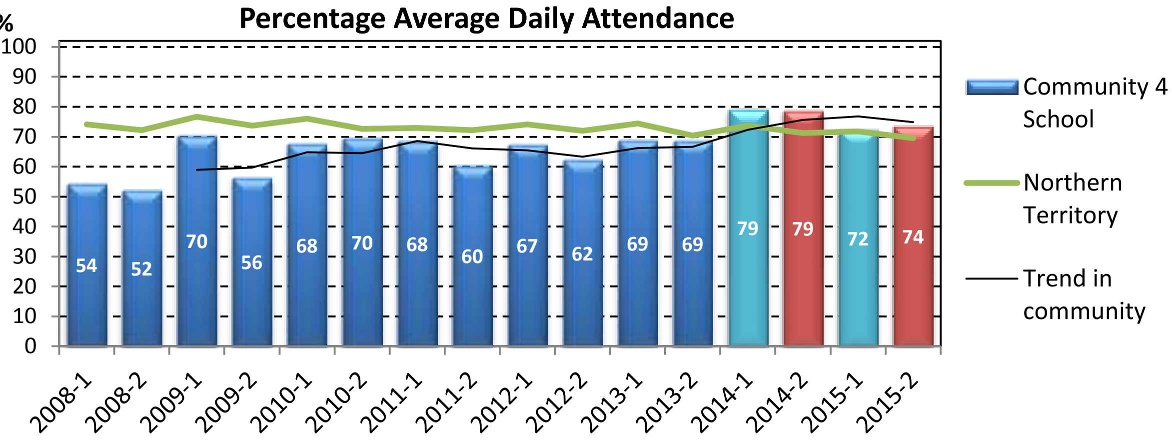
Community education

Administrative data

School attendance and enrolments

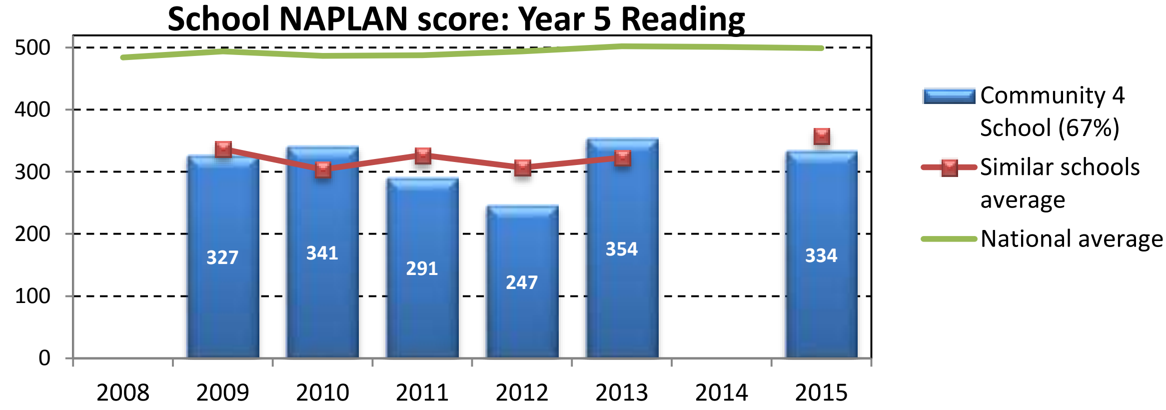
Community 4 school	2008-1	2008-2	2009-1	2009-2	2010-1	2010-2	2011-1	2011-2	2012-1	2012-2	2013-1	2013-2	2014-1	2014-2	2015-1	2015-2
Number enrolled for semester	100	98	78	86	80	73	83	82	69	74	75	80	72	82	92	91

- There has been a small drop in average daily attendance over the last year, though the drop was not statistically significant. Community 4's average daily attendance was similar or a bit better than the NT average over the last two years.



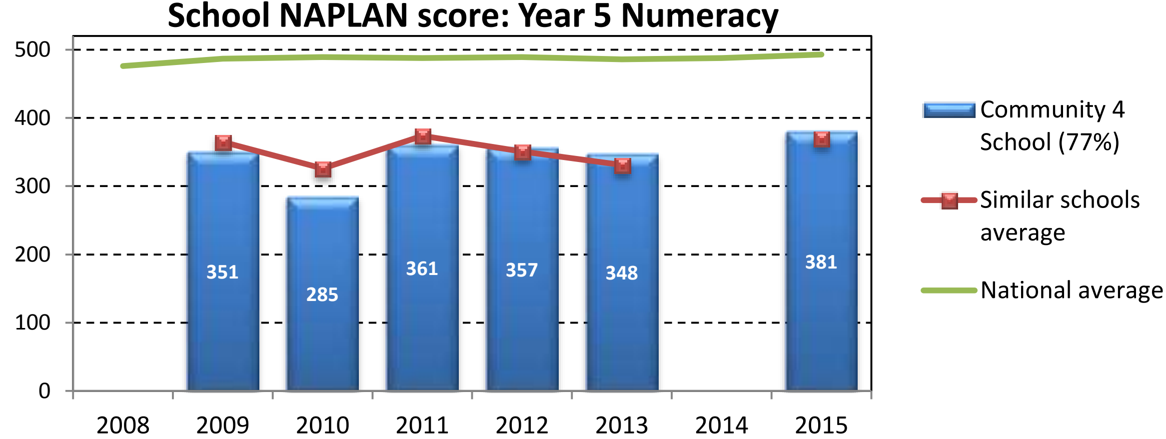
Literacy and numeracy of school students

- The school score for Year 5 reading increased from 354 in 2013 to 334 in 2015, with this decline taking the school score to just below the average of similar schools.
- The 2015 school score of 334 was 67% of the national average score of 499.

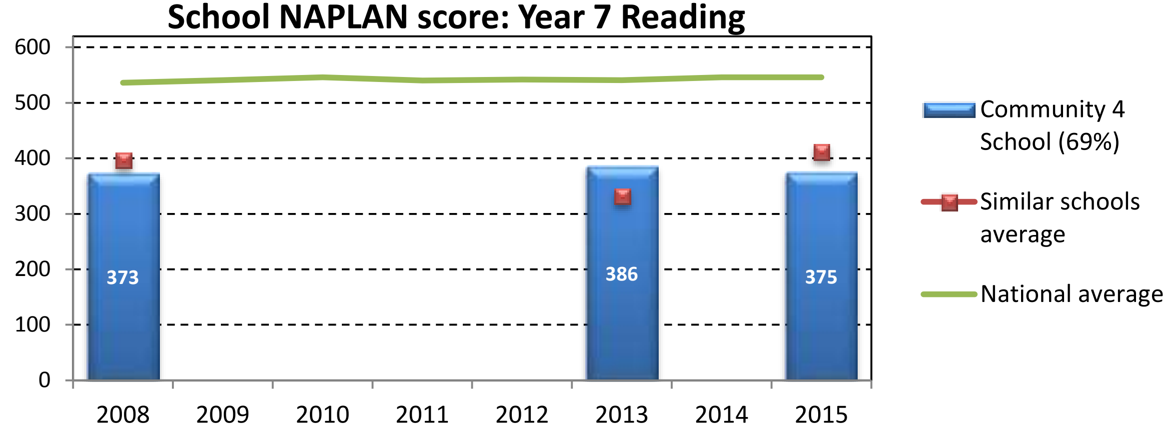


- The school score for Year 5 numeracy increased from 348 in 2013 to 381 in 2015, with this improvement taking the school score to slightly above the average of similar schools.

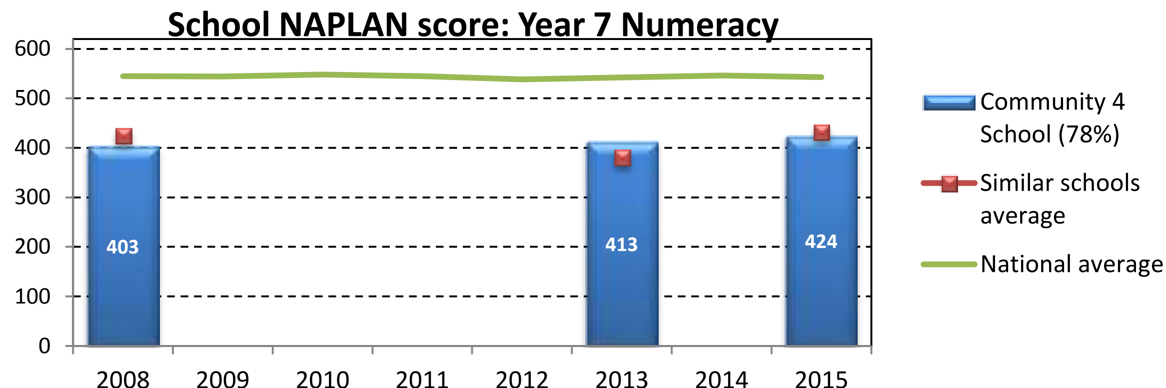
- The 2015 school score of 381 was 77% of the national average (493).



- The school score for Year 7 reading decreased from 386 in 2013 to 375 in 2015, with the school score in 2015 below the average of similar schools.
- The 2015 school score of 375 was 69% of the national average (546).



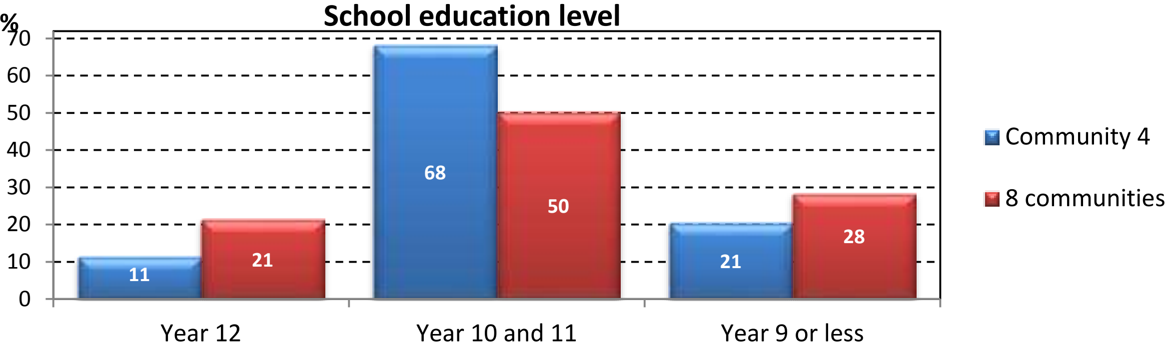
- The school score for Year 7 numeracy increased from 413 in 2013 to 424 in 2015, with this improvement taking the school score to about the same as the average of similar schools.
- The 2015 school score of 424 was 78% of the national average (543).



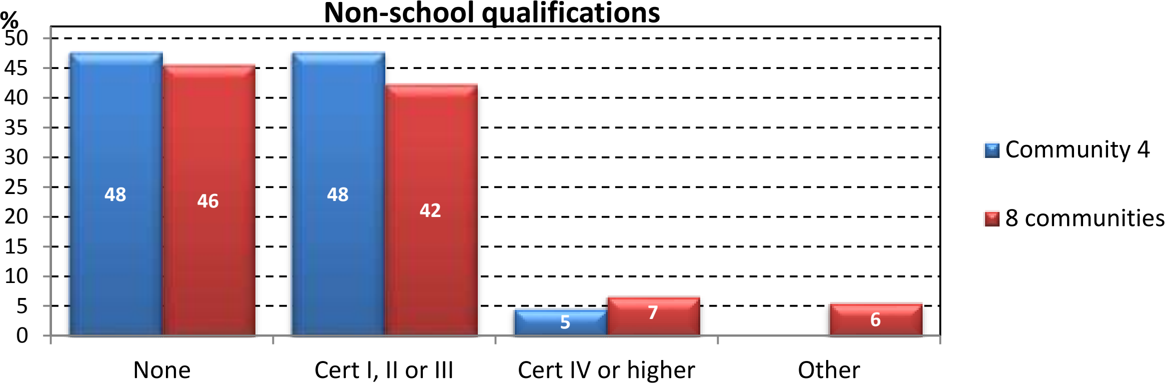
Community Survey

Adult education

- 11% of adults surveyed in Community 4 completed year 12, which was lower to that observed across all eight communities (21%).
- A higher percentage of adults in Community 4 went to Year 10/11 compared with the average of all eight communities.



- Nearly half (48%) of adults surveyed in Community 4 did not have any non-school qualifications, which was similar to that observed for all eight communities (46%).
- Forty-eight percent of adults had completed a Certificate I, II or III, compared with 42% across all eight communities.



Key informant interviews

School attendance is affected by royalty payments as parents may take children with them to regional towns for an extended period. Children often come to school tired because parents have been up late drinking or because of excess noise.

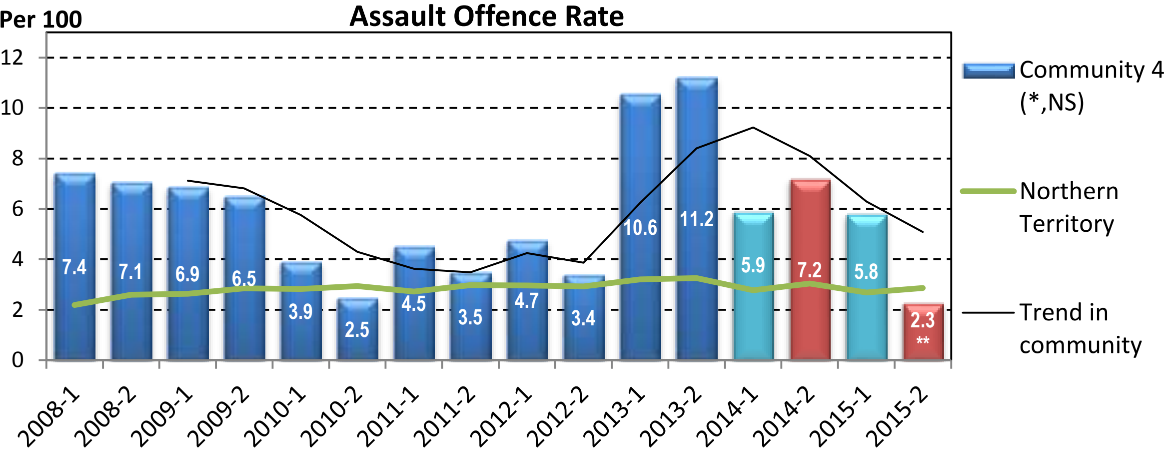
In terms of general community education, informants noted the need for more alcohol education programs and the importance of maintaining knowledge about culture.

Community safety

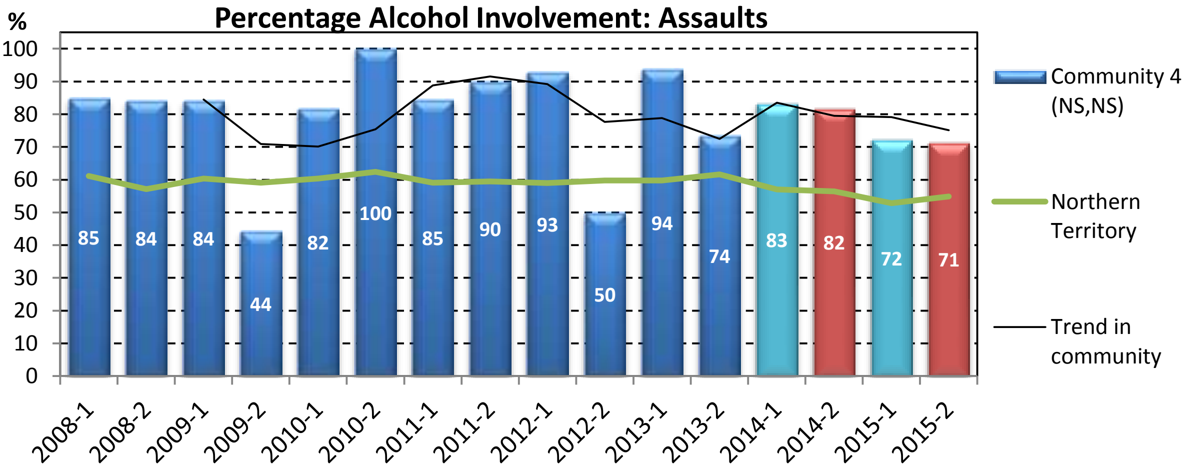
Administrative data

Assault offences

- There was a significant decrease ($p<0.01$) in the rate of assaults in Community 4 from 7.2 per 100 people in 2014-2 to 2.3 per 100 people in 2015-2.
- The assault rate in Community 4 was significantly higher than the NT rate in 2015-1, but not 2015-2, with the NT rate being 2.7 and 2.9 per 100 people respectively.

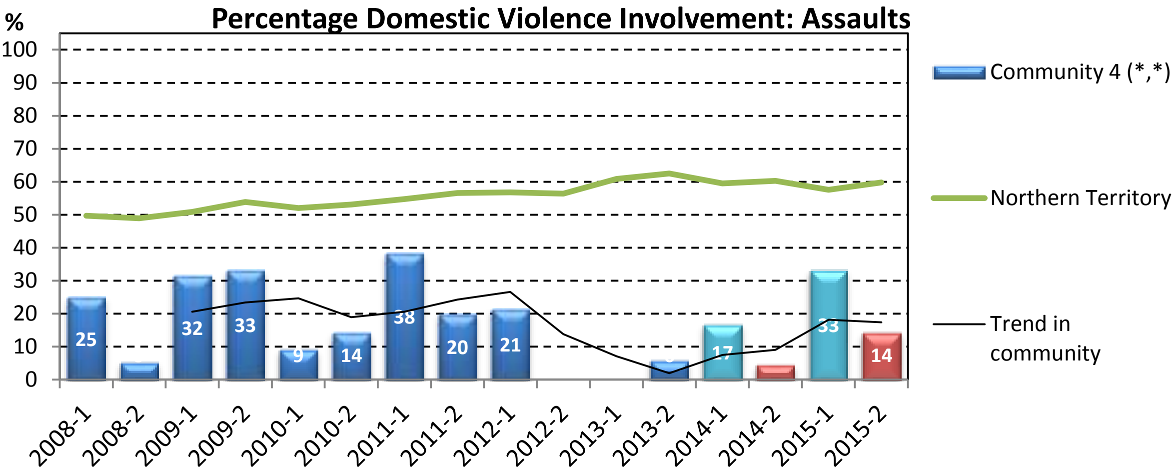


- There was a decrease in the percentage of alcohol involvement in assaults between 2014-1 (83%) and 2015-1 (72%), and also between 2014-2 (82%) and 2015-2 (71%), but this decrease was not significantly different.
- The percentage alcohol involvement in assaults for Community 4 in 2015-1 and 2015-2 was higher than that observed for the Northern Territory (53% and 55%), but this difference was not significant.

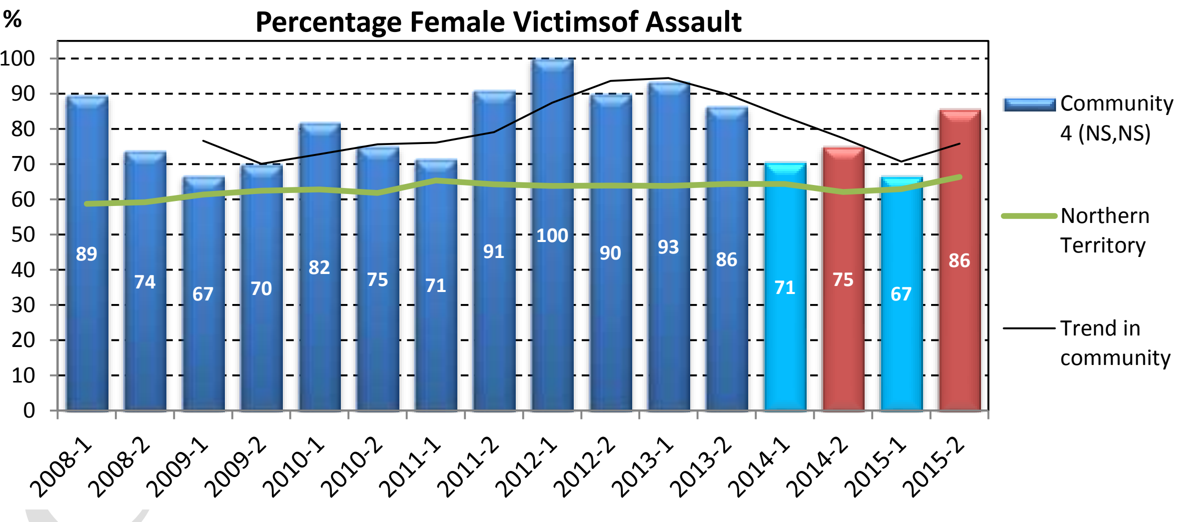


- The percentage of assaults where domestic/family violence was involved in Community 4 increased from 17% in 2014-1 to 33% in 2015-1 and from 5% in 2014-2 to 14% in 2015-2, but neither of these increases was statistically significant.

- Between 58% and 60% of assaults in the entire NT were domestic violence related in 2015, which was significantly ($p<0.05$) higher to that observed in Community 4 in both 2015-1 and 2015-2.

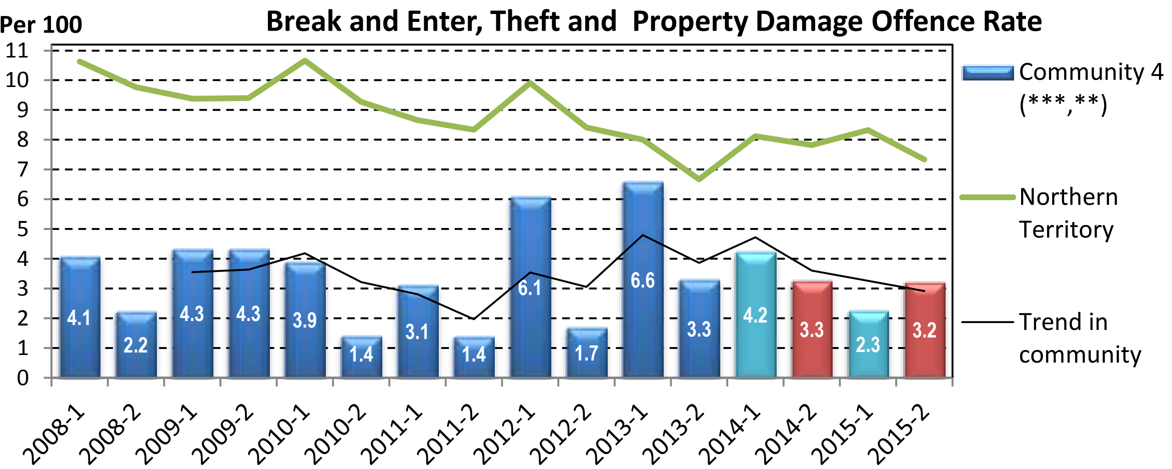


- There was a small non-significant decrease in the percentage of females who were victims of assault between 2014-1 (71%) and 2015-1 (67%), and a non-significant increase between 2014-2 (75%) and 2015-2 (86%).
- There was no significant difference in the percentage of female victims of assault in 2015-1 and 2015-2 between Community 4 and the Northern Territory (63% and 66%).



Theft, break and enter and property damage

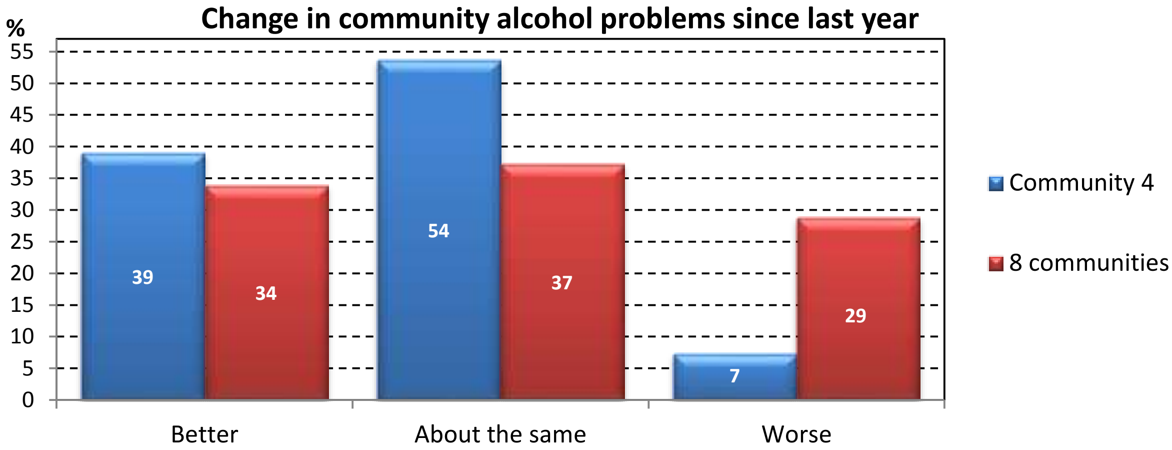
- In Community 4 there was a non-significant decrease in the theft, break and enter and property damage offence rate from 2014-1 to 2015-1 (4.2 per 100 to 3.2 per 100 people), while the rate between 2014-2 and 2015-2 was steady (3.3 to 3.2 per 100 people).
- The offence rate in 2015-1 and 2015-2 for theft, break and enter and property damage was significantly lower in Community 4 (2.3 and 3.2 per 100 people) compared with the entire Northern Territory (8.3 and 7.3 per 100 people).



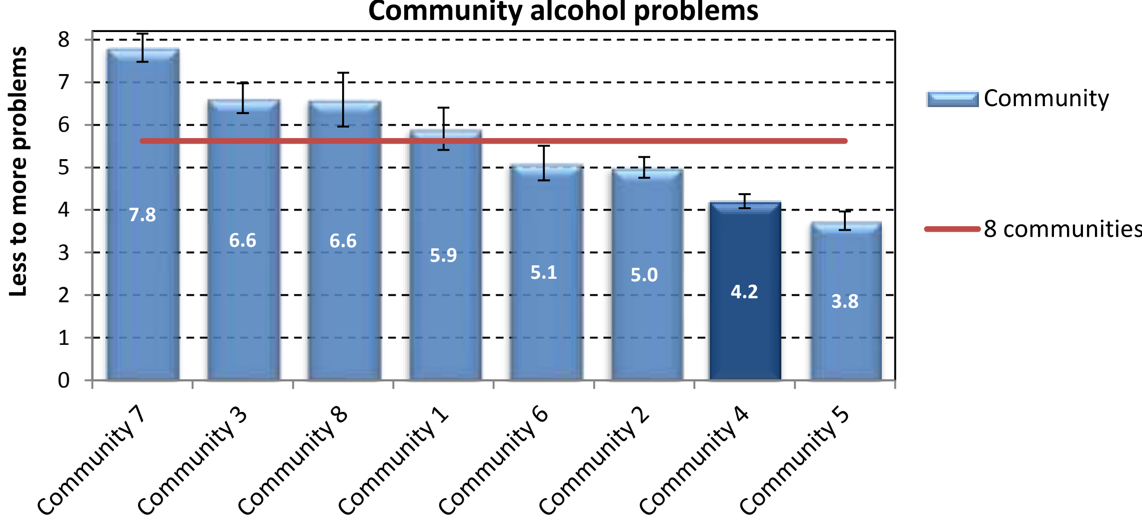
Community survey

Community and household alcohol problems

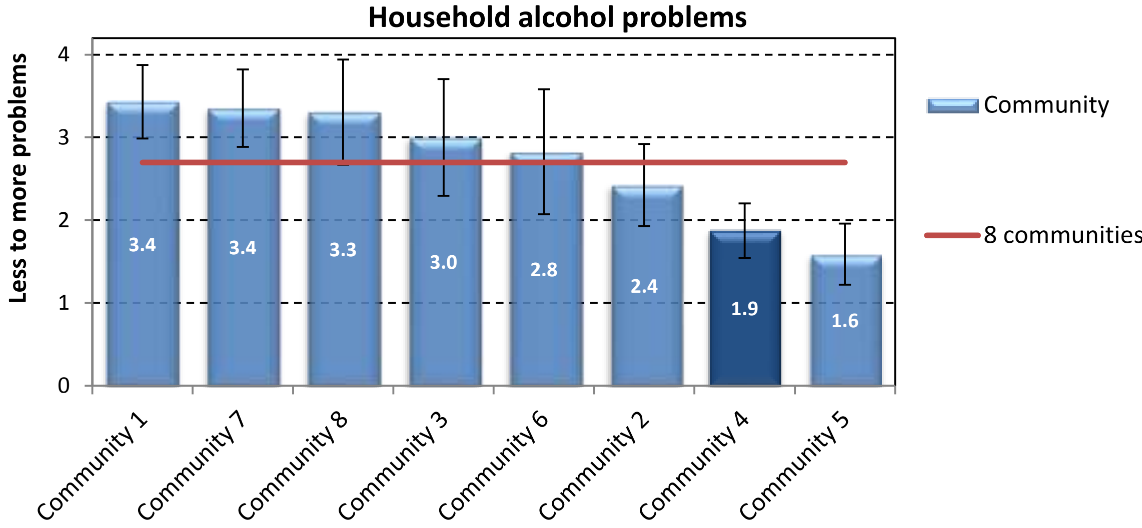
- Over half (54%) of Community 4 people surveyed said that community alcohol problems were the same compared with the previous year, which was a higher than for all eight communities (37%). Only 7% of people surveyed in Community 4 said alcohol problems had got worse in the community, compared with 29% across all eight communities surveyed.



- When asked about community alcohol problems and how often they occur, Community 4 was below the average compared with the eight communities, meaning people reported alcohol as a community problem less of the time than other communities.



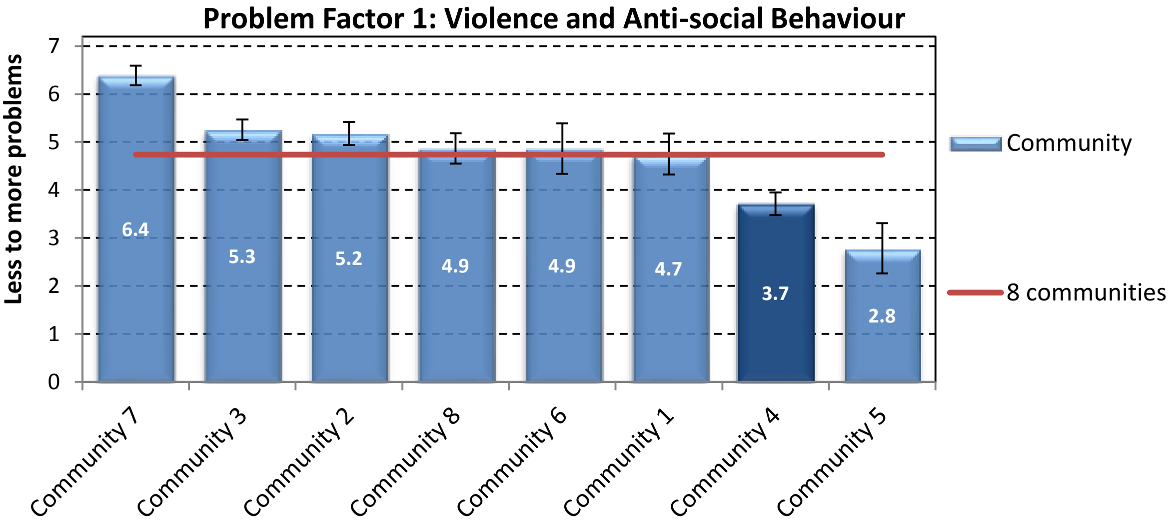
- When asked about household alcohol problems and how often they occur, Community 4 scored the second lowest, meaning people in Community 4 said that household alcohol problems occur less often compared with the other communities included in the survey.



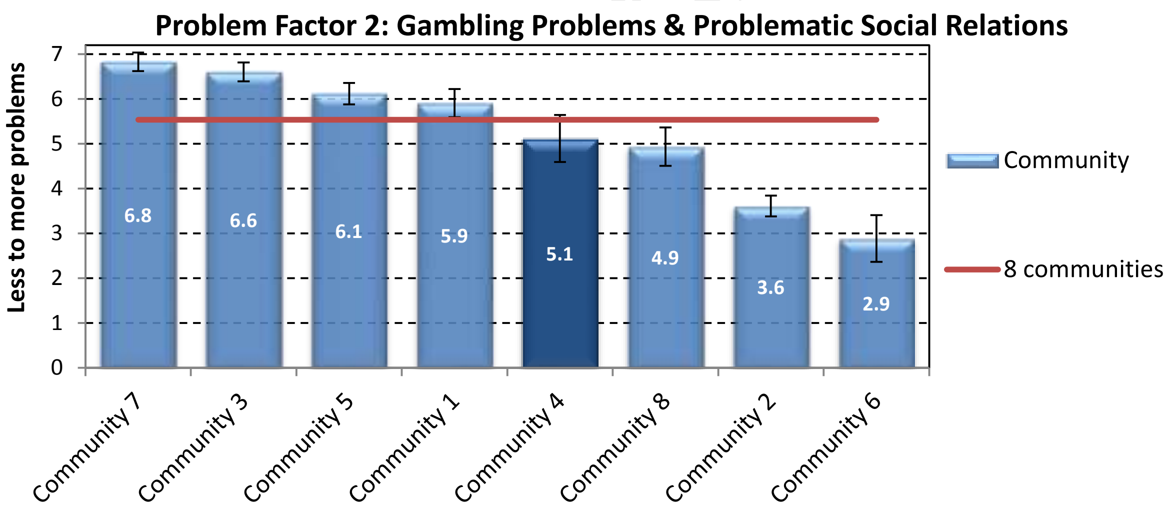
Community problems

- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
    2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
    3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.

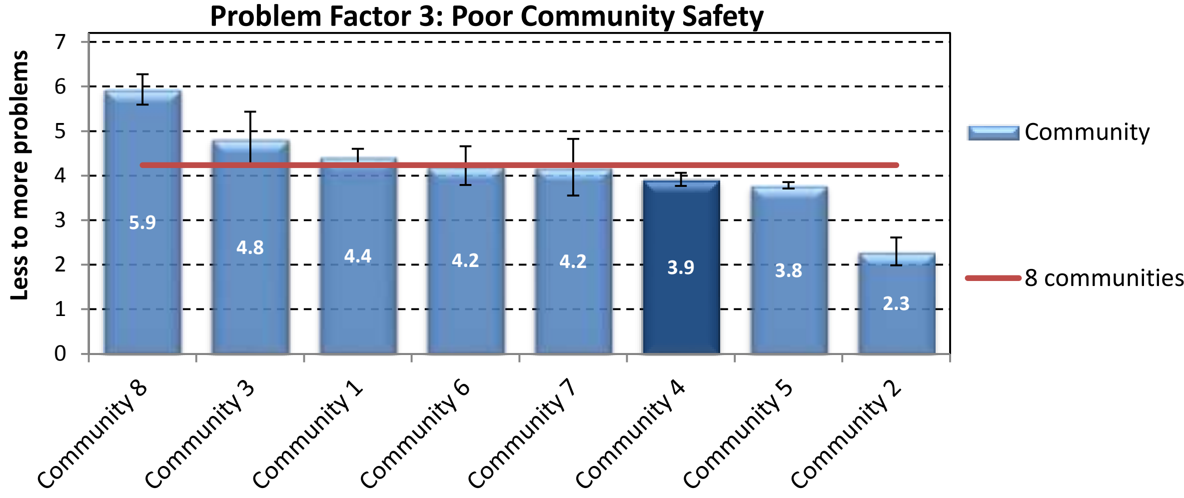
- Community 4 scored below the average of the eight communities for *Violence and Anti-Social Behaviour Problems* in the community. That is, things are a little better than the average in Community 4.



- Community 4 scored just a little bit below the average of the eight communities for *Gambling Problems and Problematic Social Relations* in the community.

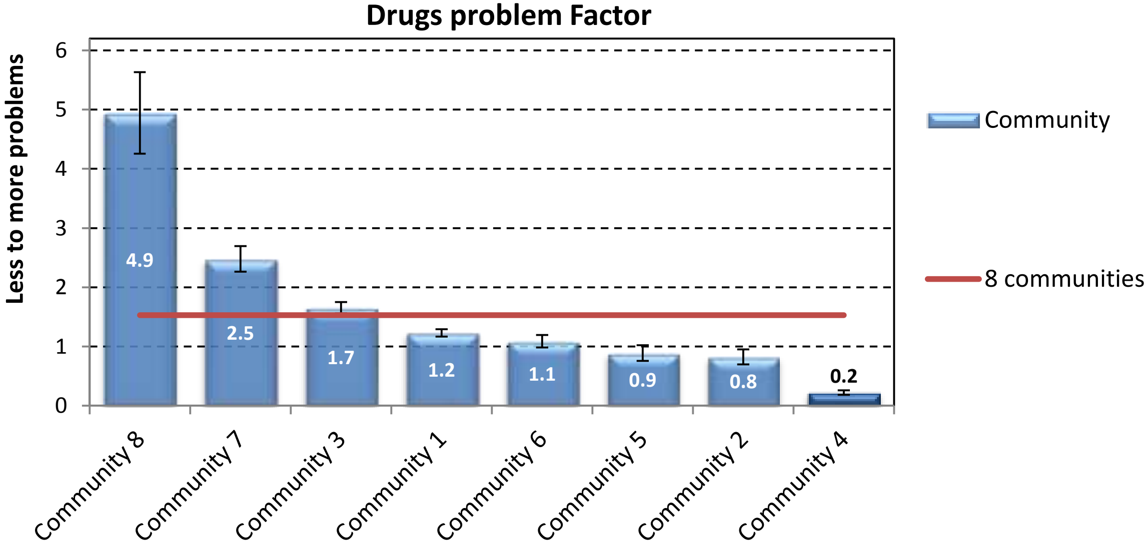


- Community 4 scored a little bit below the average of the eight communities for *Poor Community Safety* in the community.



Community drug problems

- The Community Survey also asked residents about drug problems (marijuana, sniffing, kava and ecstasy) and how much of the time over the last year they were a problem.
- The next figure shows Community 4 scored the lowest of all eight communities surveyed in how much of the time drugs were a problem. Some other communities had more problems with petrol sniffing and kava.



Key informant interviews

Views about community safety varied, with some having greater concerns about violence and conflict than others. In general, most community safety problems were perceived as being alcohol related. Several informants noted that domestic violence occurred frequently, with one noting that it was *normalised and common*. However, the relatively recent shift to pro-active policing, and the altering of police night-time shift hours to coincide with need, appears to have reduced the severity of DV assaults and other alcohol-related problems. Other issues include excess noise and conflict between families, with the latter sometimes going on for

days. One key informant noted that loud music and fighting sometimes occurred throughout the night and was still occurring when the school bus run started, however, this only happened in some pockets of the community. There was a strong consensus that royalty payments have a significant impact on community safety, as they often result in jealousy, conflict and an increase in alcohol consumption which results in more offences and anti-social behaviour. Alcohol has an impact on the safety of children, as they are at risk when people come home drunk. Although one informant noted that other family members look after children while parents are drinking this doesn't always happen, with some children being left unsupervised and others out on the streets at night while parents are drinking. Risks to both children and adults are also exacerbated by overcrowding, particularly when households include a mix of drinkers and non-drinkers.

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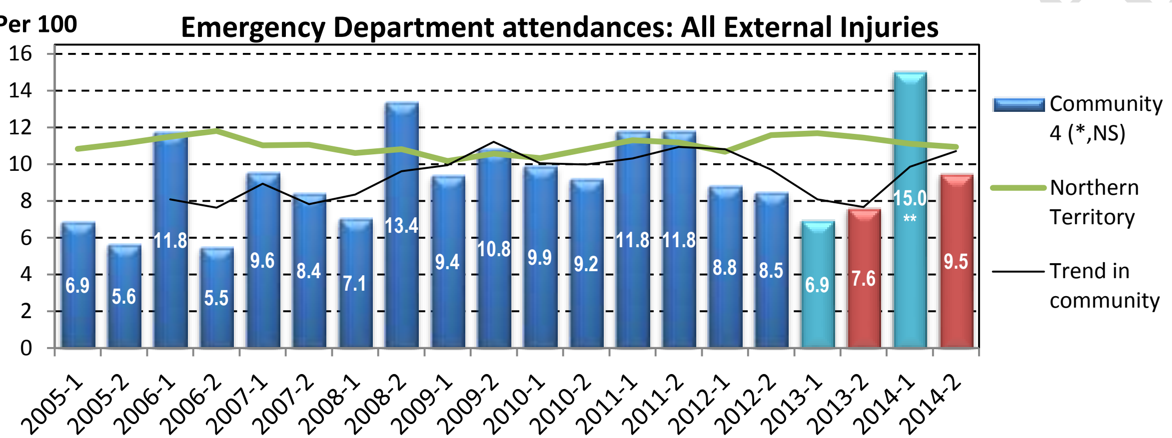
Community health and wellbeing

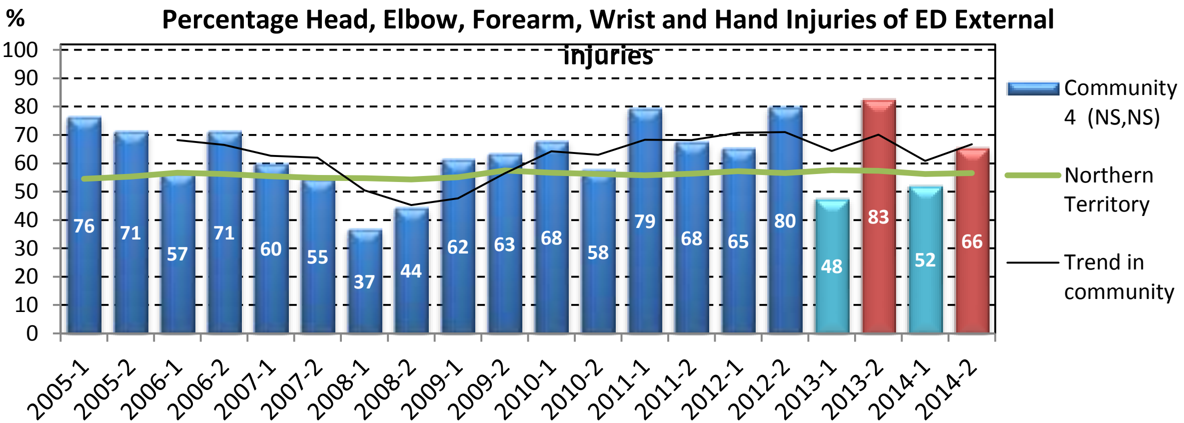
Administrative data

Emergency Department admissions for external injuries

- There was a significant (p<0.01) increase in the rate of ED external injury attendances from 6.9 per 100 people to 15 per 100 people between 2013-1 and 2014-1. The change between 2013-2 and 2014-2 was not statistically significant.
- The rate of external injury attendances at ED was significantly higher in Community 4 compared with the NT rate in 2014-1 (11.1 per 100 people), but not 2014-2 (10.9 per 100 people).



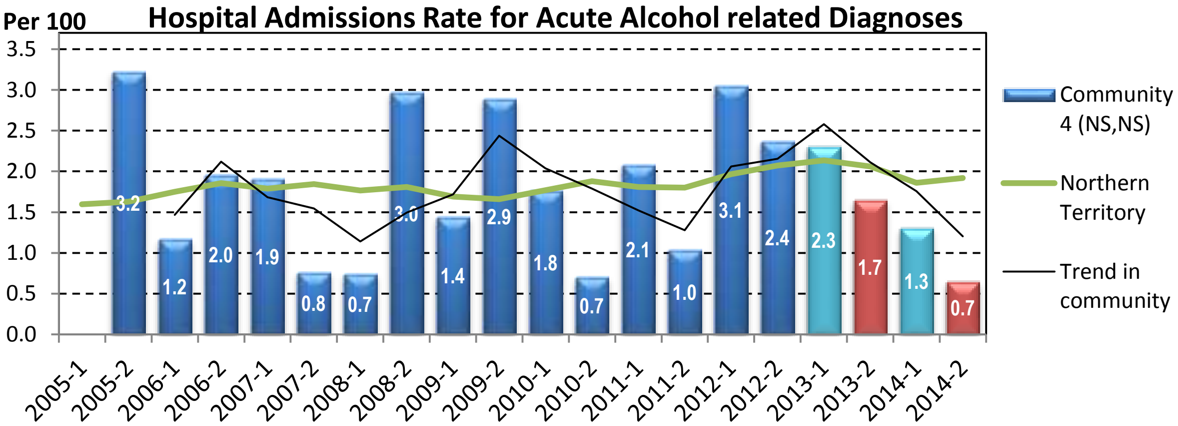
- There was a decrease in Community 4 between 2013-2 and 2014-2 from 83% to 66% in head, elbow, forearm, wrist and hand injuries as a percentage of all external injuries, though this was not significant.
- Head, elbow, forearm, wrist and hand injuries as a percentage of all external injuries was not significantly different to the NT percentage in 2014-1 (56%) and 2014-2 (57%).



Hospitalisation for alcohol-related conditions

- There has been a decreasing trend in hospital admissions for acute alcohol-related diagnoses since 2012-1, though none of the decreases over the 2013 to 2014 period were significant.

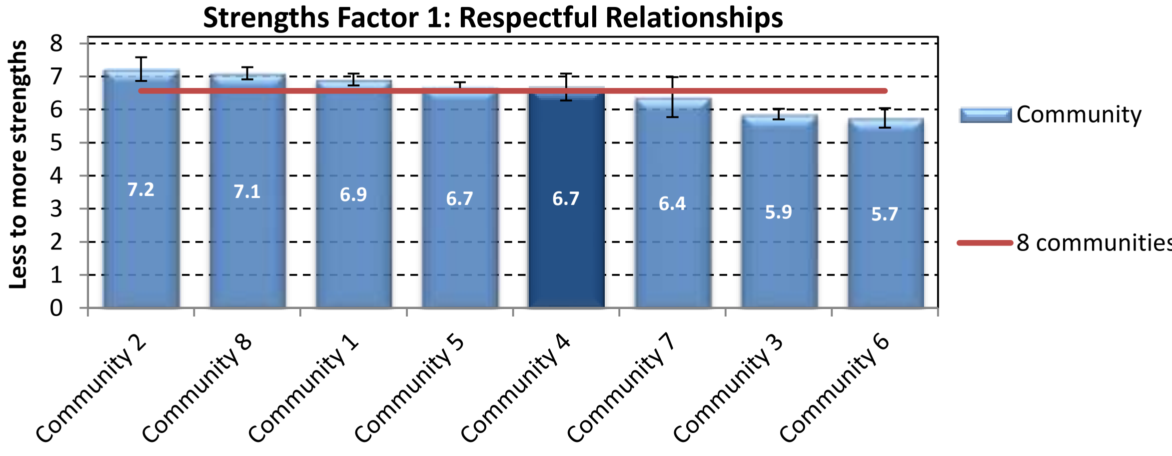
- Hospital admissions for acute alcohol-related diagnoses were lower in Community 4 than for the NT, but this difference was not statistically significant.



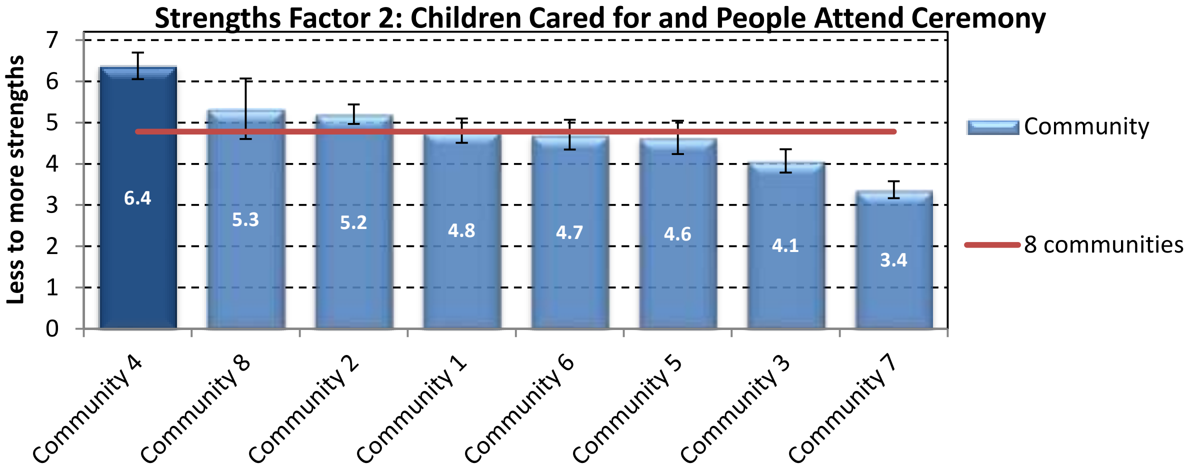
<u>Community survey</u>

Community strengths

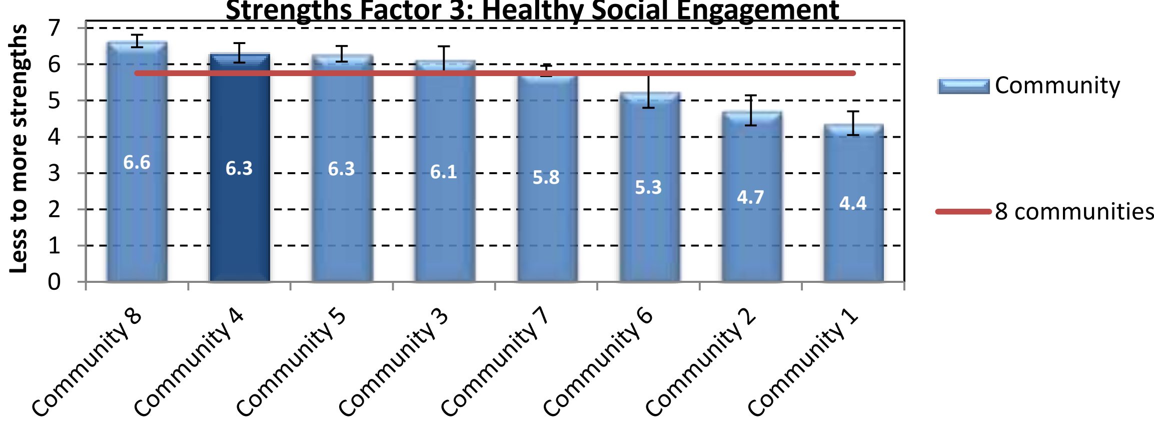
- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:
  1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) people respect Elders, (ii) people respect other community members, and (iii) people help each other.
  2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
  3. Strengths Factor 3: *Health Social Engagement* which includes three community strengths: (i) people go out for bush tucker, (ii) people do organised sports and other activities and (iii) people say no to humbug.
  - In Respectful Relationships Community 4 scored about the same as the average of the eight communities surveyed.



- Community 4 scored the highest of the eight communities for Children cared for and people attend ceremony.



- Community 4 scored second highest of the eight communities for Healthy Social Engagement.



Key informant interviews

Alcohol was perceived as having an adverse effect on personal relations and how people communicate, with emotions such as jealousy and anger more likely to emerge when someone has been drinking. One informant commented that alcohol contributes to depression and sets up a cycle of dysfunction – *a person does bad things when drunk, when they are sober they are sad because of what they've done and then they get drunk again so they can forget*. A reasonable number of women drink when they are pregnant and one informant noted that about half of the school children display behaviours associated with FASD while a few have the distinctive facial characteristics associated with foetal alcohol syndrome. One informant noted that some people are unable to go to work due to excess alcohol consumption the previous night and that some people in the community suffer from chronic health conditions related to alcohol. Concern was also expressed about the future health of young people who now begin drinking at an earlier age.

Demand factors underlying alcohol consumption included: boredom; lack of employment opportunities; changes in values; overcrowding; poor social and emotional wellbeing; and a reduction in community cohesion. The introduction of super shires to replace local community councils was perceived as having a negative impact on the community. One informant commented that under the community council model, employment opportunities were greater, community cohesion was stronger, and there was more emphasis on culture in schools. Similarly, another informant noted that community members needed to support each other more, to understand each other better and build trust. Several informants noted that there was a lack of leadership from Elders and there was a need to harness the leadership potential of young people so that they can help others. One informant commented on the importance of maintaining knowledge about culture and continuing the practice of holding men's ceremonies for two months of the year, with this perceived as an important ingredient of community cohesion because it encouraged better behaviour, more respect and older people being responsible for younger people.

Informants recommended a number of strategies for reducing alcohol-related harms and improving health and wellbeing including: effective job programs; more employment opportunities; more, and better managed, treatment and rehabilitation services; and more structured activities including school holiday programs for children. Several informants considered the CDEP program to have been very effective, as it employed around 105 people and provided practical training that was of benefit in improving and maintaining the community. By contrast, the RJCP program, current at the time of interview, had only resulted in employment for one person. However, one informant questioned the value of job programs, asserting that they did not provide genuine employment but just required people to do something for 'sit down money'.

Several informants felt that the need for early intervention was not met and that there were insufficient treatment and rehabilitation programs. In addition, current services were not seen as particularly effective, with one informant noting that vulnerable people often didn't feel comfortable going to the clinic and that it would be more appropriate to adopt a community outreach approach. In addition, people prefer to seek help from an AOD worker who is of the same gender and there is currently only one AOD worker on site. The lack of effective treatment, rehabilitation and early intervention services means that people continue to appear in court for petty offences and no real consequences, with this resulting in an escalation of the nature of the offences committed. Although women's needs were serviced quite well through the safe house and women's centre, there were no equivalent services for men. Several informants commented on the need for a men's shed, a space where men can get away from a problem or domestic argument before it escalates and where they can talk about issues with other men. Although a men's shed has been on the agenda for several years it has yet to become a reality.

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4.6 Community 5 Data Report

Highlights 2014 to 2015

- ↑↑ large or significant improvement; ↑ small or non-significant <u>improvement</u>; = no change or small change
- ↓↓ large or significant worsening; ↓ small or non-significant <u>worsening</u>; = no change or small change

Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-6 to 6)		**-**	**67% (4)**
Wholesale PAC in catchment	Mostly steady with very small increase	=	0
Community average PAC last drink	Lowest of 8 communities	↑↑	2
Frequency of drinking	More likely to drink twice per week	-	-
Number types of alcohol drank	More likely to drink only one type of alcohol	↑↑	2
Community Education (-10 to 10)			**-20% (-2)**
School attendance	About the same as NT average (74% to 80%)	=	0
Year 5 reading	Worsening & just above similar schools	↓	-1
Year 5 numeracy	Improvement & just above similar schools	↑	1
Year 7 reading	Worsening & same as similar schools	↓	-1
Year 7 numeracy	Worsening & just above similar schools	↓	-1
Adult year 12 completion	Slightly better than average of 8 communities	-	-
Adult other qualifications	Slightly better than average of 8 communities	-	-
Community Problems & Safety (-24 to 24)			**42% (10)**
Assaults offences	Significant improving trend over last 2 years	↑↑	2
Alcohol % in assaults	No substantial change over last 2 years	=	0
Domestic violence % in assaults	Significant worsening trend over last 2 years	↓	-1
Female % in assaults	No substantial change over last 2 years	=	0
Theft, stealing, break & enter	No substantial change over last 2 years	=	0
Change in community alcohol problems	88% said about the same or better	↑	1
Community alcohol problems	Lowest of 8 communities	↑↑	2
Household alcohol problems	Lowest of 8 communities	↑↑	2
Violence & Anti-Social behaviour	Lowest of 8 communities	↑↑	2
Gambling & Problematic Social Relations	Above average of 8 communities	↓	-1
Poor Community Safety	Second lowest of 8 communities	↑↑	2
Community Drug problems	Below average of 8 communities	↑	1
Community Strengths, Health & Wellbeing (-12 to 12)			**-8% (-1)**
Emergency Department attendances	Small worsening trend over last 2 years	↓	-1
% head, elbow, forearm, wrist & hand	Significant worsening trend over last 2 years	↓↓	-2
Acute alcohol hospitalisations	Small improving trend over last 2 years	↑	1
Respectful Relationships	Similar to average of 8 communities	=	0
Children Cared for &Attend Ceremony	Similar to average of 8 communities	=	0
Healthy Social Engagement	Above average of 8 communities	↑	1
Total score standardised (-52 to 52)			**20%**

Key informant interviews: Highlights

Alcohol is normative in this community, with the social club being a focal point for community socialising. There is strong support for the social club and permit system, both of which are perceived as encouraging responsible drinking through the imposition of bans on those who ‘behave badly’. Although few Indigenous community members considered alcohol

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to be a problem, some service providers believed that alcohol-related harms and problems were often hidden in order to protect perpetrators from the consequences of their actions. In general, there is a perceived need for more alcohol-related support services to be provided on-site in the community. Similarly, several informants highlighted the need for a broader spectrum of recreational opportunities to be made available.

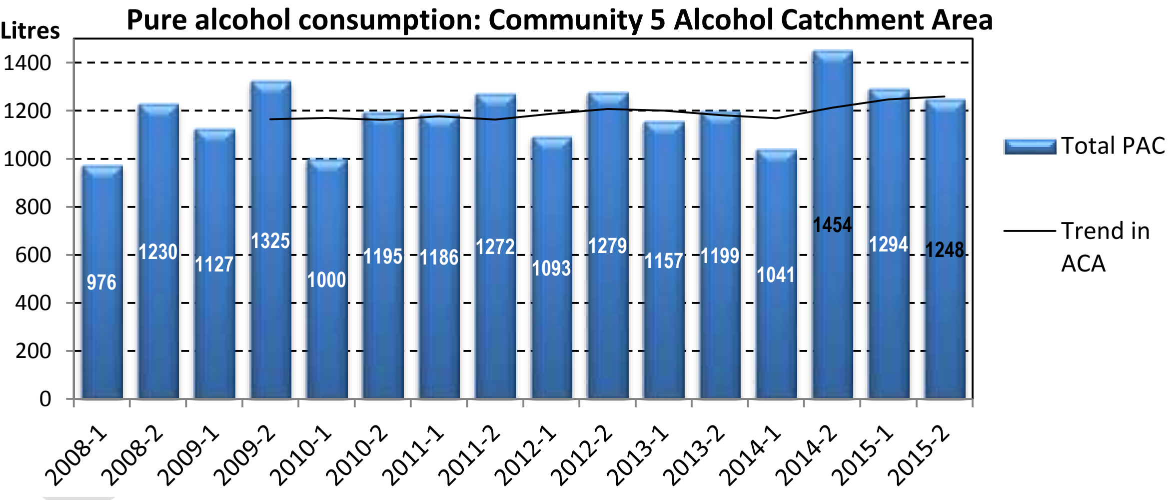
Community context

Community 5 has a population of around 475 people. Key services include a police station, health centre, school, women's centre, an arts centre, and a store. There is both a social club and a permit system. The social club is open four days a week between 4.30 pm and 7.30 pm and people have access to unlimited light and mid-strength beer. Community members who have a permit can purchase the following takeaway alcohol to drink in their homes: 12 x 375 ml full strength beer or 24 x 375 ml mid-strength beer or 3 bottles of wine per week or 12 x UDLs per week.

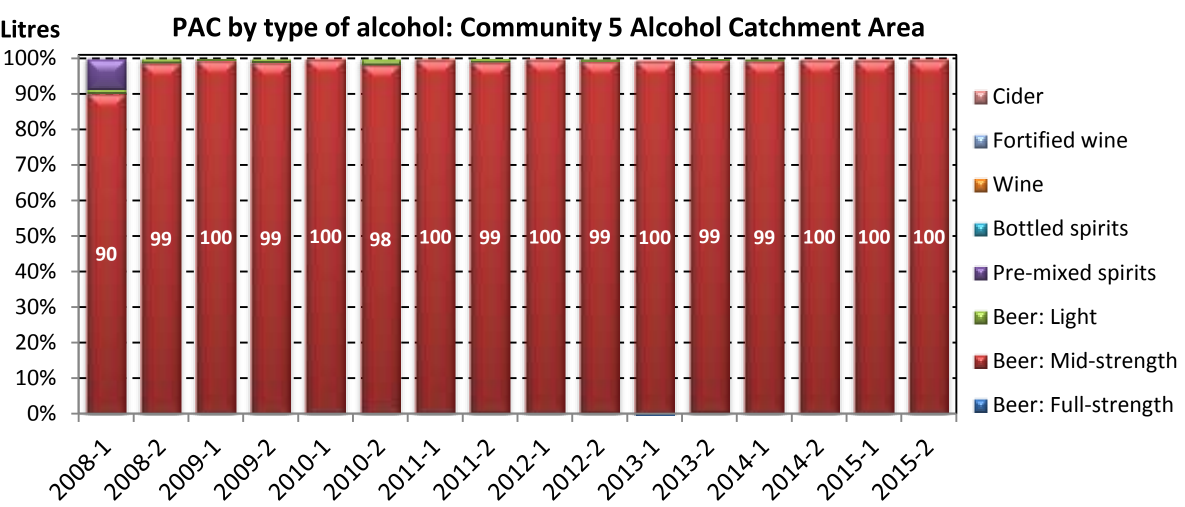
Alcohol consumption patterns

<u>Administrative data</u>

- PAC in litres by alcohol type for the Community 5 Alcohol Catchment Area (ACA – Local community social club) is shown in the graph below and represents the amount of pure alcohol consumed per 6-month period.
- There was a 24% increase in PAC from 2014-1 to 2015-1, and a 14% decrease in PAC from 2014-2 to 2015-2.



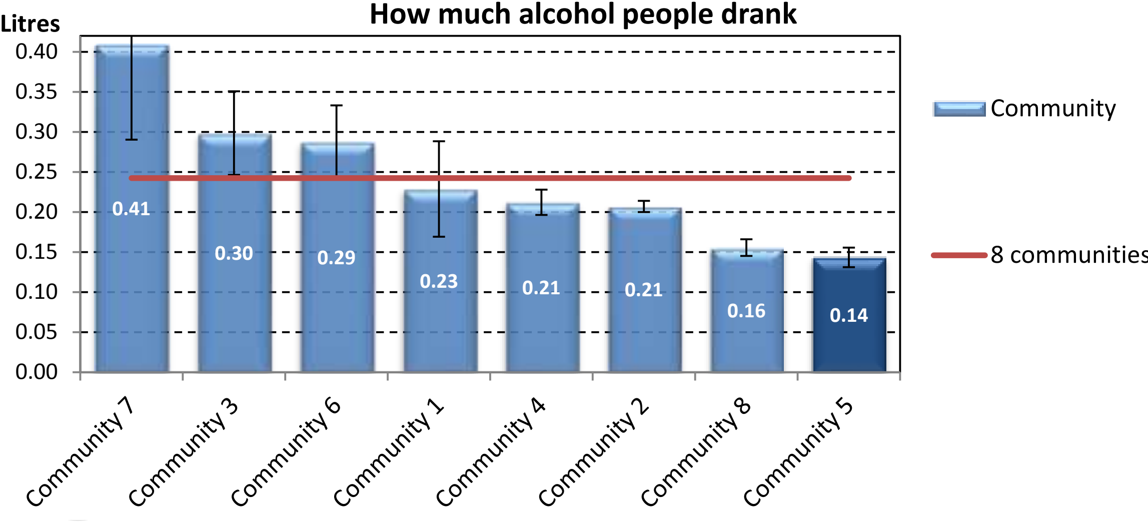
- All PAC through this ACA was consumed as mid-strength beer.



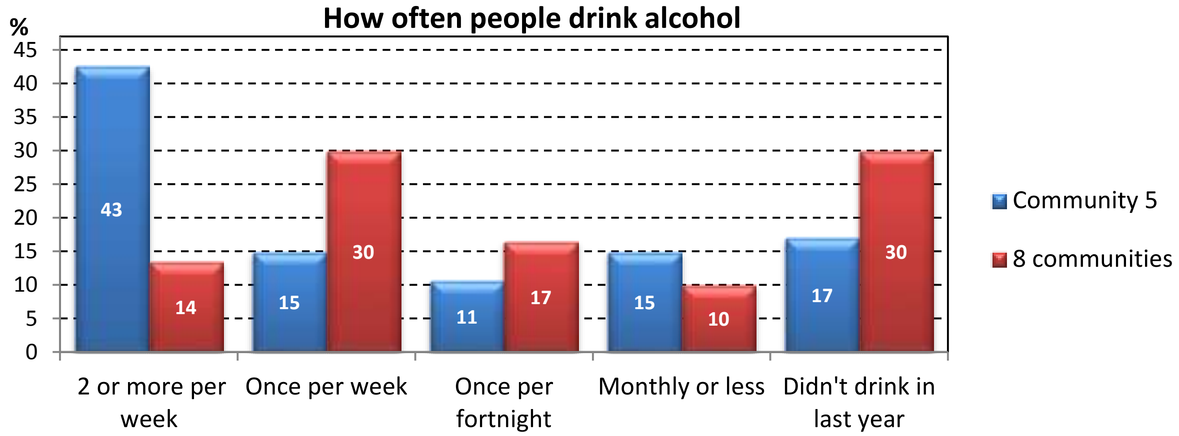
Community Survey

Pure Alcohol Consumed (PAC) Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

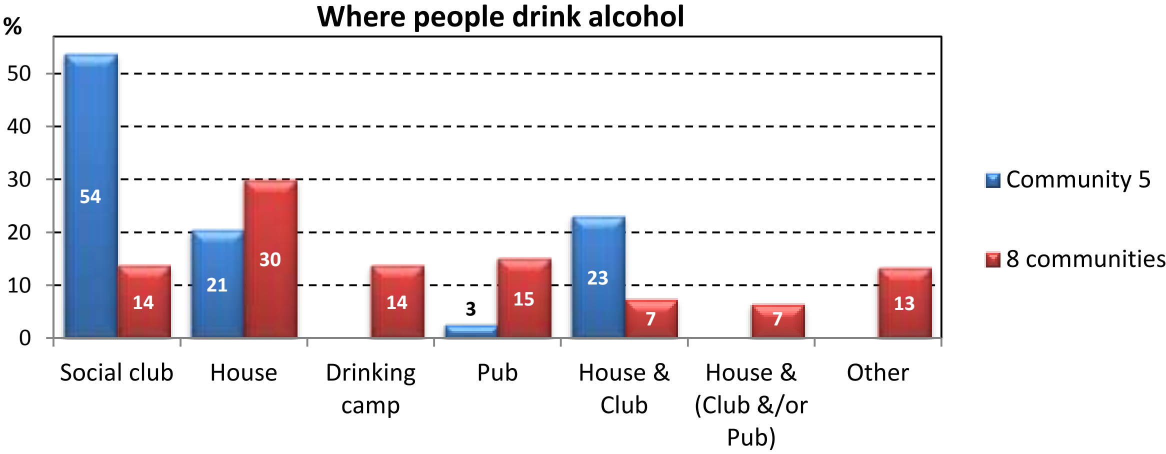
- Community 5 had the lowest average PAC from the 8 communities surveyed of 0.14 litres (approximately 12 mid-strengths or 8 full-strength beers).
- The average PAC of all eight communities was 0.24 litres (approximately 19 mid-strengths or 13 full-strength beers).



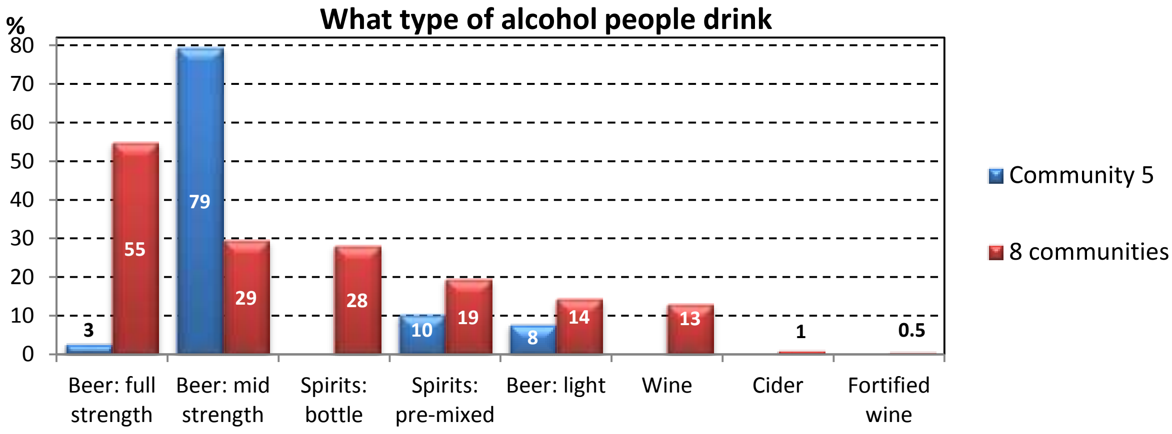
- Community 5 residents that were surveyed and drink alcohol were more likely than other communities surveyed to drink twice or more per week.



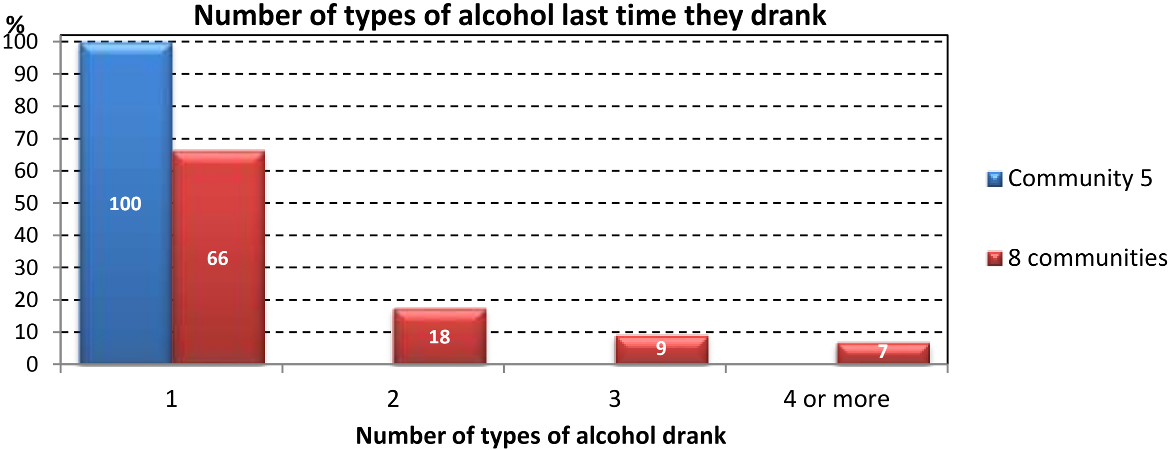
- The next figure shows where people drank and this varied depending on access to alcohol outlets. The social club in Community 5 was the most popular place to drink (54% of drinkers), followed by drinking at both the club and at a home (23%).



- Mid-strength beer was the most commonly drank alcohol type in Community 5 (79%), and was higher than the average of all eight communities. Some people also drank pre-mixed spirit cans and light beer.



- All drinkers surveyed in Community 5 only drank one type of alcohol on their last drinking occasion, which was higher than the average for all eight communities (66%).



<u>Key informant interviews</u>

Alcohol was not perceived as a major problem in Community 5 and a number of informants felt that controls that are too stringent would result in problem drinkers relocating to Darwin, where they are at substantially greater risk and do not have the support of their home community. A number of informants felt that consumption was managed effectively through the regulations governing both the social club and the permit system. The aim of these regulations is to encourage responsible drinking by banning people for behaviours associated with alcohol misuse, such as domestic violence, break-ins, or inadequate care of children. However, some informants commented that people tended to hide behaviour that will result in a banning notice and that there is strong community pressure against 'dobbing' other people in, with this making it difficult for banning processes to be either fair or effective. Strengthening skin group leadership was seen by some as an effective way of encouraging responsible behaviour, however, one informant commented that when skin group leaders recommended someone should be banned, it resulted in fighting and bullying within skin groups. Indigenous key informants expressed a strong desire for take-away alcohol to be sold from the social club rather than bought through the Darwin outlet, as this would keep profits in the community. However, one informant felt that making the social club an outlet for take-away alcohol would result in increased access, more gambling (increased motivation to gamble to obtain cash to buy take-away), more break-ins and more opportunistic purchases.

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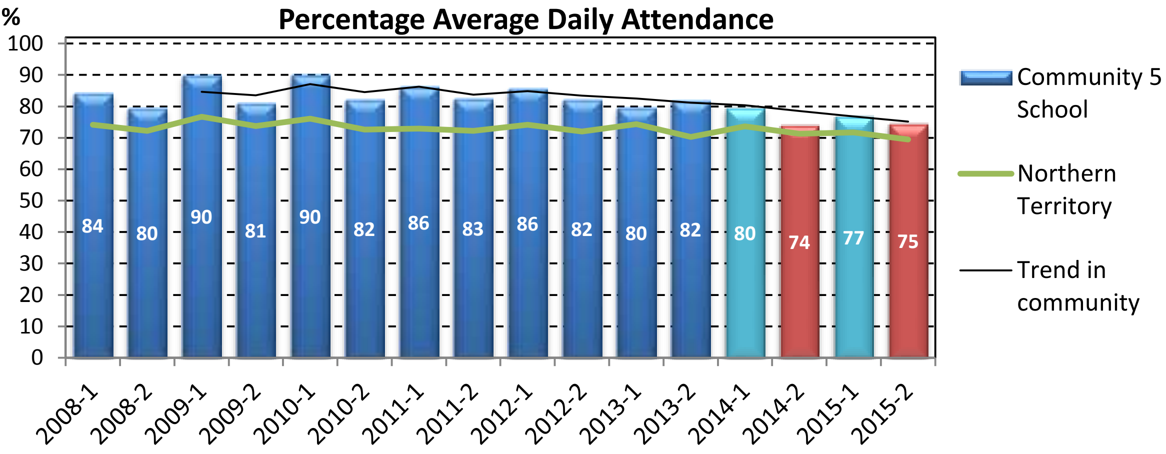
Community education

Administrative data

School attendance and enrolments

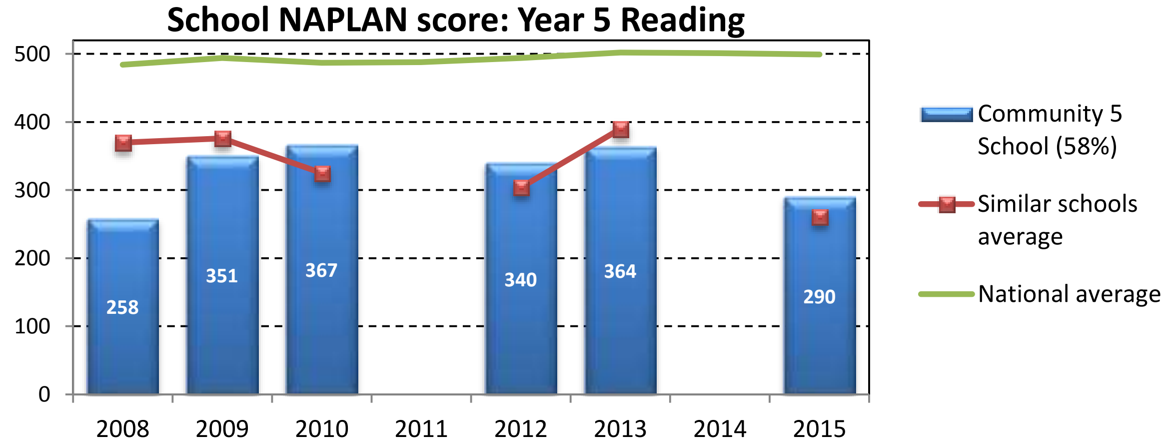
Community 5 School	2008-1	2008-2	2009-1	2009-2	2010-1	2010-2	2011-1	2011-2	2012-1	2012-2	2013-1	2013-2	2014-1	2014-2	2015-1	2015-2
Number enrolled for semester	79	77	74	72	65	65	69	69	74	75	79	78	79	74	73	69

- School attendance in Community 5 ranged between 80% and 74% over the last 2 years, which was similar to or a little above the NT average attendance rates.

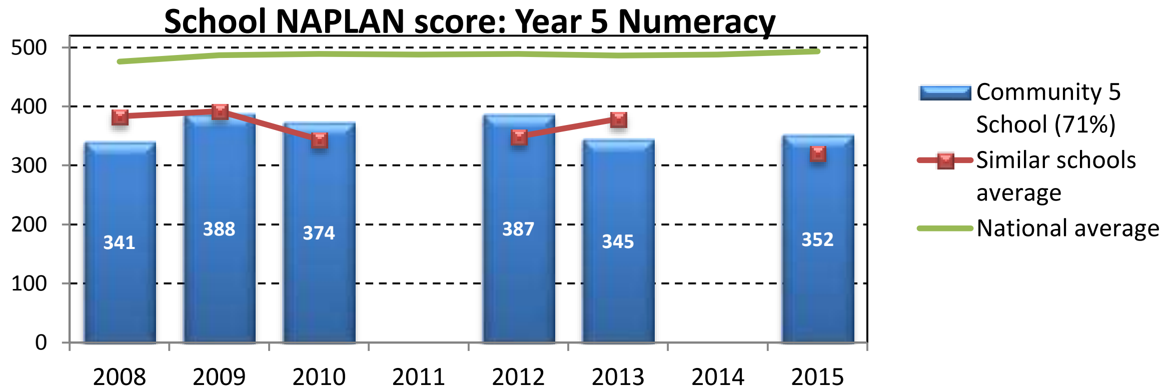


Literacy and numeracy of school students

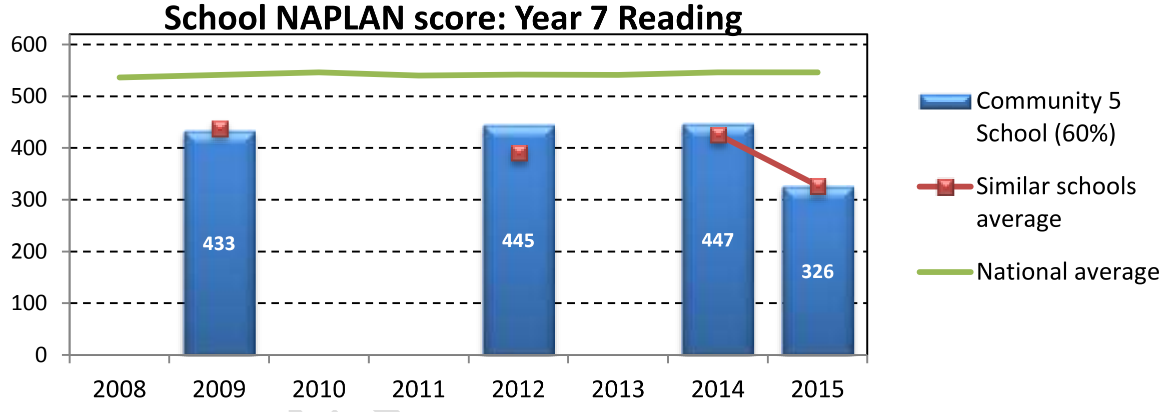
- There was a decline in the Year 5 NAPLAN school score for reading from 2013 to 2015, and this score was just above the average of similar schools,
- The Community 5 school score was 58% of the national average for Year 5 reading (499).



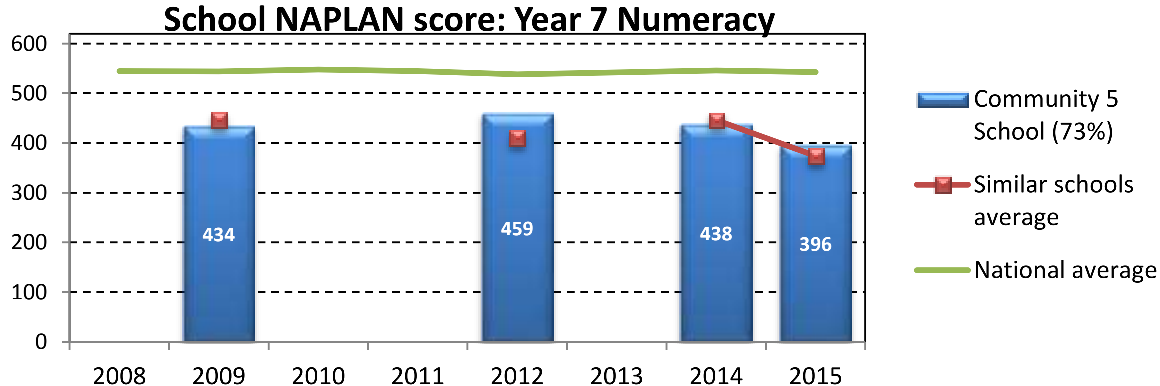
- There was a small increase in the Year 5 NAPLAN school score for numeracy, and this score was just above the average of similar schools, and this score was 71% of the national average for Year 5 numeracy.



- There was a decrease in the Year 7 NAPLAN school score for reading, and this score was about the same as the average of similar schools, and this score was 60% of the national average for Year 7 reading.



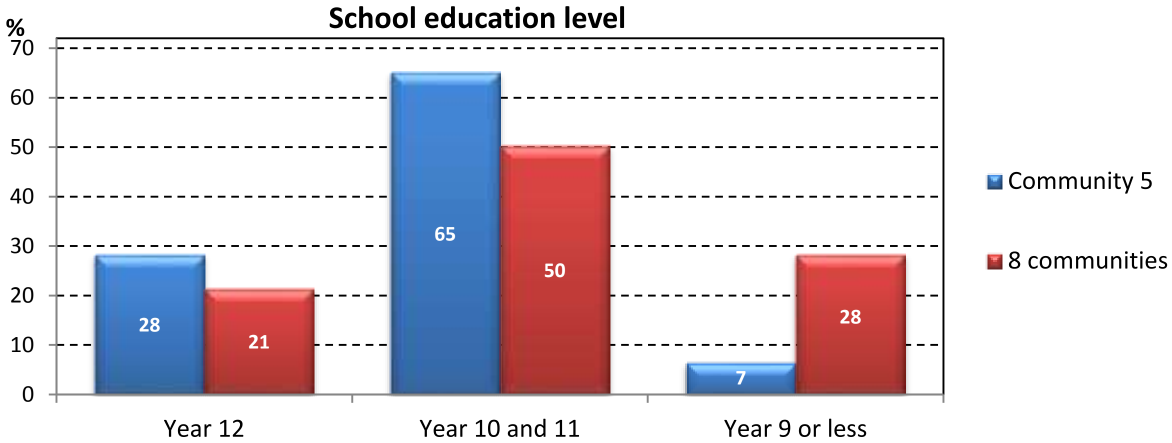
- There was a decrease in the Year 7 NAPLAN school score for numeracy, and this score was just below the average of similar schools, and this score was 73% of the national average for Year 7 numeracy.



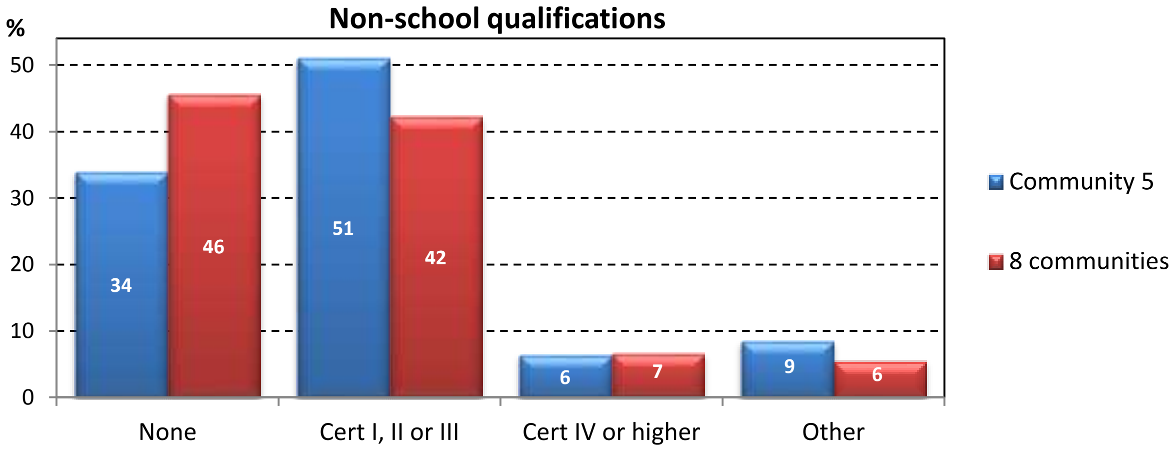
Community Survey

Adult education

- 28% of adults surveyed in Community 5 completed year, which was higher to that observed across all eight communities (21%). A higher percentage of adults in Community 5 went to Year 10/11 (65%) compared with the average of all eight communities (50%).



- More than half (51%) of adults surveyed in Community 5 had completed a Certificate I, II or III, compared with 42% across all eight communities.



Key informant interviews

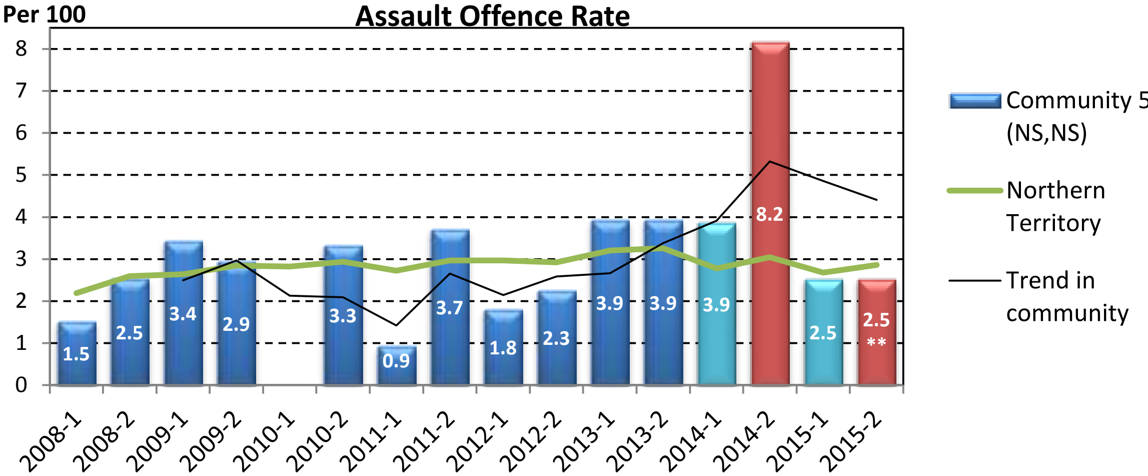
One informant commented that there was a 50:50 split between two types of families, with the first being functional and engaged and the other dysfunctional and having problems with the children. A need for organised after-school activities was also identified.

Community safety

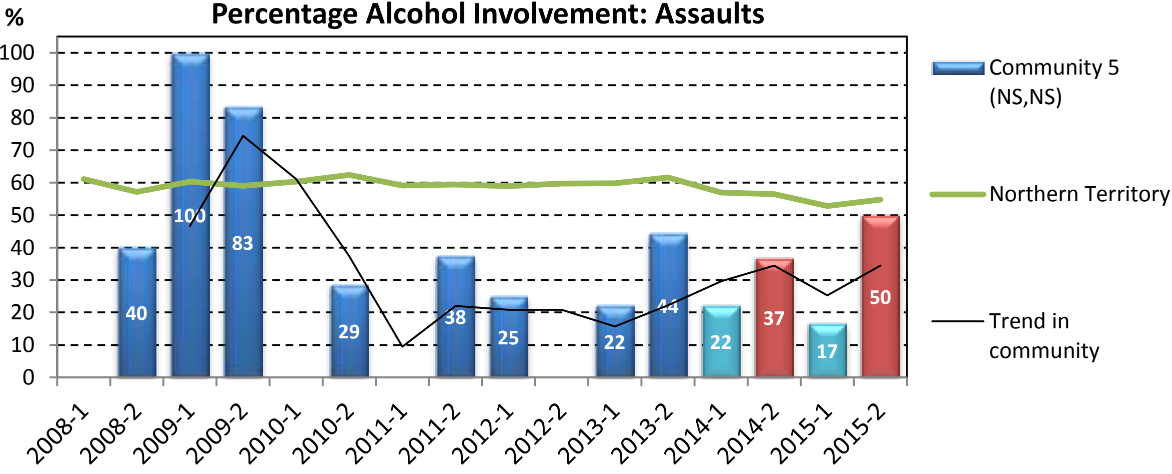
<u>Administrative data</u>

Assault offences

- There was a significant decrease ($p<0.01$) in the rate of assaults in Community 5 from 8.2 per 100 people in 2014-2 to 2.5 per 100 people in 2015-2.
- The assault rate in Community 5 was not significantly different to the NT rate in 2015-1 and 2015-2, with the NT rate being 2.7 and 2.9 per 100 people respectively.

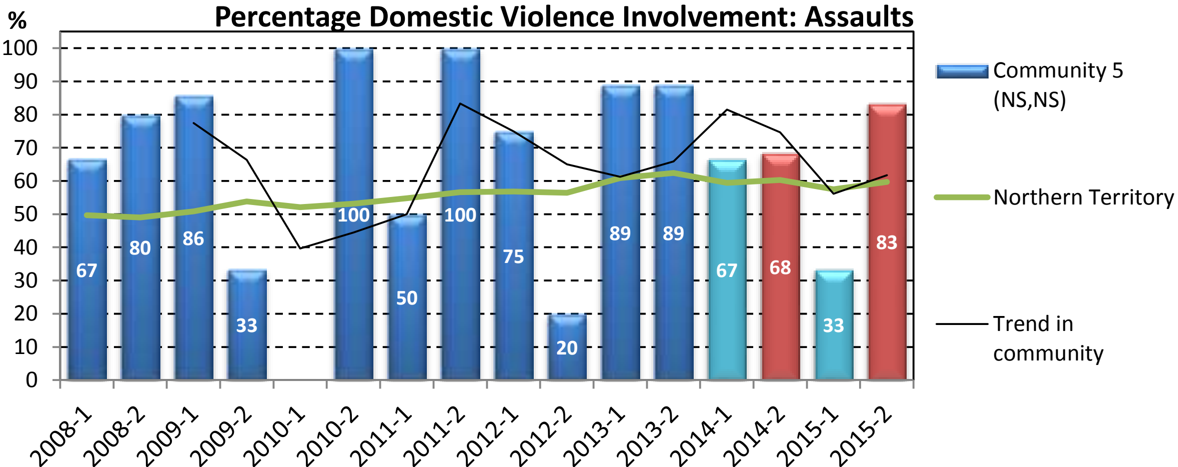


- There was no significant change in the percentage of alcohol involvement in assaults between 2014-1 (22%) and 2015-1 (17%), and also between 2014-2 (37%) and 2015-2 (50%).
- The percentage alcohol involvement in assaults for Community 5 in 2015-1 and 2015-2 was not significantly different to that observed for the NT (53% and 55%).

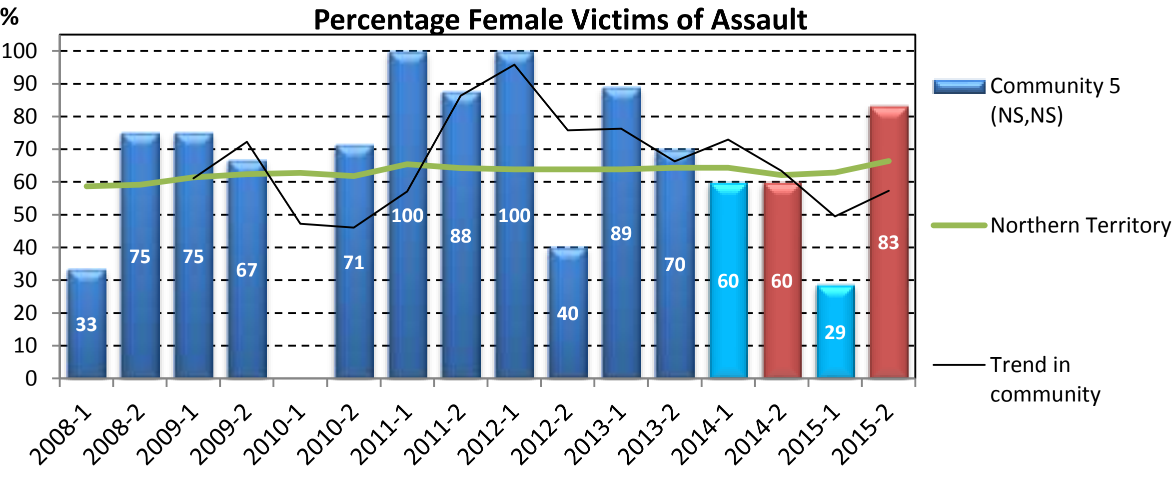


- The percentage of assaults in Community 5 where domestic/family violence was involved decreased from 67% in 2014-1 to 33% in 2015-1 and increased from 68% in 2014-2 to 83% in 2015-2, but neither of these changes was statistically significant.

- Between 58% and 60% of assaults in the entire NT were domestic violence related in 2015, which was not significantly different to that observed in Community 5 in 2015.

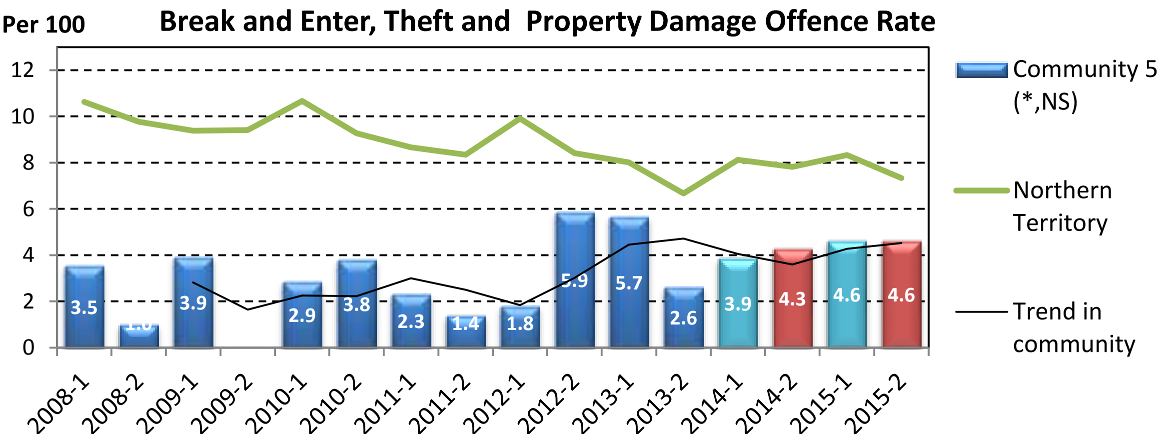


- There was a non-significant decrease in the percentage of females who were victims of assault between 2014-1 (60%) and 2015-1 (29%), and a non-significant increase between 2014-2 (60%) and 2015-2 (83%).
- There was no significant difference in the percentage of female victims of assault in 2015-1 and 2015-2 between Community 5 and the NT (63% and 66%).



Theft, break and enter and property damage

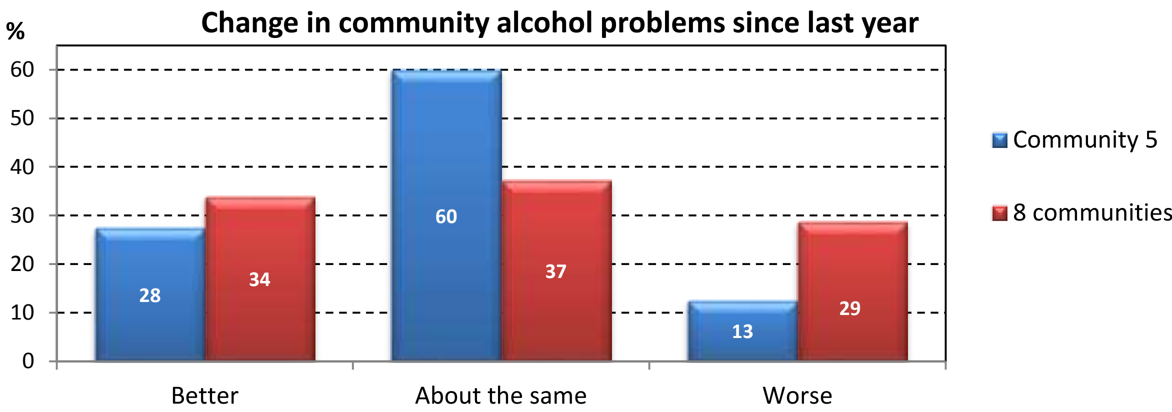
- The theft, break and enter and property damage offence rate in Community 5 has been steady between 2014 and 2015, though there was a small non-significant increase between 2014-1 and 2015-1.
- The offence rate in 2015-1 and 2015-2 for theft, break and enter and property damage was not significantly different to the NT rate (8.3 and 7.3 per 100 people).



<u>Community survey</u>

Community and household alcohol problems

- Most (60%) of people surveyed in Community 5 said community alcohol problems were about the same as the previous year, and only 13% said it was worse.



- When asked about community alcohol problems and how often they occur, Community 5 scored the lowest (best) compared with the eight communities.

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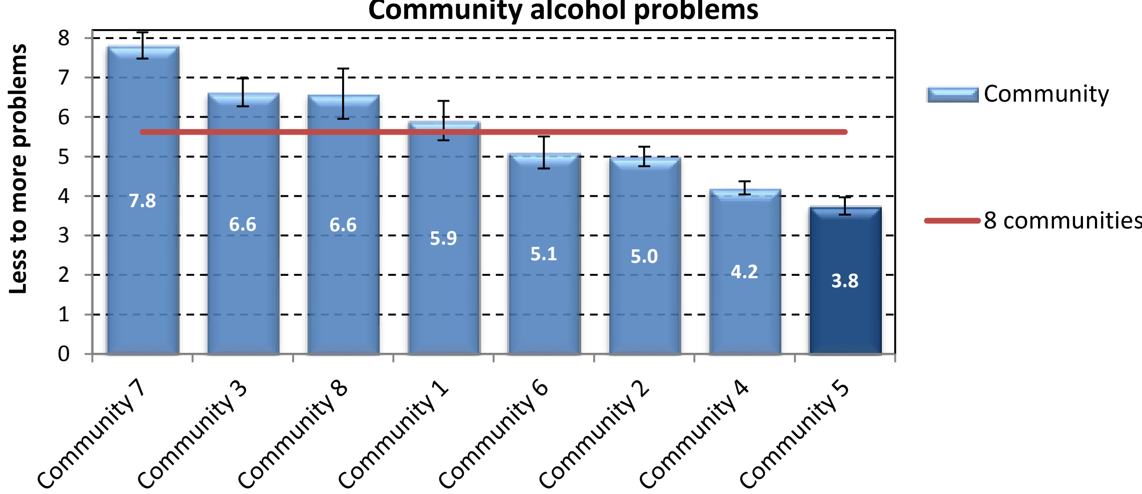
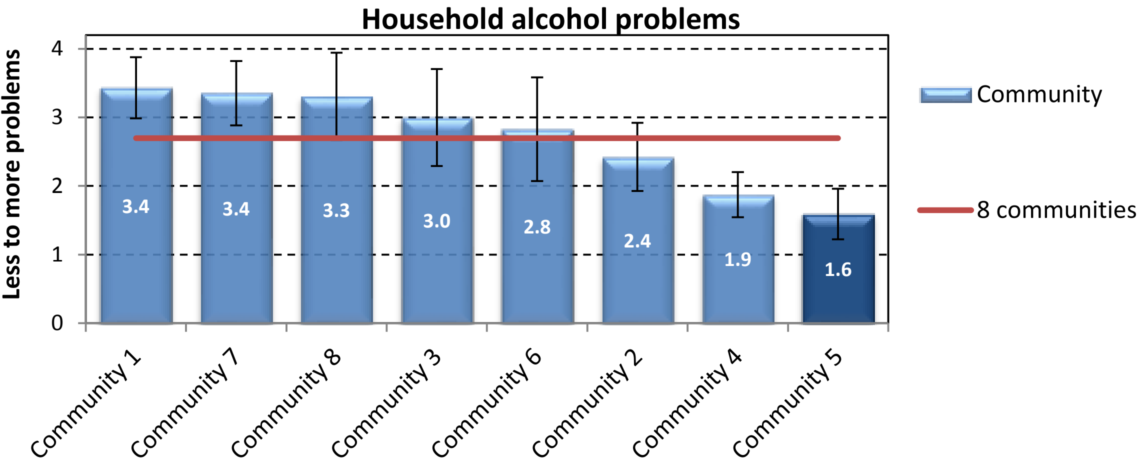
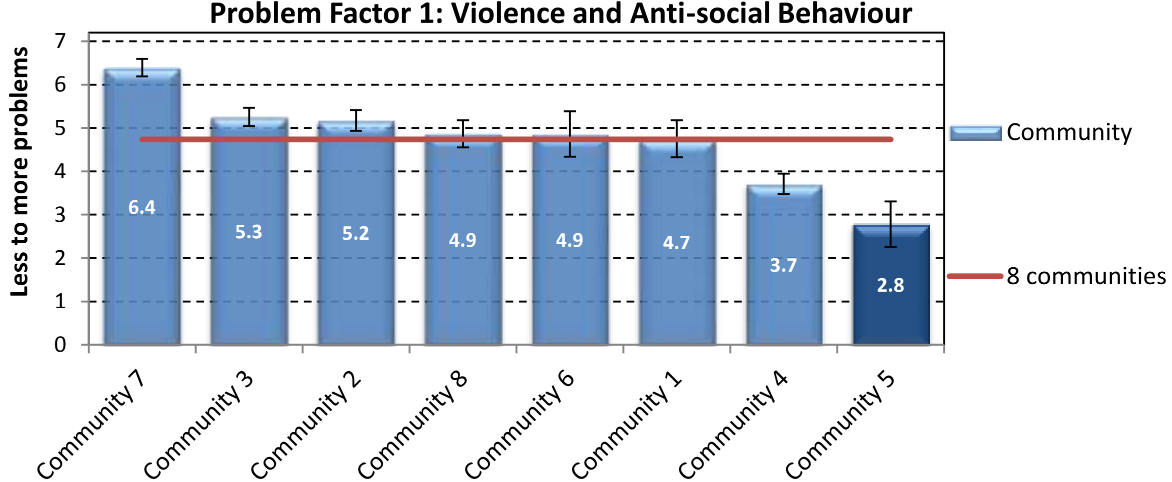


- When asked about household alcohol problems and how often they occur, Community 5 scored the lowest, meaning people in Community 5 said that household alcohol problems occur less often compared with the other communities included in the survey.

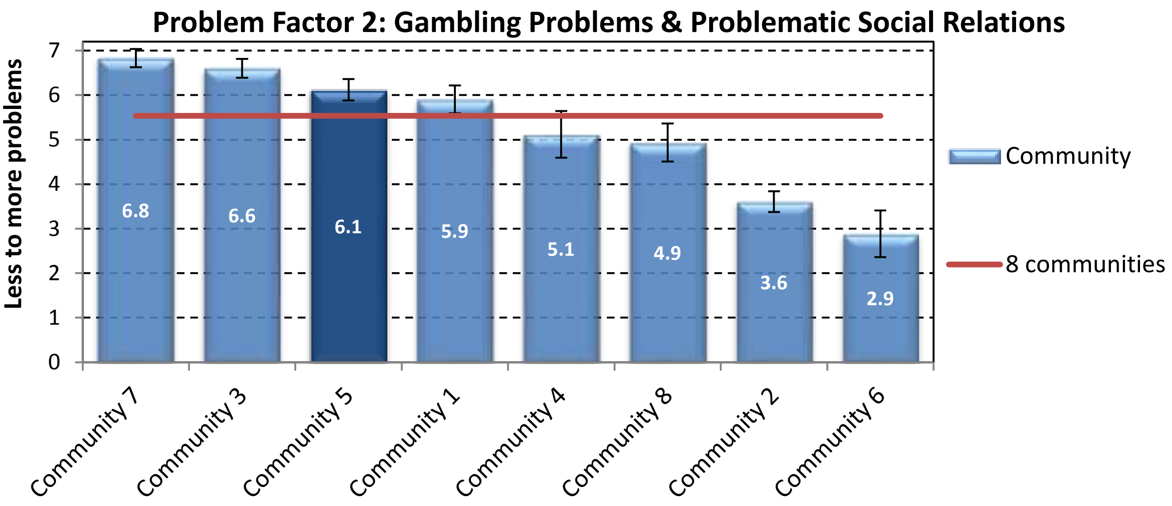


Community problems

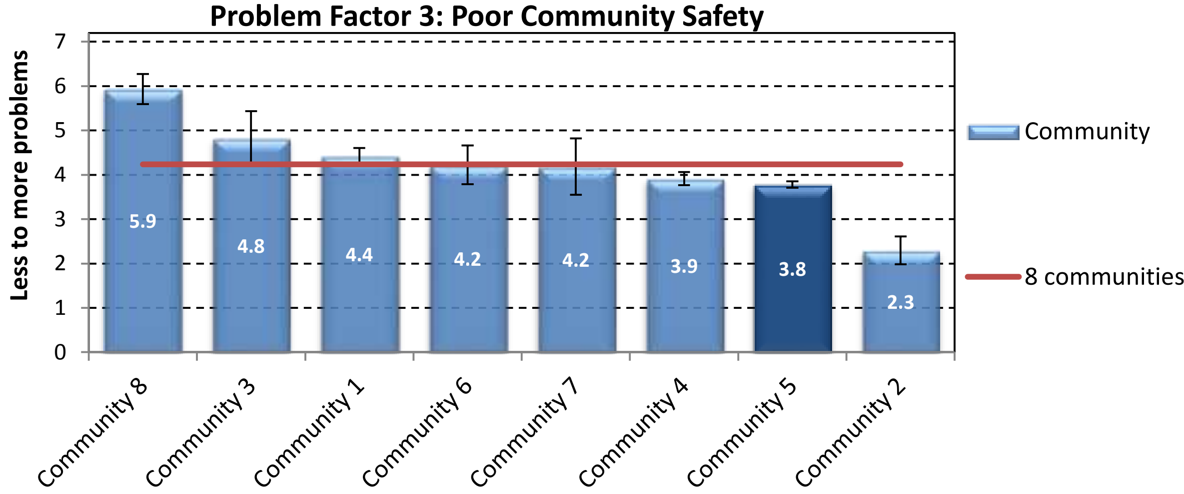
- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
  1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
  2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
  3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.
- Community 5 scored the lowest of the eight communities for *Violence and Anti-Social Behaviour Problems* in the community. That is, people said that violence and anti-social behaviour occur less often in Community 5 compared with other communities surveyed.



- Community 5 scored above the average of the eight communities for *Gambling Problems and Problematic Social Relations* in the community.

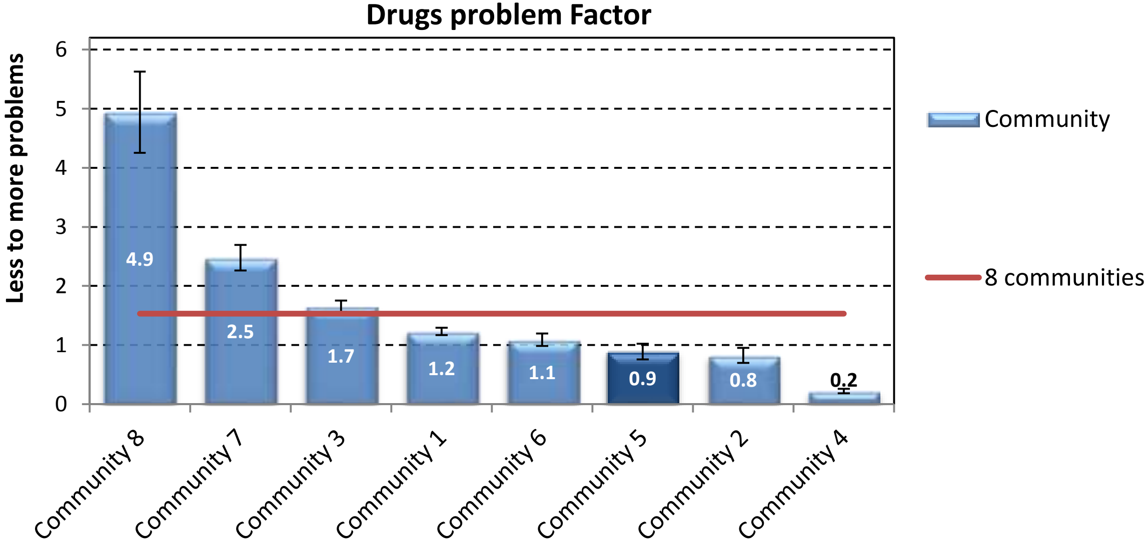


- Community 5 scored below the average of the eight communities for *Poor Community Safety* in the community, and was second lowest out of the eight communities surveyed.



Community drug problems

- Community 5 scored below the average of the eight communities for community drug problems. Some communities had more problems with petrol sniffing and kava.



Key informant interviews

Alcohol was perceived as affecting community safety through anti-social behaviour, fighting, domestic violence, and break-ins. According to one informant domestic violence incidents were under-reported. This was attributed to pressure from within the community to hide such incidents, as perpetrators who are identified are banned from the club. Several informants felt that some children were at increased risk of harm because they were left unsupervised on the streets while parents were drinking in the club or in groups, and also because some parents would return home drunk. One informant noted that break-ins to steal alcohol were occurring more frequently, and at significant distances from the community (up to 60 kms), with children as young as 14 involved. Although one informant commented on how much people enjoyed themselves in the club another noted that anti-social behaviours spiked both during

and after club hours. Two informants commented that problems had escalated over the last year, with one noting that this could be partly explained by the relocation of some families from another community in the region to this community. As these families are used to restrictions on the amount they can drink (six cans of beer), it was considered that they may have found it difficult to adjust to the unlimited amounts of mid- or light-strength beer now available to them during social club hours. Bad weather, distance, and lack of equipment, were identified as factors that sometimes impede the ability of police to achieve good response times and to implement proactive policing practices.

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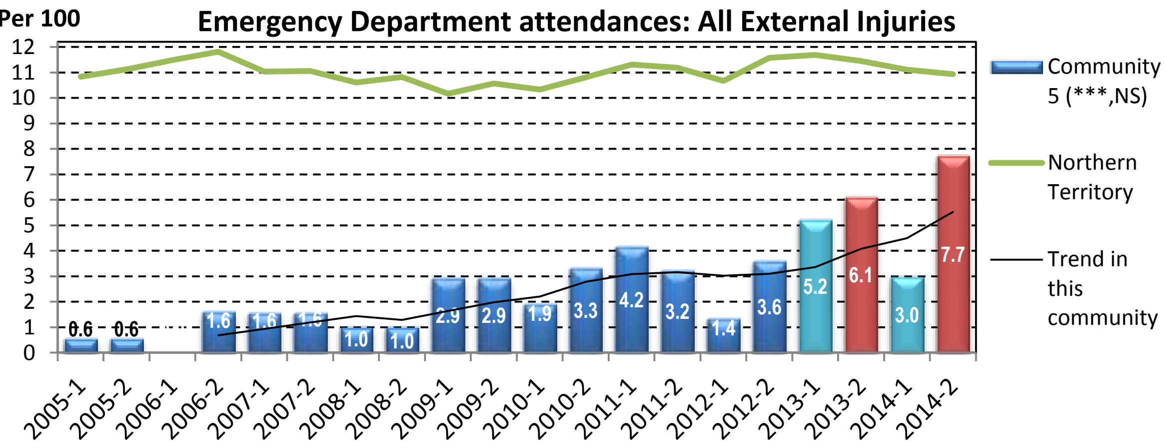
Community health and wellbeing

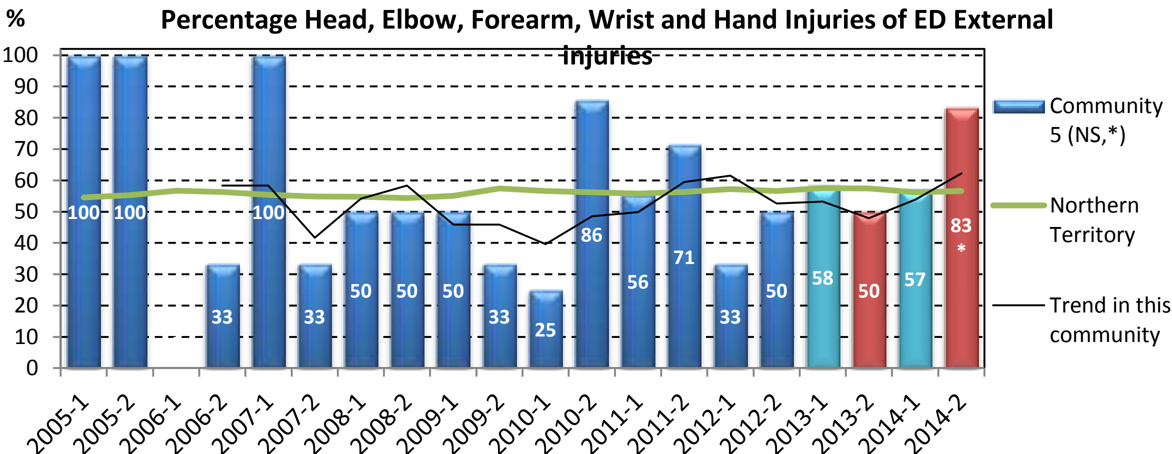
Administrative data

Emergency Department admissions for external injuries (e.g. broken bones, cuts etc)

- There was no significant change in the rate of ED attendances between 2013-1 and 2014-1 or between 2013-2 and 2014-2, but the last 2 year trend is increasing.
- The rate of external injury attendances at ED was significantly lower in Community 5 compared with the NT rate in 2014-1 (11.1 per 100 people), but not 2014-2 (10.9 per 100 people).



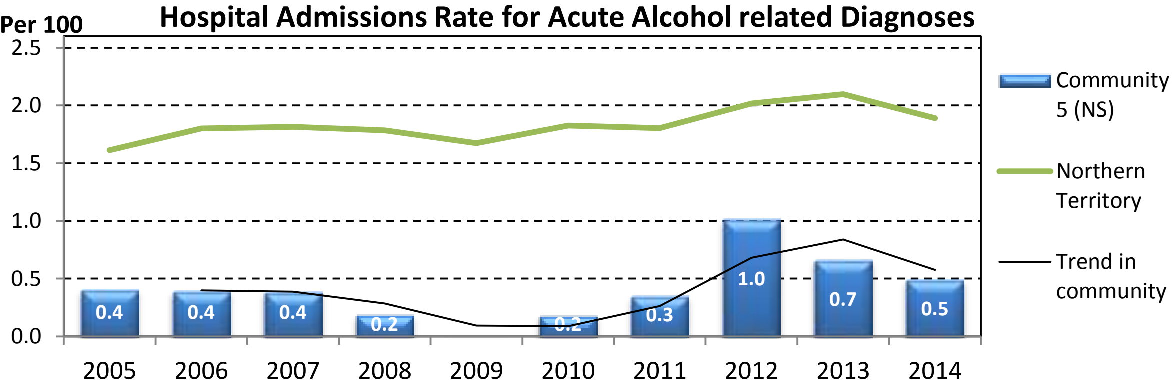
- There was a significant ($p<0.05$) increase between 2013-2 and 2014-2 from 50% to 83% in head, elbow, forearm, wrist and hand injuries as a percentage of all external injury ED attendances.
- Head, elbow, forearm, wrist and hand injuries as a percentage of all external injuries was significantly higher than the NT percentage in 2014-2 (57%) and 2014-1 (56%).



Hospitalisation for alcohol-related conditions

- There were very few hospital admissions from Community 5 for acute alcohol related diagnoses over the last two years.

- Hospital admissions for acute alcohol-related diagnoses were lower in Community 5 than for the NT, but this difference was not statistically significant.

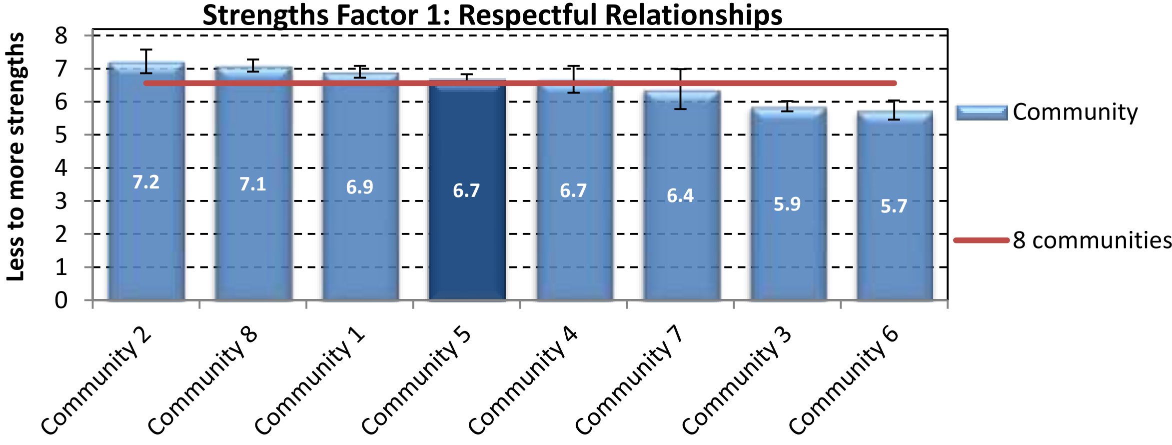


<u>Community survey</u>

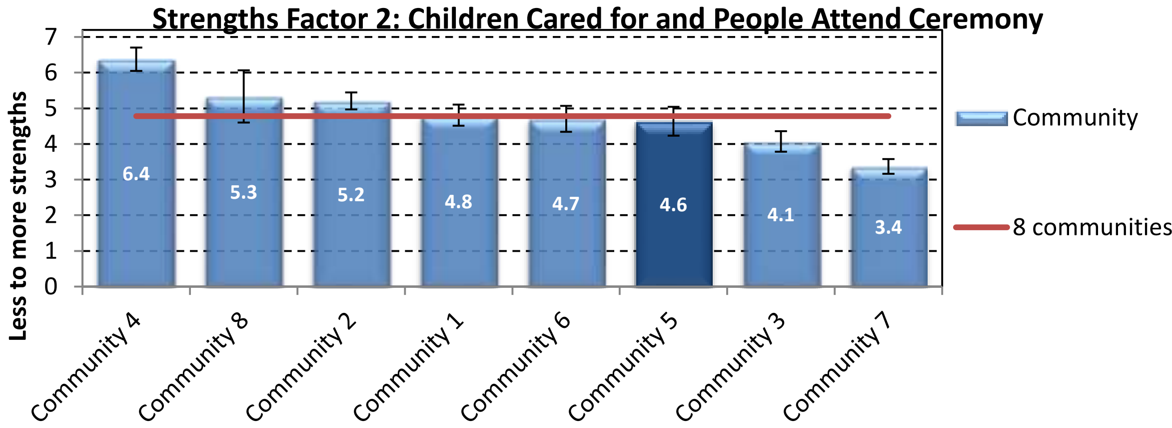
Community strengths

- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:
  1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) people respect Elders, (ii) people respect other community members, and (iii) people help each other.
  2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
  3. Strengths Factor 3: *Health Social Engagement* which includes three community strengths: (i) people go out for bush tucker, (ii) people do organised sports and other activities and (iii) people say no to humbug.

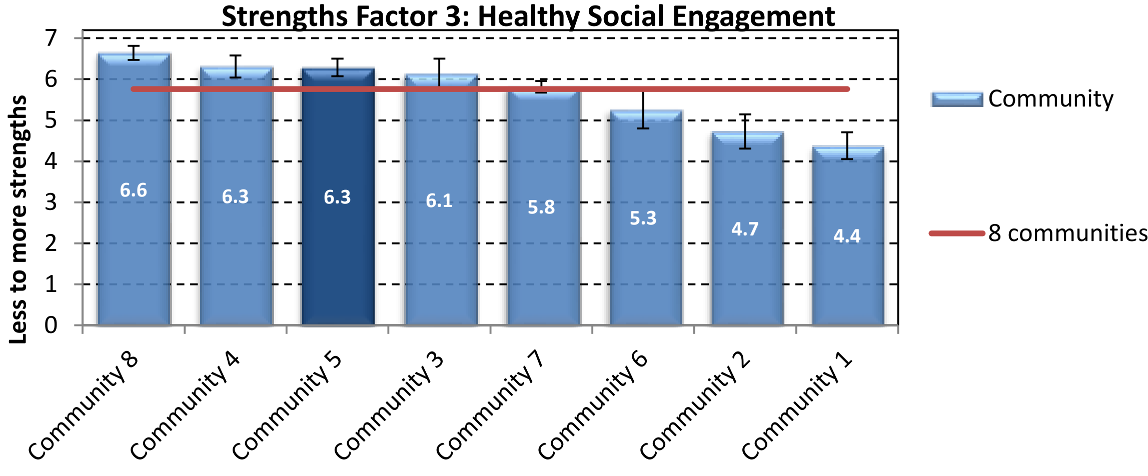
- In *Respectful Relationships* Community 5 scored about the same as the average of the eight communities surveyed.



- Community 5 scored just below the average of the eight communities surveyed for Children cared for and people attend ceremony.



- Community 5 scored above the average of the eight communities for Healthy Social Engagement.



<u>Key informant interviews</u>

One informant commented that there were relatively few alcohol-related clinic presentations, as most problem drinkers go to Darwin. However, community members who returned from Darwin were often very sick. Poor mental health was identified as a problem, with this frequently related to grief issues due to having to deal with premature deaths. Although few informants identified child neglect as a major issue, several commented that children were tired and hungry at school, particularly after social club nights. One informant commented that child neglect was more likely to be linked to cannabis use than to alcohol and another noted that gambling also had an adverse effect on children's care. There has been no formal diagnosis of FASD in Community 5 but one informant thought that around five out of sixty students were likely to have FASD, with this based on facial features, behaviours and family history.

One informant noted that alcohol was perceived by most community members as central to socialising and having a good time. Other factors that informants felt contributed to the demand for alcohol included: a poor sense of self-worth due to poor relationships and a lack of support from family and friends; use of alcohol to medicate for mental health problems; boredom and a lack of employment and recreational opportunities; and parental modelling of excess drinking. A number of strategies for reducing demand were identified, including: more family programs; a rehabilitation service based in Community 5; more alcohol free social activities with an emphasis on family and culture; AOD programmes based in the community and tailored to community needs (currently these are based in larger nearby community); strengthening of skin groups and leadership capacity; a safe house; diversion of profits from the social club into activities for youth and children; and opening up the social club for use during alcohol free events.

Confidential draft

4.7 Community 6 Data Report

Highlights: 2014 to 2015

- ↑↑ large or significant improvement; ↑ small or non-significant <u>improvement</u>; = no change or small change
- ↓↓ large or significant worsening; ↓ small or non-significant <u>worsening</u>; = no change or small change

Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-4 to 4)		**-**	**-50% (-1)**
Wholesale PAC in catchment	NA	-	-
Community average PAC last drink	Above average of 8 communities	↓	-1
Frequency of drinking	More monthly and non-drinkers	-	-
Number types of alcohol drank	More likely to drink only two types of alcohol	=	0
Community Education (-10 to 10)			**0% (0)**
School attendance	Steady over last 2 years & below NT average	=	0
Year 5 reading	Same as similar schools (73% of NT average)	=	0
Year 5 numeracy	Above similar schools (87% of NT average)	↑	1
Year 7 reading	None since 2010 & same as similar schools	=	0
Year 7 numeracy	None since 2010 & below as similar schools	↓	-1
Adult year 12 completion	Lower than average of 8 communities	-	-
Adult other qualifications	Slightly lower than average of 8 communities	-	-
Community Problems & Safety (-14 to 14)			**36% (5)**
Assaults offences	NA	-	-
Alcohol % in assaults	NA	-	-
Domestic violence % in assaults	NA	-	-
Female % in assaults	NA	-	-
Theft, stealing, break & enter	NA	-	-
Change in community alcohol problems	71% said better and 21% the same	↑	1
Community alcohol problems	Just below the average of 8 communities	↑	1
Household alcohol problems	Similar to average of 8 communities	=	0
Violence & Anti-Social behaviour	Similar to average of 8 communities	=	0
Gambling & Problematic Social Relations	Lowest of 8 communities	↑↑	2
Poor Community Safety	Similar to average of 8 communities	=	0
Community Drug problems	Below average of 8 communities	↑	1
Community Strengths, Health & Wellbeing (-12 to 12)			**33% (4)**
Emergency Department attendances	Significant improving trend over last 2 years	↑↑	2
% head, elbow, forearm, wrist & hand	Small improving trend over last 2 years	↑	1
Acute alcohol hospitalisations	Significant improving trend over last 2 years	↑↑	2
Respectful Relationships	Lowest of 8 communities	↓↓	-2
Children Cared for &Attend Ceremony	Similar to average of 8 communities	=	0
Healthy Social Engagement	Below average of 8 communities	↑	1
Total score (-40 to 40)			**20% (8)**

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Key informant interviews: Highlights

This community has strong leadership, with elders who provide clear guidance about acceptable behaviour and who work closely with the local council and police engagement officer to maintain the community's dry status. Although Community 6 includes several cultural groups, informants noted that these have coalesced into a cohesive community in which there is little clan conflict. Most key informants observed that there had been a

substantial decrease in alcohol problems over the last two to three years and attributed this to strong community leadership; stable service provider workforce; the choir; religion; increased awareness of the problems caused by alcohol use; cohesive community; ageing; and more employment, training and activities. Drinking is most prevalent and problematic in the 30-50 year age group. Although some younger people drink, cannabis is more likely to be a problem than alcohol for this group. Several key informants note that mainstream and cultural ways of life are well integrated in this community.

Community context

Community 6 has a population of around 230 and is located in central Australia, about 1 ½ hours' drive from a regional town. It is a significant meeting point for cultural business and for celebrations among people linked to the area. Community 6 is an APA and the closest liquor outlets are located in the nearby regional town. There is a designated drinking area on the boundary of the community. Key services and infrastructure include a clinic, school, local council offices, store, art centre, football oval, community hall, men's centre; child care; knowledge centre; and church. There is no police station in Community 6 and the community is serviced by police based in a community about 1 ½ hours' drive away.

Alcohol consumption patterns

Administrative data

No wholesale alcohol data is applicable to this community. That is, the Community 6 Alcohol Catchment Area could not be mapped to alcohol outlets reliably.

Community Survey

Pure Alcohol Consumption (PAC) in Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

- The average PAC for Community 6 residents last drinking session was 0.29 litres (approximately 23 standard drinks or 16 full strength beers), which was above the average for the eight communities surveyed.

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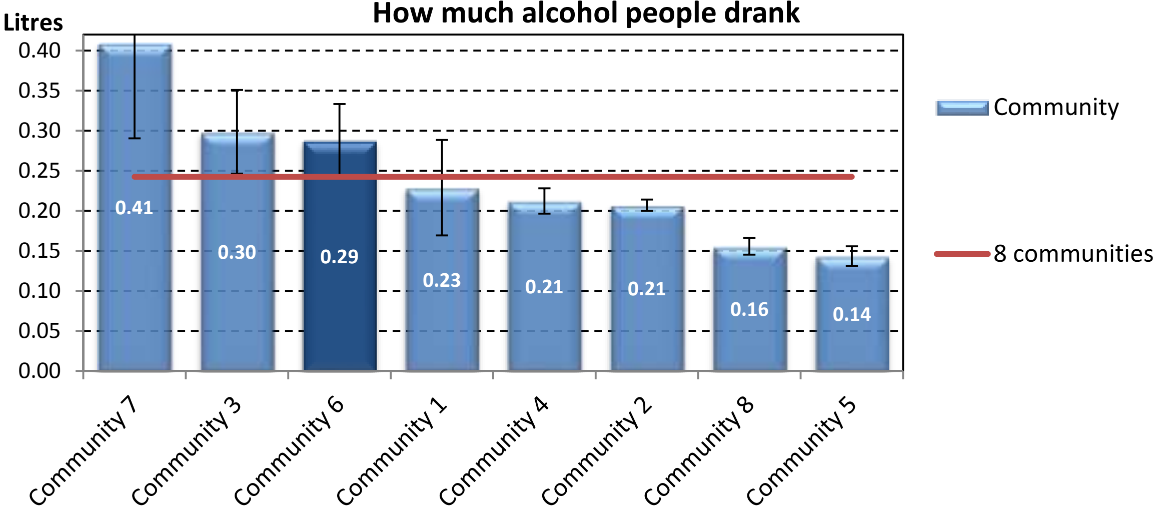
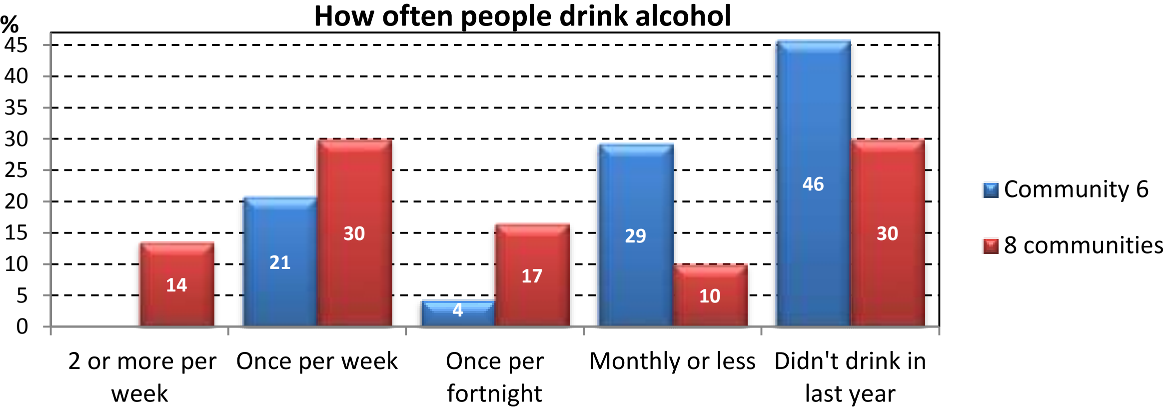


- Nearly half (46%) of the people surveyed in Community 6 did not drink alcohol in the last 12 months, which was higher than the average of all eight communities (30%). Community 6 also had a higher percentage of people drinking monthly or less and fewer drinking weekly.



- The next figure shows where people drank and this varied depending on access to alcohol outlets. In Community 6, 31% of people surveyed drank in another place, usually a regional town, while 23% drank in the local drinking camp.

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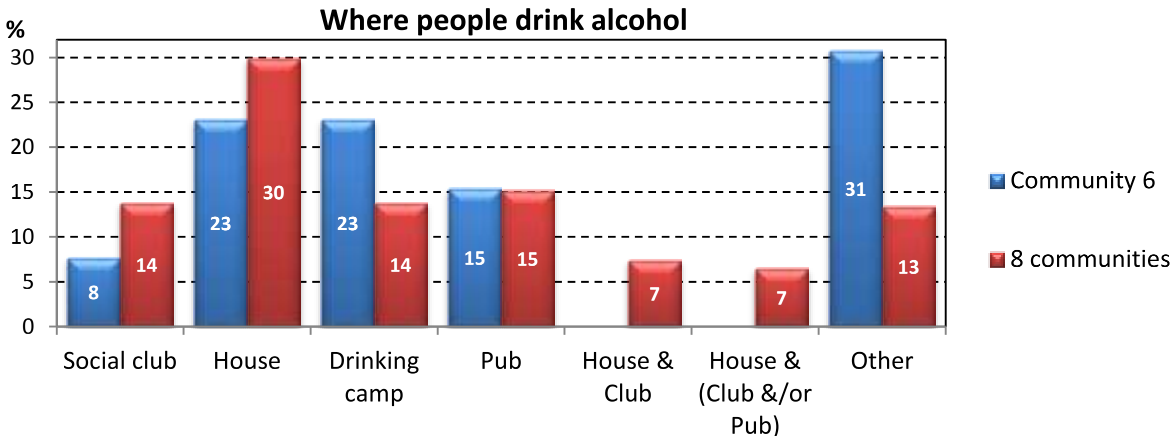
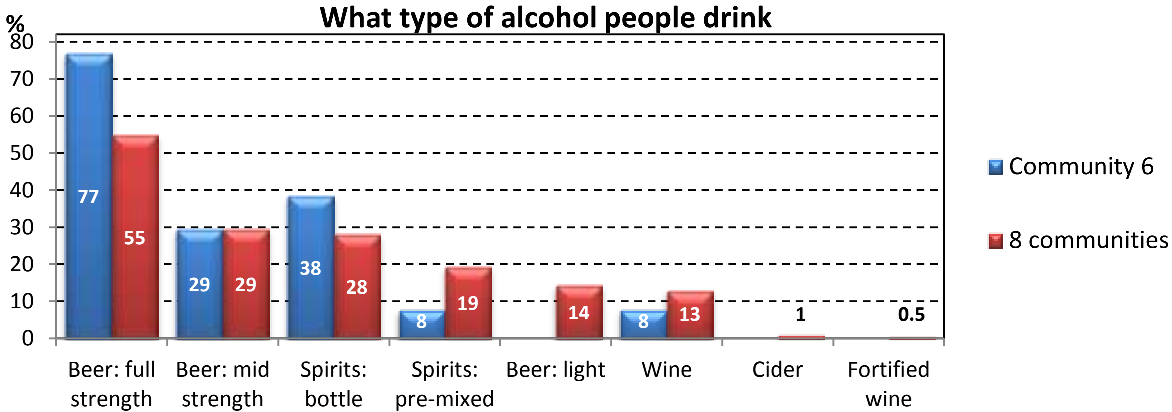
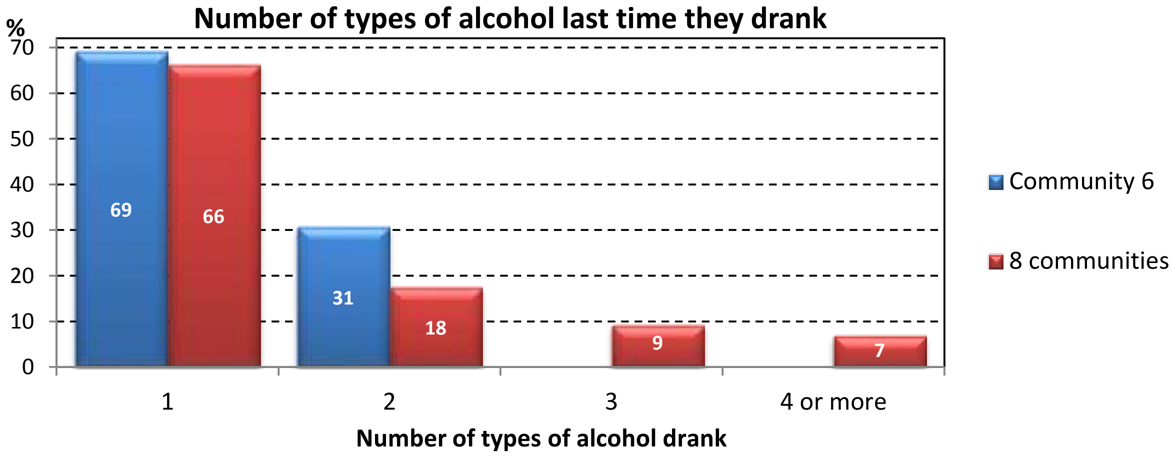


- Full-strength beer was the most commonly drank alcohol type (77%), followed by bottled spirits (38%), with both of these higher than what was observed across all eight communities. Less people drank light beer and pre-mixed spirits in Community 6 than other communities surveyed.



- Most people in Community 6 only drank one type of alcohol last time they drank, which was higher than across all eight communities (66%), and slightly more than the average of all eight communities drink two types of alcohol last time they drank.



Key informant interviews

Key informants did not perceive alcohol to be a major problem in Community 6, as most people were alcohol free most days of the week and the population included a large number of non-drinkers. Binge drinking is more common than social drinking but generally only occurs monthly whereas, in the past, there were up to three incidents a week. Alcohol consumption occurs more frequently in summer, and is more prevalent and problematic in the 30-50 year age group. Most people go to the nearby town to drink and some bring alcohol back to the community, however, the introduction of TBLs in the nearby township has reduced incidents of drunkenness in the community.

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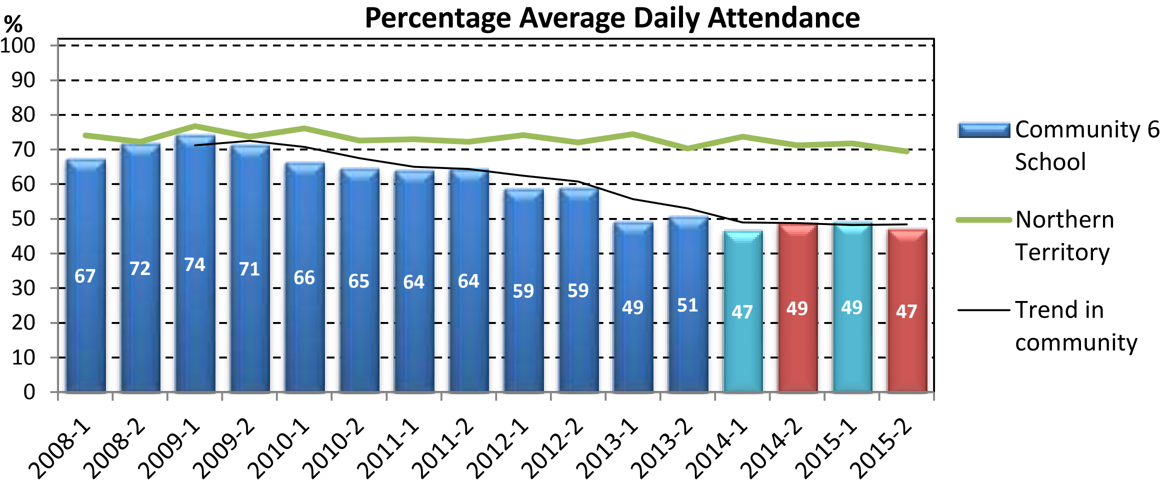
Community education

Administrative data

School attendance and enrolments

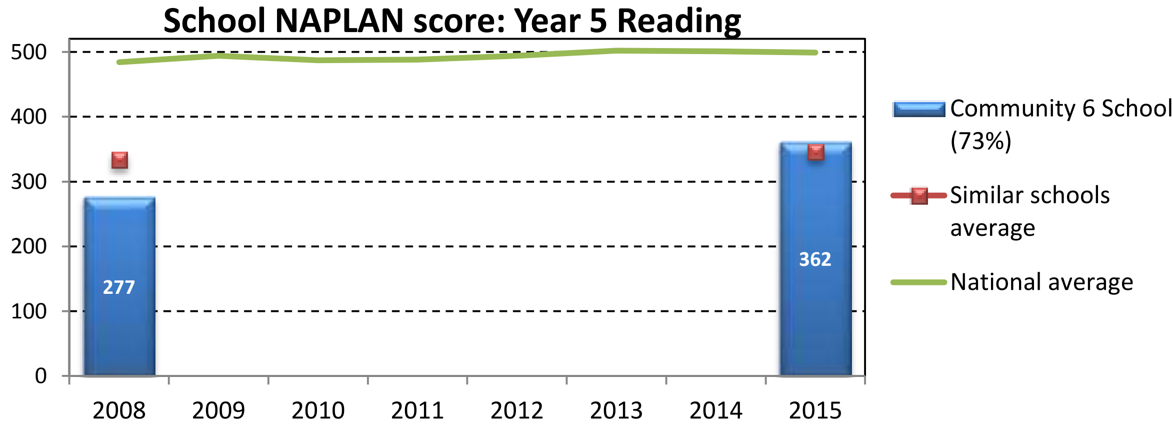
Community 6 School	2008-1	2008-2	2009-1	2009-2	2010-1	2010-2	2011-1	2011-2	2012-1	2012-2	2013-1	2013-2	2014-1	2014-2	2015-1	2015-2
Number enrolled for semester	34	34	42	40	45	36	36	27	23	27	23	24	24	26	32	26

- The last two years has seen attendance vary between 47% and 49%. The NT average attendance from 2014-2015 was 72%.



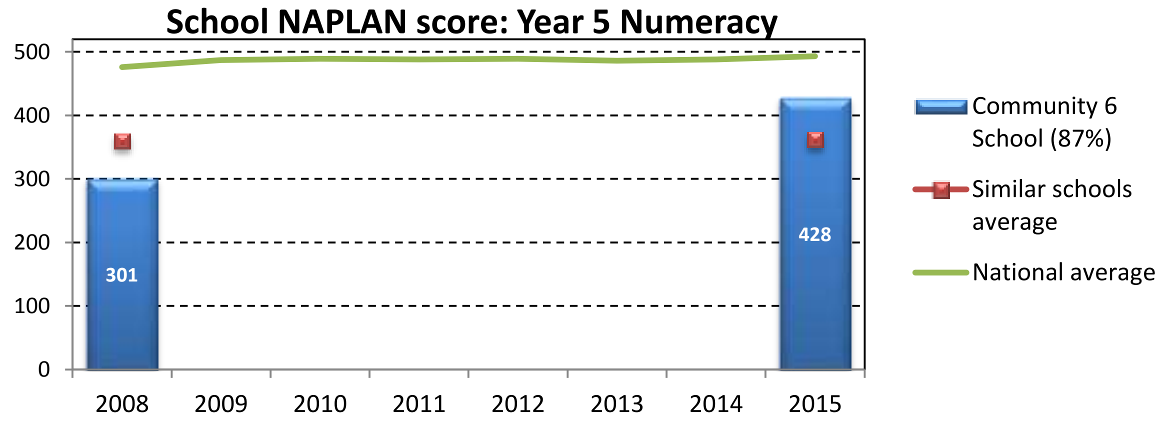
Literacy and numeracy of school students

- The school score for Community 6 Year 5 reading was 362 in 2015, which was about the same as the average of similar schools (red lines and squares).
- The 2015 school score of 362 was 73% of the national average score of 499.

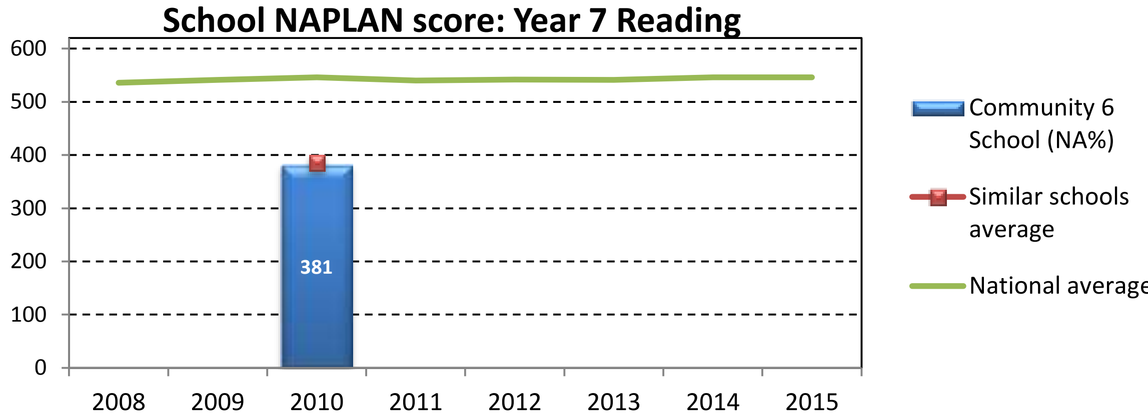


- The school score for Year 5 numeracy 428 in 2015, which was slightly above the average of similar schools (red lines and squares).

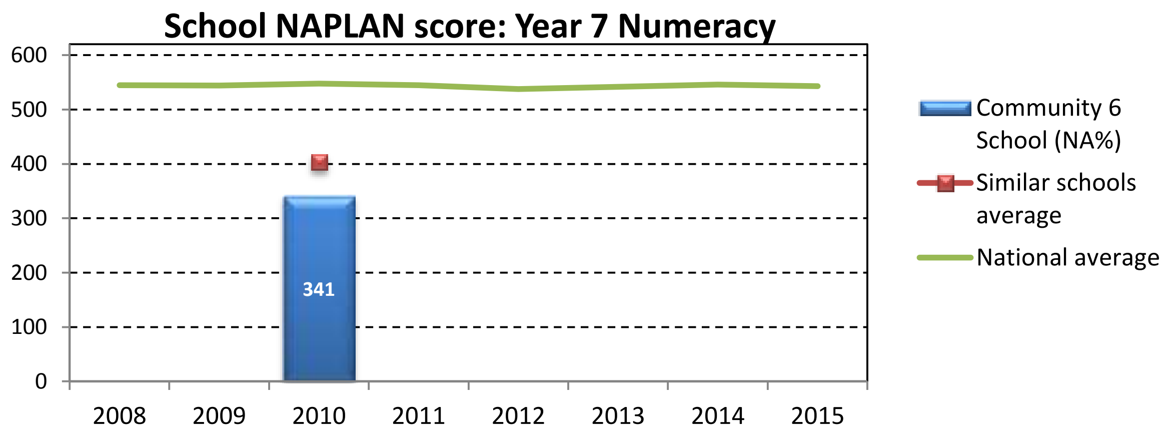
- The 2015 school score of 428 was 87% of the national average (493).



- No school scores since 2010 were available for Year 7 reading.



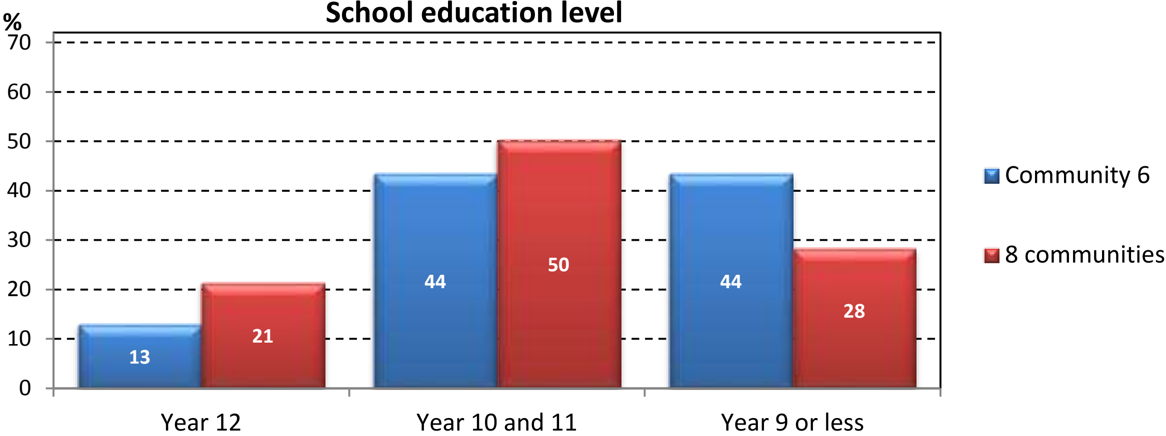
- No school scores since 2010 were available for Year 7 numeracy.



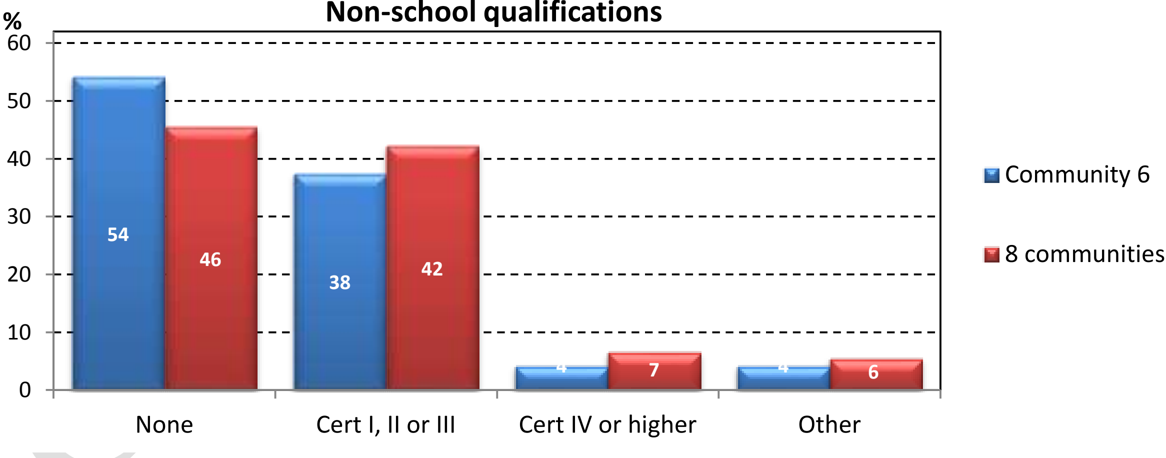
Community Survey

Adult education

- 13% of adults surveyed in Community 6 completed year 12, which was lower to that observed across all eight communities (21%). A lower percentage of adults in Community 6 went to Year 10/11 compared with the average of all eight communities, and a higher percentage had only completed school to Year 9 or less.



- More than half (54%) of adults surveyed in Community 6 did not have any non-school qualifications, which was a little higher to that observed for all eight communities (46%).
- Thirty-eight percent of adults had completed a Certificate I, II or III, compared with 42% across all eight communities.



Key informant interviews

Alcohol has some effect on school attendance but gambling has a much bigger impact than alcohol.

Community safety

Administrative data

Assault offences

No assault data could be presented as no assaults have been recorded to Community 6 since 2012/13 and none in the previous 5 years before that.

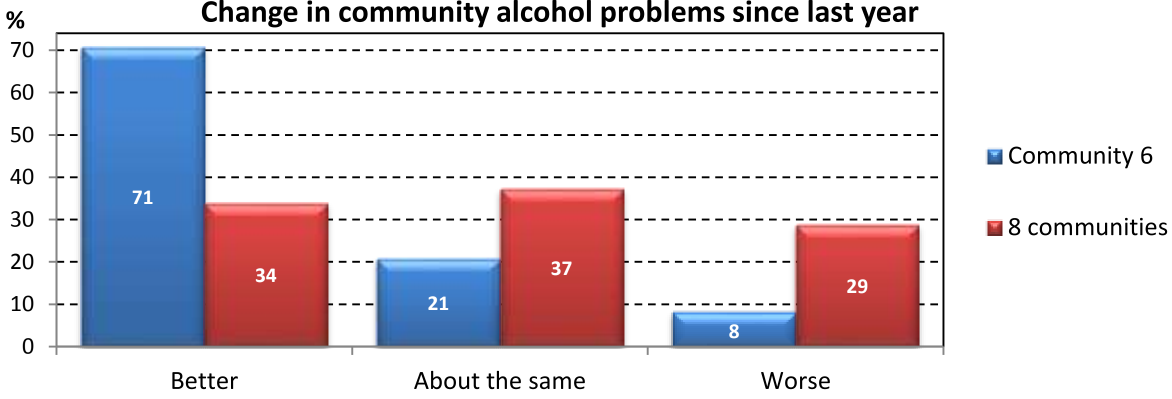
Theft, break and enter and property damage

No theft, break and enter and property damage data could be presented as none have been recorded to this community since 2012/13.

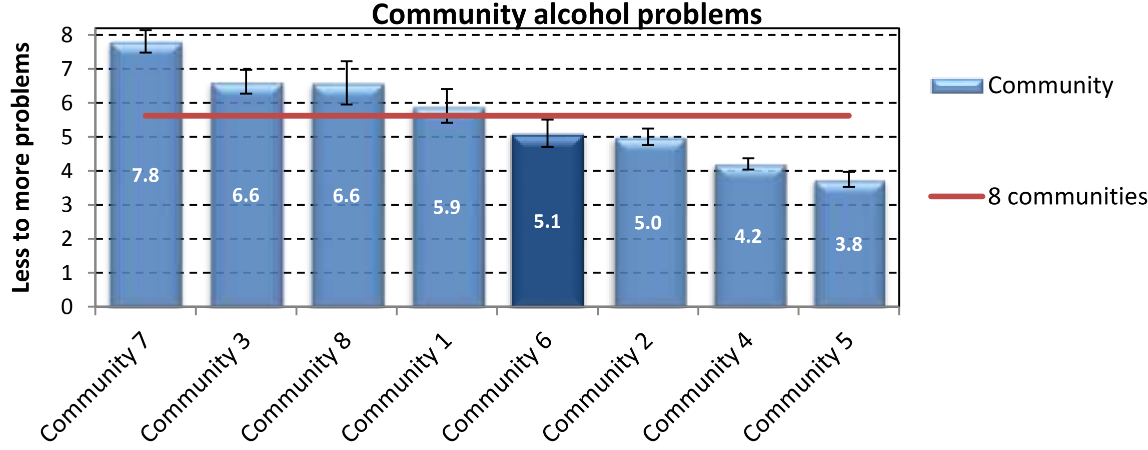
Community survey

Community and household alcohol problems

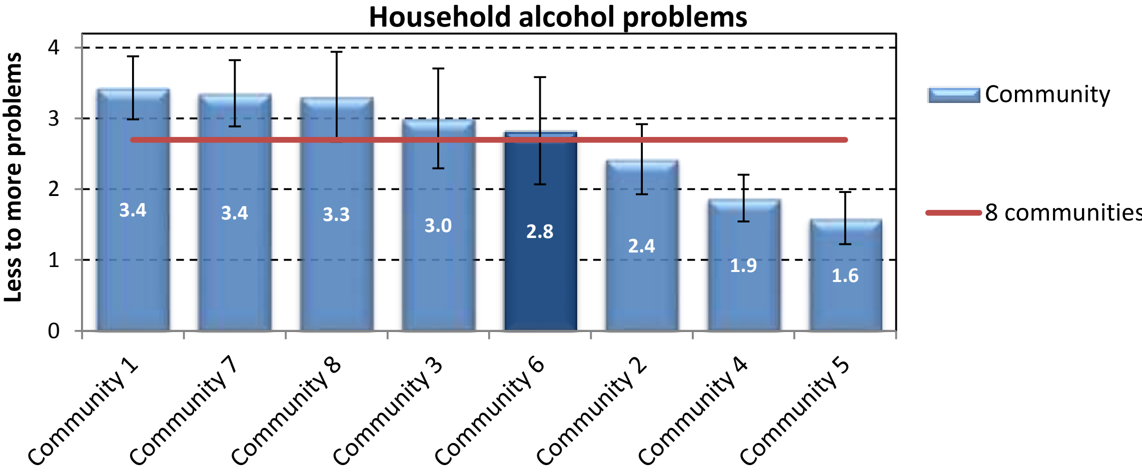
- Most people (71%) surveyed in Community 6 said that community alcohol problems were better compared with the previous year, which was a higher than for all eight communities (34%). Only 8% of people surveyed in Community 6 said alcohol problems had got worse, compared with 29% across all eight communities surveyed.



- When asked about community alcohol problems and how often they occur, Community 6 was below the average compared with the eight communities.

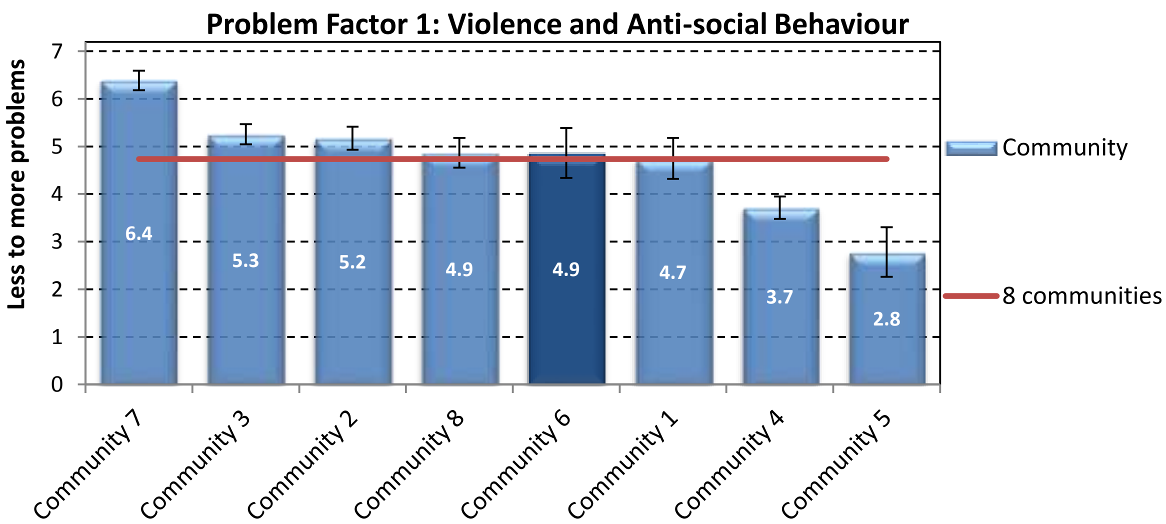


- When asked about household alcohol problems and how often they occur, Community 6 scored the just above the average of the eight communities surveyed.

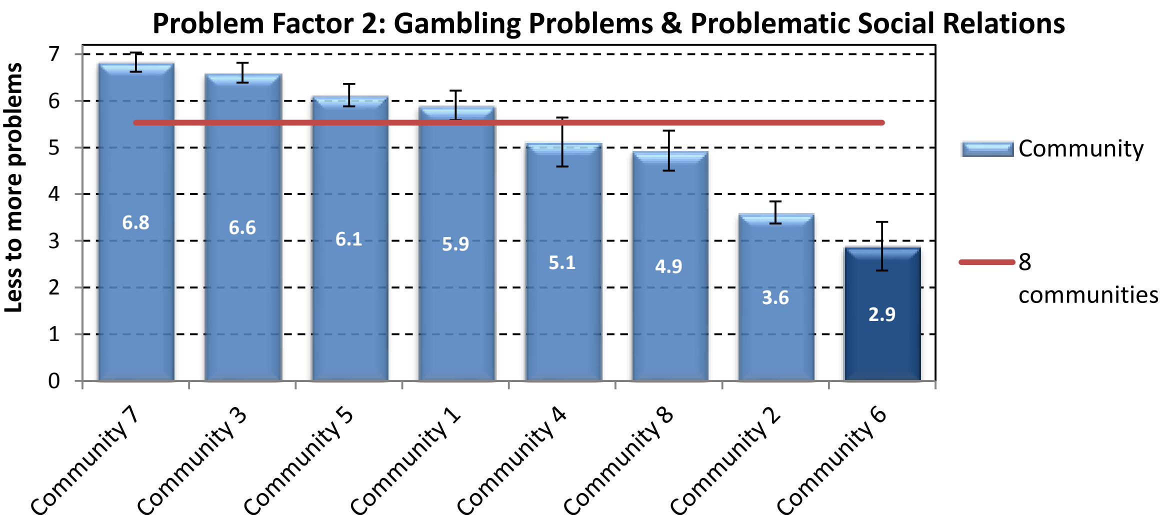


Community problems

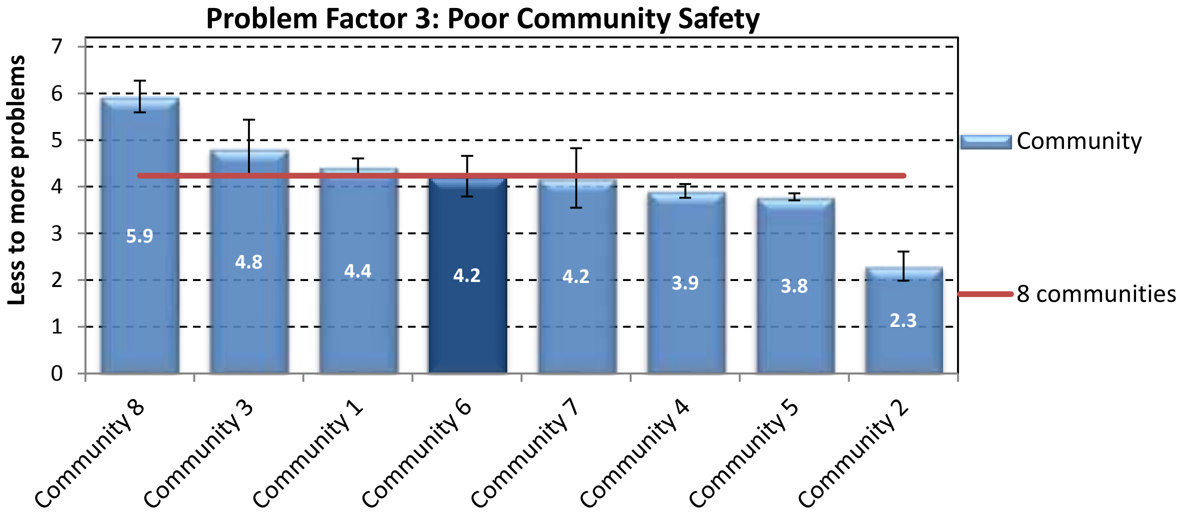
- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
    2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
    3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.
- Community 6 scored about the same as the average of the eight communities for *Violence and Anti-Social Behaviour Problems* in the community.



- Community 6 scored the lowest (best) of the eight communities for *Gambling Problems and Problematic Social Relations* in the community.

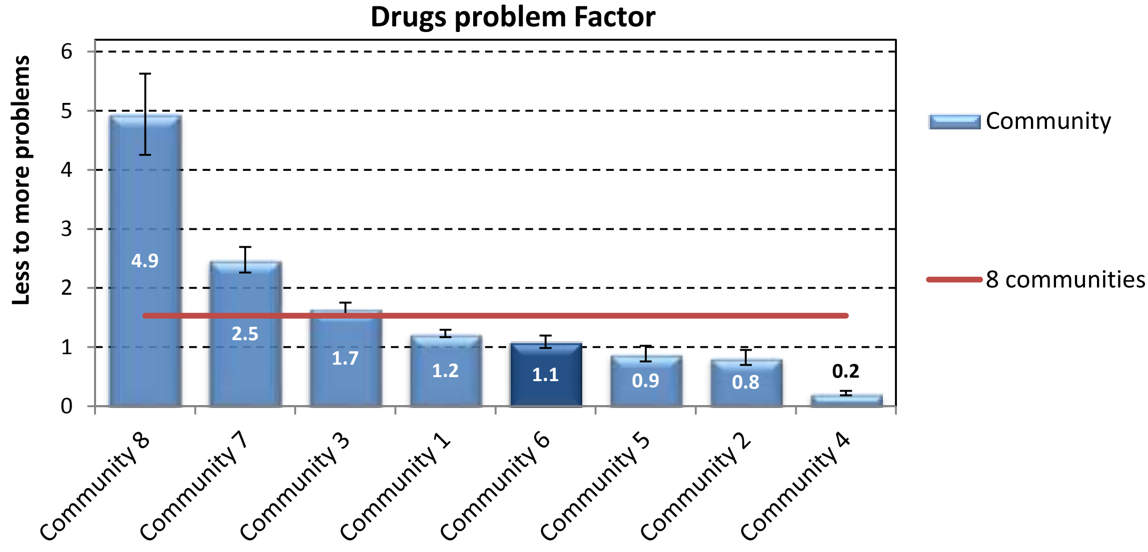


- Community 6 scored the same as the average of the eight communities for *Poor Community Safety* in the community.



Community drug problems

- The Community Survey also asked residents about drug problems (marijuana, sniffing, kava and ecstasy) and how much of the time over the last year they were a problem.
- The nest figure shows Community 6 scored around the middle of all eight communities surveyed in how much of the time drugs were a problem, but this was below the average. Some other communities had more problems with petrol sniffing and kava.



Key informant interviews

There was a general consensus among key informants that Community 6 was not a violent community. This is largely attributed to strong leadership from the Pastor (head of the community), and other Elders, who set clear standards for acceptable behaviour. Physical violence is regarded as unacceptable and individuals are encouraged to talk through problems instead of resorting to violence. Alcohol primarily affects the community by causing arguments and family fights which sometimes go on for weeks, with one informant noting that the disinhibiting effect of alcohol results in *people saying things they wouldn't say when sober*. Police have a good rapport with community members and take the time to build relationships. They receive few call-outs and most of these are related to family violence. Although teenagers spend time on the streets at night, this is not a problem in relation to young children. Alcohol-related problems are most likely to spike when there is something happening at the community and problems are more likely to arise with visitors than with residents.

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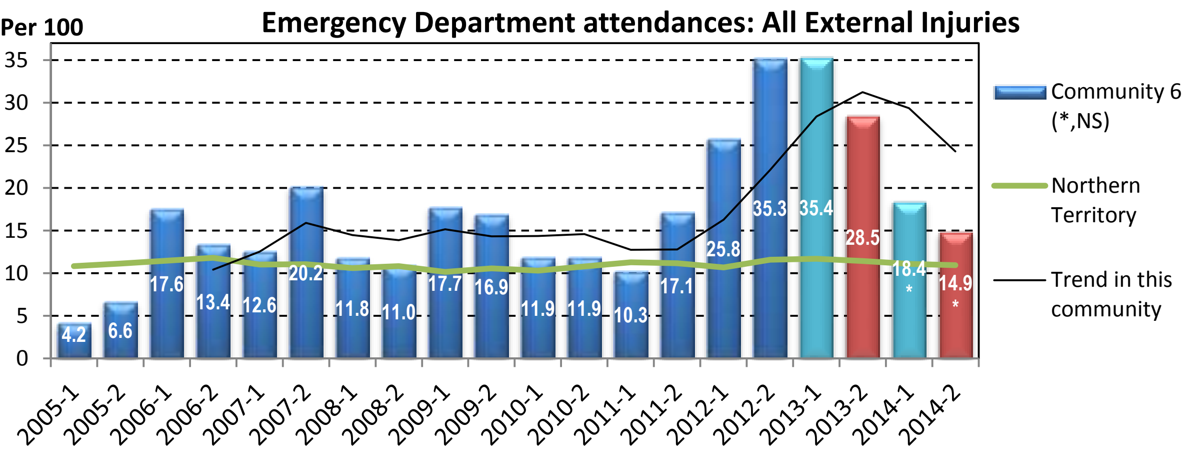
Community health and wellbeing

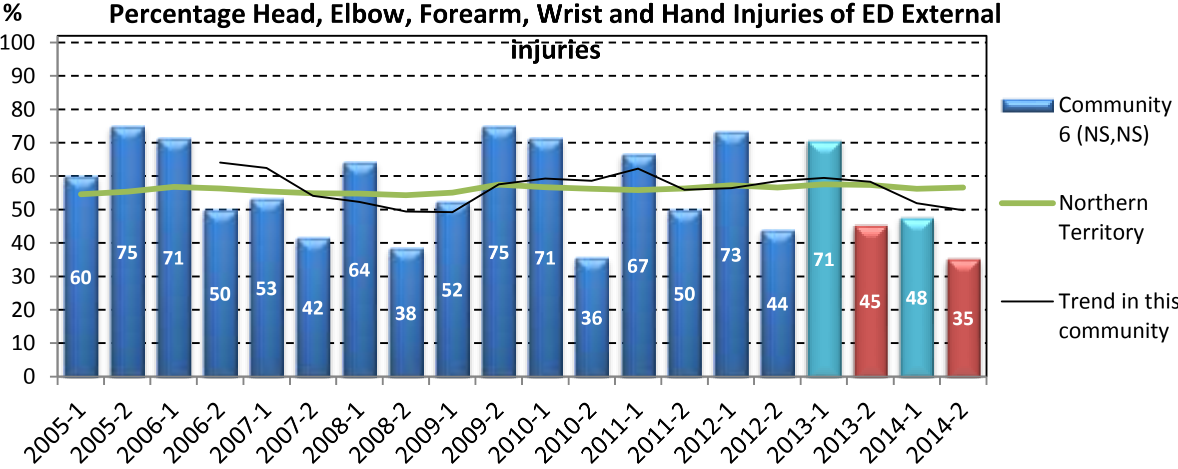
Administrative data

Emergency Department admissions for external injuries

- There were significant declines between 2013-1 (35 per 100 people) to 2014-1 (18 per 100 people), and 2013-2 (29 per 100 people) to 2014-2 (14.9 per 100 people) in the rate of external injury in ED attendances.
- The rate of attendances was 18.4 per 100 people in 2014-1 and this was significantly higher than the NT rate of 11.1 per 100 people.

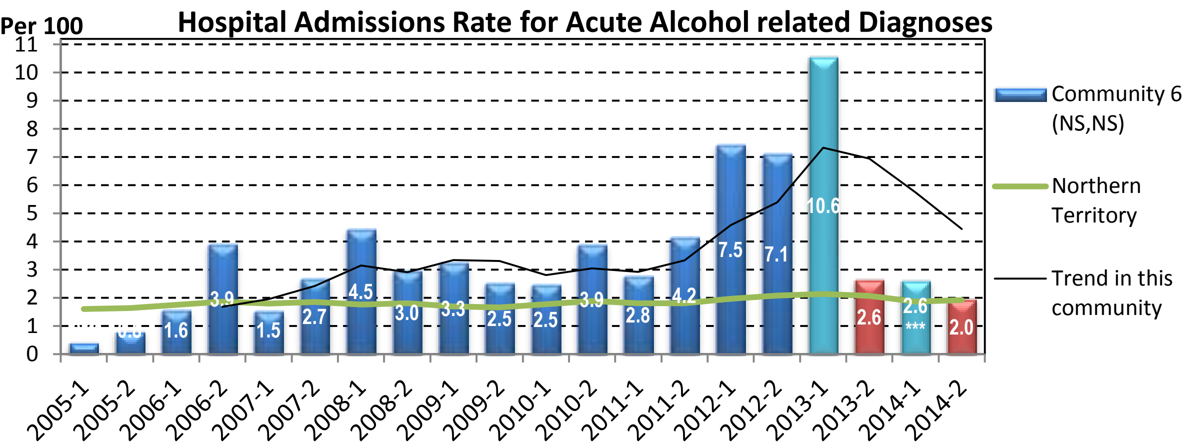


- There were non-significant declines in the percentage of external injuries in ED attendances from 2013-1 to 2014-1, and from 2013-2 to 2014-2.



Hospitalisation for alcohol-related conditions

- There was a peak in hospital admissions for acute alcohol-related conditions in 2013-1 of 10.6 per 100 people before this significantly declined to 2.6 per 100 people in 2014-1.
- The rate since 2013-2 has been similar to the NT rate.

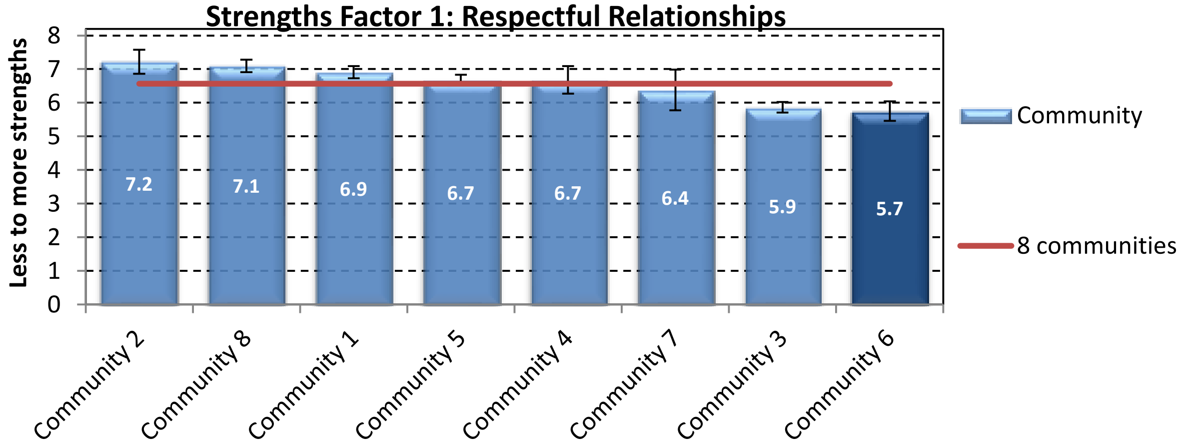


Community survey

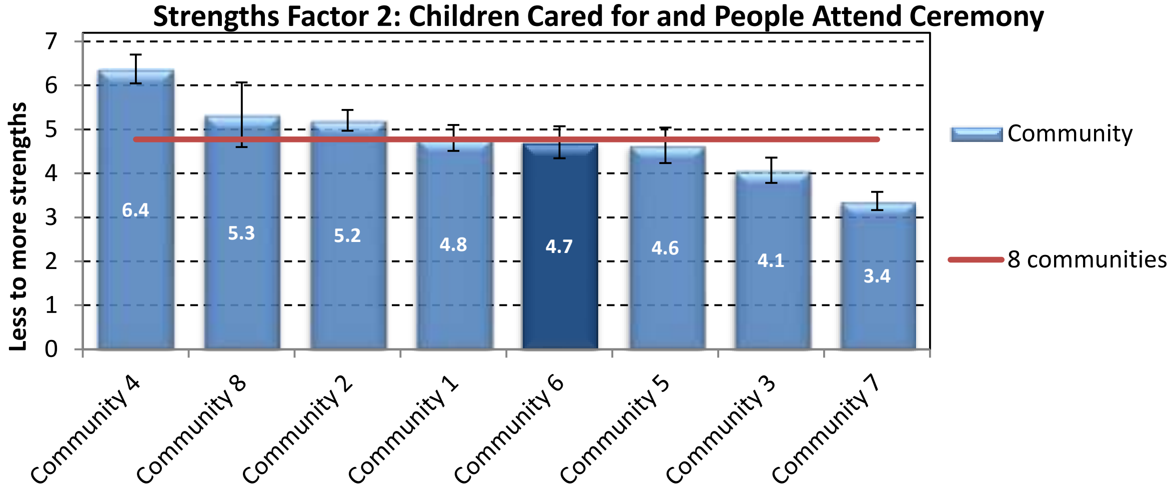
Community strengths

- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:
  1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) People respect Elders, (ii) People respect other community members, and (iii) People help each other.
  2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
  3. Strengths Factor 3: *Health Social Engagement* which includes three community strengths: (i) People go out for bush tucker, (ii) People do organised sports and other activities and (iii) People say no to humbug.

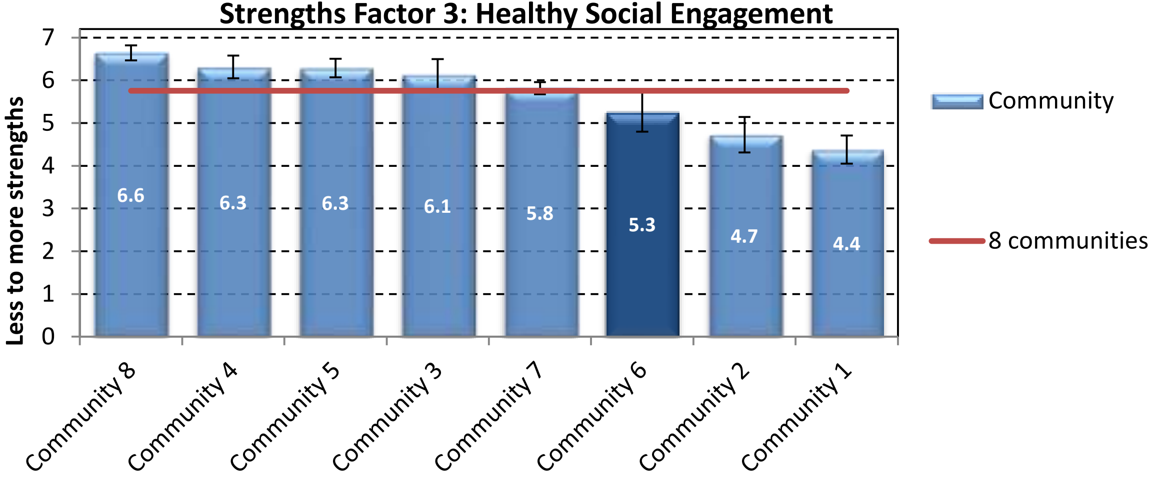
- In Respectful Relationships Community 6 scored the lowest of the eight communities surveyed.



- Community 6 scored on the average of the eight communities surveyed for Children cared for and people attend ceremony.



- Community 6 scored below the average of the eight communities for Healthy Social Engagement.



<u>Key informant interviews</u>

Alcohol has some impact on the community's health and wellbeing, with informants suggesting that this is mainly evident through alcohol-related chronic conditions in older people, people failing to turn up to work because they have been drinking, and through relationship problems. Informants identified a number of demand factors that contribute to alcohol consumption, including: peer pressure and socialising (*you drink with family - if you don't drink with others they think you think you're too good for them*); self-medication; boredom; unemployment; lack of purposeful activity, particularly for men; jealousy; addiction, particularly for older drinkers; and modelling of parental behaviour. One informant noted that while boredom and unemployment could be a contributing factor in alcohol misuse, these problems were more likely to result in cannabis use.

Key informants emphasised the importance of creating an environment where individuals could experience a sense of purpose and could make a contribution to their community. This would require the creation of real jobs (not just picking up rubbish or participating in training programs) and the provision of opportunities for purposeful activities and enterprises. Informants felt that demand and harm reduction strategies, such as education, interventions and rehabilitation, should use a family based approach rather than one focused only on the individual. One informant commented that education programs could be enhanced by involving Elders as they have greater credibility with the community than external authorities. In relation to rehabilitation it was noted that: more beds were needed; rehabilitation centres should be able to accommodate families; and more support needed to be provided to individuals after they have completed a rehabilitation program. Post-rehabilitation support should include assisting the individual to gain skills that would enable them to do something meaningful with their time once they returned to the community. Overall, informant comments suggest that there is a need to foster basic life skills such as literacy, work ethic, and a sense of responsibility, with this enabling people to become more engaged with their life and with the community more broadly. One informant commented on the beneficial effects of the recent work undertaken by the army in Community 6, with this including the building of much needed infrastructure, the provision of extra services (on-site dentist), and opportunities to participate in structured activities such as sporting and music events. Coordination of events by an army liaison officer, and the employment of a capacity building and community engagement approach, has had a positive effect on the community because people see *... all these good things happening in their community*.

Confidential draft

4.8 Community 7 Data Report

Highlights: 2014 to 2015

- ↑↑ large or significant improvement in data; ↑ small or non-significant improvement in data; = no change or small change in data
- ↓↓ large or significant worsening in data; ↓ small or non-significant worsening in data; = no change or small change in data

Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-4 to 4)			**-50% (-4)**
Wholesale PAC in catchment	Not available	-	-
Community average PAC	Highest of eight communities	↓↓	-2
Frequency of drinking	About the same as average of 8 communities	-	-
Number types of alcohol drank	More likely to drink 4 or more alcohol types	↓↓	-2
Community Education (-10 to 10)			**-25% (-1)**
School attendance	Mostly steady over last 2 years	=	0
Year 5 reading	Improvement & same as similar schools	↑	1
Year 5 numeracy	Small improvement & less than similar schools	=	0
Year 7 reading	Small worsening & less than similar schools	↓	-1
Year 7 numeracy	No change & less than similar schools	↓	-1
Adult year 12 completion	Similar to average of 8 communities	-	-
Adult other qualifications	More likely to have no further qualification	-	-
Community Problems & Safety (-24 to 24)			**-33% (-8)**
Assaults offences	Significant improving trend over last 1 year	↑	1
Alcohol % in assaults	No substantial change over last 2 years	=	0
Family violence % in assaults	Significant improving trend over last 1 year	↑	1
Female % in assaults	Significant improving trend over last 1 year	↑	1
Theft, stealing, break & enter	Significant improving trend over last 1 year	↑	1
Change in community alcohol problems	80% said things are worse	↓↓	-2
Community alcohol problems	Highest of 8 communities surveyed	↓↓	-2
Household alcohol problems	Second highest of 8 communities surveyed	↓↓	-2
Community Drug problems	Second highest of 8 communities surveyed	↓↓	-2
Violence & Anti-Social behaviour	Highest of 8 communities surveyed	↓↓	-2
Gambling & Problematic Social Relations	Highest of 8 communities surveyed	↓↓	-2
Poor Community Safety	About the same as average of 8 communities	=	0
Community Strengths, Health & Wellbeing (-12 to 12)			**-17% (-2)**
Emergency Department admissions	No substantial change over last 2 years	=	0
% head, elbow, forearm, wrist & hand	No substantial change over last 2 years	=	0
Acute alcohol hospitalisations	No substantial change over last 2 years	=	0
Respectful relationships	Just below the average of 8 communities	=	0
Attend Ceremony & Children Cared for	Lowest of 8 communities surveyed	↓↓	-2
Healthy Social Engagement	About the same as average of 8 communities	=	0
Total change in score			**-31%**

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Key informant interviews: Highlights

Alcohol is considered a major problem in this community, with around 70-80% of residents drinking to excess. This contributes to a range of problems in relation to community safety, health and wellbeing, and school attendance. There are particular concerns about children's wellbeing, and about the current generation of young people, who have few links with traditional culture and few of the skills needed to function effectively in the modern world. Fighting and disagreements are common and often extend over considerable periods of time. Although these problems have multiple causes, such as conflict between families from different cultural groups, and poor communication skills, they are often fuelled by alcohol

misuse, which neutralises cultural controls on behaviour. Some key informants commented that social pressures arising from the ... *intertwinement of families and culture*, i.e. the presence of hierarchies and cultural group politics, make it difficult for the community to work together on solving alcohol problems. The call made by some key informants for a greater police presence is likely to be related to these social pressures, as police offer a more neutral source of authority.

Community context

This community has an Indigenous population of around 600 people, is located in the northern half of the NT near both a river and a main highway and is around 120 km from the nearest regional town. Key services include a social club, store, art gallery/centre, health centre, women's centre, safe house and school. The nearest police station is located 40 kms away. Community 7 is a designated APA but has a social club and a permit system. The social club is open from 4-7 pm four days a week, with purchases limited to 6 cans of mid-strength beer for males and 4 for females but these are extended to 12 cans on Saturdays for both males and females. The permit system is largely limited to non-Indigenous service providers and only includes around 20 people. There are a number of liquor outlets within the alcohol catchment area, with these situated in a regional town located 120 km away and in three small towns located: 40 km distant; 260 km distant; and 201 km north-west of the community. None of these outlets have special restrictions limiting the purchases that can be made by residents of Community 7.

Alcohol consumption patterns

Administrative data

Community 7 Alcohol Catchment Area is difficult to define because of the range of potential outlets where alcohol could be purchased and consumed (e.g. outlets in a nearby regional town, social club in community, and other highway options). So, no wholesale alcohol data is presented for your community.

Community survey

Pure Alcohol Consumption (PAC) in Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

- The average PAC for Community 7 residents last drinking session was 0.41 litres (approximately 32 standard drinks or 23 full strength beers), which was above the average for the eight communities surveyed and the highest.

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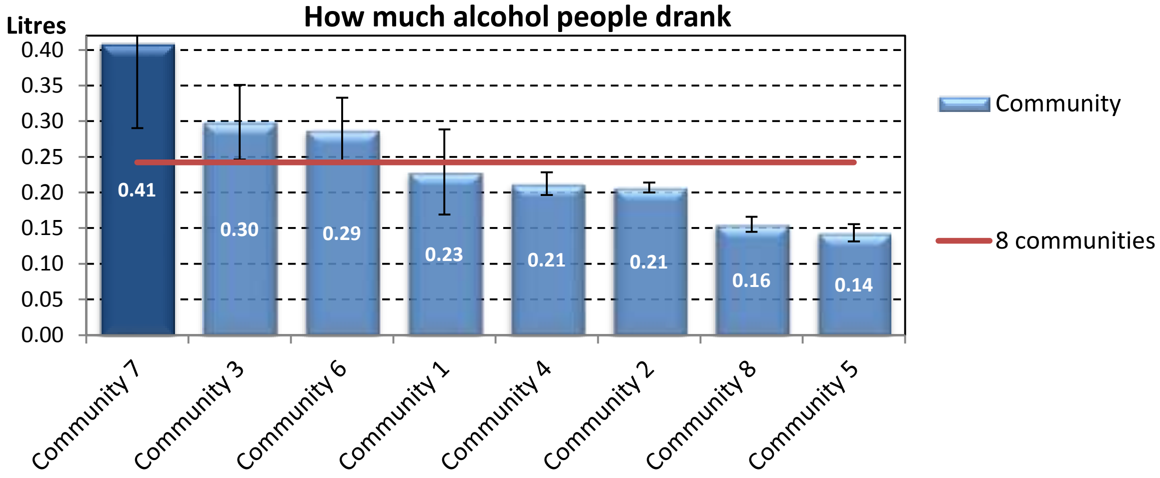
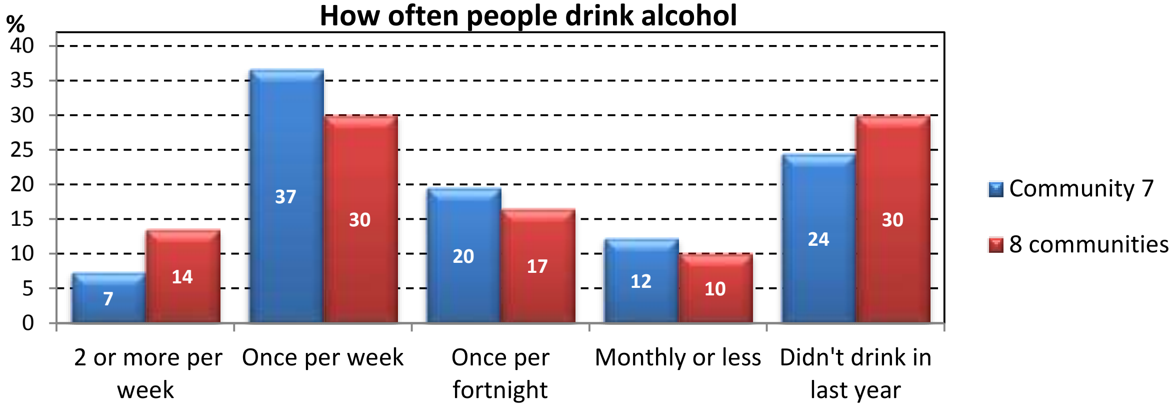
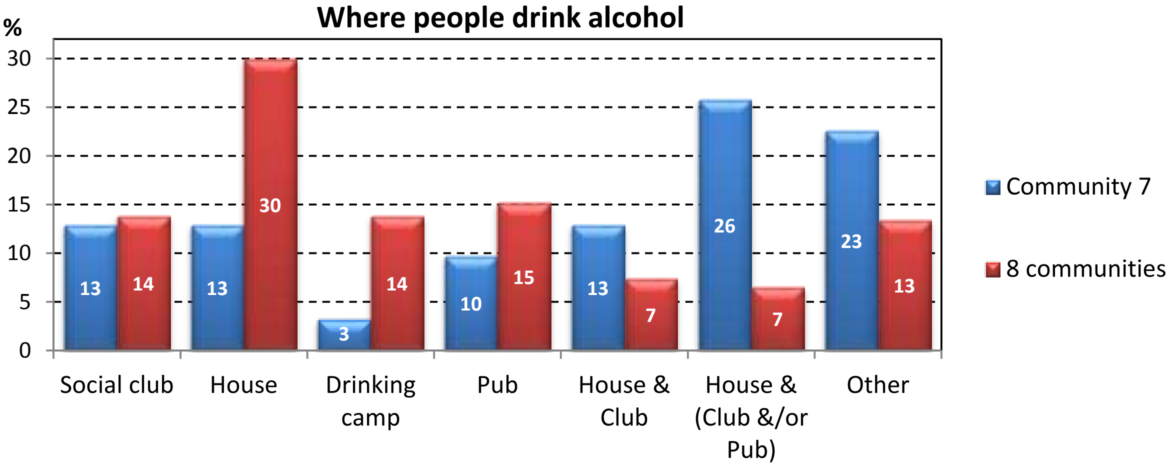


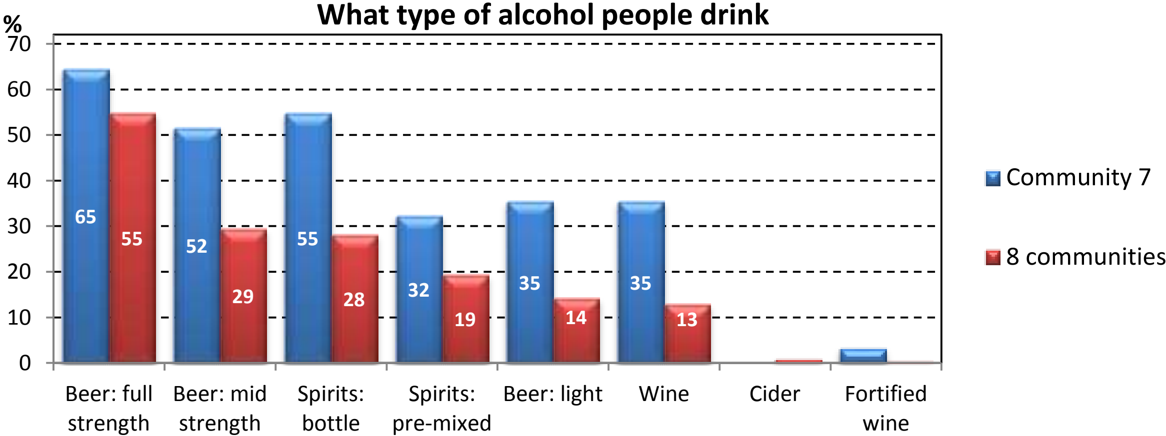
- Most people (37%) from Community 7 surveyed drink alcohol once per week, followed by once per fortnight (20%), which was similar to the average of all eight communities.



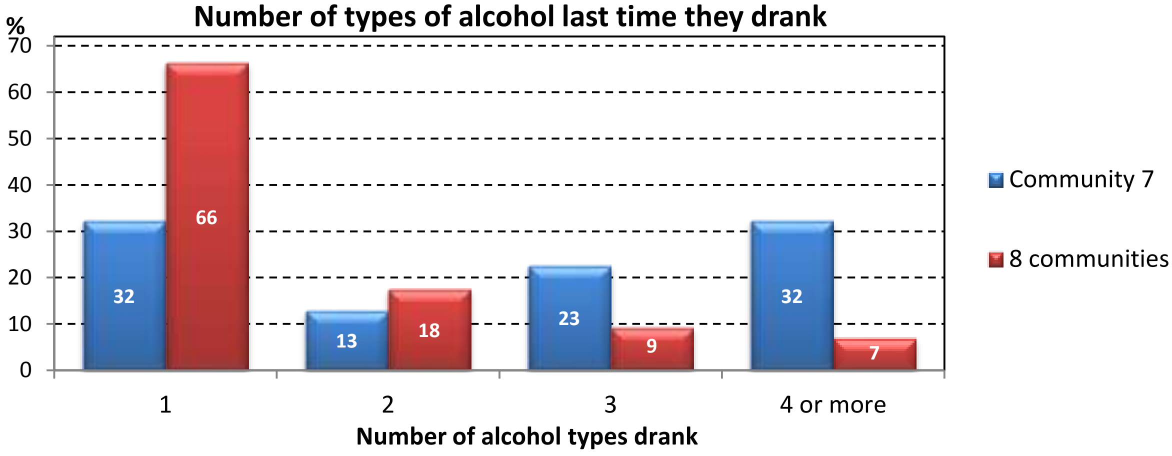
- Most people from Community 7 surveyed drank in multiple places last time they drank alcohol, with the most common being house and club and/or pub (26%), followed by other, which was usually a regional town (23%).



- Full-strength beer was the most commonly drank alcohol (65%), followed by bottled spirits (55%) and mid-strength beer (52%).



- People from Community 7 were more likely (32%) to drink four or more different types of alcohol last time they drank, compared with the average of all eight communities (7%).



Key informant interviews

The regional town near this community is a popular drinking location and is serviced by TBLs. There is also an informal drinking area near the highway at the boundary of the APA which is used by several communities. It is not considered safe, due to its proximity to the highway and its distance from the community. In addition, there are disagreements between the families who use this area.

Although this community is an APA, people still drink illegally in their homes and, according to one key informant, around 70-80% of the community drink to excess. Although this pattern appears to be spread across age groups and gender, excess consumption tends to fall away in the 50+ age group. The heaviest drinkers are mainly in their 30s and 40s while younger drinkers tend to consume more spirits. There is peer pressure to drink and drinking is normative within the community. It is more common for both younger and more serious

drinkers to consume alcohol away from the community. Alcohol is considered to be readily available through both the community social club and outlets in the local area, with one informant noting that the … *closer you get to where an alcohol outlet is the more you have a problem*. Sly grog running and bringing alcohol into the community from nearby outlets is regarded as the main source of alcohol-related problems, as there are limits on the amount of alcohol that can be consumed in the social club. The social club is highly regarded due to its ... *good drinking culture* and its ability to provide a controlled drinking environment, with this being attributed to strong management that enforces the rules. However, as one key informant noted: … *a bad manager can turn things bad fairly quickly.* TBLs have been introduced into the nearby regional town and are considered to have had a positive effect within the town and also reduced drink-driving offences and problems in the community. TBLs were seen to work because they introduced *...lots of hurdles people have to jump before they can buy their grog*. However, one informant noted that TBLs simply displaced the problem, with people being more likely to drive and drink as they go further afield to buy alcohol. In addition, those who are no longer able to access take-away alcohol tend to drink faster and more intensely in pubs than previously.

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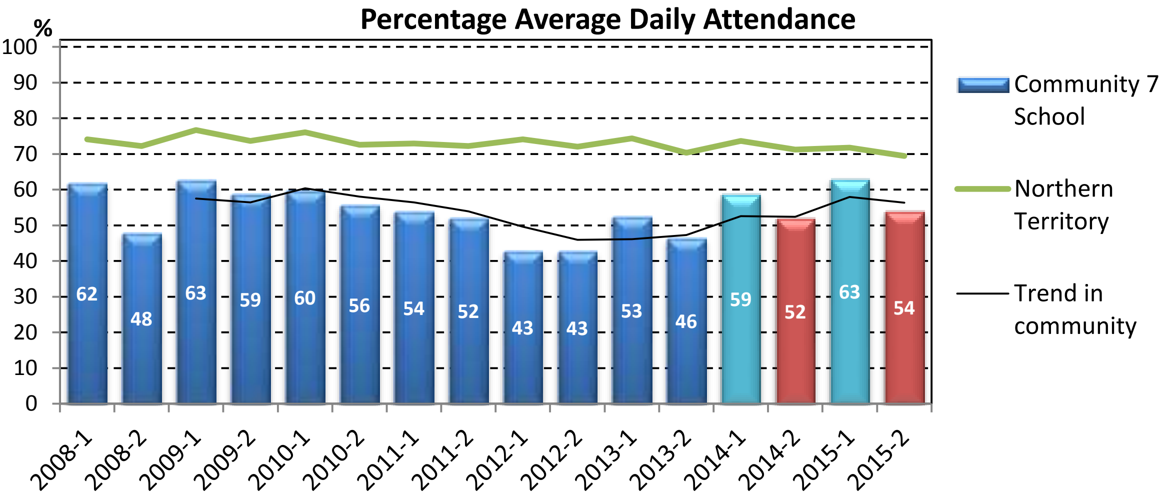
Community education

Administrative data

School attendance and enrolments

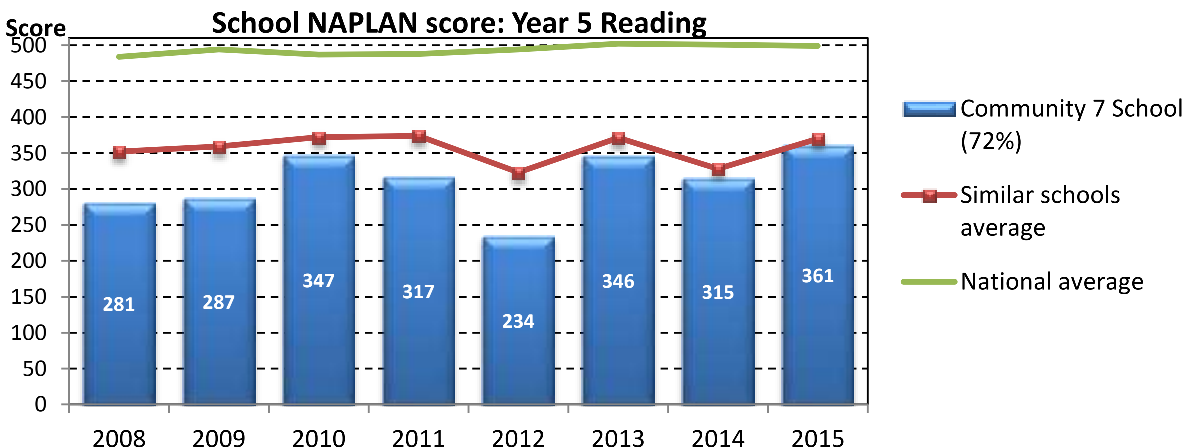
Community 7 School	2008-1	2008-2	2009-1	2009-2	2010-1	2010-2	2011-1	2011-2	2012-1	2012-2	2013-1	2013-2	2014-1	2014-2	2015-1	2015-2
Number enrolled for semester	131	119	114	108	121	125	149	132	114	133	116	114	120	115	120	133

- There was no significant change in percentage daily attendance from 2014-1 to 2015-1 or from 2014-2 to 2015-2, though attendance rates were lower in semester 2.
- The average daily attendance was lower in Community 7 than the NT average in 2015 (72%).

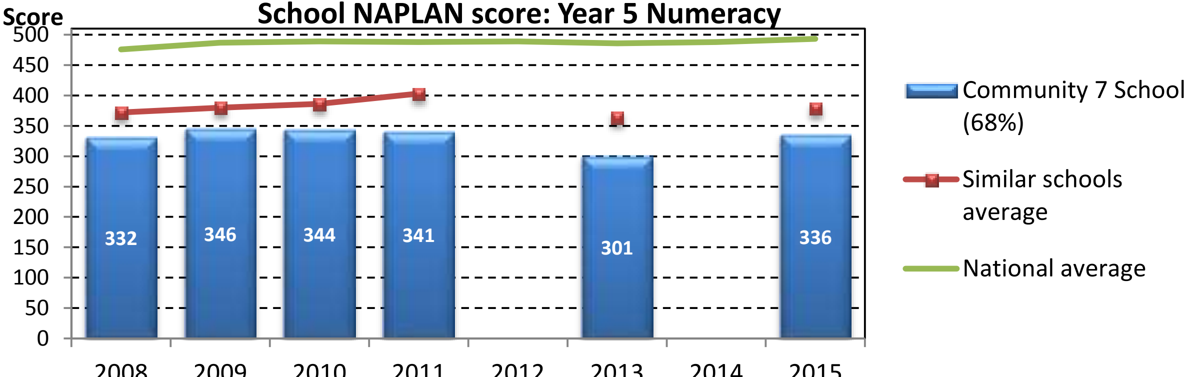


Literacy and numeracy of school students

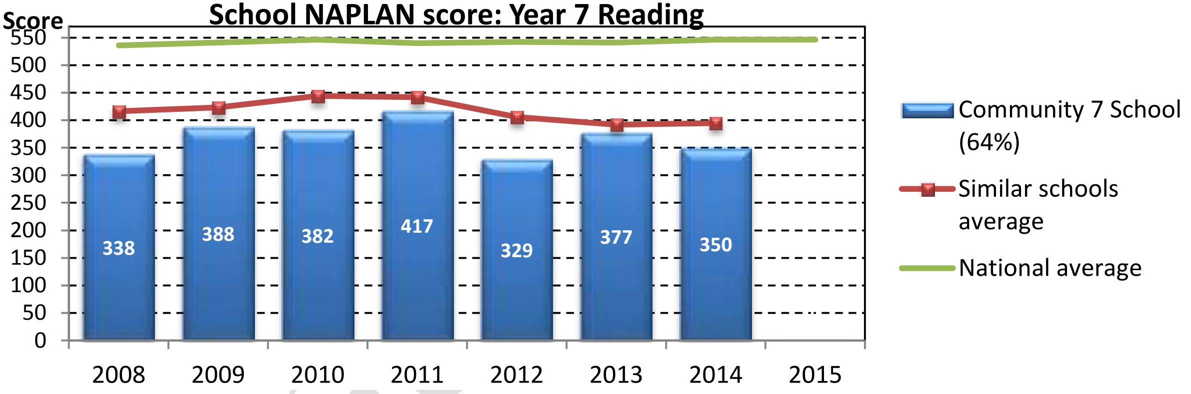
- There was an improvement in the Community 7 school score for Year 5 reading from 2014 to 2015, with the latest score about the same as similar schools. The score of 361 was 72% of the national average for year 5 reading.



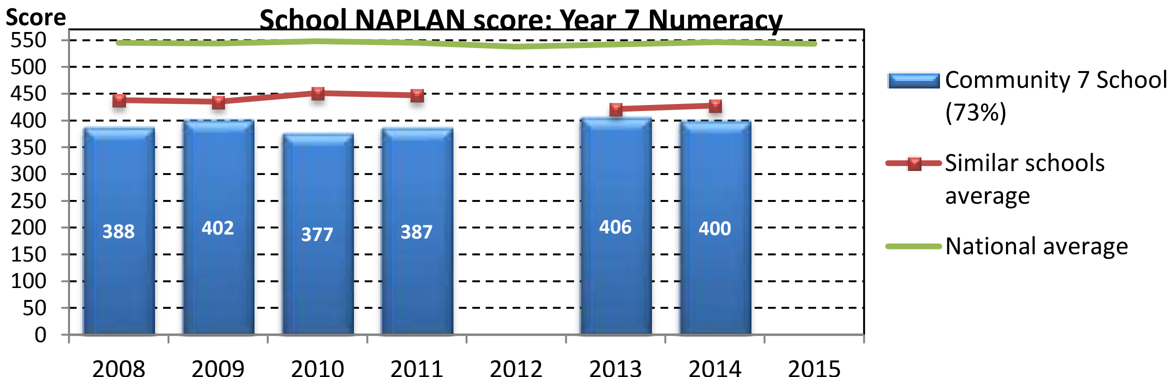
- There was an improvement in the Community 7 school score for Year 5 numeracy from 2013 to 2015, with the latest score a little lower than similar schools. The score of 336 was 68% of the national average for year 5 numeracy.



- There was a decline in the Community 7 school score for Year 7 reading from 2013 to 2014 (no data available in 2015), with the latest score lower than the average of similar schools. The score of 350 in 2014 was 64% of the national average for year 5 reading.



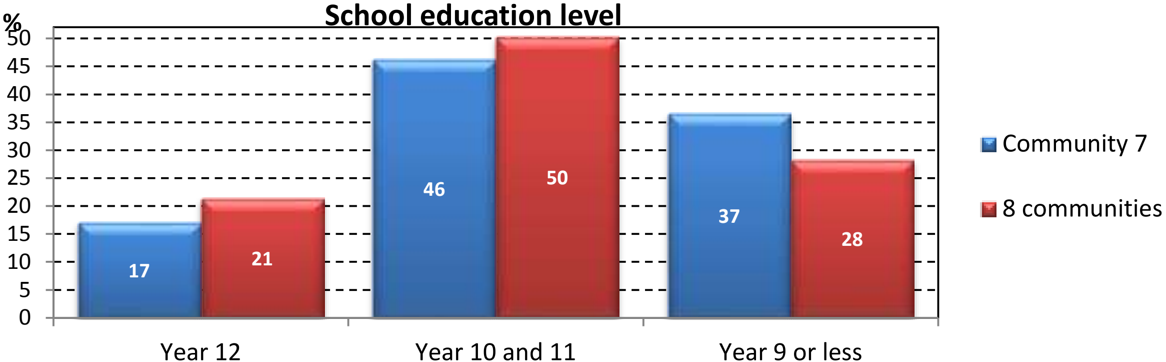
- There was a very small decline in the Community 7 school score for Year 7 numeracy from 2013 to 2014 (no data available in 2015), with the latest score lower than the average of similar schools. The score of 400 in 2014 was 73% of the national average for year 7 numeracy.



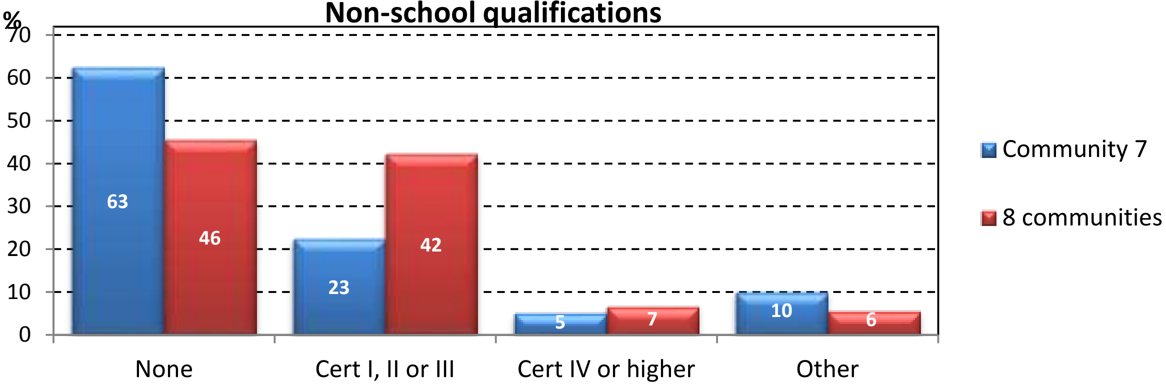
Community survey

Adult education

- Seventeen percent of adults surveyed in Community 7 had completed year 12, which was similar to the average of all eight communities surveyed.



- Sixty-three percent of adults surveyed in Community 7 had no further qualifications after school, which was higher than that observed across all eight communities (46%).



Key informant interviews

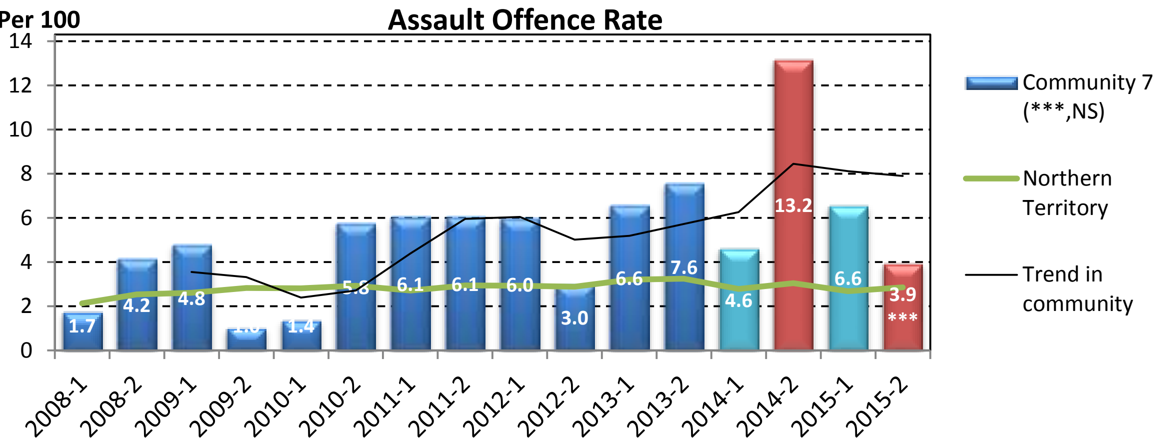
Several informants noted that both school attendance and the ability of children to make the best of their time at school were affected by the alcohol-related noise, parties and violence that occurred at night, although some noted that gambling also contributed to lack of sleep. Loss of control was regarded as a problem for all students, but particularly for boys. Children in families affected by alcohol would often go to school to have breakfast and then leave. According to one key informant, school attendance improved after TBLs were implemented in the nearby regional town. Increased efforts by truancy officers (in addition to yellow shirts) also improved school attendance.

Community safety

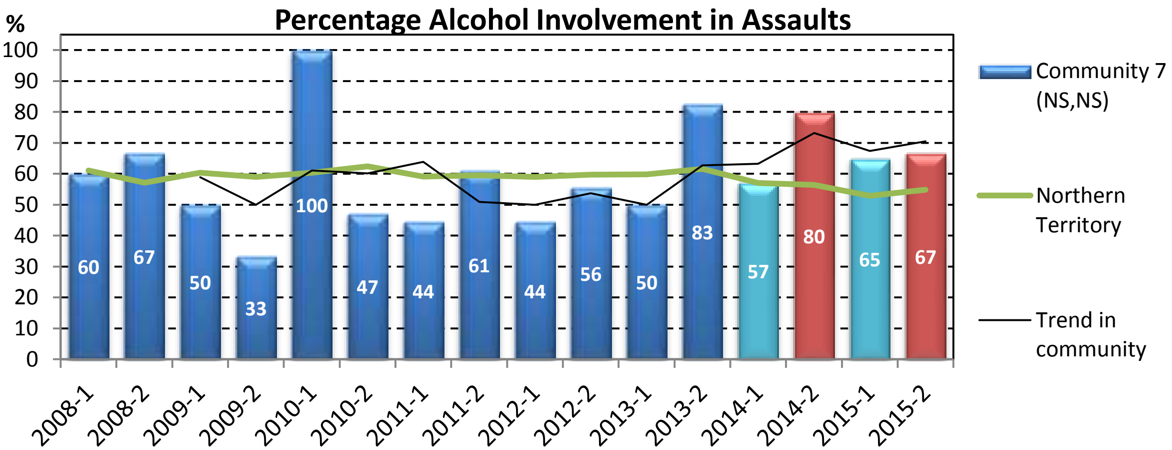
<u>Administrative data</u>

Assault offences

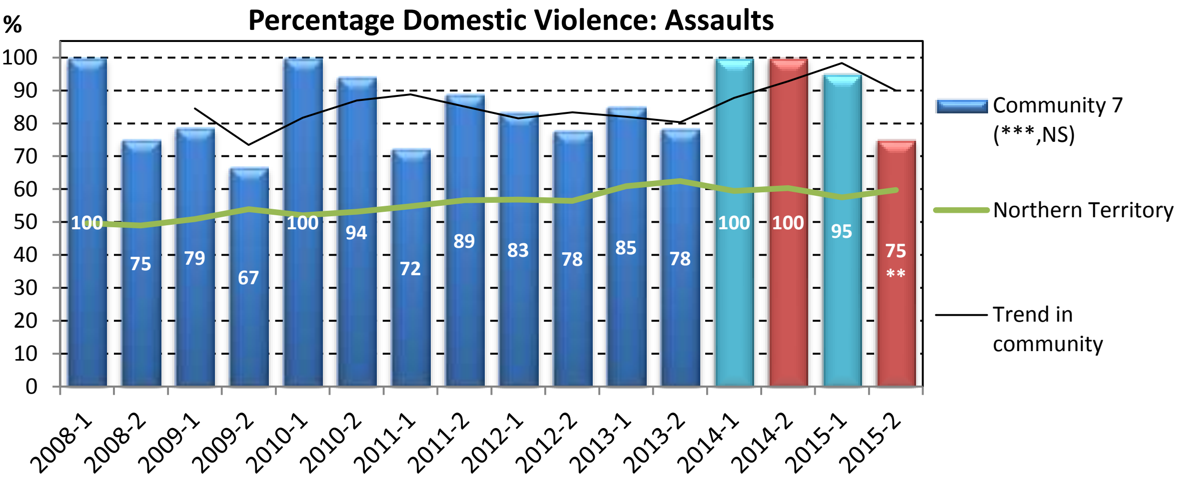
- There was very little change in the assault rate between 2014-1 and 2015-1, but there was a significant decrease from 13.2 per 100 people to 3.9 per 100 people between 2014-2 and 2015-2.
- The 2015-1 assault rate in Community 7 of 6.6 per 100 people was significantly higher ($p<0.001$) than the NT rate (2.7 per 100 people).



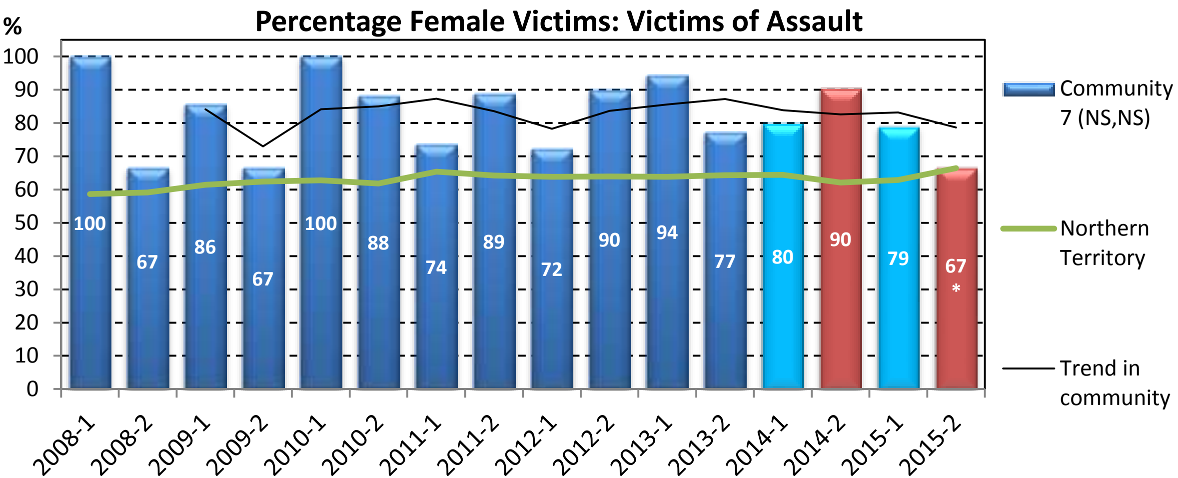
- There was very little change in the percentage alcohol involvement in assaults between 2014 and 2015, though there was a small non-significant decline from 2014-2 (80%) to 2015-2 (67%).
- Percentage alcohol involvement in assaults in Community 7 in 2015 (65% and 67%) was not significantly different to the NT (53% and 55%).



- There was a significant decline from 2014-2 (100%) to 2015-2 (75%) in the percentage of assaults where domestic violence was involved.
- Percentage domestic violence involvement in assaults in Community 7 in 2015-1 (95%) was significantly different to the NT (58%), but not in 2015-2.



- There was a significant decline from 2014-2 (90%) to 2015-2 (67%) in the percentage of assaults where the victim was female.
- In Community 7, the percentage of victims of assault that were female was not significantly different to the NT in 2015-1 and 2015-2.



Theft, break and enter and property damage

- There was a significant decline in the theft, break and enter, and property damage offence rate in Community 7 from 2014-2 (8.9 per 100 people) to 2015-2 (2.3 per 100 people).
- The 2015-1 and 2015-2 theft, break and enter, and property damage offence rate was significantly different from the NT rate (8.3 and 7.3 per 100 people).

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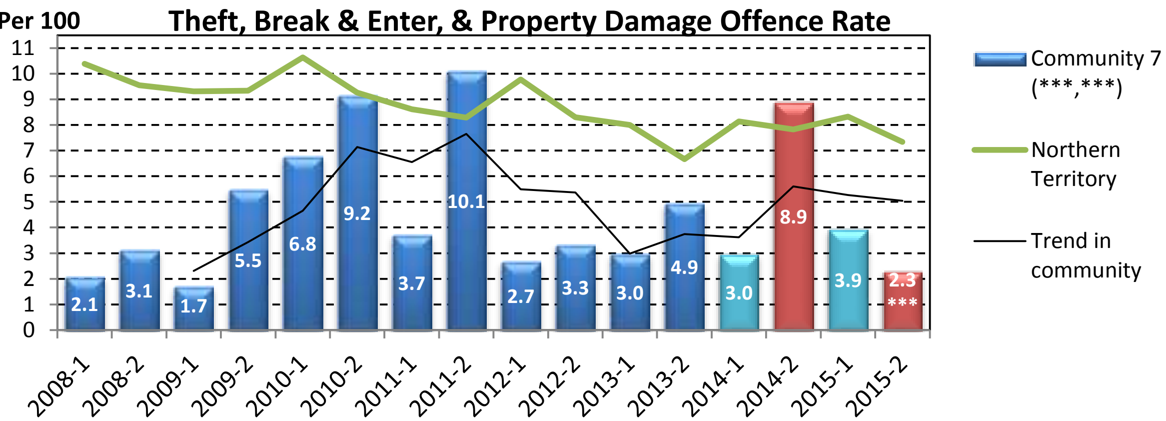
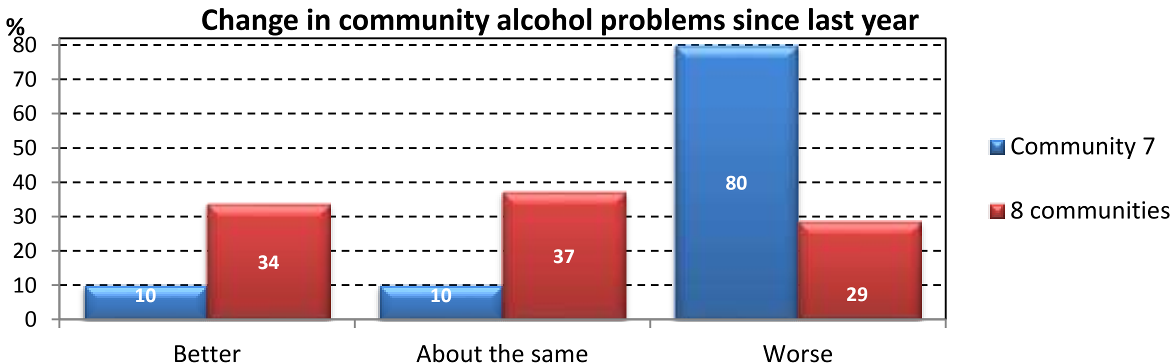


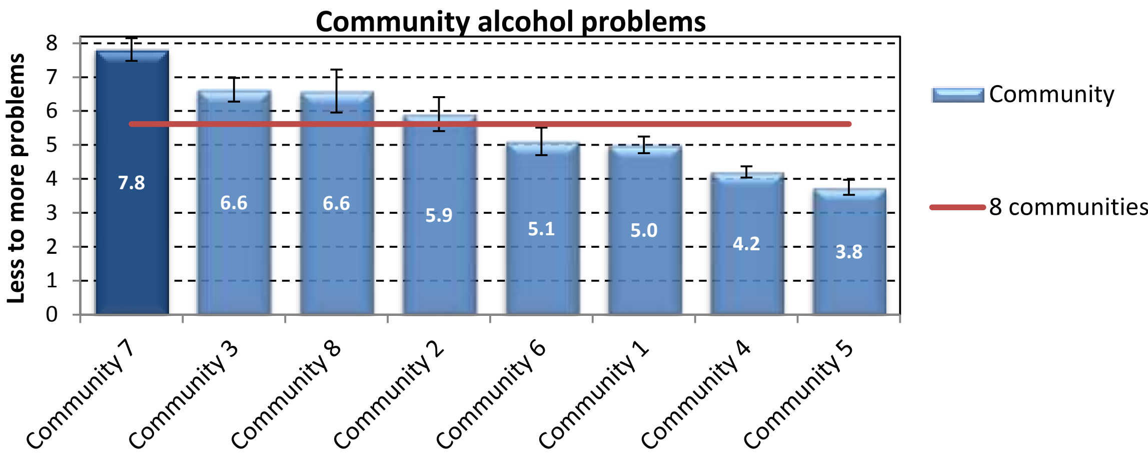
Community survey

Community and household alcohol problems

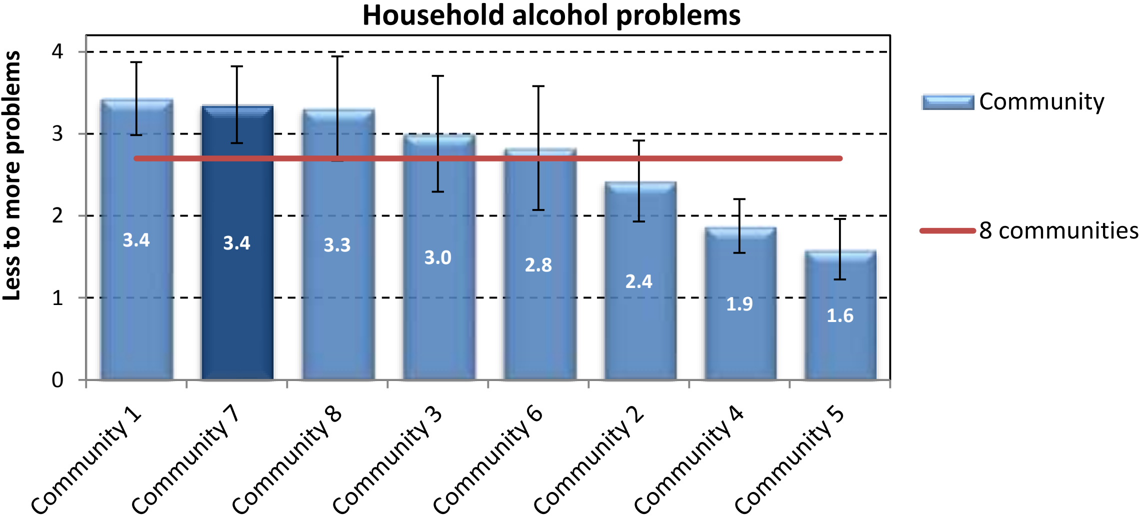
- Eighty percent of adults surveyed in Community 7, said that alcohol problems were worse than the previous year, while 10% said they were better and 10% said they were worse.



- When asked about community alcohol problems and how often they occur, Community 7 was above the average compared with the eight communities, and the highest score (worst), meaning people said community alcohol problems are occurring more of the time.



- When asked about household alcohol problems and how often they occur, Community 7 scored second highest, meaning people in Community 7 said that household alcohol problems occur more often compared with the other communities included in the survey.



Community problems

- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
    2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
    3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.

- Community 7 scored the highest of the eight communities for *Violence and Anti-Social Behaviour Problems* in the community. That is, people in Community 7 said that violence and anti-social problems were occurring more of the time in their community compared with what people in other communities said about their community.

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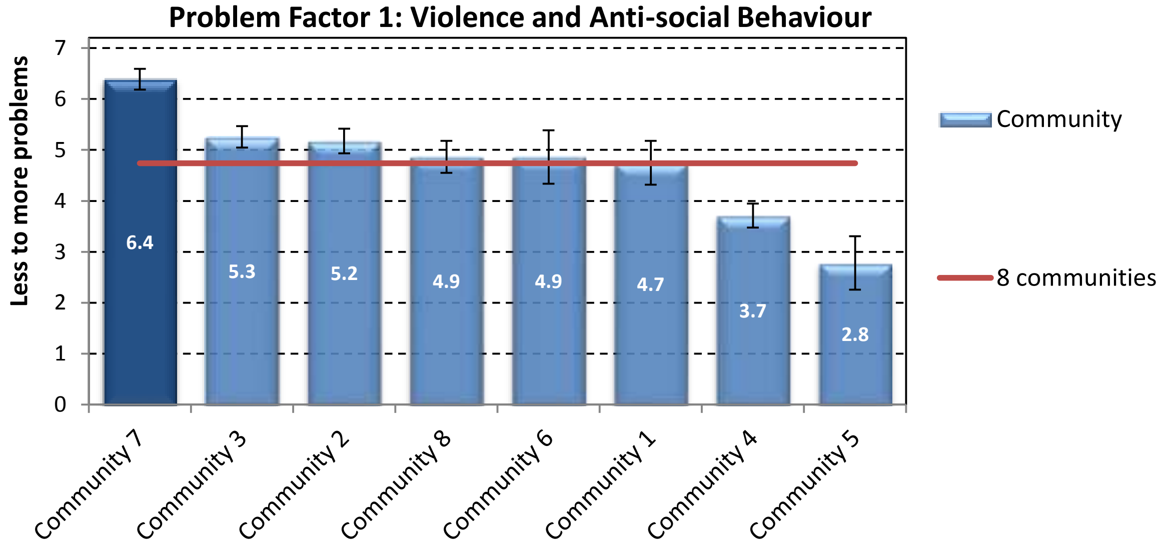
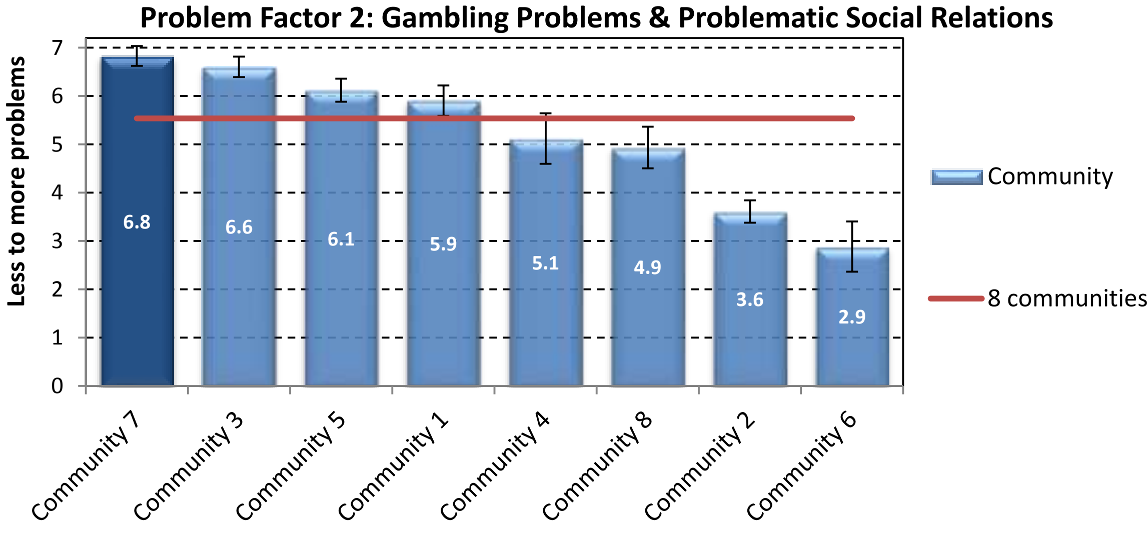
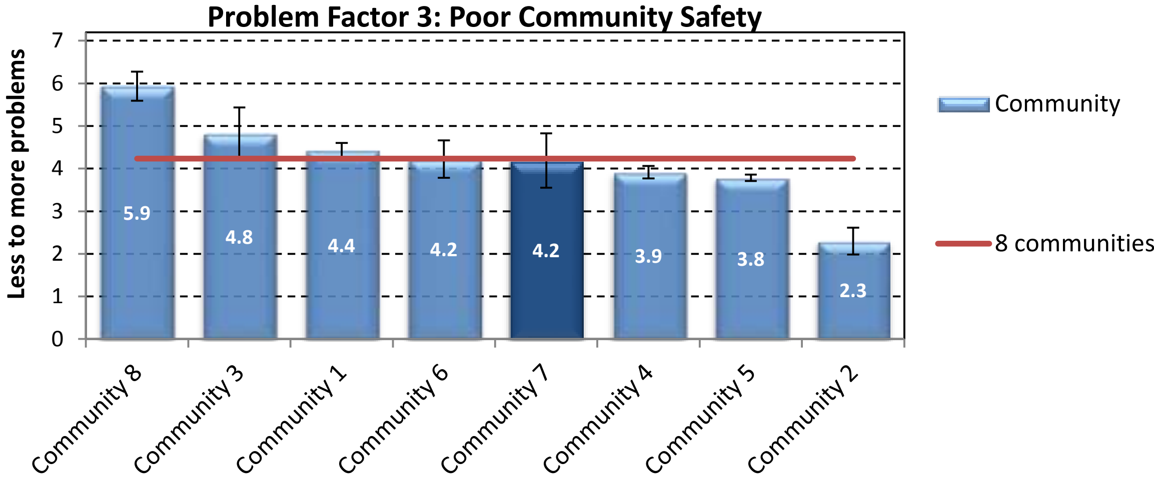


- Community 7 also scored the highest of the eight communities for *Gambling Problems & Problematic Social Relations* in the community. That is, people in Community 7 said that gambling problems & problematic social relations were occurring more of the time in their community compared with what people in other communities said about their community.

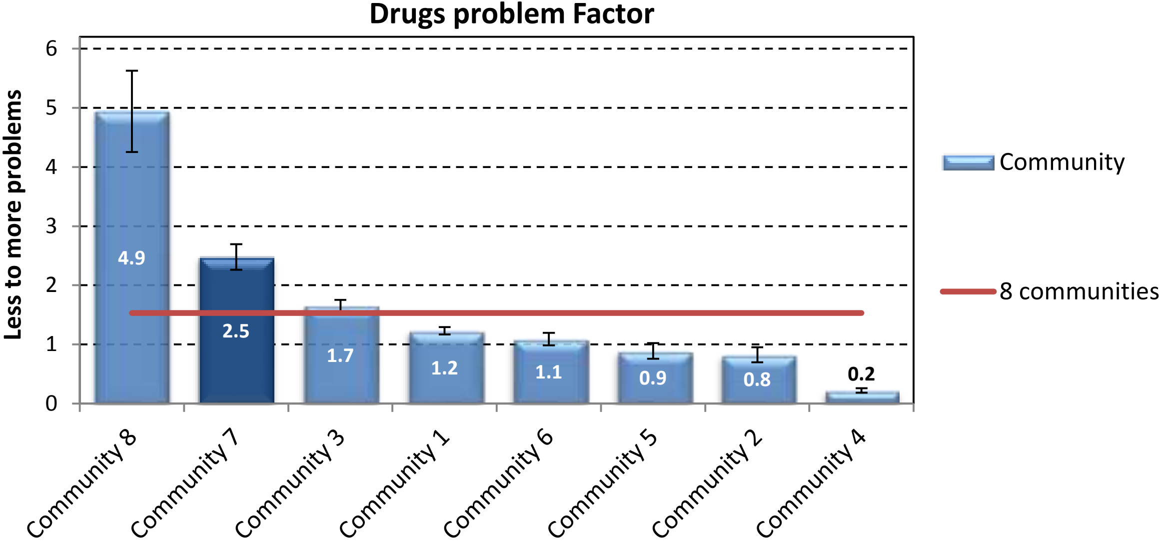


- Community 7 scored just below the average of the eight communities for *Poor Community Safety*. That is, people in Community 7 said that community safety was a problem about the same amount of the time in their community compared with what people in other communities said about their community.



Community drug problems

- The Community Survey also asked residents about drug problems (marijuana, sniffing, kava and ecstasy) and how much of the time over the last year they were a problem.
- The figure below shows Community 7 scored above the average of the eight communities in how much of the time drugs were a problem. Some other communities had more problems with sniffing and kava.



Key informant findings

Key informants commented that most domestic violence is alcohol-related and that alcohol was a major contributor to excess noise, parties, loud music and violence. Fighting between families is common and sometimes goes on for weeks, with one key informant noting that all fighting and disagreements were alcohol-related. Although this community has a safe house it is not staffed at night. In addition, the safe house is run by one family and women from some families feel reluctant to use it; consequently, they don't feel safe. Some felt that police response time to incidents was not fast enough and, in some instances, police did not arrive

until the following day. One informant commented that night patrol needed greater powers to act when things went wrong as currently they only have mediation powers and have to inform the police if they cannot resolve the issue. The informal drinking camp is regarded as unsafe partly due to its proximity to the highway and partly because it is frequented by different family groups from several communities, with this leading to conflict. The drinking camp is located some distance from the community and is too far for people to walk. This makes it difficult for people to leave when conflict occurs, which then leads to greater problems. In addition, its distance from the camp means that night patrol does not pick people up and is not available to mediate conflict or to report problems to police.

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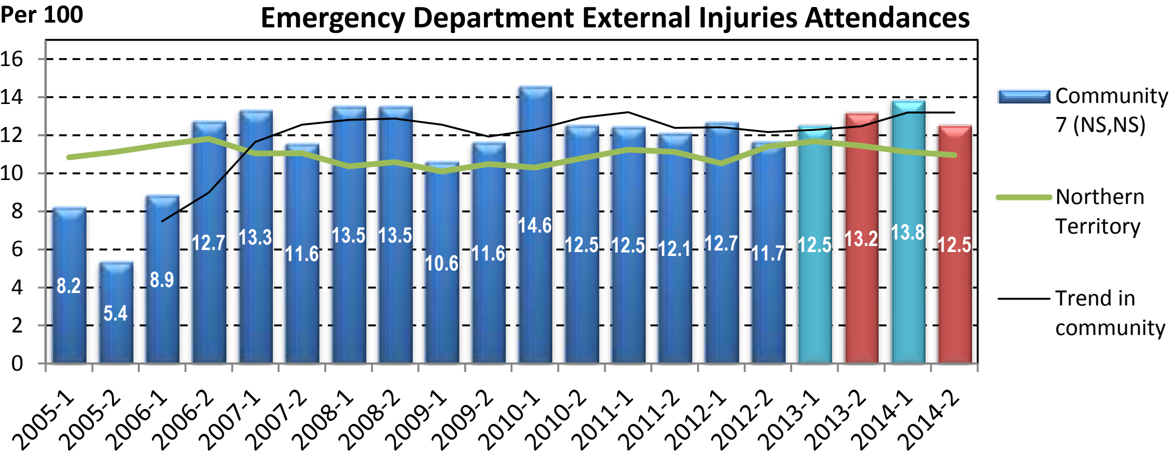
Community health and wellbeing

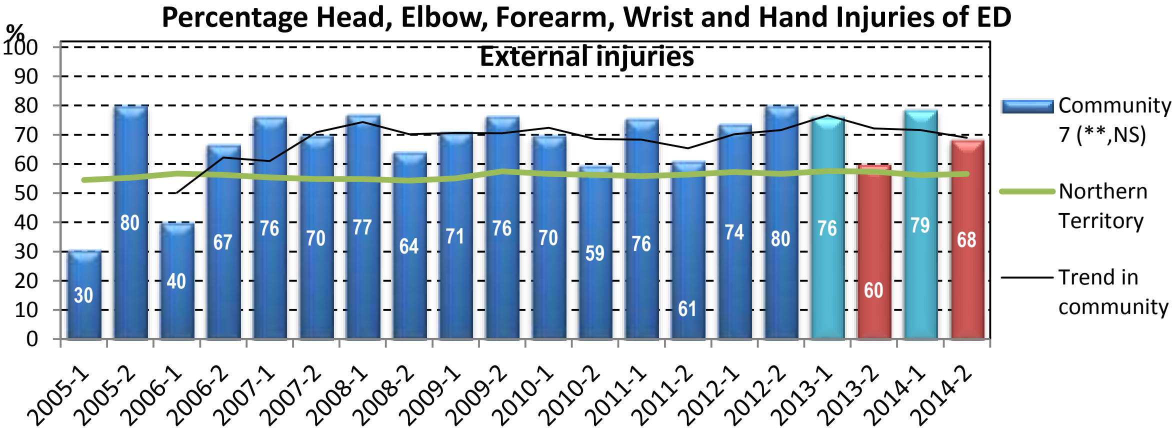
Administrative data

Emergency Department admissions for external injuries

- There was no significant change in ED attendances between 2013 and 2014, though there was a slight upward trend.
- The ED external injuries attendance rate in Community 7 was not significantly different from the NT rate (11.1 and 11 per 100 people).

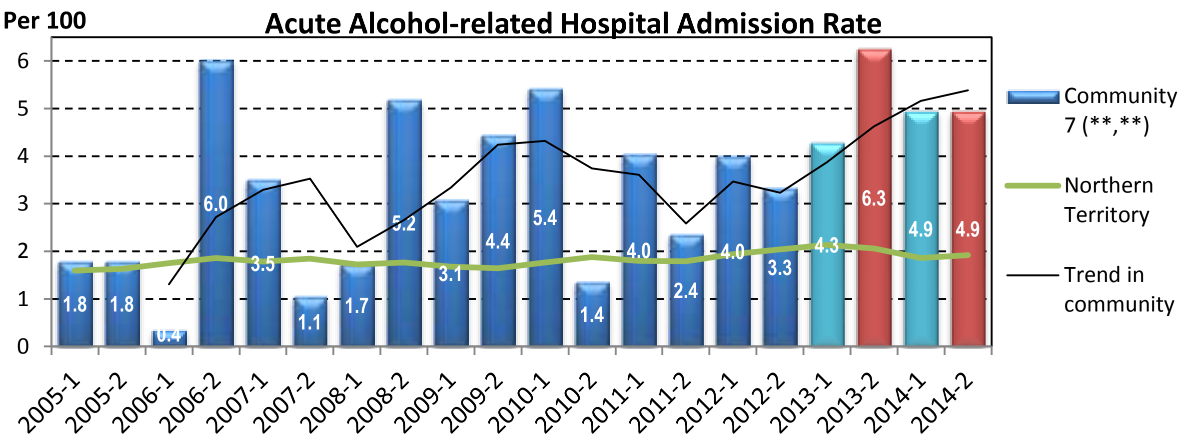


- The percentage of ED external injuries attendances that were head, elbow, wrist, forearm and hand injuries in Community 7 did not change significantly between 2013 and 2014.
- The percentage of ED external injuries attendances that were head, elbow, wrist, forearm and hand injuries in Community 7 (79%) was significantly different to the percentage for the NT (56%) in 2014-1, but not significantly different in 2014-2.



Hospitalisation for alcohol-related conditions

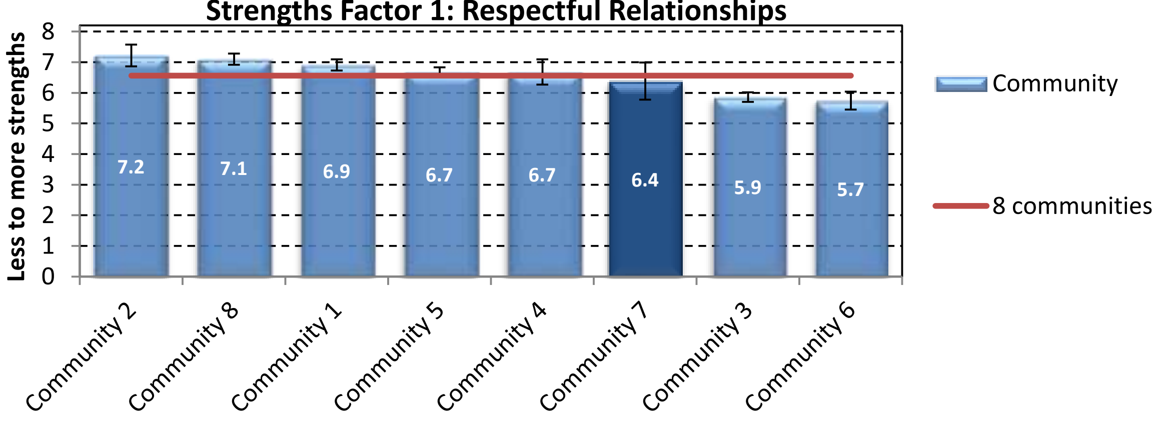
- The rate of hospital admissions for acute alcohol-related diagnoses did not significantly change between 2013 and 2014.
- The rate of hospital admissions for acute alcohol-related diagnoses for Community 7 (4.9 per 100 people) was significantly higher than the NT rate (1.9 per 100 people).



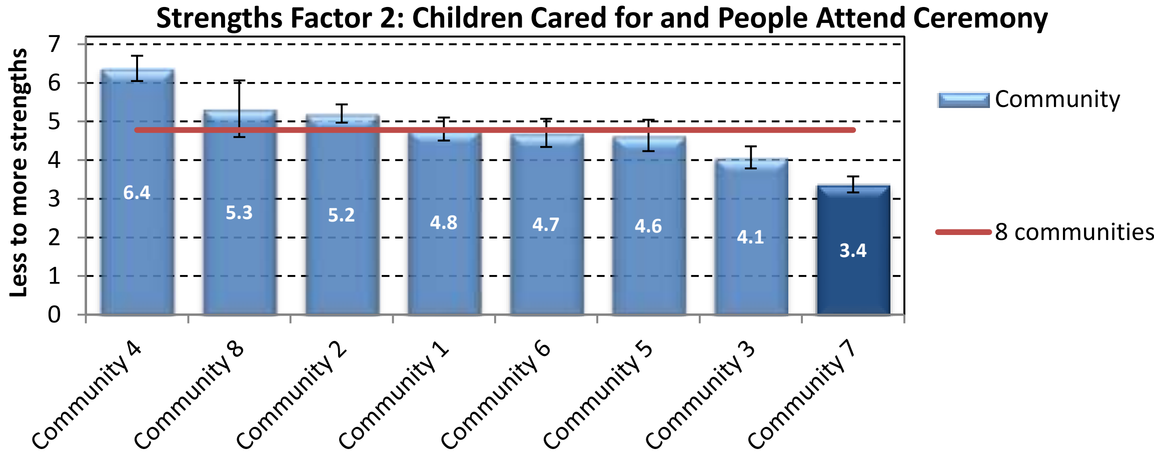
<u>Community survey</u>

Community strengths

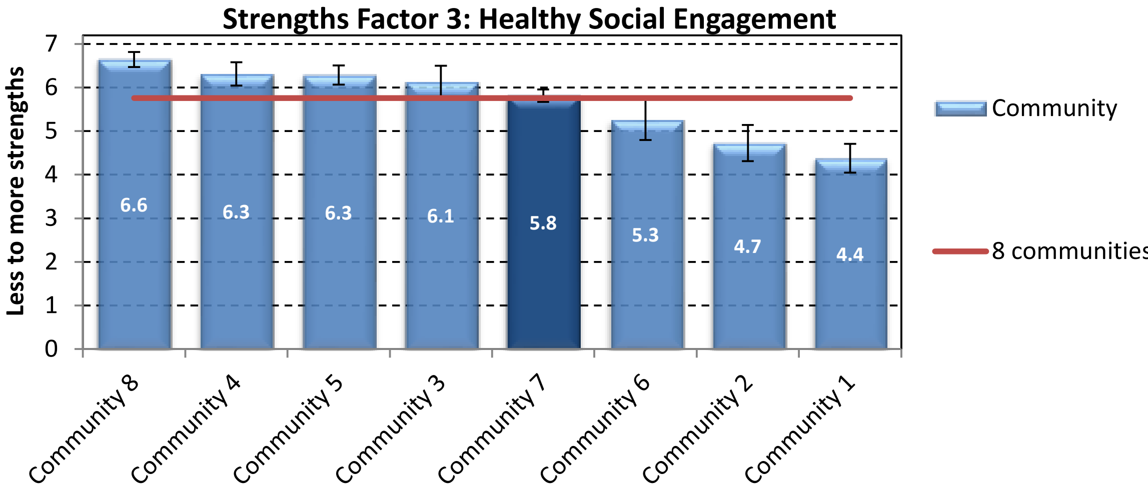
- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) people respect Elders, (ii) people respect other community members, and (iii) people help each other.
    2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
    3. Strengths Factor 3: *Health Social Engagement* which includes three community strengths: (i) people go out for bush tucker, (ii) people do organised sports and other activities and (iii) people say no to humbug.
- Community 7 scored just below the average of the eight communities in *Respectful Relationships*.



- Community 7 scored below the average and the lowest of the eight communities in *Children Cared for and People Attend Ceremony*.



- Community 7 scored the same as the average of the eight communities in *Healthy Social Engagement*. Some communities had less access to bush tucker (e.g. access to water) which may have affected their score for this measure.



<u>Key informant findings</u>

Alcohol misuse was regarded as influencing health and wellbeing through a variety of pathways. Alcohol is a high priority in the household budget and, as a result, there is less money available for food and other necessities. Basics cards, intended to ensure that adequate funds are available for necessities, are used by some residents to pay for taxis to the regional town for drinking sessions, with this costing around $400 per round trip. As a consequence, nutrition in many children is poor and some children break into the store in order to obtain food. Children whose parents drink are often cared for by grandparents and extended family. However, some children still experience neglect, with insufficient sleep and food being identified as a problem by a number of key informants. Children are also exposed to violence, and worry about their parents' drinking. One informant commented that at least two children in every class probably have foetal alcohol spectrum disorder (FASD), and noted that lack of resilience and self-control is a problem for all children at the school.

Alcohol was considered to fuel existing disagreements and tensions between individuals and families, as one key informant commented, when people are sober they may behave *very culturally,* but alcohol releases inhibitions to an extent where cultural constraints to behaviour fall away. This is exacerbated by poor communication skills and low self-esteem. Overcrowding is also a problem as it both contributes to alcohol misuse and is exacerbated by it. Lack of employment, recreational and sporting opportunities, leading to boredom, were cited as key factors in alcohol misuse and subsequent misunderstandings and fighting. Low literacy was perceived as a significant problem across the community but adult literacy classes are not well attended. One informant commented that traditional culture was being lost but there was nothing to fill the subsequent void – modern skills were not being taken up. The current generation was seen as being in the worst position as they were less literate and had few of the cultural supports available to previous generations, with one informant noting that: *They have nothing - not culture - not western skills. They are no longer attached to country .... they are lost, don't belong anywhere and turn to ganga and grog.*

Employment programs and on-country or ranger programs were regarded as strategies that might be useful in reducing alcohol misuse. Education and treatment programs were not regarded as helpful unless accompanied by adequate support and follow-up. Too often, people returned to the same environment after completing a program, with this leading to a return to drinking.

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4.9 Community 8 Data Report

Highlights: 2014 to 2015

- ↑↑ large or significant improvement; ↑ small or non-significant <u>improvement</u>; = no change or small change
- ↓↓ large or significant worsening; ↓ small or non-significant <u>worsening</u>; = no change or small change
- NOTE: The sample in Yirrkala for the Community Alcohol and Wellbeing Survey was small (n=33) and less representative of the whole community (more educated, less drinkers).

Domain/indicator	Comments	Change	Score
Alcohol Consumption Patterns (-6 to 6)		**-**	**50% (3)**
Wholesale PAC in catchment	Mostly steady	=	0
Community average PAC last drink	Second lowest of 8 communities	↑↑	2
Frequency of drinking	More likely to have not drank in last year	-	-
Number types of alcohol drank	Less likely to drink 3 or 4 types of alcohol	↑	1
Community Education (-18 to 18)			**-28% (-5)**
School attendance	Significant worsening trend over last 2 years	↓↓	-2
Year 5 reading Yirrkala	Improvement & same as similar schools	↑	1
Year 5 reading Yirrkala Homelands	Improvement & much lower than similar schools	=	0
Year 5 numeracy Yirrkala	Worsening & lower than similar schools	↓↓	-2
Year 5 numeracy Yirrkala Homelands	Improvement & just above similar schools	↑	1
Year 7 reading Yirrkala	Improvement & just below similar schools	=	0
Year 7 reading Yirrkala Homelands	Improvement & much below similar schools	↓↓	-2
Year 7 numeracy Yirrkala	Improvement & same as similar schools	↑	1
Year 7 numeracy Yirrkala Homelands	Worsening & much lower than similar schools	↓↓	-2
Adult year 12 completion	Better than average of 8 communities	-	-
Adult other qualifications	Better than average of 8 communities	-	-
Community Problems & Safety (-24 to 24)			**-21% (-5)**
Assaults offences	Improving trend over last 1 years	↑	1
Alcohol % in assaults	No substantial change over last 2 years	=	0
Domestic violence % in assaults	No substantial change over last 2 years	=	0
Female % in assaults	Small worsening trend over last 2 years	↓	-1
Theft, stealing, break & enter	Significant worsening trend over last 2 years	↑	1
Change in community alcohol problems	Most people (46%) said worse than last year	↓	-1
Community alcohol problems	Above the average of 8 communities	↓	-1
Household alcohol problems	Above the average of 8 communities	↓	-1
Violence & Anti-Social behaviour	Similar to average of 8 communities	=	0
Gambling & Problematic Social Relations	Below the average of 8 communities	↑	1
Poor Community Safety	Highest of 8 communities	↓↓	-2
Community Drug problems	Highest of 8 communities	↓↓	-2
Community Strengths, Health & Wellbeing (-12 to 12)			**25% (3)**
Emergency Department attendances	Significant worsening trend over last 1 year	↓	-1
% head, elbow, forearm, wrist & hand	Significant worsening trend over last 1 year	↓	-1
Acute alcohol hospitalisations	Significant worsening trend over last 1 year	↓	-1
Respectful Relationships	Second highest of 8 communities	↑↑	2
Children Cared for &Attend Ceremony	Second highest of 8 communities	↑↑	2
Healthy Social Engagement	Highest of 8 communities	↑↑	2
Total score (-60 to 60)			**7%**

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Key informant interviews: Highlights

Alcohol abuse is seen as a major issue and a key factor in domestic violence, family conflict, anti-social behaviour and loss of culture. However, cannabis and volatile substance abuse (VSA) are also perceived as significant problems, although the population groups affected are more specific and the effects less pervasive than alcohol. Managing alcohol is problematic due to this community's close proximity to a range of liquor outlets in the nearby town. Although the community permit system works well in theory, its efficacy is adversely affected by kinship obligations which make it hard for people to comply with the regulations and difficult for police to determine who is breaking these regulations.

Community context

Community 8 has a population of around 1000 and is located in north east Arnhem Land. The AMP for Community 8 includes nearby homelands and another small community. A nearby (approximately 20 kms) town is not covered by the AMP but is included in the Alcohol Catchment Area as it is a primary access point for alcohol consumption and purchase. Services available in Community 8 include schools, a store, health centre, child care, education centre, craft shop, women's resource centre and sports association. The nearest police station is located in the nearby town about 15 minutes' drive away. Community 8 has a 'graded' permit system in which the amount and type of alcohol that can be purchased on the initial permit can be increased once the ability to comply with permit regulations has been demonstrated. The nearby town has an open permit system which allows permit holders unlimited access to any type of alcohol. The East Arnhem Supply Plan, including the permit system, is currently under review.

Alcohol consumption patterns

Administrative data

- PAC in litres by alcohol type for the Community 8 alcohol catchment area is shown in the graph below and represents the amount of pure alcohol consumed per 6-month period.
- There was a 4% decrease in PAC from 2014-1 to 2015-1, and a 3% increase in PAC from 2014-2 to 2015-2.

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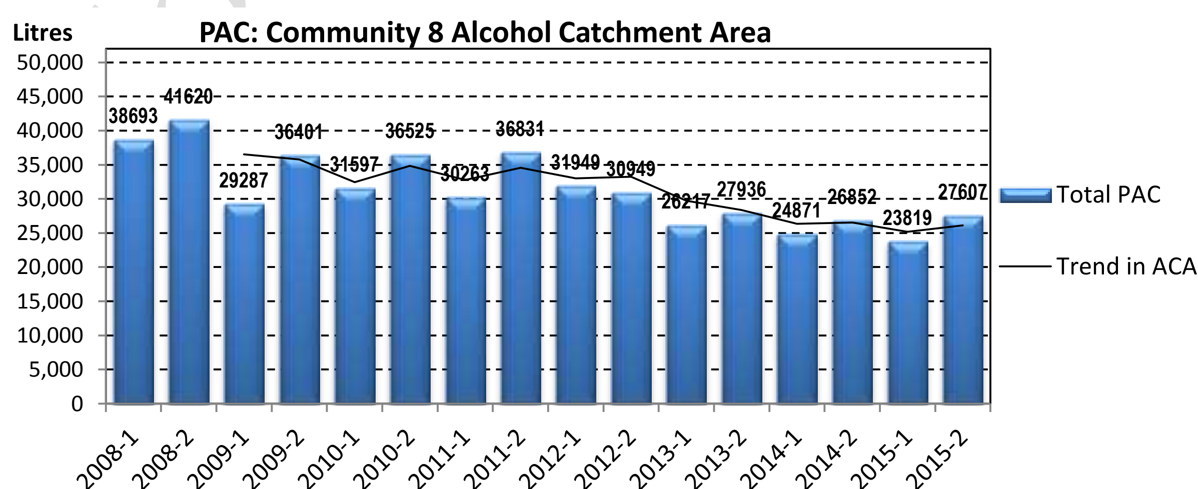
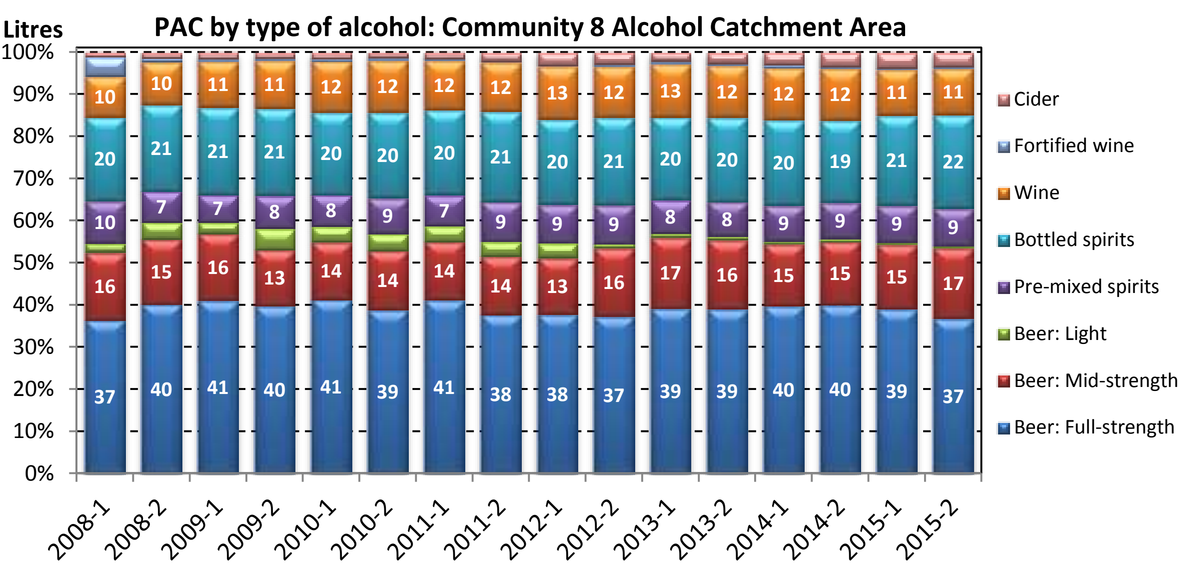


- There has been little change in the proportion of different alcohol types consumed in the ACA, with full-strength beer making up the largest portion of PAC.



Community Survey

PAC (pure alcohol consumption) Litres	0.10	0.15	0.20	0.25	0.30	0.35	0.40
Number of standard drinks (mid-strength cans)	8	12	16	20	24	28	32
Number of full-strength cans (approximate)	6	9	11	14	17	20	23

- Community 8 had the second lowest average PAC (0.16 litres) on last drinking occasion out of the eight communities surveyed. That is, people in Community 8, on average consumed 10 full-strength cans of beer, compared with the average for eight communities of 13 full-strength cans of beer.

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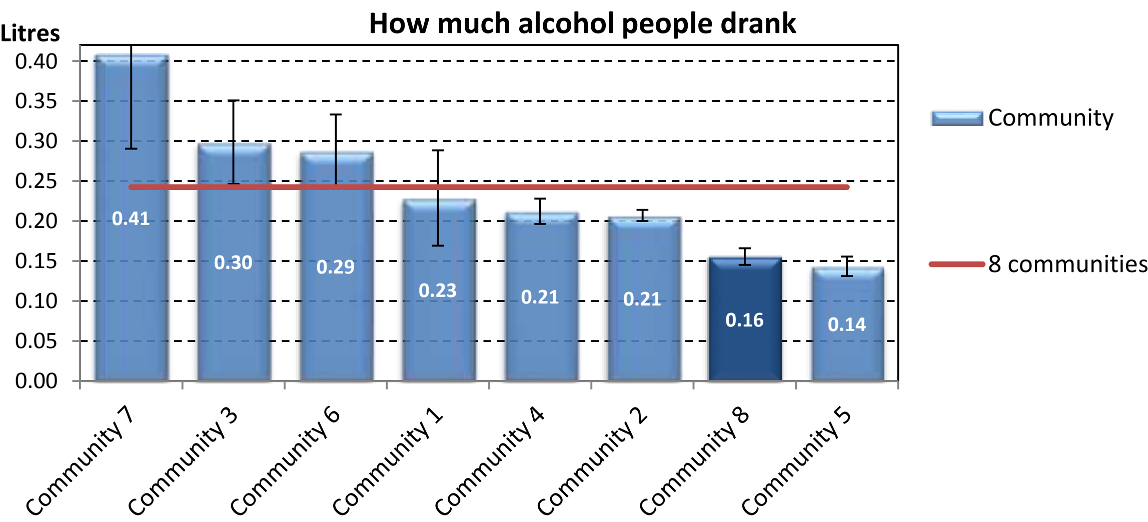
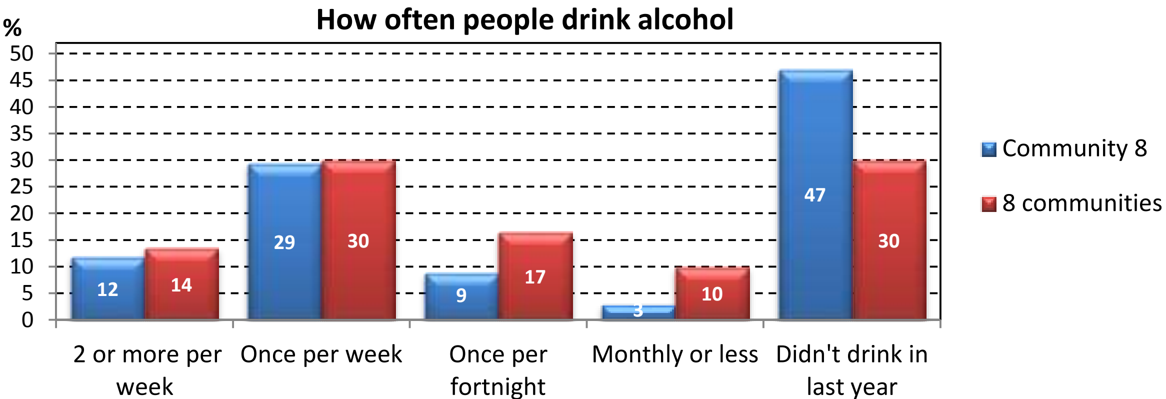
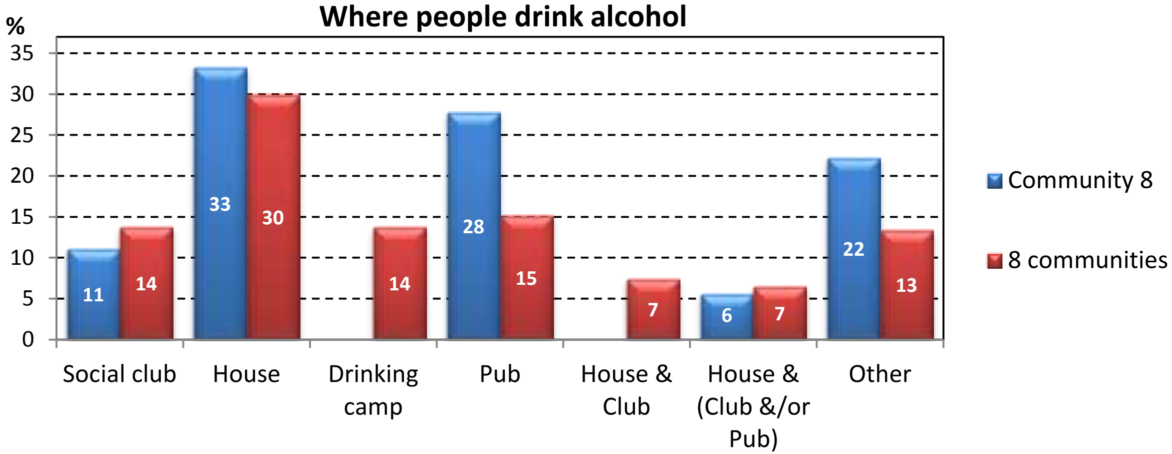


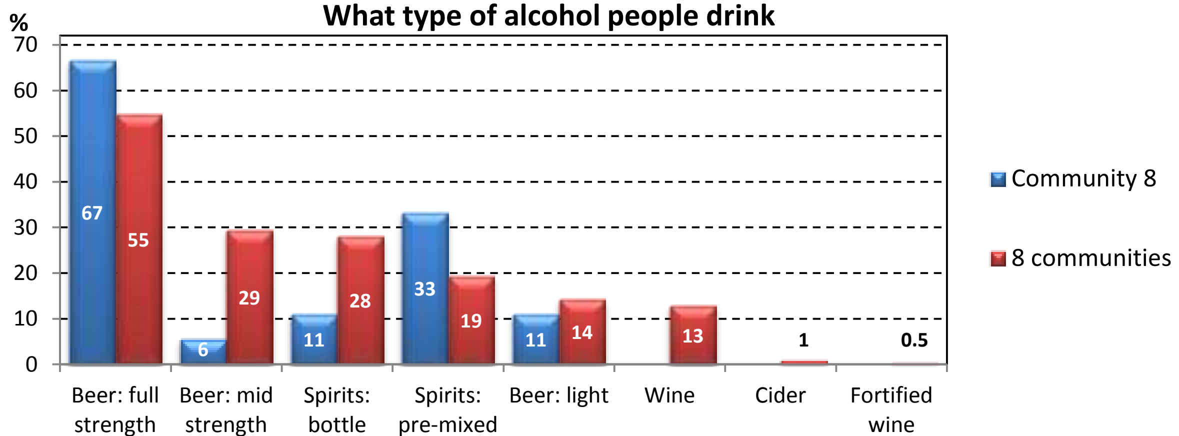
- A higher percentage of Community 8 people surveyed (47%) did not drink alcohol in the past year, compared with all eight communities (30%). Most people (29%) drank alcohol once per week.



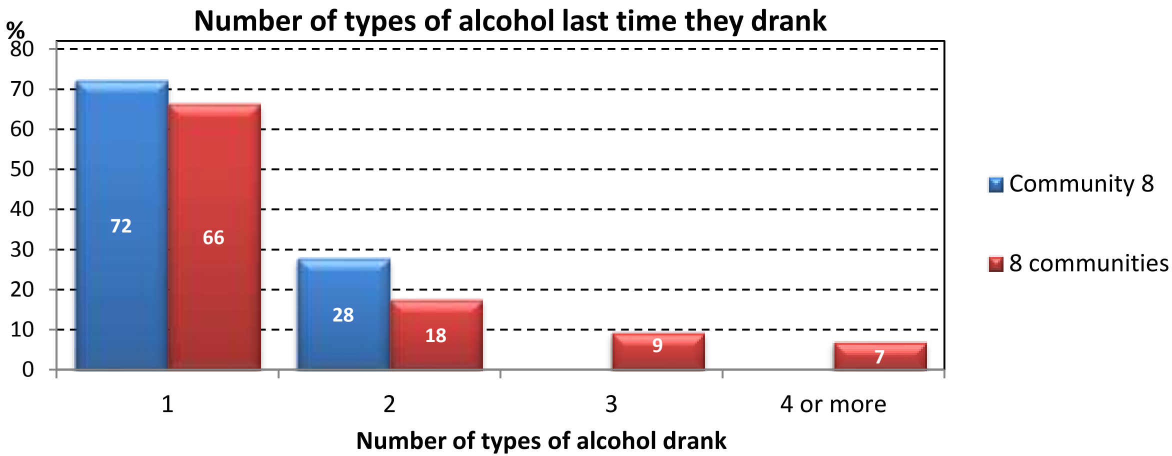
- Drinking in a friend or family home (33%) was the most common place to drink, followed by the pub (28%). People in Community 8 were more likely to drink in a pub compared with all eight communities.



- Full-strength beer was the most commonly drank alcohol type in Community 8 (67%), and was higher than the average of all eight communities (55%). Thirty-three percent of those sampled which drank alcohol, drank pre-mixed spirit cans.



- Most drinkers surveyed in Community 8 only drank one type of alcohol on their last drinking occasion (72%), followed by 28% drinking two types.



Key informant interviews

Alcohol is regarded as a major issue in Community 8, with around 80% of clinic presentations being alcohol-related. However, it is perceived as having little impact on the Community 8 homelands, as there are fewer negative influences, and cultural traditions are better maintained. Alcohol is perceived as a greater problem for younger people, particularly young men, and one informant noted that children are starting to drink at younger ages. Two types of problem drinkers were identified: weekend binge drinkers and heavy daily drinkers. Heavy drinking is perceived as normative in the nearby town and is not confined to the Indigenous population, with a local GP commenting that two thirds of the white population have alcohol problems. Although Community 8 is an APA, the permit system, together with easy access to pubs in nearby town, means that alcohol is easily accessible. Several informants noted that licensees did not always have up-to-date lists of APOs and that enforcement of responsible service guidelines was lax. People with permits were generally regarded as drinking responsibly, with most problems arising from those without permits who drank in the nearby town and returned home drunk. Perceptions of the effectiveness of the permit system varied, with one saying it worked well while another noted that breaches were common, as kinship

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obligations make it hard for people to comply with the regulations. Similarly, kinship obligations make it difficult for police to find out when regulations have been breached as people are not willing to 'dob in' relatives. Consequently, effective enforcement of permit regulations is problematic. Although some community members would like Community 8 to be totally dry (no permit system), others fear that prohibition would have a negative effect and simply result in more people drinking in the nearby town and creating problems in Community 8 when they arrive home drunk.

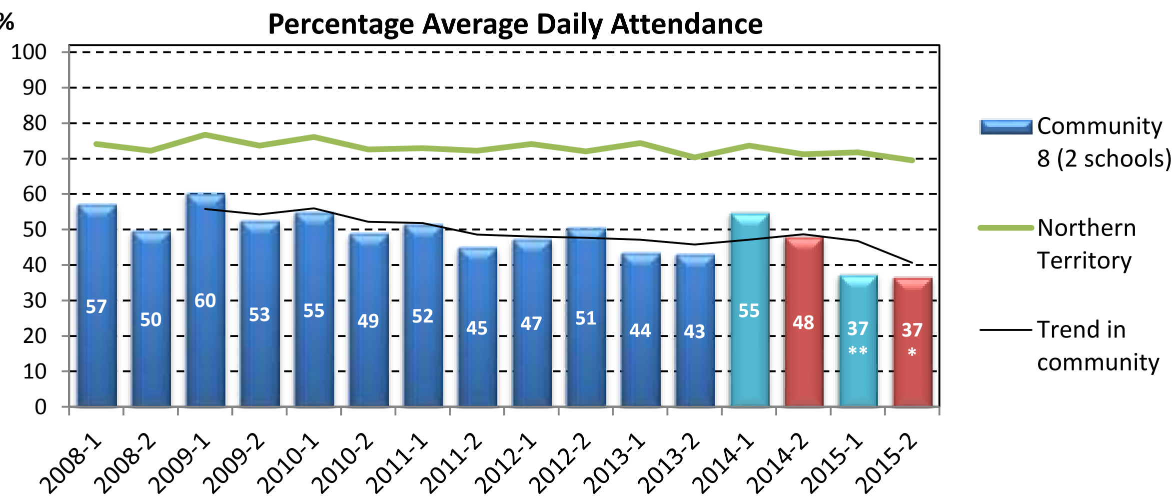
Community education

Administrative data

School attendance and enrolments

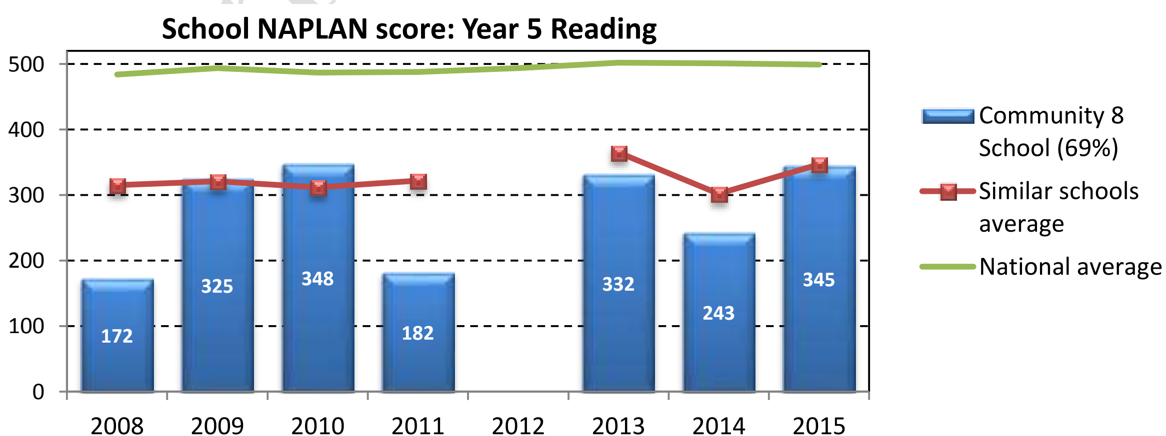
Two Community 8 Schools	2008-1	2008-2	2009-1	2009-2	2010-1	2010-2	2011-1	2011-2	2012-1	2012-2	2013-1	2013-2	2014-1	2014-2	2015-1	2015-2
Number enrolled for semester	220	215	221	222	187	182	193	165	169	169	188	166	163	156	165	147

- School attendance in Community 8 significantly ($p<0.01$) declined from 2014-1 to 2015-2 (55% to 37%), and again ($p<0.05$) from 2014-2 to 2015-2 (48% to 37%).

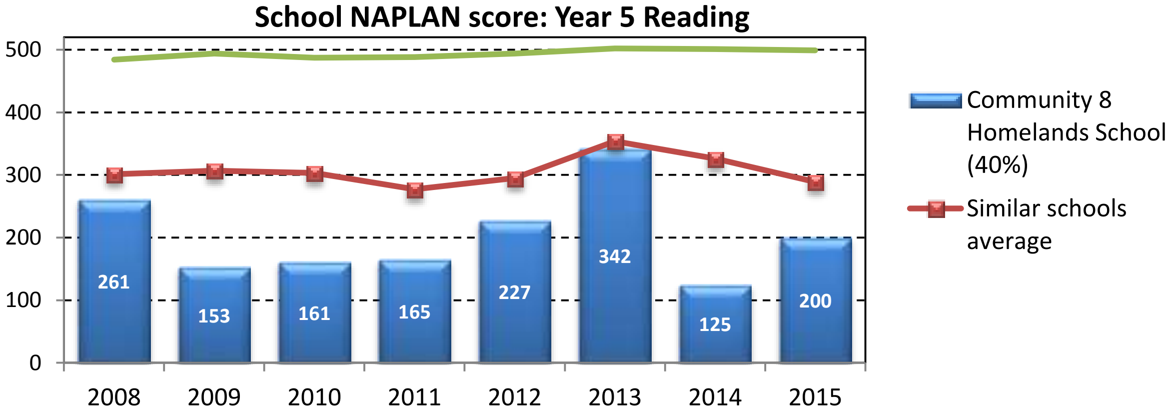


Literacy and numeracy of school students

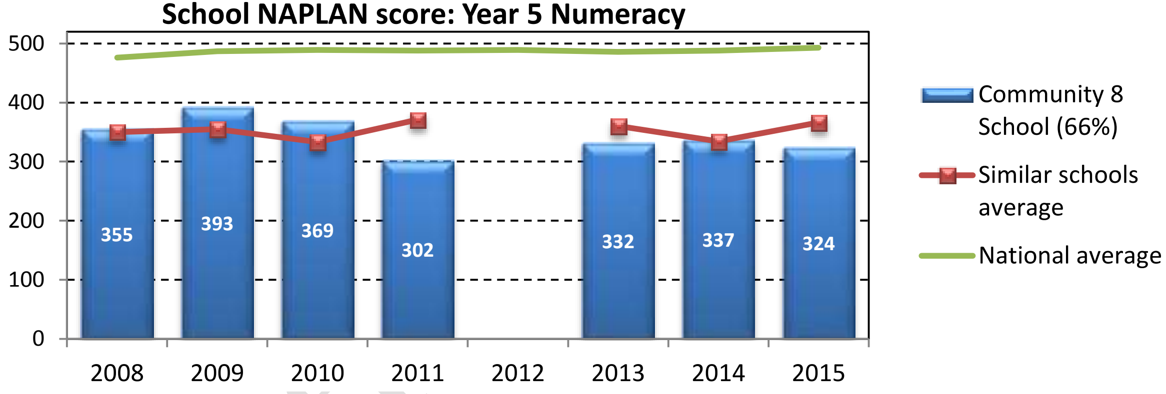
- There was an improvement in the Community 8 school score for Year 5 reading from 2014 to 2015, with the latest score about the same as similar schools. The score of 345 was 69% of the national average for year 5 reading.



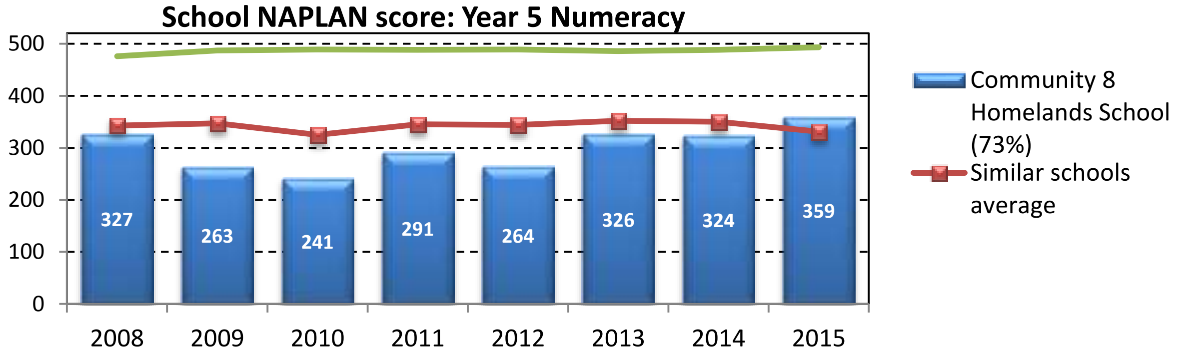
- There was an improvement in the Community 8 Homelands school score for Year 5 reading from 2014 to 2015, with the latest score much lower than similar schools. The score of 200 was 40% of the national average for year 5 reading.



- There was a small decline in the Community 8 school score for Year 5 numeracy from 2014 to 2015, with the latest score lower than similar schools. The score of 324 was 66% of the national average for Year 5 numeracy.

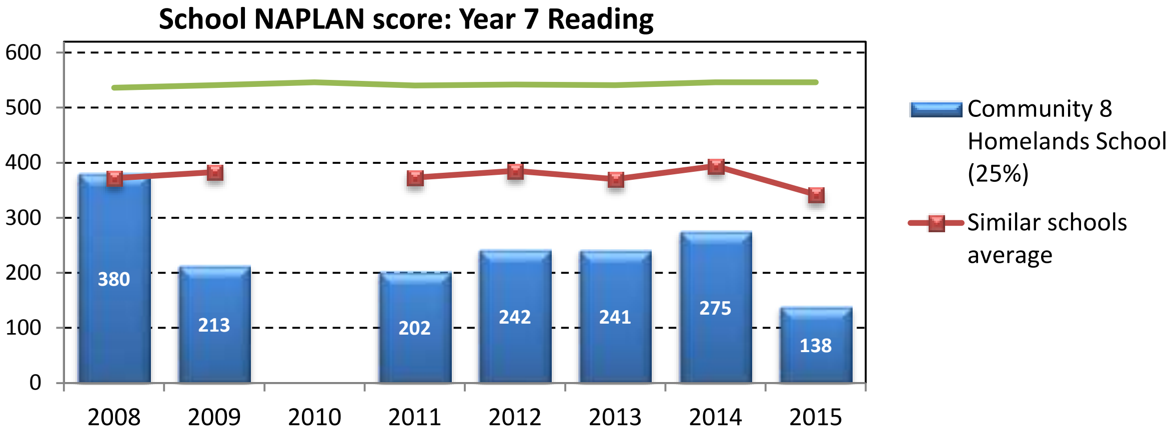


- There was a small improvement in the Community 8 Homelands school score for Year 5 numeracy from 2014 to 2015, with the latest score a little bit higher than similar schools. The score of 359 was 73% of the national average for year 5 numeracy.

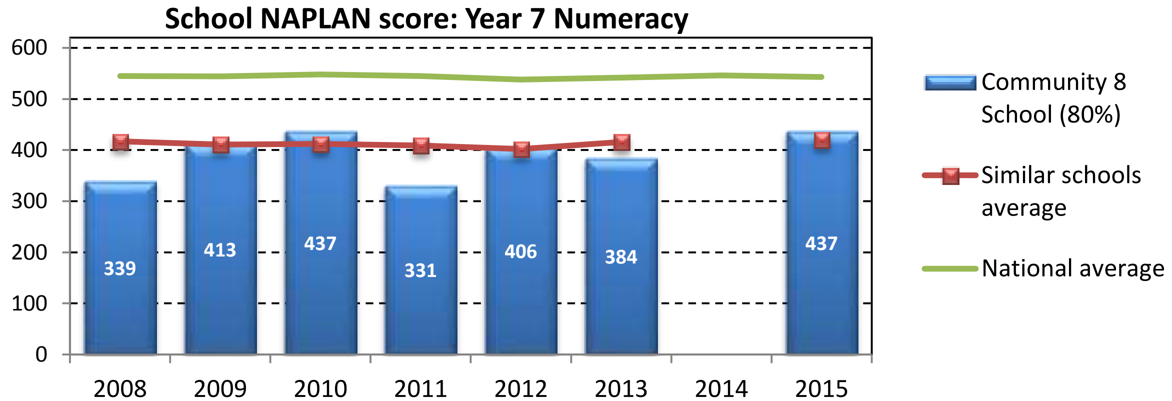


- There was an improvement in the Year 7 Community 8 school score for reading between 2014 and 2015, and this score was a little bit lower than the average of similar schools, and was 66% of the national average for year 7 reading.

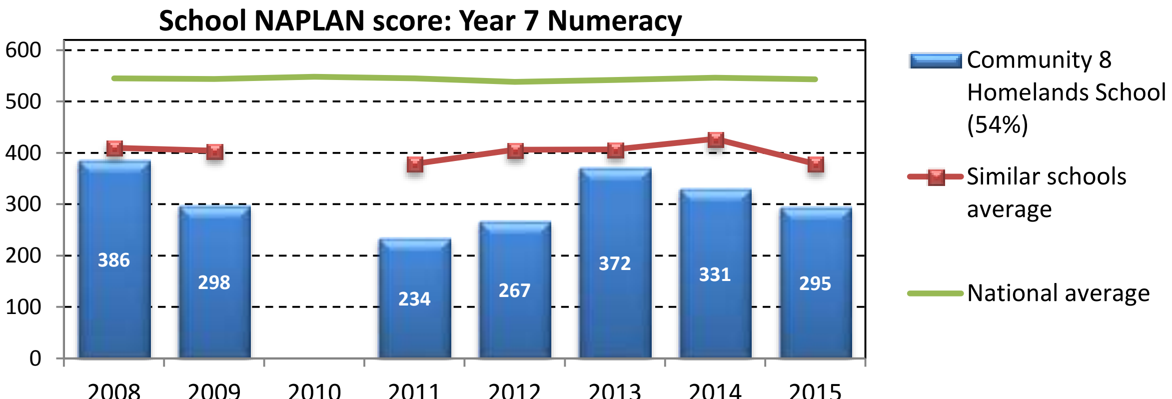
- There was a decline in the Year 7 Community 8 Homelands school score for reading between 2013 and 2015, and this score was lower than the average of similar schools, and was 25% of the national average for year 7 reading.



- There was a small improvement in the Year 7 Community 8 school score for numeracy from 2013 to 2015, and this score was about the same as the average of similar schools, and was 80% of the national average for Year 7 numeracy.



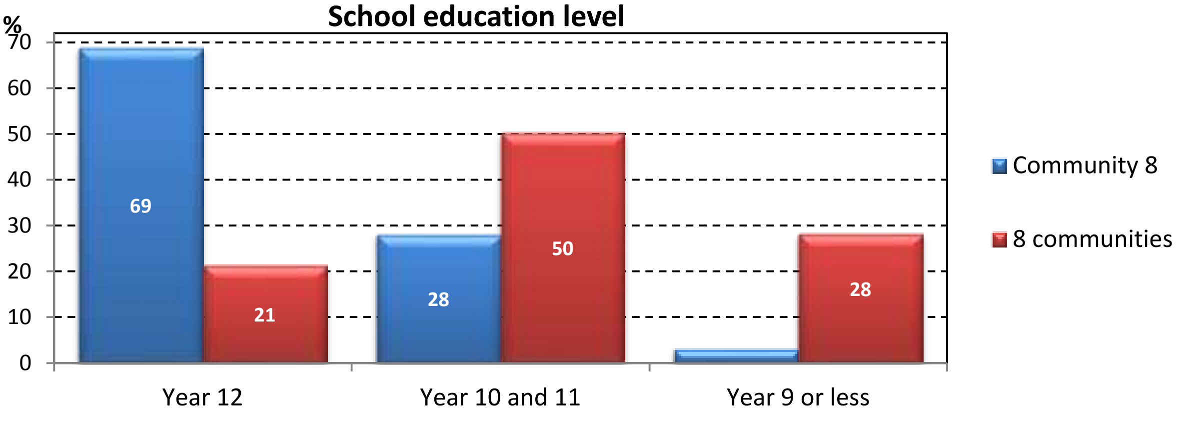
- There was a small decline in the Year 7 Community 8 Homelands school score for numeracy from 2014 to 2015, and this score was lower than the average of similar schools, and was 54% of the national average for year 7 numeracy.



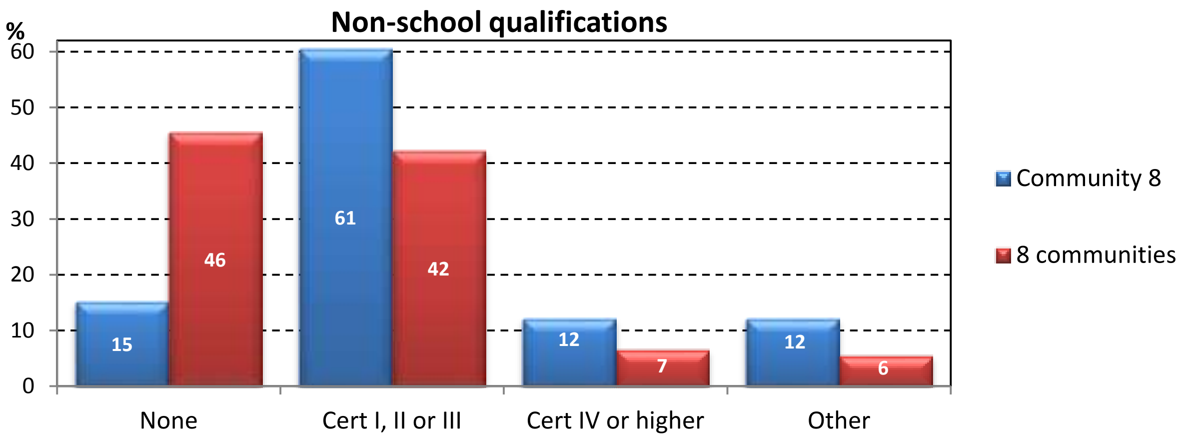
Community Survey

Adult education

- Sixty-nine percent of adults surveyed in Community 8 had completed year 12, which was higher than that observed across all eight communities (21%).



- Sixty-one percent of adults surveyed in Community 8 had completed a Certificate I-III, which was higher than that observed across all eight communities (42%).



Key informant interviews

A high proportion of children at the Community 8 school come from families with alcohol-related problems. Many children are cared for by grandparents who are also often the primary liaison point for the school. Alcohol misuse is perceived as affecting school attendance, which is around 40%, with the worst attendance days being Thursday and Friday. One informant commented that there needed to be better pathways from school into work.

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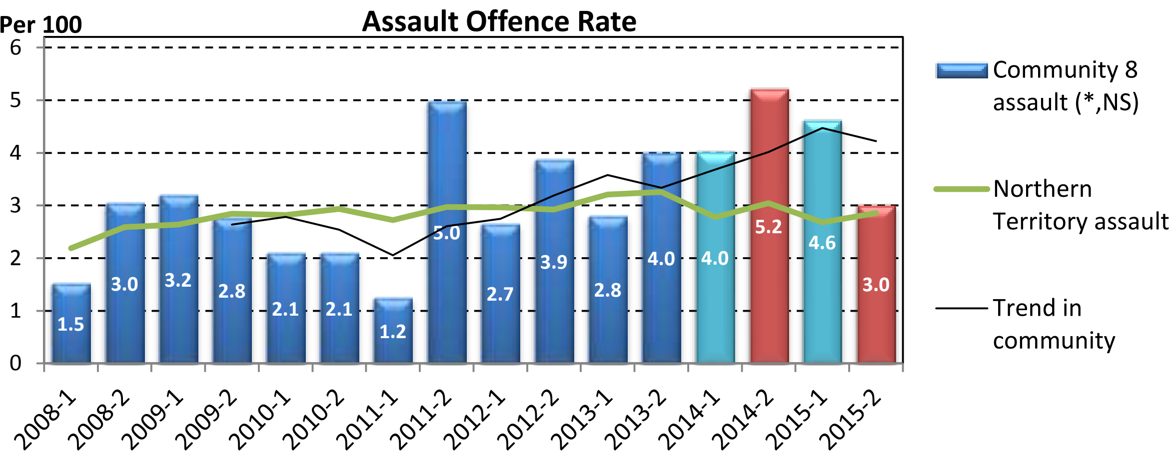
Community safety

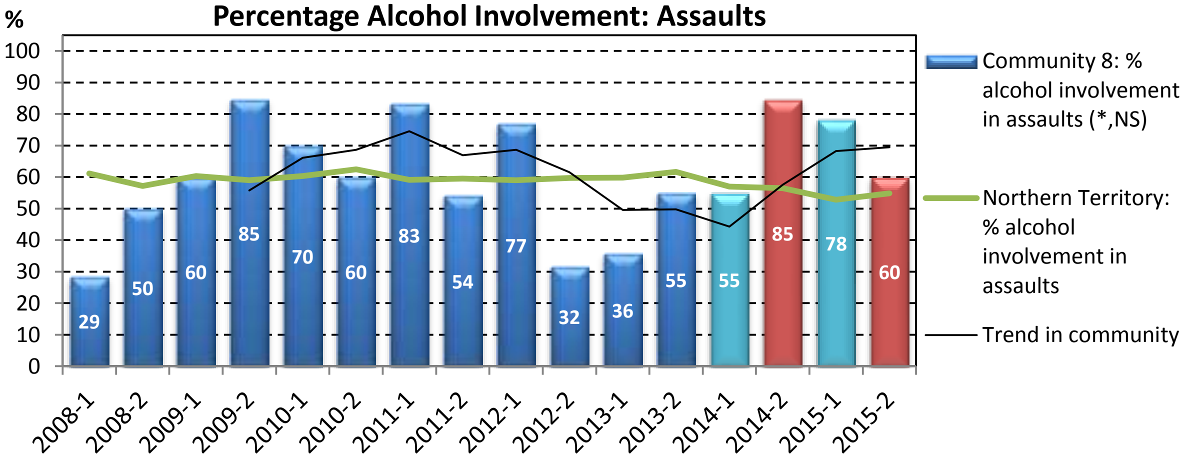
<u>Administrative data</u>

Assault offences

- There was very little change in the assault rate between 2014-1 and 2015-1, and there was a non-significant decrease from 5.2 per 100 people to 3 per 100 people between 2014-2 and 2015-2.
- The rate in Community 8 of 4.6 per 100 people was significantly higher ($p<0.05$) than the Northern Territory rate (2.7 per 100 people).

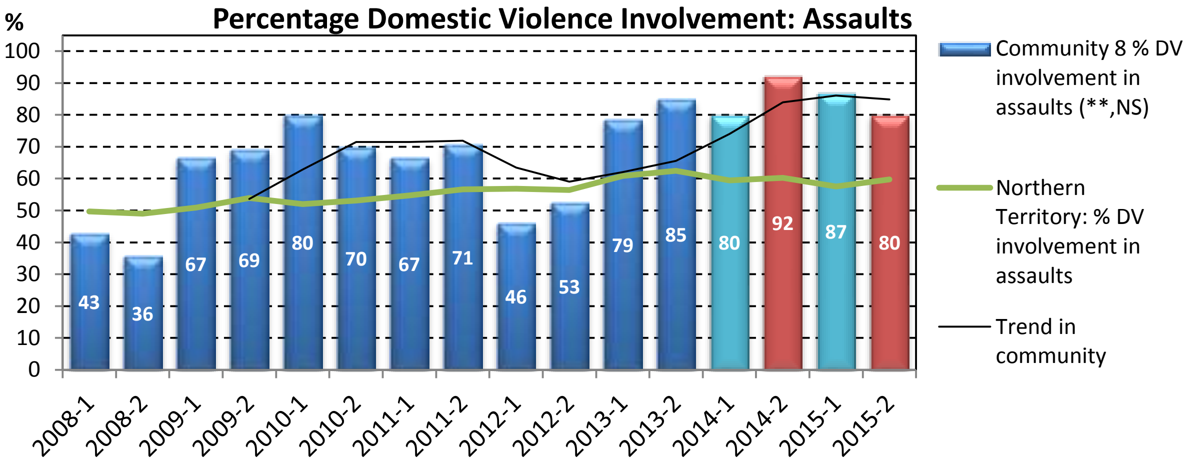


- There was no significant change in the percentage of alcohol involvement in assaults between 2014-1 (55%) and 2015-1 (78%), and also between 2014-2 (85%) and 2015-2 (60%). While the percentage decline was large the smaller number of assaults in 2015-2 weakened the statistical power to detect a difference.
- The percentage alcohol involvement in assaults for Community 8 in 2015-1 (78%) was significantly ($p<0.05$) different to that observed for the NT (53%).

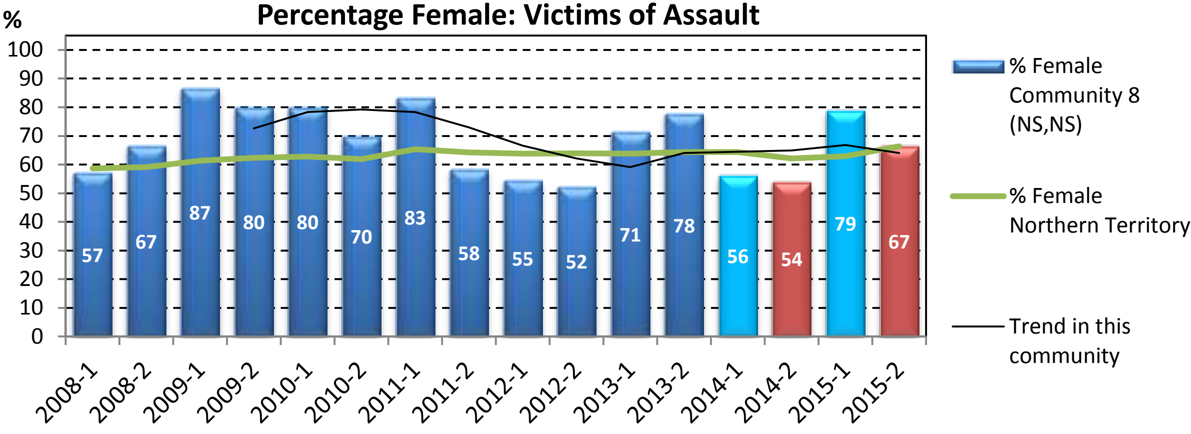


- There was no significant change in the percentage of domestic violence involvement in assaults between 2014-1 (80%) and 2015-1 (87%), and also between 2014-2 (92%) and 2015-2 (80%).

- The percentage DV involved was significantly higher in Community 8 (87%) than the NT (58%) in 2015-1, but not 2015-2.



- The percentage female victims of assault increased from 56% to 79% between 2014-1 and 2015-1, but this increase was not statistically significant.
- The trend has been steady over the last 2 years and was not significantly different to the NT.



Theft, break and enter and property damage

- There was a significant ($p<0.05$) increase in theft, break and enter and property damage rates from 4 to 7 per 100 people from 2014-2 to 2015-2.
- The trend has been increasing over the last 2 years, but is not significantly different to the NT.

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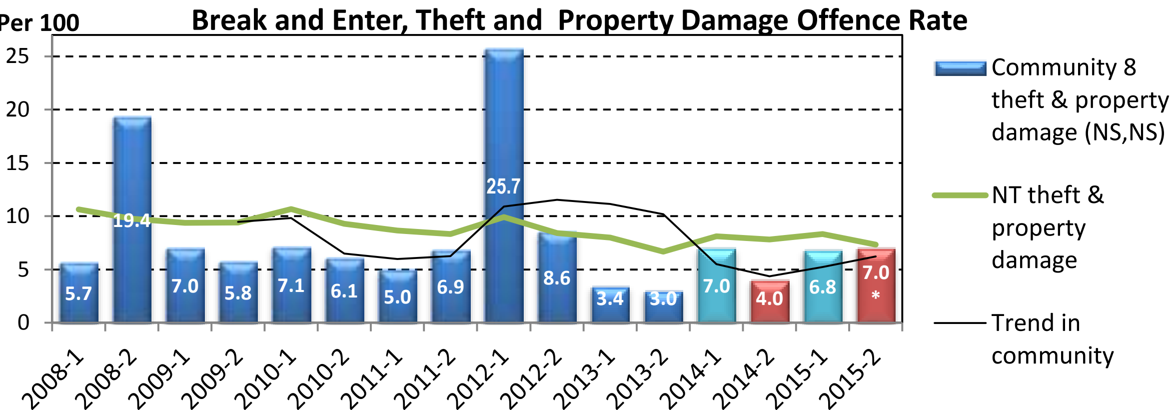
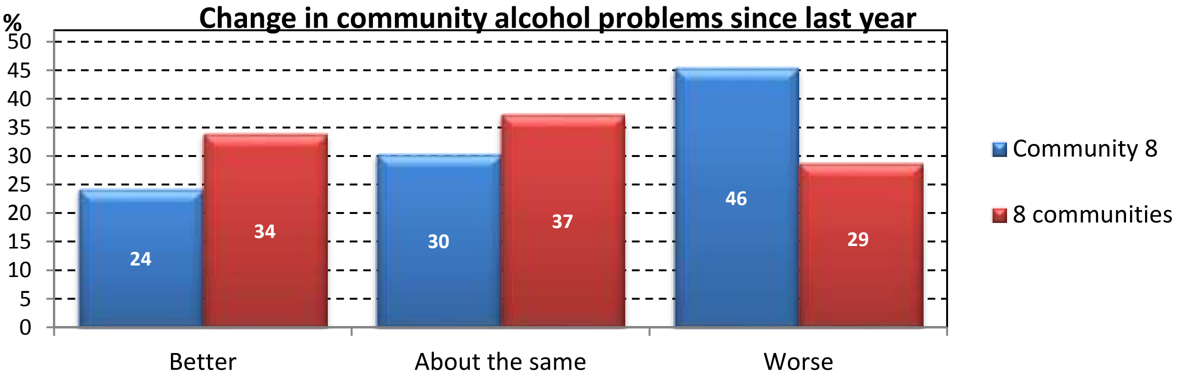


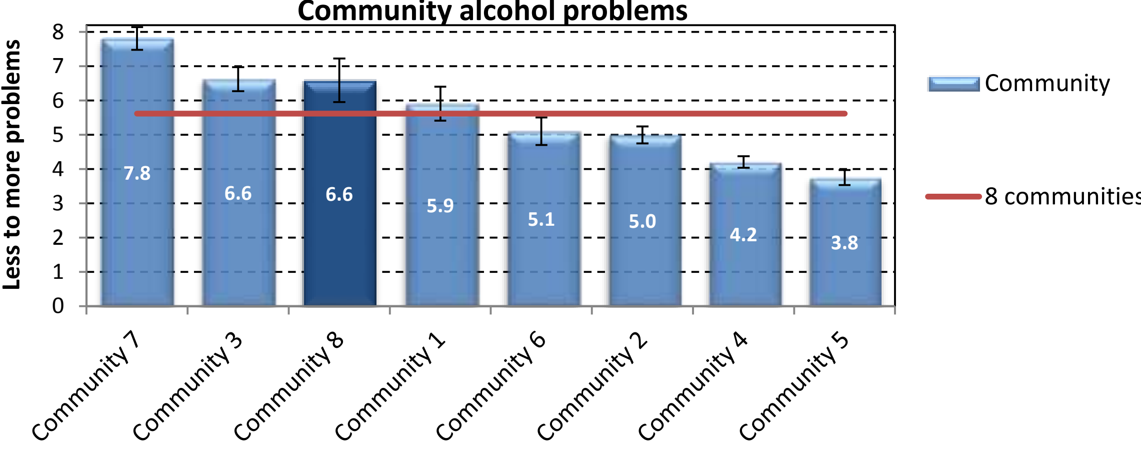
<u>Community survey</u>

Community and household alcohol problems

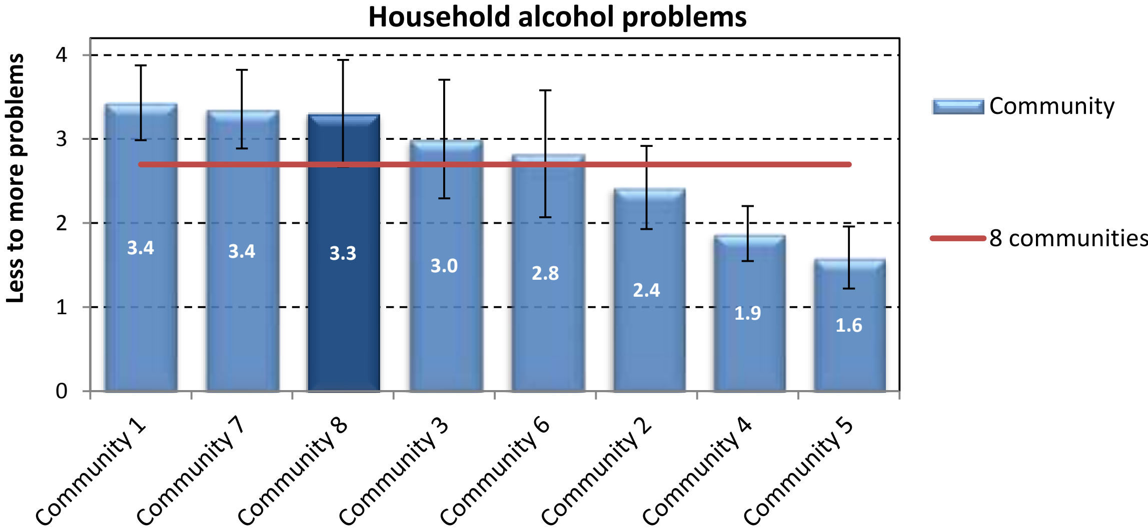
- Most (46%) of people surveyed in Community 8 said community alcohol problems were worse than the previous year, and only 24% said it was better.



- When asked about community alcohol problems and how often they occur, Community 8 scored above the average of the eight communities.



- When asked about household alcohol problems and how often they occur, Community 8 scored above the average of the eight communities surveyed.



Community problems

- The Community Survey asked residents about a list of 13 community problems and how much of the time over the last year they happened. From this list of problems three groupings were identified using the statistical technique, Factor Analysis. They were:
    1. Problems Factor 1: *Violence and Anti-Social Behaviour* which includes the three community problems: (i) seeing people fighting, (ii) noise at night and (iii) family violence.
    2. Problems Factor 2: *Gambling Problems & Problematic Social Relations* which includes three community problems: (i) gambling, (ii) humbugging and (iii) jealousy.
    3. Problems Factor 3: *Poor Community Safety* which includes three community problems: (i) people not feeling safe, (ii) youth gangs and (iii) stealing or theft, and break and enter.

- For *Violence and Anti-Social Behaviour Problems* in the community, Community 8 scored on the average of the eight communities.

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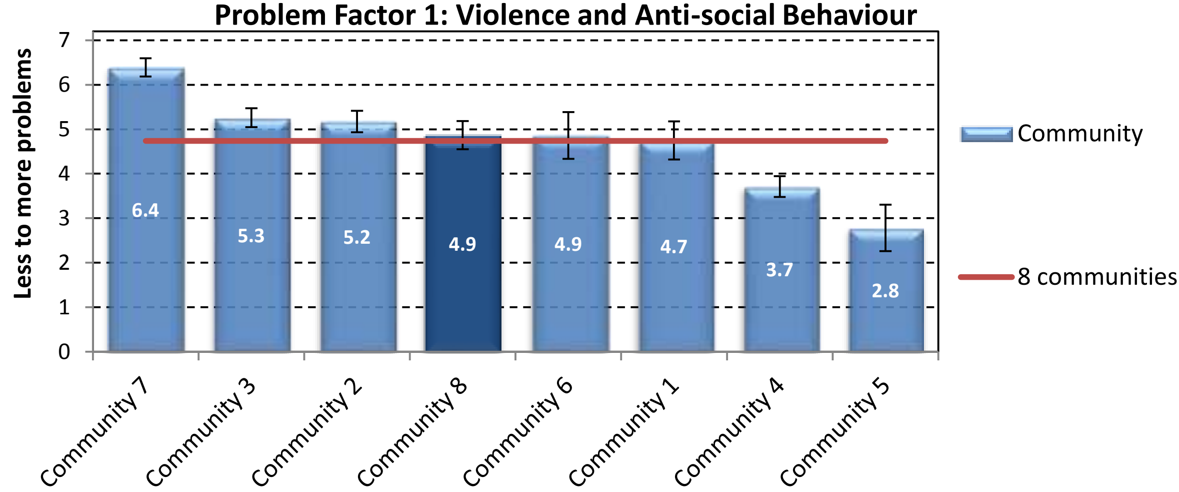
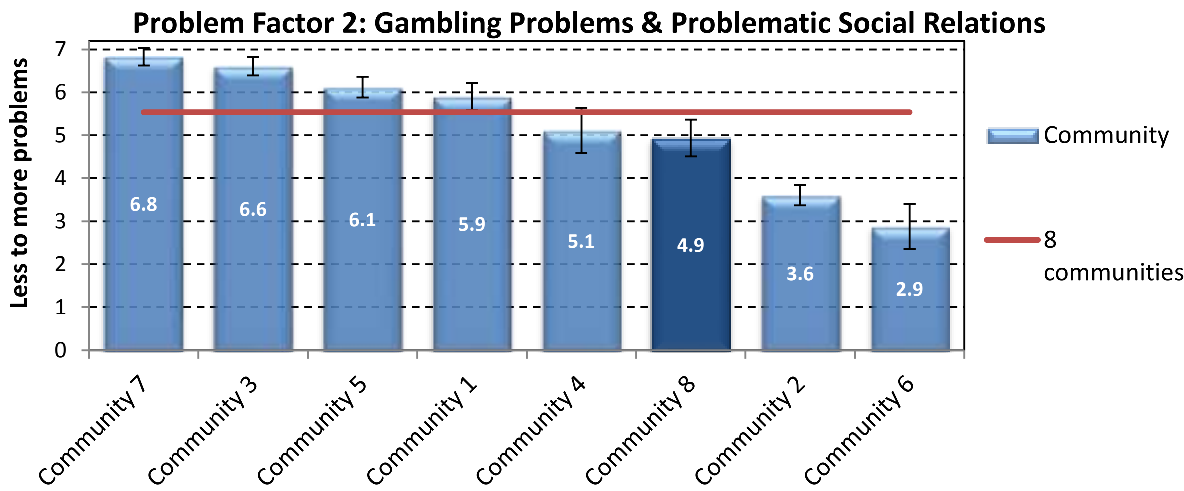


- Community 8 scored below the average of the eight communities for *Gambling Problems and Problematic Social Relations* in the community, meaning things were a little better in Community 8 compared with the other communities surveyed.



- Community 8 scored the highest of the eight communities for *Poor Community Safety*, meaning people in Community 8 said poor community safety was occurring more of the time than what people said in other communities.

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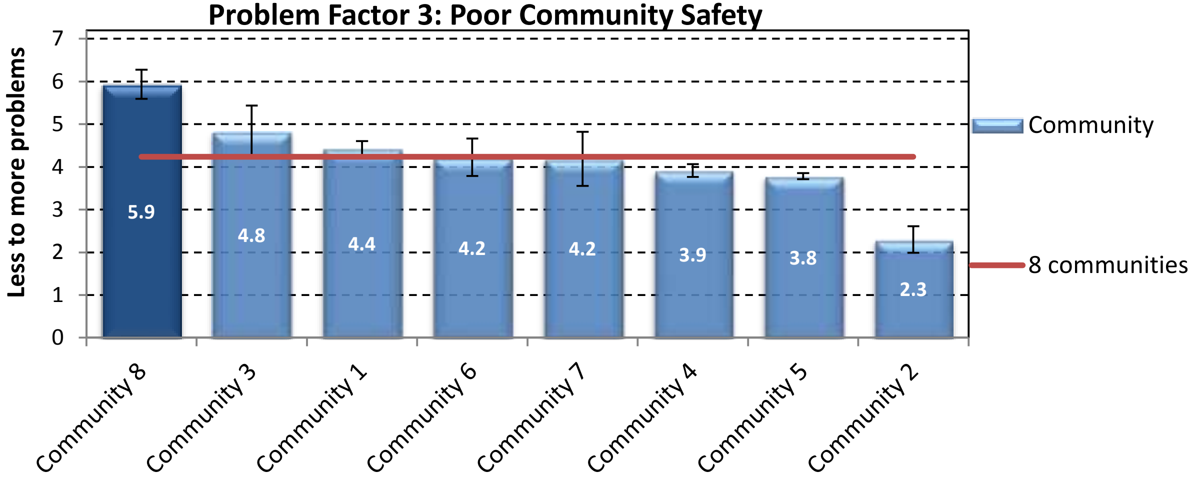
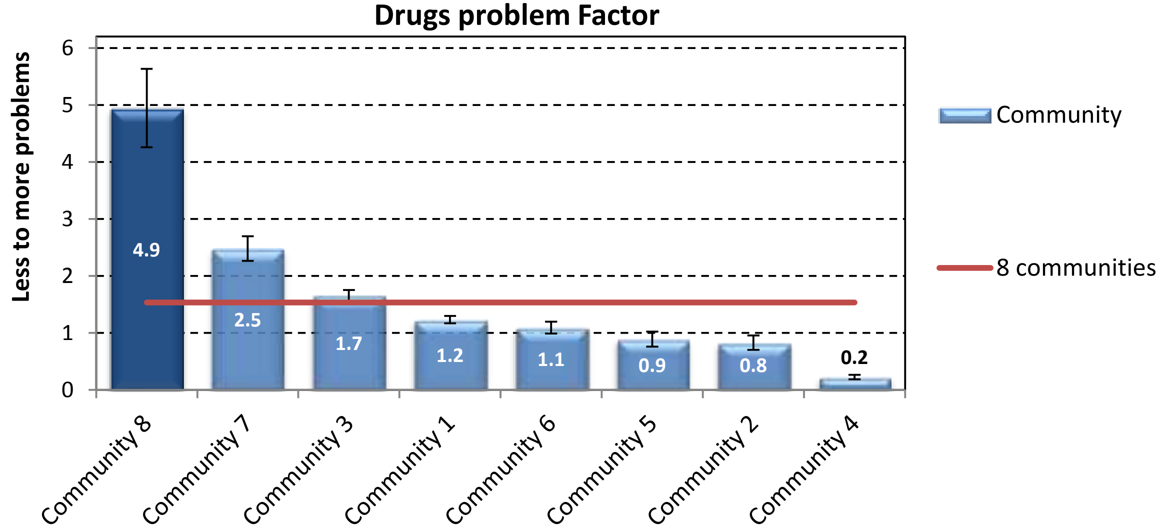


Community drug problems

- Community 8 scored the highest of the eight communities for community drug problems. Community 8 communities had more problems with petrol sniffing and kava, compared with other places.



Key informant interviews

Alcohol was perceived as contributing to domestic violence; assaults; rape; youth suicide; break-ins; and arguments and fighting. Most domestic violence in Community 8 was attributed to people without permits who drank in the nearby town. Several informants noted that alcohol misuse was a major contributor to family conflict and violence, particularly where families expressed disapproval of excess drinking or attempted to stop a family member from drinking. Public disorder offences, such as disruption to businesses and humbugging, mainly occur in the nearby town, escalate on pay days and continue until money runs out. Several informants commented on the importance of Community 8 having its own night patrol and noted that there was a need to have *local people working on the ground who would know the families and the community*. Although night patrol was initiated by local

women, and used to be staffed by local people, it now comes under the jurisdiction of the regional shire council and is based in the nearby town. One informant commented that the subsequent loss of knowledge and connections with local people has resulted in a loss of respect and trust for night patrol.

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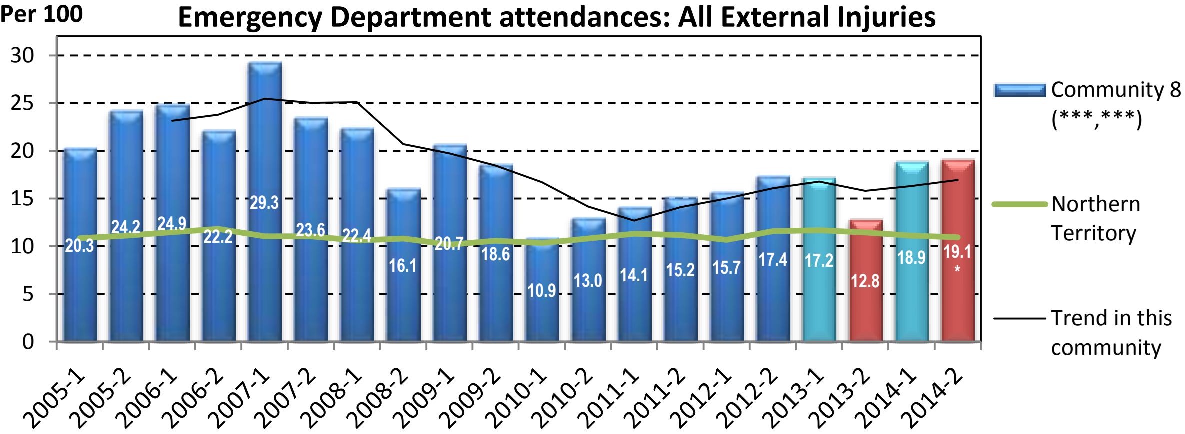
Community health and wellbeing

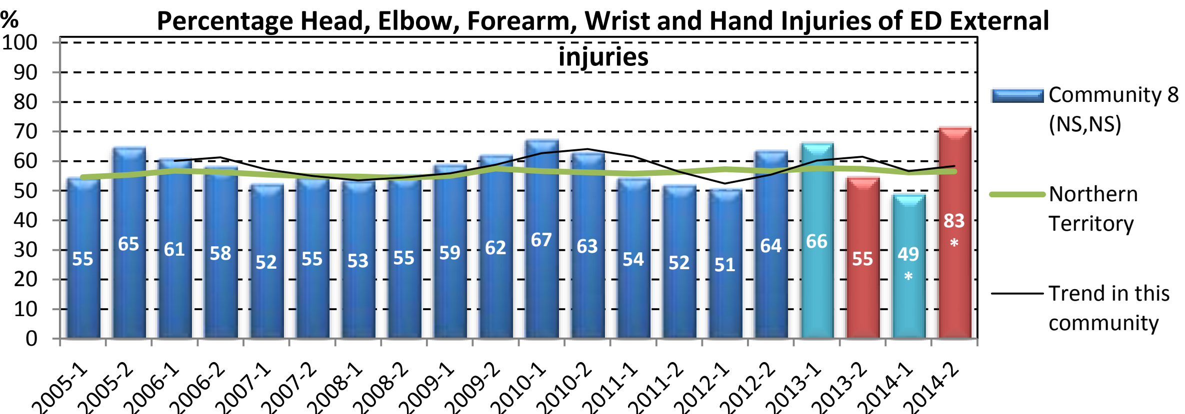
Administrative data

Emergency Department admissions for external injuries

- There was a significant ($p<0.05$) increase in the rate of ED attendances between 2013-2 and 2014-2 from 12.8 per 100 people to 19.1 per 100 people.
- In both halves of 2015 the rate in Community 8 was significantly ($p<0.001$) higher than the NT rate.

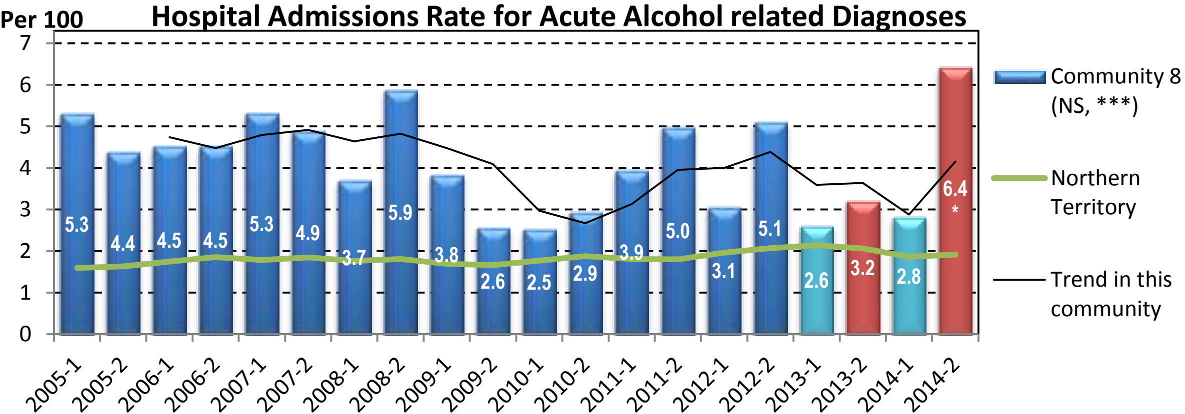


- Head, elbow, forearm, wrist and hand injuries made up the most of the external injuries in the ED admissions and as a percentage of all external injuries were mostly steady over time, but was significantly different from the NT in both halves of 2015 (56% and 57%).
- In head, elbow, forearm, wrist and hand injuries as a percentage of all external injury ED attendances, there was a significant increase ($p<0.05$) between 2013-2 and 2014-2 from 55% to 72%.



Hospitalisation for alcohol-related conditions

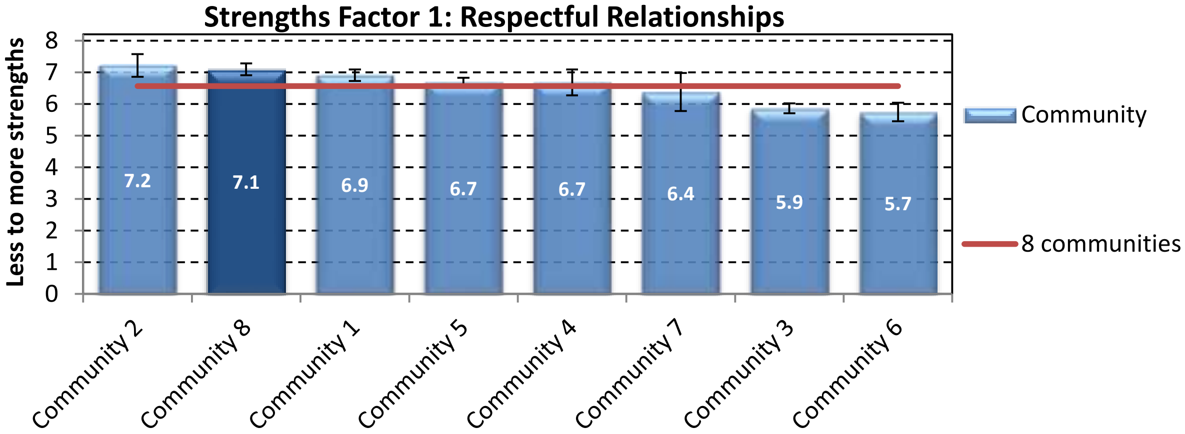
- Hospital admissions for acute alcohol-related conditions significantly increased ($p<0.05$) between 2013-2 and 2014-2 (3.2 to 6.4 per 100 people).
- The rate in Community 8 in the second half of 2015 was significantly ($p<0.001$) higher than the NT rate (1.9 per 100 people).



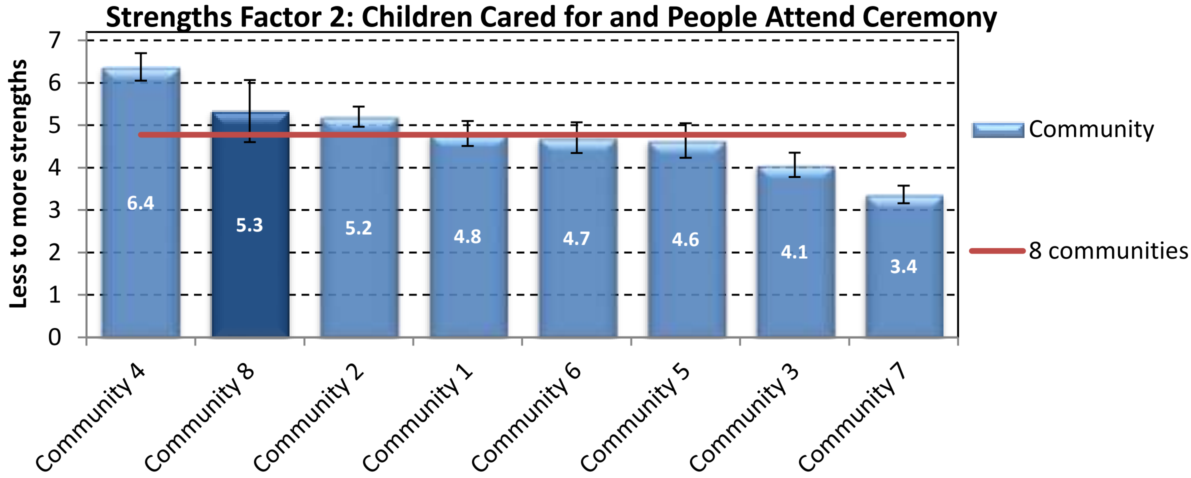
<u>Community survey</u>

Community strengths

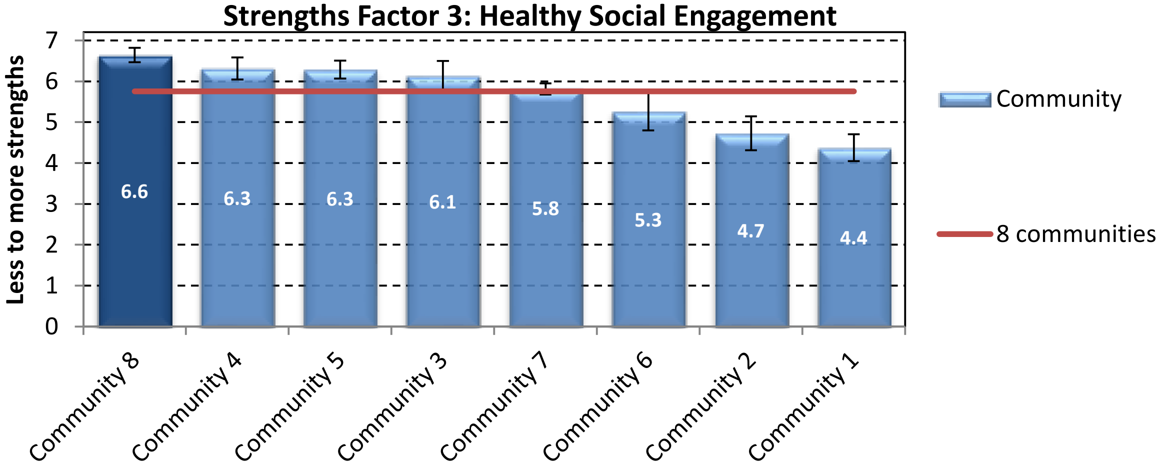
- The Community Survey asked residents about a list of 14 community strengths and how much of the time over the last year they happened. From this list of strengths three groupings were identified using the statistical technique, Factor Analysis. They were:
  1. Strengths Factor 1: *Respectful Relationships* which includes the three community strengths: (i) people respect Elders, (ii) people respect other community members, and (iii) people help each other.
  2. Strengths Factor 2: *Children Cared for and People Attend Ceremony* which includes three community strengths: (i) Children go to school, (ii) Children well looked after, and (iii) people attend ceremony.
  3. Strengths Factor 3: *Health Social Engagement* which includes three community strengths: (i) people go out for bush tucker, (ii) people do organised sports and other activities and (iii) people say no to humbug.
- In *Respectful Relationships* Community 8 scored second highest of the eight communities surveyed.



- Community 8 scored second highest of the eight communities surveyed for Children cared for and people attend ceremony.



- Community 8 scored the highest of the eight communities for Healthy Social Engagement.



<u>Key informant interviews</u>

Alcohol was perceived as having substantial effects on health and wellbeing. It was considered to contribute to a loss of culture and employment, to a break-down in relationships, and to a range of stresses associated with its negative impact on finances. Loud noise and drunkenness contribute to a loss of sleep for both children and adults, with this affecting attendance at both school and work. One informant commented there was a lack of structure and routine and that … parents just don't manage kids' wellbeing, with this resulting in inadequate nutrition, lack of sleep, and being late for school or absent altogether. Children were also left unsupervised and tended to be out on the streets at night.

Peer pressure, socialising, and modelling the behaviour of others, were all perceived as factors that contributed to the normalisation of alcohol use. A lack of positive role modelling was also identified as a factor, with many of the current generation of parents being unemployed and unable to provide a positive model to children. Lack of employment options and recreational opportunities were perceived as contributing to boredom which in turn contributed to alcohol misuse. Individuals who wished to work, and had undertaken training

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to achieve this goal, were seen as particularly vulnerable to boredom and frustration if not successful in obtaining employment, and to subsequently experience alcohol problems. Several informants commented that 'sit down' money (from both Centrelink and royalty payments), combined with few opportunities for meaningful occupation, was a disincentive to work and led to excess drinking. Royalties were perceived as causing lots of problems, with their distribution acting as a trigger for excess consumption and associated problems such as jealousy, fights, family conflict and humbugging.

Strategies to reduce alcohol problems focused on: AOD education programs; education generally, such as literacy and life skills; community based initiatives such as a non-residential rehabilitation centre and taking those with problems to Homelands; work-based justice programs; more activities; and a strengthening of leadership within the community. Traditional restraints on alcohol consumption and related behaviour were perceived as less effective than they used to be due to a weakening of cultural values and Elders' authority. For this reason, there was a strong emphasis, by some informants, on the need to strengthen leadership and cultural values within the community. One example of such a program is ████████ (customary and disciplinary law), run by █████ Aboriginal Corporation. This program works within the defined rules of acceptable behaviour within in the group's traditional cultural values. In doing this, it relies on traditional culture as a way of coping with change but also aims to re-embed traditional culture within the modern context and to integrate traditional and mainstream influences (Coordinator, ████████ Wellbeing Programme/Community Member).

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Recommendation
That community data reports be made available to the relevant Community Safety Committee, Alcohol Reference Group, Local Authority Board, or other appropriate body (pending discussions with the community), at least once per year.

Recommendation
That validation work be done on the Scoresheet on community data reports to assess the relevance and usefulness of changes over time in domain scores.

Recommendation
That further work be carried out exploring the relevance and usefulness of the community score card in the Highlights section of data reports.

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5. Composite Indicators and Assessing Relative Need

The individual community data reports presented in the previous chapter provide communities and governments with a tool that can be used to determine change across a range of indicators and domains (e.g. alcohol patterns of use, education, health and wellbeing) for a particular community. They include long term time trends in 6-monthly periods, so that changes between the same period in different years can be assessed and, where appropriate, statistical testing done to enable the community or government to assess whether a change was significant. Individual data reports are primarily for use by communities and those working in or with communities, and they are a tool that can be used to monitor and evaluate alcohol-related programs implemented in their community.

However, the information can also be analysed in a different way; one that focuses on a single year and allows for relationships to be explored between all the indicators for all communities simultaneously. Looking at data in such a way is referred to as multivariate analysis. Multivariate methods include techniques such as Factor Analysis (FA) and Principal Component Analysis (PCA), non-metric multidimensional scaling (nMDS), Multiple Correspondence Analysis (MCA), and clustering techniques (dendrograms). Each technique has its own strengths and provides a different insight into the multivariate structure of the data set. For example, PCA can be used to create a composite single dimension index from many indicators, and is the approach used by the Australian Bureau of Statistics to create the socioeconomic indexes for areas (SEIFA). However, some multivariate methods, such as Factor Analysis and nMDS, also enable the inspection of data at more than one dimension, which allows for a more nuanced understanding of how communities cluster together based on multiple indicators in two or more dimensions. These techniques provide a continuous view of how communities are related based on multiple indicators. Clustering techniques, on the other hand, create groupings of objects (e.g. communities) based on their similarity across a range of indicators.

5.1 Worked examples using 19 communities

5.1.1 PCA of hospital, emergency department and police offence data

PCA creates independent linear combinations of variables that maximise the variation across the set of variables. It allows for the examination of relationships between multiple variables simultaneously. For this worked example, data on offences (including percentage alcohol and domestic violence involvement), hospital admissions and emergency department attendances for external injuries (including percentage head, hand, wrist and forearm) have been analysed using PCA. Table 17 shows the data for 19 de-identified communities that will be used in the analysis. Six of the eight study communities that have been the focus of this project are included in the data below, but the ID assigned to communities is different to the data reports presented in Chapter 4. The analyses contained in this section are somewhat exploratory, with further data checking required before the results of the analyses could be used with confidence for the larger set of communities.

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Table 17: Community health and community safety indicators used for analysis, 2014

Community ID	Assault rate	% Alcohol in assaults	% Domestic violence in assaults	Theft, stealing Break & enter & property damage[1] rate	Emergency department external injuries rate	% Head, hand & forearm injuries In external injuries	Acute alcohol diagnoses hospital admission rate	Chronic alcohol diagnoses hospital admission rate
C1	6.0	52.5	87.5	5.1	16.1	69.2	7.2	1.2
C2	8.4	77.4	77.4	2.7	14.0	61.5	3.2	0.5
C3	5.9	100.0	84.6	1.4	19.9	61.4	5.0	0.5
C4	8.9	74.1	100.0	5.9	13.2	73.8	4.9	0.0
C5	9.5	67.0	70.9	6.8	7.2	66.7	2.0	0.1
C6	6.5	82.5	90.0	3.8	12.3	57.3	1.0	0.0
C7	3.2	53.2	80.9	7.0	4.2	61.9	1.4	0.6
C8	6.1	51.2	90.7	7.9	25.7	58.3	13.9	2.6
C9	2.9	67.6	86.5	4.4	3.3	53.5	1.0	0.2
C10	3.3	63.6	90.9	1.8	7.9	61.5	2.4	0.0
C11	3.4	85.7	92.9	4.7	19.1	62.8	4.4	0.7
C12	5.0	35.9	74.4	1.9	14.9	64.3	4.5	0.0
C13	2.7	25.6	74.4	3.1	3.1	54.5	1.3	0.1
C14	5.0	53.6	89.3	3.2	2.3	53.8	1.1	0.0
C15	2.5	19.4	74.2	7.1	10.1	65.9	4.5	0.3
C16	6.0	32.1	67.9	4.1	5.4	76.0	0.6	0.0
C17	4.3	18.3	79.3	4.3	4.6	67.0	2.4	0.3
C18	4.6	71.7	87.0	5.5	19.0	60.3	4.6	0.3
C19	9.0	18.6	70.0	16.8	22.3	67.1	8.6	0.5

NOTES: Rate per 100 people based on community estimated resident population developed for use with the data reports

1 Theft, stealing, break and enter and property damage offences (grouped)

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Table 18 shows rotated factor loadings, Eigen values and the variation explained for the 2-factor PCA solution. The first component explained 50% of the variation in the data and the second a further 31%, giving a high 81% of the variation across the eight variables being explained by these two components. The loadings in this table can be interpreted in much the same way as correlation coefficients, and they indicate how strongly correlated the variable is with the component score. The first principal component (PC) is a combined measure of hospital admission rates for acute and chronic alcohol-related diagnoses; emergency department attendances for external injuries; assaults; and theft, stealing, break and enter and property damage. All of these variables have high positive loadings on this PC (bolded). The percentage alcohol and domestic violence involvement in assaults both had high positive loadings on PC 2, while percentage head, hand and forearm injuries, and the rate for theft, stealing, break and enter and property damage, had moderate negative loadings on this component. Component scores in PCA are standardised to have a mean of zero and standard deviation of 1.

Table 18: PCA 2-factor solution loadings, Eigen values and variation explained

	PC 1	PC 2
Acute alcohol diagnoses admissions rate	**0.97**	-0.04
ED external injuries attendance rate	**0.89**	0.16
Chronic alcohol diagnoses admissions rate	**0.78**	0.13
Assault rate	**0.41**	-0.19
Theft, stealing & property damage rate	**0.49**	**-0.49**
% head, hand, forearm injuries	0.16	**-0.41**
% alcohol involvement in assaults	0.07	**0.84**
% domestic violence involvement in assaults	0.18	**0.74**
Eigen value	*2.81*	*1.76*
% Cumulative variation explained	***50%***	***81%***

Figure 6 plots the principal component scores for each of the 19 communities from the rotated 2-factor solution. Two communities, C8 and C19, stand out, with scores greater than one standard deviation from the mean on PC 1, indicating high rates across both types of offences and hospital admissions and ED attendances, with C8 nearly three standard deviations higher than the mean (of zero). C13 and C14 scored one standard deviation or more below the mean on PC 1, indicating lower rates in these communities. C3 and C11 both scored above one standard deviation on PC 2 indicating a higher percentage of assaults involving alcohol and domestic violence, and conversely C19, C16 and C17 scored low on this component.

Another way the plot can be used to classify communities is to focus on the top right and bottom left quadrants, as communities falling in these quadrants are above or below the average respectively on both components. So, offence rates in C3, C8, C11, C18, C4, C1 and C2 were above the average for both types of offences; hospital admission rates; emergency department attendance rates; and percentage alcohol and domestic violence in

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assaults, while C16, C17, C13, C15 and C5 were below average across these variables. Table 19 lists communities that have either high or low levels across the community health and safety indicators examined.

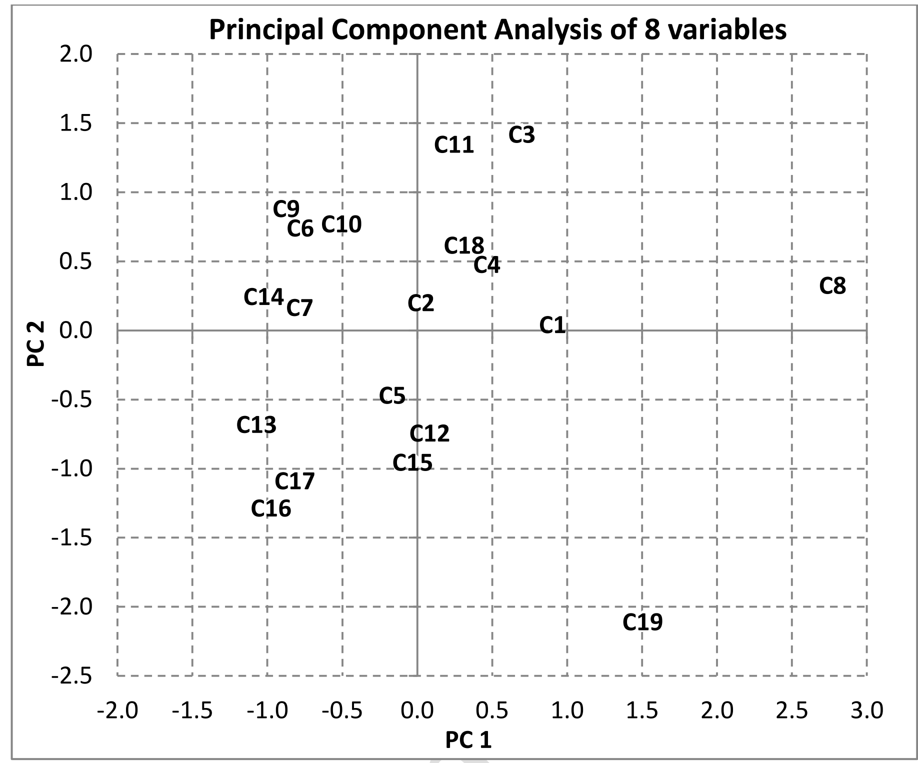

Figure 6: Principal component analysis 2-factor solution of police offence, hospital and emergency department data

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Table 19: Summary of communities with high or low levels across the community health and safety indicators

Principal Component 1 (horizontal axis) Hospital admission rate for acute and chronic alcohol-related diagnoses Emergency department attendance rate for external injuries Assaults and theft, stealing & property damage rate	
Low (better) C13 and C14	**High (worse)** C8 and C19

Principal Component 2 (vertical axis) % alcohol in assaults % domestic violence in assaults	
Low (better) C19, C16 and C17	**High (worse)** C3 and C11

Bottom left and top right quadrants Both principal components	
Below average on both (comparatively better) C16, C17, C13, C15 and C5	**Above average on both (comparatively worse)** C3, C8, C11, C18, C4, C1 and C2

5.1.2 Composite indexes

Principal component analysis can also be used to create a composite index that contains the information from multiple correlated variables. However, there are multiple ways of creating indexes, and assessing how these indexes perform in determining community need, and identifying community strengths and problems, will lead to a robust set of indexes that can be used over time in The Framework. Because there are multiple ways in which a composite index can be constructed, it is beneficial to first construct multiple indexes using different approaches, which can then be used in further analyses, and the best one selected for ongoing use in The Framework.

The Health and Safety PCA Index is a composite index using hospital admission rates for acute and chronic alcohol-related diagnoses; emergency department attendance rates for external injuries; assaults offence rate; and theft, stealing, break and enter, and property damage offences rates. The PCA yielded a single factor solution, from which a score was generated and standardised to have a maximum of 100 and a minimum of zero.

The Safety PCA Index uses the assault offence rates; stealing, break and enter, and property damage offence rates; and percentage head, hand and forearm injuries of all external injuries attended in emergency departments. Again, the PCA yielded a single factor solution, from which a score was generated and standardised to have a maximum of 100 and a minimum of zero.

The Standardised Safety Index was derived by first range standardising five variables: (i) assault; (ii) theft, stealing, break and enter and property damage; (iii) percentage alcohol involvement in assaults; (iv) percentage domestic violence involvement in assaults; and (v) percentage head, hand and forearm injuries of all external injury attendances to emergency department. That is, for each community, subtract the minimum of that variable and divide by the difference between the maximum and the minimum. This gives a value between 0 and 100, with 0 being the community that had the lowest rate and 100 the community with the highest. The average of the five standardised rates was then calculated to give a composite measure for community safety that can be used to rank communities.

The Health PCA Index uses hospital admission rates for acute and chronic alcohol-related diagnoses and emergency department attendance rates for external injuries. Again, the PCA yielded a single factor solution, from which a score was generated and standardised to have a maximum of 100 and a minimum of zero.

The Standardised Health Index was derived in a similar way to the Safety Index, but using the following variables: (i) emergency department attendance rate for external injuries; (ii) hospital admission rates for acute alcohol-related diagnoses; and (iii) hospital admission

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rates for chronic alcohol-related diagnoses. It is more a measure of hospital and emergency department utilisation.

Table 20 shows how the different indexes rank the 19 communities, while Table 21 shows summary statistics for each index. These indexes can be produced annually, and further analyses could determine if they have predictive power with regards to alcohol-related harms or could be used as (alcohol related) outcomes with other community factors analysed (e.g. programs or specific AAI initiatives) as explanatory variables in statistical modelling.

Table 20: Ranking of 19 communities using composite indexes for health, safety and a combination of both

	Health & Safety PCA Index		Safety PCA Index		Standardised Safety Index		Health PCA Index		Standardised Health Index	
ID	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score
C9	1	0	2	3	6	26	3	2	4	5
C16	2	0.1	16	63	8	27	1	0	2	2
C14	3	2	4	14	5	25	2	1	1	1
C13	4	2	1	0	1	8	4	4	3	3
C7	5	3	6	27	9	28	6	7	9	11
C6	6	5	11	32	15	37	5	5	5	7
C17	7	11	12	36	4	22	8	11	8	9
C10	8	12	3	13	13	33	9	12	7	8
C5	9	13	17	76	12	33	7	10	6	8
C2	10	22	14	48	10	32	10	22	13	21
C15	11	27	10	30	2	19	11	27	12	18
C11	12	29	5	24	18	43	15	32	16	30
C12	13	30	9	30	3	20	12	27	11	18
C18	14	32	8	29	14	35	14	31	14	24
C3	15	35	7	28	17	39	16	34	15	28
C4	16	35	18	82	19	58	13	29	10	17
C1	17	50	15	53	16	39	17	50	18	40
C19	18	65	19	100	7	27	18	58	17	39
C8	19	100	13	42	11	33	19	100	19	80

The summary statistics for each index (Table 21) indicate that they are not normally distributed, which is partially the result of the small number of communities used in the analysis (19), but also because of the skewed distribution usually with a greater spread of lower scores.

Table 21: Summary statistics for five community health and safety indexes

Index	Mean	Median	25th percentile	75th percentile
Health & Safety PCA Index	24.9	22.1	3.3	34.6
Safety PCA Index	38.3	29.7	23.8	53.2
Standardised Safety Index	30.8	31.8	25.0	36.8
Health PCA Index	24.3	21.7	4.8	31.8
Standardised Health Index	19.5	17.4	7.5	27.8

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5.2 Understanding and using the data

The above worked examples show how multivariate analysis can be used to better understand characteristics of communities and how these characteristics interact at the community level. The 2-factor PCA solution in the first section uncovered structure in the data that was not apparent by just looking at individual community profiles or simply focussing on one or two variables at a time (e.g. modelling with a single outcome or dependent variable). The PCA uncovered that communities could be separated based on two sets of factors. The first (PC1) identified a low to high trend in rates of hospital admissions, ED attendances and police offences, while the second (PC2) set of factors identified low to high trend in percentage alcohol and domestic violence involvement in assaults.

However, this example did not include all the available data. For example, it would be possible to also include school attendance data, and determine, at an ecological level, whether attendance rates correlate with other measures such as percentage alcohol involvement in assaults at the community level. This type of analysis will also be able to incorporate survey data, if the survey is carried out in enough communities. For example, the factor analysis of community problems generated three factors (violence and anti-social behaviour, gambling problems and problematic social relations, and poor community safety) from which community scores can be generated, and these, along with other community characteristics, such as the community strengths factors and alcohol consumption, could also be added to the multivariate analysis. Community contextual factors such as what resources are in the community, and types of programs being run, can also be added to the multivariate analysis, which would help to identify community contexts and AAIs or other programs that mediate or moderate the effects of alcohol-related harms.

5.3 Conclusions

Multivariate statistical techniques have the potential to identify community level relationships between variables from a range of domains. They can also be used to generate composite indexes for each domain (e.g. community health, community safety etc.) or across domains. A key benefit in collating the data for The Framework is the ability to be able to analyse and scrutinise multiple indicators from different sources, leading to improved understanding of community (ecological) level relationships between alcohol consumption, alcohol-related harms, community safety, community education, community resources and community health and wellbeing.

The data reports presented in Chapter 4 are based on analyses that enable each community to identify specific changes that have occurred over a particular time period and thereby provide a means of evaluating the impact of alcohol-related initiatives within that community. These reports will provide a useful tool for people living and working in

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communities, government, NGOs, and researchers. By contrast, multivariate analysis, with its ability to interrogate relationships between multiple variables, and to identify key differences between communities, provides a broader perspective which will enable governments to determine the effectiveness of large-scale policy and program initiatives, and to determine relative need across a range of communities.

That further multivariate analysis is carried out for more indicators, particularly with the inclusion of school attendance data and survey data (once more communities are included in the Community Alcohol and Wellbeing Survey).

Recommendation

That further multivariate analysis is carried out for more indicators, particularly with the inclusion of school attendance data and survey data (once more communities are included in the Community Alcohol and Wellbeing Survey).

Recommendation

That composite indexes be developed for each domain and their relevance and usefulness in relation to assessing change in alcohol-related problems be explored.

Recommendation

That further investigations be carried out to explore the feasibility and usefulness of producing an annual report which highlights the state of play in SFNT communities, across the indicators included in the Framework.

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6. Data collection and reporting framework

This chapter sets out processes, procedures, templates and guidelines to assist with the collection and reporting of the primary and administrative data sources that have been identified for inclusion in The Framework. Although these tools provide an initial blueprint for administering The Framework, they are not intended to be prescriptive. Their function is to provide broad guidance for implementation, and it is expected that some tools may need to be modified in line with refinements to The Framework over time. Section 1 of this chapter sets out arrangements for accessing administrative data, while Section 2 provides guidelines and templates to assist with the collection of community sourced data. Section 3 outlines procedures for reporting both community sourced and administrative data to communities.

6.1 Accessing administrative data

6.1.1 Administrative datasets that are specified for inclusion in The Framework

A key aim of this project is to ensure that agreed administrative datasets (Chapter 3) can be accessed by DoB in a timely fashion and at regular intervals. To facilitate this, a Memorandum of Understanding (MoU) has been drawn up between the Department of Business and each of the key NTG agencies that have agreed to provide data for The Framework. Each MoU will include: a record specification which sets out the specific indicators that are to be supplied; the periodicity of the data supply; the form in which data will be supplied e.g. de-identified and aggregated; and a description of data security measures. MoUs have been agreed with the following government departments:

- Department of Health
- Department of Attorney-General and Justice – this will include police data
- Department of Education

A generic MoU, together with record specifications for the respective government departments, is included at Appendix 1.

Data on NAPLAN literacy and numeracy results are sourced from the Australian Curriculum, Assessment and Reporting Authority (ACARA). This data can be accessed by completing a Data Request Application form which is available on ACARA's website at: http://www.acara.edu.au/contact-us/acara-data-access. ACARA also require a Deed of Licence Agreement to be completed and signed by both parties. An example of the Data Application Request form is included at Appendix 2.

Recommendation

That discussions be held with ACARA regarding the possibility of setting up an MoU to facilitate the automatic release of NAPLAN data. It might be possible to facilitate this through the NTG Department of Education.

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Although arrangements for accessing most of the agreed administrative datasets are set out in the MoUs, none of these cover data relating to Sober-up Shelters. This data sits under the community safety domain, but is sourced from the Department of Health. Previously, when DoB has obtained this data, it has been supplied on the basis of a simple email request, and it is expected that this will continue to be the case.

The NT Midwives data set contains information on babies and Mothers, including alcohol consumption in the first and third trimester by the Mother. Although the data is accessible and useful, there is a two year delay between collection of data and availability for use in The Framework. Issues around this data set are discussed in Chapter 7 (Section 7.1).

6.1.2 Administrative datasets to be considered for future inclusion in The Framework

The project has undertaken a comprehensive investigation of alcohol-related indicators to identify those most suitable for inclusion in The Framework, however, there are several data sources which it has not been possible to investigate over the course of the project but which should be considered in the future. These include:

- Night Patrol (Commonwealth, Department of Prime Minister and Cabinet)
- Child Notifications (NTG Department of Children and Families)
- Motor Vehicle Crashes (NTG Department of Transport)

Night patrol data

Night patrols play an important role in facilitating the safety of community members, and data from this source would provide a useful measure of changes related to alcohol consumption and related harms. Data on night patrol activities are routinely collected and submitted to the Australian Government and further investigation of the indicators included in this database is required before it can be considered for inclusion as an administrative dataset. Night patrol was also recommended by a number of key informants as a source for local data collection by community residents. If the night patrol data held by the Australian Government is unsuitable for inclusion as an administrative dataset, consideration should be given to conducting negotiations with night patrol managers regarding their ability and willingness to collect relevant data at the community level.

Child Notifications data

Alcohol misuse affects children both directly and indirectly through its contribution to family violence, poor nutrition, poor school attendance and performance, trauma and general neglect. Consequently, child notifications data has the potential to provide a useful indicator for measuring harms in remote communities and across the Territory more widely. Discussions held with a staff member from the Department of Children and Families (DCF) suggest that community level data will be difficult to obtain and that a number of obstacles will need to be overcome before data of a suitable quality can be made available. In particular, there appears to be a lack of consistency as to how data is collected, with different data collection systems

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used for urban centres and communities, and different alcohol-related flags used in case management. In addition, child protection may be activated in a location different to that from where a client resides, with the added complication that regional reporting does not use standard boundaries, with data simply being aggregated into Northern and Southern regions. It was not possible to resolve these problems within the limited time frame of this project, however, given the relevance of child notifications data, both as an alcohol-related indicator and as an indicator of community wellbeing more generally, it will be important to maintain an open dialogue with DCF with a view to including this indicator in the future. However, given the limitations identified with this data, it would be prudent to further engage DCF, with the aim of generating a conversation about improving the quality of their data, so into the future this information can be included in The Framework.

Motor Vehicle Crashes (NT Department of Transport)

The Department of Transport collects data on road crashes, including where it happened, from where the driver and passengers were from, demographics, and whether alcohol is involved. Early discussions with the data manager were positive, and indications were made that this data would be available. However, over the course of the study, no data was provided to either the DoB or Menzies. Without having had the opportunity to carry out exploratory data analysis on these data, it is impossible to know how useful they would be as an indicator in The Framework. Serious and fatal road crashes do impact on communities through grief and trauma, and can lead to increased tensions in communities if blame is ascribed to individual(s) involved. Further follow up discussions with the Department are recommended.

Recommendation

That night patrol, child notifications, local health centre, and motor vehicle crash data be followed up and assessed for data quality, and indicators added to The Framework if suitable.

6.1.3 Data delivery periods

Table 22 below sets out the year from which each data source is to be supplied and the frequency of the delivery periods.

Table 22: Data delivery periods for selected administrative datasets

Data Source	Period for data supply	Frequency of delivery
Department of Health	2005 to current	Monthly data at quarterly intervals
Sober-up Shelter	2000 to current	6-monthly data at quarterly intervals
Department of Attorney-General and Justice	2008 to current	Monthly data at quarterly intervals
Department of Education	2008 to current	Monthly data at quarterly intervals
Australian Curriculum, Assessment and Reporting Authority (ACARA)	2008 to current	Annual data at yearly intervals

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6.2 Collection of community sourced data

6.2.1 Survey Data

Conducting the survey

Although conducting a survey is a relatively straightforward process, the accuracy and quality of results is significantly influenced by the rigour with which it is administered. The survey should be conducted by staff that are trained in survey administration and who are: familiar with the questionnaire; have the skills to explain questions to participants; and have the ability to fill in the questionnaire accurately. In order for a survey in an Indigenous community to provide effective results, survey staff will need to devise a sound strategy to ensure that recommended sampling quotas are met. To achieve this they need to have a good knowledge of the community and its members or, alternatively, employ research assistants from the local community to help identify participants. Ideally, survey administrators should be neutral in relation to community politics, as personal involvement could adversely affect their ability to source unbiased responses to questions. In addition, the survey should be conducted by both a male and a female so that the questionnaire can be administered to participants by someone of the same gender.

Methods - survey

The survey should be conducted annually around the same time each year and should be completed over a period of four weeks or less in each community. Due to the resource constraints and logistical practicalities associated with surveying remote Indigenous communities, quota sampling rather than random sampling is recommended. The population from which each quota should be drawn is all Indigenous Australian adults aged 18 years or over, who have been resident in the community for at least 12 months. Quotas on age (less than 35 years/35 years and over) and gender (male/female) should be used to ensure that the sample is representative of older and younger people's views by gender.

A sample size of 40 to 65 will be adequate depending on the size of the community. This is based on sample calculations for a simple random sample, with a standard error of 5% on an estimate of 20%. The table below sets out recommended sample sizes for communities of various population sizes.

Table 23: Recommended sample size by community Indigenous population

	Population less than 300	Population 300-999	Population 1000 or more
Sample size (n)	40-45	46-54	55-65

Data analysis and weighting

The primary purpose of the CAWS is to produce community level outcome variables that can be tracked over time. We have further refined the approach from that used in the analyses contained in Volume 3 that ensures the most accurate and least biased estimates can be produced. Specifically, observations should be weighted to reflect an even sample by the

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quotas for age and sex. The survey commands from Stata v14 are then used to set up the data for analysis adjusting for the selection of communities from available communities, the selected community's population, and the clustering of people within a community. A similar analytic approach (factor analysis with the principle component factor method) should be used to create composite variables from the community problems list. The community strength questions have been modified (see Appendix 3) from the first survey, but are still amenable to a factor analysis. Factor scores will need to be generated from the factor analysis of the community problems and scores standardised to range between 0 and 10. A weighted average for communities can then be produced (with standard errors) and be presented as per community problem scores in Chapter 4 community data reports.

Resources and Survey Tools

Included in The Framework, are a range of resources and tools to assist with survey administration, as outlined in Table 24.

Table 24: Resources and tools to assist with administering the survey

Item	Comment	Availability
Questionnaire	A questionnaire has been developed and administered as part of this project and, subsequent to analyses, has been modified for future use in The Framework.	Appendix 3
IPad/tablet	The survey can be administered through either a paper or an electronic questionnaire, with each method having advantages and disadvantages as set out below. *Electronic survey on IPad or tablet* • Data only has to be entered once; • Questionnaire needs to be set up on appropriate software; • Usability is dependent on whether community has wifi; • Data may be lost if connectivity is poor or cuts out; • Training in software use will be required if electronic survey is used. *Paper survey* • Data has to be entered twice; • No additional training required.	There are a variety of software packages available. This project used surveygizmo – https://www.surveygizmo.com/
Alcohol consumption conversion table	In most surveys alcohol consumption is measured by asking the participant how many standard drinks they have consumed. However, this type of question can be hard for some people in Indigenous communities to answer, as alcohol is often purchased in bulk and drunk in a group setting without being decanted into 'standard' drinking containers. Consequently, a conversion table has been provided to assist the interviewer to convert group drink cartons into containers per person. The conversion table covers the following: beer, cider, premixed, casks, and bottled wine and spirits.	Appendix 4 **We may need to modify this card**
Prompt cards	Visual prompts to assist with Likert Scale questions Examples of standard drinks	Appendix 5 Appendix 6
Information sheet	Survey participants should be provided with an information sheet which explains the purpose and benefits of the survey. An example is included.	Appendix 7

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Item	Comment	Availability
Consent form	All participants should sign a consent form which states their agreement to participate and sets out their right to withdraw or not answer questions if they don't wish to. Each community that is surveyed should be assigned an ID number (this should match any ID number assigned by the DoB), beginning with number 1 and continuing sequentially until all communities in the survey have been assigned a number. Each participant is also assigned an ID number; this begins with the community number, followed by the number for the participant. For example, if the first community is assigned the number 1, the first participant ID number will be 1.01, the second 1.02 and so on. The participant ID number must be written in the space allocated at the bottom of the consent form and must also be included at Question 4 of the participant's survey form. Ideally, any naming and ID convention, should marry up with internal DoB community Identification.	Appendix 8
Survey folder and quota sheet	Each interviewer should have a survey folder in which to keep survey related materials. A **quota sheet** should be attached to the survey folder so that a record can be kept of how many males and females under and over 35 have been interviewed. Once a quota for one group has been met then no more people belonging to that group should be interviewed.	Appendix 9
Training manual	The Community Alcohol and Wellbeing (CAWS): Training manual has been developed for use with The Framework and contains detailed instructions on how to conduct the survey.	Appendix 10

6.2.2 Key Informant Data

Inclusion of key informant interviews in The Framework

As identified in Chapter 3, key informant interviews can be used to provide a process evaluation of specific AAIs and related community safety programs, or can be used more broadly to explore community perspectives and concerns in relation to alcohol and its management. The primary purpose of including key informant interviews in The Framework is to capture broad perspectives on alcohol-related issues, and associated program development, from people with a deep understanding of their community. Consequently, the interview schedule included in The Framework aims to:

- Obtain an in-depth understanding about alcohol-related issues in the community;
- Provide a detailed context from which to interpret administrative and survey data;
- Assess awareness of AAI and related community safety programs being implemented in the community, and explore community views on their effectiveness;
- Identify areas in which new support programs might be needed; and
- Find out whether reporting of data produced by The Framework is being adequately disseminated across the community.

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Conducting semi-structured interviews with key informants

The quality of the information obtained from key informant interviews varies markedly according to the skills of the interviewer. Staff who conduct key informant interviews should be trained in interviewing techniques and need to: have good communication skills, including the ability to listen and to build rapport; be familiar with the interview schedule and purpose of the research; and have sufficient skill to take effective notes. Interviewers should present a neutral position in relation to the questions being asked, to ensure that their own views do not influence participants' answers. Where culturally appropriate, interview staff should include both males and females so that the interview can be conducted by someone who is of the same gender as the participant. If notes rather than an audio-recording are used to document participant responses then two people should conduct the interview, one to take the notes and the other to ask the questions.

Core skills that staff will require if they are to conduct effective interviews are listed in Table 25 below.

Table 25: Essential skills for conducting semi-structured interviews

Skills	Comments
Active listening	Essential for accurate recording of responses. Increases likelihood that you will hear what is actually said rather than what you expect to hear.
Ability to build rapport with the participant	Help participant to feel relaxed – smile, use humour, be friendly, patient and respectful.
Emphasise the participant's perspective	The participant is the 'expert' and the interviewer is the 'student'. Let participant know there are no wrong or right answers.
Adapt the way you conduct the interview to suit different personalities	Some participants may need more encouragement to say what they think, others may need to be kept on track. You need to adapt your tone of voice and body language to suit the individual and to take into account their state of mind eg some questions might be personal or sensitive and might make them sad or angry.
Ability to take good notes.	Notes should be expanded on or written up as soon as possible after the interview. Can be helpful to keep notes about body language e.g. whether the person seems uncomfortable with certain questions, whether something in the body language or expression makes you think they might not be telling the truth, and why you think this.
Use 'probes' to encourage participant to elaborate on their answers.	Probes are neutral questions, phrases, sounds, and gestures that interviewers use to encourage participants to elaborate on their answers and explain 'why' or 'how'. They can be included in brackets next to each interview question or can be generated spontaneously over the course of the interview. Probes should be used when the response is brief or unclear; when the participant seems to be waiting for a response from the interviewer before continuing to speak; when they appear to have more

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Skills	Comments
	information on the subject; and to increase your understanding and encourage more explanation. Probes should not be used when responses start to become repetitive or the participant starts to get annoyed or upset by continued questions.
Ask questions in a neutral manner.	This means being genuinely interested in what the participant thinks. It is important not to use 'leading' questions or lead the participant to provide a particular answer by expressing approval or disapproval of what they say. An example of a leading or biased question and a neutral question is: Biased/leading: *Most people who care about the community think having a policeman outside a grog shop is a good thing. What do you think?* Neutral: *What are your thoughts on having policemen outside the grog shop?*

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Methods – key informant interviews

Defining key informants

For the purpose of The Framework, key informants are defined as those with extensive local knowledge of the community and an awareness of alcohol, community safety, and wellbeing issues. They generally play an active role in the day to day functioning of the community and in determining its social and cultural priorities. Typically, they will include staff from key service providers (e.g. health clinic, police, school, community store, art centre), and community members with status and influence in the community. The latter generally includes community Elders, and Indigenous members who are involved in local committees or who are working in areas such as AOD services, the clinic, the school, the safe house, and night patrol. All participants must have lived in the community for a period of 12 months or more and at least half should be Indigenous community members.

Key informant interviewee selection

Key informants will be drawn from the remote community in which Framework data is being collected. The number of interviewees can be fixed prior to data collection or, a more flexible approach can be adopted in which the aim is to continue interviewing participants until saturation point is reached, i.e. the data from new interviewees no longer bring additional insights to the research questions. Other factors to consider when determining the number to interview include the resources available and the size of the community. In this study, the minimum number interviewed in a community was seven and the maximum was 15. For remote communities, 10 interviews is a reasonable target and is usually sufficient to enable a diversity of views to be represented, however if the community is willing, and resources are available, this could be increased.

Resources and tools to assist with key informant interviews

A range of resources and tools are included in The Framework to assist in the collection of interview data, with these set out in Table 26.

Table 26: Resources and tools for conducting key informant interviews

Item	Comment	Availability
Semi-structured Interview Schedule	Based on study findings, and discussions with key stakeholders, the interview schedule has been refined for future use in The Framework. It includes a list of questions which are asked of every participant being interviewed. Depending on the question, prompts may be included to assist the interviewer to help the participant expand on their answer. The use of these prompts is at the discretion of the interviewer who can also generate their own prompts or probes as the situation requires.	Appendix 11
A Guide to Conducting Semi-structured Interviews	The Guide provides basic instructions on interviewing technique, selection of key informants, the use of probes, note-taking and links to additional resources.	Appendix 12
Participant consent form	All interviewees should sign a consent form which states their agreement to participate and sets out their right to withdraw or not answer questions if they don't wish to.	Appendix 13
Participant information sheet	Key informant participants should be provided with an information sheet which explains the purpose and benefits of the interviews	Appendix 7

Recommendation

That staff selected to conduct community surveys and key informant interviews are provided with adequate training as set out in the Community Alcohol and Wellbeing (CAWS): Training manual (Appendix 10) and the Guide for Conducting semi-structured interviews (Appendix 12).

6.2.3 Collection of local level indicators

Collection of local level indicators should be a joint project between DoB and the community, with AAI officers working with key members of each community to set up systems for collecting these data. This will include the following steps:

- Select indicators to be collected, based on their relevance to the community, and capacity and willingness of community members and service providers to collect and/or provide these data (set of indicators provided in Table 26 below).
- Determine who will collect and report the data – this may be one or several people, depending on which indicators are chosen.
- Develop a template for recording data.
- For subjective indicators, such as disruptive behaviour in the classroom, it will be necessary to develop a set of criteria to ensure that measurement of the behaviour is consistent over time.
- For indicators that are already recorded, (e.g. permit system and social club data), it will be necessary to negotiate access to, and reporting of, these data.

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- Data should be reported to the relevant community committee and also lodged with the Manager, Data Analysis and Reporting, Alcohol Policy and Strategy Unit, DoB, at quarterly intervals.

Table 27 sets out potential indicators, and key actions required to set up collection systems.

Recommendation
That in each community, a community member be appointed on a part or full-time basis to work with the AAI officer to coordinate the collection and reporting of these data.

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Table 27: Local level indicators that can be collected by communities

Data	Indicators	What would need to be done to collect and report data?	Comments/Example
School	Number of parents and grandparents engaged in children's education	• Identify potential measurement criteria • Put together template identifying: items to be measured; measurement criteria; reporting mechanisms • Review draft template with a sample of school principals • Perhaps trial it with several communities over a year and if results look useful use de-identified results to show other communities what can be done.	See Appendix 14: *Procedure for setting up a system to record an increase in school attendance on days when non-attendance is usually high.*
	Incidents of disruptive behaviour in classroom		
	Increased school attendance on days when non- attendance is typically high		
	Number of children who are tired or sleepy at school		
	Number of students late to school		
Social club	Record of social club sales	• Liaise with social club management re obtaining data • Develop template identifying data to be collected and system for reporting back to community and DoB	See Appendix 15: *Example of template for recording social club data*
	Record of people banned from club and reason for ban		
	Record of number of people over breathalyser limit		
Permit system	Number of people with permits	• Liaise with Permit Committee re obtaining data • Develop template identifying data to be collected and system for reporting back to community and DoB	Similar procedure to that shown in Appendix 15.
	Number of people on banned list and why		
Social data	Number of times night patrol issued warnings re noise and disruptive behaviour and the number of times they reported non-compliance to the police	• Night patrol already provides data to the Australian Government. It will be necessary to find out what is already collected in order to determine whether other data could or should be collected. If additional data can be collected, liaise with the night patrol manager as to the best way of doing this. • If night patrol agrees to collect additional data, develop a template for recording purposes and determine who will collect and report the data.	
	Number of young people taken home by night patrol		
	Record number of families needing special support	• For each community it would be necessary to identify whether there is an existing mechanism, eg cross-sectoral service providers' committee, such as the KidSafe Committee at Community 4, for recording changes in the number of families that need special support. • Liaise with the committee as to the best ways of recording changes.	Could be useful to discuss this with the school principal in Community 4.
	Employment data – how many people of employable age are working	Would need to liaise with service providers to determine whether information can be collected – local council might have this information – but there may be issues releasing it.	
Safe house	Record number of clients taken to safe house as a result of violence or due to fear of violence	Need to liaise with safe house regarding collection of this information – some information may already be collected. If safe house staff are happy to collect and release these data then it would be necessary to set up a template for collection.	

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6.3 Reporting results to communities

Key informants from the eight study sites provided a range of insights as to the best methods for presenting data in ways that are meaningful and relevant to the lay person, and the best ways of disseminating alcohol-related data reports to community members. A detailed account of key informants' views in relation to the reporting of data can be accessed in Volume 2 of this report.

6.3.1 Presentation of data

Informants from a wide range of communities commented on the need to present data in simple formats, as complex graphs with multiple indicators are not easy for the lay person to understand. One group of informants noted that while graphs can be useful, picture posters and comic strips are often more effective in conveying information and engaging the recipient.

Graphs: Informants' views on the effectiveness of graphs varied, with some commenting that anything other than pie graphs would be difficult for many people to understand while others were confident that a simple bar graph would be understood by nearly all community members. Comments from a range of informants suggested that:

- Bar graphs should be used in preference to line graphs;
- Graphs should be simple and show only one indicator;
- Pie graphs are the easiest for people to understand (these have limitations as they can't show trends);
- The style of graphs should be consistent e.g. if colours are used to represent a particular group this colour should be used consistently;
- Information should be included with the graph to explain what it means and, where possible, graphs should be explained face to face;
- A creative approach should be used to ensure that graphs are interesting and engaging e.g. use of pictorial effects, or combining graphs with pictures that relate to the information being depicted;

Posters: Similar principles apply as for graphs, with a strong emphasis on simplicity and creativity to ensure engagement with the material. Posters should: present key findings – not too much detail; include explanations next to diagrams or graphs; be visually interesting through the use of pictures, comic strips, and narratives; involve Indigenous people in the design; and, if possible, should be piloted with Indigenous people before using.

Video loop: These were popular with a number of informants and were perceived as having several benefits: the community could be involved in the development process; high profile local community members could be used to present and explain the data on the video; and the video could be used in group settings as a focus for discussion as well as played repeatedly in settings such as clinic waiting rooms. The value of video loops would be enhanced by the use of voice overs so that they could be presented in both English and language. One informant

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noted that the clinic was considering focusing on a different health topic each month and that a video loop presenting data on alcohol-related harms and alcohol management would be very useful for the ‘alcohol’ month.

PowerPoint: PowerPoints were seen as a useful tool that could be used by the ARG, other relevant committee, or service providers, to present data to community groups or at a community meeting.

Language: Presenting materials in language as well as in English was recommended by most informants.

6.3.2 Dissemination of data

Informants generally agreed that a DoB officer should be responsible for presenting data reports to a nominated key stakeholder committee (or committees) and that committee members would then use their networks to disseminate the findings more broadly. Methods for disseminating information can be classified into two main categories as set out below:

- **Dissemination through public mediums** such as posters, newsletters, video-loops in semi-public places, community meetings, and community barbeques. Information disseminated through these mediums would be directed at the broader community and would focus on providing the community with an overview of the report and key findings.
- **Dissemination through service providers and key stakeholders** such as the clinic, school, police and safe house. Information disseminated through these channels would be directed at specific groups. This was a popular option among key informants, some of whom felt that disseminating data to small groups was more effective than through large community meetings. This method would also enable service providers and community groups to utilise the data in the development of alcohol-related education programs or interventions. Consequently, it has the potential to both disseminate information and to directly enhance community outcomes.

These distinctions are important to make as the resources required for dissemination vary according to the method used.

<u>Dissemination through public mediums</u>

It is important to note that, in this context, ‘public’ refers to being available to community members within the community, but not to the general public outside of the community, and placement of posters would need to take this into account. The choice of public mediums for disseminating information will be influenced by the preferences of the community and the availability of infrastructure and resources at both the government and community level. Many community stakeholder groups have limited resources or secretariat services, and are likely to need additional support if they are to be the primary vehicle for disseminating

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information to the broader community, particularly if community preferences on the presentation of data are taken into account. Options for supporting communities to disseminate findings using presentation formats that are relevant and meaningful are set out below:

Option 1: The development of generic materials by the government

- Drawing on both administrative and survey data, identify a set of key indicators that are likely to provide all communities with a broad overview of alcohol-related outcomes. Employ an Indigenous graphic designer to develop a template for a poster, into which relevant data can be inserted. Space on the poster should also be set aside to include qualitative data collected through key informant interviews. The development of a generic template would enable presentation preferences to be met and would be relatively cost effective. Provided the template is developed in a way that enables DoB staff to insert the data, it should have a shelf life of several years and be useable for all communities.
- A template could also be developed for a 6-monthly or annual newsletter, with DoB staff inserting the data and the community adding relevant information about AAIs or related social and emotional wellbeing programs.
- The development of a template would enable a pre-prepared poster, and/or semi-prepared newsletter, to be included with the data report and, to some extent, this would meet community preferences for the data report to be accompanied by resources to assist dissemination.

Option 2: Supporting communities to develop their own materials

- The development of dissemination materials could be identified as an AAI and the community could be funded through this program to develop their own materials. This would foster community engagement in the alcohol management process and provide opportunities for capacity building and personal development. It would be particularly useful where a video loop has been chosen as a means of disseminating information from the data report.

Recommendation

That DoB explore the feasibility of developing generic, but culturally sensitive materials, to facilitate the presentation of alcohol-related data in a way that is relevant and meaningful to people living in remote Indigenous communities.

Dissemination through service providers

Several informants noted that service providers could use alcohol-related data to develop locally relevant early intervention and prevention activities and to push the point home about the harmful effects of alcohol and its negative impacts on the individual and the community. This information could be used with their client groups, either on a one-to-one basis or in

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group sessions or seminars. In order to facilitate this use of the data it will be important to make sure that service providers have access to the data report and that it is provided in a form that makes it easy to extract data for use in early intervention and prevention activities. This means providing the report in a word document or PowerPoint so that graphs and text can be easily copied.

Recommendation

That community data reports be provided in a format such as a Word document or PowerPoint, so relevant sections of the report can be used by community service providers or other stakeholders to develop educational materials and alcohol-related interventions that have direct meaning for the community.

Recommendation

That information in community data reports is fed back to local residents of communities through a range of mediums to ensure the information is available to as many residents as possible.

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7. Where to from here?

Key elements of The Framework are now in place: indicators from both community and administrative and data sources have been identified; methods for collecting local data from communities have been refined; agreements regarding the regular supply of administrative data have been set up with key government departments; and the best methods of reporting data back to communities have been explored. There is, however, scope for further development, particularly in relation to data quality and further investigation of administrative data indicators (Section 6.1.2). Similarly, while a range of resources have been developed to support the implementation process, and recommendations made as to key elements required for implementation, operational decisions are largely outside The Framework's scope. It is expected that the implementation and management of The Framework will be an iterative process, subject to refinements over time. Key aspects to consider in relation to the ongoing development, implementation, management and sustainability of The Framework are outlined below.

7.1 Improving the quality of data used in The Framework

If the Framework is to be effective and sustainable, then it must be underpinned by clear and transparent processes. To do this, it is essential that adequate information on data sources is made available. The data quality framework used in this report facilitates this process. It provides a summary of how the data is collected, as well as information on reliability, accuracy, interpretability and coherence. Maintaining and updating this 'metadata' will help users understand the limitations of the data and, importantly, ensure the processes involved in producing data reports are transparent.

The first phase of the project involved an exploratory analysis of the various data sets scoped out for potential inclusion in The Framework. This process, while being guided by the Data Quality Framework (as used by the ABS), was explorative, with completeness of data being influenced by a range of factors and varying by community. For example, proximity to a police station is the largest driver in counts of offences and victims of assault. While actions to improve data quality may be similar across different data sources, each data set has its own purpose and collection procedures. Therefore, each data source requires a tailored approach to improving data quality, through working with data custodians, analysts and those responsible for collection of the data. Suggestions for improving the quality of each of the data sources assessed as part of the project are now made.

7.1.1 Wholesale data on apparent pure alcohol consumption

The data on wholesale sales of alcohol by type of alcohol and outlet location is provided to the DoB and then converted to apparent pure alcohol consumption (APAC). Its value to The Framework is from a compliance point of view, rather than as an indicator that communities can use to track changes in alcohol consumption. However, it has some value in tracking alcohol consumption in certain locations, depending on factors such as remoteness and access to the outlet, and types of restrictions on sales at the venue. Further exploratory analyses are

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required to better understand alcohol catchment areas, and how different outlets are accessed by different communities. For example, grouping different outlets and matching sales by alcohol type, with information on alcohol consumption collected as part of the survey, may uncover the size and extent of alcohol catchment areas. Developing more permanent alcohol catchment area boundaries for reporting APAC would be useful to allow longitudinal data to be comparable over time and to ensure that the geography of catchment areas covers the whole of the Northern Territory. Catchment area boundaries, should, where possible, follow ABS geographic boundaries used in the Australian Statistical Geography Standard (ASGS).

7.1.2 Police offences and victims of assault

The police offences and victims data are central to The Framework as they provide measures of direct alcohol-related harms (i.e. percentage alcohol involvement in assaults). The victim of assaults data also provide information on different population segments (i.e. young and old, female) and whether domestic violence was involved. These data were very good in terms of data quality assessment, though there is some small room for improvement around missing data associated with recording domestic violence and alcohol involvement in the assaults offences, and to a lesser degree in the victim of assault data. This could be further improved through feeding back to local police stations the percentage (and number) of observations that had missing data, and emphasising the importance of collecting this consistently, to ensure data fed back to communities in community data reports (as produced in Chapter 4) can be interpreted with confidence. For example, ensuring a decline in alcohol involvement is not associated with an increase in 'unknown' alcohol involvement.

Currently, smaller communities in some regional towns are not identified in police offence data. Anecdotally, at least, these communities experience significantly higher level of crime, and not being able to pinpoint crime associated with these places, leaves gaps in the ability of the Framework to be useful for these types of locations.

7.1.3 Emergency department attendances, hospital admissions and

The ED and hospital data, like the police data, are central to The Framework. The hospital admissions data provide information on acute and chronic alcohol related diagnoses, while the ED data provides information on attendances for external injuries. The quality of the geographic coding in these data sources is, however, not well known. A study carried out in 1997 by the then named Territory Health Services (now Department of Health), on the quality of hospital (including ED) demographic data, found that 78% of geographic coding was correct, but that this varied by hospital (Condon, Williams, Pearce, & Moss, 1998). It was beyond the scope of the current project to repeat this previous study. The Territory Health Services study recommended: (i) modification of the physical layout of interview areas in admissions and emergency departments to provide privacy to patients during interviews; (ii) standardisation of admissions forms and procedures across all NT public hospitals, and a revision of the patient administration procedures manual; (iii) improved training of Patient Services department staff, particularly in relation to cross-cultural training, to improve their ability to communicate with Aboriginal people; and (iv) annual monitoring of data quality,

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including a sufficient sample in each hospital to provide a reliable measure of data quality for each hospital. These recommendations may still apply, but further investigation is required.

In addition to the above, in 2010 there was a change to the way in which the locations were recorded, affecting our abuility to produce reliable data for Community 2. Therefore, in this current study, we were unable to produce trends for this community beyond 2010. While a mapping correspondence was supplied by the DoH once this issue was identified, the quality of the correspondence was not good enough to reliably match location names before and after 2010, particularly given the relatively short timeframe of the project. Further work around accurately mapping pre- and post-2010 data for this location is required.

Lastly, the useability of the data would be improved, and users would better understand the data limitations, if the metadata (i.e. data definitions, rules of collection etc.) were provided with the data.

7.1.4 Midwives collection

Investigation is also required to identify whether data from the Midwives Collection can be extracted from the hospital admissions data warehouse, and whether this is of sufficient quality (prior to cleaning) for inclusion in the hospital admission data request. The Midwives Data Collection is not available for inclusion in The Framework until one to two years after collection, and therefore was not suitable for inclusion, though it does contain the key indicator of alcohol use by pregnant women in the first and third trimesters. Further investigation is required to determine what information is available on pregnancy and births in the hospital admissions data set. Another possible data source for information on antenatal care and alcohol use by pregnant women could be health centre data, and this option should also be investigated.

7.1.5 School attendance and enrolment

The school attendance and enrolment data is of good quality, but with known deficiencies which in some communities may limit the interpretability of the data. These include the inability of schools to capture in real time, movements of students between schools. Linking students' physical presence at a school to a unique student ID, would address this limitation, allowing for enrolment data to match where a student is attending school. Other options that may be useful to explore include developing a different indicator of attendance, such as the percentage of children attending 90% or more of the time. Further discussion with the NTG DoE on attendance measures would be required to determine the feasibility of deriving such a measure, and in determining its usefulness and interpretability.

7.1.6 NAPLAN literacy and numeracy

Literacy and numeracy data is of good quality, with limitations on interpretation, due to small numbers of students in some schools completing NAPLAN tests. However, this data is collected in a consistent way across Australia, and is already used extensively by researchers and educationalists to identify changes in literacy and numeracy across schools and for the

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same school over time. Further investigation is needed to determine whether literacy and numeracy results for cohorts of children could be presented for a school or a grouping of like schools, to enable comparison over time with the same students.

7.1.7 Sober Up Shelter

Indicators from the SuS data were recommended for inclusion at a regional level in The Framework. To better understand the reliability of the community variable used to identify the community from where the person originates, a validity study is required, as it is currently unknown what approach is used to determine from which location the person being picked up is from, or more meaningfully, where they have resided the most over the previous six or twelve months.

7.1.8 NT Government health centre data

This data was not recommended for inclusion in The Framework due to inconsistencies in the data collection over time both within the same service and in relation to differences between services. Further standardisation of data collection processes, particularly around the alcohol indicator contained in this data set, is required, in addition to improved training of the nurses, doctors and health workers entering data into the system. Indicators from this data source may well be useful for inclusion in The Framework in the future, but until training of centre staff is done to ensure all staff are entering information into the system consistently (particularly around the alcohol flag), and exploratory analysis of the data is carried out health centre by health centre, this data is not suitable for inclusion.

7.1.9 Aboriginal Community Controlled Health Services (ACCHS) data

No data was sourced from non-government managed health centres due to time constraints, limited resources, and the difficulty in contacting and arranging a suitable time to discuss the project and its data requirements with data custodians. It is unknown whether the quality of the ACCHS data is similar to the NTG health centre data, which was not of good enough quality for inclusion in The Framework. Further work is required to negotiate access to these data in communities serviced by an ACCHS, and to assess its data quality.

7.1.10 Population data

The population data used in The Framework allows for the calculation and presentation of data in the form of rates per 100 or 1000 people. The population counts for each community used in this study were developed specifically for this project. However, if a different algorithm was used then different population estimates would be generated, though in reality, most approaches to deriving a more accurate community population estimate arrive at very similar population counts (Professor T. Barnes and Dr A. Taylor, pers. comm. February 2016). In summary, the current approach adjusted for census undercount for Indigenous and non-Indigenous population counts, and allocated 'not stated' Indigenous status responses, and applied growth rates based on changes by community and region from 2006 to 2011. Community population estimates were also scaled to ensure they were the same as ABS ERPs for SA2s and the Northern Territory. This process will need to be done again in 2017 once the

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ABS releases usual resident counts for Indigenous Locations from the 2016 Census of Population and Housing.

Recommendation
That the ABS Indigenous Location (community) estimated resident population data used for denominators in calculating rates be re-calibrated once 2016 Census population usual resident population counts and estimated undercounts by Indigenous status are available.

Recommendation
That a system be setup whereby the DoB feeds back information to data custodians on the quality of data provided, thereby creating a continuous quality improvement approach to data quality.

Recommendation
That the NT Department of Health repeat the validation of hospital demographic data carried out in 1998 by Condon et al, or revisit recommendations and implement as required.

7.2 Implementation and management of The Framework

Over the longer term, the scope of The Framework will expand to include data from up to 30 SFNT communities. This will pose considerable challenges in terms of logistics, staffing, skills and resources. At a minimum, the implementation of The Framework will involve:

- Management, and ongoing development, of data provision agreements between DoB and custodians of administrative data;
- Analysis of administrative data at a variety of geographic levels;
- Annual collection of survey and key informant data from remote SFNT communities;
- Analysis of survey data from remote SFNT communities;
- Analysis of each community's key informant data;
- Maintenance of a 'contextual' database which records key events, programs, and policies that may affect community outcomes related to alcohol;
- Interpretation of results from all data sources with reference to the contextual database and alcohol-related policies;
- Reporting of data to communities and development of methods to support communities in disseminating results to residents; and
- Reporting of outcomes to government.

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The program of works described above indicates a need for strong central management and a high degree of coordination. In addition, it will be necessary to provide training to staff who are assigned to collect survey and key informant data, and to ensure that adequate supervision and support is provided when staff are undertaking the field work. An experienced statistician will be required if the analyses provided in this report are to be replicated and if the more complex multivariate analyses discussed in Chapter 5 are to be utilised. Access to research expertise, sourced either in-house or externally, would help to ensure that outputs from The Framework are of a high quality.

If fully utilised, the data included in The Framework has the potential to inform system wide policies for reducing alcohol problems, as well as fulfilling its function of monitoring and evaluating alcohol-related initiatives in individual communities. The application of multivariate analyses is critical in this respect, as these techniques provide the comprehensive information needed to facilitate a more global perspective as to the factors which influence alcohol consumption and related harms. Multivariate analyses also facilitate more precise comparisons between communities, and therefore enable relative need to be determined across a range of communities. This will be particularly important once the full complement of SFNT communities is incorporated into The Framework, as a more basic approach to statistical analysis is unlikely to provide the fine-grained analyses required for inter-community comparisons.

7.3 Sustainability of The Framework

Development of The Framework has provided a unique opportunity to undertake an audit of the administrative data that is currently available for monitoring and evaluation purposes, and to address many of the barriers that have limited its use. However, if The Framework is to be sustainable over the long term, there will be a need for continuous improvement and development, particularly in relation to data quality, and the potential addition of indicators that were unavailable for investigation during the course of this project. Similarly, if the community sourced data collection is to produce good quality information, it will be necessary to maintain the engagement of remote communities by demonstrating the value of The Framework through the provision of regular reports in appropriate formats.

Positioning The Framework to ensure that it receives the ongoing support necessary to its long term sustainability and further development will require the maintenance and strengthening of relationships with both government data custodians and external stakeholders, as well as a communication strategy that clearly sets out the benefits for both remote Indigenous communities and the government. It is important to note that while the focus of this project has been on developing datasets that can be used to monitor and evaluate AMPs and related initiatives, The Framework also provides a significant secondary benefit in that it can serve as a model for improving current approaches to the recording and release of administrative data more generally, with this having a broad application across a range of domains within government. This puts the custodians of The Framework in a good position to develop linkages with other government initiatives focused on data quality and data linkage,

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thereby increasing the potential to leverage additional funding (as a partner in other projects) that could contribute to continuous quality improvement of The Framework datasets.

A key factor in the long term sustainability of The Framework will be the appointment of a manager who not only provides effective operational management but also stays abreast of developments in this area and has a focus on continuous quality improvement. Similarly, the effectiveness of The Framework will be influenced by the extent to which resources are made available for implementation. Although it may be possible to accommodate some functions of The Framework through existing staff structures, it will be important to ensure that budget constraints are not so onerous that they compromise the capacity to achieve high quality data and outcomes.

An option that could be explored is for the NTG to partner with an external organisation with relevant technical expertise to increase accuracy, accountability and transparency of The Framework. Significant expertise is required to collect, analyse and present data collated as part of The Framework. Partnering with an external organisation with specific expertise in these areas will ensure consistency in analytic approach, independence with regards to interpretation of data, the building of expertise in generating meaningful community indicators, and ensure capacity to implement The Framework is maintained.

Recommendation

That NTG give consideration to partnering with an external organisation, with relevant technical expertise, to assist in management, collation, collection, analysis, presentation and feedback of data. A partnership with an external organisation would lead to greater accountability, transparency and sustainability of The Framework.

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7.4 Conclusion

The Framework and community data reports developed for this project are unique and novel, with no other jurisdictions in Australia providing a comprehensive set of indicators from administrative and locally collected data that assist communities and governments in monitoring indicators across a range of domains. The collation of many indicators going back six to ten years provides baseline data for future evaluations and an opportunity to retrospectively assess the effectiveness of past policy and programs.

The Framework has considerable potential to empower Aboriginal people in communities by increasing their understanding of how alcohol affects their community, and by enhancing their capacity to manage local alcohol problems on an ongoing basis. The ability to monitor and evaluate alcohol-related initiatives will facilitate the creation of a feedback loop whereby communities can gain a sense of what is working and how their efforts have made a difference. Ensuring ongoing and effective engagement with communities will maximise the

utility of The Framework in reducing alcohol-related harms in Aboriginal communities, thereby leading to improvements in community wellbeing.

The Framework's strength is that it focusses on the community, rather than the individual, thereby incorporating a population health approach. Curing the individual problem drinker will not, by itself, result in a reduction in alcohol-related harm, particularly if the community dynamics which contribute to these problems remain the same (Holmila 2000).

Appendix 1. Example of Memorandum of Understanding and record specifications for Department of Health, Police

MEMORANDUM OF UNDERSTANDING

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Northern Territory of Australia
Department of Business
GPO Box 1154
DARWIN NT 0801

MEMORANDUM OF UNDERSTANDING (MoU)

1. BACKGROUND

a) In 2014, the Department of Business of the Northern Territory Government engaged Menzies School of Health Research to develop a Place-Based Framework (PBF) to monitor and measure the effectiveness of Alcohol Management Plans (AMP) and other alcohol action initiatives in the Northern Territory as part of a National Partnership Agreement (NPA) with the Australian Government. A functional review has indicated that scope of the PBF should expand from Aboriginal communities to include urban centres and not only in an alcohol-related focus but community safety and wellbeing too.

2. PARTIES TO THE MoU

a) This agreement is between the Department of Business (DoB) of the Northern Territory Government of Level 3, NAB House, 71 Smith Street, Darwin and the Department of Health (DoH) of the Northern Territory Government of 87 Mitchell Street Darwin.

3. OBJECTIVE

a) The purpose of this MoU is for DoB and DoH to agree on an ongoing supply of community safety and wellbeing data from DoH to enable DoB to fulfil its obligations pursuant to the NPA and the evolving focus of the PBF.

4. THE PARTIES AGREE AS FOLLOWS:

a) Definitions

i. **Commencement Date** means the date of execution of the MoU;

ii. **DoB** means the Department of Business of the Northern Territory of Australia or any such other office, department or agency as may administer this MoU on behalf of the Northern Territory of Australia;

iii. **DoH** means the Department of Health of the Northern Territory of Australia or any such other office, department or agency as may administer this MoU on behalf of the Northern Territory of Australia;

iv. **MoU** means the terms and conditions contained in this Memorandum of Understanding together with the Schedules;

v. **Representative** means in respect of the contractor, an employee, officer or delegate;

vi. **Termination Date** means the date of cessation of the Memorandum of Understanding;

b) Interpretation

Unless the context otherwise specifies:

i. headings are included for reference only and shall not affect the interpretation of this MoU;

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ii. "including" and similar words are not words of limitation;
iii. writing includes any mode of representing or reproducing words in a tangible and visible form and includes facsimile transmissions and email;
iv. a reference to any document or instrument includes any variation or replacement of it;
v. a reference to a party is to a party to this MoU, and a reference to a party to a document includes the party's executors, administrators, successors and permitted assignees and substitutes;
vi. a reference clause, subclause, attachment or schedule is, unless otherwise stated, a reference to the clauses, subclauses, attachments or schedules of this MoU;
vii. a reference to time is a reference to the time in Darwin in the Northern Territory of Australia;
viii. a provision of this MoU must not be construed to the disadvantage of a party merely because that party was responsible for the preparation of this MoU or in the inclusion of the provision in this MoU.

5. TERM OF THE MoU

a) This MoU commences on the Commencement Date and expires on the Termination Date.

6. INFORMATION SUPPLY

a) For the purpose of this MoU, the parties acknowledge it is necessary for the parties to lawfully exchange de-identified and aggregated information to strengthen and support formalised local inter-agency response to community safety and wellbeing and to provide support pursuant to the NPA.

b) The parties agree that DoH will provide DoB with Hospital Separation, Emergency Department, Remote Health Clinic information and any other DoH information both parties agree to in writing.

c) Periodicity of the data supply will be as agreed as on the record specification attachment.

d) Hospital Separation, Emergency Department and Remote Health Clinic information and periodicity are clearly restricted to the record specification attachment as part of this MoU.

e) Record specifications and periodicity mentioned in subclauses c) and d) may be modified only with the agreement in writing of both parties.

f) The parties agree that employees and representatives need to work within the law while carrying out the duty of care to share information responsibly.

7. RECORDS SECURITY

a) The parties acknowledge the sensitivity and confidentiality of the information being exchanged, released and disclosed under this MoU and the requirement to ensure the security of all records to protect the privacy of individuals.

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8. COMPLAINTS AND BREACHES

a) The parties recognise and endorse the complaints process in Section 104 of the Information Act.

9. NOTICES

a) Any notice, request or other communication to be given or served pursuant of this MoU must be in writing and addressed as follows:

i. If given to DoB, addressed and forwarded to the following address:
Director -General
Licensing NT, Department of Business
GPO BOX 1154, Darwin 0801

ii. If given to DoH, addressed and forwarded to the following address:
Director Data Management & System Reporting
Department of Health
[*insert mailing address*]

b) Any method of delivery or any such notice request or other communication must be delivered by hand or sent by prepaid post, facsimile or email to the address of the Party to which it is sent.

c) A notice, request or other communication will be deemed to be received:

i. If delivered by hand, upon delivery;
ii. If sent by pre-paid ordinary post within Australia, upon expiration of two business days after the date on which it was sent; and
iii. If transmitted electronically upon receipt by the sender of an acknowledgement that the communication has been properly transmitted to the recipient

d) Either party may change the address for service of notices by giving written notice of the change to the other party.

10. NON-ASSIGNMENT

a) Neither party will assign this MoU, in whole or in part, without the prior written consent of the other party.

11. VARIATIONS

a) No agreement or understanding varying or extending this MoU shall be made other than in writing and signed by both parties.

12. COMPLIANCE WITH LAW

a) The parties must ensure that any obligations executed in accordance with this MoU comply with the laws in force from time to time in the Northern Territory of Australia.

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PARTIES TO THE AGREEMENT

NORTHERN TERRITORY OF AUSTRALIA through the DEPARTMENT OF BUSINESS of Level 3, NAB House, 71 Smith Street, Darwin in the Northern Territory of Australia (DoB)

NORTHERN TERRITORY OF AUSTRALIA through the DEPARTMENT OF HEALTH of 87 Mitchell Street, Darwin in the Northern Territory of Australia (DoH)

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EXECUTED by the parties as a MEMORANDUM OF UNDERSTANDING

SIGNED by ……………………………………….., for and on behalf of the **NORTHERN TERRITORY OF AUSTRALIA** as represented by its agency the **DEPARTMENT OF BUSINESS**, in the presence of:
Signature ………………………………………..

Signature of Witness ……………………………………….. Date ………………………………………..
Name of Witness………………………………………..

SIGNED by ……………………………………….., for and on behalf of the **NORTHERN TERRITORY OF AUSTRALIA** as represented by its agency the **DEPARTMENT OF HEALTH**, in the presence of:
Signature ………………………………………..

Signature of Witness ……………………………………….. Date ………………………………………..
Name of Witness………………………………………..

Specification for DoH data: Hospital Separations & Emergency Department admissions

Table A1. Hospital separations: Acute and chronic: and ED admissions: ICD10 codes by

- age (<16, 16-54, 55+) (young and old)
- sex (m, f)
- Indigenous (Indigenous, non-Indigenous, unknown)
- Hospital name
- Location data (postcode, locality name and/or number, SA/SLA)
- Time: from 2005 to 2015 in 6-monthly (i.e. 1 Jan – 30 Jun, 1 Jul – 31 Dec), primary diagnosis

Group	Acute Condition	ICD-10 code
1	Mental & behavioural disorders: Alcohol related	F10.0 to F10.9
	Epilepsy – special epileptic syndromes	G40.5
	Alcoholic gastritis	K.29.2
	Alcohol-induced acute pancreatitis	K85.2
	Acute pancreatitis, unspecified (collectively)	K85.9, K86.0, K85.2
	Toxic effects of alcohol – ethanol	T51.0
	Toxic effects of alcohol – methanol	T51.1
	Toxic effects of alcohol – unspecified	T51.9
	Accidental poisoning by and exposure to alcohol	X45
	Intentional self-poisoning by and exposure to alcohol	X65
	Poisoning by and exposure to alcohol, undetermined intent	Y15
	Assault - includes sexual assault;[a] neglect, abandonment and maltreatment[b]	X85-Y09, Y87.1
	Chronic Condition	**ICD-10 code**
2	Alcoholic cardiomyopathy	I42.6
	Oropharyngeal Cancer	C01-C06, C09- C10, C12-C14
	Oesophageal Cancer	C15
	Liver Cancer	C22
	Laryngeal cancer	C32
	Degeneration of nervous system due to alcohol	G31.2
	Alcoholic polyneuropathy	G62.1
	Alcoholic myopathy	G72.0
	Alcoholic liver disease	K70.0
	Alcoholic-induced chronic pancreatitis	K86.0
	Epilepsy & status epilepticus	G40, G41
	Oesophageal varices	I85, I98.2, (I98.20, I98.21)[c]
	Gastro-oesophageal laceration-haemorrhage syndrome	K22.6
	Unspecified liver cirrhosis	K74.3 - K74.6, K76.0, K76.9
	Emergency department external injury codes	
1	Injuries to the head, elbow and forearm, wrist and hand	S00-S09, S50-S59, S60-S69
2	All external injury codes	S00 to T14

[a] Sexual Assault (Y05)

[b] Neglect, abandonment and maltreatment (Y06.0, Y06.1, Y06.2, Y06.8, Y06.9, Y07.0, Y07.1, Y07.2, Y07.3, Y07.8, Y07.9)

[c] I98.20, I98.21 ceased from 30 June 2008, replaced by I98.2

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Specification for PROMIS Data: Offence counts, Victim counts & Incidents

Offences data: ANZSOC codes and groupings from PROMIS

- *Counts*: Offences
- *Time period*: Data in monthly packets, but will be reported in 6-monthly intervals.
  - 1 January 2008 and ongoing in 6-monthly periods (i.e. 1 January to 30 June & 1 July to 31 December)
- *Other variables*:
  - alc_loc (community/suburb) and SA2 for NT Balance reporting region
  - region (standard reporting region) – all other areas of NT

Group	ANZSOC code	**ANZSOC description**
1	021X	Assault **by alcohol involvement (Y, N, DK) and by domestic violence (Y, DK)**
2	071X	Unlawful entry with intent/burglary, break and enter
3	081X	Motor vehicle theft and related offences
4	08XX excluding 081X	Other theft and related offences
5	121X	Property damage
6	1041 & 1042	Possession or use of illicit drugs
7	10XX (exc 1041-1042)	Other illicit drug offences (dealing, import, export, cultivate, manufacture)
8	1319	Disorderly conduct **by alcohol involvement (Y, N, DK)**
9	13XX (excl. 1319, 1326, & 1322)	Other public order offences excl. 1319, 1326, & 1322 **by alcohol involvement (Y, N, DK)**
10	0411 & 1431	Drive under the influence or exceed prescribed content of alcohol/other substance limit

Victim data: ANZSOC codes and groupings from PROMIS

- *Counts*: Victims
- *Time period*: 1 January 2008 to 31 December 2014 in 6-monthly periods (i.e. 1 January to 30 June & 1 July to 31 December) and (6-monthly thereafter once ANZSOC codes are finalised after initial exploratory data analysis)
- *Other variables*:
  - alc_loc (community/suburb) and SA2 for NT Balance reporting region
  - region (standard reporting region) – all other areas of NT
  - Age group, Indigenous Status, Sex

Group	ANZSOC code	**ANZSOC description**
1	021X	Assault **by alcohol involvement (Victims, offenders, both, none and DK) and by domestic violence (Y, DK)**

Specification for NTG Department of Education data

Data request

Age Grade School census data: variables, categories and definitions for student level data request

Record Specification	
Field	**Value example**
Year	2008
Semester	1
School	Barunga School

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Average Enrolment	60
Indigenous Enrolment	43
Non-Indigenous Enrolment	17
Preschool Enrolment	5
Primary Years Enrolment	28
Middle Years Enrolment	15
Senior Years Enrolment	10
Overall Attendance (%)	86
Indigenous Attendance (%)	85
Non-Indigenous Attendance (%)	88
Preschool Attendance (%)	63
Primary Years Attendance (%)	89
Middle Years Attendance (%)	87
Senior Years Attendance (%)	87
Latitude	-14.523436°
Longitude	132.866464°

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Appendix 2. Example of data request application for ACARA

IMPORTANT NOTES

1. Applicants requesting data are required to refer to the ***Data Access Protocols 2012*** and are advised to review the ***Guidelines 2013*** and **draft Agreement Template** prior to submitting this form.

   ☒ Tick box to confirm applicant has read the *Data Access Protocols 2012*
2. All questions/fields must be completed (use n/a where not applicable). Incomplete applications will not be accepted.
3. Send the completed application and any additional documents by email to datarequest@acara.edu.au
4. Please note that information provided in the form (including personal information) will be used by ACARA for record keeping, decision making and policy development purposes. The information will be provided to members of ACARA data request panel, other ACARA staff (as required) and may be disclosed to the ACARA Research and Data Committee as well as members of ACARA's National Assessment, Data, Analysis and Reporting Reference Group (NADAR) for the purpose of advice and decision making. These groups include representatives from education departments, non-government school peak bodies, research experts, and other stakeholder groups. Information about how ACARA deals with personal information is available online: http://www.acara.edu.au/privacy.html

SECTION 1: ALL APPLICANTS TO COMPLETE

1.1 Name:	Matthew Stevens
1.2 Position:	Senior Research Fellow
1.3 Organisation name & ABN	Menzies School of Health Research
1.4 Address:	PO Box 41096, Casuarina, 0811
1.5 Postal address:	As above
1.6 Phone and email:	(w): 08 8946 8524 and email: matthew.stevens@menzies.edu.au

1.7 List name(s) and position(s) of all individuals and their organisations who will be given access to the data provided:

Matthew Stevens, Senior Research Fellow

1.8 Date of request: _21_/_03__/__2016____

1.9 Data required by: 20_/_04__/__2016__ *After this date I will not need the data*: ☐ **Yes** ☒ **No**

All applicants must refer to the notes regarding timeline for assessment and delivery in the Guidelines 2013

1.10 Data request:

(See the ***Data catalogue*** *that includes information on key datasets)*

Name of data sets/variables	Calendar years requested (e.g. 2009, 2010, etc.)	Additional notes (e.g. Across Australia? or any particular state/territory)
School level data for all Northern Territory schools	All available	For all Northern Territory schools. The project for which this data is being sourced is an ongoing project, with data being updated every 6 to 12 months depending on the data source (See attached methodology for more detail)
NAPLAN results	2008 to current	

1.11 Provide a list of other data sources that will be used in the proposed project/research: *[If none, indicate n/a]*

All data for the Northern Territory by community: Police data (offences, victims, incidents), alcohol consumption, hospital separations, emergency department presentations, student

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attendance and enrolment, community sourced data collection in eight communities in the Northern Territory.

1.12 Main reason for this data request:

☒ Research

☐ Other (Please specify):

1.12a Please provide a detailed description of the intended use of the requested data:

The data will be used in a project titled: Place-based Framework for Monitoring and Evaluating Community Safety and Alcohol Action Initiatives in the Northern Territory. The purpose of this project is to develop a scalable place-based framework for monitoring and evaluating these types of initiatives. The Framework will provide a sustainable model for collecting, analysing and reporting data at community, regional and jurisdictional levels. It will include: the compilation of administrative datasets for quantitative analysis; the development of reporting formats that are meaningful for local communities; and a strong qualitative component to identify locally relevant community indicators and to develop systems and guidelines to assist communities to evaluate their own Community Safety and Alcohol Action Initiatives.

Consultation with communities has found that they are very interested in receiving data regarding children's schooling. The project is also sourcing student attendance and enrolment data from the Northern Territory Department of Education, as well as data from Department of Health (hospital separations, health centre, perinatal), and Police Department (offences and incidents). Data will be sourced at the community level to enable data to be interrogated at this level and allow for aggregation to higher regional areas. In addition to using administrative data, the project will carry out consultations with eight Indigenous communities to identify local level indicators that can be collected (community sourced data collection) that will tell communities whether their initiatives are working (i.e. improving community safety and reducing alcohol-related harms). Key outcomes of the project include:

- Communities will receive administrative data reports relevant to their Community Safety and Alcohol Action Initiatives either six-monthly or annually in a form appropriate to their community;
- Communities will be provided with tools for collecting local data through which they can monitor and evaluate their Community Safety and Alcohol Action Initiatives on six-monthly or annual basis;
- Communities' capacity to monitor and evaluate Community Safety and Alcohol Action Initiatives will be increased;
- General community capacity will be increased due to community involvement in research, monitoring and evaluation processes; and
- Community safety improved and alcohol harms reduced due to better monitoring and evaluation of relevant initiatives.

1.12b How will this proposed research/project benefit students, schools and the Australian community?

Community safety and the impact of alcohol misuse in Indigenous communities in the Northern Territory is a significant issue, one that prompted the Northern Territory Emergency Response Act, and the subsequent Stronger Futures Act. The harmful effects of

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poor community safety and alcohol misuse go beyond the drinker, with families and communities also impacted. Types of harms related to children include:

- Foetal Alcohol Spectrum Disorder (FASD) is a likely contributor to poorer academic performance in the Northern Territory Indigenous communities (along with other factors).
- Lower school attendance if family has alcohol problems
- Children going hungry due to parents spending money on alcohol instead of household essentials
- Children suffering emotional problems due to exposure to alcohol-related violence and drunk people

The Framework will give Indigenous communities a tool to help them determine if their Community Safety and Alcohol Action Initiatives are working, which it is hoped will lead to improved community safety and a reduction in alcohol-related harms in Indigenous communities in the Northern Territory.

1.13 Anticipated timeframe for completion of this research/project: September 2016

1.14 List planned product(s) from the data provided (e.g. report):

- Overall project report for the Place-based Framework.
- Framework for accessing and reporting data at regular intervals to: Northern Territory Government and the Australian Government; and to communities through reports to Community Safety Committees, Alcohol Reference Groups or other equivalent committees in Indigenous communities in the Northern Territory.

1.15 Will the product(s) be published?

☐ **No**

☒ **Yes -** *Please specify the format and content of the intended publication. If possible, please also attach a sample or mock-up of this publication to the application. Notes: Under the Principles and Protocols for Reporting on Schooling in Australia 2009 and the Data Access Protocols 2012 any publication that could potentially be used to identify schools/ individuals are unlikely to be approved.*

We would like to be guided by ACARA with regards to what can be published. My understanding is that if it is published on the MySchools website, then it can be published publicly - the project would follow this protocol.

1.16 Anticipated key audience(s) of the product(s):
Indigenous Community Safety Committees, Alcohol Reference Groups or equivalent committee; Northern Territory Government; Commonwealth Government.

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SECTION 2: ONLY RESEARCHER/S TO COMPLETE

2.1 Research purpose: *[100 words max]*
The purpose of this project is to develop a place-based framework (The Framework) to monitor and measure the impact and effectiveness of Community Safety and Alcohol Action Initiatives in the NT. The Framework will provide a sustainable model for monitoring and evaluating Community Safety and Alcohol Action Initiatives by: identifying appropriate indicators; streamlining data collection and analysis; and developing formats for collecting and reporting data in a way that has relevance and meaning for local communities. In addition to the compilation of administrative datasets for quantitative analysis, the development of

The Framework will include a strong qualitative component in order to identify locally relevant community indicators informed by the views and perceptions of community members.

2.2 Key research question(s): *[100 words max]*

The primary aim of The Framework is to provide a coherent and efficient system to enable Community Safety and Alcohol Action Initiatives to be monitored and evaluated on an ongoing basis, including beyond the life of this project. The key elements to be included in The Framework package are:

- A series of minimum core quantitative indicator sets drawn from NTG administrative datasets, and other administrative datasets where appropriate, for monitoring and evaluating the effectiveness of Community Safety and Alcohol Action Initiatives at an NT wide and regional centre level, as well as for large and small remote and urban communities.
- A survey instrument to enable collection of local data from communities with Community Safety and Alcohol Action Initiatives.
- A core set of local level quantitative indicators that each community can tailor to their individual needs.
- A core set of community resource indicators.
- A set of guidelines that can be used to collect qualitative information at the local community level.
- A broad reporting framework describing procedures for reporting data to a variety of audiences. This will include:
    - Templates and procedures for reporting data, at various geographic levels, to communities and relevant government departments; and
    - A system for integrating information generated through the program logic model into the reporting framework (program logic model to be developed by the Alcohol Data Unit (ADU), NTG Department of Business).
- Protocols to facilitate timely access to data from NTG departments and other administrative data sources (e.g. Commonwealth, NGOs).
- A map showing the location of communities included in an AMP and the key services available to each community (joint Menzies and ADU undertaking).

2.3 Methodologies: *[100 words max]*

An integrated, mixed method approach will be used to develop the Place-based Monitoring and Evaluation Framework. This will include an assessment of indicators at two levels. The first level will draw on administrative data sets, which provide information at the community, regional and Territory wide levels, and the second level will draw on local data sourced directly from communities that are developing Community Safety and Alcohol Action Initiatives under the SFNT.

A basic assumption of the data framework is that the data collected and reported must be tailored to the degree of data available for geographic areas relevant to communities' Community Safety and Alcohol Action Initiatives. Not all Community Safety and Alcohol Action Initiatives can be evaluated to the same degree; however, The Framework will facilitate the ability of communities to monitor (and evaluate) their own Community Safety and Alcohol Action Initiatives.

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The development of The Framework will be structured through the following key components:

Component 1: Sourcing administrative data – exploratory data analysis; assessing data quality; identifying alcohol catchment areas and linking data at community level; and negotiating ongoing data access with administrative data custodians.

Component 2: Sourcing local data from communities developing Community Safety and Alcohol Action Initiatives under the SFNT – key informant interviews; community survey; thematic analyses of community AMPs; and community consultation to identify success indicators that can be collected by communities.

Component 3: Putting the framework together – refining administrative data requests and ongoing access and presenting indicators contained in The Framework in an appropriate medium.

2.4 Evidence of relevant institutional ethics clearance attached to this application: ☒ Yes ☐ No

If No, state why not (e.g. no ethics process in place or ethics clearance not required by the institution in this circumstance)

Ethics applications were submitted to the Central Australian Human Research Ethics Committee (CAHREC) as well as to the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC). Full ethics approval was received from CAHREC on 5 May 2015 and from HREC on 6 May 2015.

2.5. Research proposal attached to this application: ☒ Yes ☐ No

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Appendix 3. Survey questionnaire

Community Alcohol and Wellbeing Survey

Record community, date of survey and name of interviewer

Do this before the person is approached or straight after finished previous interview

1) Don't ask respondent.
Please select the community where this survey is being done*

Name of Community ____

2) Don't ask respondent.
Please record survey date* ____

3) Don't ask respondent.
Please record the name of the interviewer.*

(Type in names of people who are doing the interviews before you begin the survey)

( ) ____

( ) ____

( ) ____

( ) ____

( ) Other, please write name: ____

Explain the purpose of the survey and get informed consent.

G'day/hello, my name is [*your first name*] and I'm conducting a survey for the NTG Department of Business. Staff from this department work together with your community Elders and service providers to find the best ways of reducing alcohol-related harms and problems in your community. Answers to this survey will help leaders in your community to understand whether alcohol problems are getting better or worse.

I won't record your name, so it will not be possible for anyone else to know what you have said. You can stop at any time or if you do not want to answer a question, you can say no. What the community tells us will be reported back to your community through the [*name of committee or alcohol reference group*].

Do you agree to participate in this survey....yes/no. Could you please sign this consent form...thanks.

4) Don't ask respondent
If the person agrees to participate and has signed the consent form, mark the 'Yes' box, and type/write in consent form ID number .*

( ) Yes, write in consent form ID number: ____
( ) No, discontinue survey

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First I just need to ask you a couple of questions to make sure you can be included in this survey.

5) Have you been living in this community for 12 months or more? *

( ) Yes
( ) No, discontinue survey

6) Are you 18 years or older? *

( ) Yes
( ) No, discontinue survey

Socio-demographic information

Start survey proper

7) Record gender of respondent*

( ) Male
( ) Female
( ) Other, please state: ____

8) What is your relationship status?
[Prompt: Read out options if person unsure]

( ) Single
( ) Married/defacto
( ) Separated/divorced
( ) Widowed
( ) Don't know ( ) Refused

9) Could you please tell me how old you are? *
[If does not want to say, read out age groups]

( ) 18-24 years
( ) 25-34 years
( ) 35-44 years
( ) 45-54 years
( ) 55 or more years
( ) Don't know ( ) Refused

10) Could you please tell me the highest year of school that you finished?
[Read out if required - was that...]
[Older people may be more familiar with Leaving Certificate, which was received after 11 years of schooling back then, but equivalent to Year 12]

( ) Year 12 / Leaving Certificate / Senior Certificate
( ) Year 11
( ) Year 10 / Junior Certificate
( ) Year 9
( ) Year 8 or below
( ) Don't know ( ) Refused

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11) Have you completed any other education since leaving school? If yes, would that be a ...
[Please choose highest qualification]

( ) No
( ) Yes, Certificate I, II or III
( ) Yes, Certificate IV
( ) Yes, Diploma or Associate Diploma
( ) Yes, Bachelor Degree or higher
( ) Other
( ) Don't know ( ) Refused

I'm now going to ask you about your work situation.

12) In the last week were you: (please select the one that most applies)

( ) Employed full-time
( ) Employed on a part-time or casual basis
( ) Unemployed and enrolled in the Community Development Program, previously the Remote Jobs Communities Program (RJCP)
( ) Home duties
( ) On disability or sickness benefits
( ) On single parent pension
( ) On carer's pension
( ) On an aged pension
( ) Other ____
( ) Don't know ( ) Refused

Now I'm going to ask you about crowding in your house
13) How many people slept in your house last night? Of these, how many were:
[Prompt: make sure that babies are included in the count for under 16 years]

( ) Under 16 years ______________________
( ) 16 years or older ______________________

Alcohol / Grog Section

I would now like to ask you a few questions about grog. I just want to remind you that whatever you say to us is confidential, and no one else will know what your answers are.

14) Have you had a drink of alcohol in the last year?

( ) Yes → go to Q16
( ) No → go to Q15
( ) Don't know → go to Q16 ( ) Refused → go to Q16

15) What is the **main** reason for you not drinking alcohol in the *last year*?
[Don't read but prompt using 'your health' as an example if respondent unsure.]

[Please select only one response]

( ) Bad for family or family pressure → go to Q19
( ) Bad for your health → go to Q19
( ) Bad for the community → go to Q19
( ) Good example for younger people → go to Q19

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( ) Pregnancy (females) → go to Q19
( ) Other, please state → go to Q19: ____
( ) Don't know→ go to Q19 ( ) Refused → go to Q19

16) In the *last year*, how often would you *usually* drink alcohol/grog? [Read out if person does not say: Would that be...]

( ) Every day or nearly every day (5+ per week)
( ) A few times a week (2-4 per week)
( ) Once a week
( ) Once a fortnight
( ) Once a month
( ) A few times per year
( ) About once a year
( ) Don't know ( ) Refused

Now, I would like you to think about the *last time* you had a drink.

17) Where did you drink? (More than one box can be ticked)

( ) At home, or in a family or friend's house in this community
( ) Community Social Club
( ) Drinking camp
( ) Pub or other licensed venue (e.g. club)
( ) Other: ____

18) I want to now find out the type of grog you drank and **how much** you drank?
[Prompts: Go through alcohol types in the same order as in the table]
[Prompts: For beer, ask whether light, mid or full strength. Also check stubbie size – mostly is 375 ml]
[Please ensure the two shaded columns are accurately completed]
[Use conversion charts for group drinking]

	Number of people shared with	*** Individual container/cask size in ml (numerical only e.g. 335, 375, 500, 750, 1000, 1125, 1145, 2000, 4000)**	**Number of cartons or packs consumed**	*** Number of containers/casks/ bottles consumed (numerical only)**
Full strength beer (e.g. cans, stubbies, longnecks/tallies)				
Mid strength beer (e.g. cans, stubbies, longnecks/tallies)				
Light beer (e.g. cans, stubbies, longnecks/tallies)				
Cider (e.g. cans, stubbies, longnecks/tallies)				
Wine (e.g. bottle or cask)				
Fortified wine				

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(e.g. port or sherry)				
Bottled spirits (e.g. rum, bourbon)				
Pre-mixed spirits (e.g. UDL cans/bottles, rum and coke)				
Don't know				
Refused to answer				

19) Thinking about the *last year*, how much of the time has grog/alcohol been a problem **in your home**? Would you say... [Use Likert scale prompt card]

( ) None of the time ( ) A bit of the time ( ) Some of the time
( ) Most of the time ( ) All of the time
( ) Don't know ( ) Refused

20) Still thinking about the *last year*, how much of the time has grog/alcohol been a problem in this community? Would you say... [Use Likert scale prompt card]

( ) None of the time ( ) A bit of the time ( ) Some of the time
( ) Most of the time ( ) All of the time
( ) Don't know ( ) Refused

21) Compared to last year, do you think grog/alcohol problems have changed in this community? Would you say they are.... [Use Likert scale prompt card]
[Prompt: Can first find out if things are better or worse, and then ask if 'a lot', or 'a bit']

( ) A lot better ( ) A bit better ( ) About the same
( ) A bit worse ( ) A lot worse
( ) Don't know ( ) Refused

22) If you or a close friend or family member had a problem with grog, who or where, in this community, would you go to for help? **(select no more than two responses)**
[Don't read, but prompt using 'health centre staff']

[ ] AOD Worker
[ ] Health centre staff
[ ] Close friend or family member
[ ] Elder
[ ] Youth Worker
[ ] Other, please state: ____
[ ] Don't know [ ] Refused

23) Do you know of any programs that have been operating in your community over the last year that help people or families deal with alcohol problems?
[Prompt: For example, rehabilitation or education]

( ) Yes
( ) No
( ) Don't know ( ) Refused

24) Every year, your community receives a report about alcohol-related problems in your community. Have the results from this report been communicated to you and others in the community?

( ) Yes
( ) No
( ) Don't know ( ) Refused

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Nearly finished now!

Community strengths and problems

I am now going to ask you some questions about your community and what good and bad things are happening. The next couple of questions use the following answer options: None of the time, a little of the time, some of the time, a lot of the time, and all the time. The first one is whether any drugs are causing problems in the community.

25) From the following list of drugs, can you please tell me how much of the time they have been a problem in this community over the *last year*? For [*insert drug name*], would that be... [Use Likert scale prompt card]

	None of the time	A bit of the time	Some of the time	Most of the time	All the time	Don't know	Refused
Marijuana (gunja)							
Sniffing (petrol, glue etc.)							
Kava							
Ice							

26) This next question is about your community. In the *last year*, how much of the time have the following things been a problem in this community? Is [*insert problem*] a problem... [Use Likert scale prompt card]

	None of the time	A bit of the time	Some of the time	Most of the time	All the time	Don't know	Refused
Stealing or theft, and break and enter							
Jealousy							
Humbugging							
Family violence							
Seeing people fighting							
People not feeling safe (e.g. walking on own)							
Gambling							
Youth gangs							
Noise at night							
Other:							

27) In the *last year*, how often did you attend, or take part in the following community activities?
[Use frequency scale prompt card]

	Did not attend	About once per year	3-4 times per year	1-2 times per month	Most weeks	Don't know	Refused
Sporting events							
School events and/or programs							
Cultural events (e.g. Art, music, healthy living festivals)							

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	Did not attend	About once per year	3-4 times per year	1-2 times per month	Most weeks	Don't know	Refused
Traditional or Law Ceremonies							
Church							
Women's groups							
Men's groups							
Art groups/centres							
Other							

Thank you for taking this survey. We will make the results available to your community through the Alcohol Reference Group in the next few months.

If you need to talk to anyone about alcohol or drug problems the phone number is 1800 629 683, or for gambling related problems, 1800 858 858. The numbers are also at the back of the information sheet we gave you.

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Appendix 4. Alcohol consumption conversion chart

Beer, ciders and premixed: Converting group drink cartons into containers per person

Pack size	Number packs consumed	Shared with 0	Shared with 1	Shared with 2	Shared with 3	Shared with 4	Shared with 5	Shared with 6	Shared with 7	Shared with 8
4-pack (pre-mixed)	1	4	2	1	1	1	1	1	1	0
6-pack	1	6	3	2	2	1	1	1	1	1
10-pack (pre-mixed)	1	10	5	3	3	2	2	1	1	1
Half-a-carton	1	12	6	4	3	2	2	2	2	1
Carton	1	24	12	8	6	5	4	3	3	3
30-pack	1	30	15	10	8	6	5	4	4	3
4-pack (pre-mixed)	2	8	4	3	2	2	1	1	1	1
6-pack	2	12	6	4	3	2	2	2	2	1
10-pack (pre-mixed)	2	20	10	7	5	4	3	3	3	2
Half-a-carton	2	24	12	8	6	5	4	3	3	3
Carton	2	48	24	16	12	10	8	7	6	5
30-pack	2	60	30	20	15	12	10	9	8	7
4-pack (pre-mixed)	3	12	6	4	3	2	2	2	2	1
6-pack	3	18	9	6	5	4	3	3	2	2
10-pack (pre-mixed)	3	30	15	10	8	6	5	4	4	3
Half-a-carton	3	36	18	12	9	7	6	5	5	4
Carton	3	72	36	24	18	14	12	10	9	8
30-pack	3	90	45	30	23	18	15	13	11	10
Pack size	**Number packs consumed**	**Shared with 0**	**Shared with 1**	**Shared with 2**	**Shared with 3**	**Shared with 4**	**Shared with 5**	**Shared with 6**	**Shared with 7**	**Shared with 8**
4-pack (pre-mixed)	4	16	8	5	4	3	3	2	2	2
6-pack	4	24	12	8	6	5	4	3	3	3
10-pack (pre-mixed)	4	40	20	13	10	8	7	6	5	4
Half-a-carton	4	48	24	16	12	10	8	7	6	5
Carton	4	96	48	32	24	19	16	14	12	11

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30-pack	4	120	60	40	30	24	20	17	15	13
4-pack (pre-mixed)	5	20	10	7	5	4	3	3	3	2
6-pack	5	30	15	10	8	6	5	4	4	3
10-pack (pre-mixed)	5	50	25	17	13	10	8	7	6	6
Half-a-carton	5	60	30	20	15	12	10	9	8	7
Carton	5	120	60	40	30	24	20	17	15	13
30-pack	5	150	75	50	38	30	25	21	19	17

Pack size	**Number packs consumed**	**Shared with 0**	**Shared with 1**	**Shared with 2**	**Shared with 3**	**Shared with 4**	**Shared with 5**	**Shared with 6**	**Shared with 7**	**Shared with 8**
4-pack (pre-mixed)	6	24	12	8	6	5	4	3	3	3
6-pack	6	36	18	12	9	7	6	5	5	4
10-pack (pre-mixed)	6	60	30	20	15	12	10	9	8	7
Half-a-carton	6	72	36	24	18	14	12	10	9	8
Carton	6	144	72	48	36	29	24	21	18	16
30-pack	6	180	90	60	45	36	30	26	23	20
4-pack (pre-mixed)	7	28	14	9	7	6	5	4	4	3
6-pack	7	42	21	14	11	8	7	6	5	5
10-pack (pre-mixed)	7	70	35	23	18	14	12	10	9	8
Half-a-carton	7	84	42	28	21	17	14	12	11	9
Carton	7	168	84	56	42	34	28	24	21	19
30-pack	7	210	105	70	53	42	35	30	26	23
4-pack (pre-mixed)	8	32	16	11	8	6	5	5	4	4
6-pack	8	48	24	16	12	10	8	7	6	5
10-pack (pre-mixed)	8	80	40	27	20	16	13	11	10	9
Half-a-carton	8	96	48	32	24	19	16	14	12	11
Carton	8	192	96	64	48	38	32	27	24	21
30-pack	8	240	120	80	60	48	40	34	30	27

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Casks, bottles: Converting group drink cartons into containers per person										
Cask size	**Number packs consumed**	**Shared with 0**	**Shared with 1**	**Shared with 2**	**Shared with 3**	**Shared with 4**	**Shared with 5**	**Shared with 6**	**Shared with 7**	**Shared with 8**
1 cask/bottle	1	1	0.50	0.33	0.25	0.2	0.17	0.14	0.13	0.11
2 casks/bottles	2	2	1	0.67	0.5	0.4	0.33	0.29	0.25	0.22
3 cask/bottle	3	3	1.5	1	0.75	0.6	0.5	0.43	0.38	0.33
4 casks/bottles	4	4	2	1.33	1	0.8	0.67	0.57	0.5	0.44
5 cask/bottle	5	5	2.5	1.67	1.25	1	0.83	0.71	0.63	0.56
6 cask/bottle	6	6	3	2	1.5	1.2	1	0.86	0.75	0.67
7 cask/bottle	7	7	3.5	2.33	1.75	1.4	1.17	1	0.88	0.78
8 cask/bottle	8	8	4	2.67	2	1.6	1.33	1.14	1	0.89
9 cask/bottle	9	9	4.5	3	2.25	1.8	1.5	1.29	1.13	1
10 cask/bottle	10	10	5	3.33	2.5	2	1.67	1.43	1.25	1.11

NB: These tables will fit onto one A4 sheet (both sides) once the Appendix heading is removed.

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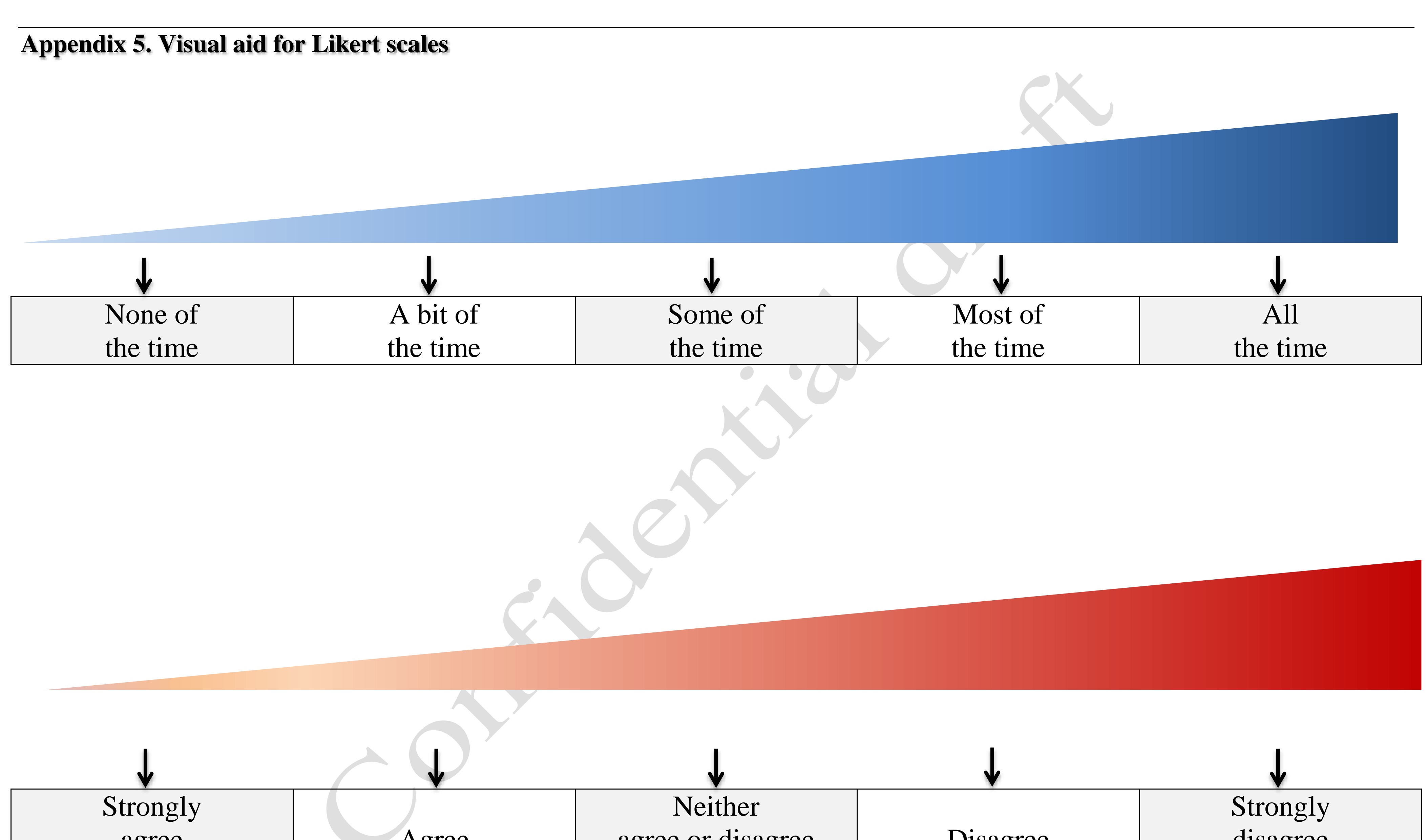
Appendix 5. Visual aid for Likert scales



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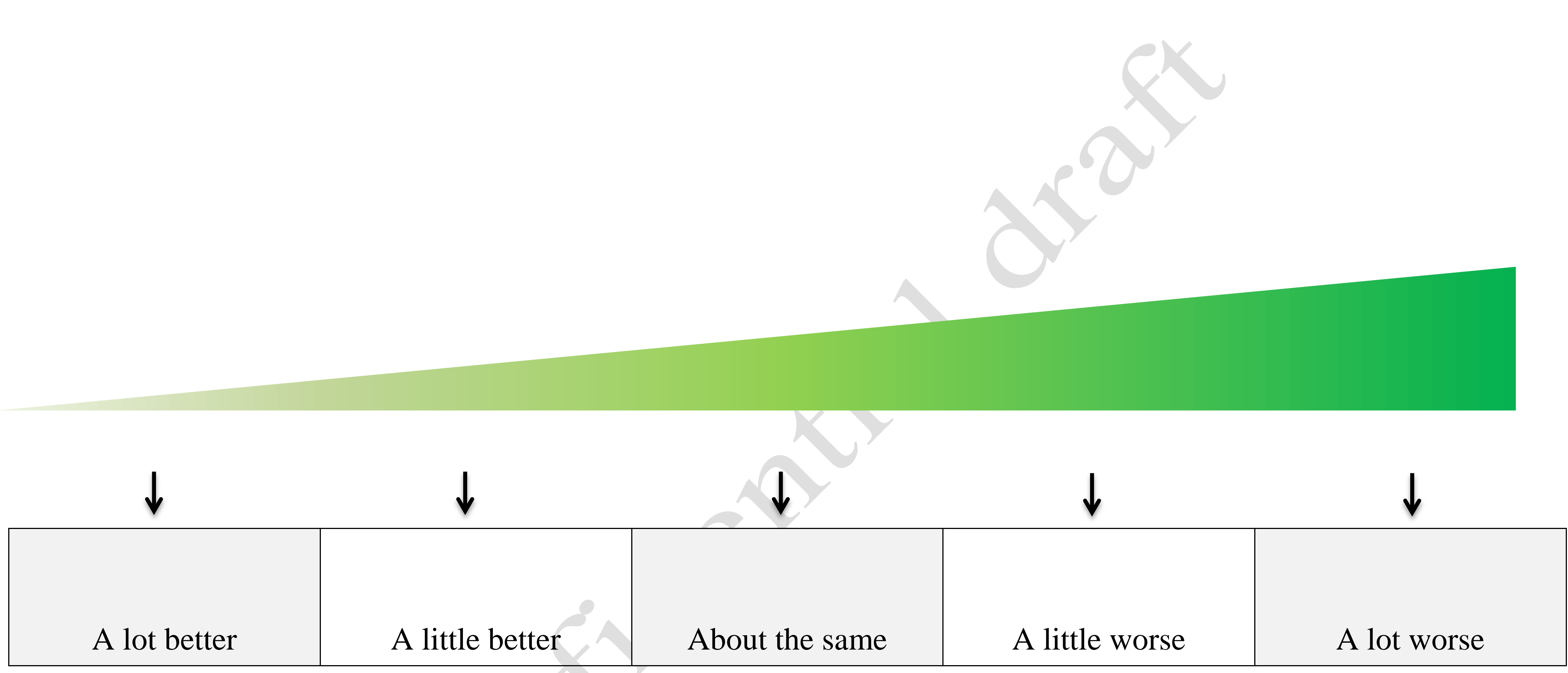

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Appendix 6. Examples of standard drinks

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These are only an approximate number of standard drinks. Always read the container for the exact number of standard drinks.

These are only an approximate number of standard drinks. Always read the container for the exact number of standard drinks. * Ready-to-Drink

Appendix 7. Example of Information Sheet

Developing a Place-based Framework for Monitoring and Evaluating Alcohol Management Plans and other Alcohol Initiatives in the NT

The Northern Territory Government has asked Menzies to work with communities to develop a way of measuring whether alcohol problems are getting better or worse. This project is called the 'Place-based Framework'.

Why is the Place-based Framework being developed?

Grog is a big issue across the Northern Territory for both Aboriginal and non-Aboriginal people. However, Aboriginal people are more likely to get sick or die from grog than other Australians. The Northern Territory Government is helping Aboriginal communities to manage alcohol so that the problems caused by grog can be fixed in your community. An important part of this is finding out whether alcohol problems are getting better or worse. Some people call this process monitoring and evaluating. This survey is part of this process and is collecting the views of community residents on alcohol use and problems, as well as community strengths. Other information separate to this survey is also being put together by Menzies and will be provided back to your community each year. This other information includes data from government (e.g. health data, crime data).

How will the Place-based Framework help communities to monitor and evaluate their own AMPs?

The Place-based Framework will:

- Help communities to know whether alcohol problems are getting better or worse;
- Help communities to collect their own local level information;
- Help communities to know what programs work best to reduce alcohol problems;
- Help communities to work out the best ways of telling (communicating) the results to the rest of the community in a way that can be understood by everyone and that fits in with your culture (make sure it's culturally appropriate).

How will Menzies work with Communities?

Menzies will have lots of talks with different members of your community. This will help them to build a picture of your community and to understand how it works. The more they understand your community the better they will be able to help you find the best way of working out which alcohol indicators will tell you the most about whether harms from grog are getting better or worse. Menzies will also be conducting a survey. This consists of a short questionnaire (a list of questions that can be answered quickly) and we would like to do this questionnaire with about 40-50 community members.

Anybody in the community who does not want to talk with Menzies, or does not want to answer the questions in the questionnaire, can also say 'No'.

If you would like to know more about the people from Menzies who will be working with you on this project please see the next page.

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Researchers from Menzies who will be working on the project

Dr Matt Stevens

Matt moved with his young family to the Northern Territory from Brisbane in 2000. He completed a Bachelor of Applied Mathematics and Statistics in 1997, and has worked across environmental, social and health research areas. Matt has been at Menzies for over 10 years working on projects in housing, social determinants of health, gambling, tobacco control and alcohol policy.

Professor Richard Midford

Richard Midford is professor of health in education at Charles Darwin University and the Menzies School of Health Research. He has undertaken research on the prevention of alcohol harm in communities, prevention of alcohol and other drug harm in workplace settings and in the development of effective school drug education.

Dr Jennifer Buckley

Jennifer moved to the Northern Territory from Adelaide at the end of 2012 and joined Menzies in 2014 to work on the Place-based AMP Framework. She has a background in health and completed a PhD in social science at Adelaide University in 2010. Jennifer has worked on a wide variety of research projects including: the impact of health and obesity on the ageing workforce; dementia and depression; suicide prevention; and foetal alcohol spectrum disorder.

Megan Whitty

Megan is currently finishing her PhD and has lived and worked in the Northern Territory for 5 years. Her doctoral thesis is based on understanding the role of implementation and evaluation when introducing alcohol interventions in various contexts. Megan has worked on a number of research projects including: the prevention of alcohol related facial trauma based at the Royal Darwin Hospital; and the evaluation of the Katherine Alcohol Management Plan.

Ronnie Burns

Ronnie has completed studies in Alcohol and other Drugs (Certificate IV), Suicide Prevention and Sexual Assault. He was an accomplished footy player, now in coaching, and was the 2014/15 Assistant Coach of the Tiwi Bombers. Ronnie is helping the Menzies team to carry out the Community Alcohol and Wellbeing Survey.

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If you need to talk to anyone about alcohol or drug problems the phone number is 1800 629 683, or for gambling related problems, 1800 858 858.

If you would like to know more about this project please contact:

Jennifer Buckley, Project Manager, on 8946 8645, or
Matt Stevens, Project Director, on 8946 8524

Email inquiries can be sent to: jennifer.buckley@menzies.edu.au

Appendix 8. Example of consent form for survey participants

Participation Consent Form

PROJECT TITLE: Place-based Framework for Evaluation and Monitoring of Alcohol Management Plans and other Alcohol Initiatives in the Northern Territory

This research is being conducted by the Northern Territory Department of Business. Contact details for the Department of Business are included below.

I agree that:

I am over the age of 18 years.

A plain language information sheet has been provided and explained to me, which outlines the aims of the project and what my involvement will be.

I have been informed that I can say No and that I can withdraw from the project at any time.

I have been informed that any information I give through interviews will be used for the purpose of the research project only.

I understand that my name will not be used in any writing made public and confidentiality will be respected in all aspects of the project.

The ownership of Aboriginal knowledge and cultural heritage is retained by the informant and this will be acknowledged in research findings and in the dissemination of the research.

I have read and understood the information provided and agree to:

Participate in a survey to meet the aims and objectives of the project	Yes	No
To have forms containing my responses to survey questions kept safely by the Department of Business	Yes	No

Name: ____________________________________

Signature: ________________________________ Date: __________

Witness Name: ____________________________

Signature: ________________________________ Date: __________

Interpreter Name (if required): ________________

Signature: ________________________________ Date: __________

Researcher Contact Details

[name] [title] Email: Tel. work: Mob:	[name] [title] Email: Tel. work: Mob:	[name] [title] Email: Tel. work: Mob:

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Appendix 9. Quota sheet (to keep track of gender/age balance in surveys)

[Name of Community]

Running tally of age/gender balance of survey respondents

Female (Under 35)		**Male (Under 35)**	
Female (Over 35)		**Male (Over 35)**	

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Appendix 10. The Community Alcohol and Wellbeing Survey Training Manual

The Community

Alcohol & Wellbeing Survey (CAWS):

Training Manual

September-November, 2015

AUTHOR
Dr Matthew Stevens (email: matthew.stevens@menzies.edu.au)

Training Booklet for the

Community Alcohol and Wellbeing Survey (CAWS)

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Definitions

Before going into the survey questions, a few definitions for terms commonly used when talking about surveys are required.

- **Interviewer**: The person administering or asking survey questions.
- **Interviewee**: The person being asked the survey questions, also known as a **respondent** or research **participant**.
- **Variable**: A variable is usually a single survey question (e.g. age), or a variable can be derived from a group of survey questions, or a survey module, to obtain a single measure of a concept. Sometimes referred to as an **indicator** (e.g. number of people in alcohol-related assaults).
- **Socio-demographics**: Refers to variables relating to age, gender, family and household composition, socioeconomic status (education and income) and mobility.
- **Informed Consent**: Is ensuring the person being interviewed understands their rights in regards to participation in the study (survey etc.). This includes telling participants about the study, and their right to refuse or not to participate.
- **Sample**: A selection of objects (e.g. people) from a population.
- **Quota sample**: A selection of people from a population ensuring the sample is selected to ensure representation of particular groups (e.g. age, sex, drinking status)
- **Scope**: The scope of a survey refers to the population to which the survey 'could be' given. For example, people over 18 years and living in this community for more than 12 months.

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Aims of the Annual Community Alcohol and Wellbeing Survey (CAWS)

When developing a survey it is important to ensure the aims of the survey are well understood. The aims of the Annual Community Alcohol Survey are to:

1. Measure alcohol harms and severity in the community over time.
2. Measure alcohol consumption in the community over time.
3. Measure the social and emotional wellbeing (SEWB) of community residents over time.
4. Measure residents' exposure to community level stressors (problems) over time.
5. Measure residents' exposure to community strengths over time.

Sample size for different community sizes

A sample size of 40 to 65 will be adequate depending on the size of the community. This is based on sample calculations for a simple random sample, with a standard error of 5% on an estimate of 20%. The table below sets out recommended sample sizes for communities of various population sizes.

	Indigenous Population less than 300	Indigenous Population 300-999	Indigenous Population 1000 or more
Sample size (n)	40-45	46-54	55-65

Quotas for sampling

Quotas on age (less than 35 years and 35 years or more) and gender (male and female) will help to ensure that the survey represents views of men and women and older and younger adults in the community. Interviewers should carry a table (see below for example), that they can add a stroke to the appropriate box, which will enable them to keep track of quotas at the end of each day of surveying.

	Male		Female	
Date	Less than 35 years	35 years or more	Less than 35 years	35 years or more
20 October 2016	III	III	III	III

An overall quota on alcohol consumption could also be included, based on the most recent data from the National Aboriginal and Torres Strait Islander Health Survey, which found that around 70% of Indigenous adults in remote NT drink alcohol. Therefore on a sample of 50, the interviewer would attempt to sample 35 drinkers and 15 non-drinkers.

Recruiting people to participate in the survey

Because random sampling is not being done for this survey, it is important that whoever is responsible for administering the survey attempt to get representative sample. The above quotas will help with this, but interviewers and those assisting to recruit people need to ensure they

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include a mix of: families from the community and people who are working and non-working. The following approaches are suggested for recruiting participants for the survey:

- holding a community BBQ to promote the survey (including distributing Menzies promotional caps, hats, squeeze footballs and rubber bracelets);
- going to Men's and Women's Centres or workshops;
- going to the Art Gallery or other 'spaces' that community members were attending;
- going to where the Remote Jobs Community Projects (RJCP) were happening;
- waiting outside community stores and approaching people as they entered or exited;
- adding a raffle component, where participants go in the draw to win a voucher from the local community store; and
- door knocking (though less often).

The Community Alcohol and Wellbeing Survey

Interviewing using surveys

When administering a survey it is important to remain calm and considerate when talking to people. The goal is to obtain information from a sample of people, using a question answer style, in a consistent and unbiased way.

Before starting the interview

Before starting the interview make sure you are well organised. This will help to ensure the interview runs smoothly and that the person being interviewed does not feel they are wasting their time. As an interviewer, you need to know the logical flow of the survey, including which questions have prompt cards or additional instructions. Part of being organised for this survey will mean completing the first three questions: the survey date, name of community, and interviewer name before you speak to the person. These questions can be completed either at the end of the previous interview, or just before you approach the next person to be interviewed. Once the person is approached, you then need to introduce the survey.

Introducing the CAWS to respondents

When carrying out research it is important that the participants in the research, in this case, the residents of this community, understand the purpose of the research and give their *informed consent* to participate. Looking at the CAWS instrument, on page 2 there is an introductory statement that gives a brief explanation of the project. This needs to be read out in full to the participant. Once you have finished reading this to the (potential) participant, provide them with a project Information Sheet. If they agree to participate, ask them to sign the hard copy consent form, tick 'yes' in the survey to Question 4, and write in the participant ID number.

ID numbers should be assigned to each community before going out into the field, beginning with number 1 and continuing sequentially until all communities in the survey have been

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assigned a number. Each participant is also assigned an ID number; this begins with the community number, followed by the number for the participant. For example, if Community X is assigned the number 1, the first participant ID number will be 1.01, the second participant ID number will be 1.02 and so on. The participant ID number must be written in both the space allocated at the bottom of the Consent form and at Question 4 of the participant's survey form. Ideally, any naming and ID convention, should marry up with internal DoB community Identification.

There are two more questions in this section that determine whether the person can participate in the survey. To be in scope (included), people must be 18 years or over and have lived in the community for 12 months or more. If the person being interviewed answers 'no' to either of these questions, then they cannot be included in the survey. Be sure to thank the person for their time and inform them that they are ineligible to participate in the survey.

Socio-demographic information

An individual's socio-demographic characteristics often influence their social and health outcomes; consequently, it is important to include questions that collect information on these characteristics. For example, do people who are employed have different drinking patterns to people who are unemployed? Are women more likely to report community alcohol problems than men? The next several questions collect information on age, gender, employment status, housing, and education. Sometimes it is not necessary to ask the question. For example, gender can usually be ascertained visually, but if unsure, please ask the person and do not make an assumption.

Many social and health outcomes and their causes vary by the socio-demographic characteristics of the person. It is important that answers to survey questions can be analysed by socio-demographic variables. For example, do people who are employed have different drinking patterns to people who are unemployed? Are women more likely to report community alcohol problems than men? The next several questions collect information on mobility patterns (out of community for 1 month or more), age, gender, employment status, and education. Sometimes it is not necessary to ask the question. For example, gender can usually be ascertained visually, but if unsure, please ask the person and do not make an assumption.

Alcohol/Grog questions

There are five questions about alcohol and drinking patterns (Q14 to Q18). The first few questions capture: whether a person has drunk alcohol in the last year; if they haven't had a drink in the last year what are their reasons for not drinking; and how often people **usually** drink alcohol.

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The next few questions are about the **last time the person had a drink**. The question is introduced as follows: *Now, I would like you to think about the* ***last time*** *you had a drink*. It is important that the interviewee is aware of the timeframe of the question and the interviewer emphasises this. Most questions in this survey are in the *last year*, though some are the *last month*, and this one is the *last time*.

Q17 asks where they drank last time. Question 18 is the most complicated question in this survey – it asks about the last time the person drank alcohol, what they drank and how much they drank. Given that people often drink in groups, the data captured in this question needs to be able to be converted back to how much the person being interviewed drank.

18) I want to now find out the **type of grog** you drank and how much you drank?
[Prompts: For how much they drank, you will need to check if in a group or on their own. If in group, check whether they all shared]
[Prompts: For beer ask about strength. Also check stubbie size – nearly always 375 ml]
[Use conversion charts for group drinking (Appendix A]

	Number of people shared with	*** Individual container/cask size in ml(numerical only e.g. 335, 375, 500, 750, 1000, 1125, 1145, 2000, 4000)**	**Number of cartons or packs consumed**	*** Number of containers/casks/ bottles consumed (numerical only)**
Full strength beer (e.g. cans, stubbies, longnecks/tallies)				
Mid strength beer (e.g. cans, stubbies, longnecks/tallies)				
Light beer (e.g. cans, stubbies, longnecks/tallies)				
Cider (e.g. cans, stubbies, longnecks/tallies)				
Wine (e.g. bottle or cask)				
Fortified wine (e.g. port or sherry)				
Bottled spirits (e.g. rum, bourbon)				
Pre-mixed spirits (e.g. UDL cans/bottles, rum and coke)				
Don't know				

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	Number of people shared with	* Individual container/cask size in ml(numerical only e.g. 335, 375, 500, 750, 1000, 1125, 1145, 2000, 4000)	Number of cartons or packs consumed	* Number of containers/casks/ bottles consumed (numerical only)
Refused to answer				

Number of people shared with: Enter '0' if drinking on their own; otherwise enter the number of people drinking with (e.g. 1, 2, 3, 4…). DO NOT include the respondent in this number, as this will be taken into account post survey in data management.

Individual container size: Different alcoholic drinks come in many varied bottle/container sizes. Beer 'stubbies' vary from 335 ml to 375 ml, pre-mixed such as UDL cans are usually 375 ml, though pre-mixed bottles vary in size from 250 ml to 375 ml.

Number of cartons/packs consumed: This mainly applies to group drinking and is best illustrated through an example. It is not necessary to record, as it is not involved in calculating pure alcohol consumed. **It is critical that the container size in mls and the number of containers consumed are filled out accurately** (number of containers consumed worked out from conversion chart).

Number of containers: This will be straight forward for people who drink on their own. For people drinking in shared situations where multiple cartons are bought, you may need to use the conversion chart that converts number of cartons/packs to number of containers depending on how many they shared with.

Example 1: Say the respondent says he first had a few beers at the social club. After this he was drinking with 4 others (total of 5 people) at the local drinking camp. He says that they bought 2 cartons of beer and 2 casks of wine between them.

- It will be easier to work out the type and amounts alcohol in the same order as they appear in the table.
- *Start with the beer*: Start with full strength beer, then mid and then light beer.
- **Question prompt**: When you drank in a group, was the beer full, mid or light strength beer?
    - Answer: Full-strength.
- **Question prompt**: How many people were you drinking with?
    - Answer: 4 other people
- They have already told us that they drank 2 cartons, but need to ask again and also check for individual container size.
- **Question prompt**: How much (many cartons) did you drink again?
- **Question prompt**: Were they standard sized stubbies/can? (standard size = 375 ml)
- Now go to the conversion chart for beer/cider/pre-mixed and look up 2 cartons in the 'number of packs consumed' (2nd column), and then along the top row to 'shared with 4 people' and go to the cell where they meet and you get 10 containers
- We know that the social clubs only sell mid-strength beer and it will be in 375 ml cans or stubbies.
- We need to ask how many specifically they had at the social club…4 beers.
- *Now on to the wine*: Need to check the size of the casks they bought. If a 2 and 4 litre, then take average, e.g. if they bought one 2 and one 4 litre cask this would be the same as three 2 litre casks, so, on the conversion chart you would pick three casks and on the survey form under 'individual container size' you would write in 2000.

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- **Question prompt**: Was that a 2 or 4 litre cask?
- We already know the person was drinking with 4 others and they had 2 casks. Now use conversion chart for casks and bottles.

	Number of people shared with	Individual container size in ml	Number of cartons or packs consumed	Number of containers consumed
Full strength beer (e.g. cans, stubbies, longnecks/tallies)	4	375	2	10
Mid strength beer (e.g. cans, stubbies, longnecks/tallies)	0	375		4
Light beer (e.g. cans, stubbies, longnecks/tallies)				
Cider (e.g. cans, stubbies, longnecks/tallies)				
Wine (e.g. bottle or cask)	4	4000	2	0.4
Fortified wine (e.g. port or sherry)				
Bottled spirits (e.g. rum, bourbon)				
Pre-mixed spirits (e.g. UDL cans/bottles, rum and coke)				
Don't know				
Refused to answer				
Other:				

Example 2: Say the respondent says he first had a few beers at the social club. After this he was drinking with 2 other (total of 3 people) at a house. He says that they bought 1 carton of beer and two 6-packs of pre-mixed spirits.

- It will be easier to work out the type and amounts alcohol in the same order as they appear in the table.
- *Start with the beer*: Start with full strength beer first, then mid and then light beer.
- **Question prompt**: When you drank in a group, was the beer full, mid or light strength beer?
    - Answer: Mid-strength.
- **Question prompt**: How many people were you drinking with?
    - Answer: 2 other people
- They have already told us that they drank 1 carton, but need to ask again and also check for individual container size.
- **Question prompt**: How much (many cartons) did you drink again?
    - Answer: 1
- **Question prompt**: Were they standard sized stubbies/can, like 375 ml? (standard size = 375 ml)
    - Answer: Yes
- Now go to the conversion chart for beer/cider/pre-mixed and look up 1 carton in the 'number of packs consumed' (2nd column), and then along the top row to 'shared with 2 people' and go to the cell where they meet and you get 8 containers
- *Now on to the pre-mixed spirits*:
- **Question prompt**: How much pre-mixed spirits did you drink?
    - Answer: Two 6-packs
- **Question prompt**: Check: Did you drink them with the same two people?

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    - Answer: Yes
- Now use conversion chart for cartons and 6-packs. Go down first column on the left until level with the two 6-packs consumed. Now go across to the column heading with consumed with 2 people. This gives number of containers consumed of 4.

	Number of people shared with	Individual container size in ml	Number of cartons or packs consumed	Number of containers consumed
Full strength beer (e.g. cans, stubbies, longnecks/tallies)				
Mid strength beer (e.g. cans, stubbies, longnecks/tallies)	2	375	1 x carton	8
Light beer (e.g. cans, stubbies, longnecks/tallies)				
Cider (e.g. cans, stubbies, longnecks/tallies)				
Wine (e.g. bottle or cask)				
Fortified wine (e.g. port or sherry)				
Bottled spirits (e.g. rum, bourbon)				
Pre-mixed spirits (e.g. UDL cans/bottles, rum and coke)	2	375	2 x 6-pack	4
Don't know				
Refused to answer				
Other:				

Following the alcohol consumption question we ask how much of the time grog has been a problem in their household, then how much of the time it's been a problem in their community, and then whether grog problems have got better or worse over the last year.

The last few alcohol-related questions ask the participant who they would seek help from if they had a problem with alcohol, whether they know about alcohol programs operating in their community, and whether results from the annual Place-based Framework report have been shared with members of the community.

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Community strengths and problems

Alcohol problems do not occur in isolation, and the environment in which drinking occurs will affect the extent and frequency of alcohol harms. Communities with strong leadership and close connection within the community will have fewer alcohol problems.

This section starts with a question about community level drug problems (by type), followed by another asking about nine other community problems such as violence, crime or youth gangs etc.

These questions are again asked using the *last year* timeframe, with the scale of ‘none of the time’ to ‘all the time’. A prompt card is available to assist with asking these questions.

The next question asks the participant whether they attend, or take part in, various community activities. It uses a slightly different scale to the community problems question. The categories are: did not attend; about once per year; 3-4 times per year; 1-2 times per month; most weeks.

Survey finished – thank the person for their time and remind them that the findings will be returned to the community [provide an approximate date].

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Appendix A: Conversion charts for group drinking

Pack size	Number packs consumed	Shared with 0	Shared with 1	Shared with 2	Shared with 3	Shared with 4	Shared with 5	Shared with 6	Shared with 7	Shared with 8
4-pack (pre-mixed)	1	4	2	1	1	1	1	1	1	0
6-pack	1	6	3	2	2	1	1	1	1	1
10-pack (pre-mixed)	1	10	5	3	3	2	2	1	1	1
Half-a-carton (12)	1	12	6	4	3	2	2	2	2	1
Carton (24)	1	24	12	8	6	5	4	3	3	3
30-pack	1	30	15	10	8	6	5	4	4	3
4-pack (pre-mixed)	2	8	4	3	2	2	1	1	1	1
6-pack	2	12	6	4	3	2	2	2	2	1
10-pack (pre-mixed)	2	20	10	7	5	4	3	3	3	2
Half-a-carton (12)	2	24	12	8	6	5	4	3	3	3
Carton (24)	2	48	24	16	12	10	8	7	6	5
30-pack	2	60	30	20	15	12	10	9	8	7
4-pack (pre-mixed)	3	12	6	4	3	2	2	2	2	1
6-pack	3	18	9	6	5	4	3	3	2	2
10-pack (pre-mixed)	3	30	15	10	8	6	5	4	4	3
Half-a-carton (12)	3	36	18	12	9	7	6	5	5	4
Carton (24)	3	72	36	24	18	14	12	10	9	8
30-pack	3	90	45	30	23	18	15	13	11	10
4-pack (pre-mixed)	4	16	8	5	4	3	3	2	2	2
6-pack	4	24	12	8	6	5	4	3	3	3
10-pack (pre-mixed)	4	40	20	13	10	8	7	6	5	4
Half-a-carton (12)	4	48	24	16	12	10	8	7	6	5
Carton (24)	4	96	48	32	24	19	16	14	12	11

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30-pack	4	120	60	40	30	24	20	17	15	13

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Pack size	Number packs consumed	Shared with 0	Shared with 1	Shared with 2	Shared with 3	Shared with 4	Shared with 5	Shared with 6	Shared with 7	Shared with 8
4-pack (pre-mixed)	5	20	10	7	5	4	3	3	3	2
6-pack	5	30	15	10	8	6	5	4	4	3
10-pack (pre-mixed)	5	50	25	17	13	10	8	7	6	6
Half-a-carton	5	60	30	20	15	12	10	9	8	7
Carton	5	120	60	40	30	24	20	17	15	13
30-pack	5	150	75	50	38	30	25	21	19	17
4-pack (pre-mixed)	6	24	12	8	6	5	4	3	3	3
6-pack	6	36	18	12	9	7	6	5	5	4
10-pack (pre-mixed)	6	60	30	20	15	12	10	9	8	7
Half-a-carton	6	72	36	24	18	14	12	10	9	8
Carton	6	144	72	48	36	29	24	21	18	16
30-pack	6	180	90	60	45	36	30	26	23	20
4-pack (pre-mixed)	7	28	14	9	7	6	5	4	4	3
6-pack	7	42	21	14	11	8	7	6	5	5
10-pack (pre-mixed)	7	70	35	23	18	14	12	10	9	8
Half-a-carton	7	84	42	28	21	17	14	12	11	9
Carton	7	168	84	56	42	34	28	24	21	19
30-pack	7	210	105	70	53	42	35	30	26	23
4-pack (pre-mixed)	8	32	16	11	8	6	5	5	4	4
6-pack	8	48	24	16	12	10	8	7	6	5
10-pack (pre-mixed)	8	80	40	27	20	16	13	11	10	9
Half-a-carton	8	96	48	32	24	19	16	14	12	11
Carton	8	192	96	64	48	38	32	27	24	21
30-pack	8	240	120	80	60	48	40	34	30	27

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Casks, bottles: Converting group drink cartons into containers per person

Cask size	Number packs consumed	Shared with 0	Shared with 1	Shared with 2	Shared with 3	Shared with 4	Shared with 5	Shared with 6	Shared with 7	Shared with 8
1 cask/bottle	1	1	0.50	0.33	0.25	0.2	0.17	0.14	0.13	0.11
2 casks/bottles	2	2	1	0.67	0.5	0.4	0.33	0.29	0.25	0.22
3 casks/bottles	3	3	1.5	1	0.75	0.6	0.5	0.43	0.38	0.33
4 casks/bottles	4	4	2	1.33	1	0.8	0.67	0.57	0.5	0.44
5 casks/bottles	5	5	2.5	1.67	1.25	1	0.83	0.71	0.63	0.56
6 casks/bottles	6	6	3	2	1.5	1.2	1	0.86	0.75	0.67
7 casks/bottles	7	7	3.5	2.33	1.75	1.4	1.17	1	0.88	0.78
8 casks/bottles	8	8	4	2.67	2	1.6	1.33	1.14	1	0.89
9 casks/bottles	9	9	4.5	3	2.25	1.8	1.5	1.29	1.13	1
10 casks/bottles	10	10	5	3.33	2.5	2	1.67	1.43	1.25	1.11

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Appendix B: Standard drinks examples

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These are only an approximate number of standard drinks. Always read the container for the exact number of standard drinks.

These are only an approximate number of standard drinks. Always read the container for the exact number of standard drinks. * Ready-to-Drink

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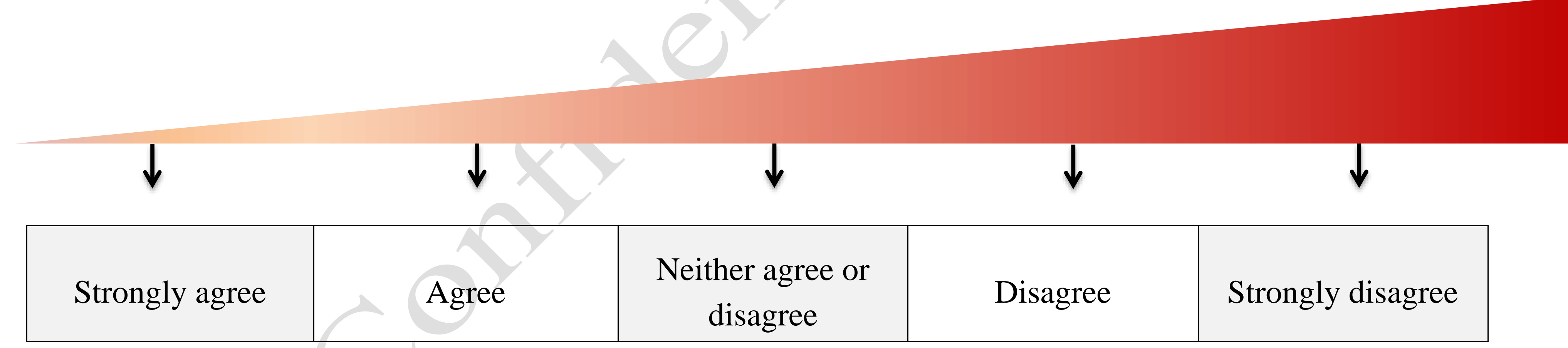
Appendix C: Likert scale visuals

None of *the time*	A bit of the time	Some of the time	Most of the time	All the time



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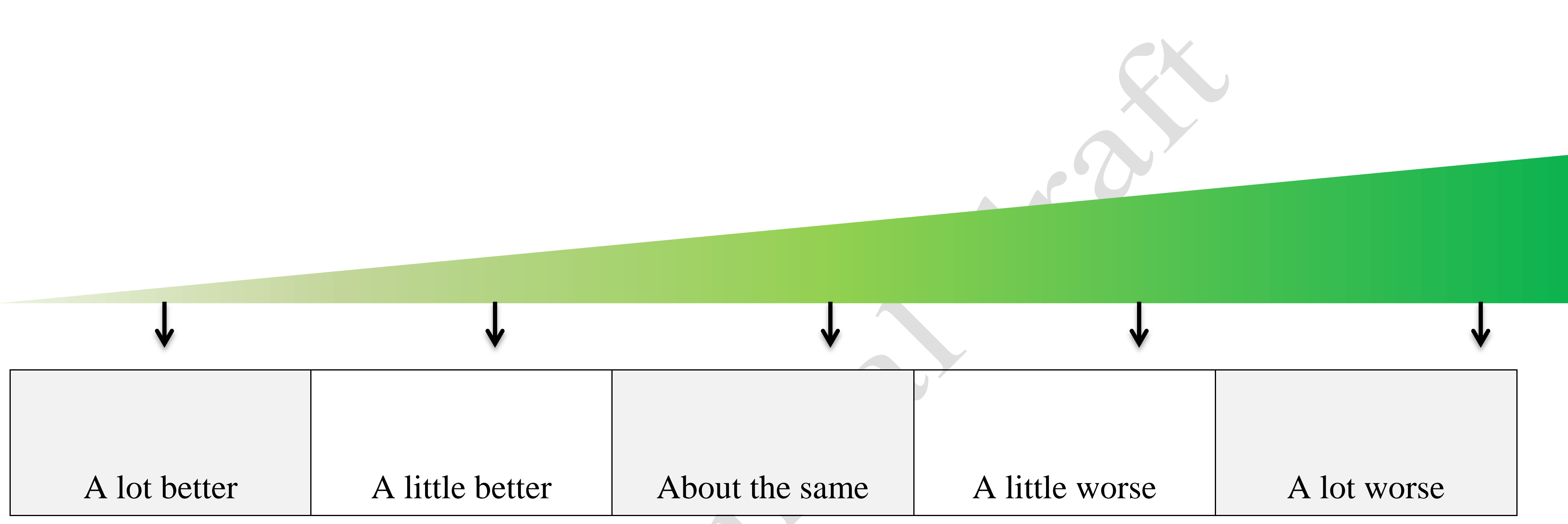

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Appendix 11. Semi-structured Interview Schedule

Semi-Structured Interview Schedule for use with Key Informants
Place-based Framework for Alcohol Management Plans and other Alcohol-related Initiatives in the Northern Territory

Archival Record

ID number	
Position title or community status of participant e.g. clinic manger, community Elder	
Indigenous status	Indigenous [ ] Yes [ ] No
Name of interviewer/s	
Site	
Name of Indigenous research assistant – if applicable	
Date	
Start and Finish time	
Consent form read out and signed	[ ] Yes [ ] No
Information sheet provided	[ ] Yes [ ] No

G'day/hello, my name is [your first name] and I'm conducting interviews for the NTG Department of Business. Staff from this department work together with people in your community to find the best ways of reducing alcohol-related harms and problems in [name of community]. The answers you give to the questions I ask in the interview will contribute to better ways of managing alcohol and reducing harms and will also help to identify the areas in which more programs are required.

Although I will record your name and contact details, this is simply so that I can give you a copy of the interview notes after I've typed them up. This means you can check that what I've written is an accurate record of what you said in the interview, if you find anything that is incorrect I will change it. Anything you say in the interview will be anonymous (it will not be possible for anyone else to know what you have said) and your name will not be used in any reports. If at any time you want to stop doing the interview just let me know, and if there are any questions you don't want to answer, that is also fine, just let me know. I am interviewing a number of people from this community and the things that are said in these interviews will be reported back to your community through the [name of the committee]

Do you agree to be interviewed? ….yes/no, Could you please sign this consent form to say that you agree [read it out] … thank you.

First, I would just like to find out a bit more about how grog has affected your community.

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1. Could you tell me about how alcohol/grog affects your community?

2. What do you think are the main things that contribute to alcohol/grog misuse in [community]?

3. Over the last year, have alcohol harms increased or decreased or stayed about the same?

    a. What are the things that have changed? *[Prompts: domestic violence; school attendance; noise levels; fewer children on streets at night; property damage etc]*

    b. Why do you think these changes have occurred? *[Prompts: eg AOD programmes; actions from AAIs; community programmes; safe houses etc]*

4. Can you tell me about any alcohol and wellbeing programs that have been run in your community? [*Prompts: e.g. family programs, men or women's groups, health programs. Have they made a difference? Do they attract many participants*? *Do you think they help your community?*]

5. Do you have any suggestions for future programs that would help to reduce alcohol problems? [*Prompts: what would these be? How would they benefit the community? What would be needed to make them successful?]*

6. As part of the Place-based Framework your [name of committee] receives a regular report telling you whether alcohol-related problems and harms have increased, decreased or stayed the same. How well do you think this information is reported and shared within the community?

    [*Prompts*]

    a. Do you know where to get this information?
    b. Is the data reported in a way that is easy to understand?
    c. Are the findings in the report adequately shared across the whole community?
    d. Are there any ways in which you think reporting could be improved?
    e. Have you used information from the report in your work or with your friends?

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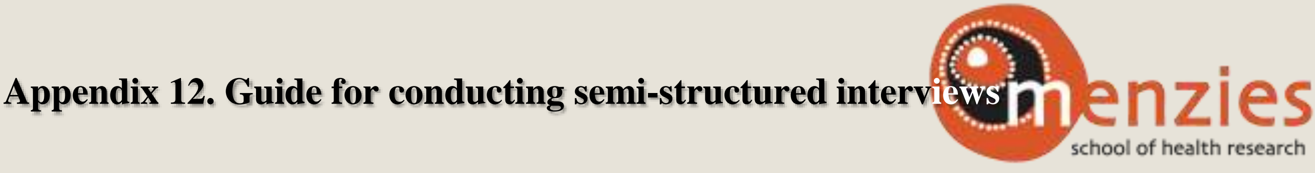
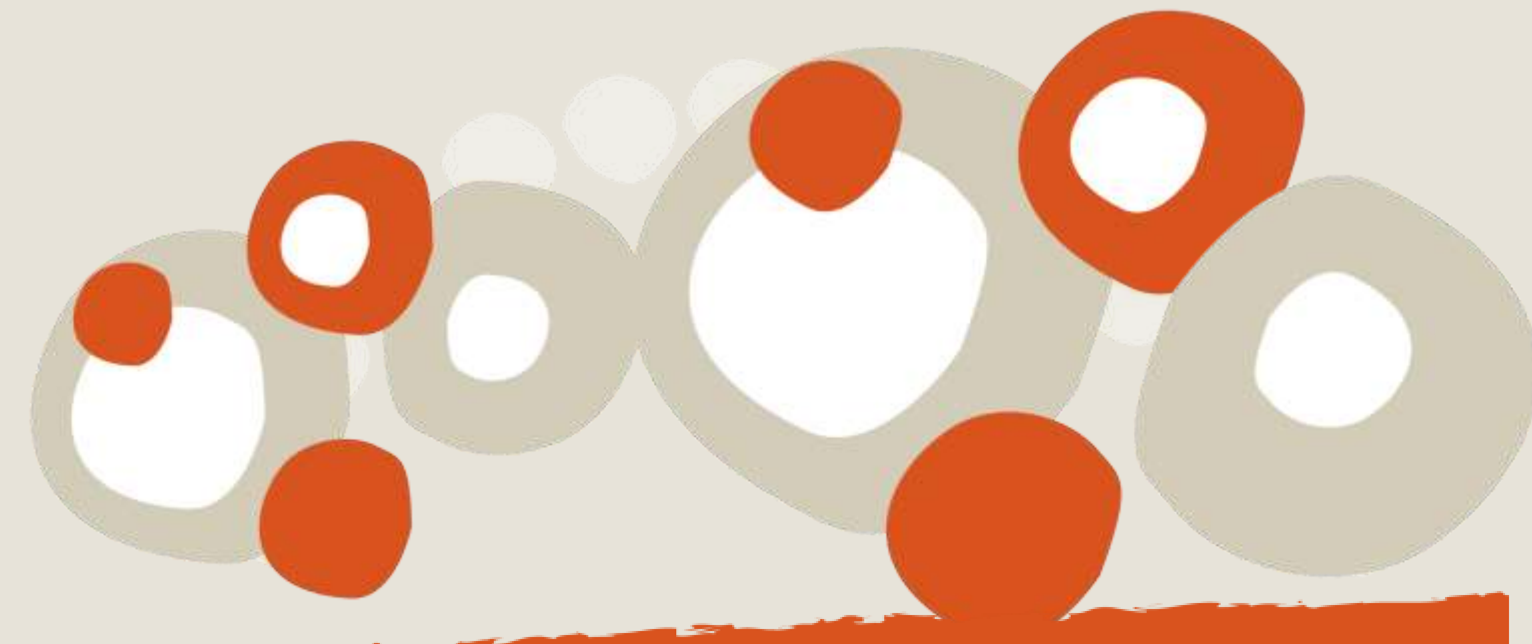
Appendix 12. Guide for conducting semi-structured interviews





A Guide to Conducting Semi-structured Key Informant Interviews

May 2016

AUTHOR

Dr Jennifer Buckley

Definitions

Before going into the survey questions, a few definitions for terms commonly used when talking about interviews are required.

- **AAI:** Alcohol Action Initiative
- **AOD:** Alcohol and other drugs
- **Archival record:** Contains information relevant to the interview such as ID number, date and time of interviewer, name of interviewer etc. .This is an essential tool for organising and keeping track of the data.
- **Interview schedule:** The interview schedule contains the questions and associated prompts that interviewers will ask participants during the interview.
- **Interviewer**: The person asking key informant interview questions.
- **Interviewee**: The person being asked the survey questions, also known as a **respondent** or research **participant**.
- **Informed Consent**: Is ensuring the person being interviewed understands their rights in regards to participation in the study (key informant interviews etc.). This includes telling participants about the study, and their right to refuse or not to participate.
- **Participant consent form:** This form sets out the rights of the interviewee with regard to participation in, or withdrawal from, the interview.
- **Population sample**: A representative selection of people from a population.

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Introduction

This guide provides basic information on how to set up and conduct semi-structured key informant interviews in the context of the Place-based Framework. It has been designed to assist staff new to interviewing and as a handbook for training purposes. If more comprehensive information on qualitative research is required, the text below is highly recommended:

Mack N, Woodsong C, MacQueen KM, Guest G, & Namey E. *Qualitative Research Methods: A Data Collector's Field Guide*, Family Health International, 2011, https://www.google.com.au/search?q=Qualitative+Research+Methods:+A+Data+Collector%E2%80%99s+Field+GuideInDepth+Interviews+and+Focus+Groups&gws_rd=cr,ssl&ei=SkWFVKb3PMLUmAWp-oH4Cg

Aims of the annual key informant interviews

Before conducting key informant interviews it is important to ensure that you understand the aims of the interview. The aims of the Framework Key Informant Interviews are to:

- Obtain an in-depth understanding about alcohol-related issues in the community;
- Provide a detailed context from which to interpret administrative and survey data;
- Assess awareness of existing Alcohol Action Initiatives (AAIs) and related social and emotional wellbeing programs and explore community views on their effectiveness;
- Identify areas in which new support programs might be needed; and
- Find out whether reporting of data produced by the Framework is being adequately shared across the community.

Setting up the interviews

Criteria for selecting key informants

For the purpose of the Framework, key informants are defined as those with extensive local knowledge of the community and an awareness of alcohol, community safety, and wellbeing issues. They generally play an active role in the day to day functioning of the community and in determining its social and cultural priorities. Typically, they will include staff from key service providers (e.g. health clinic, police, school, community store, art centre), and community members with status and influence in the community. The latter generally includes community Elders, and Indigenous members who are involved in local committees or who are working in areas such as AOD services, the clinic, the school, the safe house, and night patrol. Ideally, all participants would have lived in the community for a period of 12 months or more and approximately half should be Indigenous community members. If a person is a key service provider, such as the local school principal, you will need to interview them even if they have lived in the community for less than 12 months.

Selecting key informants

Key processes for selecting key informants include:

- Familiarise yourself with the interview schedule so that you are clear as to which areas of knowledge you wish to gather information.
- Once you are clear on the areas you wish to cover, it is a good idea to talk with your colleagues, and with a senior person/s from the community, to help identify which community members are most likely to be knowledgeable about the areas covered in the interview schedule.

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- Develop an initial list, ensuring that it contains a diverse set of representatives (e.g. gender, age, area of work or expertise, Indigenous/non-Indigenous) so that a variety of perspectives will be captured in the interviews.
- Refine the list until it includes the individuals you think are most likely to provide comprehensive answers to the interview questions.
- Before finalising the list, check that each of the proposed participants has lived in the community for a period of 12 months or more. In relation to service providers this may sometimes be difficult to achieve and, if this is the case, one option is to still include the proposed participant, but ask for another member of that organisation, who has lived there for 12 or more months, to also attend the interview.

Scheduling the interviews

- Contact the proposed participants and, after providing a brief overview of the project and explaining why you think their input would be of value, ask them if they would like to take part. As prospective participants will be giving up their time, it is important to acknowledge this and to take a flexible approach when negotiating a time for the interview. If participants would like more information you can offer to send them an information sheet.
- Setting up 10 or so interviews in a remote community can be quite time consuming so it is important to do this well in advance. However, it is important to be aware that you may have to make changes to the first timetable you prepare, as unexpected events may prevent participants from being able to keep to the pre-agreed interview time.
- When putting together the timetable, ensure that you leave sufficient time in between interviews to expand on your notes and to arrive in time for your next interview.

Data management

All information about participants, and the information they provide in the interview, is confidential and should be de-identified for analysis and reporting purposes. In order to manage confidentiality effectively each participant who has agreed to be interviewed should be assigned an ID number. This number should be included on: the archival record that is located on the first page of the interview guide; the participant consent form; and on the interview notes. Confidential information about the participant, such as name and contact details, should be filed under the ID number and stored separately from interview transcripts in a locked cabinet.

Documenting the interview

There are two methods for recording the information received through interviews:

Taking notes

Notes should be taken at every interview and be expanded as soon as possible after the interview to minimise the loss of important information. If notes are to be handwritten or typed directly into a computer, they should be as extensive as possible, with an emphasis on identifying and recording key points. In the absence of a tape or voice recorder, the interview should be conducted by two people, one to take notes and the other to ask questions. This makes it possible for one person to fully interact with the participant and to ensure that the interview flows smoothly. If two people conduct the interview they should decide on their roles in advance. At the end of the interview, the person asking the questions should check with the note-taker if any points need clarification. Shortly after the interview both staff should review the notes and add in any additional points where these have been missed by the note-taker.

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Taking effective notes is a demanding task and requires: knowledge of the issues being canvassed; strong concentration; and the ability to quickly sift through information to identify the main points being made by the participant. Although it does not provide the same level of accuracy as a tape or voice recording it can be less intimidating for the participant who may be more willing to express their true views if the interview is not recorded. Some tips for taking good notes are included below:

- Prepare your notebook in advance by writing down each question at the top of a different page; if additional space is required this could be written on a loose-leaf page and inserted at the relevant point.
- Develop your own shorthand system including abbreviations and acronyms.
- Distinguish clearly between participant comments and your own observations, for example, 'MO' could be used to indicate 'my observation'.
- In addition to documenting what the participant says, also note other information that might be relevant e.g. body language, attitudes, alignment with the views of particular groups in the community.
- Take notes strategically – don't try to get everything down but aim to pull out the main points, use key words and phrases that might trigger your memory when you expand your notes after the interview is over.
- When typing up notes it is useful to include any questions or observations made by the participant which need further consideration or follow-up.

Voice or tape recorder

A voice or tape recorder provides a complete record of the interview, ensures accuracy, provides material for direct quotations, and frees up the interviewer to engage fully with the participant. However, if you are recording the interview it is still important to take notes of key points in order to guard against the potential loss of the recording through equipment failure.

There are two ways in which recorded interviews can be used. The first is to type up the interview word for word and to then analyse the data from the resulting transcript. A second method is to use the recording to supplement and check the accuracy of the notes made at the interview. One potential disadvantage of using a tape or voice recorder is that it may inhibit the extent to which some participants feel comfortable in saying what they really think or feel about the issues being discussed. Consequently, it is important to establish in advance whether the participant is happy for the interview to be recorded. If a recorder is to be used it is essential to gain written agreement from the participant and this should be included in the participant consent form. When discussing the use of a recorder it is important to emphasise that: a recording helps to ensure accuracy and prevents key points from being lost; the audiotape will not have their name on it and will be kept in a secure location; and the interview can still go ahead without being recorded if the participant prefers this.

Preparing for the interview

In order to conduct an interview effectively it is essential to make sure that you understand the purpose of the research and are familiar with the questions on the interview schedule and related documents such as the participant consent form. This will enable you to explain things that are unclear to participants, to re-phrase questions where necessary and to use prompts effectively. Further examples of why this is important are included in Box 1. Holding a few informal practice sessions with a partner is a good means of building confidence, improving your use of prompts and identifying any weaknesses in your knowledge of the topic being interviewed.

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Before going to the interview make sure you are well organised. This will ensure that the interview runs smoothly and will help the participant to feel confident that you know what you are doing and will not waste their time. Outlined below are things you can do before the interview to make sure you are well prepared:

- Use a checklist to make sure that nothing is forgotten.

- Put together an interview pack that includes: the interview schedule; information sheet; participant consent form; notebook; pens; and voice/tape recorder (if recording interview).

- Fill in as much of the archival record (located on the first page of the interview schedule) as you can. The archival record includes the following information:

    - Participant ID number
    - Position title of key informant or status in the community
    - Indigenous status
    - Name of interviewer/s
    - Site of the interview
    - Name of the Indigenous research assistant – if applicable
    - Date
    - Start and finish time
    - Consent form read out and signed (yes/no)
    - Information sheet provided (yes/no)

Box 1. Why it is important to understand the purpose of the research

It is important to understand not only the purpose of each question, but also the purpose of the research as a whole. Depending on how structured the interview is, you may be called on to rephrase questions that are unclear to participants, or to spontaneously think of follow-up questions and probes. You should be able to recognize when a participant has provided a response that fulfils the intent of the question, when a response contains information that addresses a separate question or a scripted follow-up question, and which probes to use to elicit needed information that was absent in a participant's initial response. If the protocol permits you to ask questions out of order, being familiar with the guide also enables you to use it flexibly, taking advantage of natural shifts in the conversation. It is a good idea to review the interview guide [schedule] before every interview.

Extracted from 'Qualitative Research Methods – A Data Collector's Field Guide, p37

Conducting the interview

Step 1: Greet the participant in a friendly manner and put them at ease.

Step 2: Briefly describe the interview process (confidential nature of the interview, informed consent, question and answer, any questions they may have, how you will be recording the interview).

Step 3: Obtain informed consent, you must explain the consent form and ask the participant to sign it.

Step 4: Complete the archival record located on the front page of the interview schedule.

Step 5: Conduct the interview according to the questions on the interview schedule

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Step 6: Thank the participant for their input and remind them that you will be sending them a transcript of the interview notes to review for accuracy, and that when all the interview data has been collated and analysed the results will be reported through the [name of the committee].

Tips for conducting effective interviews

The quality of the information obtained from key informant interviews varies markedly according to the skills of the interviewer. Outlined below are a range of techniques that will help you conduct effective interviews. Although most people will have some of these skills it takes practice to develop all of them, and to apply them effectively in the context of an interview.

Table 1: Essential interviewing techniques

Skills	Comments
Active listening	Essential for accurate recording of responses. Increases likelihood that you will hear what is actually said rather than what you expect to hear.
Ability to build rapport with the participant	Help participant to feel relaxed – smile, use humour, be friendly, patient and respectful.
Emphasise the participant's perspective	The participant is the 'expert' and the interviewer is the 'student'. Let participant know there are no wrong or right answers.
Adapt the way you conduct the interview to suit different personalities	Some participants may need more encouragement to say what they think, others may need to be kept on track. You need to adapt your tone of voice and body language to suit the individual and to take into account their state of mind eg some questions might be personal or sensitive and might make them sad or angry.
Ability to take good notes.	Notes should be expanded on or written up as soon as possible after the interview. Can be helpful to keep notes about body language e.g. whether the person seems uncomfortable with certain questions, whether something in the body language or expression makes you think they might not be telling the truth, and why you think this.
Use 'probes' to encourage participant to elaborate on their answers.	Probes are neutral questions, phrases, sounds, and gestures that interviewers use to encourage participants to elaborate on their answers and explain 'why' or 'how'. They can be included in brackets next to each interview question or can be generated spontaneously over the course of the interview. Probes should be used when the response is brief or unclear; when the participant seems to be waiting for a response from the interviewer before continuing to speak; when they appear to have more information on the subject; and to increase your understanding and encourage more explanation. Probes should not be used when responses start to become repetitive or the participant starts to get annoyed or upset about continued questions. Table 2 includes examples of different types of probes.
Ask questions in a neutral manner.	This means being genuinely interested in what the participant thinks. It is important not to use 'leading' questions or lead the participant to provide a particular answer by expressing approval or disapproval of what they say. An example of a leading or biased question and a neutral question is: Biased/leading: *Most people who care about the community think having a policeman outside a grog shop is a good thing. What do you think?* Neutral: *What are your thoughts on having policemen outside the grog shop?*

Probes can be either direct or indirect. Direct probes encourage the participant to expand on their answer by asking specific questions while indirect probes encourage expansion through body language or comments designed to encourage further detail. Table 2 provides examples of both kinds of probes.

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Table 2. Direct and Indirect Probes

Direct Probes	Indirect Probes
• What do you mean when you say …? • Why do you think ….? • What happened then? • Can you tell me more? • I'm not sure I understand X • Would you explain that to me • Can you give me an example of X?	• Neutral verbal expressions such as "uh huh," "interesting," and "I see". • Verbal expressions of empathy, such as,"I can see why you say that was difficult for you". • Mirroring technique, or repeating what the participant said, such as, "So you were 19 when you had your first child . . ." • Body language or gestures, such as nodding in acknowledgment

After the interview

- If you used a tape or voice recorder, check that the recording was successful. If not, expand your notes immediately.

- Check that all interview materials are labelled with the ID number and that the participant consent form has been signed.

- Expand on and type up your notes as soon as possible to ensure they provide a clear record of the participant's comments and of your own observations. You should aim to do this within 24 hours of the interview. If notes are not reviewed and expanded on promptly there is a real risk that valuable information will be lost, as while good note-taking assists memory, the extent to which it can do this becomes less over time.

- File all interview materials in line with the data management system developed to ensure security and confidentiality of interview data.

- Once interview notes have been typed up, send a copy to participants so they can check that they are an accurate record of their comments, and can therefore confirm whether or not they are happy for you to use them in the analysis.

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Appendix 13. Example of consent form for key informant interviews

Key Informant Participation Consent Form

PROJECT TITLE: Place-based Framework for Evaluation and Monitoring of Alcohol Management Plans and other Alcohol Initiatives in the Northern Territory

This research is being conducted by the Northern Territory Department of Business. Contact details for the Department of Business are included below.

I agree that:

- I am over the age of 18 years.
- A plain language information sheet has been provided and explained to me, which outlines the aims of the project and what my involvement will be.
- I have been informed that I can say No and that I can withdraw from the project at any time.
- I have been informed that any information I give through interviews will be used for the purpose of the research project only.
- I understand that my name will not be used in any writing made public and confidentiality will be respected in all aspects of the project.
- The ownership of Aboriginal knowledge and cultural heritage is retained by the informant and this will be acknowledged in research findings and in the dissemination of the research.

I have read and understood the information provided and agree to:

Participate in an interview to meet the aims and objectives of the project	**Yes**	**No**
To have forms containing my responses to interview questions kept safely by the Department of Business	**Yes**	**No**

Name: ______________________________

Signature: ______________________________ **Date:** __________

Witness Name: ______________________________

Signature: ______________________________ **Date:** __________

Interpreter Name (if required): ___________________

Signature: ______________________________ **Date:** __________

Researcher Contact Details

[name] [title] Email: Tel. work: Mob:	[name] [title] Email: Tel. work: Mob:	[name] [title] Email: Tel. work: Mob:

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Appendix 14. Procedures and template for collecting data from local school

Procedure for setting up system to record an increase in school attendance on days when non-attendance is usually high.

NB: The procedure described below is intended as an example only, exactly how this data collection is implemented will depend on initial negotiations with the school principal.

Step 1: Meet with the School Principal, or other nominated teacher, to discuss methods for collecting and recording these data.

Step 2: Identify the days when non-attendance at school is usually high.

Step 3: Determine who would be responsible for recording data (e.g. year level teachers might record this data at beginning of the day and then submit it to the school administration officer who would then collate the total number of students attending, from all year levels).

Step 4: Determine who would be responsible for collating the data and putting it in suitable format for presenting to the relevant community committee (e.g. table format or graphs).

Step 5: Record attendance data for these days.

Step 6: Report data at quarterly intervals to the relevant community committee. A copy of the data should also be lodged with the Manager, Data Analysis and Reporting, Alcohol Policy and Strategy Unit, DoB, at quarterly intervals.

Example of template for recording attendance on days when non-attendance is usually high.

Attendance on days when non-attendance is usually high	Week 1	Week 2	Week 3	Week 4
Thursday	40	45	50	57
Friday	30	33	40	45
Total students attending	70	78	90	102
Total students enrolled	120	120	120	120

The figures recorded under each week would equal the total number of students who attended the school on the days selected for data collection.

To ensure that data is collected consistently it will be important to:

- Make sure that teachers record all attendance including that of students who arrive late
- Ensure that each teacher is aware of the need to collect this data consistently

If the school principal is interested in providing more comprehensive data then late attendance could be recorded separately, as this may also be more common on days when non-attendance is usually high.

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Appendix 15. Template for recording social club data

Sales	Week 1	Week 2	Week 3	Week 4
Cans of full strength beer				
Cans of mid strength beer				
Cans of light beer				
Any other alcoholic beverage				
Non-alcoholic beverages				
Number refused entry because over breathalyser limit				
Number banned from club				
Reason for ban e.g.				
Domestic violence				
Children not at school				
Assault				
Theft				
Possession of illegal grog				
Other reasons as appropriate				

Entry of data on form

Negotiate with the social club manager to determine who will fill in the data form and whether this will be done weekly or monthly.

Reporting of data

Determine who will report the data and the form in which the data will be reported. The person reporting the data could be the Social Club Manager, the AAI officer, or a designated community member. Decide how the data will be reported, this might be in table format or graphs.

Data should be reported to the relevant community committee on a quarterly basis and also lodged with the Manager, Data Analysis and Reporting, Alcohol Policy and Strategy Unit, DoB, at quarterly intervals.

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