Ipsos
Social Research Institute

CEA 'Framework for Action' Review

Research Report

Prepared for the NSW Ministry of Health

Ipsos SRI Project 11-025225-01

Date: 20 December 2011

Project Contacts: Ben Barnes and Will Tregoning

Mailing address: Level 13, 168 Walker St
NORTH SYDNEY
NSW 2060

Office location: Level 13, 168 Walker St
NORTH SYDNEY
NSW 2060

Office phone: (02) 9900 5100

Email: ben.barnes@ipsos.com or
will.tregoning@ipsos.com

CONTENTS

1

1. EXECUTIVE SUMMARY

1.1 Consultation objectives

In the light of substantial changes since 2000 in the number of Community Drug Action Teams (CDATs) in NSW, the broadening of issues addressed by CDATs, and changes in the policy context within which CDATs operate, the NSW Health Mental Health Drug and Alcohol Office (MHDAO) required a review of CDATs and their 'Framework For Action'. Ipsos Social Research Institute (SRI) was commissioned to undertake consultation with key stakeholders to inform the revision of the 'Framework for Action'. The aim of the consultation was to provide detailed feedback from stakeholders on the following issues.

- Preferred remit of CDATs.
- Aspects of the current CDAT approach that were working well, and those not working so well.
- Main problems currently faced by CDATs.
- Opinions on governance structure for CDATs.
- CDAT resourcing needs and sources.

1.2 Consultation method

The consultation comprised qualitative and quantitative components. The qualitative research commenced with a review of select policy documents provided by MHDAO, with the aim of informing subsequent discussions with stakeholders. Depth interviews were conducted with n=11 key informants, and consultation forums were conducted with a total of n=57 program stakeholders. One consultation forum was conducted with a total of 19 stakeholders from MHDAO; CEA Project Officers; and representatives from the Network of Alcohol and Other Drug Agencies (NADA) and other agencies. The second and third forums were conducted with a total of 38 CDAT

members. The quantitative phase comprised an online survey completed by n=310 CDAT members and other stakeholders.

1.3 Consultation findings

CDAT membership profile

- The majority of CDAT members who responded to the online survey were either employees of non-government or community managed organisations (38%), or NSW Government employees (31%). Ten percent of CDAT members who completed the survey were local residents.

- Among CDAT members who were NSW government employees, most reported that they worked in health services (Drug and Alcohol, Mental Health, or another health service).

- Non-members cited time constraints as the main reason for not being a member. Many former members said that there was no CDAT operating in their local area any more.

Perceived key aspects of CDAT approach

- Participants in the consultation generally thought that CDATs were, and should remain, focussed on health promotion related to drug and alcohol abuse.

- The use of evidence-based practices to minimise the harms associated with drug and alcohol abuse was seen as a core value of CDATs.

- Participants in the consultation generally thought that the key activity of CDATs was to build partnerships and networks within communities to address issues related to drug and alcohol abuse. This view was especially common among current CDAT members.

- The consultation identified that there were two distinct schools of thought about the way that CDATs had operated and should operate. Some participants in the consultation saw CDATs as vehicles for interagency networking, whereas others emphasised the centrality of community participation (where 'community' was understood as primarily comprising local residents and business people, as distinct from people who worked in organisations providing social services).

Perceived strengths of CDATs

- CDAT members who responded to the survey were asked to identify the strengths of their CDAT. They most often reported that the strengths of their CDAT were the commitment,

diversity or teamwork of their members; the strength of their CDATs' local networks; and the involvement of the community.

- When reflecting on the strengths of their CDAT, survey respondents only rarely mentioned the quality of the projects that their CDAT was undertaking.

Perceived key practical issues affecting CDATs

- It was noted that the total number of CDATs in the state were unevenly distributed among the Project Officers such that the amount of support that CDATs received from Project Officers varied substantially.

- Fourteen percent of CDAT members who completed the survey disagreed to some extent that their CDAT received enough support from their Project Officer. These respondents most frequently wanted their Project Officer to be more available to them and/or to regularly attend their CDATs' meetings and events.

- Attracting new CDAT members, training members, filling CDAT executive roles, and getting funding for projects and activities were identified as issues to be addressed.

- The voluntary nature of CDAT membership and the competing demands on members' time were seen as factors that limited CDATs' efficiency.

Ways to increase effectiveness and impact of CDATs

- Participants in the initial qualitative phase thought CDATs' primary needs were more Project Officer support in those areas where there were a disproportionate ratio of CDATs to Project Officers; better partnerships with key agencies other than Health; and better collaboration and knowledge sharing among CDATs.

- In the online survey, CDAT members most often suggested 'more funding' and 'more members' as ways to improve the effectiveness and impact of their CDAT. Only 8% mentioned needing more support from their Project Officer, however this small proportion might simply reflect the unequal distribution of this problem among CDATs.

Perceived clarity of role and purpose of CDATs

- There was general agreement that there was a need for greater clarity about the role, purpose and objectives of CDATs. For participants in the initial qualitative phase, clarity about role and purpose was seen as a way to prevent CDATs from floundering through lack of understanding about that they were supposed to be doing.

- Among the survey respondents, current members were significantly more likely than others to report that the role and purpose of CDATs was 'very clear' to them (59% compared with 46% overall).

- In the online survey, only 3% of current CDAT members described the role and purpose of CDATs as 'not at all clear', but nevertheless 75% thought that the role and purpose of CDATs should be spelled out more clearly.

- Survey respondents most frequently wanted greater clarity about what CDATs were actually doing; the objectives of the CDAT program and the role of individual CDATs; the importance of community participation and priority setting; and how CDATs could work with other programs or organisations.

Current and preferred target issues

- CDATs were reportedly working primarily on drug and alcohol-related issues, with a particular focus on addressing issues associated with drug and alcohol abuse by young people. There was a general agreement among consultation participants that drug and alcohol issues should remain the focus of CDATs.

- There was a cautious openness among consultation participants towards the idea that CDATs could take on a broader range of issues. This idea was supported because addressing issues related to drug and alcohol abuse was seen to require a holistic approach.

- Community wellbeing, mental health and suicide prevention were the most popular non-drug-and-alcohol issues for CDATs to add to their remit.

Perceptions of broadening of remit of CDATs

- Some participants in the qualitative phase and a substantial minority of respondents in the online survey were concerned about a potential broadening of the remit of CDATs.

    - The key concern for CDAT members was being stretched too thinly across a greater number of issues. Almost half of current members expressed this concern, even while they also supported the idea of taking on more issues. This suggests that members would like to be able to take on a wider range of issues, but that a requirement to do so might lead to substantial loss of current membership.

    - There was a perception among participants in the qualitative phase that each CDAT should be given the autonomy to determine whether or not they would address broader health and social issues related to drug and alcohol use, and to identify

appropriate projects that would address those issues conjointly. There was a strong sense that CDATs should not be *required* to address a broader range of issues.

- Another concern that was raised about a broader remit was that the focus of CDATs might shift away from drugs and alcohol. Such a shift was generally not supported by consultation participants.

- A majority of survey respondents reported that they were not concerned about a broadening of the remit of CDATs. Reasons given for this lack of concern included that they favoured a holistic approach to addressing social issues including those related to drug and alcohol; or that they thought that the CDAT approach would be useful for addressing a wider range of issues.

Perceived key considerations when deciding future hosting arrangements for CDATs

- During the qualitative phase, participants generally observed that they had insufficient information about the various hosting arrangements under consideration to be able to make an informed choice between them. However, participants were able to identify what they saw as the key considerations in deciding on future hosting arrangements. For this reason, survey respondents were not asked to vote on a future hosting model, but were instead asked to indicate what they thought were the key considerations in deciding on future hosting arrangements. The key considerations were developed on the basis of views expressed during the qualitative phase. All considerations were seen as 'very important' by substantial majorities of respondents, with the only exception being 'simplify the auspicing arrangements for CDATs' which was seen as very important by a slight majority (51%).

- Participants in the qualitative phase were able to identify various advantages and disadvantages of retaining the current hosting arrangements, or devolving hosting to one or many NGOs.

    - Participants observed that an advantage of the current arrangement was that NSW Health had a presence across the whole state; that being under the umbrella of the Ministry of Health meant that Health employees were more likely to attend; and that being under the umbrella of a government department in general gave the program a legitimacy that facilitated the involvement of other departments, agencies and organisations.

    - NSW Health did receive some criticism as host, due to what were perceived as its time-consuming bureaucratic processes and its lack of experience and expertise in community engagement.

- Few stakeholders recommended devolvement to the NGO sector but nevertheless, improved community involvement and reduced administrative burden were identified as possible benefits of devolvement.

- Concerns with devolvement to the NGO sector were the loss of the current benefits associated with being under the umbrella of NSW Health, and uncertainty about to the agenda of an NGO host (for example, whether harm minimisation would be supported fully).

- Survey respondents were given the opportunity to provide open-ended comments about future hosting arrangements. The most common response, given by 11% of all respondents and 13% of respondents who were current CDAT members, was that current arrangements should be retained.

- Participants generally thought that, under any possible arrangement, NSW Health's role should include providing clear policy directives; funding; guidance on resource development; and expertise and evidence in the field of drug and alcohol health promotion. Participants often specified that they thought that the policy directives from NSW Health should provide CDATs with direction while allowing CDATs a degree of autonomy.

2

2. CONSULTATION CONTEXT

2.1 Background

The NSW Drugs and Community Action Strategy (2000)[1] was developed in response to community demand at the NSW Drug Summit in 1999[2]. In the years since the Strategy introduced the concept of Community Drug Action Teams (CDATs) much has changed. Among these changes, policy and funding and delivery responsibility moved from the Department of the Premier to NSW Health in 2005; and hosting of the regional Community Engagement & Action Program (Project Officers) was devolved to Area Health Services (now Local Health Districts (LHDs)) in 2008.

CDATs continue to work primarily to reduce drug and alcohol related harms. Over the years, however, the scope of CDAT activities has diversified to include areas such as mental health, personal resilience, social connection and community capacity building through skill development and engagement. Currently, there are more than 80 active CDATs who provide nearly 160 community-based activities annually, involving over 1000 people delivering those activities.

In addition to the changes outlined above, and described in more detail below, 2011 saw the election of a new NSW Government with a significant policy focus on healthy communities, as well as continuing National Health Reform and the establishment of new Local Health Districts. In the light of these changes, a review of CDATs and the framework within which they operate was required.

[1] New South Wales Premier's Department, 2000, *NSW Drugs and Community Action Strategy: Framework for Action*, Sydney, NSW Premier's Department.
[2] NSW Government, 1999, *NSW Drug Summit Government Plan of Action*, Sydney, NSW Government.

CDATs and their evolution

A timeline of the evolution of CDATs is shown in Figure 1 below. Further detail about key documents in this timeline is provided below the figure.

Figure 1: Timeline of evolution of CDATS

1999	At NSW Drug Summit, community leaders requested greater involvement in drug policy and action.
2000	'Framework For Action' published, introducing the Community Engagement and Action (CEA) program and CDATS as the primary instrument of the CEA. CDATs were organised in nine regions. Focus on illicit drugs. Overseen by Community Drugs Strategies (CDS), within Department of Premier (DP).
2003	Evaluation of CDATs conducted by Evaluation Unit within the Office of the Director-General of the Premier's Department. Alcohol misuse added to remit of CDATs.
2005	CDS moved from DP to NSW Department of Health.
2006	Second evaluation of CDATs conducted by Eureka Strategic Research.
2007	CDS became part of NSW Health Mental Health and Drug and Alcohol Office (MHDAO). MHDAO reviewed governance options and recommended devolving management of CDATs to non-government sector, or Area Health Services, while retaining small team for policy development and oversight within Department of Health.
2008	Area Health Services funded until July 2011to host Project Officers. Number of CDATs reached 80. Need for review of CDATs and Framework identified. MHDAO requested approval to develop new Framework for Action, including potential devolvement of PO roles to non-government sector.
2009	Project Manager (PM) appointed to oversee Project Officers. Review of CEA initiated, undertaken by PM, examining functions of CDATs, future activities, and governance.
c. April 2010	PM resigned without completing the consultation. Consultation had been conducted with five AHS D&A directors; MHDAO; the Network of Alcohol and Other Drug Agencies (NADA); and three CEA POs
May 2010	NSW Health Drug and Alcohol Council approved in principle to devolve the delivery of CEA to the non-government sector, and advised that NADA work with MHDAO to develop a transition plan and outline a 'Framework for Action'.
July 2010	NADA submited proposal to undertake consultation with CDATS and other community members to review framework; geographical boundaries for administration; and governance arrangements to support CDATS in transition to NGO sector.
August 2010	MHDAO briefed minister on devolvement to NGO sector. Transfer not supported by minister as 'outcome of discussions with Commonwealth on D&A services' not yet clear.
May 2011	Ipsos Social Research Institute commissioned to undertake the current consultation.

The *NSW Drugs and Community Action Strategy* (2000) was developed in response to community demand at the NSW Drug Summit in 1999 and specifically aimed to achieve the following objectives:

- enhance stakeholder and community participation in developing and implementing strategies to deal with regional and local issues;
- facilitate better coordinated and collaborative action by government, non-government agencies and community groups in relation to illicit drugs;
- provide greater stakeholder and community awareness of the causes, incidence and impacts of illicit drugs, and of the Government's strategies to address these problems;
- provide more customised responses by governments and others to meet the varying circumstances of different communities (geographic and cultural);
- create more effective links with, and mobilisation of resources from, other funding programs and initiatives; and
- encourage better alignment of the priorities and efforts of government at local, regional, State and national levels.[3]

The Strategy introduced the concept of Community Drug Action Teams (CDATs) and described a 'Framework for Action' under which these were to operate. The 'Framework for Action' was intended as a guide to assist the work of CDATs in reducing the impact of drugs and alcohol in their local communities, rather than a policy document.

The 'Framework for Action' outlined the tasks assigned to individual CDATs. In implementing the Strategy at the local level it was intended that, with the support of their Regional Project Manager, CDATs would undertake the following activities.

- Consult with their local community on illicit drug-related issues.
- Maximise links wherever appropriate with other local and regional initiatives (e.g. Families First, Safer Towns and Cities, Local Government programs and school programs that have a 'whole of school' perspective).
- Develop alliances that promote shared responses to drug issues and avoid duplication of effort.
- Promote innovative ways to deal with resource needs.

[3] New South Wales Premier's Department, 2000, *NSW Drugs and Community Action Strategy: Framework for Action*, Sydney, NSW Premier's Department.

- Develop and implement a Local Drug Action Plan to Regional Coordination Management Group and/or Regional Drug Advisory Group.
- Facilitate community education campaigns on illicit drug issues in their localities.
- Disseminate information developed through the Community Drug Information Strategy.
- Encourage and assist key agencies and individuals (who do not normally implement activities to address drug issues) to incorporate practices into their work.[4]

A comprehensive evaluation of the first four years (1999/2000 – 2000/2003) of the CDAT Program was conducted by the Evaluation Unit within the Office of the Director-General of the Premier's Department in 2003. The Government's response to the recommendations in the report included an outline of the following proposed actions: refine the Strategy direction in an updated Strategic Framework with revised plans; develop an Evaluation Framework, with data collection and performance indicators at the local, regional and state levels; and prioritise capacity and skill-building activities for CDATs.

In 2006, Eureka Strategic Research conducted a comprehensive evaluation of the second four years of the CDAT Program (2003/2004 - 2006/2007)[5]. The evaluation, which examined whether the CDAT Program was operating efficiently and effectively, again recognized a need for a review of the Framework. It was recommended that the document be updated to reflect best elements of current practice and redirect efforts where practice fell short; provide executives with the opportunity to think deeply about the program's future and how to achieve it; and finally to refresh, refocus and re-launch the program. The evaluation highlighted the need for clearer demonstration of high-level support for CDATs; clarification of CDATs' place and importance within a broader strategy; and promotion of CDAT successes as a way of building broader credibility for CDATs and consistency among CDATs.

In a request for approval to develop a new framework, submitted to the Minister for Health in September 2008[6], the need to respond to issues identified in the two evaluations conducted to date was outlined. The submission stated that there had been a marked decline in the relevance of the 'Framework for Action' (2000) due to a number of factors. These included the following:

- alcohol misuse was added to CDATs' remit in 2003;

---

[4] New South Wales Premier's Department, 2000, *NSW Drugs and Community Action Strategy: Framework for Action*, Sydney, NSW Premier's Department.

[5] Eureka Strategic Research, 2006, *Evaluation report on the Community Drug Action Team Program,* Sydney, [prepared for NSW Department of Health]

[6] Moore, R, 2008, 'Request for approval to develop a new framework of action for CDATS', Sydney [briefing to the Minister for Health]

- Community Drugs Strategies (CDS) moved from Department of Premier and Cabinet (DPC) to NSW Health in 2005;
- CDS became part of Mental Health and Drug and Alcohol Office (MHDAO) in 2007;
- regional staff 'devolved to and managed by' the eight Area Health Services (AHSs); and
- the number of CDATs increased from 3 in 2000 to 80 in 2008.

The request identified a need for the Framework to integrate with NSW State Plan and NSW Health Plan; MHDAO plans; 'new community engagement and action strategies'; and potential changes to governance.

2.2 Consultation objectives

In the light of substantial changes in the number of CDATs in NSW, the broadening of issues addressed by CDATs, and changes in the policy context within which the CEA Program was operating, a review of CDATs and the 'Framework for Action' was required. MHDAO established an Advisory Group to assist it in the development of a new Framework. Ipsos Social Research Institute (SRI) was commissioned to undertake this consultation with key stakeholders of the CEA Program, to form a basis for the revision of the 'Framework for Action'. The aim of the consultation was to provide detailed feedback from stakeholders on the following issues.

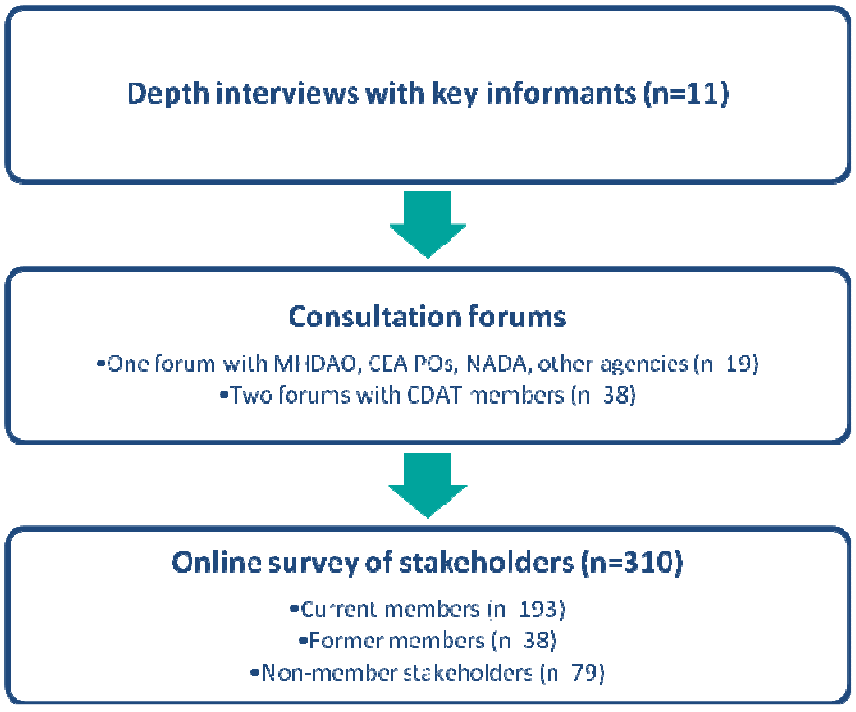
- Preferred remit of CDATs.
- Aspects of the current CDAT approach that were working well, and those not working so well.
- Main problems currently faced by CDATs.
- Opinions on governance structure for CDATs.
- CDAT resourcing needs and sources.

3

3. CONSULTATION METHOD

The consultation comprised qualitative and quantitative components. The qualitative research commenced with a review of select policy documents provided by MHDAO, with the aim of informing subsequent discussions with stakeholders. Depth interviews were conducted with n=11 key informants, and consultation forums were conducted with a total of n=57 program stakeholders. The quantitative phase comprised an online survey completed by n=310 CDAT members and other stakeholders.

Figure 2: Research components



Ipsos Social Research Institute

3.1 Qualitative research

The qualitative research commenced with a review of select policy documents provided by MHDAO, with the aim of informing subsequent discussions with stakeholders. A summary of these documents is provided in the Background section of Chapter 2 of this report.

For the qualitative phase of the research, a discussion guide was developed by Ipsos SRI in consultation with NSW Health MHDAO and the Framework for Action, Related Governance, Delivery and Resourcing Project Advisory Group (the Advisory Group). The discussion guide covered the following areas:

- Perceptions of the values and practices central to CDATs
- Preferences for the role and purpose of CDATs
- Practical issues affecting CDATs
- Views on CDAT governance and support arrangements

The discussion guide was used for the depth interviews and for the consultation forums. It is included as Appendix A of this report.

Eleven depth interviews were conducted with key informants to the review. Interviews were conducted over the telephone by Ipsos SRI project team members. Each interview lasted for approximately 45 minutes.

Subsequently, three three-hour consultation forums were conducted. A total of 57 stakeholders attended one of the three forums. One forum was conducted with a total of 19 stakeholders from MHDAO; CEA Project Officers; and representatives from the Network of Alcohol and Other Drug Agencies (NADA) and other agencies. The second and third forums were conducted with a total of 38 CDAT members.

Analysis of qualitative research

Interviews and forums were audio recorded. Immediately following each interview the facilitator took detailed notes, organised by key themes. For the forums, an Ipsos SRI team member took detailed notes during the discussion. Analysis was conducting using these notes, with reference to the audio recordings where necessary to check that the notes accurately reflected what was said by the participants. Findings from the interviews and forums were organised under the key themes and synthesised. Checking of qualitative data was then conducted via an iterative process in which emerging hypotheses were tested and retested by going back to examine notes and recordings.

3.2 Quantitative research

Following the analysis of data from the qualitative phase, a questionnaire for the online survey was devised by Ipsos SRI in consultation with MHDAO and the Advisory Group. The questionnaire was informed by views expressed by participants in the qualitative phase.

The survey was conducted online, with the option for respondents to complete the survey on paper if they did not have internet access. No respondents took up the option to complete a paper version of the survey.

The online survey was programmed and hosted by I-View, Ipsos' fully owned fieldwork subsidiary. A link to the survey was direct-mailed to a list compiled by CEA Project Officers. The lists comprised the email addresses of CDAT members and other stakeholders in each Project Officer's area. A website was also set up where potential respondents who were not on the list could go and enter their email address to have a survey emailed to them. The link to this site was circulated by Project Officers through their networks, and to NADA members.

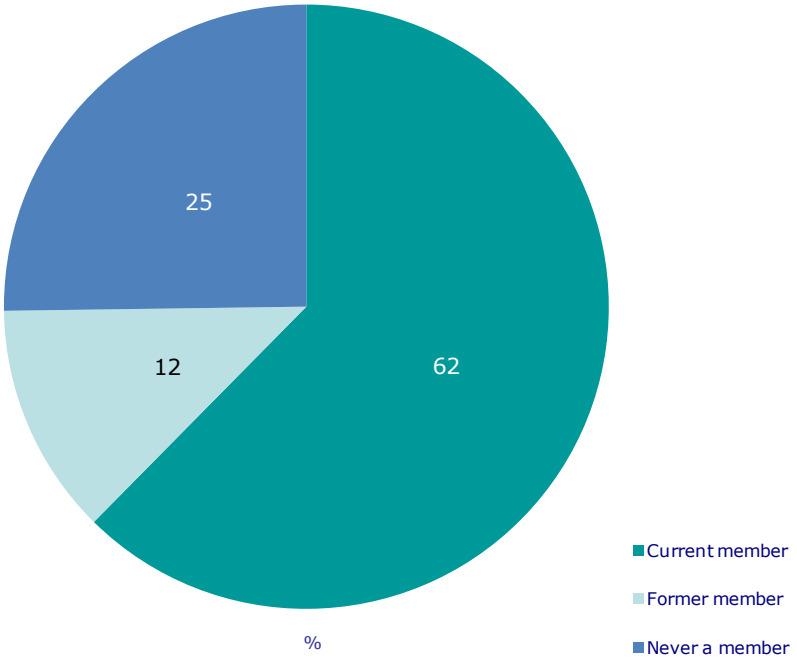
Fieldwork took place over a three week period between September 29 and October 21 2011. During this fieldwork period, Project Officers reported that some people on the sample list had not received the emailed survey, apparently because the email had been blocked by their spam filters. For this reason, supplementary fieldwork was carried out between October 21 and November 6 2011. During this stage, an open-access web-hosted survey was set up and a link to the site was sent to all addresses on the original sample list, as well as to Project Officers and to NADA to distribute through their networks.

Online survey respondents

The survey achieved a final sample size of 310.

The Community Drug Action Team (CDAT) membership status of online survey respondents is depicted in Figure 3 overleaf. Nearly two-thirds (62%) of respondents reported that they were current CDAT members. A further 12% reported that they were former members. One-quarter (25%) of respondents reported that they were never CDAT members.

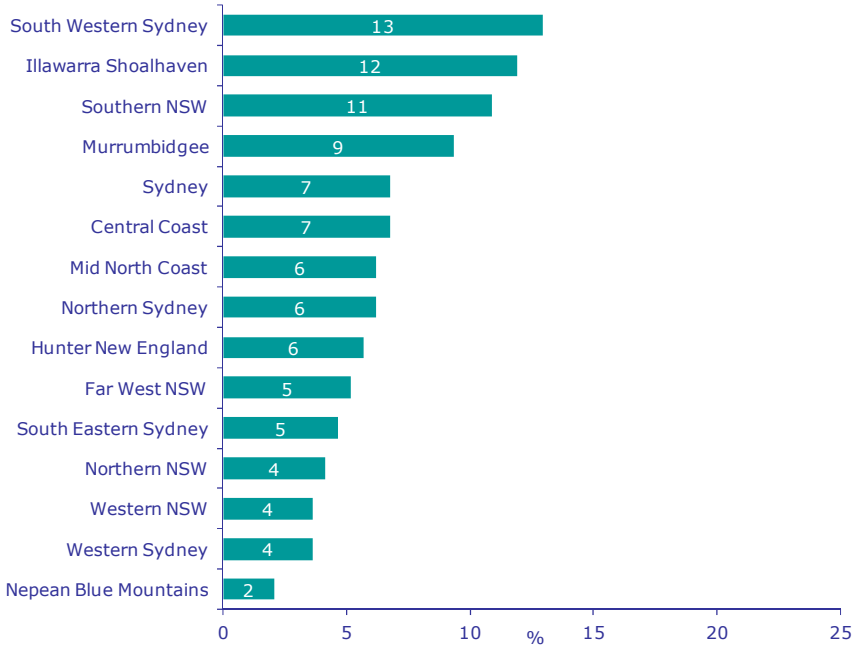
Figure 3: Current CDAT membership status



Q: Current CDAT membership status n=310

The sample composition by regions in which the CDATs of current members were based is depicted in Figure 4 below. The most commonly reported regions were South Western Sydney (by 13% of respondents); Illawarra Shoalhaven (12%); Southern NSW (11%); and Murrumbidgee (9%). In descending order of proportion of the sample, other regions were: Sydney (7%); Central Coast (7%); Mid North Coast (6%); Northern Sydney (6%); Hunter New England (6%); Far West NSW (5%); South Eastern Sydney (5%); Northern NSW (4%); Western NSW (4%); Western Sydney (4%); and Nepean Blue Mountains (2%).

Figure 4: Distribution of CDATs among respondents



Q: In which region is your CDAT based? n=193

Data Analysis

The Ipsos SRI project team conducted statistical analyses on the resulting data using the industry-leading software program SPSS. More complex analyses, including exploring any statistically significant differences between sub-groups of stakeholders, was also conducted where appropriate. The survey results are presented in Section 4 of this report.

Test choice

For categorical data, chi-square tests were used.

For questions asked of all respondents, any significant differences in the data on the basis of CDAT membership status (current member, former member, never a member) are reported.

The effect of LHD location (i.e. metropolitan or regional/rural) on survey responses was also analysed. The questions included in this analysis were those about

- strengths of, and practical issues affecting, CDATs;
- perceived clarity of role and purpose of CDATs;

- concerns regarding the broadening of remit; and
- considerations for future hosting arrangements.

Any relevant significant differences are reported on a question-by-question basis. A significance level of $p<0.05$ has been adopted throughout.

Arrows have been used on charts to signify statistically significant differences. Solid blue arrows alongside a proportion indicate that that proportion is larger (⇧) or smaller (⇩) than would otherwise by expected if there were no statistically significant differences between groups.

It should be noted that due to rounding, percentages in charts for single response questions may not sum to 100%.

For open-ended questions requiring verbatim responses from respondents, responses were coded into relevant categories and only the most frequently mentioned responses have been charted.

4

4. CONSULTATION FINDINGS

4.1 CDAT membership profile

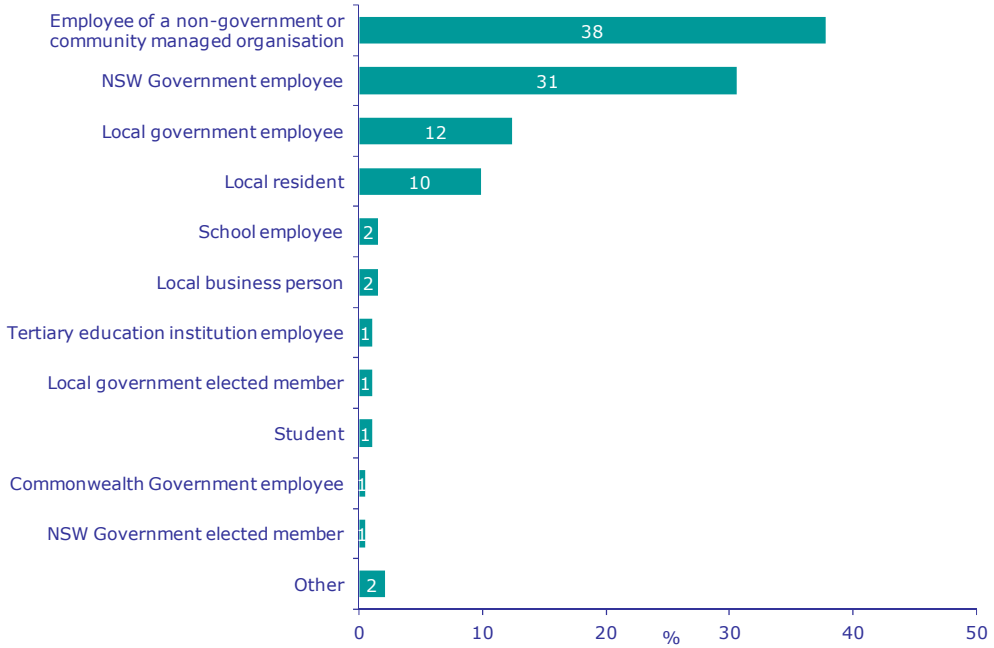
Summary

- The majority of CDAT members who responded to the online survey were either employees of non-government or community managed organisations (38%), or NSW Government employees (31%). Ten percent of CDAT members who completed the survey were local residents.
- Among CDAT members who were NSW government employees, most reported that they worked in health services (Drug and Alcohol, Mental Health, or another health service).
- Non-members cited time constraints as the main reason for not being a member. Many former members said that there was no CDAT operating in their local area any more.

Findings from the quantitative phase

Online survey respondents were asked to indicate the capacity in which they were members of their CDAT, and, where relevant, the type of organisation that they worked for. As depicted in Figure 5 overleaf, nearly two-fifths of respondents reported that they were employees of non-government or community managed organisations (38%) while slightly less than one-third reported that they were NSW Government employees (31%). Twelve percent reported that they were local government employees. One in ten respondents reported that they were local residents (10%). In descending order of proportion of the sample, other reported capacities were school employee (2%); local business person (2%); tertiary education institution employee (1%); local government elected member (1%); student (1%); Commonwealth Government employee (1%); and NSW Government elected member (1%).

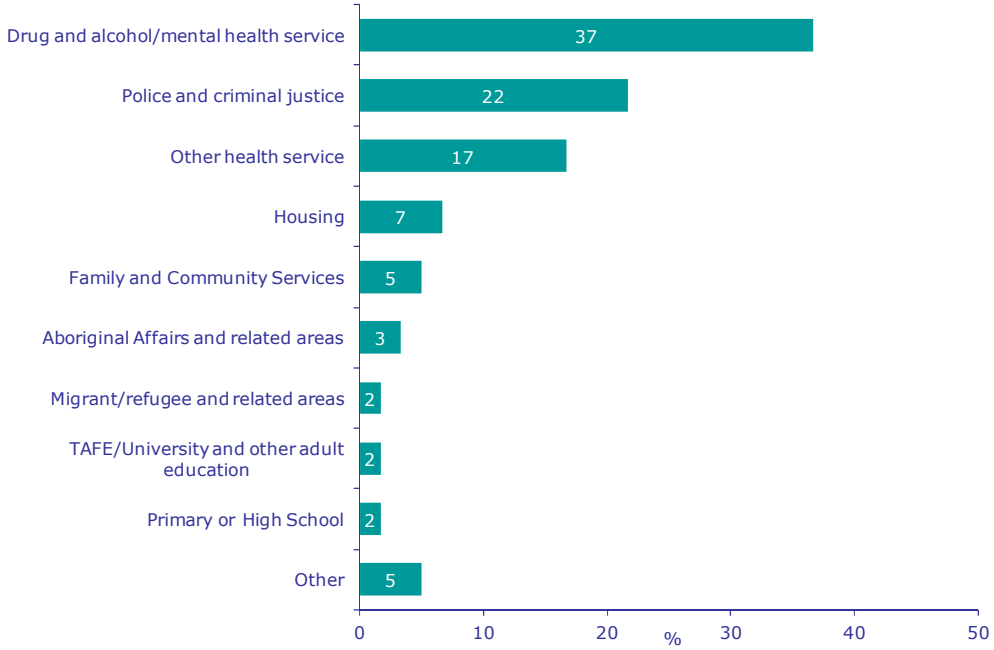
Figure 5: CDAT membership profile



Q: Which of the following best describes you, as a member of your CDAT? n=193

NSW Government employees were asked 'by which type of NSW Government Department or Agency are you employed?' The results are depicted in Figure 6 overleaf. Nearly two-fifths of NSW Government employees reported that they were employed in a drug and alcohol/mental health service (37%). More than one-fifth reported that they were employed by police and criminal justice (22%) and a slightly smaller proportion (17%) reported that they were employed in another health service (i.e. a health service not specifically focused on drug and alcohol and/or mental health). In descending order of proportion of the sample, other reported departments or agencies were housing (7%); family and community services (5%); Aboriginal affairs and related areas (3%); migrant/refugee and related areas (2%); TAFE/University and other adult education (2%); and primary or high school (2%). Five percent of respondents reported that they were employed by another department or agency.

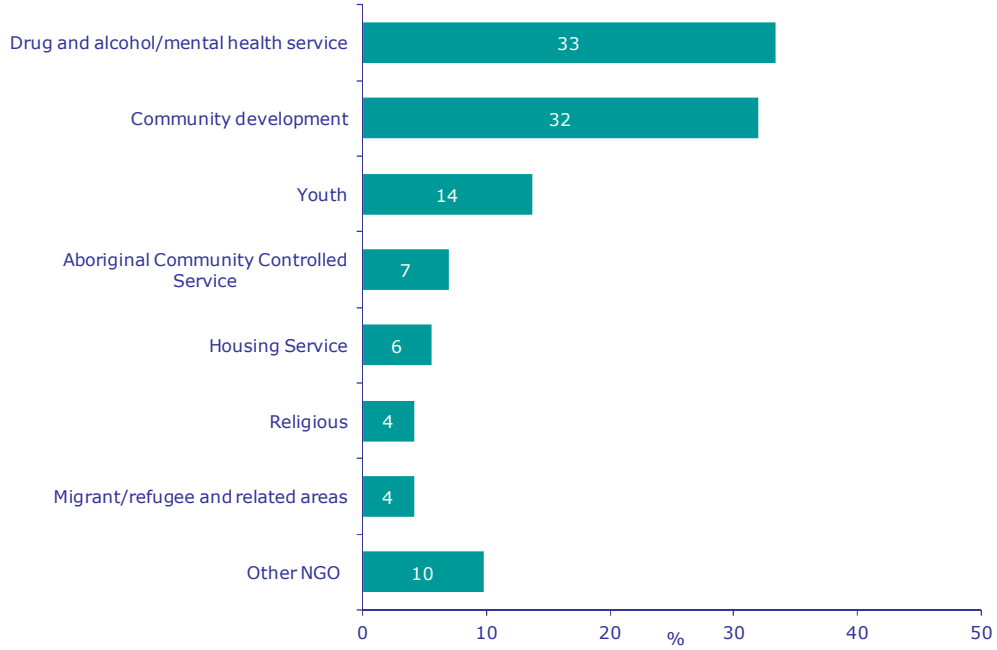
Figure 6: NSW Government employees



Q: By which type of NSW Government Department or Agency are you employed?
n=60

Non-government organisation (NGO) employees were asked 'what kind of non-government or community managed organisation do you work for?' The results are depicted in Figure 7 overleaf. One-third of NGO employees reported working for a drug and alcohol/mental health service (33%) and an almost equal proportion in community development (32%). Fourteen percent reported that they worked for a youth organisation; 7% an Aboriginal community controlled service; 6% a housing service; 4% a religious organisation; and a further 4% an organisation working with migrants and refugees or in related areas. One in ten respondents reported that they worked for another type of NGO (10%).

Figure 7: Non-government organisation employees

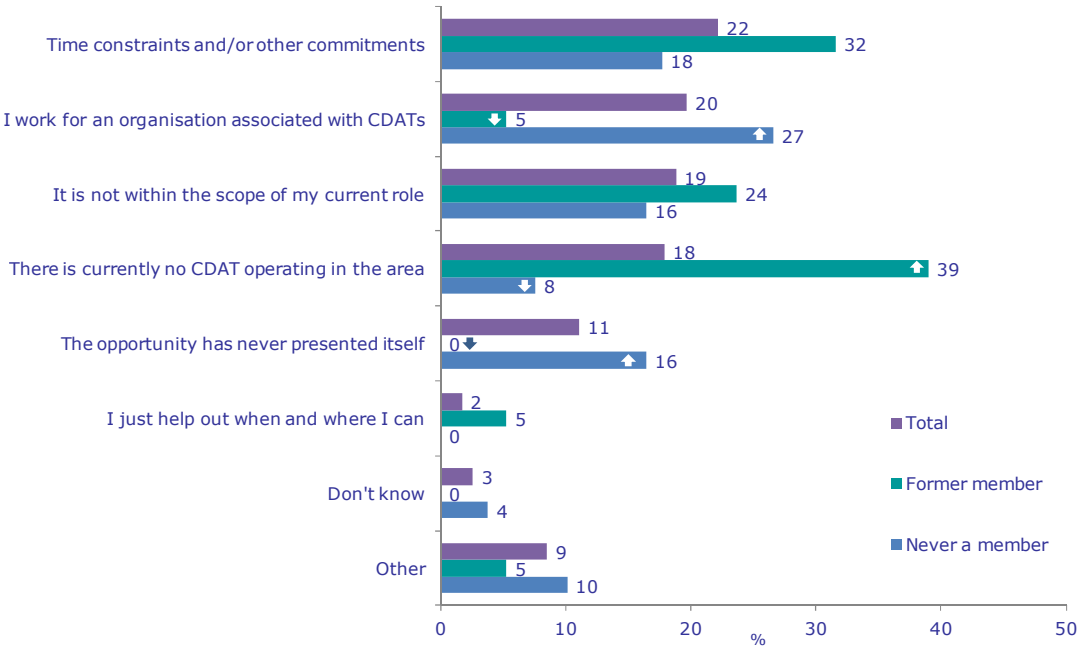


Q: What kind of non-government or community managed organisation do you work for? n=72

CDAT non-members' reasons for not being a member

CDAT non-members were asked 'why do you not currently belong to a CDAT team?' They were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent. The results are depicted in Figure 8 overleaf. Twenty-two percent of non-members gave responses that were coded as 'time constraints and/or other commitments'. Similar proportions were coded as 'I work for an organisation associated with CDATs', 'it is not within the scope of my current role' and 'there is currently no CDAT operating in the area' (20%, 19% and 18% respectively). Eleven percent of respondents gave responses that were coded as 'the opportunity has never presented itself' and two percent 'I just help out when and where I can'.

Figure 8: Reasons why not a CDAT member



Q: Why do you not currently belong to a CDAT team? n=117

The following significant differences were observed between different groups' reasons for not being CDAT members.

- **Former CDAT members** were significantly **less** likely to report 'I work for an organisation associated with CDATs' (5%) and 'the opportunity has never presented itself' (0%) and significantly **more** likely to report 'there is currently no CDAT operating in the area' (39%) compared with all respondents (20%, 11% and 18% respectively).

- Respondents who had **never been CDAT members** were significantly **more** likely to report 'I work for an organisation associated with CDATs' (27%) and 'the opportunity has never presented itself' (16%) and significantly **less** likely to report 'there is currently no CDAT operating in the area' (8%) compared with all respondents (20%, 11% and 18% respectively).

4.2 Perceived key aspects of CDAT approach

Summary

- Participants in the consultation generally thought that CDATs were and should remain focussed on health promotion related to drug and alcohol abuse.
- The use of evidence-based practices to minimise the harms associated with drug and alcohol abuse was seen as a core value of CDATs.
- Participants in the consultation generally thought that the key activity of CDATs was to build partnerships and networks within communities to address issues related to drug and alcohol abuse. This view was especially common among current CDAT members.
- The consultation identified that there were two distinct schools of thought about the way that CDATs had operated and should operate. Some participants in the consultation saw CDATs as vehicles for interagency networking, whereas others emphasised the centrality of community participation (where 'community' was understood as primarily comprising local residents and business people, as distinct from people who worked in organisations providing social services).

Findings from the qualitative phase

Depth interview and consultation forum participants were asked to identify what they saw as the key values and practices of CDATs. Participants generally agreed that the key practice of CDATs was to address drug and alcohol issues, with a focus on health promotion.

Evidence-based practice and harm minimisation were seen as key values for CDATs. Participants considered harm prevention a 'common ground' that was imposed on the program by NSW Health, but they generally did not have a problem with this imposition. It was also noted that definitions or perceptions of what 'harm minimisation' could comprise differed between CDATs.

CDATs practices were seen as based on a holistic approach to drug and alcohol issues that worked by building resilience within communities rather than through a case management approach. Participants thought that a core practice of CDATs was to bring together different individuals and groups within the community to build partnerships, identify local drug-and-alcohol-related problems and work collaboratively to develop and implement local strategies to address those problems. There were mixed views about the extent to which CDATs actually

worked in that way, with some participants observing that CDATs had taken on a narrower role of finding ways to apply NSW Health's projects and campaigns locally.

CDATs were seen as an information exchange between community members, NSW Health and other agencies. Some participants thought that in practice the flow of information was only in one direction: from NSW Health to CDATs.

There were conflicting views about whether it was a core practice for CDATs to operate as an inter-agency, or whether the core of CDATs was community participation. Some thought that the way a CDAT operated could be left up to its membership, such that some could operate as inter-agencies, while others could be primarily comprised of community members with few or no agency workers. Other participants were less catholic in their views and thought that CDATs were less effective if they were only inter-agencies. This latter group thought that CDATs should have it as their core to be a 'broader coalition' with a focus on community development.

Findings from the quantitative phase

In the online survey, respondents were presented with 13 statements about CDATs and asked to indicate for each statement the extent to which they agreed that it described a key strength of the CDAT approach that should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program. The extent of agreement with each of these 13 statements is shown across five separate charts below. The statements have been ordered in descending order of overall agreement.

Figure 9 overleaf shows the three statements that gained the highest overall agreement.

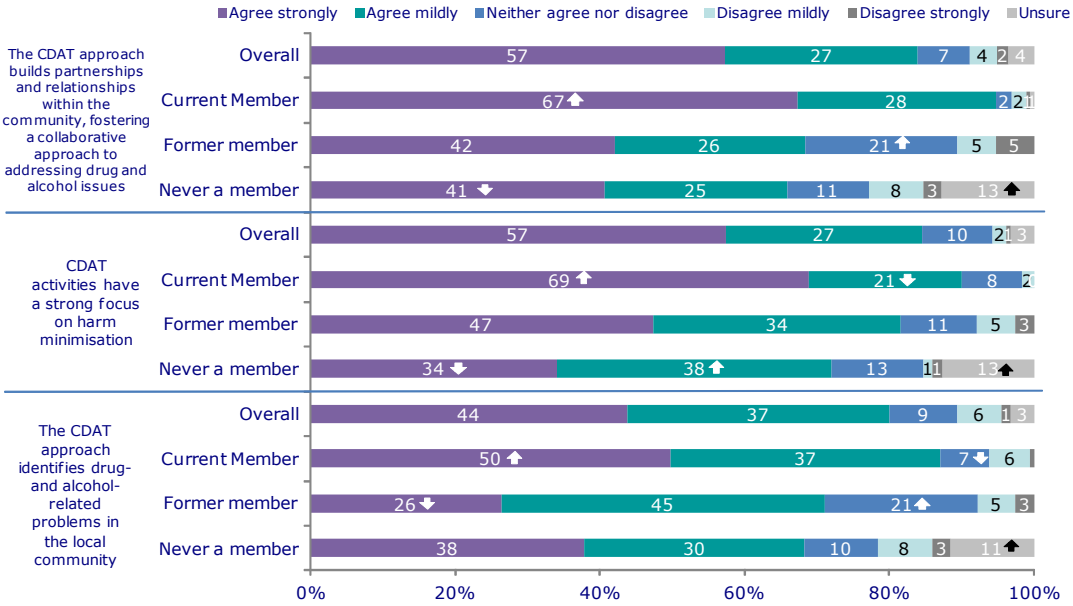
The majority of respondents reported that they agreed strongly that 'the CDAT approach builds partnerships and relationships within the community, fostering a collaborative approach to addressing drug and alcohol issues' (57%) and a further 27% reported that they agreed mildly. Two percent reported that they neither agreed nor disagreed, two percent disagreed mildly and one percent that they disagreed strongly. One percent were unsure.

More than half of respondents reported that they agreed strongly that 'CDAT activities have a strong focus on harm minimisation' (57%) and a further 27% reported that they agreed mildly. One in ten reported that they neither agreed nor disagreed (10%). Two percent of respondents reported that they disagreed mildly and one percent that they disagreed strongly. Three percent were unsure.

Forty-five percent of respondents reported that they agreed strongly that 'the CDAT approach identifies drug and alcohol-related problems in the local community' and a further 37% reported that they agreed mildly. Nine percent reported that they neither agreed nor

disagreed. Six percent of respondents reported that they disagreed mildly and one percent that they disagreed strongly. Three percent were unsure.

Figure 9: Perceived importance of features of CDAT approach



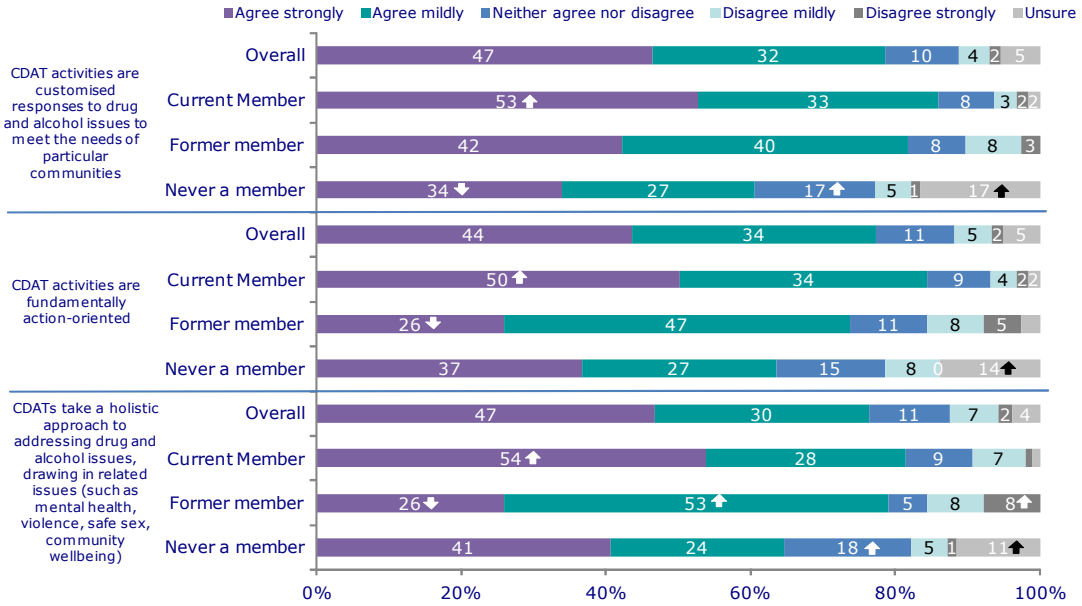
Q: To what extent do you agree that each of the following is a key strength of the CDAT approach and should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program? Base: n=310

Figure 10 overleaf shows that nearly half of respondents reported that they agreed strongly that 'CDAT activities are customised responses to drug and alcohol issues to meet the needs of particular communities' (47%) and a further 32% reported that they agreed mildly. One in ten respondents reported that they neither agreed nor disagreed (10%). Four percent reported that they disagreed mildly and two percent that they disagreed strongly. Five percent were unsure.

Forty-four percent of respondents reported that they agreed strongly that 'CDAT activities are fundamentally action-oriented' and a further 34% reported that they agreed mildly. Eleven percent reported that they neither agreed nor disagreed. Five percent of respondents reported that they disagreed mildly and two percent that they disagreed strongly. Five percent were unsure.

Nearly half of respondents reported that they agreed strongly that 'CDATs take a holistic approach to addressing drug and alcohol issues, drawing in related issues (such as mental health, violence, safe sex, community wellbeing)' (47%) and a further 30% reported that they agreed mildly. Eleven percent reported that they neither agreed nor disagreed. Seven percent of respondents reported that they disagreed mildly and two percent that they disagreed strongly. Four percent were unsure.

Figure 10: Perceived importance of features of CDAT approach



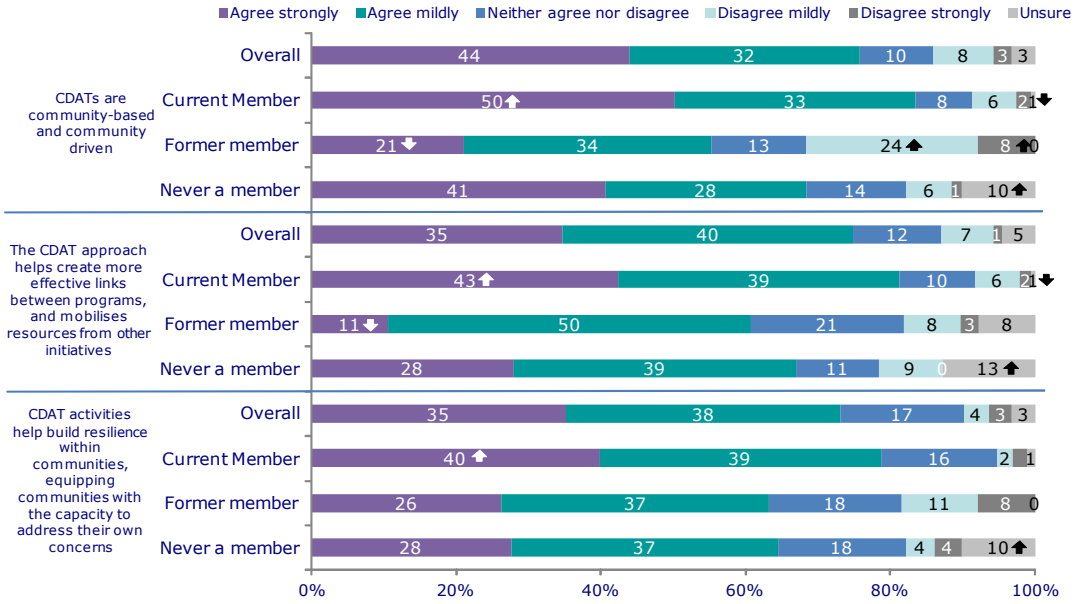
Q: To what extent do you agree that each of the following is a key strength of the CDAT approach and should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program? Base: n=310

Figure 11 overleaf shows that 44% of respondents reported that they agreed strongly that 'CDATs are community-based and community driven' and a further 32% reported that they agreed mildly. One in ten reported that they neither agreed nor disagreed (10%). Eight percent of respondents reported that they disagreed mildly and three percent that they disagreed strongly. Three percent were unsure.

Two-fifths of respondents reported that they agreed mildly that 'the CDAT approach helps create more effective links between programs, and mobilises resources from other initiatives' (40%) and a further 35% reported that they agreed strongly. Twelve percent reported that they neither agreed nor disagreed. Seven percent of respondents reported that they disagreed mildly and one percent that they disagreed strongly. Five percent were unsure.

Nearly two-fifths of respondents reported that they agreed mildly that 'CDAT activities help build resilience within communities, equipping communities with the capacity to address their own concerns' (38%) and a further 35% reported that they agreed strongly. Seventeen percent reported that they neither agreed nor disagreed. Four percent of respondents reported that they disagreed mildly and three percent that they disagreed strongly. Three percent were unsure.

Figure 11: Perceived importance of features of CDAT approach

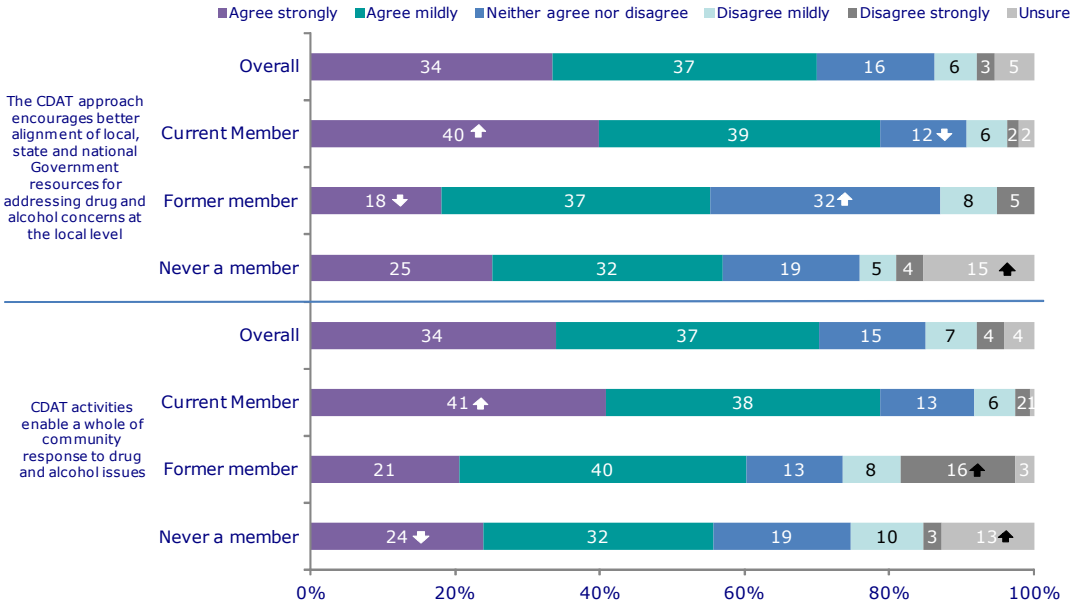


Q: To what extent do you agree that each of the following is a key strength of the CDAT approach and should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program? Base: n=310

Figure 12 overleaf shows that 37% of respondents reported that they agreed mildly that 'the CDAT approach encourages better alignment of local, state and national Government resources for addressing drug and alcohol concerns at the local level' and a further 34% reported that they agreed strongly. Sixteen percent reported that they neither agreed nor disagreed. Six percent of respondents reported that they disagreed mildly and three percent that they disagreed strongly. Five percent were unsure.

Nearly two-fifths of respondents reported that they agreed mildly that 'CDAT activities enable a whole of community response to drug and alcohol issues' (37%) and a further 34% reported that they agreed strongly. Fifteen percent reported that they neither agreed nor disagreed. Seven percent of respondents reported that they disagreed mildly and four percent that they disagreed strongly. Four percent were unsure.

Figure 12: Perceived importance of features of CDAT approach

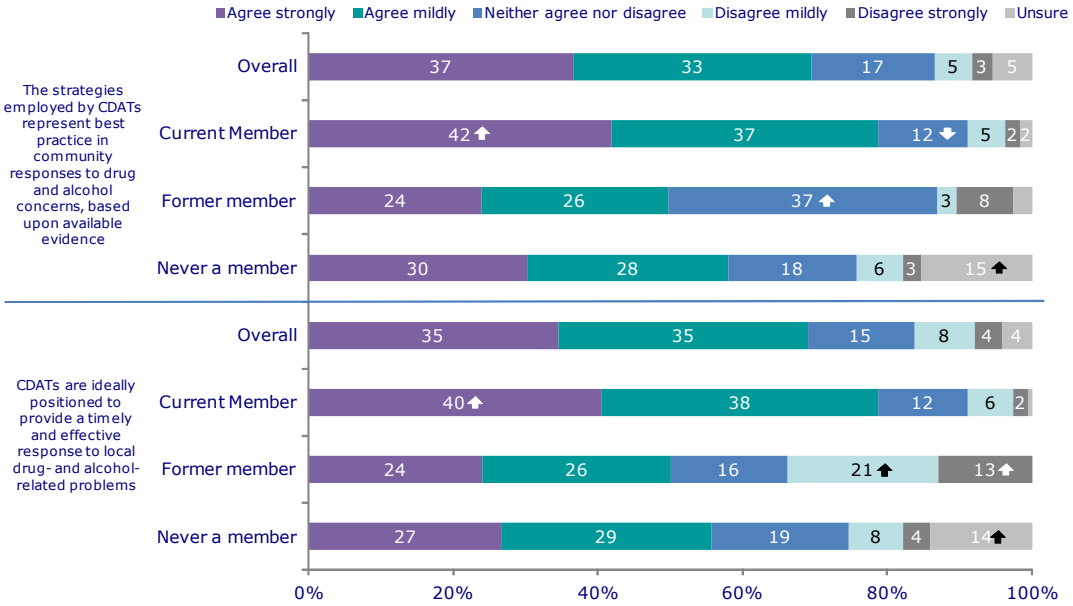


Q: To what extent do you agree that each of the following is a key strength of the CDAT appraoch and should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program? Base: n=310

Figure 13 overleaf shows that nearly two-fifths of respondents reported that they agreed strongly that 'the strategies employed by CDATs represent best practice in community responses to drug and alcohol concerns, based upon available evidence' (37%) and a further third reported that they agreed mildly (33%). Seventeen percent reported that they neither agreed nor disagreed. Five percent of respondents reported that they disagreed mildly and three percent that they disagreed strongly. Five percent were unsure.

A roughly equal proportion, 35% each, reported that they agreed strongly and agreed mildly that 'CDATs are ideally positioned to provide a timely and effective response to local drug- and alcohol-related problems'. Fifteen percent reported that they neither agreed nor disagreed. Eight percent of respondents reported that they disagreed mildly and four percent that they disagreed strongly. Four percent were unsure.

Figure 13: Perceived importance of features of CDAT approach



Q: To what extent do you agree that each of the following is a key strength of the CDAT approach and should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program? Base: n=310

Significant differences by membership status

The following significant differences were observed between the membership categories within the sample with regard to the extent that they agreed that each of the statements above represented 'a key strength of the CDAT approach that should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program':

- **Current CDAT members** were significantly
    - **more** likely to report that they **agreed strongly** with all statements compared with all respondents; and
    - **less** likely to report that they **agreed mildly** that 'CDAT activities have a strong focus on harm minimisation' (21%) compared with all respondents (27%)
- **Former CDAT members** were significantly
    - **less** likely to report that they **agreed strongly** with six of the 13 statements compared with all respondents. These were:
        i. 'CDATs are community-based and community driven' (21% compared with 44%);

ii. 'The CDAT approach encourages better alignment of local, state and national Government resources for addressing drug and alcohol concerns at the local level' (18% compared with 34%);

iii. 'CDAT activities are fundamentally action-oriented' (26% compared with 44%);

iv. 'The CDAT approach helps create more effective links between programs, and mobilises resources from other initiatives' (11% compared with 35%);

v. 'CDATs take a holistic approach to addressing drug and alcohol issues, drawing in related issues (such as mental health, violence, safe sex, community wellbeing)' (26% compared with 47%); and

vi. 'The CDAT approach identifies drug and alcohol-related problems in the local community' (26% compared with 44%).

- **more** likely to report that they **agreed mildly** that 'CDATs take a holistic approach to addressing drug and alcohol issues, drawing in related issues (such as mental health, violence, safe sex, community wellbeing)' (53%) compared with all respondents (30%).

- **more** likely to report that they **disagreed mildly** that 'CDATs are community-based and community driven' (24%), that 'CDAT activities help build resilience within communities, equipping communities with the capacity to address their own concerns' (11%) and that 'CDATs are ideally positioned to provide a timely and effective response to local drug- and alcohol-related problems' (21%) compared with all respondents (8%, 4% and 8% respectively).

- **more** likely to report that they **disagreed strongly** with four statements. These were:

i. 'CDATs are community-based and community driven' (8% compared with 3%);

ii. 'CDAT activities enable a whole of community response to drug and alcohol issues' (16% compared with 4%);

iii. 'CDATs take a holistic approach to addressing drug and alcohol issues, drawing in related issues (such as mental health, violence, safe sex, community wellbeing)' (8% compared with 2%); and

iv. 'CDATs are ideally positioned to provide a timely and effective response to local drug and alcohol-related problems' (13% compared with 4%).

- Respondents who had **never been CDAT members** were significantly

  - **more** likely to report being **unsure** for all statements compared with all respondents.

  - **less** likely to report that they **strongly agreed** with four statements compared with all respondents. These were:

    i. 'CDAT activities have a strong focus on harm minimisation' (34% compared with 57%);

    ii. 'The CDAT approach builds partnerships and relationships within the community, fostering a collaborative approach to addressing drug and alcohol issues' (41% compared with 57%);

    iii. 'CDAT activities enable a whole of community response to drug and alcohol issues' (24% compared with 34%); and

    iv. 'CDAT activities are customised responses to drug and alcohol issues to meet the needs of particular communities' (34% compared with 47%).

  - **more** likely to report that they **agreed mildly** that 'CDAT activities have a strong focus on harm minimisation' (38%) compared with all respondents (27%). They were also significantly more likely to report that they neither agreed nor disagreed that 'CDATs take a holistic approach to addressing drug and alcohol issues, drawing in related issues (such as mental health, violence, safe sex, community wellbeing)' (18% compared with 11%) and

  - **more likely** to report that they **disagreed mildly** that 'the CDAT approach builds partnerships and relationships within the community, fostering a collaborative approach to addressing drug and alcohol issues' (8% compared with 4%).

4.3 Perceived strengths of CDATs

Summary

- CDAT members who responded to the survey were asked to identify the strengths of their CDAT. They most often reported that the strengths of their CDAT were the commitment, diversity or teamwork of their members; the strength of their CDATs' local networks; and the involvement of the community.

- When reflecting on the strengths of their CDAT, survey respondents only rarely mentioned the quality of the projects that their CDAT was undertaking.

Findings from the quantitative phase

In the online survey, CDAT members were asked 'what are the strengths of your CDAT?', and were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent. The results are depicted in Figure 14 overleaf.

Nearly two-fifths of CDAT members gave a response that was coded as 'commitment of members' (37%). Twenty-eight percent were coded as 'good local networks and partnerships' and 22% 'members drawn from a wide range of sectors/services'. Slightly less than one-fifth were coded as 'community involvement/focus'; 16% 'good teamwork among members'; 13% 'expertise of members / awareness of issues'; and 11% that their strength was in being 'proactive and responsive'. Seven percent gave a response coded as 'strength of leadership / well-organised'; 6% 'considered and innovative in relation to approaches to D&A'; and 5% the 'quality of projects'.

Figure 14: Strengths of individual CDATs

Q: What are the strengths of your CDAT? (open ended) n=193

4.4 Perceived key practical issues affecting CDATs

Summary

- It was noted that the total number of CDATs in the state were unevenly distributed among the Project Officers such that the amount of support that CDATs received from Project Officers varied substantially.

- Fourteen percent of CDAT members who completed the survey disagreed to some extent that their CDAT received enough support from their Project Officer. These respondents most frequently wanted their Project Officer to be more available to them and/or to regularly attend their CDATs' meetings and events.

- Attracting new CDAT members, training members, filling CDAT executive roles, and getting funding for projects and activities were identified as issues to be addressed.

- The voluntary nature of CDAT membership and the competing demands on members' time were seen as factors that limited CDATs' efficiency.

Findings from the qualitative phase

Depth interview and consultation forum participants were asked to identify what they saw as the key practical issues affecting CDATs. Participants generally agreed that filling executive roles on CDATs was challenging due to the voluntary nature of the role and the competing demands on members' time. Membership in general was also identified as a challenge in some areas.

The burden of administration was identified as a challenge for some CDATs. Administrative tasks included organising meetings; writing and distributing meeting minutes; recruiting members; writing grant applications; and keeping track of receipts. Different CDATs had different arrangements for undertaking these tasks, and in some cases the Project Officers assisted, but in general there was a perception that more Project Officer support was required to undertake these tasks.

Auspicing was noted as a challenge for some CDATs, but reported experiences in this area were variable; some participants reported no problems finding or working with their auspice organisation. Participants with personal experience of working on or with CDATs noted that finding an organisation to auspice the CDAT, and then maintaining a good working relationship with the auspice organisation, could be challenging and time consuming. For these

participants, a high level of bureaucracy involved in accessing funding was the most frequently mentioned challenge in the working relationship with the auspice.

Insurance was identified an issue that was challenging for many CDATs. It was clear from the discussions that some participants who worked with or on CDATs were confused about the insurance arrangements with NSW Health for CDATs, and during the course of the consultation it became evident that some CDAT members might have misunderstood the extent to which their activities were covered by NSW Health's insurance policy. Some CDAT members were using the insurance policies of their local council or other local service organisations to cover their activities. In some cases this arrangement was seen as sufficient, but it was more often seen as inadequate and unsatisfactory.

Balancing the involvement of service providers and community members of CDATs was identified as a challenge. Some participants noted that careful organisational management within the CDAT was important to ensure that community members felt able to participate in the CDAT meeting without being intimidated by the expertise of professional members. These participants emphasized the importance of an organisational model built around a community development approach, in which the involvement of community members would be held as a fundamental principle.

Insufficient support from Project Officers in some areas was noted as an issue. The lack of a Project Officer in the Greater Western region was mentioned as a key challenge for CDATs in that area. It was also often noted that some Project Officers had too many CDATs over too large a geographical area to be able to give each CDAT sufficient support and face-to-face contact.

Some participants observed that CDATs lacked sufficient funds to run projects, due to the low level of funding available through the program. Some CDAT members also commented that they thought that they spent too much time trying to access funds from other sources. Views on this issue were variable, however, with some participants not seeing funding as a major issue for the CDATs with which they worked.

Some CDATs were seen as being isolated from other CDATs due to the lack of conferences or other avenues of inter-CDAT communication. Isolation was seen as a problem in that it prevented CDATs learning about projects or approaches used in other areas and being refreshed and inspired through contact with other CDATs.

A recent shift in Department of Family and Community Services funding towards a case management approach was noted as a key challenge by some participants. They observed that staff of community services organisations that were funded under case-management models were not funded to participate in community projects like CDATs, and therefore had ceased to be involved.

Findings from the quantitative phase

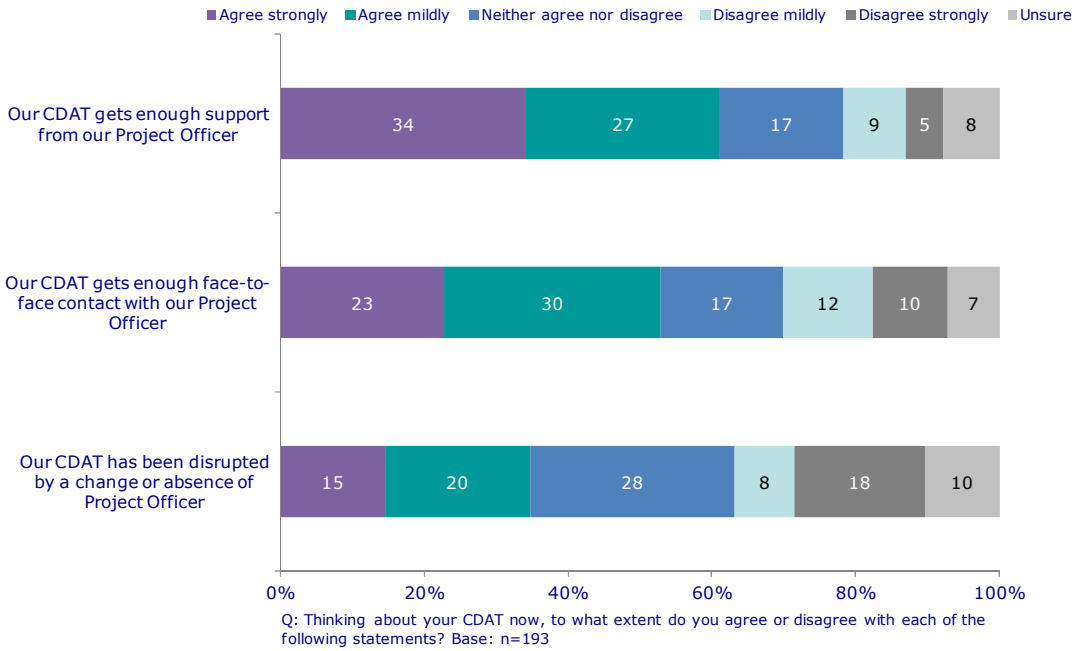
To identify perceptions of key practical issues affecting CDATs, CDAT members who responded to the survey were presented with 15 statements and asked to indicate for each statement the extent to which they agreed that it described their CDAT. The extent of agreement with each of these 15 statements is shown across five separate charts below.

Figure 15 overleaf shows the level of CDAT members' agreement with three statements about Project Officers. More than one-third of CDAT members reported that they agreed strongly with the statement that 'our CDAT gets enough support from our Project Officer' (34%) and a further 27% reported that they agreed mildly. Seventeen percent reported that they neither agreed nor disagreed. Nine percent of CDAT members reported that they disagreed mildly and five percent that they disagreed strongly. Eight percent were unsure.

Thirty percent of CDAT members reported that they agreed mildly with the statement that 'our CDAT gets enough face-to-face contact with our Project Officer' and a further 23% reported that they agreed strongly. Seventeen percent reported that they neither agreed nor disagreed. Twelve percent of CDAT members reported that they disagreed mildly and one in ten that they disagreed strongly (10%). Seven percent were unsure.

Twenty-eight percent of CDAT members reported that they neither agreed nor disagreed with the statement that 'our CDAT has been disrupted by a change or absence of Project Officer'. Twenty percent reported that they agreed mildly and a further 15% agreed strongly. Eighteen percent of CDAT members reported that they disagreed strongly and eight percent that they disagreed mildly. One in ten was unsure (10%).

Figure 15: Practical issues currently affecting CDATs



Q: Thinking about your CDAT now, to what extent do you agree or disagree with each of the following statements? Base: n=193

Figure 16 overleaf shows that nearly half of CDAT members reported that they agreed mildly with the statement that 'our members have the skills to make the CDAT function effectively' (46%) and a further 30% reported that they agreed strongly. Fourteen percent reported that they neither agreed nor disagreed. Seven percent of CDAT members reported that they disagreed mildly and one percent that they disagreed strongly. Three percent were unsure.

More than one-quarter of CDAT members reported that they agreed mildly with the statement that 'people who join our CDAT generally stay as members for a long time' (26%) and a further 18% reported that they agreed strongly. Greater than one-fifth reported that they neither agreed nor disagreed (22%). Eighteen percent of CDAT members reported that they disagreed mildly and seven percent that they disagreed strongly. One in ten were unsure (10%).

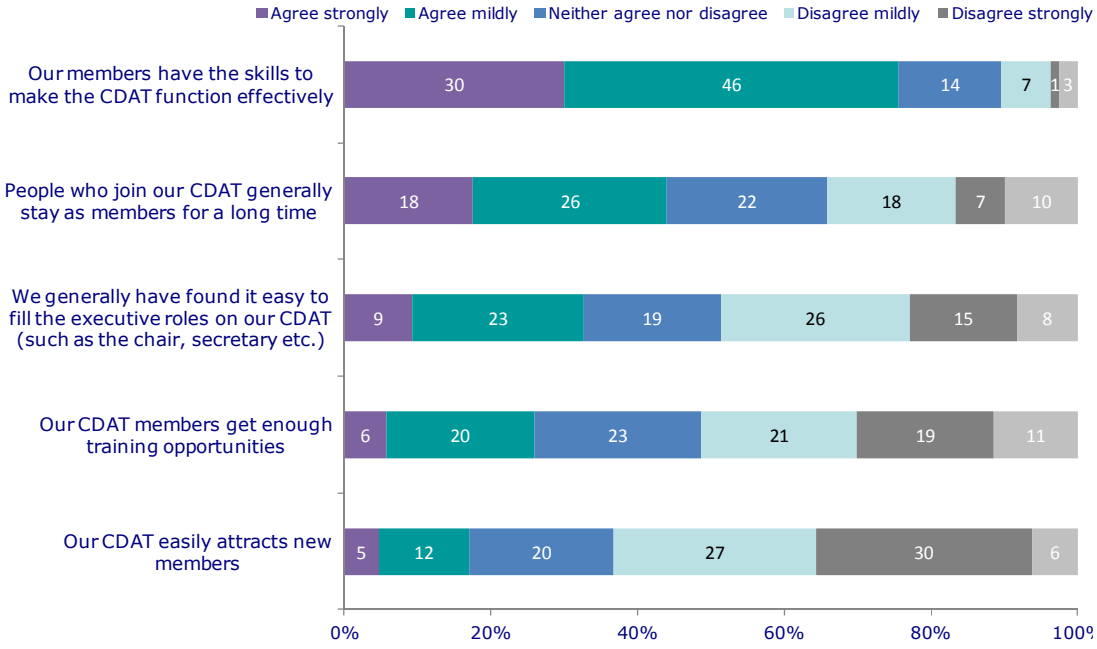
Over one-quarter of CDAT members reported that they disagreed mildly with the statement that 'we generally have found it easy to fill the executive roles on our CDAT (such as the chair, secretary etc.)' (26%) and a further 15% reported that they disagreed strongly. Slightly less than one-quarter reported that they agreed mildly (23%). Nine percent reported that they agreed strongly. Nineteen percent of CDAT members reported that they neither agreed nor disagreed. Eight percent were unsure.

Just under one-quarter of CDAT members reported that they neither agreed nor disagreed with the statement that 'our CDAT members get enough training opportunities' (23%). Roughly one-fifth reported that they disagreed mildly (21%) and a further 19% reported that they

disagreed strongly. Twenty percent of CDAT members reported that they agreed mildly and six percent that they agreed strongly. Eleven percent were unsure.

Thirty percent of CDAT members reported that they disagreed strongly with the statement that 'our CDAT easily attracts new members' and a further 27% reported that they disagreed mildly. One-fifth reported that they neither agreed nor disagreed (20%). Twelve percent of CDAT members reported that they agreed mildly and five percent that they agreed strongly. Six percent were unsure.

Figure 16: Practical issues currently affecting CDATs



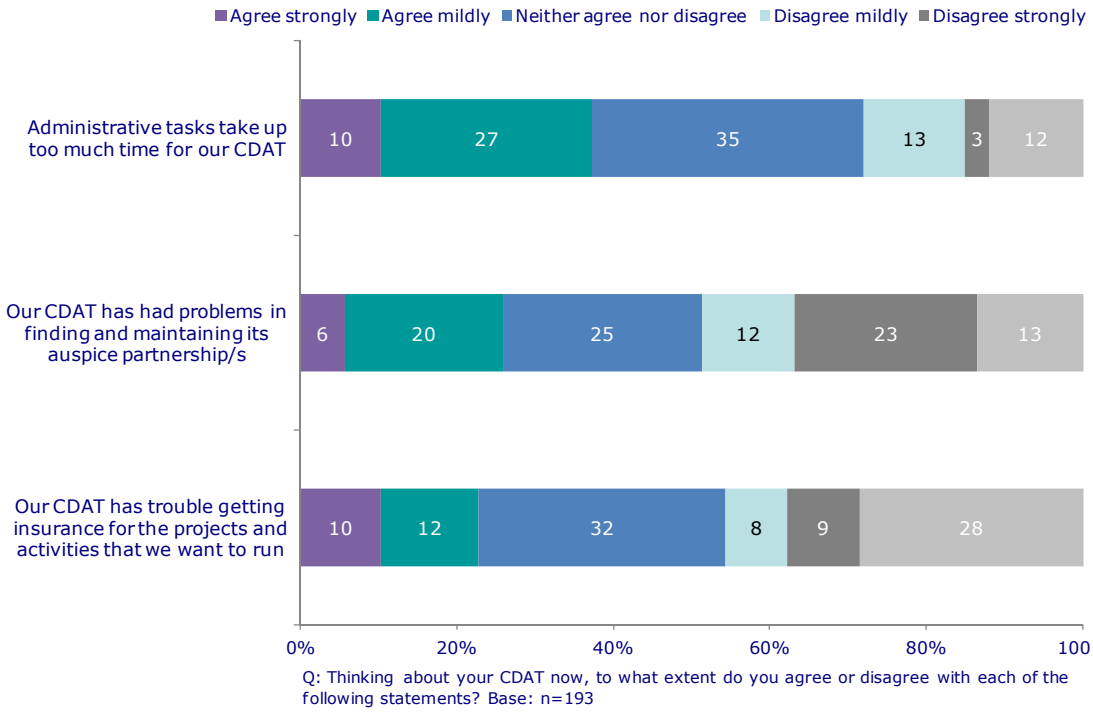
Q: Thinking about your CDAT now, to what extent do you agree or disagree with each of the following statements? Base: n=193

Figure 17 below shows that more than one-third of CDAT members reported that they neither agreed nor disagreed with the statement that 'administrative tasks take up too much time for our CDAT' (35%). More than one-quarter reported that they agreed mildly (27%) and a further one in ten reported that they agreed strongly (10%). Thirteen percent of CDAT members reported that they disagreed mildly and three percent that they disagreed strongly. Twelve percent were unsure.

One-quarter of CDAT members reported that they neither agreed nor disagreed with the statement that 'our CDAT has had problems in finding and maintaining its auspice partnership/s' (25%). Slightly less than one-quarter reported that they disagreed strongly (23%) and a further 12% that they disagreed mildly. One-fifth of CDAT members reported that they agreed mildly (20%) and six percent that they agreed strongly. Thirteen percent were unsure.

Slightly less than one-third of CDAT members reported that they neither agreed nor disagreed with the statement that 'our CDAT has trouble getting insurance for the projects and activities that we want to run' (32%). Twelve percent reported that they agreed mildly and a further one in ten reported that they agreed strongly (10%). Nine percent of CDAT members reported that they disagreed strongly and eight percent that they disagreed mildly. Twenty-eight percent were unsure.

Figure 17: Practical issues currently affecting CDATs

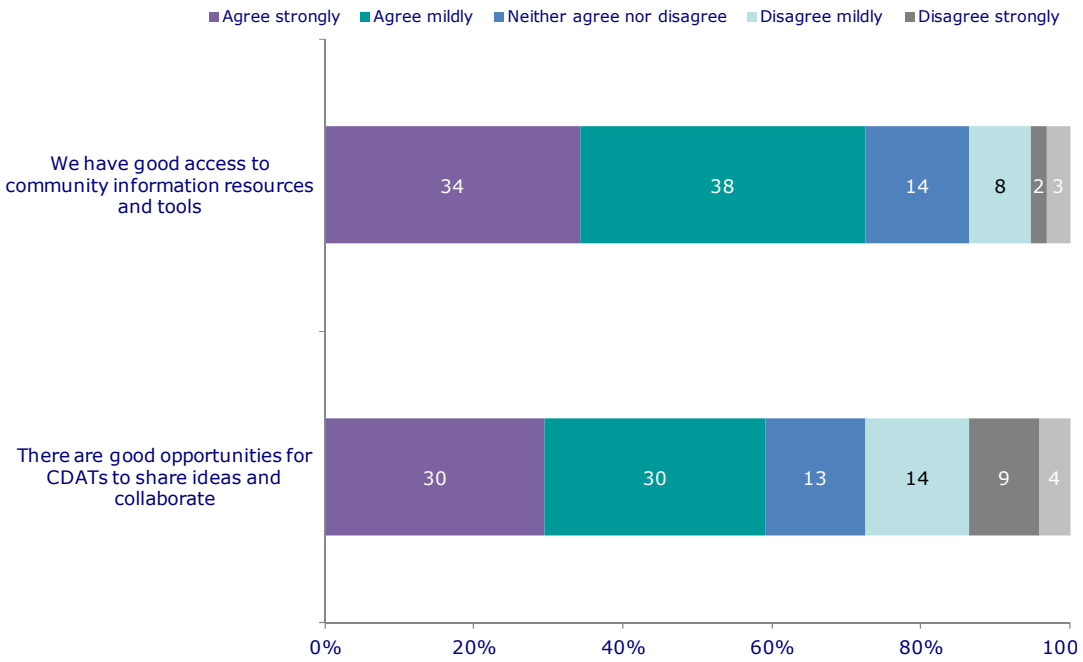


Q: Thinking about your CDAT now, to what extent do you agree or disagree with each of the following statements? Base: n=193

Figure 18 below shows that nearly two-fifths of CDAT members reported that they agreed mildly with the statement that 'we have good access to community information resources and tools' (38%) and a further 34% reported that they agreed strongly. Fourteen percent reported that they neither agreed nor disagreed. Eight percent of CDAT members reported that they disagreed mildly and two percent that they disagreed strongly. Three percent were unsure.

Thirty percent of CDAT members reported that they agreed strongly and another 30% agreed mildly with the statement that 'there are good opportunities for CDATs to share ideas and collaborate'. Fourteen percent reported that they disagreed mildly and a further nine percent reported that they disagreed strongly. Thirteen percent of CDAT members reported that they neither agreed nor disagreed. Four percent were unsure.

Figure 18: Practical issues currently affecting CDATs

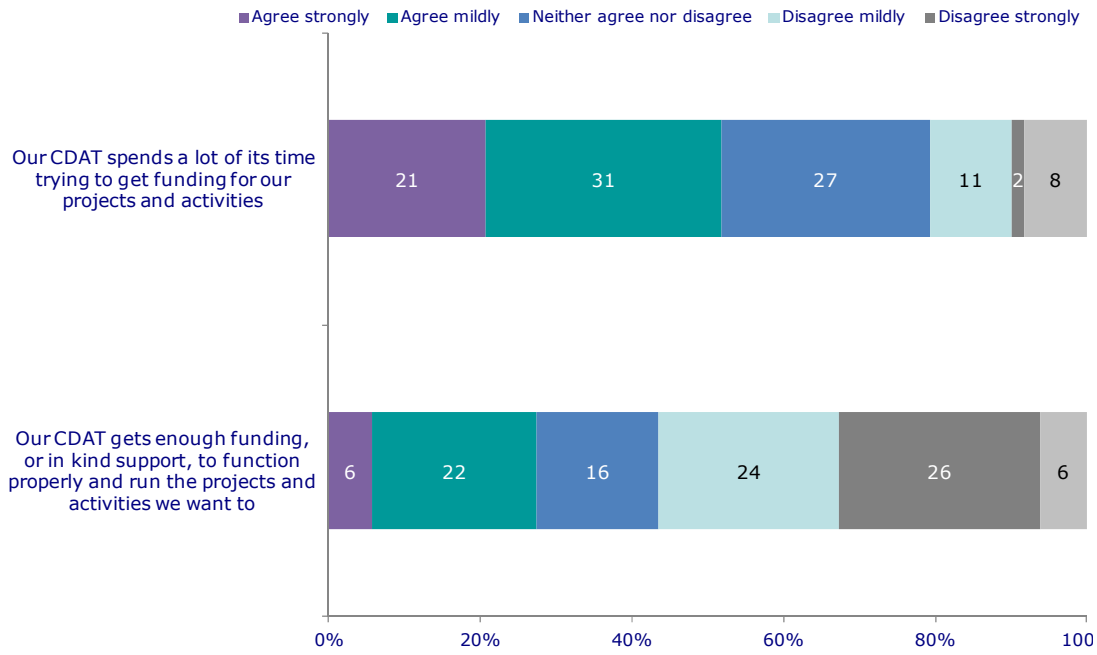


Q: Thinking about your CDAT now, to what extent do you agree or disagree with each of the following statements? Base: n=193

Figure 19 below shows that nearly one-third of CDAT members reported that they agreed mildly with the statement that 'our CDAT spends a lot of its time trying to get funding for our projects and activities' (31%) and a further 21% reported that they agreed strongly. More than a quarter reported that they neither agreed nor disagreed (27%). Eleven percent of CDAT members reported that they disagreed mildly and two percent disagreed strongly. Eight percent were unsure.

More than a quarter of CDAT members reported that they disagreed strongly with the statement that 'our CDAT gets enough funding, or in kind support, to function properly and run the projects and activities we want to' (26%) and a further 24% reported that they disagreed mildly. Greater than one-fifth reported that they agreed mildly (22%) and six percent agreed strongly. Sixteen percent of CDAT members reported that they neither agreed nor disagreed. Six percent were unsure.

Figure 19: Practical issues currently affecting CDATs

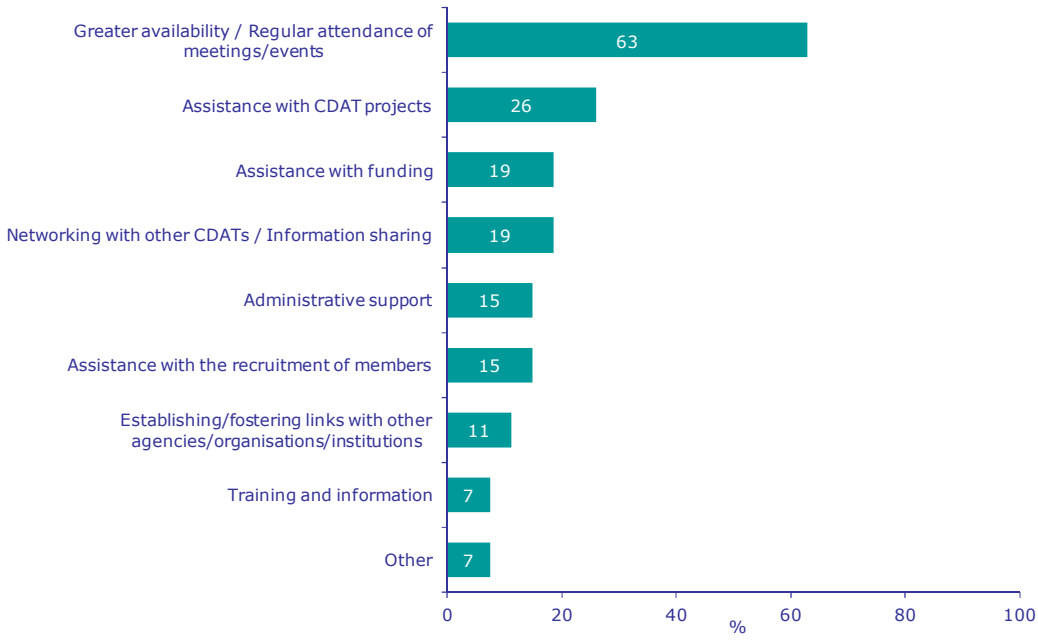


Q: Thinking about your CDAT now, to what extent do you agree or disagree with each of the following statements? Base: n=193

CDAT members who reported that they disagreed mildly or disagreed strongly with the statement 'our CDAT gets enough support from our Project Officer' were asked 'what further support would you like to receive from your Project Officer?' They were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent.

The results are depicted in Figure 20 below. Nearly two-thirds of these CDAT members gave a response coded as 'greater availability / regular attendance of meetings/events' (63%). Roughly one-quarter gave a response coded as 'assistance with CDAT projects' (26%). Slightly less than one-fifth gave a response coded as 'assistance with funding' (19%); an almost equal proportion 'networking with other CDATs / information sharing' (19%); 15% 'administrative support'; 15% 'assistance with the recruitment of members'; 11% 'establishing/fostering links with other agencies/organisations/institutions'; and seven percent 'training and information'. Seven percent reported that they would like another type of further support from their Project Officer.

Figure 20: Further support from Project Officers



Q: What further support would you like to receive from your Project Officer?
n=27

4.5 Ways to increase effectiveness and impact of CDATs

Summary

- Participants in the initial qualitative phase thought CDATs' primary needs were more Project Officer support in those areas where there were a disproportionate ratio of CDATs to Project Officers; better partnerships with key agencies other than Health; and better collaboration and knowledge sharing among CDATs.

- In the online survey, CDAT members most often suggested 'more funding' and 'more members' as ways to improve the effectiveness and impact of their CDAT. Only 8% mentioned needing more support from their Project Officer, however this small proportion might simply reflect the unequal distribution of this problem among CDATs.

Findings from the qualitative phase

Depth interview and consultation forum participants were asked what additional support they thought that CDATs needed. Participants generally thought that the Project Officers provided the CDATs with good support given the amount of time they had available to spend with each one, but it was unanimously held that there was a need for more Project Officers because some were overstretched by the number and geographic dispersion of the CDATs for which they were responsible.

Some participants argued that there was a need to facilitate better partnerships with key agencies, for example police and the Office of Liquor Gaming and Racing (OLGR). Some CDATs were seen to have developed good relationships at the local level but there was a perception that CDATs would benefit from more assistance at the local level and at the departmental/agency level to facilitate these relationships.

A need for greater facilitation of collaboration and knowledge-sharing between CDATs was regularly mentioned by participants. Some mentioned a need for better or more information resources, or help with developing their own. A need to streamline the processes in grant administration, to reduce the time-burden it imposed on CDATs, was also mentioned by some participants.

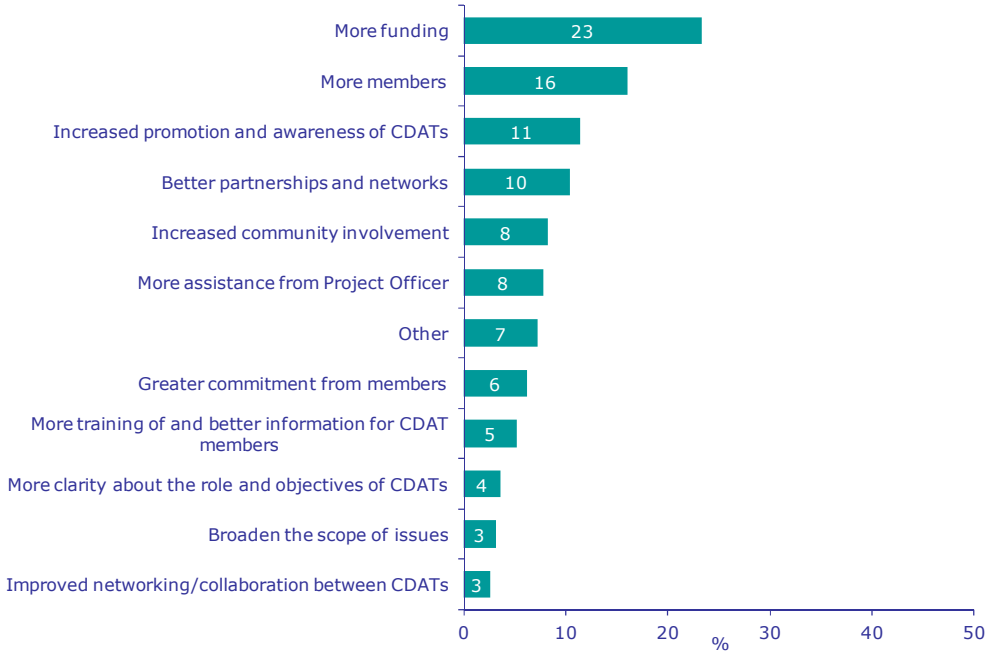
Some participants thought that CDATs needed more funding to run projects, but generally also thought that any increases should be based on asking CDATs what they needed.

Findings from the quantitative phase

CDAT members who responded to the survey were asked 'how do you think the effectiveness and impact of your local CDAT could be improved?' and were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent. The results are depicted in Figure 21 below.

Nearly one-quarter of CDAT members reported that the effectiveness and impact of their local CDAT could be improved with 'more funding' (23%). Sixteen percent gave a response coded as 'more members'; 11% as 'increased promotion and awareness of CDATs'; and one in ten as 'better partnerships and networks' (10%). Eight percent gave a response coded as 'increased community involvement'; a roughly equal proportion 'more assistance from Project Officer' (8%); six percent 'greater commitment from members'; five percent 'more training of and better information for CDAT members'; four percent 'more clarity about the role and objectives of CDATs', three percent 'broaden the scope of issues' and an almost equal proportion 'improved networking/collaboration between CDATs' (3%). Seven percent of CDAT members reported that the effectiveness and impact of their local CDAT could be improved in another way.

Figure 21: Possible ways to improve local CDATs



Q: How do you think the effectiveness and impact of your local CDAT could be improved? n=193

4.6 Perceived clarity of role and purpose of CDATs

Summary

- There was general agreement that there was a need for greater clarity about the role, purpose and objectives of CDATs. For participants in the initial qualitative phase, clarity about the role and purpose was seen as a way of ensuring that CDATs did not flounder through lack of understanding about that they were supposed to be doing.

- Among the survey respondents, current members more significantly more likely than others to report that the role and purpose of CDATs was 'very clear' to them (59% compared with 46% overall).

- In the online survey, only 3% of current CDAT members described the role and purpose of CDATs as 'not at all clear', but nevertheless 75% thought that the role and purpose of CDATs should be spelled out more clearly.

- Survey respondents most frequently wanted greater clarity about the objectives of the program and the role of individual CDATs; the importance of community participation and priority setting; what CDATs are currently doing; and how CDATs can work with other programs or organisations.

Findings from the qualitative phase

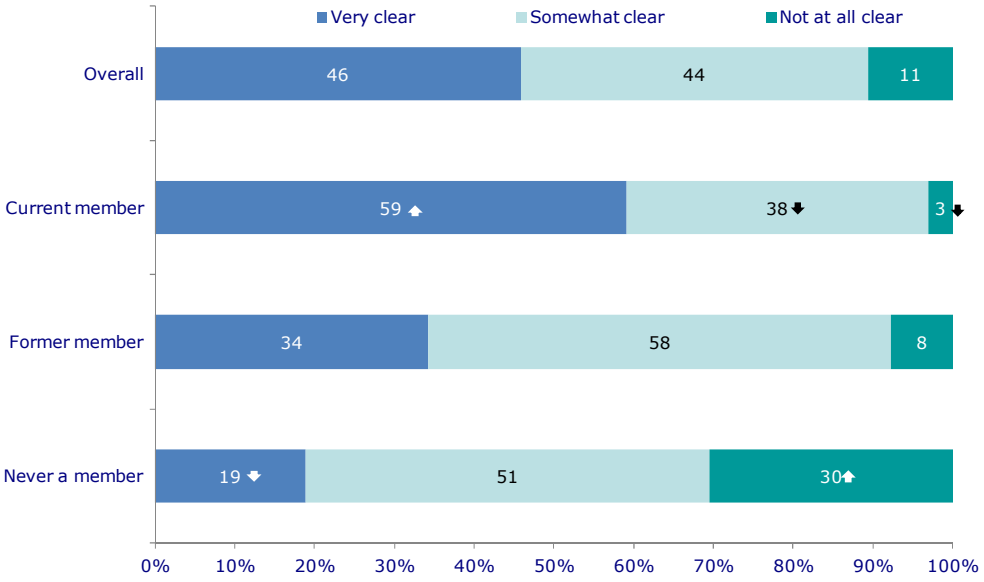
There was a consensus among consultation participants that CDATs lacked a clearly-stated strategic and policy directive. The extent to which participants saw this as a problem seemed to be related to the type of interaction that they had with CDATs. It was seen as a salient problem by participants with more distant, high-level experiences of CDATs, and by participants who had seen particular CDATs flounder in the absence of a clear understanding of what they should be doing. Others participants who had contact with strong and effective CDATs saw this problem as less acute. Generally speaking, however, participants thought that CDATs would benefit from additional clarity around the objectives of the program and the intended remit of CDATs.

When discussing the need for greater clarity about the program objectives and remit, many participants observed that the program should retain an element of community autonomy within the overarching structure of the program. This was seen as key to ensuring that communities remained engaged and empowered to address their local issues.

Findings from the quantitative phase

Survey respondents were asked 'how clear to you are the current role and purpose of CDATs?' The results are depicted in Figure 22 below. Forty six percent of respondents reported that the current role and purpose of CDATs were 'very clear' and a slightly smaller proportion that they were 'somewhat clear' (44%). Eleven percent of respondents reported that they were 'not at all clear'.

Figure 22: Clarity of role and purpose of CDATs



Q: How clear to you are the current role and purpose of CDATs? Base: n=310

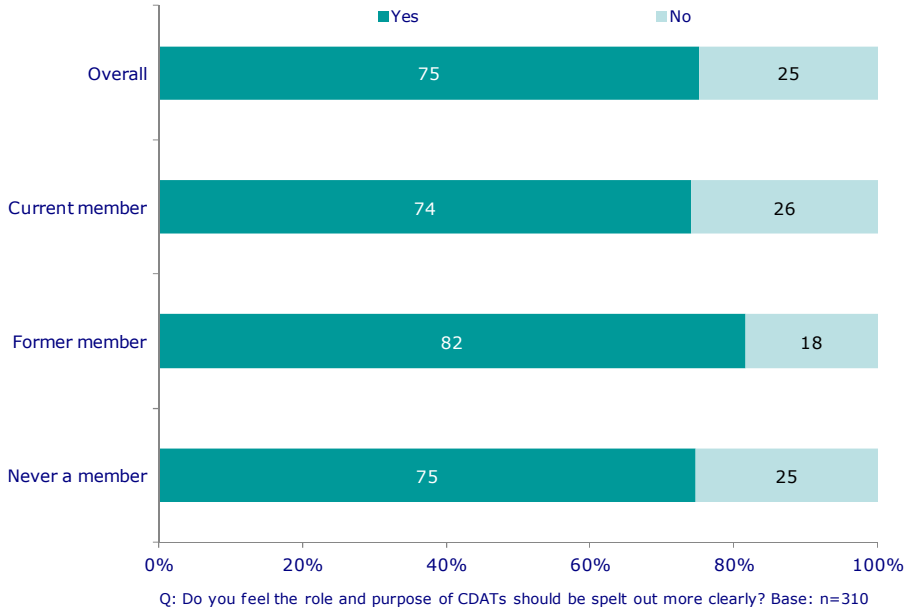
The following significant differences were observed between the membership categories within the sample with regard to the clarity of role and purpose of CDATs.

- **Current CDAT members** were significantly **more** likely to report that the current role and purpose of CDATs are 'very clear' (59%) and significantly **less** likely to report that they are 'somewhat clear' (38%) and 'not at all clear' (3%) compared with all respondents (46%, 44% and 11% respectively).

- Respondents who had **never been CDAT members** were significantly **less** likely to report that the current role and purpose of CDATs are 'very clear' (19%) compared with all respondents (46%) and significantly more likely to report that they are 'not at all clear' (30% compared with 11%)

Respondents were asked 'do you feel the role and purpose of CDATs should be spelt our more clearly?' The results are depicted in Figure 23 below. Three-quarters of respondents replied 'yes' (75%).

Figure 23: Should the role and purpose of CDATs be spelled out more clearly?



Q: Do you feel the role and purpose of CDATs should be spelt out more clearly? Base: n=310

Significantly **fewer** respondents in Rural & Regional NSW Local Health Districts indicated that the role and purpose of CDATs were 'very clear' (39%) compared with all respondents (46%), and significantly **more** reported that the role and purpose of CDATs were 'not at all clear' (14%) compared with all respondents (11%).

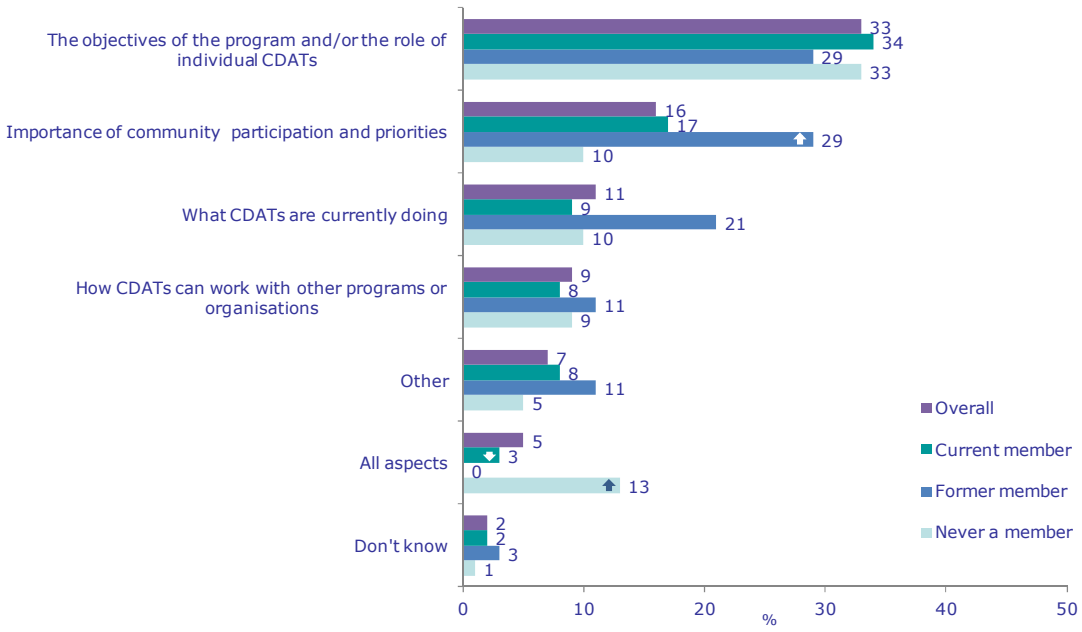
Among respondents who indicated that the role and purpose of CDATs were 'very clear', 38% reported that they thought the role and purpose should nevertheless be spelt out more clearly (28% of all respondents).

Respondents were asked 'which aspects of the role and purpose of CDATs do you think should be made clearer?' They were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent.

The results are depicted in Figure 24 overleaf. One-third of respondents gave a response coded as 'the objectives of the program and/or the role of individual CDATs' (33%) should be made clearer. Sixteen percent gave a response coded as the 'importance of community participation and priorities'. Eleven percent of respondents gave a response coded as 'what CDATs are currently

doing'; nine percent as 'how CDATs can work with other programs or organisations'; and five percent as 'all aspects'. Seven percent of respondents reported that something else should be made clearer.

Figure 24: Aspects of role and purpose to be made clearer



Q: Which aspects of the role and purpose of CDATs do you think should be made clearer?
Base: n=310

The following significant differences were observed between the membership categories within the sample with regard to the clarity of role and purpose of CDATs:

- **Former CDAT members** were significantly **more** likely to give a response coded as the 'importance of community participation and priorities' (29%) should be made clearer compared with all respondents (16%).
- **Current CDAT members** were significantly **less** likely to give a response coded as 'all aspects' (3%) should be made clearer compared with all respondents (5%).
- Respondents who had **never been CDAT members** were significantly **more** likely to give a response coded as 'all aspects' (13%) should be made clearer compared with all respondents (5%).

4.7 Current and preferred target issues

Summary

- CDATs were reportedly working primarily on drug and alcohol-related issues, with a particular focus on addressing issues associated with drug and alcohol abuse by young people. There was a general agreement among consultation participants that drug and alcohol issues should remain the focus of CDATs.

- There was a cautious openness among consultation participants towards the idea that CDATs could take on a broader range of issues. This idea was supported because addressing issues related to drug and alcohol abuse was seen to require a holistic approach.

- Community wellbeing, mental health and suicide prevention were the most popular non-drug-and-alcohol issues for CDATs to add to their remit.

Findings from the qualitative phase

Current remit

There was general agreement among depth interview and consultation forum participants that the current remit of CDATs was to work in the area of drug and alcohol health promotion, with flexibility to take on related issues (for example, mental health, homelessness, or lighting in local parks) if CDAT members deemed it necessary or useful to do so.

CDATs were seen to focus primarily on issues related to alcohol abuse, with cannabis abuse the second most common issue. It was noted, however, that the focus of different CDATs differed dependent on the key concerns of the community in the area. Some participants observed that in the early days of the program, heroin use had been a key issue for CDATs but in more recent years the importance of heroin had waned.

Participants saw CDATs as working across age groups within their communities, especially in undertaking family-orientated prevention activities, but it was observed that many CDATs focused on drug and alcohol use by young people. It was also observed that the population that a CDAT focused on was influenced by the CDAT members, depending on their priorities (for example, if they thought that a particular group had acute problems or was under-served by mainstream services) and abilities (for example, the ability to engage with a particular group within the community).

Some participants who had observed the program from a high level or from an outside organisation pointed out an apparent lack of clarity and consistency about the populations with which CDATs worked.

Preference for remit of CDATs

Engaging and assisting communities to identify and address local problems was seen as a fundamentally sound approach, and it was often observed that disadvantaged communities required a holistic approach involving work across multiple areas and problems. Participants therefore believed that the CDAT approach would be beneficial for also addressing other health and social issues within communities. However, they generally wanted the program's objectives to remain drug and alcohol related.

Participants were particularly interested in working with mental health/drug and alcohol co-morbidity issues. This was seen to draw on existing expertise within CDATs and the Mental Health and Drug and Alcohol office of NSW Health. However, some participants were hesitant about their CDAT getting involved in mental health issues because they perceived that dealing with those issues required specialised professional expertise.

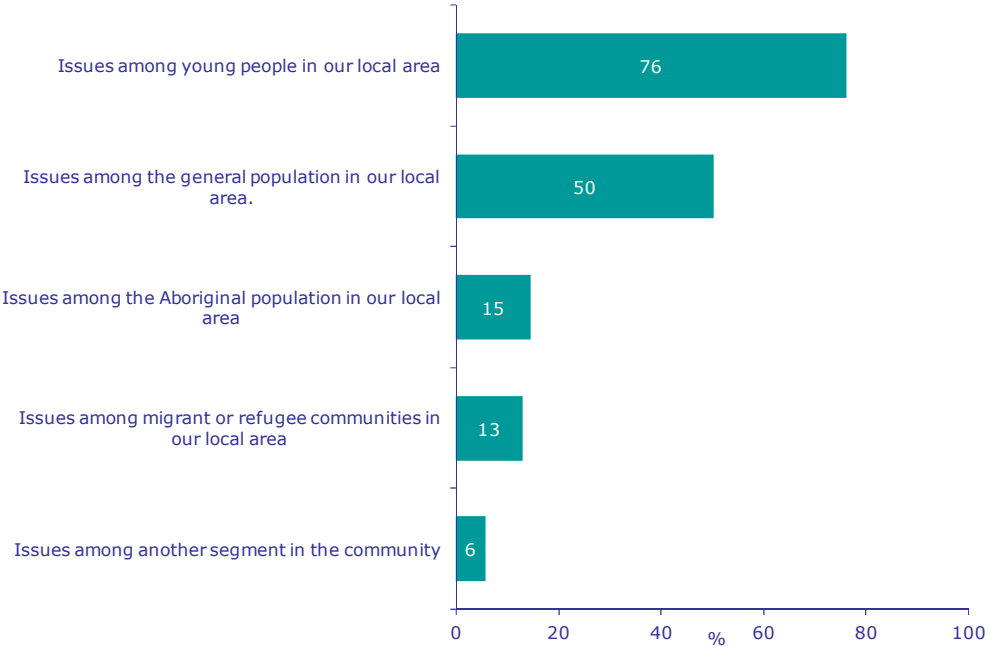
Most participants did not want a broadening of the program objectives to promoting 'healthy lifestyles' in general. This broader objective was seen as one more appropriately dealt with through a broader range of initiatives, including those of mainstream service providers and government departments and agencies. Some participants also perceived a need for Local Health Districts (LHDs) to undertake more health promotion activities, and expressed concern that 'healthy lifestyles' community teams might tempt LHDs to continue to defer responsibility for health promotion.

The idea of having multiple action teams within a single area, each addressing different health or social issues, was mostly not supported. Participants were concerned that each team would draw from the same small pool of 'activist' community members and service providers, leading to diminished CDAT membership.

Findings from the quantitative phase

CDAT members who responded to the survey were asked to describe the main focuses of their CDAT. The results are depicted in Figure 25 overleaf. More than three-quarters of respondents reported that one of the main focuses of their CDAT was 'issues among young people in our local area' (76%) and half reported 'issues among the general population in our local area' (50%). Fifteen percent of CDAT members reported 'issues among the Aboriginal population in our local area'; 13% 'issues among migrant or refugee communities in our local area'; and six percent 'issues among another segment in the community'.

Figure 25: Main focus of CDAT



Q: Which of the following best describes the main focus of your CDAT? n=193

Respondents were presented with a number of CDAT issues and asked to indicate, firstly, if their CDAT worked on that issue and, secondly, if they would like their CDAT to address that issue in the future. The results are depicted in Table 1 overleaf. Alcohol (92%) was the issue that the largest proportion of respondents reported that their CDAT was working on. This was followed by cannabis (56%); other illicit drugs (53%); and community wellbeing and social cohesion/inclusion (52%).

Preferred issues

The 'Current' column in Table 1 shows the proportion of all current members who indicated that their CDAT was working on an issue. The 'Preferred – Current member' column shows the proportion of all respondents who indicated either that their CDAT was working on the issue, or that they would like their CDAT to work on the issue in the future. The figures in parentheses in that column indicate the proportion of current members who said their CDAT was not working on that issue, but that they would like their CDAT address that issue in the future.

The 'Former member' and 'Never a member' columns display the proportions of respondents in those groups who indicated that they wanted CDATs to work on each issue in the future. The 'Preferred – Overall' column shows the mean of the other 'Preferred' columns.

Alcohol (96%) received the highest overall support as an issue to include among the future remit of CDATs, followed by cannabis (81%); other illicit drugs (80%); community wellbeing and social cohesion/inclusion (77%); mental health (74%); misuse of prescription drugs (70%); use of drugs and alcohol whilst pregnant (68%); tobacco smoking (62%); suicide prevention (58%); safe sex (54%); and violence generally (54%).

Table 1: Current and preferred target issues of CDAT

	Current	Preferred			
		Overall	Current member	Former member	Never a member
Alcohol	92%	96%	99% (7%)	95%	89%
Cannabis	56%	81%	82% (26%)	84%	79%
Other illicit drugs	53%	80%	82% (28%)	76%	77%
Misuse of prescription drugs	22%	70%	69% (47%)	82%	66%
Use of drugs and alcohol whilst pregnant	25%	68%	65% (39%)	74%	75%
Tobacco smoking	31%	62%	64% (34%)	63%	54%
Community wellbeing and social cohesion/inclusion	52%	77%	82% (32%)	68%	65%
Mental health	40%	74%	79% (39%)	61%	67%
Suicide prevention	19%	58%	61% (42%)	45%	56%
Safe sex	26%	54%	59% (33%)	40%	48%
Violence generally	21%	54%	62% (41%)	40%	42%
Domestic violence	13%	49%	54% (41%)	40%	42%
Bullying	13%	44%	50% (37%)	34%	35%
Men's issues	10%	42%	48% (38%)	32%	32%
Women's issues	10%	39%	45% (34%)	32%	30%
Obesity	2%	32%	39% (37%)	24%	18%

Q: For each one, please indicate if your CDAT currently works on the issue (current members only; n=193). Then please also indicate if you would like your CDAT to work on that issue in the future (all groups; n=310).

Darker shading represents significantly higher value, lighter shading represents significantly lower value.

The following significant differences were observed between the issues that the different groups wanted CDATs to work on in the future.

Current CDAT members were significantly **more** likely compared with all respondents to prefer that the following issues be included among the future remit.

- Alcohol (99% compared with 96%).
- Community wellbeing and social cohesion/inclusion (82% compared with 77%).
- Mental health (79% compared with 74%).
- Violence generally (62% compared with 54%).

- Bullying (50% compared with 44%).
- Men's issues (48% compared with 42%).
- Obesity (39% compared with 32%).

Former CDAT members were significantly **less** likely compared with all respondents to prefer that mental health be included among the future remit (61% compared with 74%).

Respondents who had **never been CDAT members** were significantly **less** likely compared with all respondents to prefer that the following issues be included among the future remit.

- Alcohol (89% compared with 96%).
- Community wellbeing and social cohesion/inclusion (65% compared with 77%).
- Violence generally (42% compared with 54%).
- Men's issues (32% compared with 42%).
- Obesity (18% compared with 32%).

4.8 Perceptions of broadening of remit of CDATs

Summary

- Some participants in the qualitative phase and a substantial minority of respondents in the online survey were concerned about a potential broadening of the remit of CDATs.
    - The key concern for CDAT members was being stretched too thinly across a greater number of issues. Almost half of current members expressed this concern, even while they also supported the idea of taking on more issues. This suggests that members would like to be able to take on a wider range of issues, but that a requirement to do so might lead to substantial loss of current membership.
    - There was a perception among participants in the qualitative phase that each CDAT should be given the autonomy to determine whether or not they would address broader health and social issues related to drug and alcohol use, and to identify appropriate projects that would address those issues conjointly. There was a strong sense that CDATs should not be *required* to address a broader range of issues.
    - Another concern that was raised about a broader remit was that the focus of CDATs might shift away from drugs and alcohol. Such a shift was generally not supported by consultation participants.
- A majority of survey respondents reported that they were not concerned about a broadening of the remit of CDATs. Reasons given for this lack of concern included that they favoured a holistic approach to addressing social issues including those related to drug and alcohol; or that they thought that the CDAT approach would be useful for addressing a wider range of issues.

Findings from the qualitative phase

Depth interview and consultation forum participants were asked to identify their preferences for implementation of wider remit for CDATs. There was a perception among participants that each community should be given the autonomy to determine whether their CDAT would address broader health and social issues related to drug and alcohol abuse, and to identify appropriate projects to address those issues conjointly. Participants identified a need to have a 'conversation' with CDAT members about how to make that shift, and for it to be presented to them as a possibility rather than a requirement. Participants also generally thought that an increase in funding for CDATs to run projects could be required, but some argued that any increases should be based on asking CDATs what they needed.

Participants brought the issue of the remit of CDATs back to a need for clarification of the objectives of the program, and identified a need for a framework that made clear how that broadened remit fit with the program objectives.

There was some concern that drug and alcohol issues might 'fall off the agenda' for some CDATs if drug and alcohol use became just one issue among many that a CDAT could choose to address, and the attention of the CDAT members therefore became more thinly-spread.

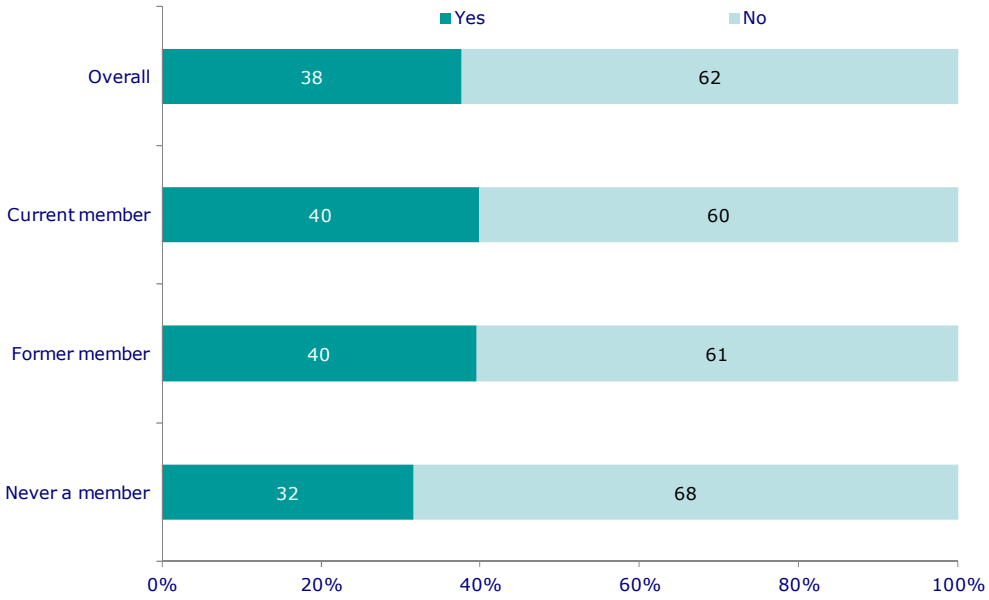
It was noted that a broadened remit for CDATs would create a need for further training of and information resources for CDAT members and Project Officers in the issues that they were taking on (for example, in evidence-based population-level methods for addressing mental health issues). Some participants were also concerned that CDAT members could become overwhelmed or burnt out if they perceived that they had been tasked with multiple health and social issues in their local area.

Mainstream service organisations were seen by some participants as relatively hamstrung, in comparison to CDATs, by what participants perceived to be the electoral unpalatability of evidence-based community development approaches to addressing drug and alcohol issues. On this basis, some participants argued that drug and alcohol issues should be retained at the core of the program because of the lack of mainstream alternatives to community action to address those issues.

Findings from the quantitative phase

Survey respondents were asked if they would have any concerns about the role of CDATs being broadened to cover some of the issues listed in Table 1 above. The results are depicted in Figure 26 below. Nearly two thirds of respondents reported 'no' (that is, they would not have any concerns about the role of CDATs being broadened) (62%) and the remaining 38% reported 'yes'.

Figure 26: Concerns regarding the broadening of remit

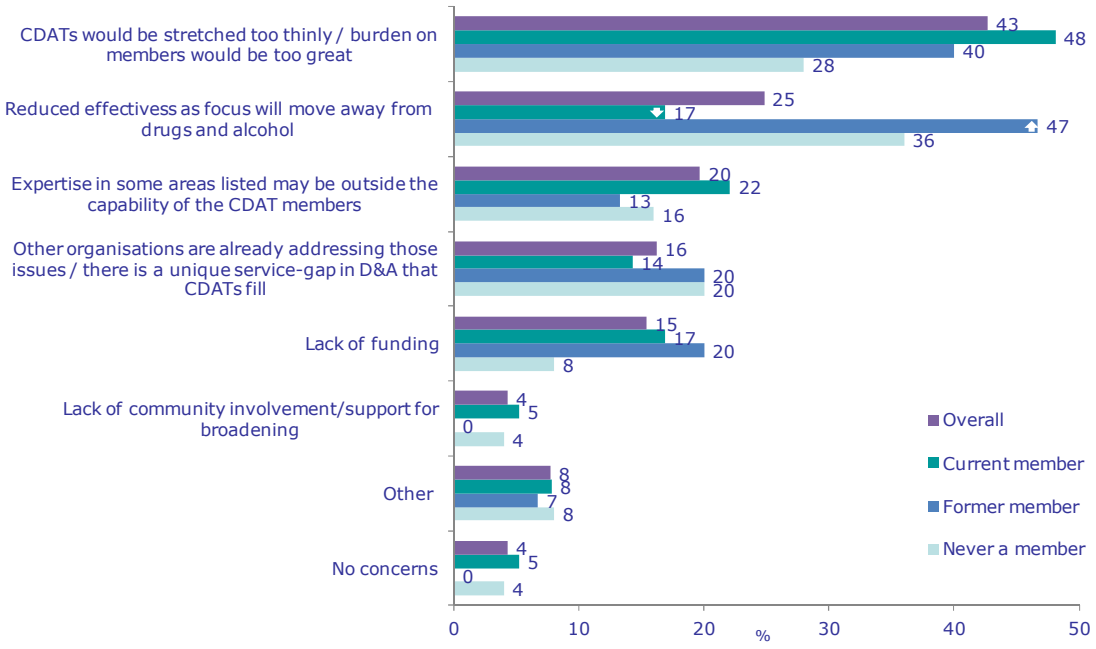


Q: Would you have any concerns about the role of CDATs being broadened to cover some of the issues listed in the previous question? Base: n=310

Respondents who reported that they would have concerns about the role of CDATs being broadened were asked 'what concerns do you have about the role of CDATs being broadened to cover some of those issues?' They were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent.

The results are depicted in Figure 27 overleaf. Forty-three percent of respondents with concerns gave a response coded as 'CDATs would be stretched too thinly / burden on members would be too great'. One-quarter of respondents gave a response coded as 'reduced effectiveness as focus will move away from drugs and alcohol' (25%); one-fifth as 'expertise in some areas listed may be outside the capability of CDAT members' (20%); 16% as 'other organisations are already addressing those issues / there is a unique service-gap in D&A that CDATs fill'; and 15% as a 'lack of funding'. Four percent of respondents with concerns gave a response coded as a 'lack of community involvement/support for broadening' while eight percent reported another concern.

Figure 27: Concerns about the role of CDATs being broadened



Q: What concerns do you have about the role of CDATs being broadened to cover some of those issues? Base: n=117

The following significant differences were observed between the membership categories within the sample with regard to concerns about the role of CDATs being broadened:

- **Current CDAT members** were significantly **less** likely to give a response coded as 'reduced effectiveness as focus will move away from drugs and alcohol' (17%) compared with all respondents (25%).

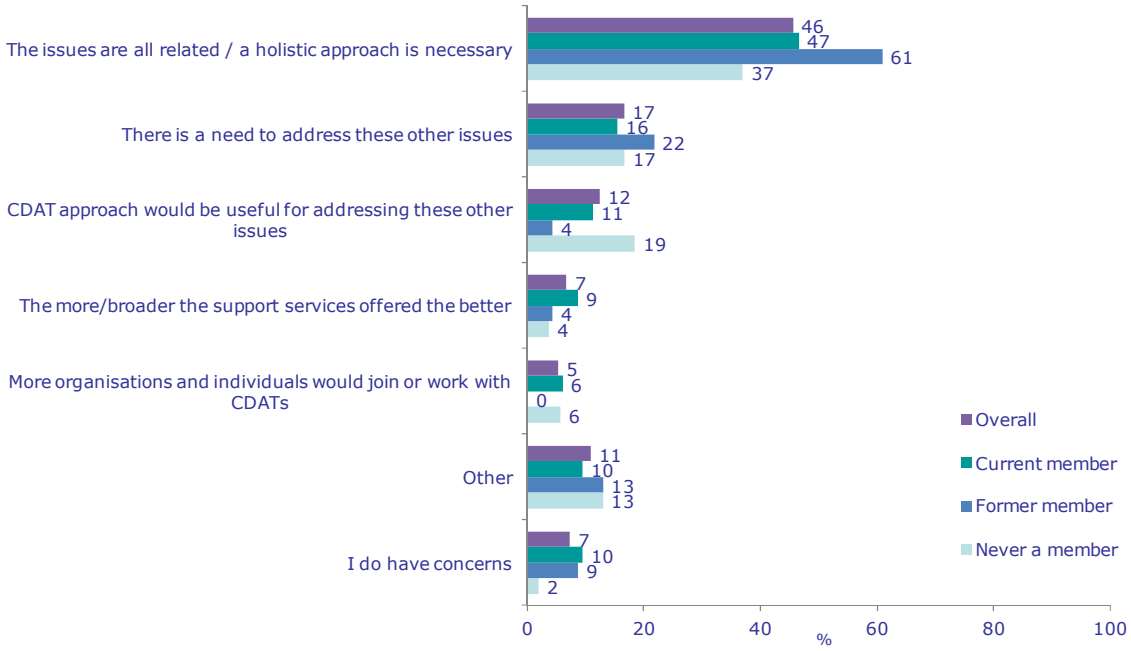
- **Former CDAT members** were significantly **more** likely to give a response coded as 'reduced effectiveness as focus will move away from drugs and alcohol' (47%) compared with all respondents (25%).

Despite concerns about CDAT members being stretched too thinly if the remit was broadened, Table 1 in Section 4.7 indicates willingness among respondents for CDATs to take on more issues. To investigate this apparent contradiction, additional analysis was conducted. It was found that the number of issues that respondents wanted CDATs to work on in the future (zero, one, two, three or more) did not differ significantly on the basis of whether a respondent expressed the concern that 'CDATs would be stretched too thinly / burden on members would be too great' if the remit was broadened. The absence of any significant differences indicates that those who were concerned about CDATs being stretched too thinly were not necessarily the same respondents who wanted to take on fewer or no additional issues in the future.

Respondents who reported that they would not have concerns about the role of CDATs being broadened were asked why they were not concerned. They were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent.

The results are depicted in Figure 28 below. Nearly half of respondents who reported that they would not have concerns gave a response coded as 'the issues are all related / a holistic approach is necessary' (46%). Seventeen percent gave a response coded as 'there is a need to address these other issues'; 12% 'CDAT approach would be useful for addressing these other issues'; seven percent 'the more/broader the support services offered the better'; and five percent 'more organisations and individuals would join or work with CDATs'. Eleven percent of respondents reported another concern and seven percent that, in fact, they did have concerns.

Figure 28: Reasons for lack of concern



Q: Why are you not concerned about the potential broadening of the role of CDATs to cover some of those issues?
Base: n=193

Ipsos Social Research Institute

4.9 Perceived key considerations when deciding future hosting arrangements for CDATs

Summary

- During the qualitative phase, participants generally observed that they had insufficient information about the various hosting arrangements under consideration to be able to make an informed choice between them. However, participants were able to identify what they saw as the key considerations in deciding on future hosting arrangements. For this reason, survey respondents were not asked to vote on a future hosting model, but were instead asked to indicate what they thought were the key considerations in deciding on future hosting arrangements. The key considerations were developed on the basis of views expressed during the qualitative phase. All considerations were seen as 'very important' by substantial majorities of respondents, with the only exception being 'simplify the auspicing arrangements for CDATs' which was seen as very important by a slight majority (51%).

- Participants in the qualitative phase were able to identify various advantages and disadvantages of retaining the current hosting arrangements, or devolving hosting to one or many NGOs.

    - Participants observed that an advantage of the current arrangement was that NSW Health had a presence across the whole state; that being under the umbrella of the Ministry of Health meant that Health employees were more likely to attend; and that being under the umbrella of a government department in general gave the program a legitimacy that facilitated the involvement of other departments, agencies and organisations.

    - NSW Health did receive some criticism as host, due to what were perceived as its time-consuming bureaucratic processes and its lack of experience and expertise in community engagement.

    - Few stakeholders recommended devolvement to the NGO sector but nevertheless, improved community involvement and reduced administrative burden were identified as possible benefits of devolvement.

    - Concerns with devolvement to the NGO sector were the loss of the current benefits associated with being under the umbrella of NSW Health, and uncertainty about to the agenda of an NGO host (for example, whether harm minimisation would be supported fully).

- Survey respondents were given the opportunity to provide open-ended comments about future hosting arrangements. The most common response, given by 11% of all respondents and 13% of respondents who were current CDAT members, was that current arrangements should be retained.

- Participants generally thought that, under any possible arrangement, NSW Health's role should include providing clear policy directives; funding; guidance on resource development; and expertise and evidence in the field of drug and alcohol health promotion. Participants often specified that they thought that the policy directives from NSW Health should provide CDATs with direction while allowing CDATs a degree of autonomy.

Findings from the qualitative phase

Depth interview and consultation forum participants were asked to consider the relative merits of Local Health Districts (LHDs) or the non-government sector hosting the program. Participants were also asked to consider the relevant merits of hosting by one or by many organisations if the program was hosted by the non-government. In general, participants wanted more detailed information about what was involved in each option, and in the absence of that information they were hesitant to express final opinions. Therefore, although many concerns were raised in this section of the consultation, they were raised within the context of a perception of insufficient information, and therefore it may be possible for some or all of those concerns to be addressed within any of the models. Furthermore, some participants expressed a view that the most critical factor for the way that each CDAT operated was the kind of people involved in the CDAT, and their level of commitment. These participants anticipated the CDATs could therefore work under a range of different models. Participants were also asked to consider whether an expanded remit for CDATs would change their perception of the appropriate support options. Many perceived that it would make little difference, although some thought that an expansion of remit beyond drug and alcohol would present difficulties for the program being hosted by a drug and alcohol NGO.

Most important considerations when deciding best arrangement of support for CDATs

Participants identified the following as the most important considerations when deciding best arrangement of support for CDATs.

- Clarify the objectives of the program and the role of CDATs.

- Ensure the policy directive from NSW Health is clear and that it is implemented.

- Base the program in a clear and appropriate theory of change, and ensure that CDATS are supported to implement that theory of change.

- Ensure that the hosting organisation supports harm minimisation as a principle.

- Ensure that the level of funding for the program is not reduced; and give a clear commitment to ongoing support of the program (i.e. by including it in forward estimates/budgets).
- Simplify the auspicing arrangements for CDATs.
- Ensure that CDATs can have a strong relationship with their Project Officer, and have good administration support.
- Avoid significant turnover of Project Officers, who hold a great deal of corporate memory.
- Ensure that representatives from government departments and agencies, and especially NSW Health, continue to see CDATs as important.
- Ensure that there is no brand clash between the hosting organisation and the objectives of the program.

Participant perceptions of the program being hosted by LHDs

Participants suggested that the option of having LHDs host the program had the following strengths.

- A link with communities for NSW Health, and an opportunity for communities to engage with government.
- Ability for NSW Health to get involved in education of communities about drug and alcohol health promotion.
- Ability to NSW Health to use the program as a way to manage community expectations about the extent to which drug and alcohol problems can be resolved by the Department itself.
- The clear association with NSW Health would provide CDATs with a sense of legitimacy, and would assist in gaining the involvement of others in the health sector.
- The CDATs could utilize the specialist health-related expertise and information available through NSW Health.
- CDATs would be seen to be a priority of government, and actively supported by it.
- The support of one government agency was seen to encourage and facilitate the involvement of other government agencies.
- NSW Health was seen to be relatively neutral in its involvement in how CDATs operated organisationally, and this was seen to be a strength in that it gave CDATs a level of autonomy.

- NSW Health was seen to offer a consistent presence across the state.

- There are already the existing management structures in place within some LHDs, and current Project Officers would be more likely to be retained if they could remain within NSW Health.

Participants suggested that the option of having LHDs host the program had the following weaknesses.

- NSW Health was seen to not have many other community engagement programs, and therefore to not have expertise in facilitating community engagement. LHDs were also seen to be not necessarily 'in touch' with communities, or have strong community-level networks.

- NSW Health was seen to have high levels of bureaucracy which imposed administration burdens on CDATs and sometimes made it more difficult to hire staff.

- Different LHDs were seen to operate in different ways, such that the program would not be supported in consistent ways across the different LHDs.

- LHDs were seen to be oriented towards a clinical model of health care, and to not see health promotion as a priority. There was concern that Project Officers might be 'pushed' toward taking on that clinical model, or that the Project Officers might be isolated within the LHD if they pursued health promotion.

Participant perceptions of program being hosted within NGO sector

Participants suggested that the option of having the NGO sector host the program had the following strengths.

- NGOs are strong in community development and have a long history of being close to communities. NGOs were seen to be able to call on existing networks with communities in a way that would be beneficial for the program.

- Some thought that this model would lead to better auspicing arrangements for CDATs, but others thought it would make no difference.

- Some thought that this model would lead to better insurance arrangements for CDATs, but others thought it would make no difference.

- Some participants observed that in the NGO sector the program would not be bound by public service workplace agreements, thereby potentially reducing staff costs and making hiring easier.

Participants suggested that the option of having the NGO sector host the program had the following weaknesses.

- Participants' main concerns with the NGO model were that they did not understand what it would entail; that there was a possibility of disruption to the current operation of the program; and that the positive aspects of hosting by the LHDs, as noted above, would be lost.

- Current Project Officers might not want to make the switch to working in the non-government sector, leading to a substantial loss of corporate knowledge and disruption of existing relationships with CDATs.

- Unevenness of presence of a single or multiple NGOs across different local areas.

- There was some concern that an NGO might not engage enthusiastically with the program and the issues that it was trying to address, but rather be focused only on compliance with the terms of the funding agreement.

Perceptions of relative merits of hosting by single or multiple NGOs

- Participants noted that few large NGOs had a presence across all areas of the state, such that it might be difficult for a single existing organisation to deliver the program consistently across the whole state.

- Participants noted that small NGOs did work across large areas, so might be restricted in the breadth of networks that they could bring to a role in hosting CDATs. It was also noted that if the program was hosted by multiple different organisations, this might reduce the opportunities for CDATs to work and share knowledge with other CDATs hosted by different organisations.

- There was a concern that if the program was hosted by multiple different organisations, there would be inconsistencies between the way different CDATs were managed.

- Some observed that if multiple different small NGOs hosted the program, each host would be better tied in with communities in each CDAT's area, in comparison with a single large NGO. This was seen as particularly important for regional responses to drug and alcohol issues, given the deeper connections that some small NGOs have with communities in those areas.

- It was noted that there could be substantial logistical problems for NSW Health if it was to work with CDATs hosted by multiple different NGOs, and if it had to manage the contracts of multiple different NGOs. Some also thought that there would be reduced cost effectiveness and increased inefficiencies if the program was hosted by multiple different NGOs, as each would replicate the same kind of administrative work of the others.

Perceptions of merits of forming a new NGO to operate the program

- Some participants thought that a key advantage of this option would be that the organisation would come with no 'baggage', such that it would have (and would be perceived to have) a clear focus on the program.

- It was noted by some that this model had proven successful in Western Australia.

- There were concerns expressed about how costly and time consuming it would be to 'start from scratch'.

- Some participants thought that a new NGO would seem artificial and isolated, and would have no existing networks from which to work.

Suggestions of other structures or programs to deliver the program

The following suggestions were each made by individual participants.

- Have a model in which Project Officers are given funding, and then fund community members to come together as a group to run projects to address specific issues in an ad hoc manner. This model would do away with the regular meetings and operate more like a regular grants program.

- Adopt the *Communities for Children* funding model used by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). In this model,

> *a key local non-government organisation (Facilitating Partner) in each site acts as broker in engaging smaller local organisations to deliver a range of activities in their communities. In implementing their local initiative, Facilitating Partners establish a Communities for Children Committee with broad representation from participants in their community. The Facilitating Partner oversees the development and implementation of strategies and activities and manages the funding allocation for the site. Much of the funding is allocated to other local service providers to deliver the activities.*[7]

- Integrate the program with similar work being done through Liquor Accords, supported by the NSW Office of Liquor Gaming and Racing.

7 Department of Families, Housing and Indigenous Affairs 2011, 'Communities for Children', viewed 28 November 2011, http://www.fahcsia.gov.au/sa/families/progserv/communitieschildren/Pages/default.aspx

- Use the *SMART Recovery* model in which an organisation runs with a small number of paid staff whose role is to go to local areas and train people in the SMART model, then leave the trainees to implement the model.

Perceived role NSW Health should play in supporting program

Participants generally thought that NSW Health should support the program by providing policy clear directives; funding; guidance on resource development; and expertise and evidence in the field of drug and alcohol health promotion. Participants often specified that they thought that the policy directives from NSW Health should provide CDATs with direction while allowing CDATs a degree of autonomy.

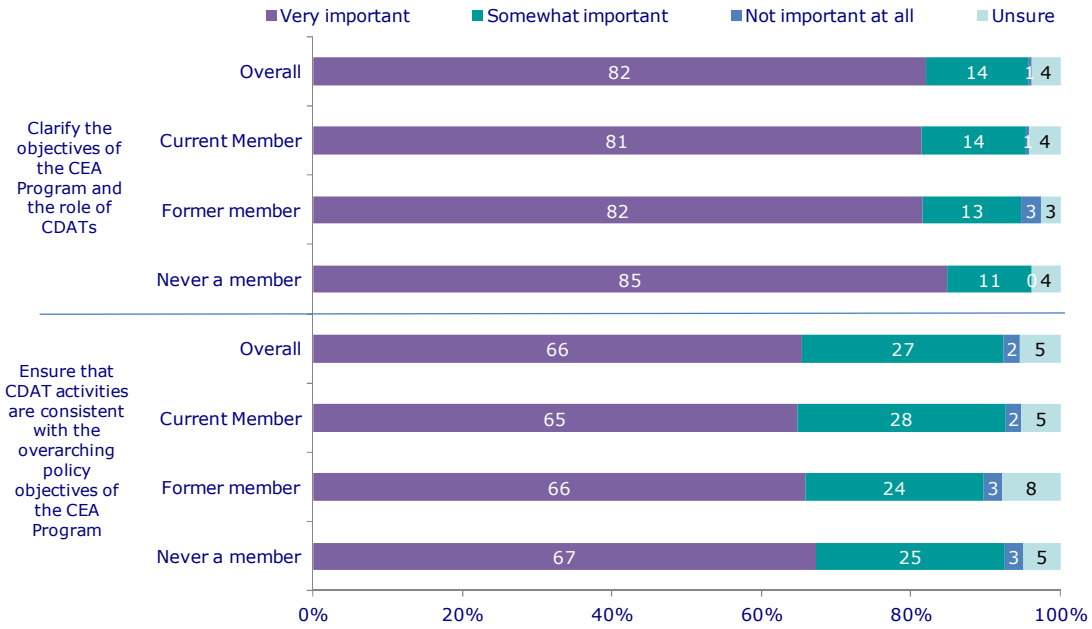
Findings from the quantitative phase

Survey respondents were shown a list of 11 considerations when deciding hosting arrangements for the future and asked to indicate how important they thought each of the considerations was. The perceived level of importance of each consideration is shown across four separate charts below.

Figure 29 overleaf shows that more than four-fifths of respondents reported it was 'very important' to 'clarify the objectives of the CEA Program and the role of CDATs' (82%) and a further 14% reported it was 'somewhat important'. One percent reported it was 'not at all important'. Four percent of respondents were unsure.

Two-thirds of respondents reported it was 'very important' to 'ensure that CDAT activities are consistent with the overarching policy objectives of the CEA program' (66%) and a further 27% reported it was 'somewhat important'. Two percent reported it was 'not at all important'. Five percent of respondents were unsure.

Figure 29: Considerations for future hosting arrangements



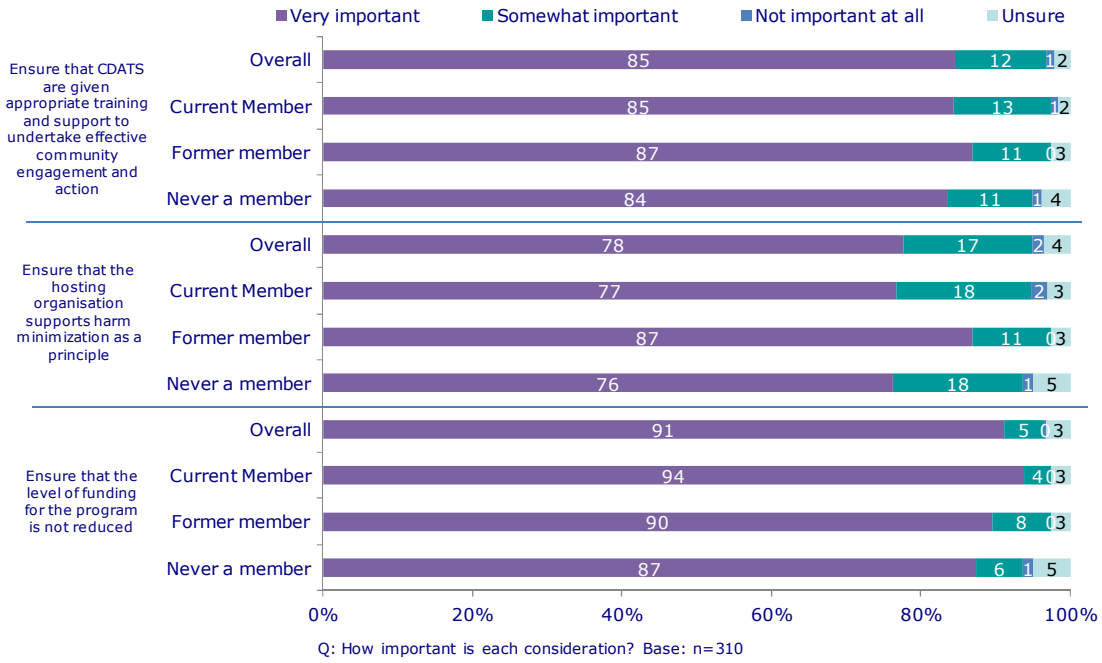
Q: Below is a list of considerations when deciding hosting arrangements for the future. Please indicate how important you think each of the considerations is. Base: n=310

Figure 30 overleaf shows that 85% of respondents reported it was 'very important' to 'ensure that CDATS are given appropriate training and support to undertake effective community engagement and action' and a further 12% reported it was 'somewhat important'. One percent reported it was 'not important at all'. Two percent of respondents were unsure.

Nearly four-fifths of respondents reported it was 'very important' to 'ensure that the hosting organisation supports harm minimisation as a principle' (78%) and a further 17% reported it was 'somewhat important'. Two percent reported it was 'not important at all'. Four percent of respondents were unsure.

More than nine in ten respondents reported it was 'very important' to 'ensure that the level of funding for the program is not reduced' (91%) and a further five percent reported it was 'somewhat important'. Less than one percent reported it was 'not important at all'. Three percent of respondents were unsure.

Figure 30: Considerations for future hosting arrangements



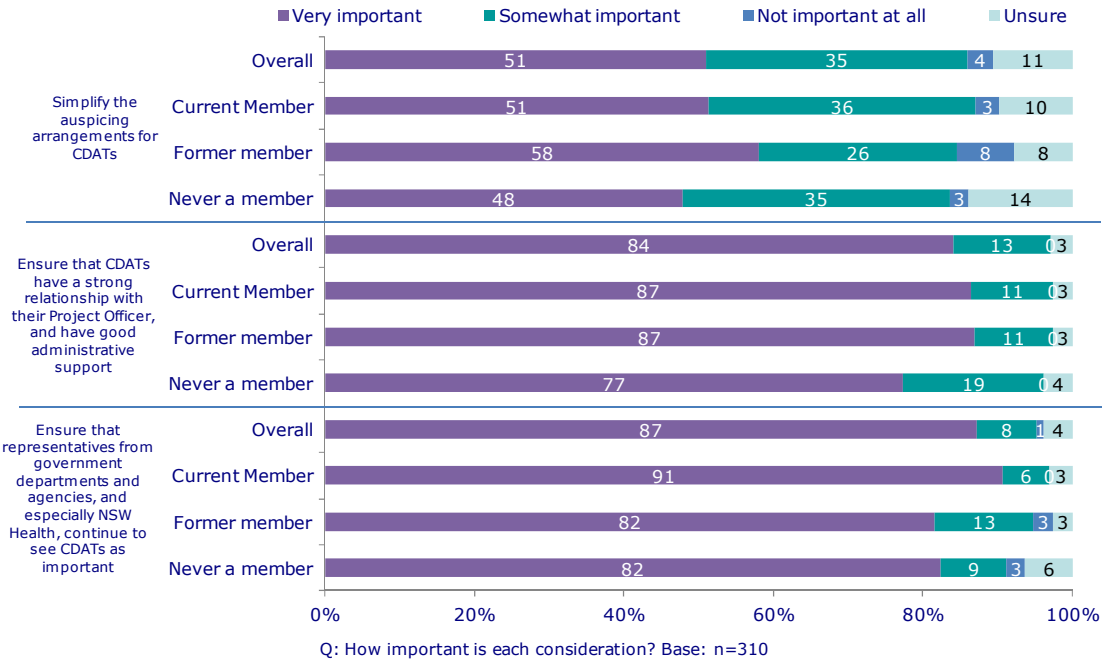
Q: How important is each consideration? Base: n=310

Figure 31 overleaf shows that more than half of respondents reported it was 'very important' to 'simplify the auspicing arrangements for CDATs' (51%) and a further 35% reported it was 'somewhat important'. Four percent reported it was 'not important at all'. Eleven percent of respondents were unsure.

More than four-fifths of respondents reported it was 'very important' to 'ensure that CDATs have a strong relationship with their Project Officer, and have good administrative support' (84%) and a further 13% reported it was 'somewhat important'. Less than one percent reported it was 'not important at all'. Three percent of respondents were unsure.

Eighty-seven percent of respondents reported it was 'very important' to 'ensure that representatives from government departments and agencies, and especially NSW Health, continue to see CDATs as important' and a further eight percent reported it was 'somewhat important'. One percent reported it was 'not important at all'. Four percent of respondents were unsure.

Figure 31: Considerations for future hosting arrangements



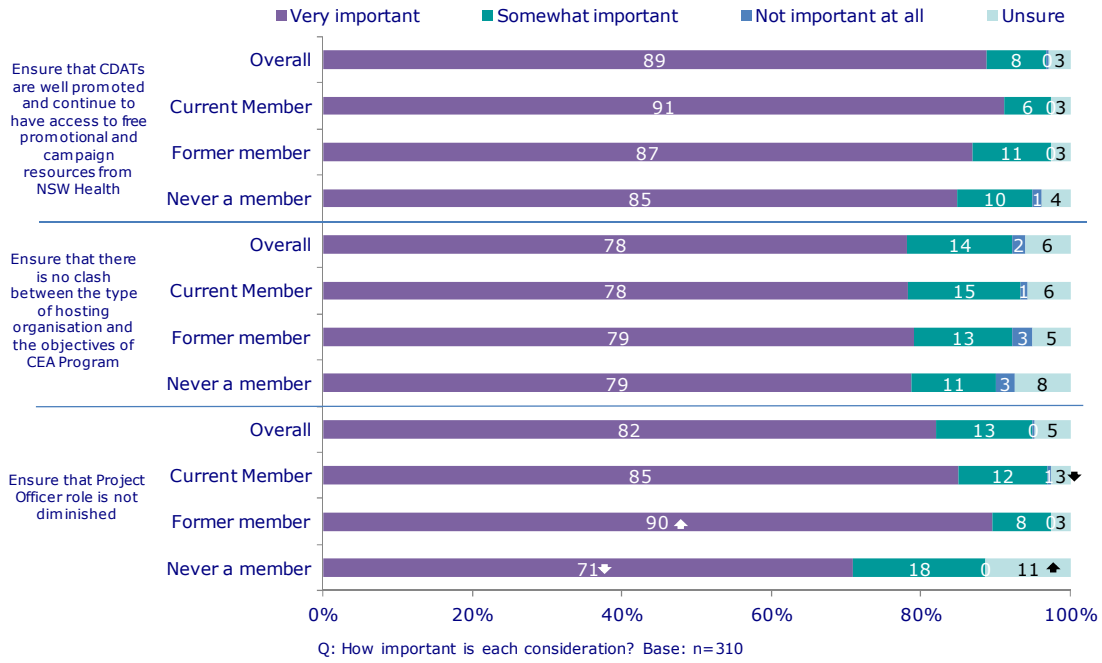
Q: How important is each consideration? Base: n=310

Figure 32 overleaf shows that nearly nine in ten respondents reported it was 'very important' to 'ensure that CDATs are well promoted and continue to have access to free promotional and campaign resources from NSW Health' (89%) and a further eight percent reported it was 'somewhat important'. Less than one percent reported it was 'not important at all'. Three percent of respondents were unsure.

Nearly four-fifths of respondents reported it was 'very important' to 'ensure that there is no clash between the type of hosting organisation and the objectives of CEA Program' (78%) and a further 14% reported it was 'somewhat important'. Two percent reported it was 'not important at all'. Six percent of respondents were unsure.

More than four-fifths of respondents reported it was 'very important' to 'ensure that Project Officer role is not diminished' (82%) and a further 13% reported it was 'somewhat important'. Less than one percent reported it was 'not important at all'. Five percent of respondents were unsure.

Figure 32: Considerations for future hosting arrangements



Q: How important is each consideration? Base: n=310

The following significant differences were observed between the membership categories within the sample with regard to how important each of the considerations was indicated to be:

- **Former CDAT members** were significantly **more** likely to report it was 'very important' to 'ensure that Project Officer role is not diminished' (90%) compared with all respondents (82%).

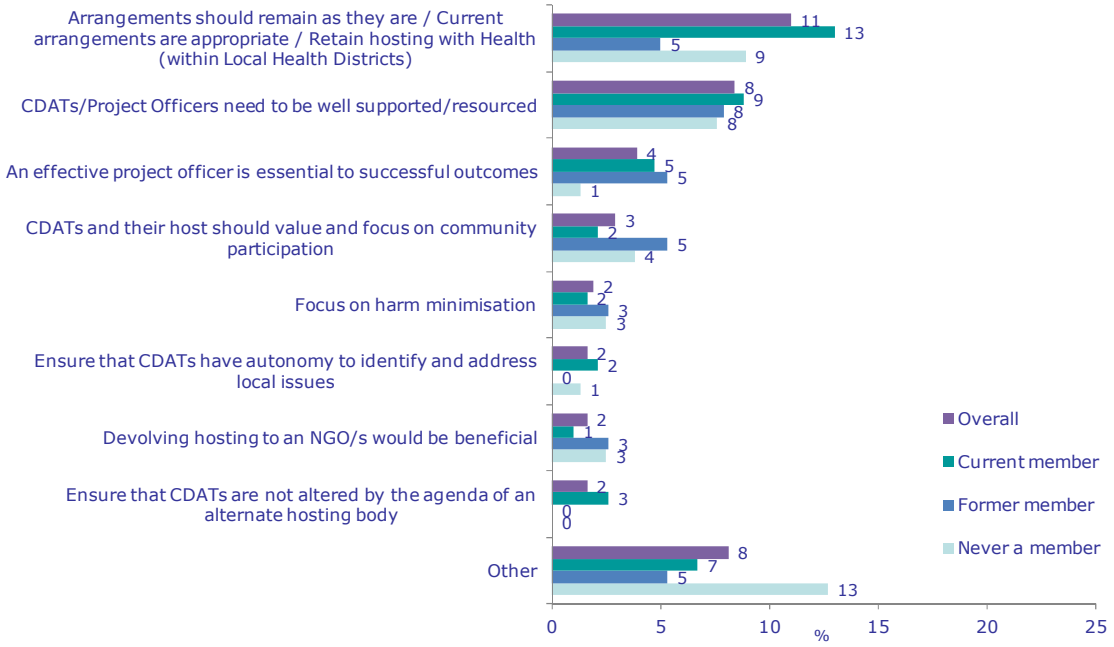
- Respondents who had **never been CDAT members** were significantly **less** likely to report it was 'very important' to 'ensure that Project Officer role is not diminished' (71%) compared with all respondents (82%) and significantly **more** likely to be unsure (11% compared with 5%).

- **Current CDAT members** were significantly **less** likely to be unsure as to whether it was important to 'ensure that Project Officer role is not diminished' (3%) compared with all respondents (5%).

Respondents were asked 'Do you have any further comments about CDATs' current or future hosting arrangements?' They were provided with a text box to record an open-ended response. The responses were coded during the analysis phase. Where applicable, multiple codes were used for the response of a single respondent.

The results are depicted in Figure 33 below. Nearly one-third of respondents did not answer (31%). Eleven percent gave a response coded as 'arrangements should remain as they are / Current arrangements are appropriate / Retain hosting with Health (within Local Health Districts)' and nine percent as 'CDATs/Project Officers need to be well supported/resourced'. Four percent of respondents gave a response coded as 'an effective project officer is essential to successful outcomes'; three percent that 'CDATs and their host should value and focus on community participation'; two percent that hosting arrangements should 'focus on harm minimisation'; and roughly equal proportions that hosting arrangements should 'ensure that CDATs have autonomy to identify and address local issues' (2%); that 'devolving hosting to an NGO/s would be beneficial' (2%); and that hosting arrangements should 'ensure that CDATs are not altered by the agenda of an alternate hosting body' (2%).

Figure 33: Further comments about hosting arrangements



Q: Do you have any further comments about CDATs' current or future hosting arrangements? (open-ended)
Base: n=310

A

APPENDIX A: DISCUSSION GUIDE FOR INTERVIEWS AND FORUMS

Introduction

- Introduce Ipsos-Eureka
- Ipsos-Eureka has been commissioned by NSW Health to undertake a consultation with key participants of the Community Engagement and Action (CEA) Program, so as to form a basis for the revision of the 'Framework for Action' policy document guiding the CEA Program and delivery of support for CDATs.
- Our questions today will focus on your:
    - views on what values and practices are central to CDATs;
    - preferences for the remit of CDATs;
    - views on the key practical issues facing CDATs including resourcing requirements; and;
    - opinions on governance structure and delivery options.
- If you or a CDAT you are involved with has expertise in particular areas, can you please draw upon that when answering the questions? For example, if you are from a CDAT in a rural and remote area, consider how the issues discussed would affect CDATs in rural and remote areas?
- Thank participant(s) for their participation in this participant consultation project.
- Key Informant Interviews: The interview will take no longer than 1 hour
- Group Interviews: This session will last no longer than 3 hours
- Seek permission to audio tape. Audio taping for Ipsos-Eureka's internal purposes only. Quotes will not be attributed and quotes that may identify you will not be included.

1. Context setting: perceptions of the values/practices central to CDATs

- **What are the key values that underlie the activities of CDATs?**

- [**PROBE ON**: Building on strengths (asset-based community development), harm minimisation, partnerships & community engagement, local responses to local issues (drawing upon and building local social capital).

2. Preferences for the role and purpose of CDATs

- **What do you understand to be the current purpose of Community Drug Action Teams?**

- **What are the health issues that CDATs are tasked to focus on?**
- **What are the populations CDATs currently work with?**
- **Do you think the role and purpose of CDATs is clear?**
- **Do you think it needs to be clearer?**
- **In your opinion, is the approach taken by CDATs one that would be beneficial for also addressing other issues within the community? Why /why not?** [After getting spontaneous answers, if not mentioned, **PROBE FOR**: suicide prevention, mental health, community well-being, obesity, other]
- **What concerns would you have about the role of CDATs being broadened?** [After getting spontaneous answers, if not mentioned, **PROBE FOR**: capacity of CDAT members to know about a wide range of topics, important but unpopular areas of activity being abandoned in favour of non-confrontational areas (e.g. shift from illicit drugs to community well-being)]
- **What issues would need to be addressed before you would support the role of CDATs being broadened?** [After getting spontaneous answers, if not mentioned, **PROBE FOR**: provision of appropriate training, adequate additional funding, additional Project Officer support, changes to Terms of Reference, introduction of working groups, etc]

3. Practical issues affecting CDATs

- **In your view, what are the biggest issues or problems facing CDATs in terms of how they operate?** [**PROBE FOR**: CDAT member skills to deliver projects, access to training and support and information and resources, building and maintaining partnerships, auspicing arrangements, attracting additional funds, insurance, Project Officer recruitment, capacity of Project Officer to provide adequate support to CDATs across large areas.]
- **Are there any areas in which CDATs would benefit from additional supports?** Please provide details.

4. Views on arrangements for support for CDATs

- **Do you know who currently hosts the Community Engagement and Action (CEA) Program?** (IF NECESSARY: that is, the program which supports CDATs across NSW) [Explore level of knowledge]

[IF NECESSARY:] Currently hosting of the CEA Program is divided between NSW Health and the Local Health Districts. Project Officers, providing direct support to CDATs, are based in the Local Health Districts. All other functions (grants management, state-wide policy and resource development) are undertaken by NSW Health, within the Mental Health Drug and Alcohol Office (MHDAO).

- **What do you think are the strengths of the CEA Program being hosted by the Local Health Districts, and what are the weaknesses?**
- **What are the strengths and weaknesses of delivery of the CEA Program being hosted by the Non Government Organisation sector?**
- **If the CEA Program was to be hosted in the NGO sector in the future, should it be hosted by a single NGO or multiple Non-Government Organisations? What are the reasons for your answer?**
    - What are the pros and cons of each option?
- **Would it be beneficial to form a new NGO specifically to operate the CEA Program?**
- **Are there other structures or programs that you could suggest could deliver the CEA Program?**
- **Do you think that any future expansion to the role of CDATs would impact on what you would consider to be the best arrangement of support for CDATs? In what way? Why?**
- **What do you think are the most important considerations when trying to decide what might be the best arrangement of support for CDATs?**
- **What role should NSW Health play in supporting the CEA Program?**

Final comments

- **Do you have any further suggestions as to how the CEA Program could run more effectively, and what direction you would like to see it follow in the future?**

Closing

- **Thank you for taking time to contribute.**
- **NSW Health will provide you with a copy of the summary of the data obtained from this consultation process.**

B

APPENDIX B: ONLINE SURVEY QUESTIONNAIRE

HEADINGS WILL NOT APPEAR IN FIELD VERSION. ALL QUESTIONS ARE SINGLE RESPONSE ONLY UNLESS OTHERWISE STATED. ALL UPPER CASE TEXT IS PROGRAMMING INSTRUCTIONS.

[SURVEY STATUS BAR AT BOTTOM OF EACH PAGE]

Introduction

This online survey should take around **15 minutes** to complete. We ask you to complete the survey prior to Friday October 21.

[DOUBLE LINE SPACE]

Please be assured that your responses will remain **confidential**, as all responses will be combined. NSW Health will not know how any individual CDAT or person has answered. Nor will you be asked to name a CDAT with which you are associated.

[DOUBLE LINE SPACE]

Please read each question and follow the instructions to record your reply.

Please DO NOT use the 'Back' and 'Forward' buttons in your browser. Rather, please use the buttons at the bottom of each screen.

Only **one person** will be able to use this link to access the survey.

If you would like to take a break and return to the survey later, simply close the window and click on your original survey link in your email invitation to return.

1 Screener and demographics

1.1 Do you currently belong to a Community Drug Action Team (CDAT)?

Yes	1
No	0

1.2 [IF1.1=0] Have you ever belonged to a CDAT team?

Yes	1
No	0

1.3 [IF1.1=0] Why do you not currently belong to a CDAT team? [CAPTURE OPEN-ENDED RESPONSES VERBATIM]

1.4 [IF 1.1=1] In which region is your CDAT based?

Central Coast	1
Illawarra Shoalhaven	2
Nepean Blue Mountains	3
Northern Sydney	4
South Eastern Sydney	5
South Western Sydney	6
Sydney	7
Western Sydney	8
Far West NSW	9
Hunter New England	10
Mid North Coast	11
Murrumbidgee	12
Northern NSW	13
Southern NSW	14
Western NSW	15
I'm not certain but we meet in:_____ (please specify town/suburb)	99 [OPEN ENDED FIELD]

1.5 [IF 1.1=1] Which of the following **best** describes you, as a member of your CDAT?

Local resident	1
Local business person	2
Student	3
Employee of a non-government or community managed organisation	4
Local government employee	5
Local government elected member	6
NSW Government employee	7

NSW Government elected member	8
Commonwealth Government employee	9
Commonwealth Government elected member	10
School employee	11
Tertiary education institution employee	12
Other (please specify)	99 [OPEN ENDED FIELD]

1.6 [IF 1.5 = 3] Are you involved in the CDAT as part of your study?

Yes	1
No	0

1.7 [IF 1.5=7] By which type of NSW Government Department or Agency are you employed?

Housing	1
Police and criminal justice	2
Family and Community Services	3
Schools – Primary or High	4
TAFE/University and other adult education	5
Aboriginal Affairs and related areas	6
Migrant/refugee and related areas	7
Drug and alcohol/mental health service	8
Other health service	9
Other (please specify)	10 [OPEN-ENDED FIELD]

1.8 [IF 1.5=4] What kind of non-government or community managed organisation do you work for? [MULTIPLE RESPONSE]

Community development	1
Drug and alcohol/mental health service	2
Aboriginal Community Controlled Service	3
Migrant/refugee and related areas	4
Housing Service	5
Religious	6
Other NGO (please specify)	7 [OPEN-ENDED

	FIELD]

2 Practices central to CDATs, and views on the broadening of their remit

2.1 How clear to you are the current role and purpose of CDATs?

Very clear	2
Somewhat clear	1
Not at all clear	0

2.2 Do you feel the role and purpose of CDATs should be spelt out more clearly?

Yes	1
No	0

2.3 [IF 2.2=1] Which aspects of the role and purpose of CDATs do you think should be made clearer? [CAPTURE OPEN-ENDED RESPONSES VERBATIM]

2.4 [IF 2.2=0] Why don't you think that the role and purpose of CDATs needs to be made clearer? [CAPTURE OPEN-ENDED RESPONSES VERBATIM]

2.5 To what extent do you agree that each of the following is a key strength of the CDAT approach and should be maintained regardless of future changes to the Community Engagement and Action (CEA) Program?

	[RANDOMISE ORDER OF PRESENTATION OF ITEMS]	Agree strongly	Agree mildly	Neither agree nor disagree	Disagree mildly	Disagree strongly	Unsure
A	CDAT activities have a strong focus on **harm minimisation**	4	3	2	1	0	98
B	CDAT activities help **build resilience** within communities, equipping communities with the capacity to address their own concerns	4	3	2	1	0	98
C	CDATs are **community-based** and community driven	4	3	2	1	0	98
D	CDAT activities enable a **whole of community response** to drug and alcohol issues	4	3	2	1	0	98
E	The CDAT approach builds **partnerships** and relationships within the community, fostering a collaborative approach to addressing drug and alcohol issues	4	3	2	1	0	98
F	The CDAT approach encourages better **alignment of local, state and national Government resources** for addressing drug and alcohol concerns at the local level	4	3	2	1	0	98
G	The CDAT approach helps create more effective **links between programs**, and mobilises resources from other initiatives	4	3	2	1	0	98
H	CDAT activities are fundamentally **action-oriented**	4	3	2	1	0	98
I	CDAT activities are **customised responses** to drug and alcohol issues to meet the needs of particular communities	4	3	2	1	0	98

J	The strategies employed by CDATs represent **best practice** in community responses to drug and alcohol concerns, based upon available evidence	4	3	2	1	0	98
K	CDATs take a **holistic approach** to addressing drug and alcohol issues, drawing in related issues (such as mental health, violence, safe sex, community wellbeing)	4	3	2	1	0	98
L	The CDAT approach **identifies drug- and alcohol-related problems** in the local community	4	3	2	1	0	98
M	CDATs are ideally positioned to provide a **timely and effective** response to local drug- and alcohol-related problems.	4	3	2	1	0	98

2.6 [IF 1.1 = 1] While some CDATs focus on issues across the whole community, others focus more exclusively on particular groups. Which of the following best describes the **main focus** of your CDAT? (You can select more than one answer for this question.) [MULTIPLE RESPONSES ALLOWED]

The **main focus** of my CDAT is on issues among…

[RANDOMISE ORDER OF ITEMS BUT LEAVE '… another segment in the community (please specify)' LAST]	
… the **general population** in our local area.	1
… **young people** in our local area.	2
… the **Aboriginal population** in our local area.	3
… **migrant or refugee communities** in our local area.	4
… another segment in the community (please specify)	5 [OPEN-ENDED FIELD]

2.7 [IF 1.1=1] The list below shows a range of health and social issues. For each one, please indicate if your CDAT currently works on the issue. Then please also indicate if you would like your CDAT to work on that issue in the future. (You can tick both boxes.)

	[DO NOT RANDOMISE ORDER]	2.7.1 [IF 1.1=1] My CDAT currently works on this issue: [CHECK BOXES, MULTIPLE RESPONSE ALLOWED]	2.7.2 [IF 1.1=1] I would like my CDAT to work on this issue in the future: [CHECK BOXES, MULTIPLE RESPONSE ALLOWED]
A	Alcohol	1	1
B	Cannabis	1	1
C	Other illicit drugs	1	1
D	Misuse of prescription drugs	1	1
E	Mental health	1	1

F	Suicide prevention	1	1
G	Obesity	1	1
H	Tobacco smoking	1	1
I	Violence generally	1	1
J	Domestic violence	1	1
K	Safe sex	1	1
L	Use of drugs and alcohol whilst pregnant	1	1
M	Bullying	1	1
N	Men's issues	1	1
O	Women's issues	1	1
P	Community wellbeing and social cohesion/inclusion	1	1
Q	Other issue not listed above	1	1

2.7.3 [IF 2.7.1Q=1] What other health and social issues does your CDAT work on? [CAPTURE OPEN ENDED RESPONSES VERBATIM]

2.7.4 [IF 2.7.2Q=1] What other health and social issues would you like your CDAT to work on in the future? [CAPTURE OPEN ENDED RESPONSES VERBATIM]

2.8 [IF 1.1=0] The list below shows a range of health and social issues. For each one, please indicate if you would like CDATs to work on that issue in the future.

	[DO NOT RANDOMISE ORDER]	2.8.2 [IF 1.1=0] I would like CDATs to work on this issue in the future: [CHECK BOXES, MULTIPLE RESPONSE ALLOWED]
A	Alcohol	1
B	Cannabis	1
C	Other illicit drugs	1
D	Misuse of prescription drugs	1
E	Mental health	1
F	Suicide prevention	1
G	Obesity	1
H	Tobacco smoking	1
I	Violence generally	1
J	Domestic violence	1
K	Safe sex	1

L	Use of drugs and alcohol whilst pregnant	1
M	Bullying	1
N	Men's issues	1
O	Women's issues	1
P	Community wellbeing and social cohesion/inclusion	1
Q	Other (please specify)	1 [OPEN-ENDED FIELD]

2.9 Would you have any concerns about the role of CDATs being broadened to cover some of the issues listed in the previous question?

Yes	1
No	0

2.10 [IF 2.9=1] What concerns do you have about the role of CDATs being broadened to cover some of those issues? [OPEN-ENDED RESPONSE]

2.11 [IF 2.9=0] Why are you not concerned about the potential broadening of the role of CDATs to cover some of those issues? [OPEN-ENDED RESPONSE]

3 Practical issues currently affecting CDATs

3.1 [IF 1.1=1] What are the strengths of your CDAT? [OPEN-ENDED RESPONSE]

3.2 [IF 1.1=1] How do you think the effectiveness and impact of your local CDAT could be improved? (Please provide as much detail as possible.) [OPEN-ENDED RESPONSE]

3.3 [IF 1.1=1] Thinking about your CDAT now, to what extent do you agree or disagree with each of the following statements?

	[RANDOMISE ORDER OF PRESENTATION OF ITEMS]	Agree strongly	Agree mildly	Neither agree nor disagree	Disagree mildly	Disagree strongly	Unsure
A	Our CDAT has been disrupted by a change or absence of Project Officer	4	3	2	1	0	98
B	Our CDAT gets enough support from our Project Officer	4	3	2	1	0	98
C	Our CDAT gets enough face-to-face contact with our Project Officer	4	3	2	1	0	98
D	Our CDAT easily attracts new members	4	3	2	1	0	98
E	People who join our CDAT generally stay as members for a long time.	4	3	2	1	0	98
F	We generally have found it easy to fill the executive roles on our CDAT (such as the chair, secretary etc.)	4	3	2	1	0	98
G	Our members have the skills to make the CDAT function	4	3	2	1	0	98

	effectively						
H	Our CDAT has had problems in finding and maintaining its auspice partnership/s	4	3	2	1	0	98
I	Our CDAT has trouble getting insurance for the projects and activities that we want to run	4	3	2	1	0	98
J	There are good opportunities for CDATs to share ideas and collaborate	4	3	2	1	0	98
K	Our CDAT members get enough training opportunities	4	3	2	1	0	98
L	Our CDAT gets enough funding, or in kind support, to function properly and run the projects and activities we want to	4	3	2	1	0	98
M	Our CDAT spends a lot of its time trying to get funding for our projects and activities	4	3	2	1	0	98
N	Administrative tasks take up too much time for our CDAT	4	3	2	1	0	98
O	We have good access to community information resources and tools	4	3	2	1	0	98

3.4 [If 3.2B=0 or 1] What further support would you like to receive from your Project Officer? [OPEN-ENDED RESPONSE]

4 Views on arrangements to support CDATs

4.1 Hosting of the Community Engagement and Action (CEA) Program is currently divided between NSW Health and the Local Health Districts. It is possible that hosting arrangements will be changed in the future and there are various pros and cons for the different possible hosting arrangements.

Below is a list of considerations when deciding hosting arrangements for the future. Please indicate how important you think each of the considerations is.

		Very important	Somewhat important	Not important at all	Unsure
A	Clarify the objectives of the CEA Program and the role of CDATs	2	1	0	98
B	Ensure that CDAT activities are consistent with the overarching policy objectives of the CEA Program	2	1	0	98
C	Ensure that CDATS are given appropriate training and support to undertake effective community engagement and action	2	1	0	98
D	Ensure that the hosting organisation supports harm minimisation as a principle	2	1	0	98
E	Ensure that the level of funding for the program is not reduced	2	1	0	98
F	Simplify the auspicing arrangements for CDATs	2	1	0	98
G	Ensure that CDATs have a strong relationship with their Project Officer, and have good administrative support	2	1	0	98
H	Ensure that representatives from government departments and agencies, and especially NSW Health, continue to see CDATs as important	2	1	0	98
I	Ensure that CDATs are well promoted and continue to have access to free promotional and campaign resources from NSW Health	2	1	0	98
J	Ensure that there is no clash between the type of hosting organisation and the objectives of CEA Program	2	1	0	98
K	Ensure that Project Officer role is not diminished	2	1	0	98

4.2 [NON_COMPULSORY] Do you have any further comments about CDATs' current or future hosting arrangements? [OPEN-ENDED RESPONSE]

5 Closing

5.1 [NON_COMPULSORY] Please use the text box below if you would like to make suggestions or comments about any of the following areas.

- New partnerships that you would like to be developed for your CDAT or the CEA program generally.
- Projects, strategies and practices that you would like CDATs to adopt.
- Future opportunities or threats for your CDAT or the CEA program generally.

[OPEN-ENDED RESPONSE]

Thank and close

You have reached the end of the survey. Thank you very much for participating.

If you have any queries about the online survey, please contact Will Tregoning at Ipsos Social Research on (02) 9900 5100.

At the conclusion of the 'Framework for Action' Review, a report outlining the review process and its findings will be distributed via CDAT Project Officers. This information will also be available on the CDAT website www.cdat.com.au.

Ipsos
Social Research Institute