

Project plan

(subject to change in consultation with all stakeholders)

The East Arnhemland Remote Community Kava Health Impact Monitoring Project.

Title

The East Arnhemland Remote Community Kava Health Impact Monitoring Project.

Short title

The Kava Health Monitoring Project.

Aims

The general aim is to monitor kava-related harms in selected east Arnhemland remote communities.

Specific aims are to monitor and report on:

1. indicators of kava-related harm, particularly the health impacts of kava use;
2. kava use patterns;
3. kava market characteristics;
4. community attitudes to kava use, the kava market and kava licensing;
5. possible interventions to minimise harms.

Research questions

Specific questions that may be addressed are:

1. what harms are associated with kava use?
2. what are suitable indicators of those harms?
3. what factors influence the harms?
 - 3.1. factors should include:
 - 3.1.1. use vs. non-use
 - 3.1.2. quantity and frequency of use
 - 3.1.3. age
 - 3.1.4. sex
 - 3.1.5. use of licit vs. illicit kava
 - 3.1.6. licensed vs. unlicensed communities
4. what are the use patterns of kava?
 - 4.1. areas of interest include:
 - 4.1.1. poly-drug use
 - 4.1.2. licit vs. illicit use
 - 4.1.3. expenditure

- 4.1.4. perceptions of risks and benefits
- 4.1.5. severity of psychological dependence
5. what are the market characteristics of illicit kava?
 - 5.1. areas of interest include:
 - 5.2. price
 - 5.3. availability
 - 5.4. source
6. what are community and/or user attitudes to kava use?

Geographical scope:

The geographical scope is selected communities in East Arnhemland. The geographical scope may expand opportunistically.

Methodology

This project will employ mixed methods, based on the approaches variously known as 'Rapid Assessment and Response', 'Rapid Assessment Methodology', 'Rapid Situation Assessment' and 'Rapid Appraisal'. As the various names indicate, this approach was developed to allow rapid or speedy assessment. In this case, speed is not a particular requirement and it is the other characteristics of these approaches that are more applicable, including:

- cost-effectiveness
- flexible approach
- combination of data collection techniques
- use of multiple data sources and types of respondents
- linkages to interventions
- triangulation or corroboration to identify situation characteristics, emerging trends and suitable responses or interventions

While specific methods will develop over time, likely techniques for data collection include:

- collection of quantitative data from service providers, including remote clinics, regional hospitals, Aboriginal Health Services, Police, Kava wholesalers/ retailers and NGO's;
- semi-structured interviews with community based or visiting 'key informants';
- focus groups or semi-structured group interviews;
- structured interviews with Kava users;
- community surveys;
- observation.

Instruments

A variety of data collection instruments will need to be developed, including:

1. data collection proformas – eg for clinics and Police
2. key informant interview guides
3. focus group interview guides
4. user survey questionnaires
5. general community resident survey questionnaires

Participants

Given the methods outlined above participants will probably include:

1. as key informants
 - a. Aboriginal Health Workers
 - b. Other nursing and medical staff
 - c. Council members
 - d. Council staff
 - e. Police Officers
 - f. Store operators
 - g. Kava retailers and wholesalers
 - h. Outstation resource staff\Other service providers
 - i. Selected community members

2. as survey or group participants
 - a. all of the above
 - b. various samples of community members, including people who use and/or obtain kava or other licit or illicit drugs

Sample sizes

Participant numbers cannot be specified at this point as they depend on opportunity, geographical coverage and the specific data collection activities undertaken.

However, approximate parameters would be:

- a minimum of five key informants on each community for individual consultation
 - given the recognised value of Aboriginal Health Workers it will be particularly important that the participation of this group is maximised
- a minimum of one focus group or group interview on each community with at least five participants – ideally multiple focus groups would be available representing community sub-groups of interest, eg youth, kava users, etc
- a statistically appropriate sample size if any general community surveys are undertaken
- a sample size that ensures saturation if any qualitative user group surveys are undertaken – for this activity a minimum sample of around thirty users (and where users of specific drug types, particularly kava, may be targeted) would be desirable; ‘snowballing’ or chain sampling will be the most appropriate recruitment method in this case.

It is likely that key informant interviews and focus groups/group interviews will be conducted on all communities included in the eventual geographical scope and that survey activities will be conducted on a small number of communities drawn from the total.

Stages

It is likely that this project will progress in stages. The content of the stages described below are flexible and likely to change due to circumstance and after consideration by a reference group. A draft work plan with timeframes is included at the end of this plan.

Stage 1 will involve

- recruitment of project officer

Stage 2 will involve:

- establishing steering and reference groups;
- establishing relationships with key informants, including primary health staff and others – Aboriginal Health Workers, clinic nurses, medical officers, Police officers, kava wholesalers and retailers, council staff, outstation resource staff, community residents and others as appropriate;
- identifying appropriate quantitative kava related harm indicators – possibly including clinical presentations, crime, public order issues, poly-drug use and selected economic indicators (such as kava sales data);
- identifying the capacity of remote agencies and/or staff to collect related data
- discussing with communities the options for qualitative research involving community members – including kava user surveys, key informant interviews or focus groups;
- proposing a reporting format and timetable.
- a first report to the steering committee that collates and comments on the utility of proposed harm indicators and any identified characteristics or trends;

Stage 3 will involve:

- obtaining ethics committee approvals for qualitative studies;
- preparing and piloting qualitative survey instruments for users and key informants.

Stage 4 will involve:

- implementing the qualitative survey(s) in one or more communities;
- reporting harm indicator and key informant comment at regular intervals.

Risks and ethics

The principal ethical issues for this project concern the wellbeing and privacy of individuals involved in interviews and focus groups and may include community members, key informants and kava users.

There is also some risk that a community may be identified through published reporting and come to be regarded as problematic in respect of drug use.

These issues can generally be addressed through the use of appropriate research methodologies, informed consent procedures and record keeping security.

Early in this project, certainly within the first six months, an application should be submitted to the appropriate Human Research Ethics Committee for the interview and/or survey components of the project to ensure that the activities undertaken minimise any potential risks.

Resources

A project officer will be appointed and managed by AODP to have principal responsibility for this project. The project will have an operational budget, with the main expenditure item likely to be travel costs. AODP will provide appropriate infrastructure.

Data collection and analysis activities will be supported by the AODP research and evaluation staff. At different times this may include: data entry, questionnaire development, statistical analysis, data presentation. Support may also be provided by other AODP staff, including Policy Officers and Community Support Officers.

Reporting:

Formal reporting to a steering committee and/or reference group by the project officer should occur quarterly for the first twelve months of the project. More frequent and less formal reporting should occur with the officer's supervisor and the AODP research staff.

The formal report formats and content should be determined in once the project officer is employed and in consultation with the reference group. However, the data collection techniques listed above under 'methodology' suggest a framework for formal reports consisting of:

1. a list of the communities the report covers
2. a report on any system development activities – ie activities related to developing an ongoing monitoring system such as data recording procedures in remote health clinics
3. a presentation of quantitative data sources identified and data collected, including:
 - a. health data
 - b. crime data
 - c. sales data
 - d. an analysis of trends and points of interest
4. a list of key informants contacted and their comments against pre-determined areas of interest and other comments
5. a list of focus or other group consultations carried out and their comments against pre-determined areas of interest and other comments
6. a report on any survey activities and results
7. a summary of key findings, particularly emerging trends and areas of corroboration between data sources.

Given the formative nature of the stages outlined above, the content of the reports may change over time, with earlier reports focusing on project development issues and later reports focusing on results. Individual reports may also address specific tasks or topics of interest raised by the reference group or stakeholders from time to time.