Review of Alcohol and Other Drug Services Provided to Young People in Tasmania

Andrew Biven & Carl Kinsella

1998

Aboriginal Drug and Alcohol Council (SA) Inc.
53 King William St
Kent Town SA 5067
PH: 08 8362 0395
Fx: 08 8362 0327
Http://www.adac.org.au

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Andrew Biven
PO Box 9
Mylor
SA 5153

Ph: 08 8388 5634
E-mail: andrewb@senet.com.au

Carl Kinsella
14 Parry St
Redwood Park
SA 5097

Ph: 08 8289 3419
E-mail: carlk@netadvantage.com.au

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PART A

1. SUMMARY OF RECOMMENDATIONS

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Recommendation 2

That the regional forums for AOD services be enhanced by creating a democratic structure and that limited funding be made available to them to promote regional co-operation.

Recommendation 3

That in decisions regarding funding for NGOs, the role of the regional ADS managers be in an advisory capacity only.

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That the State Managers office of the ADS assume a liaison function with the NGO's and other funded Government services and that 'key worker' networks be encouraged.

Recommendation 5

That AOD services recognise the benefits of close liaison with the youth sector and establish networks to facilitate co-operation.

Recommendation 6

That AOD services provide AOD training to workers in the youth sector.

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That Output Working Groups be established covering the areas of treatment services, education and health promotion and that these include representatives from the major players in the AOD sector.

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That networking be promoted as best practice in the AOD sector and training in networking skills be provided to increase understanding and to provide training in effective methods.

Recommendation 9

That a Service Delivery Co-ordinating body be established to oversee the implementation of the TDSP and to co-ordinate the detailed service planning envisaged in the TDSP.

BALANCE OF SERVICES

Recommendation 10

That a dedicated unit responsible for promotion, co-ordination and delivery of Health Promotion in the AOD sector be created.

Recommendation 11

That a dedicated unit responsible for promotion, co-ordination and delivery of Education and Training services in the AOD sector be created.

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That the shift in emphasis towards preventative and early intervention activities be continued, although not at the expense of reducing treatment services.

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That specialist youth AOD workers work with other youth services by providing training, expert advice and back-up support to enable them to better deal with young people attending their services with AOD problems.

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That negotiations commence with appropriate youth services for them to assume greater responsibility for the sobering-up needs of young people.

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That the review of services presently provided from 56 Collins St considers the special needs of young people requiring sobering-up and/or detoxification.

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That the Salvation Army Bridge program and the Launceston City Mission's Missiondale program be assisted to better deal with the needs of a wider range of young people through the involvement of the specialist youth AOD workers in advocacy, policy development, training and support roles.

Recommendation 20

That limited funding be made available to assist these programs to improve their accessibility by and effectiveness with young people.

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That specialist youth AOD workers work to facilitate access by their client groups to services providing longer-term accommodation to young people through advocacy, training and back-up to these services.

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That AOD workers establish close working relationships with psychiatric services in their area and that funding be made available for joint training for AOD and psychiatric service workers to further co-operation between the two sectors.

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That peer education be recognised as a best practice model and that services work towards incorporating peer education processes as one aspect of their work.

Recommendation 24

AOD services and Sexual Health should examine the possibility of working in conjunction with user groups such as the Tasmanian Users Group (TUG) in developing peer education programs and adequate funding be provided for these purposes.

Recommendation 25

That specialist AOD services network with services providing life-skills training and other relevant services to ensure access to these services by young people with AOD issues.

Recommendation 26

That the provision of a research function to provide information on needs and for service evaluation be investigated.

DUPLICATION OF SERVICES

Recommendation 27

That the DECCD institutes an accreditation process for all organisations wishing to participate in school drug education programs.

Recommendation 28

That through the Service Delivery Co-ordinating Body, measures be instituted to effectively co-ordinate all organisations delivering school drug education programs.

Recommendation 29

That school drug education programs be supported by one SDO position in DEN responsible for research and program development and two SDO positions in the DECCD responsible for implementation.

Recommendation 30

That organisations providing school drug education programs develop written policies covering these programs and that this be a necessary requirement for accreditation.

Recommendation 31

That the Life Education Centre be encouraged to participate in the networking and service development initiatives of the AOD sector and that it be subject to the normal regulation of the sector.

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That administration of Life Education Centre funding be transferred to the ADS.

CO-LOCATION OR ONE STOP SERVICES

Recommendation 33

That the co-locations currently under consideration in Hobart and Launceston be pursued and that beyond these two co-locations, a broadly-based working party be established to consider other co-locations in the youth sector.

Recommendation 34

That The Link, Your Place and 110 Bathurst Street services be combined into a consortium, with the Link and 110 Bathurst Street co-locating and Your Place maintaining its separate premises.

Recommendation 35

That the AOD youth worker position in the North be reviewed along with other ADS positions with a view to creating another specialist youth AOD position for the North.

Recommendation 36

That the ADS specialist youth worker positions in Hobart and Launceston be transferred to suitably placed NGO organisations.

FUNDING

Recommendation 37

That NGOs be funded adequately to meet the requirements of good governance, and in accordance with the outputs assigned to them by the Service Delivery Co-ordinating Body of the TDSP.

Recommendation 38

That service agreements be negotiated for the duration of the TDSP

2. BACKGROUND

In December 1996, the Tasmanian Drug Strategic Plan (TDSP) was released. The TDSP provides a framework for action from 1996 to 2000, and identifies strategic goals, priority areas and methods for such action. In addition, the Commonwealth sought with the States to negotiate the National Drug Strategy funding within a new broad banded approach through a National Public Health Partnerships Agreement. Consequently, the Minister directed the Department of Community and Health Services (DCHS) to undertake a review of the effectiveness of Government funded alcohol and drug services provided to young people in Tasmania.

A Steering Committee (see Attachment 1) consisting of representatives from the Alcohol and Drug Services (ADS), other Government Departments and Non-Government Organisation (NGO) representatives was appointed to assist in the implementation of the review. This committee met on several occasions prior to the appointment of the Consultants to establish the Terms of Reference and consider the method of conduct of the review.

The Aboriginal Drug and Alcohol Council of SA Inc. were commissioned to undertake the review and released Mr Andrew Biven and Mr Carl Kinsella from their duties. They were assisted with comments by Ms Cassandra Dunn of the Drug and Alcohol Services Council of South Australia (DASC). The Steering Committee met with the Consultants on three occasions during their visit to Tasmania from 6th October to 17th October 1997, and again on 25th November to consider a draft of the report.

During the term of the consultancy the Prime Minister, The Hon. John Howard, announced a new initiative, 'Tough on Drugs' with increased funding to be made available for treatment, education and law enforcement. It is expected that this will increase the funding available to the sector. At the time of writing this report the full details of this new initiative had not been announced and, therefore, its impact on youth services in Tasmania were unclear

Young People in Tasmania

According to the 1996 Australian Bureau of Statistics Census of Population and Housing, there were 459,659 people living in Tasmania. Of this, 92,863 were classified as being young people (ie. 12-25 years of age). This represents 20% of the Tasmanian total population.

The number of young Tasmanians has been steadily declining since 1981 when there were 105,000 young people to 96,000 in 1991 to its present total, 92,863.

The current review is concerned with the three identified regions: North, North-West and South. The youth population breakdown for these regions is as follows:

North	26,475	28.5%
North-West	20,543	22.2%
South	45,752	49.3%

3. INTRODUCTION

The report is presented under six broad headings - co-ordination, balance of services, gaps in services, duplication of services, co-location and funding - rather than under the six Terms of Reference as detailed below. It is presented in this way as many of the issues raised and recommendations made address more than one Term of Reference. Rather than attempt to tie each recommendation back to a particular Term of Reference, some general comments are made about each one and the report then continues on the basis of the six headings mentioned above.

3.1 Terms of Reference

The Terms of Reference as drafted by the Steering Committee were:

1. Examine and report on the appropriateness of the range of alcohol and drug services provided to young people in Tasmania.

2. Evaluate the efficiency and effectiveness of current Government-funded alcohol and drug services provided to young people in Tasmania, and comment on the extent to which services are consistent with the Tasmanian Drug Strategic Plan (1996-2000).

3. Examine the total expenditure on alcohol and drug services provided to young people in the community and recommend an appropriate balance between health promotion, education and treatment services.

4. Identify duplications and gaps in services within both the Government and non-Government sectors (eg. drug education, health promotion, assessment, treatment and counselling services) and recommend the most appropriate course of action to minimise these.

5. Examine and comment on the feasibility of a one-stop alcohol and drug service for young people, and/or the co-location of services.

6. Comment on the level of service co-ordination and linkages that currently exists between service providers.

3.2 Scope of the Review

While the review was essentially of services provided to young people, many of the issues raised had a wider coverage. Many of the organisations consulted provided services to a wider cross-section of the community. Even those designated as youth specific often have a broader sweep - parents and the general community and around the arbitrary 25 year old cut-off point. It was not possible to limit sources

to comment only on those facets of their work that related to the youth sector. Hence, many of the points of discussion and recommendations go beyond the youth area or have ramifications for the whole sector.

4. METHODOLOGY

4.1 The Consultation Process

The consultation involved three distinct processes:

i. Prior to and during the consultation visit to Tasmania, the Consultants collected considerable documentation about the services under review, the drug and alcohol sector in Tasmania and the youth sector. Annual and other reports, evaluations, research and surveys were all perused.

ii. A literature review was conducted, specifically looking at what has been written on youth drug and alcohol services in Australia, drug and alcohol services in Tasmania and the implementation of the National Drug Strategy (NDS).

iii. The Consultants visited Tasmania for two weeks to conduct a series of interviews with all the major stakeholders. The interview was of a semi-structured nature (see Attachment 3). Following completion of these interviews, the information collected was collated and is presented in the report as the 'Viewpoints from the consultation process'.

4.2 'Sources' of Information

When referring to the information gained during the consultancy phase, points of information are referred to as 'sources'. During the consultancy, people were seen by the consultants individually or in groups from the same agency. Time restrictions prevented the consultants from conducting multiple individual interviews with people from the same service. All people were given the opportunity to follow-up with a phone call.

A 'source' can refer to either an individual point of view or that of a group, depending on the forum in which it was raised. Where a point was raised in a group discussion and had general agreement it was counted as one 'source' of information. By quoting the number of sources who made a particular point, the consultants are not implying any increased validity for that point - but that it was of more widespread interest or concern than other issues may have been.

The amount of information obtained during the consultancy phase was large and the report does not attempt to canvas every topic raised by those consulted. Nor do the consultants accept as accurate or concur with all of the views included in the 'Viewpoints from the consultation phase'. These viewpoints represent the common points of view put to the consultants, usually by more than one source. They are significant in that they are the views of those managing or delivering services and

are informed by experience, by professional training and by an in-depth knowledge of local situations.

4.3 Available Data

The lack of reliable data on which to base recommendations was a significant problem throughout the process. The consultants found that few of the services consulted had accurate and reliable data collection and analysis systems.

The ADS was relying on a data system adopted from the Western Australian Drug and Alcohol Information System (WADAISy). This was found by all who used it to be inadequate to the task and most organisations kept other statistics alongside this system for their internal use.

WADAISy was found to be unable to provide the sort of information needed to determine what each organisation was doing in the areas of treatment, health promotion and education and for the most part, incapable of providing even simple information about proportions of young people in their client groups.

Very few organisations reported getting any statistical returns from the raw data they sent to ADS monthly. As a result they either ceased sending the data or spent little time and effort on the data they sent in. This difficulty has been recognised by ADS and at the time of the consultation a Project Officer with ADS was working on developing a new data collection system.

4.4 Summary of Consultations

The consultants met with a total of 86 individuals from 25 different organisations (17 NGOs and 8 Government departments) in single and group interviews. They also conducted four forums for allied organisations. A total of 35 individuals representing 28 organisations attended. The consultants also conducted telephone interviews with three people - two from the University of Tasmania and one from an NGO (A list of the organisations consulted appears as Attachment 2).

Of the 86 people personally interviewed, 15 were from ADS, 16 from other Government Departments and 55 were from NGOs. Of these 86 people, 16 were in management or co-ordinator positions, 44 were other staff members, 14 were voluntary workers and 12 were committee or board of management members.

The consultants spent from one to four hours with each organisation. Where organisations had a number of offices in different cities, all offices were visited.

4.5 Young Peoples' Views

At the first meeting of the Steering Committee with the consultants, the issue of direct consultation with young people was discussed. It was agreed that given the limited timeframe for the review and that any truly representative consultation with young people would need to accommodate the diverse range of young peoples' views (those of the unemployed, school attenders, employed, homeless, drug-using, non-drug using, rural, city, conservative, socially active etc), proper consultation would not be possible.

For similar reasons, the views of the parents of young people could not be incorporated directly into the review. However, the consultants stated that they would be seeking out and including relevant youth consultations that had been conducted by other groups in the past. And, while recognising the inherent limitations, the consultants would also be relying on the direct service providers to represent the views of their clients.

At the time of this meeting the Steering Committee referred to the Inter-departmental Committee on Alcohol and Drugs (IDCAD) for the TDSP the need to develop strategies for incorporating young peoples' views as part of the monitoring actions for the TDSP.

The consultants made use of the following youth consultations:

Australian Youth Policy & Action Coalition Inc. (1997) Young People Staking Their Claim: Youth Gathering '96 Conference Proceedings Canberra Publishing & Printing: ACT.

Boyce, J. (1994) It's Time for a Yarn The Link Youth Health Service: Hobart.

Brockdorff, A. (1997) Youth Health Centre Project Consultation Report Launceston

Brockdorff, A., Walker, T. & Pawson, R. (1997) Youth Spaces Consultation Project Launceston City Council: Launceston

Community and Health Services (1994) Tasmanian Health Strategy for Young People 1995-1998 The Views of Young Tasmanians. Community and Health Services: Hobart

Hales, E. (1997) Drugs and Young People: Knowledge, Perceptions and Use Drug Education Network: North West Tasmania

Parkin, P. (1995) The Needs Assessment of the Drug Prevention Issues of Young People in the Derwent Valley Drug Education Network Inc.: Hobart

Parkin, P. (1996) 'Our Choice' Evaluation Drug Education Network: Hobart

5. ADDRESSING THE TERMS OF REFERENCE

1. Examine and report on the appropriateness of the range of alcohol and drug services provided to young people in Tasmania.

In examining the appropriateness of the drug and alcohol services for young people in Tasmania, it is necessary to look at the roles of each organisation providing services to young people and how all these services fit together to make up the youth drug and alcohol sector. One must have in mind some ideal balance of services if one is to comment on the appropriateness of the range of these services. There is nothing in the literature to suggest what this ideal balance should be, most comments being directed towards a shift in emphasis away from treatment and towards preventative measures without in any way defining the ultimate outcome.

The issue of appropriateness is further complicated by the fact that few of the services reviewed were youth specific. Only five organisations could truly be said to be directed solely at young people, and even with these there was the issue of services provided to parents of young people (often a substantial proportion of their workload) and around the arbitrary cut-off point of young people as under 25 years of age.

Most other services had a significant youth target or client group. Whilst services could estimate the numbers of young people they had as clients, they could not in any meaningful way determine their relative inputs into their different client groups, let alone their inputs into the areas of treatment, education and health promotion. Lack of accurate information will be highlighted throughout this report.

In light of these difficulties, it is felt that questions of appropriateness are best dealt with when looking at the gaps and duplications in services for young people. This is what is required under Term of Reference number 4 and is specifically dealt with in this report.

2. Evaluate the efficiency and effectiveness of current Government-funded alcohol and drug services provided to young people in Tasmania, and comment on the extent to which services are consistent with the Tasmanian Drug Strategic Plan (1996-2000).

Given the limited timeframe for this review, it was agreed that it would not be possible to conduct internal reviews of those drug and alcohol services which target young people and to comment on their efficiency and effectiveness individually. Rather, the review was to look at the strategic balance of services looked at by

service type (treatment, health promotion, education), by geographic distribution and by target group.

When viewed in this light, this Term of Reference also equates with questions of appropriateness and of gaps and duplications as it asks what services and what mix of services will best deliver the outcomes identified in the TDSP. In making comment about the extent to which services are consistent with the TDSP, the consultants were again hampered by the lack of data.

3. Examine the total expenditure on alcohol and drug services provided to young people in the community and recommend an appropriate balance between health promotion, education and treatment services.

The lack of accurate statistical information collected by individual organisations and as required by funding bodies meant that only estimates of the proportion of expenditure on services to young people could be made, based on information provided by organisations about the relative emphasis on the various aspects of their overall service. Most organisations reviewed provided services to a wider range of target groups than just youth and did not attempt to divide expenditure into individual target areas of their service.

The issue was further complicated by the lack of universal definition of what activities should be described as 'education' and what as 'health promotion'. Few organisations kept reliable data about the balance of their services.

The review of the literature reveals that there is no recognised ideal balance of services. The National Drug Strategy talks of trends - of moving the balance away from treatment and towards prevention. Beyond this there are no clear guidelines. Single and Rohl (1997) state that the decision on the balance is a necessarily subjective appraisal of the relative magnitude and nature of the problems and effectiveness of the alternative interventions.

The recommendations made in this area call for a continuing shift in the balance towards preventative efforts through the development of specialist units but that this shift should not be made at the expense of effective treatment services given the difficult funding situations for most of the NGOs providing treatment.

The consultants were aware that a number of the recommendations made may have industrial ramifications and that appropriate consultation with those concerned would be required.

4. Identify duplication and gaps in services within both the Government and non-Government sectors (eg drug education, health promotion, assessment, treatment and counselling services) and recommend the most appropriate course of action to minimise these.

Duplications and gaps form a major part of the report. Each is afforded a separate section with recommendations. The duplications and gaps identified by participants during the consultation process concentrated heavily on gaps in treatment services. The solutions sought often required expenditure on new dedicated services for young people.

The consultants were of the view that such expenditures were unrealistic in the current economic climate and were often difficult to justify given the small target populations of these services. Recommendations is this area instead sought to encourage the development of co-operative undertakings with existing youth services to fill the gaps.

The lack of adequate health promotion activities was recognised as a gap by few of those consulted but was often alluded to in conversation during the interviews. When it was recognised by participants during the consultation process, it was seen as a gap across the spectrum of the Alcohol and Other Drugs (AOD) area, not just in the youth area.

Rural areas were identified as being under-serviced in comparison with the major urban areas where most of the offices of the AOD services were located. Again, this observation applied to the sector as a whole, not just the youth services.

School drug education services were the source of much comment and suggestion for reform. Recommendations are included in the section of the report dealing with duplications.

5. Examine and comment on the feasibility of a one-stop alcohol and drug service for young people, and/or the co-location of services.

Co-location of services is regarded as a best practice model in the youth services area. A number of specialist youth AOD services in Tasmania are already co-located, others are actively considering co-locations and awaiting the outcome of this review. Co-location implies a range of youth services (accommodation, employment, AOD, recreation, health, etc) located within one building or within easy access of others.

One-stop drug and alcohol services would deliver the same result but within one service. However, best practice in the youth sector and the AOD sector points to co-

located services as preferable to single services attempting to provide for the multiplicity of needs of young people. Spooner and others (1997) wrote:

> 'No single service delivery method ..... is seen as superior. Rather, a range of service delivery methods, as well as a range of service components, are seen as necessary for the various youth who make up the target group. Whether all such services can be delivered by one organisation is doubtful. Rather, the service system must be better coordinated so that client-treatment matching, case management and system planning can be facilitated.'

The question of co-location is afforded its own topic in the review and recommendations are made supporting co-locations currently being considered and encouraging consideration of further co-locations.

6. Comment on the level of service co-ordination and linkages that currently exists between service providers.

During the consultancy phase, a great deal of comment was received about co-ordination and linkages. It was an issue which underpinned all other matters in the review. It resulted in recommendations regarding the need for a peak body for the AOD NGOs, for structures to improve ADS liaison with the NGOs and other funded GOs and for some sort of implementation process for the Tasmanian Drug Strategic Plan (TDSP) as a way of defining and rationalising the co-ordination of services in the AOD sector.

PART B

1. COORDINATION OF SERVICES

Early on in the consultation process it became apparent that the level of co-operation and co-ordination among the various sectors, organisations, service types and individuals associated with youth AOD issues was of concern to many of those consulted. Co-ordination refers to efforts to organise the delivery of services jointly so that efficiency and effectiveness are maximised. Co-operation refers to any efforts by different organisations to work together at any level for mutual benefit.

Of past attempts to promote a co-operative climate in the AOD field, the view was expressed by a number of sources that there was no understanding of the benefits to be derived and that, therefore, organisations had tried to go it alone. Contrary to this view, the consultants found that there was a general recognition of the importance of co-operative efforts to sustain service development in the field. There was also a willingness expressed to actively participate in co-operative efforts as most people recognised the old truism of 'united we stand, divided we fall' and, indeed, many felt the situation had got to a 'struggle for preservation' situation.

There were many examples of co-operation between some organisations and individuals, pointing the way to the possibility of achieving more widespread co-operation. Workers have supported other organisations in specific projects, sat on management committees of associated services, relieved staff from other services and co-location plans have been developed.

The evidence exits for the goodwill to enable a process of co-operation in the sector and the government can assist as an active supporter and participant in the process and, through judicial use of funding, promote co-operative approaches.

1.1 Co-ordination/Co-operation

Viewpoints from the consultation process

· Nearly half the sources mentioned the need to improve co-operation between organisations and sectors. Co-operation was cited at various levels:-

a) among NGOs in the AOD sector

b) within regional areas/towns and cities

c) between NGOs (and other GOs) and the ADS

d) between the AOD sector and the youth sector

e) among organisations providing similar services eg school drug education

· A number of sources mentioned the demise of the Australian Drug Foundation (ADF) as an effective peak body and several said that there was a need to revive the concept to strengthen the NGO sector and improve consultations between the government sector and NGOs.

· There were a number of interagency forums to which different agencies belonged - mostly based on regional areas. Generally, youth services had stronger networking and interagency forums than did AOD services. The Northern Youth Co-ordinating Committee (NYCC) was given as an example of an effective co-ordinating body.

· A number of NGOs expressed concern about their lack of opportunity to be consulted by the ADS and other government departments on a range of issues (including the TDSP for some NGOs). They felt there should be some formal mechanism to ensure NGO consultation takes place.

· The restructuring of government departments and staff turnover in some NGOs were mentioned as factors contributing to breakdowns in co-ordination and co-operation.

· Instances were given of complete lack of communication between services in the same town or city - '.... works here but I wouldn't have a clue about what they are doing.' In these instances it appears that personality issues may have overridden professional requirements.

· A number of organisations mentioned the need to work collaboratively with the Tasmanian Aboriginal Council (TAC) and encourage them to become involved in the AOD networks. They saw this as potentially being of benefit to both the TAC and the AOD sector.

· Lack of flexibility due to minimum staffing requirements for safe work practice or because of work loads was also cited as a reason for the difficulty some organisations had in maintaining networking arrangements, attending meetings, etc.

1.2 Co-operation among NGOs in the AOD Sector

Discussion

The demise of the Australian Drug Foundation (ADF) as a peak body in Tasmania has meant that there is no effective peak body to represent the interests of NGOs in the AOD sector. Most of the sources interviewed saw this as a deficit in the field and thought a new body should be established. The ADF still operates in Victoria and Queensland as an NGO in its own right. Most states have preferred to create a new peak body to represent the NGOs. The Network of Alcohol and Drug Agencies in NSW (NADA) has been operating for many years and enjoys considerable support and recognition. The Victorian Alcohol and Drug Agencies (VADA) and the Western Australian Network of Alcohol and Drug Agencies (WANADA) are similarly recognised. Most sources in Tasmania thought it better to start with a new organisation rather than try to resurrect the ADF's role as a peak body - they felt its historical legacies could hinder a new attempt to promote co-operation and a new peak body would enjoy wider support.

In the present climate, the managers of ADS in the North and South have organised a manager's forum to bring together government and non-government representatives in their regions. These efforts are admirable but should not be seen as replacing an NGO representative body.

The benefits of creating an NGO peak body include:

- facilitating NGO representation to government and elsewhere
- strengthening the NGO sector
- facilitating co-operative arrangements such as training, policy development, professional development, sharing of expertise and resources, assistance to individual members
- assisting the ADS as a strong partner supporting AOD initiatives in general and the ADS position within DCHS

Experience interstate (NSW, Vic, WA) and in other sectors in Tasmania (youth sector with YNOT) has shown that an effective peak body must be adequately funded to carry out its tasks. Depending on the levels of funding available, models for establishing a peak body include NADA where the separate secretariat is funded by government and membership fees. An elected executive council and chairperson hold regular meetings and annual or semi-annual general meetings of all members are held. Training, research and participation in a range of forums and

consultancies are facilitated through the peak body. A newsletter is published for communication with members and others interested in the peak body. Membership is given on two levels - organisational membership for NGOs working in the AOD sector and individual memberships for other interested parties such as researchers and government employees. Such a body could also better publicise and market the benefits of NGOs much more effectively (Crosbie et al, 1997a).

There was some discussion about whether the ADS services such as the North and South regions could be members, thereby, making it a sector peak body rather than just an NGO peak body. Other sectors and interstate have accommodated government involvement through individual memberships and through close liaison with the relevant government departments. Direct membership has not been encouraged due to conflicts of interest arising at different times. The peak body at times must be able to engage the government and present alternative views of issues regarding policies, funding and service delivery. Having government membership is seen as potentially limiting this ability to present an alternate viewpoint.

In addition to salaries and administration funding for a secretariat, allowance should be made for executive travel, workshops, training and conferences. The use of tele-conferencing could reduce costs of executive meetings.

Other options which could be considered include:

- creating a part-time secretariat, locating the secretariat in an NGO;
- revolving the secretariat with the chairperson ie. funding the chairperson's NGO to fulfil that function for the duration of their term;
- contracting the secretariat function to an existing peak body secretariat in another sector (eg YNOT, TASCOSS);
- creating an NGO forum with no secretariat but with limited funding for executive members to facilitate their function, general meetings and sponsored activities such as conferences and training.

Whichever option is selected, the success of a peak body will require a greater degree of co-operation than evident in the past. It will require strong leadership from significant players in the NGO sector, support from the ADS and perseverance and goodwill to ensure that those NGOs reluctant to become involved are brought into the fold.

Recommendation 1

That an incorporated NGO peak body be established for the AOD sector with adequate funding for a secretariat.

1.3 Co-operation within regional areas between government and non-government drug and alcohol services

Discussion

Co-operation and co-ordination in the different regions varied considerably and also within areas it was good between some organisations and not for others. The value of co-operation in regional planning has been recognised elsewhere (Ali et al, 1992).

The managers of ADS North and South have initiated efforts to improve co-operation with a manager's forum chaired by them. However, there is a perceived conflict of interest involving these managers which was commented on by several sources and which limits the effectiveness of these forums. Both ADS managers have some decision-making powers regarding NGO funding in their areas. Whilst on the whole, they co-operate well, there is an element of competition between the services.

The ADS managers are responsible for the efficiency and effectiveness of their own services and are unlikely to be unbiased in their judgement between funding for their own services and funding for the NGOs in their area. They are also more likely to promote their own services' interests over those of other services, as one would expect of a good manager. The Community Change Partnership (1997) document makes mention of the need for a 'level playing field' where government is involved as purchaser and provider and refers to unnecessary competition between government and non-government services.

Services provided by the ADS and the NGOs, whilst not duplicating each other to any great extent, do overlap - NGOs and the ADS provide treatment services to similar clientele, both do school and other education programs and both have some involvement in health promotion. If cooperation is to be achieved it is important that there is a degree of equality and, hence, there is a need for these ADS managers to have only an advisory role in NGO funding decisions and to be on an equal footing in the regional advisory forums. This could be achieved by creating a more democratic regional forum with an elected chairperson and independent function.

The effectiveness of these regional forums could be improved if limited funding for regional activities were available to facilitate meetings and to promote co-operative ventures such as joint health promotion activities or staff training.

Recommendation 2

That the regional forums for AOD services be enhanced by creating a democratic structure and that limited funding be made available to them to promote regional co-operation.

Recommendation 3

That in decisions regarding funding for NGOs, the role of the regional ADS managers be in an advisory capacity only.

1.4 Co-operation between ADS and the NGOs

Discussion

> *'Governments should ensure better communication and formal input from community-based organisations into decision-making at a regional, state/territory and national level.' (ADCA, 1996)*

The involvement of NGOs in determining needs and developing Government policy has been widely acknowledged as being important (Crosbie et al, 1997a). The review of the National Drug Strategy, 'Mapping the Future', also had the following to say about NGOs:

> 'These organisations not only provide services, they also bring specialised knowledge and expertise, often from personal experience. Non-government organisations bring a sense of immediacy and a commitment which is invaluable to policy and program development.'
>
> and,
>
> '....many NGOs are able to do things which governments cannot do. They are not subject to the same constraints as government officials in being advocates for particular policies and programs, and they are less encumbered by protocol in implementation. The failure to fully engage this sector effectively weakens the NDS.'

As pointed out above, the present reliance on the managers of ADS North and South involves a perceived conflict of interest. While co-operation involving them is important, it should be on an equal footing. The recommendations imply a different method for dealing with negotiations between NGOs and the ADS on funding matters.

A greater role could be assumed by the State Manager's office of ADS by the creation of a liaison function with all the funded services (other Government, NGO and ADS North and South). This separation of function would allow the central office to deal more equitably with all competing interests. NGOs would feel somewhat more equal in their dealings with their regional ADS services which would encourage a more co-operative approach. This liaison function would include funding and service provision decisions, networking to ensure the NGOs, other GOs and the peak body's positions were known and considered in internal ADS discussions, and efforts to improve co-ordination of services.

Elsewhere in this report are other recommendations concerned with further defining roles and territories for AOD organisations, processes which will further aid co-operation.

Other efforts aimed at increasing the involvement of NGO representatives on other bodies, such as the 'service delivery co-ordinating body' as mentioned in the TDSP, should be facilitated. The prospect of such representation should encourage formation of an NGO peak body.

In a collection of position statements from the Alcohol and Other Drugs Council of Australia (ADCA), Crosbie and his colleagues (1997a) had the following to say about government and non-government service relations:

- Governments should involve non-government organisations, consumers and communities in determining needs and developing policies
- Governments should acknowledge the broad role of non-government organisations in the community
- Governments should focus on positive outcomes for clients rather than output measures

Governments also need to provide community-based agencies with an opportunity to participate in forward planning and review workshops (ADCA, 1996).

Another measure aimed at improving regional co-operation between the ADS and NGO's would be to establish key worker networks amongst AOD organisations. This would involve nominating specified staff members in the ADS regional team to

assume responsibility for networking with identified workers in associated NGOs (and other funded GOs) in their area.

Governments must begin to involve non-government organisations, local communities and consumer groups in the process of decision making, especially in areas such as service delivery, research, policy development and planning (Crosbie et al, 1997b).

Recommendation 4

That the State Manager's office of the ADS assume a liaison function with the NGOs and other funded Government services and that 'key worker' networks be encouraged.

1.5 Co-ordination between the AOD and youth sectors

Discussion

Most of the youth specific AOD services maintained good networks with local youth services and youth networks. General AOD services were less well connected, despite having substantial youth components in their target groups (usually 20% or more their client group). When AOD issues were identified by generic youth workers they were sometimes quickly referred on to specialist AOD services, indicating a need for broadening the skill base of these workers.

To promote the confidence and ability of generic youth workers and services to take on more of a role in the AOD issues of their clients (estimated by various sources that from 30% to 80% of clients of generic youth services had a significant AOD problem), training and support should be provided for these services and workers. Single and Rohl (1997) expand this point by saying that mainstream health, law enforcement and community officials need to be trained to effectively minimise drug-related harm. Similarly, Pennington (1996) recommended that in Victoria:

> 'Expanded training, professional supervision and consultation should be offered to a broader (but targeted) group of youth workers to expand the pool of workers skilled in drug and alcohol issues'.

This policy is in line with the NDS strategy of equipping general services with the ability to address a greater proportion of AOD problems of their clientele. The role of the specialist youth AOD worker is to work with generic youth services to facilitate them dealing more effectively with their clients with AOD issues. This can involve networking, advocacy, training and specialist back-up:

> 'the service system must be better coordinated so that client-treatment matching, case management and system planning can be facilitated.' (Spooner et al, 1996)

An NGO peak body could be used to facilitate networking with the youth sector. Networking at all levels could be enhanced by providing training in networking for AOD workers and managers.

In an assessment of drug and alcohol services for young people in NSW, Berg and her colleagues (1995) found that a holistic, multi-disciplinary approach was the most appropriate solution as AOD problems did not exist in isolation.

Recommendation 5

That AOD services recognise the benefits of close liaison with the youth sector and establish networks to facilitate co-operation.

Recommendation 6

That AOD services provide AOD training to workers in the youth sector.

1.6 Co-ordination between organisations (NGOs and GOs) providing similar services within the AOD sector.

Discussion

Organisations doing similar work (treatment, education or health promotion) in the same or different regions have expertise and resources that can be shared, and needs that can be addressed jointly. All organisations will benefit by co-operation at this level. The existence of professional interest groups is one example of the move towards co-operation between organisations.

The ADS has commenced with 'output working groups', joining those in the different regional ADS offices together to discuss the services in their specified output area. These have the potential to become a sector-wide series of bodies through the inclusion of NGOs and other GOs. The alternative would be to establish new sector-wide output groups under the umbrella of the 'service delivery co-ordinating body' recommended in the TDSP.

Recommendation 7

That Output Working Groups be established covering the areas of treatment services, education and health promotion and that these include representatives from the major players in the AOD sector.

1.7 Networking Skills

Viewpoints from the consultation process

· There appeared to be disenchantment with formal networking arrangements, with a number of sources stating that they did not get involved as they thought the meetings were "a waste of time" or "they don't achieve much".

· On the other hand, many of the sources indicated the importance of working together and had developed close links with some other organisations or individual workers. Most expressed preferences and prejudices based on perceptions, philosophies and personalities which may or may not have been outdated, second-hand or inaccurate - there being few opportunities to sort these things out in a formal setting.

· It appeared that government services networked well with other government services but less so with NGOs. Successful networking was often dependant on personality factors. There were some good examples of networking between NGOs and some government services.

· Good examples of networking existed where staff members of one organisation were on the management committees of other organisations - staff of the ADS, the Link and the DEN among others, were on other management committees. Other good examples of networking included the regular meeting between managers of the Burnie and Devonport Youth Alcohol and Drug Services, and their sharing of staff for relief purposes.

· A number of services talked of divisions within the NGO sector. Some felt that certain elements had undermined co-operation (abstentionists vs harm minimisers) and others that services had been set against each other due to the competition for very limited funds.

Discussion

It was apparent that some organisations did not participate in the networking and co-ordination forums currently constituted or which have operated in the past. They were unaware or unconvinced of the benefits of effective networking, often seeing such activities as time-wasting and a diversion from their proper work

activities. Other factors preventing good networking included the intrusion of personal bias against other program philosophies and personality differences. For those who take the view that many networking exercises are a waste of time and effort, it may be useful for them to remember that many individual treatment episodes, education sessions or health promotion activities also do not achieve great results, yet we persist as we know that some of these efforts do bring results.

If an understanding of effective techniques and of the benefits to be derived from networking can be fostered it is likely that greater effort will be made to maintain momentum in this endeavour. This could be achieved by sponsoring workshops in effective networking, promoting good networking through selective funding of co-operative ventures and encouraging key individuals in ADS, GOs and NGOs to work with organisations on the periphery of formal and informal networks to encourage greater participation.

Specialist reference groups have been established by the Alcohol and Other Drugs Council of Australia and there is no reason why similar groups could not exist through the proposed peak body.

Networking can be promoted by including it as an 'output' for services in their statistical returns to funding bodies. Its importance is recognised in accreditation processes such as the Community Health Accreditation and Standards Program (CHASP).

Recommendation 8

That networking be promoted as best practice in the AOD sector and training in networking skills be provided to increase understanding and to provide training in effective methods.

1.8 Tasmanian Drug Strategic Plan (TDSP)

Viewpoints from the consultation process

· The need for some sort of implementation strategy for the plan was specifically referred to by a number of sources and alluded to by many others with comments such as 'It's not a working document'. A common theme that emerged was that they saw the document as a useful starting point in improving co-ordination of services but that it needed a detailed implementation plan involving consultation and co-ordination with all the stakeholders. Some suggested that this process should be linked to funding allocations and that service agreements be drafted with both government services and NGOs, including benchmarks and performance indicators. A common comment was that the desired outcome of this process would be that services be adequately funded to do a defined task with agreed output targets.

· A number of organisations said they had used the TDSP in their planning process for 97/98. Others said they had looked at it in conjunction with their planning to ensure they were within its ambit but that they had not had to modify their plans as a result.

· Allied to consideration of the TDSP, some sources said there was a need for formalised needs assessments to be done as an initial step in a formal and systematic strategic service planning process.

Discussion

Many of the organisations, when asked about the TDSP, said they agreed with it's intention but that it wasn't a working document. They felt that there needed to be a co-ordinated process involving all the funded organisations sitting down together to work out 'who is doing what, with whom, where and how'.

Structures that exist at present to facilitate this process include ADS management, and the Inter-Departmental Committee on Alcohol and Drugs (IDCAD). Both ADS and IDCAD lack NGO representation and have separate functions other than the co-ordination role for the TDSP.

In the implementation area of the TDSP a 'service delivery co-ordinating body or bodies' is specifically mentioned with the roles of 'eliminating duplications, reducing gaps, ensuring new services are based on analysis of needs and resources and to encourage non-funded organisations to adopt the TDSP'. Membership is to include NGO representatives. To date, this body has not been established.

The need for such a body is referred to throughout this report and there appears to be widespread support from the NGOs, GOs and within the ADS for such a body. Its role would be to co-ordinate services by bringing together all those involved in the sector at a regional and output level to hammer out agreements as to the roles, target groups, regional areas and output types for each organisation. Output working groups within the process could co-ordinate the individual service areas of treatment, education and health promotion.

The Report to the Premier's Drug Advisory Group (Pennington, 1996) in Victoria said that initiatives such as outreach; training, professional supervision and consultation; intensive supportive care; research and evaluation; and, monitoring would address many of the deficiencies in the network of services if they were implemented in an integrated fashion.

The funding of organisations could be made dependant on participation in and adherence to the plans as finalised by a service delivery co-ordinating body. Each organisation would have an individual service agreement based on the agreed outputs.

Government funding would be allocated in accordance with the outputs assigned to each organisation and evaluations could be measured in terms of these agreed outputs. While resource allocation decisions would remain in the hands of the government, the co-ordinating body and output working groups would have advisory capacities.

Many of the organisations consulted have already developed good planning procedures and some have attempted to tie these to the TDSP. For a detailed planning process to succeed, all organisations must be involved through the development of their own plans. These must then be integrated through negotiation and modification into a detailed, coherent and consistent plan for the whole sector.

It was evident in the consultation process that some NGOs had expanded their charter of activities beyond what they were being funded to do and beyond the capabilities of their resources. Whilst this practice is understandable given the current insecurity of funding and need to justify one's existence, it is to be expected that the process described above of allocating roles across the state will enable all organisations to set realistic targets for the scope of their work and for these to be supported in the sector-wide plans.

If successfully implemented, such a process would not only be consistent with the desire to achieve an appropriate range and balance of services across Tasmania, it would also address effectiveness and efficiency issues and improve the level of co-

operation and linkages existing between service providers. The implementation of such a task would require considerable effort and time from all participants.

In order to ensure success, the appointment of a Project Officer for a limited period may need to be considered. Their function would be to co-ordinate the process across the state, to act as secretary to the various bodies and committees required by the process and to act as liaison officer with all the organisations involved in the process.

Recommendation 9

That a Service Delivery Co-ordinating body be established to oversee the implementation of the TDSP and to co-ordinate the detailed service planning envisaged in the TDSP.

2. BALANCE OF SERVICES

2.1 Balance of Treatment, Education and Health Promotion

Viewpoints from consultation process

- A number of sources identified treatment options as predominating and suggested that the balance needs to be tipped in favour of more education and health promotion activity.

- A number said more innovation such as the use of modern technologies like computer games and more 'gutsy' approaches were needed in drug education. Some efforts in drug education and health promotion were seen as 'safe' and middle-class, missing the target groups of young and 'at risk' people.

- A number of sources cited the need for a hypothecated tax as in the Northern Territory to improve health promotion efforts and others pointed to the West Australian health promotion effort as one to be emulated.

- Several sources said the demand remained in the treatment area and this needed to be serviced effectively, or that demand determined the balance and that it varied within their service accordingly.

- Several sources said they felt under pressure from the government or their management to shift from a predominantly treatment orientation into more preventative work.

- The concept of community development as a health promotion strategy was not well understood by AOD workers according to several sources. They saw that workers trained in treatment approaches did not value as 'productive' activities like networking and co-operative campaigns. On the other hand, some NGOs were seen as working well beyond their charters as they extended their efforts into other areas - be it a geographic area, a different client group or another aspect of AOD work.

- About one third of the sources commented favourably on the ADSs' role in providing education and training to other services. (One NGO complained of having to pay to access training for its workers) Several sources said the education and training should be made more available and given greater promotion.

- A number of sources said they found it difficult to define their work neatly into the areas of treatment, education and health promotion, citing such imprecision in definition as to whether smoking cessation or early interventions

should be classified as a treatment or a health promotion activity. One said all their work involved health promotion but with differing target areas - those with a current problem, those at risk or the general community.

- Several services queried the positioning of the Needle Exchange services within the Sexual Health Unit of DCHS rather than within the ADS, pointing out that the target group was solely intravenous drug users.

Discussion

> *'An operating principle of a strategy based on harm minimisation is to provide....a maximum range of options for intervention' Single & Rohl (1997).*

A review of the literature reveals that there is no accepted yardstick of what constitutes the appropriate balance of services:

> 'The relative effort which should be given to different types of intervention for different types of substance misuse depends on a necessarily subjective appraisal of the relative magnitude and nature of the problems and effectiveness of the alternative interventions' (Single & Rohl, 1997).

The Report to the Premier's Drug Advisory Group (Pennington, 1996) in Victoria also found that in relation to youth services: 'there is little systematic research-based knowledge about young people who have specific problems with drug use. There is even less evaluation of models of care that could form the basis for further development of youth services'.

There is a lack of reliable data about the current balance in Tasmania, especially between education and health promotion activities in the prevention area. Single and Rohl encountered a similar problem when reviewing the National Drug Strategy (1997). They concluded that it is possible to derive a general impression of the balance of effort based on impressions from individuals and organisations in the consultation process and on outputs such as reports and publications.

On this basis the consultants estimated that 65% of AOD funding in Tasmania is directed towards treatment options and 35% towards prevention. It was not possible, in any meaningful way, to divide the prevention area into education and health promotion due to lack of data, differing understandings by different individuals and organisations of what constitutes education and health promotion, the overlap of roles of staff in these areas and differing methods of reporting and collating statistics.

In commenting on the balance between treatment and prevention services, it should be noted that since the inception of the National Campaign Against Drug Abuse in 1985, there has been a consistent call for a movement away from direct treatment services and towards earlier interventions and preventative services. The ADS has reflected this shifting emphasis with the closure of the John Edis facility in 1992 and movement to more community-based services. However, the 65/35 split indicates that this momentum should continue. Single and Rohl have recommended that 50% of NDS money target treatment services, with the balance on prevention and research.

ADCA has stated that funding for prevention, research and education should be increased and sustained and that governments should ensure that adequate treatment programs and services are available to all people experiencing drug related problems (Crosbie et al, 1997a).

The proliferation of efforts put into school drug education by many organisations, the lack of dedicated health promotion units and comments by managers ('we don't do health promotion well'), the paucity of funding generally for health promotion activities compared to states with hypothecated taxes and/or health promotion foundations all point to the fact that health promotion activities have not had sufficient emphasis in the past.

Other evidence available to support this premise is the example of the 'Be Merry, Be Safe' campaign in the North which was supported by less than $10,000 of government funding and relied on the inventiveness and skills of staff to attract further sponsorships. Whilst not necessarily a negative thing in itself, it does point to the lack of funding available through government sources for major health promotion campaigns. Limited funding is available through the Health Promotion Council.

The Tasmanian Health Strategy for Young People 1995-1998 (Community and Health Services, 1995) states that there should be a re-orientation of health and community services to accept illness prevention and health promotion as a primary goal for health services and that a more equal distribution of resources must occur to achieve this.

The issue of balance of services was further complicated when trying to look at services provided to young people. Again, there was a lack of reliable data about the proportion of resources of each program which related to young people. Only five funded projects could truly be said to be solely directed to young people. These also provided assistance to the parents of young people and some also assisted a few

clients over 25 years of age. Of the other services targeting a wider client group, few kept reliable data about the proportion of clients under 25.

Health promotion activities can target very specific groups or whole populations, again making it difficult to specify what proportion is directed to young people. An assumption can be made that the major portion of spending on education is directed towards young people. However, any estimate of the proportion of health promotion activity directed to young people is difficult to justify given the lack of data. From the reports by those involved in service provision and perusal of the limited data available, it is reasonable to assume that health promotion activities are not given sufficient emphasis in the current balance of services.

Vague job descriptions, lack of planning and a reactive response role have promoted situations where staff in many organisations can determine their own balance. Often this balance is dependant on personal preferences, skill areas and allegiances or is set in response to who is most vociferous in demanding service for their particular need.

In the face of these considerations, there should be a continuing shift in emphasis from treatment to prevention but this should not be at the expense of the provision of direct treatment services. The consultation process identified a number of gaps in services in the treatment area . Lack of core funding to most organisations was also identified as a major concern. Striking the balance between treatment and prevention services should not be considered as a horse trading exercise.

James and colleagues (1996) found that prevention and intervention programs can have a powerful impact if teenage drug use is responded to through early intervention. However, ADCA found that in a survey of 150 professionals from the alcohol and other drug field throughout Australia, one of the greatest criticisms was that governments failed to provide adequate treatment programs and services for people who need them (Crosbie et al, 1997a).

Through the 'service delivery co-ordinating body' recommended in the TDSP, the process would exist for establishing the scope of the roles of each organisation in the three service areas. This recommendation also envisages the use of output targets and basing funding decisions on the roles allocated to each organisation. In this way there would be some degree of control over the balance of services and, given an effective data collection system, a means to ensure targets are met. This is consistent with the recommendations from the National Drug Strategy to:

> 'Significantly increase the proportion of treatment and prevention programs subject to systematic outcome evaluation. In addition, high priority should be given to evaluations which consider not only the

> effectiveness of programs, but also the cost effectiveness of interventions.' (Single & Rohl, 1997)

In order to promote the profile of health promotion and education, dedicated units specialising in health promotion and education and training should be established. One such model is the Centre for Education and Information in Drugs and Alcohol (C.E.I.D.A.) in NSW.

The role of these units would be to act as centres of excellence to assist all other AOD services in their health promotion or education and training efforts, to be a central resource bank with links to interstate and international expertise, to provide training and support to AOD workers implementing strategies, to advise on Statewide strategies and participate in the planning and co-ordination of their particular area of expertise.

There should be only one each of these dedicated units to service the whole state. The location of these units could be within existing ADS North and South structures, reporting directly to the State Manager, or as more independent units with other links such as to the University of Tasmania. The role of the Drug Education Network should be examined either as a collaborative partner with the ADS for one or both of these units or as a sponsor organisation for a centre of excellence.

These units, through involvement in the service delivery co-ordinating body could also be major players in the process of defining the balance of services and the roles of individual organisations in the delivery of these services.

The creation of these units would necessitate a review of the roles of ADS workers, especially those currently involved in education and training roles. This review could be extended to cover other staff roles such as the community AOD workers and the psychology unit (which is located in South but with no comparable service located in the North). As recommended in the NDS, the roles of ADS workers should continue to shift towards skilling of other health, welfare and general workers rather than direct service provision, especially in the treatment area.

The location of the Needle Exchange Program is not seen as a major issue by the consultants. From all reports it is operating well in its present location and as both the ADS and Sexual Health Unit are within the Health Advancement unit of the Department of Community and Health Services there is the opportunity to ensure proper co-ordination.

Fundamental to better co-ordination of services and movement to a more appropriate balance of services is the availability of accurate data on which to base

decisions. The information required of such a system will include standardised definitions of what activities constitute treatment, education and health promotion. From all accounts the current data collection is inadequate and many services, both government and NGO have abandoned use of the system or make only token efforts to conform to its requirements. Single and Rohl (1997) point to the need for performance indicators to allow monitoring of progress and specific outcomes. This inadequacy has been recognised by the ADS and a Project Officer was working on an improved system at the time of writing.

A number of sources raised the question of the need for an hypothecated tax with funding available for a range of health promotion activities and of establishing a health promotion foundation as a separate entity charged with responsibility for funding and facilitating a wide range of health promotion activities. Whilst recommendations on these issues are clearly outside the terms of reference of this review, the widespread opinion in favour of their adoption and the favourable impact such measures have had interstate should be sufficient to warrant consideration of these aims at a higher level of government.

Recommendation 10

That a dedicated unit responsible for promotion, co-ordination and delivery of Health Promotion in the AOD sector be created.

Recommendation 11

That a dedicated unit responsible for the promotion, co-ordination and delivery of Education and Training services in the AOD sector be created.

Recommendation 12

That the shift in emphasis towards preventative and early intervention activities be continued, although not at the expense of reducing treatment services.

3. GAPS IN SERVICES

3.1 Accessible services for young people with drug and alcohol problems

Viewpoints from consultation process

- About half of the sources pointed to the need for more hands-on and immediate response services for young people. Services such as drop-in centres, more street youth AOD and health workers and a 24 hour hotline for young people were recommended. Inadequate after-hours services for young people (particularly government services) was a recurrent theme.

- Several sources pointed out that young people are often most active in the evening and nights and their greatest needs often arise in these times. The ability to respond rapidly to their needs at these times was seen as essential as this represents a window of opportunity which is easily lost.

- Several sources wanted rapid access to information about current street drug types and quality.

- A number of sources said that there should be greater opportunities for young people to be involved in the planning and delivery of AOD services for young people.

Discussion

Whilst there was clearly a call from many service providers for more services to assist young people in 'crisis' situations, models of best practice point to the need for services to put more effort into assisting young people to deal with crises themselves rather than setting up a raft of services to rescue them once they are embroiled in difficulties. This approach is consistent with a harm minimisation philosophy and points to the need for alternatives to just setting up another service to fill the gap. Good harm minimisation strategies will assist young people to avoid the harm which leads them to seek specialist AOD services.

Young people are more likely to access telephone services and services based on new technologies due to the stigma attached to accessing AOD services. Ali and others (1992) recommended that telephone information services should be made available for delivering information and brief and early interventions.

This said, there are things which can be done to increase the ability of existing services to respond to the needs of young people in crisis. Several 24 hour information lines already exist - Lifeline, Kids Help Line and Alcohol and Drug

Information Service (ADIS). It was pointed out that few young people would access the Kids Help Line due to its name. However, Lifeline is a well recognised service and could be encouraged to be more accessible to young people through the involvement of AOD youth workers in the training and back-up support for Lifeline counsellors. ADIS operates from the detoxification unit at 56 Collins Street and is part of the ADS.

Several sources said that the ADIS service relied on staff whose training and focus has primarily been on treatment and that this was not appropriate for an information service where a wider range of skills and perspectives was required. The consultants did not specifically examine this questions but, in the light of these comments and the current review of other functions of 56 Collins St, a review of ADIS would seem appropriate and necessary as a way of improving telephone information and counselling services for young people.

At present all youth AOD services operate a normal Monday to Friday business hours service. The service at 110 Bathurst St is currently closed two mornings and one full day per week and at other times relies on the presence of a sole worker (with some volunteer back-up). Elsewhere in this report recommendations are made regarding the specialist youth AOD workers and services (see Recommendations 35 and 36). If adopted, these recommendations would open the way for greater flexibility of rostered hours of youth AOD workers, particularly for those within the NGO sector where there are fewer complications and less expense associated with out-of-hours services.

Youth services other than specialist AOD services are already dealing with AOD issues of their clients. One source estimated that 70% to 80% of all clients attending a Youth Health Centre had a significant AOD issue. Whilst generic youth services are reluctant to admit it for fear of having to take on an even greater role, most recognise that a significant part of their work involves dealing with AOD issues of their clients. Youth accommodation services frequently deal with young people affected by drugs and alcohol. Similarly, drop-in and referral services routinely assist young people using drugs. Specialist youth AOD services could not meet the demand should all young people with AOD problems attend their services rather than generic services.

Young people with AOD problems are less likely to identify as having an AOD problem - they see their drug use as a response to another issue or as recreational and fun, and therefore, are not likely to front up to an AOD service (Berg et al, 1996). It is also noted that the youth perception of a problem is not necessarily the same as the perception of workers in the field or other professionals (Spooner et al, 1996).

Stigma associated with an AOD problem, more immediate needs such as accommodation and food and integration of AOD use as a normal aspect of their lives means that most young people do not attend specialist AOD services.

The NDS recommended that 'the best approach for youth is the provision of drug and alcohol information to specialist services that are already set up to assist young people. Youth workers will, therefore, need to be trained in drug and alcohol issues and drug and alcohol consultancies should be provided to youth agencies' (NDS In Berg et al, 1996).

The role of specialist AOD services, therefore, becomes one of facilitating and assisting with the treatment of AOD problems within other types of youth services. The AOD worker advocates for the needs of young people with AOD problems, provides training for generic youth workers and services and acts as a consultant and referral point for more difficult cases.

Given the reluctance of many young people to acknowledge and seek assistance for an AOD problem, yet their preparedness to seek assistance for some of the consequences of that problem (accommodation, food, medical, financial), co-location of specialist AOD workers in settings where these consequences are dealt with facilitates effective referrals or co-working on particular problems.

Best practice models in the youth services area indicate the need to consult with young people when planning services for them. Only a few of the organisations consulted mentioned specific mechanisms set up to facilitate this. Young people were also under-represented on the staff of most organisations delivering services to young people. They were more likely to be involved as volunteers. Spooner and others (1996) found that 'youth want and need to participate in their treatment program, rather than just being told what to do. Their involvement in setting rules, program development, their own treatment plan, and so on, ensures they have a commitment to the program and assists the program to meet their needs.' Similarly, Levin (1989) argues that youth should be able to contribute positively to their own health services utilising their ideas and value systems.

In addition, the majority of staff providing services to young people were in the over 35 age group. Career paths need to be in place to enable workers in the youth area to move to other areas of AOD work at appropriate points in their careers. This may begin to occur with the implementation of the National Alcohol and Drugs Competency Standards.

Spooner and her colleagues (1996) in their assessment on the 'Nature and Treatment of Adolescent Substance Abuse' found the following in relation to accessibility:

> 'Preference has been expressed for a lot of small services, geographically dispersed so that a) youth can be close to community and family supports and b) services do not have the atmosphere of a large institution.....There seems to be little support for a principle of specific programs for specific groups, particularly as there are so many overlapping subgroups of adolescents that such a principle would be impractical. Furthermore, 'special' programs for 'special' people can be counter to the notions of treating people as individuals and of mainstream society accepting and understanding the diverse range of people who make up society. Staff training and program policies need to ensure that programs can be attractive and appropriate to all youth with substance-use problems. Occasionally, there might be some basis for a small number of specialised programs.'

The recent review of AOD programs in Victoria and the new Western Australia Drug Abuse Strategic Plan have placed an emphasis on Youth Outreach Workers as being the best placed people to deal with young peoples' AOD issues. This is highlighted by Pennington (1996) who recommended that:

> 'A specialist outreach service should be developed to support vulnerable young people involved in substance abuse. .....The management and administration of the service should be developed in such a way as to ensure that it is effective at street level, and has the knowledge and technical back-up to deliver high levels of drug expertise to the field.'

Spooner and her colleagues concluded that:

a) when planning and implementing an adolescent service, the adolescent's perspective needs to be considered, that is, adolescent tendencies, developmental stages, issues and needs, and cultural background;

b) Though difficult, balancing consistency and flexibility is necessary;

c) services need to be holistic and better coordinated with each other; and

d) services need to be close to the youth's home, or at least link in with other services that are close to the youth's home, so that continuous support can be provided.

Coleman and others (1995) recommended that services set up to address AOD issues offer a wide range of options from which the client has a choice and that these options represent the fact that brief intervention strategies are often highly inappropriate for this target group. Appropriate options for young people in the

target group may include linking with a youth specific service, peer eduction programs, and access to ongoing support.

Of particular relevance, the Tasmanian Health Strategy for Young People 1995-1998, outlined a number of principles for 'Health Service Planning and Delivery':

- Accessibility
- Advocacy
- Flexible, responsive, appropriate and relevant services
- Services that are well coordinated and integrated and, when appropriate, linked to other human services and programs.
- Recognising the distinctive need of young people
- Ensuring adequate education and training
- Community participation.

Recommendation 13

That specialist youth AOD workers work with other youth services by providing training, expert advice and back-up support to enable them to better deal with young people attending their services with AOD problems.

Recommendation 14

That the content and delivery of the ADIS telephone information service be reviewed with particular reference to providing an improved service for young people.

Recommendation 15

That AOD services investigate ways to enable greater involvement by young people in the planning and delivery of youth AOD services.

3.2 Detoxification/Sobering-up

Viewpoints from consultation process

- Sixteen sources highlighted the lack of suitable detoxification and/or sobering-up facilities for young people as a major deficiency of the present range of

services. Sobering-up facilities where young people could go (or be taken) and which provided a safe place to stay, monitoring of their physical condition and further assistance if requested, were needed. Comments on the need for detoxification services ranged from establishing new detoxification units specifically for young people to improving existing detox units to make them suitable for young people. Some sources recommended non-medical detoxification alternatives be made available for young people.

- Specific problems with the detoxification program at 56 Collins Street were raised by a number of sources. The unit was seen as unsuitable for young people in particular due to the physical layout and the willingness to refer to methadone, clients with only a short history of opiate use, or, it was claimed by several sources, with no history of opiate use. Three sources commented that there was too narrow a view of referral options for clients in the detoxification unit and that this, at times, led to inappropriate referrals of young people for methadone assessment.

Discussion

The need for adequate facilities to satisfactorily deal with sobering up and/or detoxification of young people was of concern to many of those consulted, particularly those involved in delivering treatment services.

This need was mainly raised by sources in the South. Detoxification is conducted at 56 Collins St. However, most sources commented that this facility was unsatisfactory for young people (and women) due to the physical layout. Some sources also mentioned staff attitudes as a barrier to access by young people. The review of services currently being provided from 56 Collins St should include consideration of the special needs of young people including their sobering-up needs.

In the North, Launceston has two sobering-up beds at the Launceston City Mission (an estimated 30-40% of clients are under 25) and detoxification is done at the Launceston General Hospital.

In the North-West, detoxification is available at the Salvation Army's Sulphur Creek program - 30% of clients there are under 25. However, access is difficult for sobering up, requiring transport which is usually provided by AOD workers working only day shifts. The length of stay of 3 to 4 days indicates this program provides detoxification rather than sobering up for most clients.

The literature advocates quite strongly for youth specific sobering-up and detoxification services (Mundalay, 1997; Miler & Connie, 1991) and Lennings and

Kerr (1996) outline a model of best practice based upon Dunsmore House in NSW. Youth specific sobering-up-units are also outlined in the Western Australian Drug Abuse Action Plan and the newly funded Youth Substance Abuse Service in Victoria. When investigating the need for a youth specific detox centre, Lennings and Kerr (1996) wrote:

> '....There was concern that older men may act as role models for acquiring further substance dependent behaviour and encourage young people to leave with them or introduce them to an escalated pattern of drug abuse.....Such people have very different needs and problems to youth, making young people feel marginalised and uncomfortable in such surroundings. Inflexibility in program rules and procedures were also noted as problems by youth. A lack of concomitant psychosocial education/counselling interventions were noted as a problem in retaining youth, as was the observation there was a lack of structured activities for young people.'

However, while most sources thought in terms of establishing dedicated units to provide sobering-up and detoxification services for young people, the size of target populations and relatively even distribution of population across the state make it hard to justify dedicated facilities. The city of Adelaide with 1 million population has one dedicated youth sobering-up and detoxification service (Hindmarsh Centre). Sydney has one dedicated youth specific detoxification and assessment unit (Dunsmore House).

A NADA Opinion paper (1997) recommended one bed per 100,000 population for adolescent residential detoxification and treatment programs (short-stay) - ie five for Tasmania. The economics of dedicated units requiring at least two staff and 24 hour coverage and the difficult question of location of such a unit in Tasmania (assuming only one such unit could be justified), mean that alternative solutions must be sought.

As commented upon earlier, existing youth services, particularly youth accommodation services, are routinely dealing with young people who are affected by one or more drugs, including alcohol. The alternative to setting up dedicated services is to work with selected existing services, to assist them to provide an appropriate, safe and non-disruptive (of their other activities) service for intoxicated young people. In order to achieve this, support and targeted funding would need to be made available to these services.

Funding would be needed for additional staff positions necessitated by the increased workload, for renovations to allow for separation and supervision and for training

and additional resources. Support would include training for staff and back-up support by specialist youth AOD workers. In this process of establishing sobering-up units in general youth services, the role of the specialist youth AOD worker would be to network effectively, advocate for young people with sobering-up needs, identify and liaise with suitable services, assist with training of staff and to provide the back-up for these units when they are operational. Targeted funding is of critical importance in persuading services to take on greater responsibilities.

Other organisations providing AOD services to young people should also be encouraged to be actively involved in assisting generic youth services to better serve the needs of intoxicated young people.

Recommendation 16

That negotiations commence with appropriate youth services for them to assume greater responsibility for the sobering-up needs of young people.

Recommendation 17

That funding be made available to assist such organisations to expand their roles and that specialist youth AOD workers assume responsibility for negotiation of such arrangements and for on-going support once they are established.

Recommendation 18

That the review of services presently provided from 56 Collins St considers the special needs of young people requiring sobering-up and/or detoxification.

3.3 Residential Rehabilitation

Viewpoints from consultation process

- Residential rehabilitation for young people was cited by 16 sources as a gap in current services. There were a range of opinions as to what sort of residential program(s) should be available for young people - two week, three month and six month programs, abstinence and harm minimisation models, programs providing living skills, employment skills, recreation opportunities, outdoor challenges. Some sources said therapeutic community models such as Windana in Melbourne or WHOs in Sydney should be followed.

- Half-way houses and follow-up programs were mentioned by some sources as necessary adjuncts to residential programs.

- One source said these sorts of programs should be available as alternatives to prison for young people.

- The current Christian abstinence based programs, such as the Bridge program, were seen as not suitable for younger people who often do not accept abstinence as their desired goal.

Discussion

Longer term residential treatment is currently available at the Bridge program operated by the Salvation Army in Hobart and by a newly-opened facility called Missiondale which is specifically targeting young people and is operated by the Launceston City Mission. A number of sources felt these Christian-based programs were inappropriate for young people. They felt that many young people refused to attend programs run by religious groups, that the programs offered were too 'moralistic' and one-dimensional in that only a goal of abstinence was acceptable.

The general feeling of many working in the treatment area was that there should be an alternative to the religious-based models for residential treatment. A number of reports have concluded that residential rehabilitation services should not be a priority in the overall mix of treatment services (Ali et al, 1992; Berg, 1995). However, residential services have been found to be cost-effective (Ali et al, 1992)

Dedicated youth residential services are supported in the report to the Victorian Premier's Drug Advisory Council (Pennington, 1996). However, in a small state like Tasmania, with limited resources available, it is difficult to justify tying up a considerable proportion of the overall budget in single facilities, particularly when there are services established offering residential rehabilitation for young people.

The NADA position paper (1997) specified that 5 beds per 100,000 population should be provided for residential treatment - ie about 25 beds for Tasmania. For youth specific residential treatment programs the NADA recommendation was 1 bed per 200,000 population or about 2.5 beds for Tasmania. NADA, as representative of residential NGO services, would be likely to recommend generous quotas for treatment beds. Clearly then Tasmania already has sufficient residential rehabilitation beds available at the two existing facilities.

Effort, therefore, needs to be put into working with these existing residential rehabilitation services to ensure they are accessible to and suitable for a broad range of clients including young people. This can be achieved by direct funding for youth specific programs within these facilities (youth workers, recreation programs, separate accommodation), training for staff, assistance with policy and program modification, and the involvement of youth AOD workers from other services in groups and other activities. Efforts should also be made to assist these organisations to look at those aspects of their programs which may tend to exclude young people and to work towards change.

There is evidence that organisations such as the Salvation Army and the Launceston City Mission have moved towards integrating harm minimisation principles - the Salvation Army in St Kilda is operating a needle exchange program and the Launceston City Mission talked of accepting controlled drinking as a goal for some clients.

The role of youth AOD workers should, therefore, be to work with those organisations currently providing residential services, to advocate for the needs of young people, to assist in implementing program changes, to assist with staff training and to provide ongoing back-up and input for these services. Other organisations providing AOD services to young people should also be encouraged to be actively involved in assisting residential programs to better serve the needs of young people.

Recommendation 19

That the Salvation Army Bridge program and the Launceston City Mission's Missiondale program be assisted to better deal with the needs of a wider range of young people through the involvement of the specialist youth AOD workers in advocacy, policy development, training and support roles.

Recommendation 20

That limited funding be made available to assist these programs to improve their accessibility by and effectiveness with young people.

3.4 Accommodation for young people

Viewpoints from consultation process

- Six sources said suitable accommodation for young people with AOD problems was needed. They said that shelters and other types of accommodation for young people excluded those with significant AOD problems. This type of accommodation differed from the sobering-up centre or the rehabilitation centre in that it would essentially be an accommodation service for young people with the aim of stabilising that aspect of their lives and promoting possibilities of progress in addressing drug use issues once the basic needs had been addressed.

Discussion

The importance of accommodation for young drug users is aptly summed by Brown (1991):

> '....for young people to be willingly engaged in counselling or vocational, social or recreational programs and to reach a more stable lifestyle beyond dependence upon drugs, secure accommodation was a matter of imperative necessity.....if housing could not be offered to a young person, the prospect of coaxing them to participate regularly in programs was unrealistic.....overseas research confirms that a stable setting is often of primary importance if assistance in changing a young person's way of life is to be effective'.

There are a number of services across the state specialising in assisting young people with accommodation needs. These services are currently dealing with some young people with an AOD issue (though this may not be the primary reason they have contacted that service) and it was estimated by several sources that as many as 70-80% of clients attending other youth services have a significant AOD issue.

Youth accommodation services said they prefer not to take on young people with AOD issues because they fear that AOD clients will dominate their workloads and alienate other clients. They also feel they lack the expertise to deal with this client group, that they are not funded to do it and because they see it as a specialist AOD service's responsibility.

For the same reasons as apply to establishing residential rehabilitation services for young people, it is not possible to justify dedicated accommodation services for young people with primary AOD issues. Rather, the solution should be sought through co-operation with and assistance given to existing youth accommodation services to better cope with this client group. In order to encourage accommodation services to take on this role, funding should be available to assist them with the extra workload - funding for staff, resources and alterations that may be necessitated. Without some offer of funding assistance it is unreasonable to expect organisations to take on extra and potentially difficult work.

The role of the specialist youth AOD worker is to break down any barriers to access to these services by young people with AOD problems. This can be achieved through networking, providing training to staff, support to promote organisational change, involvement in ongoing activities of these services, and as an avenue of referral and back-up for staff for difficult cases.

In addition to working with identified youth accommodation services to provide suitable accommodation for young people with AOD problems, specialist youth AOD workers should network with the Tasmanian Housing Services, Special Needs Accommodation Service to increase their access to and successful utilisation of, state-provided housing resources.

When considering the role of AOD services in the provision of longer-term accommodation, the role of 'The Haven' needs to be examined. The consultants were concerned that this service did not appear to have an effective management committee backing it up and that as a small service it is particularly vulnerable to the types of developments envisaged in the 'Changing Relationships' documents where such organisations are seen as being overlooked in favour of larger NGOs providing a range of services (Community Change Partnership, 1997). Consideration should be given to placing its resources into a youth service such as Link/Your Place with a designation to facilitate long-term accommodation for young people with AOD issues in the manner discussed above.

A pilot project in Western Australia should also be closely monitored where drug abuse treatment services for agencies providing supported accommodation for youth is being further developed in conjunction with Family and Children's Services (Western Australian Government, 1997).

Recommendation 21

That specialist youth AOD workers work to facilitate access by their client groups to services providing longer-term accommodation to young people through advocacy, training and back-up to these services.

3.5 Dual Diagnosis

Viewpoints from the consultation process

- Seven sources said services for clients with a dual diagnosis of a mental health and an AOD problem were inadequate. Whilst this applied to all clients in this category, it was particularly so for young clients. The common comment was that dual diagnosis clients were often 'lost between the chairs' - with both psychiatric and AOD services failing to adequately assist these people. The Burnie ADS worker (a former mental health nurse) had a good working relationship with the hospital psychiatric unit and this arrangement benefited clients.

Discussion

Developing suitable services for dual diagnosis clients is specifically mentioned in the TDSP and has been identified in a number of reports (Berg 1995; Miller & O'Connor, 1991). Dual diagnosis clients who tend not to be accepted by psychiatric services are those likely to be less compliant - a common profile for young people in general. Dual diagnosis clients often have difficulty accessing detoxification services. The treatment philosophies of both AOD services and psychiatric services can exclude dual diagnosis clients through entry requirements such as 'not on medication' or 'not affected by any illicit drug or alcohol'.

Best practice models in this area are projects which aim to establish links between AOD workers and mental health workers so that clients can be co-managed and treated simultaneously for their drug and mental illness problems (Berg et al, 1996). The role of AOD workers is to establish close liaison with psychiatric services to enable co-management of clients. The need to improve interaction and collaboration between mental health services and AOD treatment services was also recommended by Ernst & Young (1997).

Whilst projects such as the Gemini Dual Diagnosis Project in Darlinghurst, NSW have attempted to establish links between AOD workers and mental health workers so that clients can be co-managed and treated simultaneously, there is a problem in that there is a scarcity of specialists in both fields (Berg et al, 1995).

Recommendation 22

That AOD workers establish close working relationships with psychiatric services in their area and that funding be made available for joint training for AOD and psychiatric service workers to further co-operation between the two sectors.

3.6 Services in Rural Areas

Viewpoints from consultation process

- The inadequacy of services (treatment, education and health promotion) provided in rural and more remote areas was seen as a gap by four sources.

Discussion

Services to young people on the west coast had been recognised by the Burnie Youth Alcohol and Drug Service (BYADS) as a gap and special one-off funding was obtained for a pilot project for that area. BYADS was also looking to provide services to King Island in 1998. There were few AOD workers stationed in other rural areas, the preferred option being to service rural communities with workers from Hobart or Launceston. In other states, AOD services have been progressively moving out into community locations rather than maintaining centralised services. This has been demonstrated in New South Wales, Victoria, Western Australia and South Australia.

The uneven distribution of services across Tasmania is addressed in the recommendations regarding the implementation of the TDSP where the service delivery co-ordinating body would be able to co-ordinate the delivery of services across regions.

3.7 Peer Education

Viewpoints from consultation process

- Five sources said peer education programs such as exist on the mainland should be introduced to improve the effectiveness and reach of drug education and harm minimisation initiatives. Two sources said more education programs targeting Hepatitis C and suicide prevention among young people were needed.

Discussion

The need for Peer Education and Users Groups is well acknowledged in the literature and other programs in Australia. The review of the National Drug Strategy commented:

> 'Support for user groups is commended and should be enhanced. Users are in an excellent position to help monitor the emergence of new drugs or patterns of use at the street level. Based on their personal experience, they

> can anticipate the likely impacts of new policies and programs.' (Single & Rohl, 1997)

Similarly, Bains (In Mudaly, 1997) said that it 'is widely viewed that peer education encourages self-direction, decision-making skills, communication skills, leadership and teamwork skills in the young people who participate' . This is also supported by other research which has found that the power of peer influence even in small doses is effective for young people and that no other types of programs have the capacity to reach as broadly as peer education programs (Miller, 1996). Peer Education should be facilitated as it provides a potentially effective means of assisting people in their rehabilitation (Ali et al, 1992).

The aim of peer education then is to positively affect the behaviours and attitudes of other young people. This is done by training selected young people and then utilising their skills in the development and facilitation of education, group or individual work with young people. The benefits of utilising such an approach is that young people place credibility in information when it comes from people with whom they can identify (Prendergrast & Miller, 1996). Peer Educators are also often able to be more sympathetic and often have energy and credibility that is demonstrated in their planning and development of programs (Dunn, personal correspondence).

Groups such as the Tasmanian Users Group (TUG) could be instrumental in providing support and training for workers but funding for the piloting of such projects is needed. User groups are also well positioned to work collaboratively with Sexual Health in providing Hepatitis education to injecting drug users. In addition, training is needed for workers to train the peer educators. These efforts need to be funded appropriately and recognised as a valuable resource in addressing youth AOD drug issues.

Recommendation 23

That peer education be recognised as a best practice model and that services work towards incorporating peer education processes as one aspect of their work.

Recommendation 24

AOD services and Sexual Health should examine the possibility of working in conjunction with user groups such as the Tasmanian Users Group (TUG) in developing peer education programs and adequate funding be provided for these purposes.

3.8 Living skills programs

Viewpoints from consultation process

- Five sources said non-residential life skills, employment, recreational and ex-prisoner programs were needed.

Discussion

The extent to which AOD services should be asked to provide comprehensive services to their clients should be examined carefully. There can be a tendency for service providers to see themselves as sole custodians of appropriate assistance for their client group and to regard referral as some measure of failure of their own service. This tendency can be exacerbated where organisations face uncertain funding and, hence, feel they have to appear to be indispensable.

However, there is a need for specialist AOD services to draw boundaries around the limits of their service and recognise the benefits of referring on. Services benefit from the development of specialised skills and resources. Clients benefit through involvement in a wider range of services which discourages dependence on one service and builds self-confidence and self-reliance.

Specialist AOD services have the role of assisting the client to address their AOD issues and then of effectively referring them on to those services established to meet specific needs - accommodation, living skills, employment, education etc.

The role of the specialist AOD service worker is, therefore, one of advocacy for their clients in these other services, assisting these services to understand the special needs of this client group through networking and training, promoting organisational change where appropriate and supporting clients who are engaged in such programs.

Spooner and her colleagues (1996) go on to say:

> 'Some substance use might be functional and not problematic. However, where substance use is interfering with adolescents dealing with their problems or their lives in general, teaching life skills and providing support to deal with those problems can be a useful and effective intervention'.

Developing life-skills was also seen as important in the Tasmanian Youth Health Strategic Plan (Department of Community and Health Services, 1995) and identified in other consultations with young people in Tasmania (Brockdorff,

1997). Pennington (1996) supports this notion when he said that adolescents with substance-use problems need continuous assistance, not just a discrete program.

Brown (1991) aptly summarises the issue:

> '....young people who begin to use drugs heavily - as distinct from those who are tentatively experimenting with substances - do so largely to escape from subjective states which are intensely disagreeable to them, such as anger, frustration, loneliness, anxiety and depression. Many are unemployed, poorly educated, estranged from their families or homeless.....The challenge which presents itself to those agencies charged with the responsibility for improving the quality of life for such young people, is to alleviate those distresses which induce so many to use drugs.'

Recommendation 25

That specialist AOD services network with services providing life-skills training and other relevant services to ensure access to these services by young people with AOD issues.

3.9 Research

Viewpoints from consultation process

- Two sources said more local research into patterns of drug use and the views and needs of young people in Tasmania was needed before any service planning was done.

Discussion

The National Drug Strategy identifies research as 'the foundation for all other activities' (Single & Rohl, 1997). The lack of research in Tasmania was apparent in the consultations and the lack of data specific to Tasmania has been commented upon elsewhere in this report.

The consultants were aware of several research projects undertaken and the DEN appeared particularly active in this area. However, there appeared to be no co-ordinated approach to researching needs of young people in Tasmania.

In other states research has been carried out by specialist units such as the National Drug and Alcohol Research Centre (NDARC), the National Centre for Education

and Training in Addictions (NCETA) and the National Centre for Research into the Prevention of Drug Abuse (NCRPDA), among others.

Options which could be considered to improve the quality and quantity of research conducted into drug and alcohol issues in Tasmania include the contracting of specific research projects out to research establishments, setting up a research unit within the ADS structure, funding research projects on a needs basis and developing links with the Tasmanian University to stimulate more research.

The Pennington Report (1996) said that services should be established to monitor, evaluate and research issues associated with youth substance abuse and this is further supported by the Alcohol and Other Drugs Council of Australia who believe that a greater proportion of alcohol and other drug funding should be directed towards community-based research as well as prevention and treatment (Crosbie et al, 1997a).

Recommendation 26

That the provision of a research function to provide information on needs and for service evaluation be investigated.

3.10 Other gaps

Discussion

Several other issues were raised during discussions which warrant mention here without need for specific recommendations.

Many of the organisations consulted raised the broader issue of the context of youth drug and alcohol use. They saw alcohol and marijuana use in particular, as now occupying a central role in the lifestyles of many of the young people who in aggregate represent a youth unemployment rate in Tasmania of 18.8 percent (Office of Youth Affairs and Family, 1997).

Most people consulted were sympathetic with their situations, understanding their use of alcohol and marijuana as ways of dealing with the daily boredom, the lack of income, the loss of hope and consequent negative effects on their self esteem, motivation and vision for their future. They saw that the use of these drugs was now an integral and daily aspect of these young peoples' lives, understandable in the circumstances, generally accepted as normal behaviour by young people and their peers and by an increasing proportion of the general population:

> 'It seems to me it's like a hump from 14 to 19 years old - if we can get the kids through this hump, then they usually turn out OK. That's when they're getting bored, that's when they're experimenting, that's when they're doing lots of drugs - one of the biggest problems we've got is unemployment and you and I both know that. If we get these kids jobs then they haven't got the time to be smoking dope, they haven't got the time to do all that.'

Indeed, Spooner and her colleagues (1996) had the following to say:

> 'Substance use should not be seen as the central issue and targeting this alone while ignoring issues such as homelessness, unemployment, and alienation from family and society, is ineffective and inappropriate.'

The role of the media and business in promoting licit drug use and the perceived hypocritical stance of adults in relation to their own drug use were seen to assist young people to reinforce their own attitudes towards habitual alcohol and marijuana use as normal acceptable behaviour in circumstances of unemployment and lack of opportunity to participate in the economic activities of society.

When asked whether, in the light of this perception of the reasons for drug and alcohol use among young people, resources should be withdrawn from the youth AOD services in order to address the core issue of creating a viable future of occupation and hope for young people, most sources agreed in principle but thought that treatment and other services would need to be maintained as there would always be a proportion of the youth population who would be 'at risk' or resort to drug use for other reasons.

However, they were in agreement with the proposition that the scale of drug use, particularly the daily use of alcohol and marijuana by young unemployed people, would dramatically decline if they could find worthwhile and stable occupation of their time and a secure financial situation. Indeed, a number of sources quoted examples of this occurring with clients who went into study or got a job.

Services for families of young drug users were highlighted. Best practice models indicate that youth AOD services should include services for families. In general, the consultants found that the youth AOD services did offer these services but were not formally recognised as a core function. Pennington (1996) recommended in his report to the Victorian Premier that:

> 'Strategies should be developed to provide information to parents to assist them to provide information and support to their children. These strategies

should include information about where they get further information, or personal assistance for themselves or for their children'.

Home detoxification programs were suggested for young people. Home detoxification is suitable for a limited number of young people, with strong family or other support a key indicator of success. Suitable protocols would need to be developed and appropriate training provided to youth AOD workers before any home detoxification program is launched. Pilot programs interstate should be monitored.

The issue of a 'shooting gallery' was topical during the time of the consultant's visit to Tasmania following a newspaper report of the closure of an unofficial gallery in a city building. Such services are often high on the list of needs when current users are surveyed but service providers are less than enthusiastic about it. Measures such as this are currently being debated at the national level. Tasmania, as a relatively minor player in this field, can afford to take the lead on this issue from the outcome of this wider debate.

In a review of adolescent treatment services, Spooner and her colleagues (1996) said that it is unlikely that any program can include all of the components that are necessary to deal with all of the problems facing young people with substance-related problems. Components include:

- family and peer programs
- physical and other recreational activities
- services for dealing with the range of issues that accompany substance misuse, whether they be causal, consequential or correlational (for example, child sexual abuse, psychological problems, medical problems)
- practical assistance (for example, to organise or provide accommodation)
- mechanisms/strategies for behaviour modification (for example, a reward, or levels system) might be necessary.
- skills development programs (for example, social skills, communication skills, living skills) and cognitive restructuring.
- educational and vocational programs
- counselling

- outreach for attracting adolescents into a program before they are coerced to do so
- graduated withdrawal and structured, scheduled after-care
- monitoring and evaluation

4. DUPLICATION OF SERVICES

4.1 School Drug Education

> *'.....the youths most needing the message are those least likely to be receptive to them and they may not even be there when the messages are delivered' (Kay, 1994).*

During the consultation process, the issue of school drug education ranked second in interest to the issue of need for a co-ordinated approach to the provision of services in general. Whilst this may be to overstate its relative importance in the review, it is an indicator of the number of parties with interests in this area.

4.2 Co-ordination of School Drug Education conducted by AOD Services

Viewpoints from Consultation Process

- Twenty-nine sources made comment about one aspect or another of the provision of school drug education programs. Of the organisations consulted, fourteen were active in delivering or developing school drug education programs. About 50 of their staff were involved, ranging from doing occasional one-off requests at schools to full-time commitment to school drug education. Six sources mentioned duplication in regards to provision of school drug education programs.

- In the school drug education area there is good communication between the Department of Education, Community and Cultural Development (DECCD) and most organisations providing drug education in schools. Communication among organisations providing school drug education was less certain and there were instances of 'double-booking' cited to the consultants. One source thought that the DECCD should take the lead and bring all service providers together to sort our who is doing what in the school drug education area.

- Current practices mentioned by sources include:

    - 'getting our heads together the night before and usually we come up with something good'

    - concentration by a worker on only a few schools - one worker doing a 20 hour program for one school only, one police officer spending half of all the hours all officers spent in non-government schools in one school.

- instances where drug and alcohol workers arrived at a school to find workers from another agency sharing the same platform.
- one-off forums, particularly for end-of-year programs.
- lack of awareness by workers going into schools of the 'Principles of Drug Education in Schools'.
- NGOs not funded for school drug education work committing substantial resources to that area.
- reactive programs from organisations with no guidelines/policies about school drug education programs.

- The DECCD works with the 'Principles of Drug Education in Schools' through the recent introduction of the 'Drugs and Education: Guidelines for Tasmanian Schools and Colleges' (DECCD, 1997) document which is being circulated at present and training given. Some outside agencies adopt a 'bums on seats' approach to drug education in schools, evaluating in terms of numbers attending their sessions without much consideration of longer-term objectives or consistency with the 'Principles of Drug Education in Schools' policy.

- The education system is still somewhat compartmentalised - principals, teachers and parent groups still can have significant sway over how drug education is approached in individual schools. This allows for the proliferation of organisations and approaches evident in the school system. NGOs and the ADS often are asked into schools to address specific 'problems' rather than as part of an ongoing program as recommended in the 'Principles...'. There may be the need for the regulation of outside agencies - accreditation of individuals and organisations and their programs. Some outside agencies find it difficult to get into some schools as schools have many groups competing to run programs for students.

- Nine sources said current drug education efforts were middle-class and sanitised and therefore largely ineffective as young peoples' realities were very different to that. They felt that a much more realistic 'in your face' presentation of issues using the young peoples' realities and experiences should be adopted. Some said that teachers often represent middle-class values and are unskilled and uncomfortable about their abilities to effectively present and discuss drug issues with young people from different socio-economic backgrounds. Several sources mentioned that the use of peer educators would be a good model.

- Drug and alcohol services whose principle focus was treatment justified their participation in drug education in schools on the grounds of developing awareness and establishing links so that they could move easily into schools when called to assist with specific incidents, so that students (and parents) could access their services at other times, to assist schools to develop drug policies and with teacher development.

- Fourteen sources commented on the role of DEN. Four sources indicated a positive response to DEN's role, particularly citing DEN's impact in rural areas. Eight sources specifically mentioned the DEN as co-operative and with good networking abilities. Only two sources mentioned any difficulty in this area. Other comments indicated there was some misunderstanding of DEN's role in school drug education.

Discussion

There are fourteen services and around 50 staff involved in the provision of school drug education in Tasmania. Some organisations have Statewide coverage while others are regionally based. There is a range of differing ideologies and methodologies, and differing charters and funding bases.

Whilst there were few instances quoted of direct clash of programs, there were many instances of uneven application of programs - some schools being well served (those vocal in their requests or with high drug incident reports), others less so. Duplication, poor co-ordination and differences of opinion are inevitable where there is no central control over the delivery of drug education. From the views expressed in the consultation process, it is obvious that there is an urgent need to simplify and co-ordinate school drug education services.

At present, much discretion about the content and method of delivery of drug education programs remains with the principal and/or school council and/or health education teacher. On the whole this is responsibly exercised yet the uncoordinated exercise of individual decision-making at the school level has created the confused and uneven approach described to the consultants.

Schools are encouraged to follow the departmental guidelines including the 'Principles for Drug Education in Schools' (Ballard et al, 1994) document and training is available for teachers responsible for the delivery of the health education curriculum, of which drug education forms a part. Schools are expected to develop a comprehensive School Drug Policy covering the range of situations where drug use issues and education issues intersect. School Development Officers (SDO) employed by either the DECCD or the DEN are available to assist schools to develop their drug policies and with training and resourcing health education teachers.

A number of other AOD services whose principle focus is the delivery of treatment services also participate in school drug education programs. Most of these services are responding to requests from the schools while only a few approached schools in order to participate. The resultant practices, referred to above in the summation of the consultancy findings, indicates that there is a need for clearer guidelines and closer monitoring. AOD treatment services, particularly youth-oriented services, certainly have a role in schools. However, this role needs to be clearly defined and understood by all concerned. This role should be limited to informing the school community of its services so that pupils and parents will utilise these services when needed.

A process is needed whereby the efforts of all the players in the field can be co-ordinated, for the benefit of both the AOD services concerned and the school drug education program. Such a process could be incorporated into the implementation plan for the TDSP through an education output working group, itself a part of the Service Delivery Co-ordinating Body. This process would clarify who is doing what, where, with whom, how and why.

It should be the responsibility of the DECCD to co-ordinate participants in school drug education programs. This could be achieved by some form of accreditation instituted by the DECCD for all organisations and individuals wishing to conduct school drug education programs. In this way all programs could be monitored to ensure they are consistent with the national principles, with other aspects of the school's drug education program and that they are operating with designated subject matter, in designated areas or regions and with personnel who have received appropriate training. Training should be given to all presenters before they are allowed into school settings so that all have an adequate understanding of the 'Principles...', of the school health education course and of where their presentation fits in. Training could also assist AOD workers to refine their presentations.

All organisations conducting school drug education programs should develop appropriate policies covering these programs, including content, methodology, rationale and training for presenters.

Despite questions over the effectiveness of school drug education, the NDS report still advocates for the enhancement of school-based drug education, including starting at an earlier age and for a longer duration, a strong theoretical multi-modal approach, peer training and refusal skill training. However, the assertion as to its usefulness was not based on research but simply that school prevention is still a 'solid investment in the future' (Single & Rohl (1997).

Other major reviews have emphasised the need for drug education to be included as part of the core component in the health curriculum in schools and that action should be taken as a matter of priority to ensure sufficient teaching staff are trained in drug education (Pennington, 1996).

There will be a significant amount of money available over the next three years as a result of the Prime Minister's 'Get Tough on Drugs' strategy where $7.4 million will be spent by the Commonwealth on a schools drug strategy with the aim of zero tolerance of drugs in schools. This will be developed in consultation with State and Territory Education Ministers, non government school authorities as well as health professionals and community organisations (Commonwealth Government of Australia, 1997). The relevance that this will have on Tasmania's school drug education is unclear as, at the time of writing, no announcement had been made as to its allocation.

Recommendation 27

That the DECCD institutes an accreditation process for all organisations wishing to participate in school drug education programs.

Recommendation 28

That through the Service Delivery Co-ordinating Body, measures be instituted to effectively co-ordinate all organisations delivering school drug education programs.

Recommendation 29

That organisations providing school drug education programs develop written policies covering these programs and that this be a necessary requirement for accreditation.

4.3 School Development Officers

Viewpoints from the consultation process

- The location of School Development Officers (SDOs) within the DEN and the DECCD was a significant point of comment. Several sources apart from those associated with the DEN and the DECCD commented on the SDO positions, expressing the view that these positions ought to be DECCD positions.

Department of Education, Culture and Community Development (DECCD)

- Those within the DECCD felt that the SDOs should all be located within the departmental structure. It was felt that SDOs must be teacher-trained and within the system to gain maximum credibility and acceptance from teachers, principals and superintendents. The SDOs had to understand the workings of the department, the teaching process and be familiar with and to, the personalities involved.

- According to sources within the DECCD, the arrangements in the North-West are more effective than elsewhere. The decision of where the SDO positions should be located should be a pragmatic one, based on consideration of the reality of how the department works - that most staff are more co-operative with programs where they see the department has some ownership. The SDO role is one of being a gatekeeper - co-ordinating the flow of information and methodologies into the school system. Assisting with teaching methodologies is seen as more important than provision of curriculum material for drug education, hence the need for teacher-trained appointees within the system. People outside the department have to spend lengthy periods of time gaining acceptance and even then they don't achieve the same degree of access at all levels that the person within the system achieves.

Drug Education Network (DEN)

- Those within the DEN felt that people in the SDO positions located outside the education system maintained a focus on drug issues, had more flexibility to introduce new programs and ideas and that the DEN could muster greater resources by involving the wider community.

- The DEN's expertise was in the health services area and it was this perspective that the DECCD could not effectively provide internally. The DEN also has expertise in education issues, employing teachers in SDO positions and having people on their management committee with an education background.

- They feared that if the SDO positions were located only within the department that their focus could be diverted to other departmental matters, pointing out that departmental priorities change frequently and that in the past the DEN had to pick up and maintain the drug education role when priorities changed . The DEN's management and reporting structures ensure that the funding for drug education provided by the Government is directed to that purpose. They felt that the effectiveness of the SDOs, whether located within or outside the department, was dependant on the ability and personality of the individual.

- The DEN also pointed out that the cost of them maintaining the SDOs was much less than if they were departmental positions and queried whether the Department or ADS would be prepared to provide the additional funds required if all the positions were to be transferred to the Department.

- The DEN maintained that they have a long history of co-operative efforts with the DECCD, including with the School Developments in Health Education (SDHE) and the National Initiatives in Drug Education (NIDE), demonstrating that current staffing arrangements were effective. The DEN also has an important charter with the independent and Catholic schools.

- The DEN felt that a number of schools as well as some providers of AOD services to young people do not necessarily accept or adhere to the 'Principles ....' as the guidelines for best practice. With the current introduction of the concept of 'Health Promoting Schools', the DEN is best placed to facilitate integration of drug education because its strong links with the community assist in bridging the gap between school and community.

- The DEN has played a significant role in developing the Health Promoting Schools (HPS) concept within Tasmania and this has led to a greater acknowledgment of the need for AOD prevention and education to be incorporated within HPS. The DEN is well positioned to meet the identified needs of school communities through a primary health care model and the HPS framework with its team of community development officers (CDOs) working with SDOs. SDOs and CDOs structure service delivery of preventative AOD services to young people and schools within the HPS framework using existing education and health resources, programs and expertise. The DEN also assists schools to make appropriate organisational changes supportive of AOD promotion activities.

Discussion

The location of the School Development Officers (SDOs), one within the DECCD in the north-west, one in the DEN in Launceston (vacant at time of the consultation) and one in the DEN in Hobart, has created a degree of confusion and uneven servicing. There is duplication as there are positions in two organisations developing and conducting similar programs aimed at skilling and resourcing health education teachers and assisting schools develop their school drug policies.

The development role is being duplicated whilst the implementation role is distinct in that it is divided into three regional positions. This has created an uneven distribution of service with the SDO positions in the North and North-West responsible for two school regions of about equal size, while the SDO in the South is responsible for three school regions of much greater size. As of February 1997, there were 63 government schools in the North-West (Arthur and Barrington regions), 63 in the North (Macquarie and Forester) and 102 schools in the South (Bowen, Derwent and Hartz) .

The DEN also has a significant role in independent and Catholic schools, with parent education, community-based education and health promotion.

As would be expected, the views of the DECCD and DEN were different on the issue of the proper utilisation of these positions.

From the DECCD's point of view, these positions should all be located within DECCD - the person filling this position must be teacher trained, the person must have acceptance, credibility and access to all levels of DECCD - there should be ownership of drug education responsibilities within DECCD and the reality is that for good or bad, those working within DECCD were more comfortably working with their own and therefore results were better.

The DEN felt that a person placed outside DECCD ensured a proper focus on drug issues from the health perspective, was less likely to be diverted onto other departmental matters with little to do with drug education, had greater access to the range of expertise, resources and research across the AOD sector and, through DEN's extensive community links, had better access to a wider range of assistance and expertise resulting in a less insular approach to the development of drug education.

Other points raised in this argument included the role of personality and background of those in the SDO positions in assessing effectiveness, salary differentials, difficulty of attracting qualified teachers at Community Service Award rates, secondment of teachers, funding commitment from DECCD and the

demonstrated effectiveness of past DEN/DECCD co-operation. Whilst this is necessarily an abbreviated presentation, it does indicate the major areas of divergence of view.

While the DECCD looked at the situation as needing resolution, the DEN felt the current situation could continue. Several other sources outside the two concerned expressed opinions supporting the DECCD position.

There are few precedents to look for elsewhere as in other states the SDO function is the responsibility of the relevant education department.

The consultants saw merit in the involvement of both the DEN and DECCD. However, the SDO positions do require some clarification. There appeared to be two distinct roles which the SDOs undertook. Firstly, the role of researching, program and resource development - the preparation work involved in introducing drug education programs into schools - ie 'developing the packages.' This is the role that the DEN emphasised was its strength. The second role is that of introducing the programs and methodologies to health education teachers through school liaison and teacher training ie. 'selling the packages.' This is the role the DECCD felt had to be occupied by its own personnel.

The consultants were of the view that the DEN should maintain responsibility for the making of the packages and that the DECCD should assume greater responsibility for marketing the packages. One SDO position in DEN would be responsible for program development and for the independent and Catholic schools. Within the DECCD one position would be responsible for the North and North-West regions and one for the South, thereby redressing the imbalance in service to some extent. With the roles clearly defined, greater co-operation between the two organisations could be expected. The consultants envisage the DEN would not be locked out of schools, rather it would operate through the DECCD-based SDOs, developing, trialing and implementing new programs.

At present the school drug education program is funded by a grant from the ADS budget. Transferring one position to the DECCD would entail greater costs and the DECCD would need to make a commitment to provide the extra cost associated with such a shift. Conceptually, this is desirable as it gives the DECCD some ownership of, and greater responsibility for, school drug education programs.

Elsewhere in this report recommendations are made regarding the implementation process for the TDSP where output working groups are suggested as a means of sorting out the roles, responsibilities and areas of operation for all key players in each output area. Within this framework the DEN and DECCD could jointly define their roles and responsibilities.

Recommendation 30

That school drug education programs be supported by one SDO position in DEN responsible for research and program development and two SDO positions in the DECCD responsible for implementation.

4.4 Life Education Centre

Viewpoints from consultation process

- The Life Education Centre appears to be isolated from other providers, with no networking connections to other NGOs. It is seen by most other organisations as not following the 'Principles...' and the fact that it is directly funded by the Premier's Office is a source of dissatisfaction. Life Education is popular with principals, teachers and parents in some primary schools. It is planning to introduce secondary school programs.

Discussion

The role of the Life Education Centre was the source of disquiet for some sources who saw them as gaining preferential treatment in the face of questionable validation of their programs. Life Education is funded directly from the Department of Premier and Cabinet - it has little interaction at present with other school drug education programs or the broader AOD sector in Tasmania, relating instead chiefly to interstate Life Education programs.

Despite some controversy surrounding evaluation of its programs, Life Education continues to enjoy a high profile, strong public support and strong support from some school communities. Life Education is confined to the primary school system in Tasmania but is preparing to move into secondary school drug education following the development of programs on the mainland.

The Life Education Centres across Australia have received significant Commonwealth Government funding in recent years to develop programs to move into high schools ($960,000 in 1996/97). Whilst there seems to be much admiration in the alcohol and drugs field for their ability to raise funds, there is also controversy over whether they represent value for money in a field that is already depleted of money and whether they actual prevent harms associated with drug use. Indeed, the Hawthorne and others (1995) evaluation found that Life Education participants are actually more likely to engage in drug use.

Life Education Centres claim that the Hawthorne evaluation was methodologically flawed and changing practices make it obsolete (Wood, 1997).

A true longitudinal evaluation of all school-based drug education in Australia has never been done (Metherill in Wood, 1997) and it remains to be seen whether any of the programs have a significant impact in reducing young people's uptake of drugs and reducing the misuse of drugs.

It is likely that the Life Education Centre will remain a major player in school drug education for the foreseeable future. The impact of the recently announced 'Tough on Drugs' strategy is unknown as yet but additional funding for school education was a major plank of the platform.

In the light of these factors and, notwithstanding the evidence available about its programs' effectiveness, the best approach would be to attempt to draw the Life Education Centres into the mainstream of the NGO and school drug education networks. By encouraging them to participate in dialogue and co-operation with other service providers (in the same way as differing philosophical positions are being accommodated in the AOD treatment area), the overall effectiveness and efficiency of the delivery of school drug education may gradually be improved. Continued confrontation and isolation will only entrench views on both sides to the overall detriment of the education system.

A form of accreditation for organisations conducting school drug education programs has been recommended and it would be expected that the Life Education Centres would have to participate in this process. It would also be expected that they participate in the output working groups process as recommended for the implementation of the TDSP. In order to normalise the relationship between the Life Education Centre and the rest of the AOD sector, funding for Life Education Centres should be brought within the authority of the DCHS.

Recommendation 31

That the Life Education Centre be encouraged to participate in the networking and service development initiatives of the AOD sector and that it be subject to the normal regulation of the sector.

Recommendation 32

That administration of Life Education Centre funding be transferred to the DCHS.

4.5 Tasmanian Police Drug Education

Viewpoints from consultancy process

- Several sources questioned the role of the police in school drug education, citing variable approaches by different police officers, difficulty in co-ordinating due to officer transfers, officers straying from their brief of 'Drugs and the Law' and 'Drink-Driving', lack of understanding by police officers of the teaching environment and the inability of police officers to engage in realistic discussion with students given their role with the law.

- DECCD saw the role of the police in providing information about Drugs and the Law and Drink-driving issues. The Tasmanian Police drug education officers were not getting as involved in government schools, possibly due to greater integration of the 'Principles ....'. Police spent a total of about 80 hours in 15 government schools in the period from March 1996 to June 1997.

- According to the police, their drug education program was developed following industry-wide input and involvement from both government and non-government organisations and coordination with the DECCD. The police program is a structured one that links directly into the health curriculum. One off 'show and tell' sessions on drugs are discouraged and preference is given to schools which indicate that some thought has gone into their drug education program and which adhere tot the 'Principles of Drug Education in Schools'. Evaluations are conducted after each school program.

Discussion

The role of the Tasmanian Police was commented on by several sources in the consultation process with concerns of their effectiveness, the scope of their program and the uneven application of it. The Tasmanian Police, in conjunction with other state police forces, have been responsible for the development of the 'National Police Community Drug Education Guidelines'. Adherence to these guidelines and their own internal guidelines will ensure appropriate and effective drug education strategies are implemented.

From the information supplied by the Police Department, there may be some imbalance in the delivery of police drug education sessions. Private schools had a much greater utilisation of police services. Amongst these private schools several dominated in their call on police time. There may be a need for some internal review of these concerns.

The police should also consider utilising opportunities such as forums and output working parties to promote to the AOD sector a better understanding of the role of police in school and community drug education.

4.6 Other comments from consultation process

- Seven sources said there were no duplications as diversity and choice were essential in providing effective services for young people. Different service philosophies and personalities of workers attracted different groups of clients and no one service could cover all the sub-sets of 'youth'.

Discussion:

The need for a range of treatment options has been consistently supported in the literature. The desirability of sustaining a range of options must be considered in the context of the small target population in Tasmania. Throughout the consideration of the gaps in Tasmania's services, this was a significant factor leading the consultants to look at alternatives to developing dedicated services:

> 'An operating principle of a strategy based on harm minimisation is to provide ..... a maximum range of interventions' (Single & Rohl, 1997).

5. CO-LOCATION OR ONE-STOP SERVICES

5.1 Co-location

Viewpoints from consultation process

- Twenty sources said they thought that co-location of services or one-stop service has/would improve efficiencies and effectiveness. The benefits associated with co-location included:
    - facilitating immediate referrals - not losing as many young people in the referral process because it can be immediate and personalised. A number of sources stressed that young people need things to happen immediately or the momentum is lost.
    - sharing of management/administrative resources, sharing of expertise, improve networking, improve efficiency, release workers for other functions, joint training.
    - reduction of overheads - building rental and maintenance, electricity, telephone, equipment, vehicles, etc.
    - improve co-ordination of services and case conferencing.
    - improve access by young people to the range of available services. It was pointed out that young people often present for one reason but may need and access a broader range of services if they are immediately available. They may come for a more 'acceptable' need such as housing but their underlying problem may be drug use.
    - easily identified central location for young people which will increase awareness of all the services available.
- Whilst there was no general disagreement with the concept, a number of sources made provisos:
    - co-location requires careful design of the premises and careful consideration of the mix of services to be co-located. The mix of clients accessing the various co-located services may alienate other potential client groups.
    - services may have no control over the quality of other co-located services.

- maintaining a separate identity in a co-location may be difficult.
- internal politics among the co-located services may threaten effectiveness.

- One source presented the following model of a block of co-located services for the central Hobart area. Their vision was for a cluster of closely located services addressing immediate needs of food, accommodation and health (including drug and alcohol issues) with a number of strategies:
  - drop-in coffee shop (with cheap food)
  - sobering-up unit for young people
  - crash pad/shelter
  - boarding house for longer term accommodation
  - Link type service
  - recreation areas
- Several sources commented that some of the past opposition to the idea of co-location had come from individual workers' preferences and fears and that if it is to work in the future a long-term perspective will be required.

Discussion

> *'An holistic approach, which addresses all of the inter-related needs of young people 'at risk' simultaneously, is appropriate and best provided by a multi-disciplinary team or co-located youth services' (Berg et al, 1995).*

Twelve organisations delivering AOD services are currently in co-located situations with one or more other services (some of these are ADS services located with other health services). One service (The Link) had previously been located in close proximity to the Roadhouse and a number of sources commented that this had been a useful partnering of services. Three potential co-location arrangements are currently under consideration - with the outcomes of two of these somewhat dependant on the recommendations of this review.

The NSW Youth Plan (In Berg et al, 1996) identified barriers to young people obtaining health care as lack of understanding/responsiveness of some health care workers, concerns regarding confidentiality, inconvenient service hours and access by public transport. This plan developed principles of service delivery including support for co-location. Research conducted by Brown (1991) on access to AOD

services by young people also supports co-location and Berg and her colleague's review of youth drug and alcohol services in NSW recommended that 'rather than modifying existing AOD agencies, there should be more AOD agencies in existing youth services such as refuges, drop-in centres and juvenile justice centres and greater provision of Youth Health Centres with an AOD component'. The Tasmanian Youth Health Strategy also supports the notion of co-location of youth AOD services with other youth services.

In Launceston planning is underway for the co-location of the youth ADS worker, the Youth Health Team and possibly the DEN and in Hobart, the co-location of The Link and 110 Bathurst Street has been discussed (the relationship between The Link and 110 Bathurst Street is considered below).

The co-location of youth AOD services currently under consideration should be supported as a model of best practice for the reasons detailed. In Hobart, consideration should be given to including a component of Youth Health in a co-location.

The concept of co-locations should also be extended. In order to encourage co-locations with a wider range of youth services, a broadly represented working party (AOD, youth, local government, health, etc) should be established to explore and make recommendations regarding a comprehensive package of youth services available in a co-located position.

Consideration of co-locations should take into account the concerns expressed by some sources about the lack of services in rural areas.

Recommendation 33

That the co-locations currently under consideration in Hobart and Launceston be pursued and that beyond these two co-locations, a broadly-based working party be established to consider other co-locations in the youth sector.

5.2 NGO Youth Services

Viewpoints from consultation process

- In addition to commenting on co-location, six sources said that there were too many small NGOs and a rationalisation could provide sounder and 'sleeker' administrative and management structures and enable more resources to be channelled into direct services to clients. Several sources pointed out that rationalisation did not have to mean a reduction of service options but that a range of services could be run under one management structure. Examples of Colony 47 and the Burnie and Devonport Youth Alcohol and Drug Services were given as evidence of sound integration of a range of youth services under umbrella managements.

- As regards the balance between government and NGO services, a number of sources (both government and NGO) saw the NGO sector as better placed to provide direct client services to young people because of their ability to be more responsive, creative and utilise a greater range of people from varying backgrounds as workers and volunteers. NGOs were seen as being able to be more flexible in their approach, could access funding from a wider range of sources, were more user friendly and not as constrained by political correctness in seeking solutions that lay outside acceptable middle-class values. One government source cited their own figures showing government outpatient counselling services to be at least twice as expensive as equivalent services delivered by NGOs.

- Eight sources specifically mentioned being unsure of what the ADS community workers we doing and where, or that they were not as effective as NGO community workers.

- Five sources said the ADS youth services were more visible and effective than other ADS community services. They felt that the outlook and work styles of these particular youth workers were significant in enhancing their effectiveness. In the provision of youth services, sources both within and outside the ADS questioned the effectiveness of generalist workers to deliver services to young people. Age, outlook and work style were cited as important factors in working effectively with young people.

- There was some discussion about the number of small NGOs vying for funding in the youth AOD area. Some sources thought it was inefficient to have two youth AOD services operating in close proximity in the north-west.

Discussion

Three related issues emerge when considering the information gained from the consultation process - (i) the proliferation of small NGOs in the South, (ii) the distribution of the specialist youth AOD services and iii) the co-location of these services and whether the government positions would be more effective if placed in the NGO sector.

(i) The proliferation of small NGOs in the South

The consultants were of the view that the two youth AOD services in the North-West were a good model of an integrated approach to the provision of youth services. Each of these services was strongly grounded in its local community through its incorporation into a mentoring organisation which provided other youth services. The two services also maintain close working relations with each other both at a management and worker level.

In the South, three services employ youth outreach workers or similar (The Link, Your Place and 110 Bathurst Street). The three operate from different premises although The Link and 110 Bathurst Street are considering a co-location at 110 Bathurst Street - some doubt was expressed about the space available at this location. There were similarities and differences in service types delivered, target groups and methodologies employed. Arguments exist for the continued physical separation of Your Place from the other two because of the different client group.

However, there are benefits to be derived from a strengthening of the position of smaller organisations by association with other larger NGOs or amalgamation of a number of smaller ones to create a more stable environment. Management can be streamlined (only one co-ordinator position would be required, freeing up other positions for direct service delivery), there are advantages through greater sharing of resources (economies of scale), less duplication of effort in areas such as committee work, policy development, networking, maintenance of a resource base etc. Other benefits expected to flow from such a move would be greater flexibility in service delivery, better service co-ordination and avoidance of duplication of effort, greater flexibility in relief, staff support and back-up arrangements and less time spent on submission writing and funding efforts.

The relationship between NGOs and government in Tasmania is currently being reviewed in the 'Changing Relationships' consultancy (The Community Change Partnership, 1997). The draft report has pointed out the likelihood of the squeezing out of the small NGOs as has already begun to happen through the competitive tendering arrangements introduced in the AOD sector in Victoria (and in the welfare sector in general in South Australia). NGOs in Tasmania should look at the trends elsewhere and move to consolidate their positions before these developments

overtake them. The Link, Your Place and 110 Bathurst Street should be encouraged to enter into negotiations aimed at consolidating the services into a single management structure with responsibility for the oversight of distinct projects which can maintain their individual philosophies and approaches.

In the draft report it was stated that working cooperatively to deliver services and avoiding the duplication of services can reduce administrative costs and increase effectiveness and efficiency. The partnership working paper makes mention of the value of 'consortia' or 'auspicing agencies' whereby one funding submission is put forward to deliver a number if services but with shared financial and administrative agreements. The Community Change Partnership describes the possible process as follows:

> 'The affairs of each individual organisation are still directed by its own 'management committee', but common funding, administration, management, and support services (including public relations, research and development, service quality improvement, staff/volunteer HRD and training support, and strategic planning) needed by all the organisations are, by agreement, brought together for the consortium to manage'.

The Youth Substance Abuse Service (YSAS) being developed in Victoria is an example of a consortium management to run a number of services. The consortium comprises Turning Point Alcohol and Drug Centre Inc., Jesuit Social Services, St Vincent's Hospital and the Centre for Adolescent Health (Turning Point, 1997).

Recommendation 34

That The Link, Your Place and 110 Bathurst Street services be combined into a consortium, with the Link and 110 Bathurst Street co-locating and Your Place maintaining its separate premises.

(ii) The distribution of the specialist youth AOD services

A related issue is the unequal spread of the specialist youth AOD positions across Tasmania, particularly in the Launceston area (North region). Population figures show that the North-West has 22.2% , the North has 28.5% and the South has 49.3% of total youth population aged 12 - 25 of Tasmania. The distribution of government-funded specialist AOD youth worker positions do not reflect this distribution. The North-West has 2.6 positions, the North 1 position and the South at least 4 positions (110 Bathurst Street - 1 position, the Link funded for 1 position and Your Place funded for 2 positions).

The best practice principle acknowledges that young people are best served by specialist youth services rather than general services. The imbalance should be rectified through a re-examination of other ADS positions in the North with a view to re-assigning a further position as a specialist AOD youth position.

When considering the distribution of resources it may be wise to think about the findings of Single & Rohl (1997) who wrote:

> 'An appropriate distribution does not necessarily mean an even distribution. Factors to be taken into account include: equity, need and future potential'.

Recommendation 35

That the AOD youth worker position in the North be reviewed along with other ADS positions with a view to creating another specialist youth AOD position for the North.

iii) The co-location of these services and whether the government positions would be more effective if located in the NGO sector.

Both the current ADS specialist AOD youth workers in Launceston and Hobart have or are planning to move themselves out of their government offices and into co-located settings. In other states this trend has gone further with all government-employed AOD community workers moving into community settings. In Western Australia these positions have been transferred to the NGO sector, in NSW and South Australia they have remained in the government employ but have relocated to community health centres.

The best practice model for youth services indicates that youth specific agencies should be in co-located premises outside of mainstream hospitals and community health services, facilitating access by young people on their terms, emphasising informal contacts, after hours services and acceptance of a range of behaviours and presentations (Berg et al, 1996).

Ali and his colleagues (1992) recommended that the trend in Australia towards relocating centralised alcohol and other drug services to community-based services which are accessible and responsive to the community should be fostered.

NGOs are better placed to offer these qualities in their services with greater flexibility of employment practices, hours of operation, methods of service delivery, utilising a wider range of inputs (volunteers, students, peers), are more likely to be involved in co-operative arrangements with other services, especially with other NGOs. They are seen by young people as independent of 'the system, government or

the authorities'. There is recognition that where there is dual government and community sector provision there is a waste of resources and unnecessary competition. The discussion paper recommends that:

> 'the role of non-government organisations as providers be strongly supported, providing they can indicate quality, competence and financial and organisational capacity to deliver services cost-effectively' (The Community Change Partnership, 1997).

In the longer term, therefore, it would be beneficial to look at transferring these ADS youth positions into suitably placed NGOs. The position currently based at 110 Bathurst Street has a logical NGO link with its co-located partners, The Link and Your Place. In Launceston there is no such easily identifiable NGO to link with. However, the model developed by Burnie and Devonport Youth Alcohol and Drug Services has been identified as best practice. A similar arrangement should be sought in Launceston.

Recommendation 36

That the ADS specialist youth worker positions in Hobart and Launceston be transferred to suitably placed NGO organisations.

The review of youth AOD positions and the consideration of education and training and health promotion units as recommended points to the need for a review of all other ADS positions. While beyond the scope of this report, consideration should be given to more community based positions for other AOD workers - co-locations in community health centres and providing greater service to rural areas.

6. FUNDING

Viewpoints from consultation process

- Most of the NGOs consulted and a number other sources (including some government services) said that NGOs had been progressively squeezed over at least the last three years.

- Most NGOs said they had no more room to absorb further cuts and a number requested that as a result of this review, services should be either adequately funded or cut completely - several NGO sources said that if that involved their own agency, so be it.

- Areas of service identified as being affected by inadequate funding included:

    - compromise of occupational health and safety standards

    - over-reliance on volunteers and voluntary contributions in time and resources from paid staff

    - inability to release staff for networking and professional development

    - lowering of staff morale, increase in staff turnover and difficulty in attracting and retaining appropriate staff

    - inability to plan effectively

    - no funding available for debriefing or supervision of staff.

- One source commented that they felt that due to the lack of core funding, the committee was not meeting appropriate standards of proper governance and that there was no perception of this by the government.

- Allied to the issue of funding was that of the timing of receipt of annual allocations. NGOs were not informed of their funding until half-way through the year in which funding was granted. This situation generated great insecurity for all involved - staff, management and clients. One source spoke of drafting redundancy notices for staff on four occasions in one year due to the uncertainties of funding.

- The issues of hypothecation of taxes and/or a health promotion foundation were constantly raised as ways of ensuring adequate funding, particularly in the areas of education and health promotion. Models such as exist in the Northern Territory, Western Australia and South Australia were mentioned.

Discussion

Adequate levels of funding were a major issue for most of the NGOs consulted. Most stated that they had not received increases in funding over the last few years sufficient to cover cost increases due to inflation. Examination of funding returns from the ADS revealed that while some organisations had received little or no increases in the last three years, others had received increases at or above the level of inflation. The picture was complicated by the incorporation of an adjustment in 1996/97 to allow those organisations not paying at the Community Services Award levels to increase salaries to stipulated award levels.

It was pointed out by the ADS that during the same time, funding to the DCHS had also been under pressure and that the NGOs were participating in an across-the-board squeeze on funding. Youth AOD services are able to demonstrate increased utilisation of their services. Off-setting this indicator of the need for increased funding is that of the declining youth target population from each census since 1981, down from 105,000 in 1981 to 92,863 in 1996 (ABS, 1996).

The National Drug Strategy Review concluded that funds for prevention represented money well invested and that for every dollar invested in treatment, there is a saving of seven dollars to the health care system (Single & Rohl, 1997).

While the consultants were unable to investigate each organisation's funding situation to a sufficient depth in the time available, it was apparent to them that most NGOs were operating on shoestring budgets. It is to their credit that they have been able to achieve high standards of service with such limited resources.

The consultants were impressed with the professionalism displayed by most NGOs - planning processes and policy and program documentation were of a high standard.

As has been pointed out earlier in this report, the insecurity facing NGOs has prompted some to broaden the focus of their work in order to justify continued support. This has placed additional strain on already stretched budgets and has demanded more of staff and managements. Of real concern to all consulted was the insecurity occasioned by the timing of funding announcements - with NGOs being notified of their financial year allocations six months into the year. While they were maintained on the funding level from the previous year, many NGOs expressed the view that the anxiety and uncertainty associated with this process impacted on their service delivery and staff morale.

Adequate remuneration for staff has been address with the adoption of the Community Services Award levels. However, as most NGOs pointed out, there was

inadequate funding for other operating costs. Of greatest concern should be the impact on occupational health and safety issues including stress placed on staff due to the inability to provide relief staff during sickness, adequate cover for staff in potentially dangerous situations, including the need to have two people on duty on premises during opening hours. Careful note should be taken of the comment in the 'Viewpoints...' about proper governance of NGOs.

A number of measures recommended in this report should address some of the funding concerns - the co-location of some services and amalgamation of others would address some of the occupational health and safety issues for these organisations. However, the consultants were unable to find major areas of duplication or wastage such as would result in substantial savings which could then be applied to alleviating the funding problems of the NGOs. Other recommendations, if adopted, will require that additional funding be found.

The Challenging Relatiosnhips document (The Community Change Partnership, 1997) referred to earlier in this report has emphasised the need for NGOs to improve their efficiency. NGOs in the AOD sector will need to carefully consider their positions and move to consolidate their strengths. Further combining of services should be considered by NGO management committees.

In the discussion of the TDSP and recommendation to establish the 'service delivery co-ordinating body', the process is described whereby funding decisions can be aligned to the outputs each organisation (NGO and GO) has been assigned. This should ensure that organisations receive funding for the tasks that have been set for them.

While recognising that at present the NDS money is given annually by the Commonwealth and that, therefore, the Tasmanian Government cannot guarantee this funding to NGOs for longer periods, greater certainty could be offered to NGOs if service agreements for the duration of the TDSP were drawn up and these indicated funding intentions with the proviso of continuation of NDS contributions.

In a review of long term residential treatment for people with alcohol and other drug problems, Ernst & Young (1996) recommended that three year funding is needed and that there is a need to move from historical based funding to funding on the basis of service outcomes at a competitive cost. Also, a contribution towards the costs of replacement of staff attending training activities is needed. These recommendations are supported by the ADCA (ADCA, 1996).

In developing their Drug Action Plan, the Western Australian Government identified that the following must happen:

- Youth agency contracts will be assessed to ensure that all young people using drugs receive appropriate attention.
- Alcohol and drug agency services will be enhanced and service agreements will be reviewed to ensure that best practice in alcohol and drug treatment is being provided.

Similarly, the positional paper by NADA (1997) stated that research and evaluation must be used objectively to ensure funding is directed toward the better performing programs. This was supported further by Single and Rohl who concluded that there needs to be accountability of programs and real analysis of their effectiveness.

The results of the 'Changing Relationships' project should have a significant impact on funding in the AOD sector if the recommendations from the Discussion Paper are implemented.

There also needs to be a more realistic definition of what constitutes 'adequate' resources, including human resource development. Professional development has been recognised elsewhere in the literature as being a core agency function requiring staff time and resources by funding bodies (Pennington, 1996; Crosbie et al, 1997a; ADCA, 1996; Berg et al, 1995).

The ADCA positional paper stated:

> Governments must provide increased professional support (training and professional development, terms and conditions, career options) for people working in the drug field if they are to increase the quality and effectiveness of drug programs and services (Crosbie et al, 1997b).

The movement towards 'Alcohol and Other Drugs National Competency Standards' Community Services and Health Training Australia (1997) may be the impetus for the department to give credence to the role professional development plays in the AOD field.

Recommendation 37

That NGOs be funded adequately to meet the requirements of good governance, and in accordance with the outputs assigned to them by the Service Delivery Co-ordinating Body of the TDSP

Recommendation 38

That service agreements be negotiated for the duration of the TDSP

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ATTACHMENT 1: STEERING COMMITTEE FOR THE REVIEW OF DRUG AND ALCOHOL SERVICES PROVIDED TO YOUNG PEOPLE IN TASMANIA

Chairperson

Mr John Leary
State Manager
Alcohol and Drug Services (ADS)
Department of Community and Health Services

Members

Ms Paddy Byers
Chairperson
The Link Youth Health Service

Mr Michael Robinson
Manager, Planning and Research
Department of Police and Public Safety

Mr Graeme Cooksey
Principal Curriculum Officer,
Health and Physical Education
Department of Education, Community and Cultural Development (DECCD)

Mr John West
Manager
Burnie Youth Alcohol and Drug Service (BYADS)

Mr David Willans
Executive Officer
Youth Network of Tasmania (YNOT)

ATTACHMENT 2: LIST OF ORGANISATIONS CONSULTED

A.I.D.S. Council of Tasmania

Burnie Youth Alcohol and Drug Service (BYADS)

Department of Community and Health Services

- Alcohol and Drug Services State Office
- Alcohol and Drug Services Southern Services
  - 110 Bathurst Street
  - 56 Collins Street
- Alcohol and Drug Services Northern Services
  - Ulverstone Service
  - Northern Youth Service
- Alcohol and Drug Services Data Collection Project Officer
- Northern Youth Health Team
- Southern Youth Health Team
- Sexual Health Unit - Needle Exchange Program

Drug Education Network Inc

- Hobart Office
- Launceston Office
- Devonport Office

Department of Education, Community and Cultural Development

- Central Office
- North-West Regional Office

Devonport Youth Drug and Alcohol Service (DYADS)

The Haven

Holyoake Tasmania Inc.

Independent Committee on Drug Abuse (ICODA)

Launceston City Mission

Life Education Centre

The Link Youth Health Service

Office of the Commissioner for Licensing

Office of Youth Affairs

Department of Police and Public Safety

Quit Tasmania

The Salvation Army
- Sulphur Creek
- The Bridge Program, Hobart

Tasmanian Aboriginal Centre (TAC)

Tasmanian Users Group (TUG)

TasTranx

University of Tasmania

Your Place Inc.

Youth Network of Tasmania (YNOT)

ORGANISATIONS ATTENDING FORUMS

Huon Skillshare
Caroline House Inc
Glenorchy City Council
The Link Youth Health Service
Police and Citizens Youth Club (P.C.Y.C.)
Hobart City Council
Key Training Centre
Clare House
Red Cross Roadhouse
Colony 47
Anglicise
Dept of Community and Health Services - Devonport
Tasmania Greens Party
Case Assessment and Management Services (C.A.M.S.)
Lifeline N.W.
Centrelink
Job Placement and Employment Training Program (J.P.E.T.)
Mersey Skills Training (M.S.T.)
D.E.C.C.D.
Temcare Tasmania
The Don College
Bridges - Anglicare
N.W. Legal Centre
Devonport Youth Service
Red Cross Launceston
Karinya House
Creative Living Centre, Burnie
Family, Child and Youth Health Services

ATTACHMENT 3: INTERVIEW PROFORMA (FOR MANAGERS/SENIOR STAFF)

1. Program description

    1.1 Brief history of service (how the service started, by whom, original purpose, major changes)

    1.2 Philosophy of service (describe basic philosophy or operating principles, priorities set and reason, philosophy on education, health promotion, treatment)

    1.3 Program(s) (describe each program - aims, components, activities, inputs, youth participation/focus - proportion)

    1.4 Client profile (what are the target groups, age sex, background, situation, locality)

    1.5 Organisational structure (briefly describe how service is organised, managed, how major decisions made re management, policy and methodology)

    1.6 Staffing (how many, backgrounds, training, staff dev.)

    1.7 Administration/Funding (major sources, specified purpose, manual, evaluation/monitoring)

    1.8 Results of any reviews, evaluations (briefly summarise the results of any previous research)

    1.9 Other activities (lobbying, community action)

    1.10 TDSP (any actions taken/reprioritising to conform to TDSP, relate programs to TDSP)

2. Program Review (where there are discreet programs, do each separately)

    2.1 Youth focus (measures to ensure youth focus, accessibility, participation, awareness/sensitivity, rights) examples

    2.2 Utilisation by young people (who uses it most, which groups not accessing it, why, how do they research need, methods used)

    2.3 Responsiveness (how ensure responsive to changes) examples

2.4 Planning (how services planned, how do you determine need, who assist in planning, priority given to youth drug and alcohol issues, how often)

2.5 Evaluation (how do you know service is useful, effective)

2.6 Interactions with other services (networks, work closely with which, nature of co-operation, visits, referral) Examples

2.7 Interactions with (other) govt depts (which, how close, usefulness, consulted, how helped/not helped - training, resources, advice)

2.8 Major achievements (what organisation does well)

2.9 Major obstacles (funding, staffing, participation, management)

2.10 Funding (who decides allocation)

2.11 New developments (describe, needs, where up to in planning)

3. General views

3.1 Balance of services (health promotion\education\treatment - within each area, over/under servicing, coverage, range of services, effectiveness, gaps and duplications) examples

3.2 Specific govt. organisations (ADS, Education Dept, Police - depending on which is/are relevant - co-operation, resourcing, co-ordination, priority given to youth services) examples

3.3 Views of TDSP (harm minimisation, priority areas)

3.4 Co-location or one-stop service (barriers/opportunities, which services combine)

3.5 Needed new initiatives/Future directions (nature of problems/client/target groups, service delivery)

3.6 Government policy (thrust and direction, TDSP priorities, youth perspective)

4. General Discussion

4.1 Any other area/concern to raise within the review

Any other written documentation to help understand programs, views etc?