Community action to reduce alcohol problems: What should we try in Australia?

Community action against alcohol and its attendant problems is not a new phenomenon. The American temperance movement arose during the early 19th century as a community based effort to make people aware of the threat that alcohol posed at home and at work (Holder, 1992). However, as the movement became more powerful it became more prohibitionist and less focused on individual communities. Its political influence culminated in the 1920 enactment of national prohibition. Yet, 13 years later 'the noble experiment' was seen as a failure because of the increase in crime associated with supply of illicit alcohol and prohibition was repealed. In the wake of this failure the Alcoholics Anonymous movement arose in America and received strong support from the medical profession (Bishop and Pittman, 1994). Individual disease and addiction came to be seen as the root of the problem rather than the substance and accordingly treatment became the response of choice.

Within this paradigm, community prevention meant early identification of 'alcoholics' and provision of resources to increase availability of treatment and social support (Holder, 1992). Modern concepts of community action as prevention really arose in the early 1970s when there was an emerging appreciation of the role alcohol played in a broad range of health and social problems. This shift in emphasis from individual medical disorder to a view that acknowledged the social determinants of alcohol and other drug problems has been important in recognising the role of the community in both producing and responding to these problems. The community produces particular alcohol problems because of the way community life is organised and the community is an appropriate setting for preventing alcohol problems, because it is here that these problems are personally experienced.

The legitimacy of focusing on the population as a whole, rather than on high risk individuals, was established at this time through the work of Rose (1981, 1985) and Kreitman (1986). Rose argued very convincingly that while prevention, which concentrates on high risk individuals, leads to intervention appropriate for those individuals, its ability to reduce the burden of disease at the community level is small. Conversely, a population or community approach offers little to high risk individuals, but provides substantial aggregate benefit because so many individuals are affected. Rose (1981) talked about this as the 'Prevention Paradox'. Kreitman (1986) explored this paradox in relation to alcohol use and found that contrary to conventional wisdom the majority of alcohol problems were caused by moderate drinkers, rather than heavy dependent users, because they comprised such a large proportion of the drinking population. Subsequent research by Stockwell et al (1996) and Gmel et al (2001) has identified binge drinkers within this moderate consumption group as causing the most problems. This suggests the need for more targeted responses, but the same basic premise of Kreitman's findings remain: drinkers not considered problematic in traditional terms are in reality causing most problems.

Giesbrecht and Pederson (1992) point out that in Western societies there is pressure to cast alcohol use as a problem for the individual drinker, because cultural notions of autonomy and choice support individually oriented solutions to social problems. This makes it difficult to take an ecological approach to prevention and involve the community in controlling drinking. However, McGavran (1963) and Kreitman (1986) represent a substantial body of public health opinion in claiming that public health problems generally, and alcohol problems in particular, are unlikely to be controlled by early diagnosis and treatment of high risk individuals.

We must face the fact that the health of individuals is dependent upon the health of communities – communities as entities, not as mere aggregates of individuals.

(McGavran, 1963: p 59)

Rose (1985) pointed out there are powerful advantages to population level prevention. It attempts to remove or modify the underlying cause of the problem. It has considerable potential for change because of the large numbers involved. Once behavioural change has been achieved it is likely to be self sustaining because a new community norm has been established. In addition, such change can be initiated centrally by government decision. Polio vaccination, for example, was a public health prevention program mandated by state authority. In the alcohol area the state has exercised uniform preventative control through alcohol monopolies, regulation of trading hours and even total prohibition. However, Casswell (2000) suggested that there has been a move to less state control in western countries over recent decades and more influence of consumer forces. This has made it increasingly difficult to deal with population level alcohol problems by altering state policies and regulations. In this new environment of reduced state involvement, the community emerges as the natural vehicle for taking action against these problems.

Importantly, the community has to be involved in decision-making, rather than just being the site for prevention initiatives. Prochaska and DiClemente (1986) identified the importance of readiness to change in individuals with alcohol and other drug problems and the same is likely to apply to communities: if a community does not consider it has an alcohol problem there is unlikely to be any commitment to prevention. Thompson and Kine (1999) stress the 'principle of ownership' in change, which means that effective and lasting change is most likely to occur when the people who are affected are part of the change process. The complexity of how a community functions also has to be taken into consideration and harnessed. Here the system perspective, offered by Holder and his colleagues (Holder, 1992; Holder and Wallack, 1986), is a useful heuristic. This views the community as a complex and enduring system of interacting components such as health services, workplaces, volunteer groups, recreational facilities etc. The system is held together by some degree of community co-operation and consensus on common goals, norms and values. The system provides the context for all activities, including individual drinking behaviour and produces certain outputs including alcohol problems. If, because of bureaucratic boundaries prevention is only initiated in one community component, such as health, it is less likely to impact on other relevant components, such as the political, legal, educational, media and recreational. Greatest change is likely to be achieved by operating at the level of the overall community system. Here change means not just influencing the operation of system components, such that they all coherently support safer drinking by individuals, but also systemic change, so that the structures and operation of the whole community are altered in a way that supports safer drinking.

Aguirre-Molina and Gorman (1996), in a comprehensive review of community-based drug prevention programs, found that those with the greatest promise relied heavily on community action as the means of achieving change; sought to empower the community through involvement in all decision making; were comprehensive in terms of targets and strategies; drew on the public health model to identify factors other than the individual as causing problems and drew on the best available research to guide interventions. Yet all too often in Australia, particular agencies are funded to undertake small scale, short term community alcohol prevention projects. Often these projects also seek to change the behaviour of high risk groups such as underage youth or regular, heavy pub drinkers. Adopting such approaches needs to be re-examined, as they are likely to be ineffective and a waste of resources. If there is to be meaningful commitment to effective community action, comprehensive long term programs need to be funded in receptive communities.

Ideally these would comprise locally organised and planned community-wide intervention, whereby individual stakeholders and relevant agencies such as police, health services, drug agencies, local businesses etc, collaborate on a range of complementary interventions. Intervention would occur at a number of different levels (e.g.

community input into local licensing regulations, development of local accords, media awareness campaigns, police action on drink driving, responsible service policies, etc) so as to simultaneously target the social and physical environment, local policies and individual behaviour. Finally evaluation would be built in to the implementation plan so that the community gains an appreciation of its achievements and what is learned can be offered to other communities and contribute to the body of knowledge on community prevention.

A number of research studies have shown that community action can change norms about alcohol use and alcohol harm (Casswell, 2000). This can facilitate structural change within the community, which in turn works to reduce actual harm. A few studies have also been able to directly demonstrate a significant change in patterns of local consumption and harm (Holder et al, 1997a, 1997b). However, the demonstrably effective programs tend to be complex, long term and demanding on resources. Comprehensive community action can be an effective prevention strategy. It is expensive, but weighing against that is the breadth of effect and institutionalisation of benefit through changed community function.

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project **notes**

SHAHRP dissemination project

Nyanda McBride, Fiona Farringdon and Carole Kennedy

Past reviewers of school drug education have noted that effective school drug education programs are not readily available to teachers in a useable format. This project, which is funded by the Alcohol Education and Rehabilitation Foundation, aims to disseminate the School Health and Alcohol Harm Reduction Project (SHAHRP) education materials, by providing training to teacher educators from Government, Private and Catholic Education sectors in several states of Australia. To date, teacher training has taken place in the four states involved in the study: South Australia (three sectors); ACT (three sectors); Tasmania (three sectors) and the Goulburn North East District in Victoria.

SHAHRP, has been particularly effective in changing the knowledge, attitudes and drinking behaviours of young teenagers and has attracted widespread attention nationally and internationally. Its significance was recognised at the recent National Drug and Alcohol Awards where it won the Excellence in Research Award, and a number of UK researchers are seeking funding to replicate the program. For further details refer to the Abstracts section

Does moderate drinking prevent heart disease?

A meta-analysis and re-estimation of alcohol-caused mortality in Australia

Tim Stockwell, Tanya Chikritzhs, Kaye Fillmore and William Kerr

It was recently estimated that 6,513 lives were saved in Australia in 2001, largely as a consequence of the protective effects of low risk alcohol consumption against Ischaemic heart disease and Ischaemic stroke (Chikritzhs et al, 2003). The majority of the protective effect of low risk drinking is due to the reduced risk of Ischaemic heart disease usually experienced among adults in the middle to older years of life. While there has been a growing scientific consensus in support of the reality of such protective effects associated with 'moderate drinking', there have also been growing criticisms of the methods used within the key

Accepting the Excellence in Research Award

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studies – some of which even suggest that the protective effect may not exist or at least may be substantially smaller than currently assumed. It is proposed that studies which show large protective effects are subject to two main types of error i) failure to remove subjects with pre-existing illness