Developing a Place-based Alcohol Indicators Framework to Monitor and Evaluate Alcohol Management Plans and Other Alcohol Initiatives in the Northern Territory: Challenges and Oppor...
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Background

In the Northern Territory (NT) alcohol per capita consumption is among the highest in the world when compared with other jurisdictions. The NT experiences substantial harms associated with alcohol, particularly but not exclusively in the Aboriginal and Torres Strait Islander population. A study of alcohol-attributable deaths and hospitalisations in 2004-05 and 2005-06 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 (Skov, Chikritzhs, Li, Pircher, & Whetton, 2010). It has been estimated that alcohol-related harms cost the NT approximately $642 million per year ($406 million tangible, and $236 million intangible). Breaking this down, alcohol was a factor in 48% of road deaths, was estimated to take up 41% of policing resources, and approximately 5% of hospital admissions. Between 2002 and 2008 chronic/high risk drinking in the NT Aboriginal and Torres Strait Islander population 15 years and over increased from 6.7% to 9.7% and for males the increase was larger and statistically significant rising from 7.0% to 12.8% (Australian Bureau of Statistics, 2013a).

Alcohol Management Plans (AMPS) as a policy tool aim to deliver local responses to alcohol issues within a local community or region. AMPS are based on principles of harm minimisation, which aim to minimise the nature and extent of harm caused by the consumption of alcohol, through an integrated approach that includes supply, demand and harm reduction strategies. AMPS engage community members and local stakeholders in developing strategy plans with the aim of reducing alcohol harms in their community. The Final Report of the NT Alcohol Framework defined AMPs in the following terms:

Regional and Local Alcohol Management Plans are plans negotiated between all or some of the following: local communities, community organisations, local government, Government agencies, licensees and others. They identify needs and opportunities, and set out the responsibilities and commitments to action of the various parties to the plan. Each plan will be tailored to local conditions.

(Northern Territory Government, 2004, p 53)

AMPS were adopted as a central policy instrument by the Queensland Government in 2001 as a response to the high levels of alcohol-related violence and community dysfunction in some Indigenous communities in Cape York and elsewhere, identified in the Fitzgerald Inquiry into Cape York (Queensland Government, 2002). The AMP approach, as a key policy initiative, was adopted by the NT Government in 2004 as part of the NT Alcohol Framework. An Alcohol Management Plan (which was primarily a Supply Plan) was developed (under the NT Liquor Act) in Groote Eylandt in 2005. The first integrated AMP (including supply, demand and harm reduction strategies) was developed under the NT Liquor Act (Northern Territory Government) in Alice Springs in 2006. This was then followed by the development of AMPS (also under the NT Liquor Act) in Palmerston and the regional centres of Nhulunbuy, Katherine and Tennant Creek in 2008. Independent evaluations have been undertaken for most of these AMPS (for example see d’Abbs, Ivory, Senior, Cunningham, & Fitz, 2010; d’Abbs, McMahon, Senior, Cunningham, & Fitz, 2010; Senior, Chenhall, Ivory, & Stevenson, 2009). AMPS have also been developed in the NT for some remote communities. In 2009 the NT received funding under the Closing
the Gap National Partnership Agreement as part of the Northern Territory National Emergency Response (NTNER) to develop AMPs in remote communities and in other prescribed communities (town camps) that would then come under the Northern Territory National Emergency Response Act (Commonwealth of Australia).

In 2012, the Commonwealth Government passed the Stronger Futures in the Northern Territory Act (Commonwealth of Australia), which effectively superseded the NTNER Act introduced by the previous Government in 2007. Under the Stronger Futures Act AMPs became a central policy instrument for managing alcohol-related harms in remote Indigenous communities in the NT. The SFNT Act outlines how AMPs will be developed and implemented including a set of rules – the AMP Minimum Standards, which were introduced in February 2013. One of the Minimum Standards covers 'monitoring and evaluation'.

The NT Department of Business has engaged the Menzies School of Health Research to develop an evaluation framework suitable for monitoring and evaluating AMPs in Indigenous communities in the NT. As a first step in doing so, Menzies has been commissioned to prepare a scoping paper which sets out the parameters of the tasks involved in developing an evaluation framework, identifies key challenges to be addressed in developing an evaluation framework, and indicates how those challenges will be approached.

The paper is set out in the following sections:

- Key objectives of the Evaluation Framework;
- Scope of evaluation activities;
- Key challenges;
- Data and indicators;
- Next steps.

The issues set out in the abovementioned sections of this scoping paper should be regarded as a basis for further discussion and refinement among parties likely to be involved, either in contributing data to ongoing monitoring and evaluations, to conducting evaluations, or in using the products of evaluations.

**Key objectives of Evaluation Framework**

In a discussion paper prepared for a workshop on 22 January 2014, attended by representatives of NT and Commonwealth Government agencies as well as staff from Menzies, the Senior Director of Alcohol Policy and Strategy, NT Department of Business, set out a number of Guiding Principles to be incorporated into the proposed Evaluation Framework (Alley, 2014). According to these, the Framework should:

- be sustainable over the longer term
- be based on a model of community ownership and engagement
- consider collection of qualitative data as well as quantitative data to monitor progress and measure success.
- consider engaging community members, local service providers and Alcohol Reference Groups (community and stakeholder AMP governance groups) in both determining the success measures and in collecting and reporting on success measures and other data
• include capacity building mechanisms
• be able to capture local priorities and alcohol success indicators while ensuring ability to measure the impact of AMPs and the measures/strategies in place to reduce alcohol harms across communities and AMPs in the NT, and
• be cognisant of and be able to meet the Stronger Futures Minimum Standards, in particular Minimum Standard 4 - Monitoring, reporting and evaluation.

Participants at the workshop itself (see Appendix 1 for list of participants) made further suggestions regarding the Framework, suggesting that it should:

• Ensure the project is meaningful for small communities and acknowledges service relationships
• Report data in different forms for different stakeholders, e.g. community, government departments
• Incorporate community participation and Aboriginal cultural values at all levels
• Keep the primary focus on alcohol, but gather information on other drugs so any displacement trends are captured
• The minimum data set should be layered to capture broader community level change as well as change in consumption and individual harm
• There should be two points of accountability – government and community
• Community owned indicators should be incorporated in any elaborated framework that goes beyond the minimum data set
• Report successes back to communities
• Communities should be involved in the interpretation of data, and
• Select data that can be tracked and reported over time.

Many of these principles and criteria can be condensed into the following three key objectives.

The Evaluation Framework should:

1. Facilitate ongoing monitoring and evaluation of the implementation and outcomes of AMPs in individual Indigenous communities, and reporting of the outcomes of monitoring and evaluation to appropriate agencies and the communities involved;
2. Enhance the capacity of communities involved in AMPs to develop their own priorities, methods and criteria for monitoring and evaluating the implementation and outcomes of AMPs in their communities, and to modify those AMPs if necessary on the basis of evidence generated;
3. By facilitating comparisons between the implementation and outcomes of AMPs in individual communities, contribute to identifying determinants of effectiveness of AMPs in reducing alcohol-related harms.
Scope of evaluation activities

Two types of AMP are currently to be found in the NT:

- Regional centre AMPs developed under the NT Liquor Act for Alice Springs, Tennant Creek, Katherine, Groote Eylandt and the Gove Peninsula;
- AMPs in remote communities, some of which were initiated prior to the introduction of the Stronger Futures Act, but all of which will nonetheless be evaluated within the framework devised for the Stronger Futures context.

The primary focus of this Framework is on the monitoring and evaluation of AMPs under SFNT. However, the Framework will also address the development of a minimum data set for measuring alcohol related harms in regional centres as well as in larger and smaller remote communities and other alcohol protected areas. Such a database will be required to provide comparison across communities and the NT in measuring progress in addressing alcohol related harms. There is also a degree of overlap between the types of AMPs, in that both the Gove Peninsula AMP and the Groote Eylandt AMP include communities that may develop their own individual AMPs under Stronger Futures, and town camps (alcohol protected areas) exist in most regional centres.

According to information provided by the Department of Business, there are 29 communities in regional centres, urban and remote communities in the NT that are currently being supported to develop and implement AMPs. This includes 22 under the Stronger Futures AMP processes belonging to the second category. In 17 of these, the community has already endorsed their AMP. However, under Stronger Futures, AMPs do not enjoy formal recognition until they have been approved by the Commonwealth Minister, and at this stage none have been formally approved.

The Evaluation Framework that is the subject of this paper will be expected to primarily cover the 22 communities for which AMPs are currently in train, as well as any additional AMPs that may be developed in future under Stronger Futures.

Key challenges

The Evaluation Framework should meet a number of key criteria:

1. **Flexibility**: Can be applied across heterogeneous communities
2. **Scalability**: Can be scaled up from the level of a local community to larger meaningful geographic areas (e.g. catchment areas of particular centres of alcohol supply, police administration areas, hospital catchment areas)
3. **Utility**: Can be used to generate information for local communities that allows for comparison over time and with other locations and regions in the Northern Territory.
4. **Sensitivity**: Identify indicators that are most sensitive to the impact of alcohol use at the community level
5. **Sustainability**: Develop processes and systems that facilitate regular update of the place-based Framework indicators (building and supporting community capacity).

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1 The total may be slightly higher given ongoing development of AMPs and if a number of communities already incorporated in existing AMPs are included.
6. **Consultation:** Undertake regular community consultation so that the alcohol indicators are understood locally and seen as relevant.

7. **Communication:** Develop processes and systems that underpin reporting of indicators at local and other geographic levels in a timely manner, including feedback reports to local communities with AMPs.

8. **Quality improvement:** Develop processes and systems that lead to improved data quality of the indicators used in the place-based Framework.

The Evaluation Framework also faces distinctive challenges, of which three are particularly salient. These are:

- Quality and availability of data;
- Identifying trends in communities with small populations;
- Likelihood of contextual changes, as a result either of changes in policies relating to alcohol, or of changes in other policy areas that nonetheless impact on social conditions at a community level (e.g. defunding of training or employment programs).

**Quality and availability of data**

In principle, two kinds of data (especially, but not only, quantitative data) are available for evaluation: routinely collected administrative data, such as police offences or hospital separations, and primary data generated as part of the evaluation process. Both face distinctive constraints in this context.

**Administrative data**

Administrative data are usually generated from the provision of government services and can be viewed as a by-product of these services. Governments use these data in determining service need and budget requirements, and less commonly for evaluating and monitoring change for small geographic areas (e.g. discrete Indigenous communities). Some scoping work has been conducted on using administrative data in the NT for monitoring and evaluation purposes, and to assist in assessing relative need in communities and regions, particularly in the area of the social determinants of health (Sicilliano, Stevens, Condon, & Bailie, 2006). There are considerable advantages to using administrative data sources for such purposes where data is considered of good enough quality. Using administrative data can be seen as value-adding, and most of these government data sources have complete coverage in scope across the whole of the NT.

However, many remote communities covered by Stronger Futures do not have on the ground representation of agencies that we normally rely on for administrative data, in particular, police stations and hospital emergency departments. Similarly, although the NT Licensing Commission collates quarterly ‘wholesale supply’ data for liquor outlets, in cases where outlets serve drinkers from a variety of communities (i.e. most of them) it is impossible to apportion sales (if we take ‘wholesale supply’ as indicative of ‘sales’) to particular communities. Most communities do, however, have health clinics and schools.

An assessment of data quality and its subsequent ‘fitness for use’ will need to be made, and ongoing efforts to improve data quality will be required to ensure such data are reliable and accurate over time. Data quality is a multidimensional concept, dependent on a range of factors. Agreement to proceed with the
collection of data for various indicators can be used to determine accessibility (data availability) and relevance (direct versus proxy indicators). Once agreement is obtained from data custodians to release data, then the timeliness dimension (indicator availability in a timely manner) of quality can be determined. Deciding on a framework which describes the relationships between indicators will determine the coherence dimension of quality, which is measured across all indicators. Determining accuracy can be achieved by examining the data at various geographies, looking for consistent trends over time within and between indicators. Specific issues that will need to be accounted for in assessing accuracy will be inaccurate geographical coding, inconsistent geographies between data sets, incomplete coverage, missing data, and changes in coding and collection policies over time.

Where the accuracy of incidents ‘flagged’ as involving alcohol is questionable because of subjective judgement, response priorities, service practices etc, indirect or proxy measures have been developed to measure and compare trends in alcohol-related harm (e.g. offences with known high risk of alcohol involvement, rather than specific offences including only alcohol). The need for proxy measures in the context of this project will be assessed primarily in light of record reliability, although low prevalence levels of incidents directly related to alcohol may also mean high frequency proxy measures are preferable.

**Primary data**

The second kind of data that can be used are primary data generated specifically for evaluating AMPs. Both quantitative and qualitative primary data will be generated as part of evaluations. In particular, data that relates to local community priorities, such as vandalism or street litter, as distinct from the governmental priorities implicitly encoded in data such as police incidents and hospital separations, are likely to be generated in any evaluation. However, primary data will need to address distinctive constraints, of at least two kinds.

The first relates to costs: collecting primary data in a context of remote communities scattered across a large geographic area is extremely expensive. The second relates to issues of language and literacy and will affect the capacity of communities to participate in a sustainable way in the collection of primary data (see below for more on this). In most Aboriginal communities in the NT English is spoken as a second or third language, and levels of literacy and numeracy are low.

**Intersection between sustainability and data quality**

Given the constraints and issues of data quality associated with both primary and administrative data, there is a strong need to implement processes that will facilitate both collection and quality of primary and administrative data.

First, feedback of data to communities (and regions) in a form that they can use will make the importance of data collection become more relevant to them. Feedback processes are critical to maintaining sustainability of AMP evaluations. Second, once data collection is seen as relevant, then it will provide impetus for improving the quality of data collected by communities.
By ensuring data feedback is relevant and assisting communities to understand how data can be used, they will better understand the benefits that the data can provide. These benefits extend beyond the evaluation of AMPs as good quality information on communities can be used in grant applications, assessing the effectiveness of other programs running in communities, and as a source of information for community organisations. This approach is akin to the continuous quality improvement approach used in the NT and elsewhere across Australia to improve the quality of services delivered by health centres to the Aboriginal and Torres Strait Islander population, which is managed by Menzies School of Health Research through One21Seventy – the National Centre for Quality Improvement in Indigenous Primary Health Care (Bailie, Si, O’Donoghue, & Dowden, 2007; One21Seventy, 2014).

Identifying trends in communities with small populations

Many of the indicators of alcohol-related harms commonly used in research and evaluation – such as alcohol-related car crashes and hospital separations for alcohol-attributable conditions – assume a large population size, rendering sufficient numbers of the indicators concerned to identify trends. In small populations these indicators are often of limited value. For example, an increase in alcohol-related vehicle fatalities from a particular community from 2 to 3 represents a 50% increase, but may simply reflect the fact that in one year there were two people killed in one accident, the next year three people, also in one accident.

The Australian Bureau of Statistics (ABS) estimates that the Northern Territory population was approximately 235,000 people as of 30 June, 2012, with approximately 111 males for every 100 females (Australian Bureau of Statistics, 2013b). Around 132,000 people live in Darwin (including Palmerston and Litchfield), 41,000 in Alice Springs and surrounds, while the remainder are spread across the Barkly (6,700), Katherine (21,000) and Arnhem Land (35,000) regions. The most significant characteristic of the population is that more than a quarter (63,000) identify as Aboriginal and Torres Strait Islander, of which more than 40,000 live in discrete Indigenous communities scattered across remote and very remote regions of the NT ranging in population size from twenty to a few thousand (Australian Bureau of Statistics, 2007). There are over 120 communities in the Northern Territory with 50 or more people which contain most of the 40,000 plus Indigenous people, though there are around 600 communities with a population of less than 50 (Australian Bureau of Statistics, 2007; Hoffman & Bailie, 2003). The small population size of many communities, coupled with the sparseness of the NT population generally, both create significant challenges associated with data collection and in using large-scale administrative data sources.

Likelihood of contextual changes

The conditions under which people purchase and consume alcohol are shaped by a large number of contextual factors, of which NT and Commonwealth policies – particularly in relation to drinking by Indigenous people – are the most prominent. Recent years have seen a virtual policy pageant of changes in this area, including, but not limited to, creation of Prescribed Areas, Public Restricted Areas, introduction and abolition of the Banned Drinkers Register and mandatory treatment. It would be naïve to assume that changes will not continue to occur. This means that the Evaluation Framework must:
- Be sensitive to possible effects of contextual factors on alcohol use in particular settings, and
- Be robust and flexible enough to take account of possible future changes in contextual factors.

**Case studies**

Collection of more detailed and nuanced data from a subset of locations will be required to better understand the impact and effectiveness of AMPs in different settings. A subset of locations will be used for this more detailed information due to the high costs associated with primary data collection in the NT. This more detailed data is likely to be a mixture of qualitative and quantitative data. This will allow for triangulation of assessment of the impacts and effectiveness of AMPs across all the data (i.e. administrative data, and the detailed quantitative and qualitative data). It will also give more prominence to the local meaning of any contextual changes associated with the AMP. Primary data collection, both qualitative and quantitative, will be further explored in future work carried out by Menzies School of Health Research.

**Data and indicators**

**Towards a scalable place-based reporting framework**

A scalable place-based framework is necessary due to the varying reporting requirements needed to make the AMP evaluation successful. Figure 1 summarises the hierarchical nature of a proposed reporting framework, while Box 1 provides more detailed information on the four geographical domains. It is important to note that the figure below does not represent the overlap that may occur between circles two (fringe community drinking areas) and three (alcohol catchment areas). For example, two communities may share a fringe drinking area, and similarly, multiple communities will often be in the same alcohol catchment area (ACA).

The geographic scope or reach of an AMP (denoted by the mauve amoeba in Figure 1) may in theory include all four geographical domains and will be dependent on a range of factors such as whether the community has its own commercial alcohol supplier, kinship ties between communities (and places of significance) and the roads and geographic spaces that connect these places. The scope of the AMP will largely be defined by the community for which it applies, though availability of data will also play some role in how the Framework is populated. Figure 1 should be seen as a simplified diagram highlighting various spatial data reporting requirements associated with AMPs.

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**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 community (geographical area) where the AMP was advanced.
2. The community (or town/city) including fringe areas where drinking occurs.
3. 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).
4. 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.
Scalability

The framework needs to be flexible in its ability to provide meaningful reporting of a wide variety of indicators. Scalability refers to the ability of the framework to provide reporting of indicators at varying geographic levels depending on: (i) data quality, (ii) issues of confidentiality surrounding public disclosure of commercially sensitive alcohol sales data for commercial alcohol outlets, and (iii) the purpose of the data being reported (e.g. community needs; reporting requirements for the Stronger Futures legislation).

The advantage of having a scalable geographic reporting system is that it allows for indicators to be interrogated at differing geographic levels. This will provide a means of investigating data quality issues and will also provide a more nuanced ability to produce indicators for differing purposes. For example, indicators for small populations (areas/communities) will exhibit large natural variation over time, and it is important to be able to separate this natural (random) variation from real changes occurring as a result of AMPs. To circumvent the problem of natural variation, indicators will need to be reported for areas larger than communities in order to provide an accurate picture of changes over time associated with AMPs and broader policy and practice initiatives.

The constraint on the framework of scalability necessitates that indicators will need to be available at a community level to allow flexible aggregation across time and places. This will also ensure that information is meaningful and useful for the individual communities from which the data originates. Furthermore, the geography used for reporting requirements will also need to align wherever possible with ABS statistical boundaries.
Direct and indirect alcohol-related harms

Alcohol-related harms can be both direct, affecting the individual drinker (e.g., conviction for drink driving) and indirect, affecting others (e.g., poor school attendance by children of a drinker). It is important to identify and capture indirect harms which arise from the broader social and community impacts of alcohol use, in addition to the direct measures of harm that are available.

In addition to indirect harms associated with alcohol, proxy indicators may need to be used in some areas due to small populations and resultant indicators varying randomly on a short term basis (e.g., year to year) or for other reasons due to inconsistent reporting of the type of incident. An example of a proxy measure would be ‘all ambulance callouts’ as a proxy for alcohol-related call outs. This has been used in an evaluation sales and advertising restrictions in a remote community in north-west Australia (Midford et al., 2010). In this study approximately 80% of ambulance call outs were alcohol related. The use of proxy measures mitigates some of the issues associated with small populations and data quality (see below).

Indicators used in previous NT AMP evaluations

Previous evaluations of AMPs in the NT have drawn on five types of outcome indicators. For reasons already discussed, not all of these will be applicable to evaluations in remote communities. However, they provide a starting point for development of an Evaluation Framework for remote communities in the NT. The five types of data are:

- quarterly trends in alcohol sales as indicated by wholesale supply of alcohol to outlets in or connected to the AMP site;
- presentations at (or evacuations to) the ED (Emergency Department) of relevant Hospital for injuries and alcohol-related disorders;
- separations at relevant hospital for injuries and alcohol-related disorders;
- trends in incidence of alcohol-related and other assaults, as recorded in PROMIS data system; and
- trends in public order incidents and apprehensions for public drunkenness as reported by NT Police.

Each of these is elaborated below.

Trends in alcohol sales

The NT Alcohol Data Unit collates quarterly reports on supplies of liquor by wholesalers to retail outlets in the NT, as reported to the NT Licensing Commission. These amounts are converted to equivalent amounts of pure alcohol, using conversion factors based on the percentage of alcohol normally contained in various beverage categories. Data generated by these conversions can then be used to track amounts of pure alcohol (as well as amounts of various beverage types) supplied to individual outlets. In order to respect commercial confidentiality, outlets can be grouped – for example into public hotels, clubs, off-licenses and other outlets.
Emergency Department presentations for injuries and alcohol-related disorders

The NT Department of Health collects data on presentations at Emergency Departments. Two groups of conditions are particularly relevant:

- injuries, classified under the International Classification of Diseases as codes S00 to T14 (World Health Organization, 2007). These are itemized in Table 1 below.
- ‘mental and behavioural disorders due to alcohol use’ (codes F10.0 – F10.9) (itemized in Table 2).

ED records also distinguish males and females, Indigenous and non-Indigenous persons. These variables should be included in data collected for monitoring and evaluation.

### Table 1: Injury codes used in examination of Emergency Department presentations (ICD10)

<table>
<thead>
<tr>
<th>ICD10 code</th>
<th>ICD10 description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S00-S09</td>
<td>Injuries to the head</td>
</tr>
<tr>
<td>S10-S19</td>
<td>Injuries to the neck</td>
</tr>
<tr>
<td>S20-S29</td>
<td>Injuries to the thorax</td>
</tr>
<tr>
<td>S30-S39</td>
<td>Injuries to the abdomen, lower back, lumbar spine and pelvis</td>
</tr>
<tr>
<td>S40-S49</td>
<td>Injuries to the shoulder and upper arm</td>
</tr>
<tr>
<td>S50-S59</td>
<td>Injuries to the elbow and forearm</td>
</tr>
<tr>
<td>S60-S69</td>
<td>Injuries to the wrist and hand</td>
</tr>
<tr>
<td>S70-S79</td>
<td>Injuries to the hip and thigh</td>
</tr>
<tr>
<td>S80-S89</td>
<td>Injuries to the knee and lower leg</td>
</tr>
<tr>
<td>S90-S99</td>
<td>Injuries to the ankle and foot</td>
</tr>
<tr>
<td>T00-T07</td>
<td>Injuries involving multiple body regions</td>
</tr>
<tr>
<td>T08-T14</td>
<td>Injuries to unspecified part of trunk, limb or body region</td>
</tr>
</tbody>
</table>

### Table 2: Codes used to examine trends in presentations for mental and behavioural disorders due to alcohol

<table>
<thead>
<tr>
<th>ICD10 code</th>
<th>ICD10 description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10.0</td>
<td>Mental &amp; behavioural disorder due to alcohol use acute intoxication</td>
</tr>
<tr>
<td>F10.1</td>
<td>Mental &amp; behavioural disorder due to harmful alcohol use</td>
</tr>
<tr>
<td>F10.2</td>
<td>Mental &amp; behavioural disorder due to alcohol – dependence syndrome</td>
</tr>
<tr>
<td>F10.3</td>
<td>Mental &amp; behavioural disorder due to alcohol withdrawal state</td>
</tr>
<tr>
<td>F10.4</td>
<td>Mental &amp; behavioural disorder due to alcohol use - withdrawal state with delirium</td>
</tr>
<tr>
<td>F10.5</td>
<td>Mental &amp; behavioural disorder due to alcohol use - psychotic disorder</td>
</tr>
<tr>
<td>F10.6</td>
<td>Mental &amp; behavioural disorder due to alcohol use - amnesic syndrome</td>
</tr>
<tr>
<td>F10.7</td>
<td>Mental &amp; behavioural disorder due to alcohol - residual &amp; late onset psychotic disorder</td>
</tr>
<tr>
<td>F10.8</td>
<td>Mental &amp; behavioural disorder due to alcohol – other mental &amp; behavioural disorders</td>
</tr>
<tr>
<td>F10.9</td>
<td>Mental &amp; behavioural disorder due to alcohol – unspecified mental &amp; behavioural disorders</td>
</tr>
</tbody>
</table>

Hospital separations for injuries and alcohol-related disorders

Quarterly data for the same ICD-10 codes should also be collated for hospital separations. Two approaches will be taken to the gathering of the hospital separations.

1. Place-based: where the person is recorded as having come from (this may or may not be the community from which the person is usually resident), and...
2. Community-based: linking the person’s individual HRN (unique identifier) to the community from which they are a usual resident.

This approach will allow for some assessment of how a community’s AMP may or may not lead to people moving into regional centres (as an unintended consequence of AMP or other contextual factors occurring in the community).

Alcohol-related assaults

Trends in assaults recorded in the NT Police PROMIS (Police Real-time Online Management Information System) data base can be monitored as an indicator of alcohol-related violence. As Table 3 shows, records distinguish assaults according to both alcohol involvement and association with domestic violence.

<table>
<thead>
<tr>
<th>Table 3: Assaults as recorded in PROMIS database</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Offence type</strong></td>
</tr>
<tr>
<td>Alcohol-related</td>
</tr>
<tr>
<td>Not alcohol-related</td>
</tr>
<tr>
<td>Alcohol involvement not known</td>
</tr>
</tbody>
</table>

Total alcohol-related assaults

Total assaults

Anti-social behaviour incidents & apprehensions for public drunkenness

‘Incidents’ are events that come to the attention of police – whether from their own observations or reports by other persons – that may or may not lead to an offence being recorded. Categories that most typically reflect levels of alcohol-related anti-social behaviour are recorded under one or other type of ‘disturbance’, ‘drunk person’ or ‘drunk driver’. In addition, police record apprehensions for public drunkenness, and whether persons apprehended are taken to police cells or the sobering-up shelter. Data items suited to monitoring trends are itemized in Table 4 below.

<table>
<thead>
<tr>
<th>Table 4: Incidents as recorded by police</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Event</strong></td>
</tr>
<tr>
<td>Disturbance</td>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Drunk driver</td>
</tr>
<tr>
<td>Drunk person</td>
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<tr>
<td>Apprehensions for public drunkenness</td>
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</table>
Next steps

As mentioned above, this scoping paper represents the first steps, rather than the last word, in developing an Evaluation Framework for AMPs under Stronger Futures. Comments are welcome.

Once the scoping paper is finalised and accepted, we will move onto the next stages. Exact data specifications will need to be formulated and close liaison with key data personnel within departments providing data will be needed to ensure data requirements are met and limitations associated with the process can be documented. Evaluating the impact and effectiveness of AMPs will provide communities, governments and non-government agencies with evidence about what does and does not work in minimising harms associated with excessive alcohol consumption. Populating the Evaluation Framework with data and information from a range of sources will require buy-in and cooperation across government departments, service agencies and participating communities. However, there is great opportunity to value-add to these existing administrative data sources, improve the quality of these data over time and incorporate salient community perspectives.
## Appendix 1: Place-based AMP Evaluation workshop participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Alley</td>
<td>Department of Business - Alcohol Policy &amp; Strategy</td>
</tr>
<tr>
<td>Veronica Snook</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Moira McCreesh</td>
<td>Department of Business - Alcohol Policy &amp; Strategy</td>
</tr>
<tr>
<td>Vivienne Blandy</td>
<td>Department of Business - Alcohol Policy &amp; Strategy</td>
</tr>
<tr>
<td>Carolyn Whyte</td>
<td>Department of Attorney General and Justice</td>
</tr>
<tr>
<td>Katherine Van Gurp</td>
<td>NT Police</td>
</tr>
<tr>
<td>Camille Damaso</td>
<td>Department of Chief Minister</td>
</tr>
<tr>
<td>Jo Wright</td>
<td>Department of Health -</td>
</tr>
<tr>
<td>Tanya Salabay</td>
<td>Department of Community Services</td>
</tr>
<tr>
<td>Jo Murray</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Zoe Langridge</td>
<td>NT Police</td>
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<tr>
<td>Kaitlyn Goodger</td>
<td>NT Police</td>
</tr>
<tr>
<td>Michelle Brown</td>
<td>Department of Business</td>
</tr>
<tr>
<td>Steve Guthridge</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Jacqui Pearce</td>
<td>Australian Government Department of Prime Minister and Cabinet</td>
</tr>
<tr>
<td>Jenny Scott</td>
<td>Consultant – Power Waterhouse and Company</td>
</tr>
<tr>
<td>David Cooper</td>
<td>Aboriginal Medical Services Alliance of the Northern Territory [AMSANT]</td>
</tr>
<tr>
<td>Professor Peter d’Abbs</td>
<td>Menzies - Substance Misuse Studies</td>
</tr>
<tr>
<td>Professor Richard Midford</td>
<td>Menzies/CDU - Centre for Child Development &amp; Education</td>
</tr>
<tr>
<td>Dr Matt Stevens</td>
<td>Menzies - Wellbeing and Preventable Chronic Disease</td>
</tr>
</tbody>
</table>
References


Australian Bureau of Statistics. (2007). Housing and Infrastructure in Aboriginal and Torres Strait Communities, Australia, 2006 Cat. no. 4710.0. Canberra: Commonwealth of Australia.


Northern Territory Liquor Act, Northern Territory Government.


