A new framework for action 2015–2017

Community Engagement Action Program

Contributing to the prevention and reduction of alcohol and other drug related harm by building the capacity of communities through facilitating and supporting Community Drug Action Teams across NSW.

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Abbreviations and Acronyms:

ADF   Australian Drug Foundation
AOD   Alcohol and Other Drugs
CDAT   Community Drug Action Teams
CEAP   Community Engagement and Action Program
DAPCP Drug and Alcohol Population and Community Programs

Foreword

Since Community Drug Action Teams (CDATs) were established in 2000, they have matured and expanded across scores of metropolitan, regional and rural communities in New South Wales, promoting greater awareness of alcohol and other drug (AOD) harm and successfully introducing prevention strategies at the local level.

CDATs revolve around community members, local services providers and business-people who share a desire to work with others to make a difference and a passion for making their community safer, healthier, stronger, and more connected. While each team is unique, they share a commitment to minimising harm associated with AOD misuse within their communities.

The NSW government recognises CDATs as a crucial community-driven platform for addressing AOD issues. CDATs' inherent connection to their communities allows them to resolve issues that the government alone would struggle to address. The government will continue to support them and integrate their actions within other healthy lifestyle activities.

CDATs are embarking on an exciting new phase in their evolution. The Australian Drug Foundation (ADF) has been appointed to manage the Community Engagement and Action Program (CEAP) on behalf of the NSW government, providing leadership and support to CDATs across NSW. This change will generate further momentum and strengthen this already successful program.

The CEAP *Framework for Action*, initially published in 2000, was developed to guide the work of CDATs. Since then, CDATs have undergone many changes. Through these changes they have gone from strength to strength and, over time, CDATs' structures and approaches have outgrown the existing *Framework*. With the appointment of the ADF to manage and coordinate the CEAP, it is timely to update the *Framework* in line with this new direction.

This new *Framework for Action* articulates the principles that the NSW Ministry of Health and ADF will use to guide CDATs in their work. It provides an exciting blueprint for the CEAP and will support CDATs to make a powerful contribution to reducing alcohol and other drug harm across NSW, now and into the future.

Some of the key areas of focus for the CDATs under the *Framework for Action* will include:
• Alcohol misuse
• Fostering communities to work together to prevent drug and alcohol problems
• Collaboration between CDATs to pool resources
• Responding to emerging local issues

The purpose of this *Framework* is to provide broad overarching principles under which the CEAP and CDATs function.

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❶ Introduction

1.1 Background

The NSW Drug Summit 1999 was a landmark event, bringing together people from Government, community representatives, medical experts, and people experiencing substance use problems to respond to issues arising from illegal drug use in the community.

Community Drug Action Teams, more commonly known by their acronym CDATs, were a key initiative of the Summit and are crucial for supporting community stakeholders to address drug related concerns at a local level. In 2003, the NSW Summit on Alcohol Abuse recommended that CDATs also have responsibility for addressing alcohol misuse, and this focus was added to their responsibilities.

The NSW Government elected in 2011 has a strong mandate from the community to improve the health and wellbeing of the people of NSW.

The NSW 2021: A plan to make NSW number one outlines how the NSW Government will rebuild the economy, deliver quality services, and strengthen the local environment and communities. CDATs are contributing to the Plan though their work in improving the health of NSW communities by preventing and reducing alcohol and other drug (AOD) related harm. The new Framework for Action builds on previous work in the drug and alcohol sector and sets a clear direction for further initiatives focused on the prevention of AOD harm.

The Framework for Action supports the Government's vision for the Community Engagement and Action Program (CEAP) and the CDATs, which are the centrepiece of the program, including their guiding principles, governance and membership arrangements, and priorities for action. The Framework emphasises the importance of community participation and broad-based stakeholder partnerships in the development and delivery of the CEAP and communicates the aim of the CEAP, its management by the Australian Drug Foundation (ADF), and the aims and objectives of CDATs.

The ADF website provides more information for community members and stakeholders on CDATs and their work: **adf.org.au/cdat.**

1.2 The Public Health Context

The harm associated with alcohol misuse and drug use is a concern to communities across NSW.

1.2.1 Prevalence of alcohol misuse

According to the 2013 National Drug Strategy Household Survey (NDSHS), almost 1 in 5 Australians aged 14 or older consumed more than 2 standard drinks per day on average, exceeding the lifetime risk guidelines, and 1 in 4 drank in a way that placed them at risk of an alcohol-related injury from a single drinking occasion, at least once a year.

• The 2013 NSW Population Health Survey reported that the rate of alcohol consumption at levels that pose a health risk over a lifetime among over 16 year olds in NSW could be as high as 26.6%.

1.2.2 Prevalence of illegal drug use

According to the 2013 National Drug Strategy Household Survey (NDSHS):

• About 8 million people Australians aged 14 and over (41.8%) reported that they had used an illegal drug at least once in their lifetime and almost 3 million (15.0%) had used an illegal drug in the last 12 months.
• In NSW, 14.2% of people aged over 14 years reported using an illegal drug in the last 12 months.

Across Australia, there has been little change in recent use of illicit drugs over the past decade but use of some drugs has declined and for others use has increased.

In NSW, cannabis remains the most commonly used illegal substance, followed by ecstasy, cocaine, methamphetamines, hallucinogens and synthetic cannabinoids. 9.5% of NDSHS respondents in NSW aged 14 years and older reported cannabis use within the last 12 months, while 2.4% reported ecstasy use and 1.4% reported methamphetamine use. Pharmaceutical drug misuse was reported at 4.4% for NSW, compared to 4.7% nationally.[i]

1.2.3 Alcohol and other drug related harms

The impact of AOD misuse – both illegal and legal – is significant, and can result in destructive and harmful effects on individuals and communities throughout NSW. Alcohol and drug misuse can lead to injury, illness and losses of life, diminish the quality of life for many individuals and their families, and impact on community amenity.

Excessive consumption of alcohol (binge drinking) is a major cause of health and social harms. It is a major contributor to domestic[ii] and public violence[iii] and road and other accidents[iv]. Long-term heavy drinking is a major risk factor for chronic disease (including liver disease) and brain damage[v], and contributes to family breakdown and broader social dysfunction. Alcohol consumption during pregnancy can cause birth defects and disability[vi]. There is increasing evidence that drinking during childhood and the teenage years can interrupt the normal development of the brain with long-term consequences[vii].

Though the population prevalence of illegal drug use is much lower, the harms associated with use are extensive. Like alcohol, illegal drugs can contribute to road accidents and violent incidents, and to family breakdown and social dysfunction[viii]. Illegal drug use is also a significant contributor to crime within the community[ix]. Unsafe injecting is a major cause of blood-borne viral infections and illegal drug use can create a range of other health impacts. Legally available drugs and psychoactive substances can also cause serious harm. The misuse of inhalants, such as petrol, paint and glue, can cause brain damage and death[x]. The misuse of pharmaceutical drugs can have serious health impacts and their trafficking contributes to drug-related crime[xi].

Illegal and pharmaceutical drug misuse can also contribute to or exacerbate mental health problems[xii]. Critically, AOD misuse contributes to and reinforces social disadvantage experienced by individuals, families and communities. Children living in households where parents are misusing drugs are more likely to develop behavioural and emotional problems, perform poorly in school and be the victims of child maltreatment[xiii].

(Note: Information on alcohol and illegal drug interventions can be found in appendix 3.)

1.3 The Policy and Practice Context

The CEAP project reflects the alcohol and other drug sector policy and practice context.

1.3.1 Policy context

The National Drug Strategy 2010-2015 aims to build safe and healthy communities by minimising tobacco, AOD related health, social and economic harms among individuals, families and communities.

The CEAP embraces the Strategy's overarching approach of harm minimisation and supports the Strategy's three pillars of:

- Demand reduction to prevent uptake of tobacco, alcohol and other drugs; reduce misuse of these substances; and support people to recover and reintegrate into the community.
- Supply reduction to prevent, stop, disrupt and reduce production and supply of illegal drugs and also regulate the availability of legal drugs.
- Harm reduction to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The CEAP also contributes to the goals of the New South Wales Government's plan NSW 2021: A plan to make NSW number one – in particular 'to keep people healthy and out of hospital' – and supports other priority actions, including:

- Reduce total risk drinking to below 25% by 2015.
- Preventing high risk alcohol abuse in public areas and reducing risky drinking in the home through delivering interventions at local public drinking hotspots, and delivering education campaigns on alcohol sales to minors.
- Preventing and reducing the level of crime through the development of programs that provide social and sporting activities for at-risk young people.
- Fostering opportunity and partnership with Aboriginal people, for example, through programs that bring community elders and younger people together so they may learn about culture, land and history.

1.3.2 Theoretical framework

CDATs operate within the broad context of community development and the public health principles of effective action and best practice in health promotion. There have been a number of international conferences held since 1986 that have articulated key components of health promotion and how to build public health policy. The conferences outlined theoretical and practical progression in the understanding and operation of public health, health promotion, and the social determinants of health. The Charters can be found on the WHO (World Health Organisation) website. They provide a key fundamental policy background for public health models and have influenced the development of the CEAP.

1.3.2.1 Social determinants of health

Social determinants of health include factors that contribute to the physical, mental, emotional, and spiritual health of people, such as level of income, employment, education, and housing. These factors are shaped by the distribution of money, power and resources at global, national and local levels, which themselves are influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. (More information can be found in appendix 2.)

1.3.2.2 Social determinants of drug use

Drug-use behaviours are the result of interaction between developmental processes and environmental factors. Different risk factors are salient at different times of life and earlier factors influence the development of further risk of drug abuse. Social, cultural, economic, and physical environments shape and influence individual's developmental pathways, just as an individual's genetic predispositions influence their development[xiv].

1.3.2.3 Community capacity building

Building community capacity involves increasing the strength, power, capability and potential of a community to respond to its identified needs rather than encouraging reliance on outside solutions and responses.

The principles of capacity building include:
• Matching systems with people
• Paying attention to community demand
• Working with a local context
• Creating linkages between different people and institutions
• Training people as agents of change
• Working simultaneously from 'bottom up' and 'top down' directions.

1.3.2.4 Community mobilisation

Community involvement is fundamental in the process of developing strategies because it can identify specific concerns, community objectives and any barriers to program success. Community mobilisation is a process through which action is planned, carried out and evaluated by the community on a participatory and sustained basis. Mobilisation allows the community to contribute to the process in ways that are convenient and interesting to them, ensuring ongoing community involvement.

1.4 A New Framework for Action

Reducing alcohol and drug misuse is a public health priority. Taken together smoking, alcohol misuse and illegal drug use accounted for 13.1% of the total burden of disease and injury in Australia in 2003[xv] while the total social cost of drug use (tobacco, alcohol misuse and illegal drugs) across Australia was estimated to be $55 billion per annum in 2004-05[xvi]. A range of prevention, early intervention, and treatment programs and services are required to reduce this harm.

By working together to identify and address local issues, communities and government agencies can combine forces to improve the health and wellbeing of an area. This approach is consistent with the NSW Government's commitment to addressing issues at a local level through community engagement and action.

Whilst the CEAP maintains its original essence the operational environment has changed significantly. The ADF, an NGO with over 50 years of experience in addressing alcohol and drug related harm, has now been appointed to manage the CEAP from 2015–2017.

The primary aim of the CEAP is:
To build the capacity of communities by facilitating and supporting CDATs to contribute to the prevention and reduction of alcohol and other drug related harm.

The specific objectives of the CEAP are to:
• Promote and support broad-based community participation in CDATs.
• Facilitate co-ordinated and collaborative action between agencies and groups with common goals in addressing local AOD issues and across NSW more broadly.
• Increase communities' capacity to develop locally based initiatives to contribute to the prevention of the uptake and misuse of illegal drugs and alcohol and contribute to reductions in drug and alcohol related harm.
• Support community engagement and development activities that are relevant to identified specific community and state-wide needs.

The Australian Drug Foundation (ADF) has a key role in supporting CDATs to meet these objectives through management of the CEAP.

CDATs have evolved and adapted beyond the previous Framework for Action to meet new and emerging challenges, including many CDATs progressively increasing their focus on alcohol misuse.

The new Framework for Action 2015–2017 recognises and incorporates these changes and sets out the current objectives, scope of work and functions of CDATs. In doing so, it intends to guide the work of CDATs in addressing issues concerning the impact of alcohol and drugs in their community.

The focus of CDAT activity will be on primary prevention, although some activities relate to early intervention, such as creating connections between people affected by alcohol and/or drug misuse who make contact at CDAT events and local services. Primary prevention may include activities targeted to universal (whole), selective (at risk), or indicated (early symptoms) population groups. NSW's primary care and specialist alcohol and drug treatment services remain responsible for treatment provision across the State, and any associated secondary/tertiary prevention strategies.

The new Framework for Action guides the work of CDATs and is useful to anyone who works with CDATs and wishes to reduce AOD related harms in their communities. This includes community members, private businesses and service providers, church and religious groups, academics and researchers, non-government organisations, and local and State government agencies.

❷ Community Drug Action Teams

2.1 What is a CDAT?

A CDAT is a group of people working together to reduce alcohol and other drug harm within their local community. CDATs are at the centre of the NSW Government's CEAP.

CDATs may be local service interagency coalitions, or networks, but all have a common feature of community-focussed partnerships.

CDATs work from the principles of community development, which supports individuals and groups to effect positive change in their communities. CDATs harness the assets inherent in each locality to build the capacity of a community to create solutions that meet local needs and address local challenges. Every community has space, physical and financial resources. Additionally, everyone in the community (including individuals, businesses and organisations) possess skills, talents and experience that they can use in order to make their community a better place to live. A strong community is built through identifying and mobilising collective community assets for the benefit of the area.

All individuals and groups have the potential to contribute positive assets, including time, creativity, fresh perspectives, knowledge, experience, enthusiasm and energy. When mobilising assets for community building purposes it is important to recognise and proactively include the capacities of those who may be relatively disempowered or marginalised in the community, for example: Aboriginal and Torres Strait Islander people; young people; older people; people with physical or intellectual disabilities or mental illness; economically disadvantaged people; people from culturally and linguistically diverse (CALD) backgrounds; Gay, Lesbian, Bisexual, Transgender and Intersex people; and people from rural and remote locations. Capacity building practices aim to provide all community members with the opportunity to fully contribute to community building, giving individuals a sense of purpose and worth and creating safe, vibrant and resilient communities.

While CDATs have an important role they cannot do everything and need to prioritise and focus their energy on community action. The Annual Action Plan (2.9.1) is designed to help the CDAT with this.

2.2 Guiding Principles

CDATs will be guided by several core practice principles. These include:

- Encouraging the active involvement of a broad range of community members using a proactive and inclusive approach to participation.
- Working in partnership with other stakeholders to align the work of CDATs with other prevention initiatives in NSW to ensure increased impact and avoid unnecessary duplication.
- Focusing on prevention of AOD related harms locally and connecting individuals experiencing substance use difficulties (directly or through their family and friends) with local services.
- Adopting appropriate supply, demand and harm reduction strategies.
- Ensuring that activities and events implemented by CDATs are evidence-informed and implemented in line with best practice.
- Ensure a commitment to critical reflection and continuous improvement within CDATs focused on achieving maximum benefit and the efficient use of resources.

2.3 Aims and Objectives of CDATs

With the support of the ADF through the CEAP, CDAT objectives are to:

- Work to increase community awareness and knowledge of AOD related harms, including health, mental health and social problems.
- Contribute to the prevention of misuse of alcohol and legal drugs and illegal drug use, through a range of appropriate local community activities and initiatives.
- Contribute to the reduction of total risky drinking to below 25% as expressed in the state plan: NSW 2021: A plan to make NSW number one. (This refers to the total percentage of people in NSW drinking at risky levels. From 2004 to 2013 in NSW the rate of alcohol consumption by adults over 16 years at levels that pose a health risk over a lifetime significantly decreased from 33.3% to 26.6%. Source: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.)
- Promote protective factors in their communities to reduce the impact of AOD related harms.

2.4 Outputs and Outcomes

The results CDATs seek to produce include, but are not restricted, to:

Outputs

- Broad-based community participation in CDAT committees and/or project groups.
- Clear, evidence-informed annual Action Plans linked to local and State priorities.
- Design, delivery and evaluation of appropriate locally based initiatives to address drug and alcohol related harms.
- Procurement and mobilisation of local cash and in-kind financial and practical resources to support CDAT activities.

Outcomes contributed to:

- Improved community awareness and knowledge about AOD related harms and how to prevent them.
- Reduced rates of risky drinking, illegal drug use, and misuse of legal drugs in local communities.
- Reduced rates of AOD related harms in local communities.
- Increased protective factors in their communities to reduce the impact of AOD related harms.

2.5 CDAT Membership

Community members join CDATs for a range of reasons such as a personal concern about the impact of alcohol and other drugs in their community and/or to support the CDAT on behalf of their employer. Ideally each CDAT's membership will reflect its community's social and cultural diversity and include local community members as well as people representing key non-government and government agencies. Two types of participation will be encouraged – committee level and project groups.

2.5.1 CDAT Committees

Each CDAT Committee consists of approximately 8-12 people and should, wherever possible, include a minimum of three community representatives (i.e. people who live in the local area such as business people and sporting club members.) The CDAT committee is encouraged to also seek membership from health and welfare agencies who have an interest in AOD issues. These could include: youth sector services; Local Health Districts AOD services and other related services; NGO AOD and health promotion service providers; Medicare Locals; police and/or local Government; Aboriginal health and welfare services; homelessness services.

The ADF will support CDAT committees across NSW to meet their aims and objectives based on the CDAT terms of reference. Working in collaboration with the ADF, each Committee will elect a Chairperson, a Secretary and an Treasurer. As CDATs are not legal entities their funds are managed by an auspice agency whose membership on the CDAT is essential. An auspice agency is a local organisation, such as an NGO or local Council, that agrees to assist the CDAT by managing the funds as the CDAT Committee directs. Should a CDAT become a legal entity they could not then be considered volunteers of the ADF under the CEAP and therefore would not be covered by ADF insurance.

At times CDATs can struggle to keep consistent members attending and participating in meetings and projects. If a CDAT's Committee meeting is consistently not attended by at least half of its members then decisions made cannot be assumed to have the support of the Committee. In these situations the ADF will work with the CDAT to build membership. A CDAT can become inactive if there is not sufficient local support for it to function.

2.5.2 Project Groups

CDAT Committees may choose to lead and support one (or more) CDAT project group within their area to maximise grassroots community participation. They may also choose to support one or more other areas without their own endorsed CDAT. These project groups can be created for a particular activity or event linked to the CDAT Action Plan. This acknowledges that there are likely to be many people who want to be involved in a CDAT but who do not want to play a long-term role. Project groups will facilitate short-term, targeted volunteer participation. Project groups should encourage people from the identified target groups in the community (e.g. young people or parents), to be members.

2.6   CDAT Endorsement

While the ADF is responsible for managing the CEAP, it is the responsibility of the NSW Ministry of Health to formally endorse the formation of a new CDAT. Endorsement by the NSW Ministry of Health is the Government's acknowledgement that the CDAT has undertaken appropriate steps to formally create a membership, develop terms of reference, identify local drug and alcohol issues and develop a plan to address these issues. Only an endorsed CDAT will be eligible to receive financial and practical program support through the ADF. Affiliated groups would need to partner with an endorsed CDAT to be part of the CEAP.

Each newly proposed CDAT will be asked to demonstrate: local community support; appropriate broad-based representation; capacity to raise local cash and/or in-kind contributions from government and non-government agencies and/or businesses; an auspice body that has agreed to hold any funds on behalf of the CDAT; and a willingness to commit to the guiding principles and policies and procedures outlined in this Framework for Action. A CEAP Senior Community Development Officer will work alongside the proposed CDAT as they go through this process.

An open meeting for all interested community members and organisations will be held to discuss the application. The meeting will be hosted by the ADF and should include all parties with an interest in participating in the CDAT Committee and a range of other local community representatives.

When the ADF is satisfied that the proposed CDAT meets the criteria the CDAT's written application for formal endorsement will be forwarded to the NSW Ministry of Health. Endorsement may then be granted and the NSW Ministry of Health will give the decision in writing to the nominated representative of the proposed CDAT Committee.

A CDAT can be unendorsed if the CDAT no longer works to their terms of reference or experiences major difficulties. In a situation of this kind the ADF would investigate and make a recommendation to NSW Health.

2.7 CDAT Locations

CDATs are spread across NSW and each CDAT is the product of a concerted effort by committed individuals and organisations. CDATs are not required to conform to formal catchment boundaries but are encouraged to keep an overview of activities across multiple local government areas that align with key government service boundaries (e.g. Local Health Districts) and provide support as able.

It is important that there is an equitable distribution of available CEAP resources and support across NSW . The ADF will work to coordinate the number and locations of CDATs across the life of the Framework over time to reflect this equitable distribution.

2.8 CDAT Roles and Responsibilities

The CDAT's role is to contribute to the prevention and reduction of AOD related harm in a way that meets local priorities and concerns and which links with CEAP priority issues set by the Australian Drug Foundation in collaboration with the Ministry of Health.

2.8.1 CDAT Committees

CDAT Committees meet on a regular basis throughout the year (at least six times). The frequency of meetings will be determined at the local level. Meetings need to be informal enough to maximise community participation and discussion but structured enough to allow decisions to be made and actions to be allocated. Committees should keep minutes of their meetings.

The CDAT Committee will be responsible for:

- Holding annual elections for Committee office bearers (Chairperson, Treasurer, Secretary, etc.).
- Developing and promoting Terms of Reference for its meetings and its overall approach to activities and reviewing as necessary.
- Maximising community participation on the CDAT committee and Project Groups and ensuring diversity of representation.
- Building relationships with key local and statewide stakeholders.
- Maximising links wherever appropriate with other local, regional and state-wide alcohol and other drug prevention initiatives to avoid duplication.
- Showing how the local priority issues they identify relate to statewide data and priorities and demonstrating how the activities they plan in response are consistent with accepted policy and practice.
- Developing and submitting an annual action plan that outlines all of the CDAT's intended activities.
- Developing and submitting a project plan and, subsequently, an evaluation report and budget acquittal for each CEAP funded activity.
- Procuring financial and in-kind resources through the CEAP Small Grants Program and other local, statewide or national sources.
- Overseeing and supporting the successful implementation of annual action plan events and activities through the Committee members, project groups or other delegated stakeholders.

2.8.2 Project Groups

CDATs may choose to implement project groups to plan and implement specific project activities over the calendar year. The frequency of these meetings will therefore be determined by the nature of the project (for example a one-off event or activities throughout the year) and will be at the discretion of the CDAT Committee. Project groups could support CDAT committees by:

- Maximising community participation in CDAT annual events and activities.
- Contributing to ideas for and the design of CDAT annual events and activities.
- Implementing agreed events and activities.
- Assisting with the evaluation of events and activities through the provision of feedback.

2.9 Types of CDAT Activities

CDATs have implemented a wide range of effective projects and events over the history of the CEAP. They work across the community with an approach consistent with the principles of harm minimisation. This work can utilise a combination of whole of population (universal prevention) and more targeted approaches focused on vulnerable/high-risk groups (selective prevention) and groups with emerging signs of substance use difficulties (indicated prevention). While the possible scope is wide, CDATs that focus their time and energy are more likely to complete successful and well evaluated projects. The process of completing the CDATs Annual Action Plan is designed to guide the CDATs towards an evidence informed plan.

Specific audiences may include:
• Young people
• Aboriginal and Torres Strait Islander people
• People from CALD and emerging communities
• People experiencing unemployment, housing difficulties, and/or social isolation
• People who have experienced traumatic or adverse life events and/or mental health difficulties
• People living in rural and remote communities.

Events and activities may be implemented through a range of group/community settings including:
• Local government social and/or cultural community events (e.g. festivals)
• Schools, TAFEs, Universities and other education facilities
• Workplaces
• Sports clubs, hobby and recreation groups
• Playgroup and other parent groups
• Broader community settings, community meeting spaces
• Youth specific meeting places (e.g. pubs, clubs).

Each CDAT needs to be able to show that events and activities are evidence-informed in regards to what works and what   does not work, derived from the experiences of local, national or international pilots, projects and programs. Over recent times several major reviews have been written that identify the most effective and cost effective strategies for AOD prevention.[xvii] [xviii] (See App. 3) CDATs are encouraged to familiarise themselves with such reviews and avoid doing things that have been tried before and are known to be ineffective, regardless of the level of enthusiasm and community support for the initiative.

The type of events or activities the CDAT plans will depend on the audience and the intended outcome (i.e. awareness raising, reduction in risk factors (see App. 2), increase in protective factors, attention to supply, demand and harm minimisation issues, contributing to healthy public policy or organisational capacity building, etc.).

For examples of CDAT activities go to **adf.org.au/cdat**

2.9.1 Action Plans and Project Plans

CDATs will be required go through a planning process to develop and submit an Annual Action Plan that lists all their proposed events, activities, and associated rationale for the year ahead in a simple format. Annual Action Plans should take into account state-wide, Local Health District Population Health Unit, local government and primary health prevention activities to ensure that local AOD promotion, prevention and early intervention activities are aligned and mutually supportive.

In addition to the Annual Action Plan, CDATs will also be required to submit a Project Plan for each proposed Small Grants funded activity, over a certain financial threshold. This plan provides details about proposed events and activities and their respective aims, specific objectives and how these will be measured/monitored, key responsibilities, timelines, budgets, and risk management arrangements. Guidelines and templates will be provided to facilitate this process and are available on the website adf. org.au/cdat. A Senior Community Development Officer will be available to assist CDATs to complete their plans.

CDATs will be expected to submit their Action Plan and Project Plan along with their on-line request for funding under the Small Grants Program (see App. 1). Their local Senior Community Development Officer will review funding requests and make recommendations to the grant assessment panel.

2.10 Monitoring and Evaluation

CDATs will be required to monitor and report on all activities and projects implemented against their Action Plan. CDATs will submit an annual Evaluation and Acquittal Report to the ADF through their Senior Community Development Officer. The Report should include a summary of all activities planned and undertaken during the year (highlighting which activities are funded through an ADF Small Grant), budget reconciliation and an evaluation component for each completed activity.

The evaluation component should include activity reporting and a critical reflection on the process of implementing the activity or project. The critical reflection should aim to explore and describe:

Project feasibility

• Was the project able to be delivered as planned?

• Were there any specific barriers/challenges in the chosen setting or with the chosen target audience?

Project acceptability

• Was the uptake of, or engagement with, the project/activity as expected?

• Did the target audience/key stakeholders find the project appropriate, meaningful and/or acceptable?

Key learnings

• What were key barriers/solutions for the delivery of the project?

• What would you do differently next time?

CDATs are required to undertake more detailed impact and outcome evaluations for activities funded over a certain financial threshold. The ADF will provide practical support to CDATs to strengthen their planning and evaluation.

The NSW Ministry of Health will commission an impact and outcome evaluation of the CEAP to ensure that the program is meeting its aim and objectives.

2.11 Effective community action on alcohol and other drugs

• Grassroots community prevention programs can have a significant impact on reducing AOD problems. These programs are more likely to reduce harm when coupled with advocacy for legislative change.

• There is now a body of evidence demonstrating best practice in community prevention, which should be considered when planning prevention initiatives.

• Community activities are best focused on primary or 'upstream' prevention where programs aim to protect people from developing an AOD-related problem.

• It's important for communities to work together on prevention programs rather than individuals trying to develop their own approaches that don't leverage related initiatives.

• When identifying and communicating AOD problems, credible data and research needs to be used, rather than relying on people's perceptions or media reports.

• Consulting with stakeholders and the target audience early in the planning stages can have a huge impact on the success of a prevention program.

• Setting realistic objectives and writing down a program plan can help ensure everyone is on the same page; objectives are more likely to be achieved and the program can be evaluated, which is important when trying to gain further funding.

2.12 Success Factors for a CDAT

The ADF will work with CDATs to weave the below critical success factors into their practices:

- A strong and competent CDAT Chair and motivated and engaged CDAT membership, including committed local community members.
- Clearly identified roles, functions and activities for the CDAT Committee, Project group/s and the auspice agency.
- Strong partnerships and networks among key stakeholders in government, non-government, community, welfare and business sectors.
- Coordination that links local and regional action and is supported by skilled staff.
- Dedicated financial and human resource support from both government and non-government sources for administrative management and delivery of the program and the CDAT activities.
- Creating linkages to source good local data to guide the activities of the CDAT. For example: working with the LHD and LGA to gain access to local health, crime and other social statistics; undertaking needs analyses identifying areas to be addressed; and undertaking an audit of current services and activities.
- A clear strategic policy statement positioning the CDAT aim and objectives within state and national drug and alcohol policy frameworks, demonstrating relationship or connection between CDATs and Government.
- Having goals and a collaboratively developed, measurable, outcome-focussed plan of action, coupled with appropriate monitoring and evaluation.
- Community ownership of the solutions to legal and illegal drug and alcohol problems. This can be facilitated through regular open communication between CDATs and the local community about the plans and actions of the CDAT, as well as promoting to the community its achievements in addressing legal and illegal drug and alcohol issues.
- Capacity to mobilise additional human, financial and 'in-kind' resources to undertake CDAT activities in the community.
- Access to capacity building through training for CDAT members to develop skills for facilitating local plans and undertaking activities.
- Recognition that sustainable approaches to community drug and alcohol action require time and are not subject to 'quick fixes'.
- Appropriate and meaningful evaluation of CDAT activities that contribute to the CEAP across NSW.

Appendix 1 Program Support

The Australian Drug Foundation (ADF) has been contracted to manage all aspects of the CEAP for the period 2015–2017. The ADF will provide high-level strategic advice, access to funding, and practical on-the-ground support to each CDAT. This support will be delivered through a network of Senior Community Development Officers (SCDOs) spread across NSW. The SCDOs will in turn report to the ADF NSW Community Programs State Manager.

Senior Community Development Officers

The SCDOs will be available to assist communities to establish, maintain and deliver on the aims and objectives of the CDATs. Each SCDO will be responsible for supporting CDATs in a defined geographic area of regional or metropolitan NSW, although they may also collaborate with other SCDO colleagues to support CDATs in a neighbouring area. Creating greater flexibility around catchment 'boundaries' is central to ensuring greater equity and increased integration of CDAT activities across NSW. SCDOs will support CDATs as they address local AOD-related concerns in their community by:

- Encouraging and facilitating broad based community participation in CDATs.
- Working with CDATs to plan and deliver projects that address regional alcohol and drug related harm.
- Building and supporting the quality of planning, implementation and evaluation of the CDAT activities.
- Assisting the CDAT to present themselves and their work accurately and meaningfully to ADF, NSW Health, the sector and the wider community in reports, sector journals and the media.
- Assisting CDATs and their associated project groups to learn from and work with each other across common themes and build on each other's successes.
- Assisting CDATs to apply for and acquit Small Grants to the ADF.
- Assisting CDATs to develop their Annual Plan and submit a project plan and risk management plans for each project.
- Assisting the Small Grants Assessment Panel by providing analysis and advice of how well applications meet the objectives of CDATs and the administrative requirements of the Small Grants Fund.
- Facilitating the creation of new CDATs in areas of high need and/or the linking of existing CDATs.
- Maintaining ongoing communication with CDATs through their Chairperson and attending CDAT committee meetings and CDAT activities whenever possible, either face-to-face or using technology to attend virtually.
- Provide general information, advice and support to CDATs to assist them to fulfil their aims and objectives.

The Small Grants Program

NSW Ministry of Health provides an annual pool of funding to support the activities of each CDAT. The ADF has been commissioned to oversee and manage the distribution of these funds through the Small Grants Program.

The ADF will develop a statement of requirements and an associated application form, which it will distribute to each CDAT. The purpose, general objectives and specific focus of the grants, including what will and   will not be funded and what the funds can and cannot be used for, will be described in the documentation. Funding will be available to each CDAT on an annual basis to undertake approved activities that form part of their Action Plan. A CDAT must be formally endorsed by the NSW Ministry of Health to be eligible to apply.

The ADF will call for applications from CDATs and assess each submission against a checklist that includes: population demographics and other indicators of need; a measure of community readiness and 'buy-in'; the rationale and evidence for and purpose of the proposed activity; strength of the core CDAT committee and project group/s; capacity of the local government and other organisations to contribute matching cash or in-kind resources; and a clear link to the local Action Plan.

The ADF's SCDOs will review all applications and prepare a summary and list of recommendations that will be considered by an Assessment Panel. This Panel will include: ADF CFO, National Community Programs Manager, NSW Community Programs Manager, the ADF Research Manager, a representative from NSW Ministry of Health and an independent assessor. The Panel will make final decisions about grant allocations.

In addition to the Small Grants Funding it is expected that each CDAT will also seek financial and/or in-kind support from a range of other sources. Such cash or in-kind contributions may be available from sources including:

• Other NSW Government agencies
• Local Government
• Commonwealth Government
• Philanthropic associations and service organisations
• The corporate sector, including local businesses

Tools and Information Resources

The ADF has also been commissioned to provide a range of supporting tools and information resources through its website. This content will be included in the specific landing page on the ADF website: **adf.org.au/cdat.** The ADF has a wide range of resources for the CDATs to use for planning, implementing and evaluating activities and to help them promote their work in the community. Over time the ADF will introduce new content and resources. The ADF has moved appropriate CDAT content from the 'Your Room' website to the ADF website. 'Your Room' still has many useful resources for CDATs however.

Training and development

A series of training and development workshops, seminars and conferences have been delivered for and by CDATs over the years. Training and development is an important activity in building the capacity of CDAT members and, in turn, their communities. CDAT members should liaise with their SCDOs about getting involved in the most appropriate capacity building activity for their team.

Appendix 2. Social determinants of health

The determinants highlighted in Figure 1 interact with each other to either increase or decrease an individual's exposure to health risks. Underlying these social determinants are a number of developmental factors that can create risk or protect an individual engaging in harmful behaviour, these are known as risk and protective factors. CDATs can work to reduce risk factors and/or build protective factors in their community.
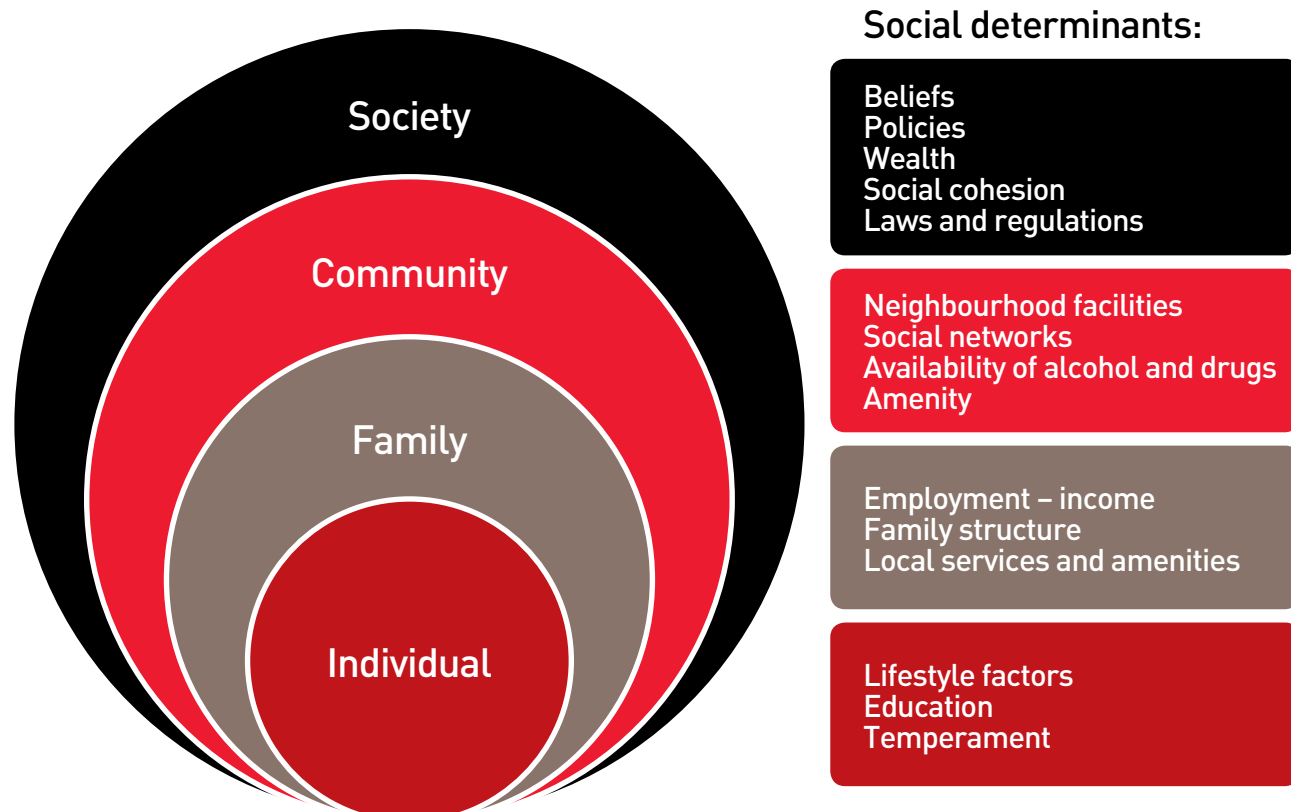

Social determinants:

Beliefs
Policies
Wealth
Social cohesion
Laws and regulations

Neighbourhood facilities
Social networks
Availability of alcohol and drugs
Amenity

Employment – income
Family structure
Local services and amenities

Lifestyle factors
Education
Temperament

Figure 1: *Australian Drug Foundation. Adapted from Dahlgren G & Whitehead M 1991, Policies and Strategies to Promote Social Equity in Health, Institute for Futures Studies, Stockholm*

Risk and protective factors

Developmental risk and protective factors are variables located in personality and in significant relationships that operate on children, adolescents and young adults that increase or decrease the likelihood of them engaging in unhealthy or hazardous behaviours. Developmental risk and protective factors are independent variables (i.e. they are not merely opposites).

For younger children having an easy, shy or cautious temperament and social and emotional competence is developmentally protective, while in adolescence protective factors are family attachment, parental harmony and religious affiliation[xx]. Developmental factors that promote early and problematic drug use for younger children are neglect, school failure and aggression, while for adolescents they are a sensation seeking personality, parental AOD problems, peer drug use, low involvement with adults, favourable attitudes to drug use and availability of drugs in the community[xxi].

Risk factors that may increase the likelihood of problematic alcohol and drug use

Early age

Early age risk factors identified that increase the likelihood that children develop behavioural and adjustment problems and could become involved in harmful drug use include:

- Inherited vulnerability (males)
- Maternal smoking and alcohol use
- Extreme social disadvantage
- Family breakdown
- Child abuse and neglect

School age

- Early school failure
- Childhood conduct disorder
- Aggression
- Favourable parental attitudes to drug use

Adolescence

- Low involvement in activities with adults
- Perceived and actual level of community drug use
- Availability of drugs
- Parent-adolescent conflict
- Parental alcohol and drug problems
- Poor family management
- School failure
- Deviant peer associations
- Delinquency
- Favourable attitudes to drugs

(Source: Loxley,W., Toumbourou, J.W., Stockwell, T. et al. (2004) Prevention of substance use, risk and harm in Australia: A review of the evidence, Perth: National Drug Research Institute.)

No single factor causes drug misuse; however, these factors assist in identifying who is at greatest risk and enables   the development of prevention programs that target vulnerable populations (Universal/ Selective) and or individuals (Indicated) for example:

- People who are in emotional distress, disengaged and disconnected from society through lack of employment, mental health problems, people dealing with trauma and people in abusive relationships.
- Young people who are disconnected from school; children with learning difficulties or from families that do not function well; children with parents who have drug problems; young people without role models that provide a pathway to a solid future by completing school, engaging in training or holding a steady job.

People in the above situations are vulnerable because they can often find comfort in heavy use of legal drugs (e.g. alcohol tobacco and pharmaceuticals) and illegal drugs. People can be in   these situations through no fault of their own – children cannot choose their parents or family circumstances and no one chooses to have mental health problems.

Appendix 3. What the evidence tells us

The following section outlines statistics related to consumption and evidence based interventions for alcohol, illegal drugs and pharmaceuticals. It is not a comprehensive review of the evidence. The following statistics are accurate at the date of publication. Updated statistics and full reports on interventions relevant for CDATs can be found through the ADF website and/or with the assistance of the ADF team.

If a CDAT wants to work on an activity that is not supported by current evidence then the project may not be funded through the Small Grants program. However it is recognised that the evidence base for community action on AOD is not extensive and that the profile of communities that CDATs work with are not necessarily those that were the subject of existing research (eg a small rural community). CDATs are supported and encouraged to contribute to the evidence base by participating in research.

Alcohol has been separated from other drug use to highlight interventions specifically related to alcohol.

Alcohol

Alcohol is the most widely used drug in Australia.

According to 2013 **National Drug Strategy Household Survey (NDSHS)** data:

- 86.2% of Australians aged over 14 years had drunk alcohol at some stage in their life.
- 37.3% of drinkers consumed alcohol on a weekly basis.
- The average age at which Australians first tried alcohol was 17.2years (this figure is based on the whole population, not the most recent cohorts; for the current younger generation (14-24 year olds), the average age of initiation is 15.7 years).
- Males are far more likely than females to consume alcohol in risky quantities and 18-24 year olds are the age group most likely to engage in risky drinking.
- Australians living in remote or very remote areas are significantly more likely to drink at levels of lifetime risk (34.9%) compared to those living in cities (16.7%) or regional areas (19.1-22.6%). They are also more likely to drink at single occasion risky levels (over 4 drinks per session).
- Indigenous Australians were more likely to abstain from drinking alcohol than non-Indigenous Australians (27.9% compared with 22.0% respectively). However, among those who did drink, a higher proportion of Indigenous Australians drank at risky levels.

51.6% of Australian drinkers consume alcohol in excess of the **Australian Guidelines** at least once a year, with 25.9% consuming more than the recommended maximum of two standard drinks per day. (Centre for Alcohol Policy Research, 2013, **Over the limit PDF1.5MB**.)

1 in 6 Australian drinkers (15.8%) consume more than 11 drinks per occasion at least once a month. (Centre for Alcohol Policy Research, 2013, **Measuring risky drinking PDF:1.2MB**.)

Youth drinking

The 2013 NDSHS reports that most underage young people (12-17 years old) had not drunk alcohol in the preceding 12 months compared to those who had (71.2 versus 28.8%), and 68.1% had never had a full serve of alcohol.

Looking at the NDSHS data in more detail:

- 1 in 4 (25.1%) 12-17 year olds drink at low risk levels (two drinks a day or less). Young Australians (aged 14–24) have their first full serve of alcohol at 15.7 years on average.
- By the time young people reach the legal age to purchase alcohol, 61.5% are drinking at low risk levels and 21.3% are drinking at risky levels (above the Guidelines).

  In general however, there is a decrease in alcohol consumption for underage drinkers compared to the 2010 NDSHS data.

National Alcohol Indicators Project (NAIP) bulletin 12: Trends in estimated alcohol-attributable deaths and hospitalisations in Australia reports that from 1996-2005, an estimated 32,696 Australians aged over 15 years and older died from alcohol-related injury and disease caused by risky/high risk drinking, and 813,072 were hospitalised over that 10-year period. More recently, in 2012-13 there were 51,981 alcohol-attributable hospitalisations in NSW alone[xxii].

Evidence based interventions for alcohol

The most effective measures to reduce alcohol related problems are the reduction of economic and physical availability via pricing, taxation, trading hours, number and density of outlets and availability of low alcohol products[xxiii]. The following table, which summarises the effectiveness of different interventions, extends Babor et al's work to include Australian evaluations[xxiv]. Many of these interventions are outside of the scope of CDATs but are shown here to encourage CDATs to focus their energies where they are most likely to reduce the impact of risky drinking.

For an overview of recommended patterns of investment in prevention of risky substance use and harm across the whole community for all drugs see Table 2: Alcohol and drug strategies.

Illegal drugs

The 2013 National Drug Strategy Household Survey (NDSHS) report found:
- 15.0% of Australians aged 14 years and over had used drugs (including the misuse of prescription medications) on at least one occasion in the past 12 months and 36.8% had used an illegal drug at some point in their lifetime.
- The illegal drug that people are most likely to have tried is cannabis (34.8%) compared to other drugs such as ecstasy (10.9%), hallucinogens (9.4%), cocaine (8.1%) or meth/amphetamines (7.0%).
- Looking at recent use (within the past 12 months), cannabis is again the most popular (10.2%) followed by pharmaceuticals (4.7%) and ecstasy (2.5%).
- Generally men are more likely than women to use drugs and those in the 20-29 years age group are more likely than other age groups to use drugs.
- Although most jurisdictions reported a slight increase in illegal drug use since the previous survey, the increase in NSW is noteworthy (14.2% up from 13.8% in 2010).

Illegal drugs are estimated to cost the community approximately $8 billion a year[xxv].

Table 1 Evidence-based Interventions – Alcohol (Ref xxiv)

Strategy or intervention		Effectiveness	Breadth of research	Cross-cultural testing	Cost to implement	Australian evaluation
Regulating physical availability	Total ban on sales	★★★	★★★	★★	High	★★
	Minimum legal purchase age	★★★	★★★	★★	Low	
	Hours and days of sale restrictions	★★	★★	★★	Low	★★
	Restrictions on density of outlets	★★	★★★	★★	Low	●
	Staggered closing times for bars and clubs					0
	Server liability	★★★★	★	★	Low	★
	Different availability by alcohol strength	★★	★★	★	Low	0
Taxation and pricing	Alcohol taxes	★★★	★★★	★★★	Low	★★
	Hypothecated tax to pay for treatment /prevention					★★★
	Setting floor prices / banning discounting					★★
Drink-driving counter-measures	Sobriety checkpoints	★★★	★★★	★★★	Moderate	
	Random breath testing	★★★	★★★	★	Moderate	★★★
	Lowered BAC limits	★★★	★★★	★★	Low	
	Administrative licence suspension	★★	★★	★★	Moderate	
	Low BAC for young drivers	★★★	★★	★	Low	★
	Graduated licensing for novice drivers	★★	★★	★★	Low	
	Designated drivers and ride services	0	★	★	Moderate	★
	Ignition interlocks					★
Treatment and early intervention	Brief intervention in primary health settings	★★	★★★	★★★	Moderate	★★★
	Alcohol problems treatment	★	★★★	★★★	High	★★★
	Thiamine supplementation					★★
	Workplace interventions					●
	Mutual help/self-help attendance	★	★	★★	Low	
	Mandatory treatment of repeat drink drivers	★	★★	★★	Moderate	
Regulating promotion	Advertising bans	?	●	●	Low	●
	Advertising content controls	?	●	●	Low	●
Education and persuasion	Alcohol education in schools	0	★★★	★★	High	★
	University student education	0	★	★	High	
	Parent education	?	●	●	Moderate	●
	Public service messages / Mass media campaigns	●	●	●	Moderate	★
	Warning labels / National drinking guidelines	0	★	★	Low	★
	Alcohol education in schools	0	★★★	★★	High	★

Rating	Evidence of effectiveness
0	Lack of effectiveness
★	Limited effectiveness
★★	Moderate effectiveness
★★★	High degree of effectiveness
?	No evidence available
●	Warrants further research (in Australia)

Table 2: Alcohol and drug strategies

Overview of recommended patterns of investment in prevention of risky substance use and harm across the whole community

Substance type	Risk patterns	Main risk populations	Harm prevalence	Recommended supply reduction strategies	Recommended demand reduction strategies	Recommended harm reduction strategies	Main recommended level of application
Tobacco	Regular use Dependence	General	Leading cause of drug-related harm overall	Taxation*** Government Monopoly ★	Brief intervention*** School drug education**	Restrictions on smoking in public places*** Smoke-free alternatives	Universal
Alcohol	Intoxication Regular use	General Males	2nd leading cause of harm 1st in some regions	Taxation*** Controls on hours and density of outlets** Minimum drinking age of 21 years***	Brief intervention*** Treatment*** Community action on local policy**	Random breath testing of drivers*** Safe glassware* Thiamine-fortification of drinks & flour***	Universal
Cannabis	Regular use Dependence	General Males	Low for health related harms, high for criminal justice costs	Prohibition with civil penalties*	Brief intervention*** Treatment***	Use of civil penalties to reduce social harms with criminal penalties*	Universal Selective
Other illegal substances	Overdose Intoxication Dependence	Socially and developmentally disadvantaged Males	Lower than legal drugs for health and social costs, high for law enforcement costs	Control of precursor chemicals ★	Treatment*** Developmental prevention** Diversion from criminal justice system*	Needle exchanges*** Hepatitis B vaccination for users*** Prescribed heroin** Safe injecting rooms*	Targeted
All substances	Intoxication Regular use Dependence	General Young people Males Disadvantaged	Substantial: 12.4% of all deaths	Legal structures and practices to promote health and safety	Early life interventions: Post-natal home visits** Pre-school preparation**	Public education about the care of intoxicated persons at risk of fatal overdose*	Universal Selective

Source: Adapted from Loxley,W., Toumbourou, J.W., Stockwell, T. et al. (2004) *Prevention of substance use, risk and harm in Australia: A review of the evidence*, Perth: National Drug Research Institute.

Note: ******* Strong evidence for wide implementation;

     ** Strong evidence for implementation with evaluation;

     * Promising, needs further research to define best practice;

     ★ Strong rationale, further research recommended.

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