PREVENTION OF ALCOHOL-RELATED PROBLEMS IN THE COMMUNITY CONTEXT

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DEALING WITH ALCOHOL PROBLEMS IN THE COMMUNITY: THE HISTORICAL BACKGROUND

Many problems from alcohol occur within the community, impinge on others in the community, and often are responded to – whether informally or formally -- by community members and institutions.[1]   The community is thus a primary locus for policies, actions and efforts to prevent the problems occurring.

The preventive effort may be an informal intervention by a family member or neighbour – e.g., taking the car keys out of the hand of an intoxicated person – or by a social group – e.g., parents deciding against bringing alcohol for the picnic on a joint family outing. It may be an action by a community-based officer or agency – a lecture by a teacher, a warning by a policewoman, or a planning decision on an application to open a bar. Or it may be adoption of a policy by the municipal council or other authority – e.g., a closing-time policy which reduces the number of drunk people in the streets at 3am.

A century and more ago, much of the action in temperance movements grew out of and focused on the community level. Where temperance sentiment was strong, a local prohibition ordinance might pass, or the municipality might take over the alcohol retail trade and run it as a municipal monopoly. But in the course of the 20th century, the power to make such decisions was increasingly focused at higher political levels than the community – at state, provincial or national levels.[2] In temperance cultures – that is, countries with a strong temperance movement history[3] – there are examples of the local government level still retaining decisive power over the fact and conditions of alcohol availability, but it is relatively uncommon. More commonly, there is little power at the community level to determine promotion, price levels and the general availability of alcohol, and only limited power to control the conditions of sale and consumption. Increasingly, free trade agreements are limiting the control powers even of national governments.[4,5]

Meanwhile, spurred by cultural changes and generational reactions against temperance, alcohol availability and consumption increased substantially in the temperance cultures in the 1960s and 1970s,[6] with further increases in availability, under the impetus of neoliberal open-market and competition policies, in more recent decades (e.g., for Australia, Roche & Steenson;[7] for the UK, Measham[8]). However, in counterpoint to these trends, there were increasing public concerns about alcohol as a source of social and health problems.

Alcohol-related problems thus came back on the agenda for public policy. The initial focus in many places was on drinking-driving, but by the 1970s concerns started to extend across a broader range of problems, and became a topic for public health consideration and action.[9] Along with this, alcohol problems and policies became increasingly a subject of social and public health research.[10,11]

THE WAVE OF INTERNATIONAL INTEREST IN COMMUNITY ACTION PROJECTS TO PREVENT ALCOHOL-RELATED HARMS

In this context of renewed concern about alcohol issues, a tradition began to form of community action projects aiming to prevent alcohol problems. Researchers recognised that many alcohol problems impinged on and were dealt with at the community level, and that working at this level offered preventive opportunities. More generally, the public health and social welfare literature had often focused on the community as a site for initiatives and experiments in social change (e.g., Paul[12]). Drawing on study design models from other areas of public health (e.g., Maccoby et al.[13]), early projects compared communities in three categories with respect to intervention, with one site or set of sites receiving community organization and education, plus media messages; another receiving only the messages; and a third receiving neither (i.e., a control site). A California project with this design, focusing on changing attitudes to drinking, was unable to show any changes.[14] A New Zealand project, focusing on attitudes to alcohol policies, was able to show differential results: sites with a community organiser as well as media messages maintained support for public health-oriented policies while support declined in the control sites.[15]

International interest in community action research projects on alcohol problems grew rapidly in the 1980s. In 1989, a week-long conference in Toronto on "Research, action and the community: experiences in the prevention of alcohol and other drug problems",[16] drew 60 participants and included presentations from Australia, Botswana, Canada, Finland, India, Israel, New Zealand, Poland, Sweden, UK, USA and USSR. Altogether, five further international conferences on community action research on alcohol problems were held, in 1992 in San Diego, California,[17] in 1995 in Greve-in-Chianti, Italy, in 1997 in Malmö, Sweden, in 1998 in Russell, New Zealand,[18] and in 2002 in Helsinki, Finland.[19] Since the early 2000s, there have been some further studies in this tradition,[20] but the research tradition of community action projects appears to have lost some of its momentum.

MAIN APPROACHES IN THE COMMUNITY ACTION PROJECTS

As Graham and Chandler-Coutts noted,[21] the community action projects have combined traditions of evaluation research with the action research tradition of Kurt Lewin.[22] Committed community organisers and workers are an essential element in most community action projects. Those which got under way in the 1980s and afterwards were primarily financed as national research or demonstration projects, which entailed a substantial investment in research or evaluation staff. This usually meant that the projects would be staffed from two different traditions and orientations: by community organizers whose success depended on believing in what they were doing, and by researchers with a professional

commitment to scepticism about effectiveness. Collaborating members of the community, the third element in such projects, often had their own ideas about how to proceed. As a result, it was remarked, community action projects could be a fairly "unstable mixture".[23]

Particularly in the U.S., but not only there, the funding environment for community action projects favoured progressively more elaborate evaluation designs. To show an effect in a target community was not enough; far preferable was a comparative study involving also a control community. Even better would be a design where it is not a single intervention community and a control community, but rather a set of intervention communities and a set of controls, so that statistical testing of results could be carried out with communities as units of analysis. The result of this escalation of design standards was a series of studies involving multiple communities, not only in the U.S.[24-26] but also in Sweden[27] and Australia.[28]

The multiple-community trials had to face in acute form a general issue facing community action projects: to what extent were the actual interventions in the community to be determined by community members' definitions of problems and intervention approaches, and to what extent by research teams? Compromising on the problems to be addressed tended to result in a restriction of focus – the prevention focuses in U.S. projects, for instance, have been largely on underage drinking and on alcohol-related injuries, particularly from drinking-driving. Where the design required comparable interventions in multiple communities, the communities necessarily had little say in what problems to emphasise and intervention approaches to take. As Saltz et al.[26] have emphasised, such an approach raises the issue of the extent to which the interventions were actually implemented, which they commented "has been largely ignored by the research community".

The alternative approach has been for the researchers to stand back and accept community decisions about what the focus and the intervention approach will be. But relatively recent multi-site studies using this approach in three countries have shown few significant effects from the varied interventions as a whole.[27-29]

MODES OF INTERVENTION AND EVIDENCE ON THEIR EFFECTIVENESS

In earlier community action projects, a substantial component was often educational or information approaches aimed at the persuading the individual drinker to change -- approaches which were adapted from general health education approaches and were in principle politically unproblematic (though in both California and New Zealand, alcohol industry interests successfully objected to messages they regarded as using sex to sell limiting drinking). It proved difficult for evaluations to show any behavioural change in drinking from such approaches; even findings of changes in attitude have not been common, although Casswell et al.[15] were able to show some effects on attitudes to alcohol policies. Approaches in terms of education or public information continue to be commonly chosen by communities when they are given a large say in the interventions used. Two of the three interventions implemented in all of the communities in the Swedish 6-community study, for instance, were "information and media advocacy" and a primary school "social and emotional training" program.[27]

From the 1990s onward, the community action project tradition paid more attention to the interactional and situational nature of most drinking in the community. Underlying these approaches has been the recognition that alcohol consumption is primarily a social behaviour, heavily influenced by social norms and environments, and that there is a social interactional element in many problems relating to drinking. Analyses by Holder and others[30,31] drew attention to the structures in the community which are involved in the availability of alcohol and the prevention or handling of alcohol-related problems – including the alcohol retailing system; emergency and other health subsystems; the policing subsystem; the political (local government) subsystem; as well as such "subsystems" as occupational, ethnic and other subcultures.

One focus has been on alcohol sales and drinking contexts, and on environments that harbour or encourage high-risk drinking.[32] A number of studies tried working on problems prevention with alcohol retailers, in various versions of "responsible beverage service" programs. The findings from such interventions have been mixed,[33;34, p. 150-152, 244] with effectiveness generally dependent on the addition of an enforcement aspect through licensing or police sanctions, as in the Stockholm STAD project.[35]

Responsible beverage service is one among a number of strategies affecting the conditions of alcohol availability with the aim of reducing drinking-related harms. There are much stronger indications of effectiveness for other strategies affecting availability, such as limits on opening days or hours, and limiting the number of sales outlets.[34, pp. 131-136, 243-244] But it is unusual in modern states for local jurisdictions to have power to control these limits on availability. Communities in Norway do have powers concerning closing hours, and there is strong evidence that these have made a difference there.[36] In the Australian city of Newcastle, changes including earlier late-night closing, implemented as the last action by a state authority as it was abolished, produced dramatic and lasting reductions in alcohol-related problems.[37,38] However, generally in Australia as in many other places, community interest groups have limited opportunity to influence and local governments have little power to control the conditions of alcohol sales and service in their jurisdiction.[39] In California, as elsewhere, alcoholic beverage commercial interests have had substantial influence in state politics, and have long strongly preferred that these powers be kept in central rather than local government hands. Wittman[40] describes how greater local control over the conditions of alcohol sales has been won by local governments in California not through political channels in the state legislature but through several decades of civil court suits.

The situation is somewhat different in jurisdictions with state ownership of at least part of the alcohol sector. Given that their responsibility is generally defined in part as acting in the public health interest, state alcohol monopolies have often been more open than private interests to experiments in alcohol control, including even a random-assignment experiment in intervention.[41] There is thus a relatively strong tradition of alcohol control experiments at the community level in several Nordic countries,[42,43] many with substantial findings of effectiveness.

One sector where local governments usually do have substantial control powers over the local alcohol market is the fact that there is usually a substantial amount of land, roadways and municipal facilities under their control. They are likely to have power, for instance, to control advertising on municipal land, facilities and public transport,[44] as well as

being able to set conditions for alcohol service, for instance, at a wedding reception in a city hall or park. In Ontario, Canada, there has been a substantial program of research and intervention aiming at reducing alcohol problems through Municipal Alcohol Policies adopted and implemented by local governments.[45]

There are, of course, other institutions and entities at community levels – what Holder[30] describes as "subsystems" -- which are relevant to alcohol problems prevention. Some work in Australia has begun on looking more systematically at alcohol problems prevention in occupational, ethnic, religious and other subcultures, social worlds and environments, particularly those where heavy drinking is part of the social life.[46] The Alcohol and Drug Foundation has signed up the clubhouses of many local sports clubs -- important institutions in Australian life -- to a "Good Sports" initiative which has had substantial success in diminishing the centrality of drinking in club life, as well as promoting responsible serving practices there.[47] In another forthcoming initiative, Victorian Health Foundation-funded projects will be seeking to reduce alcohol problems in other subcultures and social contexts within communities.[48]

CONCLUSION

This chapter has focused on efforts at the community level to reduce or prevent alcohol-related problems – whether by reducing drinking or by reducing harms from drinking. Many such harms must be reacted to at the community level, and in many communities there is substantial awareness of the harms and willingness to act to reduce them. But, in an era when alcohol has been thought of quite separately from other psychoactive drugs, and when neoliberal ideas of reducing government intervention in consumer markets have held sway, local governments have usually been restricted by central governments from taking strong actions to reduce alcohol-related problems through restrictions on the alcohol market.

As concerns about alcohol-related problems have increased in recent decades, in delayed reaction to the increases of availability in the temperance cultures, communities have often sought to respond preventively in various ways. But communities have often lacked the power to respond through policy measures. As concerns have risen, central governments have often acted to increase local responsibility for countering alcohol problems, but have usually not transferred powers which would enable effective action.[49] In particular, it is rare for local governments to have any power to reduce the number of sales points by retracting licenses to sell alcohol; "cumulative impact" of too many licenses in a neighbourhood may be officially recognised,[50,51] but the solutions do not go beyond freezing the number so that new licenses are not granted in the neighbourhood.

Trends in the increasing concern about dealing with alcohol problems at the community level can be seen reflected in the development of the research literature.   First came efforts to tackle the issues through individually-oriented education or public information campaigns. These were succeeded by an era of community action projects to develop and evaluate changes in community practices related to drinking, and particularly in the on-premise serving of alcohol. More recently, community-based initiatives have expanded to involve a wider range of community "subsystems". Central governments have

edged towards greater responsibility for local authorities to deal with preventing alcohol-related problems, although often without a commensurate increase in local authority over the conditions of alcohol sale. Responding to this trend, there has been increased research attention to policy formation and implementation at the community level, including the issue of institutionalising changes so that they persist beyond the end of an implementation project.[31]

The cumulative result of four decades of implementing and evaluating community-based approaches to preventing or minimising alcohol-related harms is a substantial literature recording successes and failures and their conditions for a wide variety of approaches and strategies of implementation. A quite comprehensive review of the literature is now available.[52] Those planning or undertaking new community initiatives are well advised to take into account the literature's findings, which are at least as strong concerning what does not work as they are on approaches which can show success.

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