

## **Multi-component programmes**

An approach to prevent and reduce alcohol-related harm

*Betsy Thom and Mariana Bayley*

**This report reviews international experience of community-based prevention programmes to address alcohol-related harms at local level.**

Debate following the publication of the Alcohol Harm Reduction Strategy for England (2004) and the implementation of the Licensing Act (2003) raised concerns about the cost of alcohol misuse to individuals and communities. A key part of national strategy is a focus on local responsibility for policy implementation and an expectation that stakeholders – local authorities, professional groups, the alcohol trade and ‘communities’ – will work together to reduce the problems.

The report describes a ‘multi-component’ model to prevent and reduce harm, with evidence from programmes in the USA, Australia and Scandinavia. The approach typically requires a programme of multiple, co-ordinated initiatives rather than ‘stand-alone’ projects, and an emphasis on encouraging change in local policies, structures, systems and drinking cultures. The involvement of local communities is central to most programmes. The report reveals problems in implementing and sustaining this approach as well as the advantages it offers. Discussions with a small group of professionals showed widespread use of ‘partnership’ approaches and suggested that the use of a more explicit multi-component model would be helpful to map alcohol-related problems and design local strategies.

*Multi-component programmes* will be of interest to policymakers, researchers and professionals working at local level.



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## **An approach to prevent and reduce alcohol-related harm**

**Betsy Thom and Mariana Bayley**



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# 1 Introduction

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## The policy context

After more than a decade of pressure and campaigning from health and alcohol-specific lobbies (e.g. Alcohol Concern, 1999; Raistrick *et al.*, 1999), a national *Alcohol Harm Reduction Strategy for England* was issued in 2004 (Prime Minister's Strategy Unit, 2004). Key elements of the national strategy are an emphasis on local responsibility for policy implementation and an expectation that stakeholders – local authorities, professional groups, the alcohol trade and 'communities' – will work together in partnership to develop responses to alcohol-related harm appropriate to the local area. Drug and Alcohol Action Teams, Primary Care Trusts and Crime and Disorder Reduction Partnerships are some of the existing organisations and networks seen as relevant to policy development and to the provision of an organisational base for implementing local strategies. More specifically, the national strategy stresses the need to ensure that interventions to reduce harm are:

- coherent, as isolated interventions are unlikely to succeed
- sustained, as short-term initiatives will have little long-term impact
- strategic, as, without a co-ordinated strategy, there is likely to be little progress
- measured, as, without ways to chart progress, the success of the strategy cannot be evaluated.

The advantages of a coherent strategy based on a programme of co-ordinated, multiple approaches and projects to tackle alcohol-related harms have been examined in trials and

demonstration projects for over two decades. The adoption of a 'multi-component' approach would appear to provide a suitable framework for meeting national objectives to deliver coherent, sustained, strategic and measured action to address alcohol-related harm at the local level.

## Defining 'multi-component' programmes

What distinguishes the multi-component approach from a single component approach is:

- the existence of a strategic framework with a theoretical basis for action
- the identification of problems defined at local levels
- a programme of co-ordinated action (projects) to address the problem based on an integrative programme design where singular interventions run in combination with each other and/or are sequenced together over time
- identification, mobilisation and co-ordination of appropriate agencies, stakeholders and local communities
- clearly defined aims, objectives, indicators and measures of effectiveness for the programme as a whole (although individual projects or activities will also have specified aims, objectives and outcome measures)
- evaluation as an integral part of the programme from the start.

Multi-component programmes typically emphasise modifying drinking cultures and

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effecting change or modification in local policies, structures and systems – for instance, by improving local policies on alcohol, by strengthening collaborative networks between professional or stakeholder groups, or by involving local communities in efforts to achieve change. In community-prevention approaches, whole communities form the target-intervention group rather than individuals within the community.

### Background and rationale for multi-component programmes

The impetus to mount ‘multi-component’ programmes rather than single-component projects came initially from action to prevent cardiovascular disease – where it was hailed as successful (see discussion in Farquhar and Fortmann, 1992; Hyndman *et al.*, 1992) – and, subsequently, from international research on alcohol (e.g. Holder and Howard, 1992; Holmila, 1997; Holder, 1998; Hanson *et al.*, 2000).

Research on alcohol, as in other areas of health, supports the use of strategies that focus on populations as a whole in preventing and reducing the burden of disease (Rose, 1981, 1985; Edwards *et al.*, 1994). In tackling alcohol-related problems in moderate or less heavy drinkers, the work of Kreitman (1986) was also important in legitimating a whole-community approach. Kreitman’s ‘prevention paradox’ suggests that population-level measures are best suited to influencing the consumption patterns of less problematic drinkers who are unlikely to show up among treatment- or help-seeking populations but who, nevertheless, add to the sum of alcohol-related harm in a community.

One aspect of the response to alcohol-related

harm that gained general consensus as early as the 1960s was the need for action and services to be ‘community based’, and developed and managed at local level. As state control lessened in the name of free trade, greater competition and consumer benefit, increasing responsibility was placed on local authorities and local communities to develop strategies and services to respond effectively to alcohol problems. Work by Tether, Robinson and colleagues (Tether and Robinson, 1986; Robinson *et al.*, 1989) provided a rationale for co-ordinated action at local level; described community-based awareness, education, workplace, advice and treatment, and criminal justice projects; and offered a guide to local action. There were also attempts to set up structures to facilitate action. ‘Umbrella’ organisations aiming to co-ordinate local activities in the voluntary sector (treatment, counselling and advice on problem drinking) emerged in the 1960s and their functions were later consolidated within a new organisation, Alcohol Concern, in 1983 (Thom, 1999). In the 1980s, the establishment of a network of regional alcohol misuse co-ordinators was intended to initiate strategy to support intersectoral working at local level (e.g. Means *et al.*, 1990); and, throughout the country, ‘Alcohol Forums’ were established with a similar purpose. These structures largely disappeared as new forms of management and co-ordination emerged (e.g. Drug and Alcohol Action Teams). Since the mid-1990s, the policy emphasis on ‘joined-up thinking’, ‘joint working’ and ‘multi-agency partnerships’ has increased considerably. The establishment of multi-agency groups, such as Crime and Disorder Reduction Partnerships, Drug Action Teams, Health Zones and ‘Healthy Cities’ initiatives – although not all specifically

required to address alcohol issues – opens opportunities to develop multi-component programmes to reduce alcohol-related harm and offer a variety of models and approaches to inform local initiatives.

However, until recently, prevention and community-based interventions have consisted largely of single-component or groups of ‘stand-alone’ projects, such as educational and ‘diversionary’ projects for young people, action to address alcohol-related violence and anti-social behaviour, local media campaigns and treatment responses (Raistrick *et al.*, 1999). These activities have been developed and delivered by numerous agencies, often working in isolation from one another. Formal evaluation of projects was (and is) rare; but, when evaluation of any kind was conducted, it was for individual projects rather than for the effectiveness of an action *programme*. A small-scale scoping exercise, carried out for the Health Education Authority in 1995–96, found that single-component projects aimed at specific target groups (especially young people, offenders, professional groups) and at specific contexts (pubs, workplaces, health settings, schools) were the norm. A few examples were reported of ‘partnership’ schemes, mainly between alcohol advisory services and the criminal justice service, and there were some reports of attempts to co-ordinate activity within a local area. None of these, however, could be seen as ‘multi-component’ (Thom *et al.*, 1997). Despite encouragement from central government departments to become involved in addressing alcohol problems (e.g. Finney and Simmons, 2003; Tierney and Hobbs, 2003), progress towards ‘multi-component’ approaches has been slow, although there appears to be an

increasing interest in, and use of, ‘partnership’ and multi-agency projects.

Greater efforts have been made in the UK to mount a ‘comprehensive’ approach to tackling drugs misuse. Between 1990 and 1999, the Drugs Prevention Initiative, for instance, developed drug prevention teams, community demonstration projects and comprehensive schools programmes (e.g. Project Charlie). Many of the projects adopted a holistic approach ‘setting local drugs problems in the context of wider community problems’ and aimed to discover ‘what works’ (Home Office, 1997–99). The 1998 report from the Advisory Council on the Misuse of Drugs (ACMD, 1998) emphasised the importance of including an environmental dimension in public health thinking and mentioned ‘multi-component programmes’ in the list of promising approaches. More recently, the Youth Justice Board funded a national programme of projects targeted at substance use by young offenders, with the aim of reducing reoffending, substance use and related harms (Hammersley *et al.*, 2004). ‘Communities against Drugs’ is another major government-funded programme specifically intended to mobilise local community initiatives and partnership approaches to tackling drugs misuse (Drugs Strategy Directorate, 2001). Evaluation of these programmes has been variable and published reports have discussed the initiatives at a national rather than at a local community level. Currently, the ‘Blueprint’ programme, described as ‘a universal multi-component programme’, targets schools, parents and the media, and includes increased action to restrict the availability of legal and illegal substances to under-age youth (Baker, 2006).

Although the notion of ‘multi-component’

approaches now appears to be gaining currency in the UK, evidence for this approach comes largely from research and demonstration projects conducted in the USA, Australia, New Zealand and Scandinavia. The evidence in favour of multi-component approaches is still unclear – although this may be accounted for, at least in part, by the difficulties of evaluating these programmes – which we will address later. In their overview of the evidence available in the early 1990s, Hyndman *et al.* (1992) concluded that the critical question as to the value of multi-component programmes, compared to highly focused, single-component interventions, remained unanswered. Subsequent research and evaluations may shed new light on the evidence. However, the literature illustrates the many implementation difficulties faced in attempting to mount multi-component strategies, to initiate sustainable responses in local communities and to ‘mainstream’ approaches deemed successful in one area into other local contexts. These issues will be considered later.

### Aims and methods

This project aimed to:

- review the international, English language literature on multi-component programmes as an approach to prevent and reduce alcohol-related harms
- extract main themes and issues relevant to considering the development of such programmes in the UK context
- investigate whether multi-component programmes were already in operation or being developed in local areas in England

- consider the opportunities and barriers to mounting multi-component programmes in a variety of local contexts.

Four main methods were adopted.

A narrative literature review of English language publications subsequent to 1990 was undertaken to identify international multi-component programmes and key themes regarding the initiation, implementation and evaluation of the programmes. A list of multi-component programmes initiated or continuing post-1990 was compiled. The cut-off date of 1990 was chosen for practical reasons, to manage the (unexpectedly) large body of literature and because we were interested in extracting themes and issues relevant to the development of programmes in the UK; older programmes were described and reviewed in later literature.

The list of programmes was then sent to 11 ‘experts’ who had been involved in research on multi-component interventions in the USA, Australia, New Zealand and Europe. They were asked to identify any major programmes, with or without publications, which we had missed.

A scoping exercise was conducted to investigate whether multi-component programmes had been established in the UK and to examine questions concerning the implementation of a multi-component model into different local contexts. Interviews were conducted (by a mix of face-to-face and telephone discussion and email questionnaire) with 25 respondents, representing different types of organisations (Drug and Alcohol Action Teams, Alcohol Action Teams, Crime and Disorder Reduction Partnerships, Primary Care Trusts) and located in different geographical areas (see Table 1).

Finally, the draft report was sent for comment to all respondents to the scoping exercise and to two peer reviewers with experience of research into multi-component programmes. Their comments were taken into account for the final report.

**Table 1 Areas represented in replies received to the scoping exercise**

Area	Total
<b>England</b>	
<i>North</i>	
Urban	1
Inner-city	1
Rural	1
<i>Midlands</i>	
Urban	2
Inner-city	1
Rural	2
<i>South</i>	
Rural	1
<i>London</i>	
Inner-city	4
Suburbs	1
<i>Home counties/commuter</i>	5
<i>South</i>	
Seaside resort	1
<i>South West</i>	
Urban	1
Rural	2
<b>Scotland</b>	1
<b>Wales</b>	1
<b>Total</b>	<b>25</b>

### Understandings of 'multi-component programme'

Examination of the literature had already alerted us to differences in terminology used to describe 'multi-component programmes'. The scoping exercise further illustrated the confusion around the definition and understanding of this approach. We introduced respondents to multi-component programmes by defining what we meant by the term and by giving examples from the international literature.

Following our explanation, activities planned to achieve specific targets were conceptualised by respondents as a 'multi-component approach' for the purposes of our research; but the notion of 'multi-component' was not a familiar or operational term they used themselves. Almost exclusively, respondents preferred to discuss initiatives within the context of 'partnerships', which seemed to be a more accurate description of the implementation structures and alliances formed to tackle alcohol-related problems in their local areas.

### Structure of the report

Preliminary reading of the literature helped to generate a number of broad themes, which were used as guidelines for further selection of material, for 'interrogating' the literature and for questioning scoping respondents.

Chapter 2 provides an overview of the identified programmes, their aims, structures and components. In the third chapter, we discuss programme evaluation and consider the question of whether multi-component

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programmes 'work' or are more likely to succeed than stand-alone projects. Chapter 4 offers a short introduction to two main theoretical frameworks that inform the development and implementation of many multi-component programmes. In Chapter 5, some key issues influencing the development

of multi-component approaches are considered and finally, in a brief 'Endnote', we sum up the potential for multi-component approaches to make a contribution in the UK context, taking account of the influence of national policies on local action.

## 2 Overview of multi-component programmes

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### Programmes identified from literature and expert consultation

Thirty-three multi-component programmes were identified from the published literature and expert consultation: USA (seven), Australia (seven), New Zealand (five), Sweden (four), Finland (three), Italy (three), UK (three), Poland (one). Programmes and references to published work are listed in Appendix 3. No publications were found for some of the programmes reported and we are aware that the lists may not include the newest programme initiatives.

### Programmes from the scoping sample

Respondents outlined a total of 15 initiatives that they felt were ‘multi-component’ (Table 2). An important distinction to emerge from the discussions was the difference between programmes that had alcohol as their primary focus (12) and programmes where alcohol was seen as an important aspect of another problem, e.g. crime reduction, ‘city centre’ and ‘night-time economy’ disorder. A further main distinction was made between long-term projects and short-term campaigns organised around events such as football matches or festivities such as Christmas. Only five of the

reported programmes conformed to a strict definition of ‘multi-component’ programme derived from the international literature and three of these had been recently initiated by the Alcohol Education and Research Council (AERC) as action research projects (Mistral *et al.*, 2006). The remaining programmes shared many of the features of multi-component programmes but generally lacked an explicit theoretical framework to guide strategy development, selection of initiatives and programme implementation procedures. Evaluation of the programme as a whole (as opposed to evaluation of specific aspects or stand-alone initiatives within the programme) was rarely included. As mentioned earlier, respondents preferred the concept of ‘partnership’ or ‘multi-agency’ and we have used this term in Table 2. Although these programmes do not satisfy completely the multi-component model, they have been included as useful examples of programme approaches in the UK.

The kinds of interventions currently being developed in the UK to tackle alcohol-related harm may be exemplified by a comparison of five programmes that on the surface appear to be similar. We have purposefully selected city centre programmes to illustrate differences between the approaches noted in Table 2.

**Table 2 Scoping sample programmes**

Approach	Alcohol is focus	Alcohol is embedded
<i>Multi-component</i>	4	1
<i>Partnership strategically co-ordinated</i>	8	2
Long-term projects	5	
Short-term or targeted campaigns	3	
<i>Total</i>	12	3

## Multi-component programmes

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### Multi-component, alcohol-focused approaches

Of the 15 projects identified in the interviews, four had adopted multi-component approaches to tackle alcohol-related problems and three of the programmes, initiated through AERC training workshops, employed Holder's Community Prevention Trial model (Holder, 1998). One of these – a city centre programme designed to reduce alcohol-related injury, violence and disorder – is outlined in Box 1.

#### Box 1 A city centre, multi-component alcohol intervention

##### *Project title: Reducing alcohol-related injury, violence and disorder in the city centre*

This is a city centre in Scotland with an ongoing multi-component programme, based on Holder's theoretical framework. The overall aim of the programme is to reduce alcohol-related injury, violence and disorder in the city centre. As an alcohol-prevention trial it builds on the activities and structures that already exist in the city.

It began in 2004 and is scheduled to run for five years, funded through AERC and local resources. AERC support has allowed for more comprehensive evaluation and reporting than would otherwise have been possible.

There are five programme components:

- responsible serving practices to reduce customer intoxication, disorder and injury
- environmental design to reduce alcohol-related disorder and crime

*Continued*

- transportation to reduce alcohol-related injury, disorder and violence
- outlet density to reduce alcohol-related disorder
- media/community engagement.

The population group targeted is a 'city-centre community' characterised by a transient population of people commuting to work and leisure sites rather than a stable, residential population. 'Residents' such as students and people on overnight stays are included but they do not form a cohesive group. The community targeted to bring about change in social values is a 'transient and business' population, which takes messages back to residential communities.

National policy contexts and nationally set priorities were considered in the choice of focus and target outcomes for the trial. This has helped to avoid policy tensions and has been useful in seeking support and resources.

The overall outcome evaluation includes use of proxy measures – for example, reduction in accident and emergency attendance. Process evaluation of individual components is included and is supplemented with 'snapshot research'. The programme is externally evaluated.

#### *Summary*

The programme has been developed to tackle alcohol-related harms using a theoretical framework; there is a clear implementation structure; there

*Continued*

are identifiable components; changing community norms and values are addressed; and evaluation is integrated within the programme.

### **A multi-component approach in which alcohol is embedded**

The second example (Box 2) describes an alcohol initiative embedded in a multi-component project launched specifically to tackle crime, with alcohol-related crime a key priority rather than the sole or major focus.

#### **Box 2 Alcohol embedded in a town-centre approach to reduce violent crime**

##### *Project title: Town Centre Safety Partnership*

This town located in the Home Counties, has a lively night-time economy and its pubs, bars and night clubs are visited by up to 15,000 people every weekend. A Community Safety Strategy has been developed, with an overall objective to tackle town centre violent crime and where a key priority is to reduce alcohol-related crime. Project development is theoretically informed (the SARA problem-solving model – discussed later).

The project was officially launched in April 2004 and is ongoing. It receives funding from two main sources: a Basic Command Unit Fund from the Home Office and Building Safer Communities Fund through the Crime and Disorder Reduction Partnership.

*Continued*

The project is partnership based and the following components are identifiable:

- enforcement – e.g. anti-social behaviour orders mean people can be banned from the town centre for two years
- intelligence gathering and sharing of information about offenders visiting the area
- Pubwatch scheme
- media/marketing – messages on water bottles
- CCTV
- responsible beverage service to discourage binge drinking via trade promotions.

The population targeted for the reduction in violent crime is defined as users of the night-time economy who tend to be aged 18 to 25/26. Media messages are directed at this age band. It is emphasised that making the trade more responsible through responsible beverage service (RBS) training will help to change attitudes, values and the culture of drinking, thereby influencing change in a subsystem that supports alcohol-related crime and associated problems.

Evaluation is integral to the SARA model and this is being overseen by the police force evaluator. Overall outcome measures for alcohol are proxy measures based on weekly monitoring of data on numbers of violent crimes, alcohol confiscations, arrests, dispersal orders, etc. The SARA model requires continuous reappraisal of the process to ensure that the real

*Continued*

problem has been identified or that the most appropriate intervention has been implemented.

### *Summary*

This project is theoretically based; it has a number of identifiable components; it attempts to change community attitudes and values; and builds in evaluation measures. Although discussion with the respondent centred on alcohol, it is understood that the initiative is located within a programme whose overall objectives focus on crime and disorder reductions and not specifically on alcohol-related harms.

### **'Partnership' approach: alcohol focused**

Of the eight projects identified as strategically co-ordinated partnerships with alcohol as a focus, six were developed as part of local alcohol strategies or through alcohol-focused strategic groups. We have distinguished between five longer-term projects, which were designed to be ongoing and sustainable, and three interventions, which were either brief and/or with a clear, short-term, targeted focus. For example, two focused on the Christmas period. Box 3 describes a long-term project and Box 4 a short-term Christmas campaign.

### **Box 3 An ongoing city centre partnership approach to tackle alcohol problems**

#### *Project title: City centre project*

This metropolitan city centre initiative in the North of England addresses a number of alcohol-related crime and disorder objectives. It aims to reduce the number of violent assaults related to alcohol misuse, and to encourage and support responsibility among licensees, and responsible drinking and behaviour among individuals, especially on their home journeys.

The project began in 2000 and is ongoing. It is funded by the Home Office via the police; Neighbourhood Renewal Funds via the Crime and Disorder Reduction Strategy; and the Neighbourhood Renewal Strategy Fund.

The project is a multi-agency approach with the following identifiable components:

- enforcement – increase in policing of night-time buses/bus stops
- responsible beverage service – working with licensed industry to identify hotspot areas/problem premises; support offered regarding vertical drinking, layout, promotions; award scheme for best bar; bar staff training
- transportation – linking with taxi firms
- local authority – licensing
- media/education – messages concerning responsible drinking.

*Continued*

Messages are targeted directly at the under-25 age group coming into the city centre; older people are also encouraged into the city centre to change its demographic profile, which can have a positive knock-on effect.

There is no formal programme evaluation; there is monitoring of alcohol-related arrests, which are used as proxy measures for evaluating the impact on alcohol-related harm.

There are plans for the programme to be rolled out across the whole city centre, as the project is currently located in the North of the city.

### *Summary*

This partnership approach has most of the features of an alcohol multi-component programme in place, as it is strategically co-ordinated – there is a local alcohol strategy and action plan; it has identifiable components and aims to change community norms and values. It would need to be underpinned by a theoretical model that incorporated evaluation measures to be fully multi-component.

### **Box 4 A specifically targeted, short-term alcohol campaign**

#### *Project title: Christmas safer drinking campaign*

This is a campaign, implemented within a metropolitan area with a well-developed

*Continued*

night-time economy. It runs over the Christmas and New Year period. It aims to address personal safety and safer drinking, and to reduce alcohol-related harm among perpetrators or victims of violence.

The project adopts a multi-agency partnership approach, building on strong existing partnerships, especially between the police and council. It also involves the Portman Group, which funded leaflets and generated media coverage via a marketing company based in the area. The following components are identifiable:

- transportation – working with Transport for London on a pilot taxi project to get people home safely and reduce illegal minicabs
- licensed premises – working with joint police and council licensing teams, in partnership with street wardens, police officers, community safety team and council enforcement officers
- enforcement – addressing problem behaviour, licensing
- stepping up of activity of multi-agency tasking group, using the principle of shared data to provide intelligence
- media/information – posters in licensed premises with safer drinking/alcohol-related behaviour messages; safer drinking information emails sent out – can target businesses, which cascade messages to employees, also mobile text messages – not necessarily specific to Christmas campaign, used to promote the 'Drinkwatch' website, providing information on a safe night out with

*Continued*

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links to 'Project Sapphire' (a police project that aims to improve rape investigation and victim care).

The population targeted is generic – visitors to city centre, both transient and residential population. Commuters can be targeted via their employers. Data has shown that alcohol-related crime and anti-social behaviour correlate with pub closing time; 18- to 29-year-old males are most likely to be victims and perpetrators.

There is no formal programme evaluation. Proxy measures of numbers of drunk and disorderly picked up by police decreased but ambulance calls for drunk and disorderly increased.

High visibility of posters suggests anecdotally that the campaign was successful. However, there are problems in disentangling the rise in crime at Christmas with the increase in people visiting the city centre.

Reliance on premises to display information can be problematic, as they are not always compliant – customers may be deterred if they believe they might become victims.

### *Summary*

This partnership approach has most of the features of an alcohol multi-component programme in place, as it is strategically co-ordinated – there is a local alcohol strategy; it has identifiable components; and aims to change community norms

*Continued*

and values through media/information campaigns. In the international literature, multi-component approaches can be based around specific activities, e.g. Christmas campaigns. This project would need overall conceptualisation, an implementation strategy and evaluation to conform to a multi-component model.

### **'Partnership' approach: alcohol embedded**

Two projects were described whose overall aim is to tackle violent crime in town centres or public places. These projects are strategically co-ordinated, with alcohol-related harms a priority within the broader focus of crime reduction. Box 5 describes one of these initiatives.

### **Box 5 A town centre approach to reduce violent crime**

#### *Project title: Public place violent crime programme*

This programme is taking place in the South of England with a mix of rural, urban and seaside locations. Its focus is on reducing violent crime and anti-social behaviour associated with alcohol; also the fear of crime. The approach builds on existing local structures, local economy and local ecology where robust partnerships already exist.

The programme began in 2004 and is government funded for three years through a Performance Reward Grant, with bonuses for achieving stretched targets.

*Continued*

Within the partnership approach the following components can be identified:

- enforcement
- transportation
- licensing.

The population targeted is younger people aged 20 to 30, both men and increasingly women, the aim being to make town and city centres more vibrant for more diverse sectors of the population. There is little activity designed to change the values and culture of drinking at the community level.

There is no programme evaluation but reporting back to government departments via Public Service Agreement targets. Alcohol outcome measures are by proxy numbers of arrests.

The scoping respondent felt that this programme grew too wide, too quickly and organisation was slow at the beginning. It will deliver some reductions but will fail to deliver the public place violent crime target. However, there are many added positive initiatives arising from this partnership work; the programme also builds in sustainability of approaches.

### *Summary*

This is a strategically co-ordinated programme with a number of identifiable components. For it to adopt a multi-component model, it would need a theoretical framework to provide guidelines for design and evaluation; implementation already appears to be

*Continued*

in place through partnership alliances. Changing community norms and the culture of drinking would also require attention. This could be addressed via responsible beverage service and/or media/education messages. The current programme focuses attention on crime rather than specifically on alcohol-related harm.

### **Programme aims**

Programme aims vary from those that are quite specific and focused regarding the problem to be addressed, the target group and the desired outcome to programmes with a more general focus. Operation Safe Crossing, for instance, aimed to reduce the number of youths crossing the USA/Mexican border to drink in Tijuana, lower their returning blood alcohol counts (BACs) and achieve reductions in alcohol-related crashes. The Scandicci Community Alcohol Action Project in Florence adopted a more general aim to promote responsible drinking and to prevent alcohol-related problems in the sectors of health, school and possibly traffic. The Metropolitan Project in Helsinki began without imposing any particular goal, since its aim was to find out what worried the local community and what kind of action was most feasible in attempting to reduce harm.

A considerable number of programmes focus on young people, aiming to prevent or reduce alcohol use as well as alcohol-related harm. The prevention of drink-driving is another important focus, especially in programmes in the USA, Australia and New Zealand. Many programmes include the development of local

## Multi-component programmes

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policy and strategy as an additional aim of the programme. The Rifredi Project in Florence aimed to bring an awareness of the risks of drinking wine as well as other types of alcoholic beverages and to change alcohol policy within the community. In other cases, this is regarded as an essential element of a programme but not specified as the main aim.

Overall, programmes in the USA, Australia and New Zealand appear to adopt more specific aims targeted at particular groups (such as young people) or particular harms and harmful behaviours (such as drink-driving, alcohol-related violence). The aims of programmes in the Scandinavian countries and in Italy have been described in more general terms and are directed towards a wider spectrum of the population. Box 6 provides information on the aims of a range of programmes described in the literature. Programmes are listed under the main aim but many have more than one aim; in particular, most programmes aim to influence community systems and change drinking norms, and most aim to mobilise local communities.

(Note: descriptions of programmes often draw on more than one publication. To simplify referencing, the main publications consulted are listed under the programme title in Appendix 3.)

### **Box 6 Programme aims (published literature)**

#### *Reduce alcohol-related injuries and deaths*

- Community Trials Project (USA)
- Saving Lives (USA)

*Continued*

- Operation Safe Crossing (USA)
- COMPARI (Australia)
- Maori Collaborative Drink-drive Project (New Zealand)
- Waikato Rural Drink-drive Project (New Zealand)

#### *Young people*

#### *Prevent/reduce alcohol use/alcohol-related harm among adolescents/young people*

#### *Reduce commercial and social access to alcohol for under-age youth*

- Project Northland (USA)
- Operation Safe Crossing (USA)
- Communities Mobilising for Change (USA)
- Auckland Regional Community Action Project (New Zealand)
- Youth and Alcohol Project (New Zealand)

#### *Prevent availability-related alcohol problems*

#### *Prevent/reduce alcohol-related harm*

- California Community Planning Project (USA)
- Scandicci (Italy)
- Partysafe (Australia)
- Kungsholmen (Sweden)
- STAD (Sweden)
- Kirseberg (Sweden)
- Lahti (Finland)
- Metropolitan Project, Helsinki (Finland)

#### *Reduce alcohol-related violence/disorder*

- Surfers' Paradise (Australia)
- STAD (Sweden)

*Continued*

### *Change policies and practices and community norms*

- Communities Mobilising for Change on Alcohol (USA)
- Rifredi, Florence (Italy)

References are listed under programmes in Appendix 3.

### **The scoping sample**

The focus of the majority of the projects was on alcohol-related problems in town or city centres, with one programme concentrating on public places more generally. Although we achieved a wide regional spread of interviews, this town centre focus could be a result of a bias in our sample towards urban areas; at the same time, it may well reflect current national priorities and perceived concerns regarding the 'night-time economy' and related problems. Over half of the projects had aims that were part of broader violent crime and anti-social behaviour objectives. Stated main aims included to:

- reduce town/city centre/public place alcohol-related violent crime/anti-social behaviour/disorder (eight programmes)
- promote safer drinking/personal safety around the Christmas period/reduce excessive drinking longer term – also city centre focused (three programmes)
- reduce number of date rapes and increase awareness of alcohol-related harm and vulnerability as part of a safer town project (also linked to domestic violence) (two programmes)

- identify and reduce the impact of alcohol misuse on a range of community safety and health-related indices (one programme, not city centre)
- reduce alcohol-related harm among young people (one programme).

Additional, specific aims for some of the above projects included to:

- reduce alcohol-related injury
- address hate crime
- address problems of under-age drinking
- address the problem of street drinkers.

Because of the town centre focus, the population targeted by almost all the projects was users of the night-time economy who tend to be young people aged 18 to 25, mostly males, though increasingly females. They were identified as the most likely victims and perpetrators of alcohol-related harm. In three areas the age profile was slightly older, up to 35 years. In major metropolitan areas, such as inner-city areas of London or Glasgow, transient populations were also targeted, the idea being to discourage possible troublemakers from coming into the area and also to target 'outsiders' to take home messages to their resident communities. Only one project addressed the problems of younger teenagers (13 to 17 year olds).

### **Programme structures**

All of the programmes described in the literature reviewed were initiated by local authorities, health authorities, research groups or similar professional organisations

## Multi-component programmes

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and agencies. Often the research group was commissioned or appointed by another regional or local institution. In this sense, programmes are 'top-down' initiatives. However, as Treno and Holder (1997a) comment in relation to the Community Trials Project, there is an assumption in multi-component programmes that grass-roots action and community mobilisation or participation are an essential element for the success of local prevention effort. Thus most programmes include efforts to incorporate a 'bottom-up' approach, particularly in the implementation phase. Some programmes are described as a 'community-science partnership' (Community Trials Project – Holder, 2000); as combining a 'top to bottom' with a 'bottom to top' strategy (Kirseberg – Hanson *et al.*, 2000; Rifredi – Allamani *et al.*, 2000), or as a 'down-top' approach (Scandicci – Allamani *et al.*, 2003).

To differing degrees, all the programmes stressed the importance of involving the local community. For some programmes, this was a major focus; for instance, the Waikato Rural Drink-drive Project and Maori Collaborative Drink-drive Project aimed to build community capacity (Stewart and Conway, 2000; Conway and Casswell 2003); Metropolitan Suburbs Project, Helsinki, began with consultation to identify community concerns and appropriate methods to address the problems (Holmila, 2000). As a result, implementation structures generally included a steering or co-ordinating committee made up of the research team and representatives from local authorities and institutions – the police, health, education, voluntary organisations and, in a few cases, the church.

In the USA, programmes usually appointed a full- or part-time co-ordinator who was a local resident; but this was reported less frequently in other countries, possibly reflecting differences in the resources allocated to the programmes. The Kungsholmen Project in Stockholm (Romelsjö *et al.*, 1993), for instance, set up a local 'reference group' with representatives of major community 'stakeholders'; in addition, the academic team became members of existing collaborative groups using a newsletter as a vehicle for sharing information and keeping in touch. Many programmes initiated local 'task groups' to develop and deliver a variety of activities.

### The scoping sample

'Top-down' initiation was also a feature of programmes identified in the scoping sample. The three new multi-component programmes that started in 2004 in the UK resulted from the initiative of a research funding council bringing together local collaborating teams of professionals. Most of the projects were multi-agency partnership projects set up under the umbrella of community safety and involving police and local/county councils, other statutory and voluntary organisations, licensees and commercial organisations. Local alcohol strategies were in different stages of development, ranging from draft strategies to fully comprehensive strategy and action plans.

In some areas, a task group had been assembled to develop and implement the project strategy within existing partnerships; in others, new coalitions had been formed – for example, a self-funding stakeholder partnership group, sustainable on the basis of each member paying an annual subscription. There was one example

of a community programme led by a university research group.

In three metropolitan city areas, new, dedicated alcohol co-ordinator posts had been created specifically to develop local alcohol strategies and co-ordinate alcohol-related activity. The organising role appeared to be taken up by the alcohol lead within the Drug and Alcohol Action Teams (DAATs) in other areas.

There were, then, similarities between programmes reviewed from the literature and those discussed in interviews, especially with regard to using task groups and dedicated co-ordinators, existing networks and co-ordinating groups to forward the programme.

### Programme components

As with the term 'multi-component programme', the term 'component' was unfamiliar to many of the people we spoke to in the UK scoping exercise. We also found some difficulties in attempting to extract information about programme components from the literature – for example, in distinguishing a programme component from an 'activity'. Some programmes have components that are also multi-project or comprise sets of activities. The Community Trials Project (USA) provides a useful example in trying to clarify the terminology (Holder, 2000).

Holder (2000) describes a programme to reduce alcohol-related injuries and deaths in three communities. Adopting a systems approach to the conceptualisation of the problem, the researchers identified five mutually reinforcing intervention components designed to achieve change in the drinking

environment. These were:

- 1 community mobilisation to develop community organisation and support
- 2 responsible beverage service to establish standards for servers and owners/ managers of on-premise alcohol outlets
- 3 a drinking and driving component to increase local drunk-driving enforcement efficiency and increase the actual and perceived risk of detection
- 4 an under-age drinking component to reduce retail availability of alcohol to minors
- 5 an alcohol access component to use local zoning powers and other municipal controls of outlet numbers and density to reduce alcohol availability.

Each component had its own aims and objectives, and included a range of intervention activities. For example, activities to tackle under-age drinking (the fourth component) included:

- off-premise employee training, which focused on improving employees' knowledge of state under-age laws, increasing awareness of their responsibility and role in prevention, teaching appropriate procedures for age identification and detection of false identification, and teaching methods and skills for refusing sales; and owners' and managers' training, which included support for the development and implementation of store policies to reduce sales to minors

## Multi-component programmes

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- enforcement of the under-age alcohol sales laws, which used warning letters from the police to sales outlets, a series of decoy operations, further letters warning of the decoy trials and citations issued to outlets selling to decoy purchasers
- media advocacy to draw attention to the issues of under-age drinking through news coverage of the enforcement activities, and other news events, which highlighted more general issues (Grube, 1997; Holder, 2000).

A 'component' is, therefore, a broad type (or group) of prevention activity that addresses some aspect of the conceptual model, has its own set of prevention activities and is designed to be mutually reinforcing with other components (Holder, 2000, p. 848).

A wide range of components and activities were found in the various programmes. All programmes reported a specific component or some activities aimed at community mobilisation; all made use of the media (newspapers, television, video, films). Other frequently reported components included activities to promote responsible beverage service, enforcement measures – to tackle drink-driving, under-age drinking and sales to minors – and training in awareness and skills for a range of professional groups, parents, peers and volunteers. For the most part, programmes concentrated on prevention activities and did not include the treatment and rehabilitation sectors. However, the Scandinavian programmes were an exception, including health-related activities such as screening in primary care, providing support for the families of problem drinkers and promoting

the implementation of brief interventions in primary care settings. Source of funding and, in one case, links to a World Health Organization (WHO) study on brief interventions may account for the difference.

Box 7 shows the components/activities reported for one example from each of the five groups in Box 6 above.

### **Box 7 Examples of programme components/activities**

#### *Reduce alcohol-related injuries and deaths*

#### *Maori Collaborative Drink-drive Projects (New Zealand) – two communities*

Both used: mix of policy, community mobilisation/capacity building, advocacy/awareness/education to change norms and behaviours. Environmental and community-based activities included initial extensive networking to ensure community 'ownership'; engagement of Maori stakeholder groups, including Maori elders, in the development of culturally appropriate strategies to improve drinking environments and increase support for random breath testing; culturally appropriate intervention included the use of *marae* – local gathering places – and Maori educational settings (pre-school to school leaving) and use of the media and awareness materials. Project 1: WHANAU/TU BADD – initiation of a group of young male Maoris (Brothers against Drink-Driving) and a rugby team (BADD Company) were formed.

*Continued*

Project 2: WHIRIWHIRI TE ORA  
 – strategies to reduce drink-driving: programme co-ordinator, Maori wardens and police visits to *marae*, schools and other public places to deliver awareness messages; used symbols of commitment (wearing a blue ribbon, learning a song about the programme); introduction of host responsibility practices and education for bar staff; policy action to prevent proposed liquor outlet.

*Young people*

*Prevent/reduce alcohol use/alcohol-related harm among adolescents/ young people*

*Project Northland (USA)*

Multiple components directed at: schools behavioural curricula; peer leadership initiatives; parental involvement; community change. They included: teacher training, joint child–parent assignments and a variety of child–parent activities, election and training of peer leaders, production of parent notes, newsletters about the project, training field staff in community change strategies, recruitment and training of community ‘task force’ members, general media campaign.

*Prevent/reduce availability-related alcohol problems*

*Metropolitan Project, Helsinki (Finland)*

Activating and informing young people (joint working with teachers, youth workers, police, city professionals); media advocacy (local newspapers); mini-

*Continued*

intervention in the community health care centre (with doctors and nurses); educational campaign at a large worksite (with occupational health centre and the church); promoting responsible alcohol service in restaurants, shops, kiosks (with business owners and others); campaigns to discourage public drinking by young people (with police, youth workers); educational messages delivered as part of community events (with community workers and church); providing increased support for recovering alcoholics (with self-help organisations, church, community workers, alcohol clinics); holding meetings and discussions with community activists.

*Reduce alcohol-related violence/disorder*

*Surfers’ Paradise (Australia)*

Task groups collected data and examined issues: (a) safety of public spaces task group (e.g. testing whether children could reach public telephones); (b) security and policing task group (e.g. implemented ‘neighbourhood watch’, piloted a registration and training programme for security personnel, implemented a trial programme of shuttle buses to ensure safe exit from nightclub area and reduce drunk-driving); (c) community monitoring task group (media liaison); (d) venue management task group (e.g. encourage involvement of licensees, engage in consultation and decision making, e.g. shift of emphasis from alcohol to entertainment, use of risk assessment and development of

*Continued*

## Multi-component programmes

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model house policies and code of practice, set up monitoring committee).

### *Change policies and practices and community norms*

#### *Rifredi, Florence (Italy)*

Public information (using alcohol carousel, children's drawings); community school programme (e.g. health education course for teachers); training for primary health care professionals and volunteers involved in transportation of traumatised people to hospital emergency rooms.

### **The scoping sample**

As noted earlier, while projects with a theoretical base, such as the AERC-funded programmes, conceptualised components in the sense outlined by Holder (2000, p. 848), respondents did not use the term 'component', referring instead to 'action' or 'intervention'. Box 8 gives an example of how interrelated activities are proposed within five 'action' headings for a city centre programme to reduce alcohol-related problems. These five 'actions' or components provide the framework for developing the overall project. Each component has an evidence base and its own aim and range of actions that address the overall programme objective.

### **Box 8 Components of a city centre project**

*Project: an AERC-funded programme to reduce alcohol-related injury, violence and disorder in a city centre*

Actions:

- 1 *Responsible serving practices*: to reduce customer intoxication, disorder and injury
  - *Rationale*: legal and health education for on-licence staff together with enforcement measures will reduce intoxication per se and potential for alcohol-related harms.
  - *Activities*: development of server training; implementation of codes of practice within licensed premises including environmental measures; enforcement of legislation around alcohol sales to intoxicated people; enforcement of change from glass to plastic containers.
  - *Links to existing work*: mandatory server training for new licence-holder expected by city licensing board; research commissioned by health to examine how reductions in harm could be effected in licensed premises; hotspot analysis targeting police resources; glass-free policy development and implementation.
- 2 *Environmental design*: to reduce alcohol-related disorder and crime
  - *Rationale*: links to above component – changes in environmental design of on-licensed premises, e.g. physical layout, vertical drinking and in

*Continued*

trouble areas will reduce disorder associated with intoxication and potential for disorder.

- *Activities:* significant locations identified by police hotspot analysis; white lighting used within hotspot areas; in CCTV-monitored areas call-in phones could be developed to report disorder.
- *Links to existing work:* subgroup formed within community safety forum addressing day- and night-time economy within a hotspot.

3 *Transportation:* to reduce alcohol-related injury, disorder and violence

- *Rationale:* strong links with above component – moving people away quickly and efficiently from licensed premises and potential trouble hotspots will reduce disorder and harm. Minimises numbers of troublemakers and victims on street.
- *Activities:* develop integrated transport to manage large volume of people; erect barriers in taxi queues; free taxi phone calls to improve pickups and reduce queuing; provide safer night buses, e.g. using bouncers.
- *Links to existing work:* licensing body working to develop increase in taxis and buses.

4 *Outlet density:* to reduce alcohol-related disorder

- *Rationale:* strategically reducing access to alcohol availability by limiting numbers of licensed

*Continued*

premises. Based on premise that there is a link between numbers of licensed premises and alcohol-related problems.

- *Activities:* lobbying licensing body to consider outlet density as important. In line with national emphasis on over-provision; baseline study required to identify trends in problems and growth in premises; use of study to adopt no new licences where required, also to improve standards of existing premises.
- *Links to existing work:* national policies will affect local policy and action; Safer Pub award scheme adopted.

5 *Media/community engagement*

- *Rationale:* raising the profile of activities and issues within the overall programme through media coverage creates changes in community perception of areas, e.g. safer city centres, which in turn promotes changes in population visiting city centres.
- *Activities:* to develop and establish a 'brand' identity for the city centre alcohol action group; engaging local media support for initiative; conference planned to cover night-time economy issues; awareness raising and dissemination of media/community engagement approach.
- *Links to existing work:* communications subgroup of city centre alcohol action group to be given more prominent profile in media.

### Examples of components and activities (scoping sample)

Examples of components and activities found in the UK projects have been drawn from interviews and information from local alcohol strategies where they existed in respondents' areas. The description is illustrative of the range of initiatives rather than comprehensive. Activities fall into eight groups.

#### 1 Enforcement

Most of the UK projects include police enforcement activities targeting alcohol-related crime and anti-social behaviour, and helping to reduce the fear of crime among the general public. Further reassurance is provided by the presence of extra community wardens and policing of hotspot areas such as bus stops, taxi queues and food outlets in some projects.

- Pubwatch schemes were in place in about a third of the projects and are designed to limit intoxication and alcohol-related disorder. Information gathering and intelligence sharing among licensees and police helps to monitor the movement of troublemakers and limit access to alcohol. The scheme can improve communication and co-operation between the partners involved, which may include business and statutory sectors together with police and licensees.
- Licensing was identified as a component in about half of the projects and was closely linked with responsible beverage service, seeking to control both alcohol access and availability. This involves police and local authority licensing officers educating licensees about

legislation. Problem behaviour among licensees breaching the law is acted upon via enforcement and proactive licensing involving the visible presence of officers used as a deterrent. Hotspot areas and problem premises can be identified and licensees supported in terms of advice regarding layout, vertical drinking, promotions, etc.

- Responsible beverage service (and training) schemes are designed to control the availability of and access to alcohol, and to encourage attitude change among bar staff and other personnel. About half of the projects included responsible beverage service as a component, aiming to reduce drunkenness and potential disorder among customers through training of bar staff in licensing laws, alcohol education, how to prevent underage drinking, how to ensure personal safety and manage conflict. It is hoped that successful implementation would influence trade policies. Discouraging binge drinking through alcohol promotions was implemented via a Pubwatch scheme and voluntary code of conduct in one town centre initiative. A voluntary charter that stopped drinking promotions was instigated in another area. In another city centre, an index was being developed which provided information on a number of measures including: levels of drunkenness (assessed through observation and blood alcohol), where alcohol had been consumed, where entry had been refused, together with demographics, etc. This

was used to target partnership resources to prevent under-age selling and alcohol misuse, and has been reported as being successful in informing the training of bar staff.

- 'Best bar' award scheme: good practice was promoted by an award scheme for the 'best bar' in one city centre project where the incentive was recognition and publicity, with the benefit of encouraging attitude change towards drinking among staff and customers.

### 2 *Environmental design*

Interventions within this component seek to change the physical and socio-cultural environment in ways that discourage alcohol-related problems. Policy change is also an objective. CCTV monitoring and community radio provide surveillance, which can be deployed in hotspot locations to identify peripatetic offenders and improve the rate of response to problems; about a quarter of the projects included this. In one project a voluntary organisation monitored the community radio network and CCTV within the town centre. This can have added value, such as reassurance of taxi drivers. Other environmental measures to reduce alcohol-related harm included plastic bottles used to minimise glassings, special bottle tops to reduce drink spiking and locating bottle banks outside night clubs. In one residential area an alcohol-free zone had been implemented.

### 3 *Expansion of non-licensed premises*

Expanding non-licensed premises addresses community norms and structures by associating socialising with alternatives to drinking.

Non-licensed premises may be designed and marketed to attract a younger clientele. Outreach and youth workers may use venues to target/offer support to key groups.

### 4 *Outlet density*

It has been suggested that a concentration of licensed premises can increase alcohol-related disorder and that limiting outlet density can influence alcohol availability and related problems; one AERC programme included this as a component. Responses to the implementation of the Licensing Act 2003 have included the designation of 'saturation' areas by some local authorities. This is a step towards limiting further expansion of drinking venues in those areas.

### 5 *Transportation*

A transportation component is a preventative measure designed to change the structure of the environment. Transportation was identified in nine projects, where the aim is to reduce the numbers of potential troublemakers and victims on the street by moving people away from licensed premises and potential problem hotspots, such as food outlets and taxi/bus queues. There is also less disruption for residents and other travellers. This approach involves working with local taxi firms and transport to get people home safely; but providing extra bus routes can be problematic because of wide dispersal of destinations. Designated driver concessions, e.g. offering free soft drinks/free admission to one group member agreeing to drive, can provide an incentive for people to use their own car and reduce public transport/taxi demand and limit queues, which are often the focus of disturbance. Added benefits can be to tackle

## Multi-component programmes

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illegal, unlicensed minicabs. Supporting the aim of the transportation component, wallet-size cards with transport information, licensed taxi numbers, maps and safe drinking information were distributed in two projects.

### **6 Media (information/education)**

Almost half of the projects included a safety / health promotion component delivered through media campaigns. Campaigns varied in their messages and desired level of effect, aiming to create awareness and educate people about alcohol-related issues. The campaigns focused on: under-age drinking, binge drinking, safer drinking / personal safety posters in licensed premises, emails cascaded via businesses to employees, text messages in a Christmas campaign – ‘Christmas through the eyes of children’ campaign. Most projects focused on the negative impact of alcohol; in contrast, one project offered legal and health advice about alcohol to teenagers and aimed to portray drinking more positively. In one area, safe drinking messages were printed on water bottles.

### **7 Media advocacy (community involvement/engagement)**

Media advocacy was evident in four of the projects. This approach addresses community structures by attempting to change norms and values around safety and drinking. Social diffusion theory predicts that key individuals can take up new messages and filter them through to their wider social circles and spheres of influence. In the four projects, media advocacy is used to change community perceptions of troubled town centres that have become safer, thus aiming to attract a wider demographic profile of town centre users.

*We're engaging the community through the media and through a monthly newsletter and feedback. We're engaging all the agencies that can make a difference through regular feedback. We've found in other projects that, if you go public in a responsible way, then that is a powerful way of reaching and influencing local politicians and the movers and shakers.*

(Project leader, West)

### **8 Young people's festival**

A youth project included a proposed one-day festival to promote responsible drinking among teenagers. This non-alcoholic event was designed to change young people's perceptions around socialising without alcohol and educate them about alcohol-related issues.

## Choosing components

In most programmes described in the published literature, choice of relevant components and activities was generally ‘evidence based’, drawing on the international research literature for guidance on what might work in a particular cultural or social context. Two examples from the Community Trials Programme (USA) illustrate these points.

Voas *et al.* (1997) describe a drinking and driving component based on deterrence theory, which suggests that the rate of drinking and driving varies with the certainty of detection, and that the key factors are the perceived probability of detection and the swiftness and severity of the sanctions. Research studies cited by Voas indicated short-term success of initiatives to change driver behaviour but problems in maintaining long-term effects. The drinking and driving component (part of the

Community Trials Programme) incorporated high-visibility policing approaches, specialised training for police officers, public information and community mobilisation. To combat the tendency towards decreasing effectiveness as the novelty of the initiatives wore off, the focus of the enforcement effort and associated news coverage was altered, using different activities, every three to six months to maintain visibility and interest. The overall impact of the approach was to stop the trend towards a decrease in arrests over time, and to stimulate and maintain public interest in the problem.

Within the same programme, Reynolds *et al.* (1997) describe an 'alcohol access component' based on research evidence, which suggests that a reduction in alcohol availability, achieved through reducing the geographic density of on-premise outlets, would result in lower levels of consumption and alcohol-related harm (in this programme, especially alcohol- and traffic-related injury). The component aim, of reducing outlet density, was tackled by initiatives to change and strengthen local policy and regulations on alcohol, e.g. through local preventive zoning and land use planning approaches. A large number of organisations and agencies were involved in reviewing the local situation and considering options for action. The situational factors differed between the three experimental sites. In the Northern California site, concern centred around gang violence taking place in the neighbourhood with the highest concentration of alcohol outlets. However, the community members (the coalition group) decided to focus on achieving land use and policy change across the city as a whole. In the Southern California site, action prior to the programme had already tackled

the problem of outlet density and initiated policy change. The interest here lay in further development of policy and in continuing community redevelopment efforts. The South Carolina site differed in that its population was dispersed across a rural county, alcohol licences were issued by the State with little involvement from local governments and coalition members were generally not familiar with land use policies or policy options for tackling outlet density problems. Citizens' protest action was one factor in achieving more local control over the issuing of licences and policy changes were initiated.

### **Synergistic effects: 'the whole is greater than the sum of the parts'**

Examples from the Community Trials Programme illustrate the ways in which components begin from a research evidence base, adapt aims and activities to allow for local differences, and frequently address objectives such as long-term maintenance, gaining citizen support or strengthening local networks, which are additional to the intervention goal or seen as a necessary prerequisite to achieving change.

Multi-component programmes share another important feature in that components are designed to be mutually reinforcing. For example, the two components described above are mutually reinforcing in that the 'access to alcohol' component attempted to limit alcohol sales at high-risk settings such as garages or sports events where driving was likely to occur. A third component, 'responsible beverage service', interacted with 'drinking and driving' in a number of ways, including: identification of site of last drink; 'risk' establishments identified in arrests and

roadside surveys, and display at retail outlets of enforcement information on drinking while intoxicated. 'Responsible beverage service' also interacted with 'access to alcohol' in securing the support of owners and managers to limit new outlets, in requiring training for specific establishments and in local zoning to encourage training for all establishments. As might be expected, 'community mobilisation' (using public awareness of the issues, encouraging involvement of relevant groups such as Mothers against Drink-Driving, etc.) cut across all components (Holder *et al.*, 1997a). As the authors note, there were expected synergistic effects between components but many interactive effects are possible, and some of these may produce tensions and conflict. For instance, measures to address drinking and driving might threaten the support of licensed establishments to accept responsible beverage service. Identification and prevention of potential problems should be built into component design.

### Questions emerging from the literature and the scoping exercise

For the most part, new programmes are in countries that already had some experience of adopting a multi-component approach. One of the reasons for this may be the emergence of an international network of experts coming predominantly from the USA, Australia, New Zealand and Scandinavia. Holmila (2001a) reports that the inspiration for the Finnish research came from the USA, Canada and New Zealand, and notes the establishment of a network of researchers grouped around meetings of the Kettil Bruun Society between

1989 and 1999.

The influence of the international 'expert' network is illustrated in the recent spread to the UK of a multi-component approach explicitly based on international experience. A paper from England was given in 1992 at a Kettil Bruun thematic meeting (Mathrani, 1993), but there appears to have been no substantial follow-on until recently. In 2004, three programmes were initiated in the UK. These were a direct result of a training workshop arranged by the Alcohol Education and Research Council and run by Professor Harold Holder (USA) and Professor Sven Andreassen (Sweden), two of the leading experts. The programmes are funded partially by the AERC and partially from local resources.

Clearly, national and local policy contexts influence responses to alcohol-related harm and the potential for mounting multi-component programmes will vary depending on factors such as the national perspective on alcohol consumption and related harms, on the priority given to alcohol compared to other health and social problems, and on the resources available to support such initiatives. However, review of the literature and discussion with scoping respondents indicated a number of issues that arise across contexts and that are important in considering the possibilities for further expansion of a multi-component model in the UK.

First of all is the major question, 'Does it work?' Is there any evidence that multi-component programmes work or that they are more successful than stand-alone projects? This is discussed in Chapter 3.

As mentioned above, although initiatives described by respondents in the scoping survey may have been theoretically informed, this was

not explicit or particularly apparent even where there were written policy strategies. So Chapter 4 tackles a second question, 'Is there value in adopting an explicit theoretical framework for developing programmes and which theories may be useful?'

Chapter 5 considers key factors that may enhance or impede the success of programmes

in the short term and in the long term: policy tensions arising from the national–local interface, the problems of transferring initiatives reported as successful in one local (or national) context to other contexts, issues stemming from the perceived importance of community mobilisation and the problem of 'institutionalisation' of change.

# 3 Does it work?

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## Why evaluate?

The case for the evaluation of intervention programmes and activities has been well made. Evaluation provides a powerful tool, which enables policymakers and practitioners to review the aims and outcomes of initiatives, to inform programme planning and implementation, and to explain what works (or not) and why. Typically, multi-component programmes may include:

- formative evaluation, which pilots and assesses possible interventions, provides feedback and options for action
- process evaluation, which looks at the implementation process, documents activities, decisions, events, etc., and offers explanations for what has occurred and how it may have affected the programme and the outcomes; process evaluation may also feed back into the implementation
- outcome evaluation, which measures the change from baseline in selected variables.

## Approaches to evaluation

All programmes identified from the international literature were set up with evaluation built in from the start and with the intention of increasing the chances that observed changes were the result of the intervention programme rather than of other causes.

Most multi-component community programmes test interventions in 'naturalistic' situations where variability in delivery of intervention and in acceptance of the

intervention by the community is expected (Holder and Howard, 1992; Ross, 1992).

Classical experimental designs – such as randomised controlled trials – may be used in some programme components (e.g. school-based components), but are generally not viable as a method of evaluating multi-component programmes that target change at community level. 'Naturalistic' evaluation approaches are closely linked to action research traditions where there is little control over community action and where there is emphasis on process evaluation and explanation of the dynamics of community interaction with the programme intervention (see Holmila, 1997; Casswell, 2000; Graham and Chandler-Coutts, 2000).

Some programmes used *randomisation* in selecting intervention and control communities (Communities Mobilising for Change, USA – Wagenaar *et al.*, 2002; Project Northland, USA – Williams *et al.*, 1999).

More frequently *quasi-experimental approaches* were adopted. These projects chose matched sites for comparison with intervention sites (Saving Lives, USA – Hingson *et al.*, 1996; Holder *et al.*, 1997a; California Community Planning Demonstration Project, USA – Wittman and Biderman, 1993; COMPARI, Australia – Midford and Boots, 1999; Partysafe, Australia – Cooper *et al.*, 2001; Metropolitan Suburbs Project, Finland – Holmila, 2003; Kungsholmen Project, Sweden – Romelsjö *et al.*, 1993; Project STAD, Sweden – Wallin, 2004).

'Before and after' measurement of a range of variables is common to all the programmes reviewed. An improvement on the single-point, 'before and after' approach is to use *interrupted time series* where measures are taken at several time points before, during

and after the intervention. Programmes using time series measures as part of the evaluation included: Partysafe (Australia – Cooper *et al.*, 2001); Operation Safe Crossing (USA – Voas *et al.*, 2002); Communities Mobilising for Change ((USA – Wagenaar *et al.*, 2002); Saving Lives (USA – Hingson *et al.*, 1996); Kungsholmen Project (Sweden – Romelsjö *et al.*, 1993); STAD (Sweden – Wallin, 2004).

What is frequently missing from programme reports and evaluation studies (in the literature and the scoping sample) is a *narrative account* of action, which enables us to understand why projects may work in one setting and not in another. This point is emphasised by Holmila (2003, p. 83) who proposes that programme evaluation should aim at presenting results in the form of ‘theory based narratives concerning the inner mechanisms of communities in action’. A narrative account of action would help in generalising evaluation results by creating a theory of action, which could be tested and applied elsewhere.

### The scoping sample

In the international multi-component programmes, evaluation characteristically includes formative, process and outcome evaluation, and the collection of baseline data. In contrast, within the scoping sample, evaluation was broadly conceptualised as a measurement of change against baselines and there was a reliance on anecdotal evidence rather than formal evaluation in many cases.

The kinds of measures used in developing prevention activity were limited both in capturing the effects of alcohol-related harm and in identifying trends at the local level; they tended to be proxy measures available

from existing sources, such as arrests or numbers accessing services. Data on patterns of consumption at the local level, such as binge drinking or leisure users’ consumption, were usually not available. This contrasts with the way in which evaluation is often conducted in the treatment sector, where validated outcome measures are employed to assess reductions in alcohol consumption and related harm.

In two cases, a SARA problem-solving circle was used to guide the stages of development, implementation and evaluation. Derived from criminology and applied in the context of addressing alcohol-related crime, this is a process-oriented model (see Figure 1).

It was generally acknowledged by scoping respondents that formal evaluation of projects should be conducted, though agencies would need to develop the understanding and skills, and have the resources required for a comprehensive evaluation characteristic of multi-component approaches. Importantly, comprehensive local data on alcohol were needed to establish baseline measures. For instance, many respondents stressed the need to measure numbers of people presenting with alcohol-related involvement at Accident and Emergency departments.

### ‘Real-world’ problems

Reports in the literature of the delivery and evaluation of programmes document many ‘real-world’ problems.

- In the California Community Planning Demonstration Project (Wittman and Biderman, 1993), where ‘minimal’ intervention in two cities was compared

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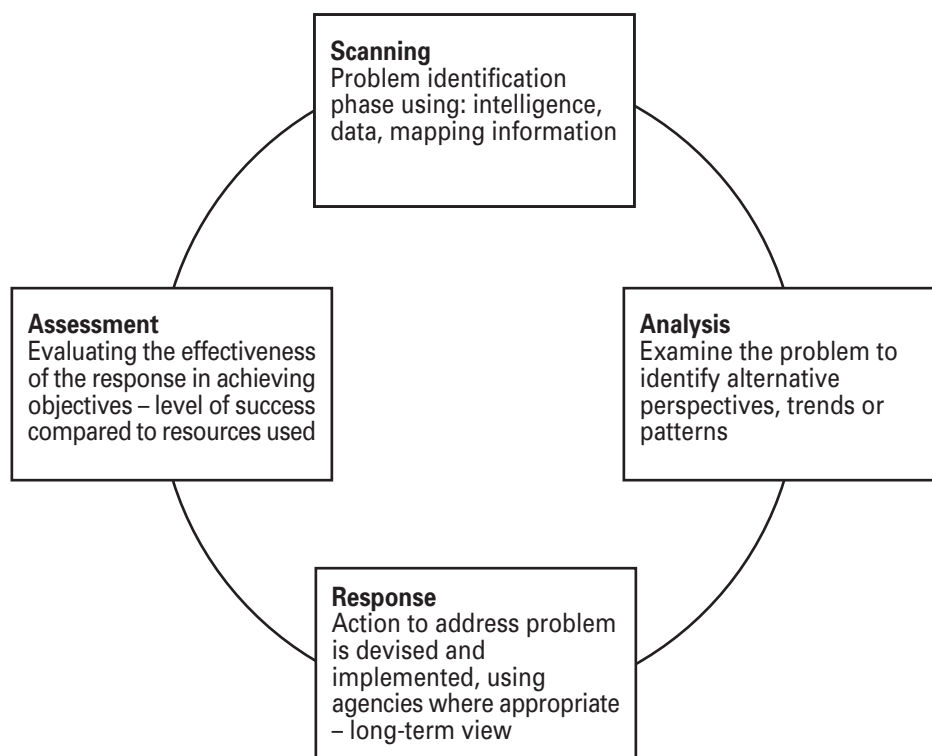
with 'enhanced' intervention in two other cities, failure to secure continuing support from the 'minimal' cities led to changes in the programme design.

- Attempts to use 'interrupted time series' measures in hospital settings in the Kungsholmen Project failed because patients refused consent to blood tests (Romelsjö *et al.*, 1993).

- The COMPARI project found that archival data on mortality were not good enough for 'time series' measurement (Midford and Boots, 1999).

A particular problem arises in programmes that aim to foster a high degree of community engagement and programme ownership.

Figure 1 Problem-solving SARA circle



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This problem-solving method, developed in America in the late 1970s, has been adopted by Crime and Disorder Reduction Partnerships to provide solutions to issues of crime and disorder. The SARA process should take into account the features of the location, the victim, the offender and the time of the incident/problem. It is essential to revisit all phases of the process to ensure that the real problem has been identified or that the most appropriate response has been devised/implemented.

Adapted by Gary Ray, Project Manager, Crime and Drug Strategy Unit, Herts from Eck and Spelman (1988).

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- Midford and Boots (1999) highlight the tensions between using a community development (mobilisation) approach and a quasi-experimental evaluation design, which, in the case of COMPARI, led to some poor-quality evaluation data. They explain the difficulty as a mismatch between two paradigms: scientific enquiry, derived from positivist thinking, which seeks facts and the causes of social phenomena, and generally uses quantitative data; and the naturalistic paradigm, stemming from phenomenological thinking, which aims to understand social phenomena from the perspective of the individuals involved, generally through the use of qualitative data. One example of the problems they report was the 'before and after' survey of key informants. For a variety of reasons, a significant proportion of key informants interviewed prior to the project were unfamiliar with COMPARI activities, staff changes meant that replacement informants also did not know the project; on the other hand, individuals closely involved with the project who were not part of the initial interview group were not interviewed on completion of COMPARI. Data from the control city were similarly affected. Attempting to improve the 'science' of evaluation may result in loss of programme flexibility and community involvement to the extent that Midford and Boots (1999, p. 54) conclude that:

*There is limited value in using quasi-experimental evaluation designs to evaluate*

*community mobilisation projects that emphasise a community development approach.*

Such tensions between 'science' and 'pragmatism' and the value of a 'naturalistic' approach are acknowledged and illustrated in other studies (e.g. Holmila, 1997, 2003; Casswell, 2000; Stewart and Conway, 2000). Some researchers have concluded that there is little value in using comparative or control sites, or that such an evaluation approach does not suit the programme design (e.g. Surfers' Paradise – Homel *et al.*, 1994; Kirseberg – Hanson *et al.*, 2000; ARCAP, New Zealand – Casswell *et al.*, 2003)

Midford *et al.* (1995) propose a mix of methodologies where components are evaluated using experimental design and the overall programme is assessed using a naturalistic, case-study approach (in Casswell, 2000, p. 68). In effect, many programmes use a mix of approaches and methods, although the balance between positivist and naturalistic design varies (e.g. Lahti – Holmila, 1997; Kirseberg – Hanson *et al.*, 2000).

The use of formative and process evaluation (in addition to outcome evaluation) is a key concern, especially in programmes with a strong focus on community development and engagement. Within a flexible, organic programme framework, systematic process documentation and evaluation of community mobilisation and programme implementation helps to inform decision making, steer the programme and explain the dynamics of community change.

The adoption of evaluation approaches is, of course, linked to issues of 'top-down' and 'bottom-up' development. Where programmes

lean towards 'top-down', a more rigorous, 'scientific' evaluation design may be possible, whereas 'bottom-up' programmes are likely to require a more flexible approach based on action theory. Treno and Holder (1997a) discuss the strengths and limits of both approaches but point out that many aspects of community organisation have not been researched in relation to action on alcohol, and that assumptions about grass-roots prevention efforts are largely untested.

Other considerations, common to evaluation work generally, are also raised and discussed extensively in the literature: the role of the researcher in relation to local policy making and implementation teams (e.g. Casswell, 2000); the tensions that can arise between the use of research (the 'facts') and advocacy approaches to action (Moore and Holder, 2003); issues around reporting 'success' by actors with vested interests (Gliksman *et al.*, 1995; Giesbrecht, 2003); the fact that evaluation, itself, can be seen as an intervention (Sulkunen *et al.*, 2003); and the advantages and disadvantages of independent evaluation conducted by someone external to the programme (Holder *et al.*, 1997a). The need for independent, external evaluation of programmes can also be questioned as a necessary requirement for good evaluation (Holder *et al.*, 1997a).

### Evidence from the research

There is no simple answer to the 'Does it work?' question. Studies carried out from the late 1970s to the mid 1980s showed that risk factors (smoking, dietary fat intake) for developing cardiovascular disease could be reduced by targeting communities with strategies that

combined community organisation and health education (US Department of Health and Human Services, 2000). But such trials had a narrowly defined clinical endpoint and were primarily targeted at individual behaviour change. They are not, therefore, automatically relevant in designing and evaluating alcohol-related community action programmes (Allamani *et al.*, 2000; Giesbrecht, 2003).

Evidence from international alcohol research has provided some guidance as to what is likely to work at the level of 'stand-alone' initiatives (Box 9).

#### Box 9 Does it work?

##### *Least effective interventions*

- Voluntary codes of bar practice
- Promoting alcohol-free activities
- Alcohol education in schools
- College student education
- Public service messages
- Warning labels
- Designated drivers and ride services

##### *Most effective interventions*

- Minimum legal purchase age
- Government monopoly of retail sales
- Restriction on hours or days of sale
- Outlet density restrictions
- Alcohol taxes
- Sobriety checkpoints
- Lowered BAC limits
- Administrative licence suspension
- Graduated licensing for novice drivers (i.e. the full licence is gained in stages)
- Brief interventions for hazardous drinkers

Babor *et al.* (2003)

While such findings are relevant in choosing and designing programme components, they do not tell us whether, or what kind of, combinations may result in effective multi-component interventions. In part, this is because of the expected synergistic effect of the components and also the possible cumulative effects over time; but also, from research conducted so far, it is not possible to determine the contribution of particular components to programme outcomes as a whole (US Department of Health and Human Services, 2000). Educational and awareness efforts, in particular – often cited as ineffective in changing behaviour – are regarded as a vital element of most multi-component programmes.

In strictly experimental, ‘scientific’ terms, the evaluation design and approaches of most multi-component alcohol programmes would be considered weak (Babor *et al.*, 2003) and we have recognised above some of the problems that have emerged from programme evaluations. However, the general consensus in the literature is that multi-component programmes can bring about change, especially where there is a strong emphasis on developing and implementing local policies and on fostering community involvement. Appendix 2 gives the outcome measures, results and conclusions drawn in 11 major programmes, providing an indication of how these programmes have been evaluated by the researchers involved and the extent to which outcome measures have been reported as indicating success.

Substantial successes are reported from some programmes (e.g. Community Trials Project – Holder *et al.*, 1997a; Holder, 2000; Surfer’s Paradise – Homel *et al.*, 1994; Operation

Safe Crossing – Voas *et al.*, 2002; Saving Lives – Hingson *et al.*, 1996), while, for others, the results were more mixed (e.g. Lahti – Holmila, 1997; Communities Mobilising for Change – Wagenaar *et al.*, 1996 in US Department of Health and Human Services, 2000; Kirseberg – Hanson *et al.*, 2000; STAD – Wallin *et al.*, 2003a).

### Long-term success

A further issue in assessing success is the longer-term impact of the programme. In most cases we know very little about what happens once a programme ends. In the case of Surfers’ Paradise, the gains made in the reduction of violence were lost once the intervention had finished. The researchers concluded that, although unfortunate for the community, the decayed effect increased confidence that the initial change had been due to the programme and not to unexplained, exogenous factors (Homel *et al.*, 1994). The question of sustaining and building on change is acknowledged in the literature as a crucial but an under-researched topic.

### Conclusion

There is now considerable evidence that favours prevention and harm-reduction action that targets populations, social systems, social structures and normative factors that create or sustain harmful patterns of drinking. This seems to hold true for national as well as local action (Babor *et al.*, 2003). The evidence from this overview of multi-component programmes suggests that, despite many unresolved questions and the difficulties encountered in initiating and implementing programmes, a multi-component approach has a greater chance

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of success than stand-alone projects that target specific groups, behaviours or environmental and situational drinking contexts more or less in a vacuum. Whether prevention and harm-reduction activity is co-ordinated into a multi-component programme focused directly on alcohol problems or embedded as a set of co-ordinated components into a multi-component programme with a wider focus (e.g. community safety) will depend on local priorities and resources. In either case, the lessons from the international literature indicate that a theoretically informed, strategic approach that

tackles change at the community level is needed to guide the selection and implementation of activities. Evaluation (formative, process and outcome) of the programme as a whole, as well as of sets of components and individual projects, is equally important, not just in assessing the success of the programme, but also in generating understanding of the dynamics of change within communities and systems, in learning the reasons for success and failure of initiatives, and in planning future action to sustain gains as communities and localities evolve and change over time.

## 4 Theoretical frameworks

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The emerging international 'expert' network has produced a considerable body of literature, which not only describes community-based multi-component programmes but has also stimulated examination of theoretical frameworks, evaluation approaches and the evidence base for adopting this model as a response to tackling alcohol-related harm. A strong case is made for basing multi-component community responses on a sound theoretical framework that guides the conceptualisation of the problem, the design and implementation of the intervention programme and its evaluation.

The concept of 'community' is complex and has been extensively examined elsewhere. Within multi-component community-prevention programmes, 'community' represents a geographical area within which a public health and environmental focus directs attention towards local policies, regulatory systems and practices that affect the production, distribution and consumption of alcohol. The primary aim of the programme is to effect structural and normative change by working through community institutions rather than directly targeting individuals, although specific population groups (e.g. young people) may be defined as the 'problem' group. Holmila (2001b, p. 163) provides a useful view of community-based interventions, which:

*... alter the social, cultural, economic and physical environment in ways that modify or counter in varied and not always predictable ways the conditions that favour the occurrence of alcohol-related problems.*

This basic distinction between achieving individual behavioural change and achieving change at the level of the whole community is a

key element in the wide range of social change models and theories that inform the design and execution of multi-component programmes.

Different theories may be employed at the level of the programme design as a whole and at the level of individual projects or activities (programme components) within the programme.

- The Community Trials Programme, for example, adopted a 'community systems' model of intervention with five components, within which 'deterrence theory' was used as the basis for a drink-driving component (Voas *et al.*, 1997) and a conceptual model drawing on 'top-down' and 'bottom-up' theories informed the community mobilisation component (Treno and Holder, 1997a).
- School-based interventions used in Project Northland (Williams *et al.*, 1999) were influenced by social learning theory. This programme also adopted a 'multi-level' approach to tackle demand for, and supply of, alcohol through staged interventions covering the sixth through to the twelfth grades of school.

The emphasis on environmental and structural change does not mean ignoring individual behaviour change; the former is seen as a route to achieving sustainable change in individual behaviour. Some programmes (e.g. COMPARI – Midford and Boots, 1999) combine components targeting both individuals and the community.

We focus below on two main theoretical approaches to achieving social change in communities that have influenced

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conceptualisation at programme level. They are the 'community systems' approach and the 'community action' approach.

### A 'community systems' approach

An important outcome of international exchange is the emergence, development and diffusion of a 'systems theory approach' as an appropriate model to inform the overall design of multi-component programmes. Emerging from intellectual roots in social psychology, general systems theory and community-based prevention, systems theory has provided the basis for the development of a comprehensive community response in some of the best-known alcohol trials and appears to have influenced much of the research in this field. It is exemplified in the work of Holder and colleagues in the USA (e.g. Holder, 1998 and publications listed under the Community Trials Program in Appendix 3).

Holder (1998, p. 10) describes 'a new paradigm for prevention', which enables us to see the community as a 'system':

*... best understood as a whole composed of a set of interacting parts or subsystems. Each subsystem has its own organizing processes that influence, and in turn are influenced by, other subsystems.*

The community is conceptualised as a dynamic, complex, interacting system composed of a number of subsystems that influence alcohol use and contribute to alcohol-related problems, and which themselves adapt to changing circumstances.

Placing 'consumption' as the central subsystem in his model, Holder suggests five

other subsystems that impact on consumption. These are:

- retail sales subsystem (alcohol availability and promotion)
- formal regulation and control subsystem (rules, administration and enforcement)
- social norms subsystem (community values and social influences that affect drinking)
- legal sanctions subsystem (prohibited uses of alcohol)
- social, economic and health consequences subsystem (community identification of, and organised responses to, alcohol problems).

Programmes that explicitly adopt a systems framework for action tend towards a 'top-down' approach led by project management and research groups; they adopt goal-oriented interventions and, normally, control (or at least comparison) areas are chosen; intensive programme evaluation is built into the design of the project. However, to varying degrees, almost all programmes also include components or interventions designed to mobilise the community and encourage some 'bottom-up' participation. Romelsjö *et al.* (1993), for instance, describe a procedure common to other programmes, whereby the work is initiated 'from above' but aims to replace this with 'bottom-up' activities. Linked to this, most programmes also use a range of models stemming from 'community action' approaches, particularly in developing programme implementation.

### A 'community action' approach

A second body of theory informing the development of most programmes and the understanding of social change comes from the tradition of community action. This has had a strong influence on programme design but, as Giesbrecht and Rankin (2000, p. 45) comment, there is a vast variation in community action models including: a 'grass-roots' model linked to revolution or protest; working through the existing community structure such as the mayor and elected representatives; working with local professionals in such a way that community members are placed in a largely passive role; and the use of financial incentives to encourage community action. Each approach differs somewhat in the extent to which local people or groups control and 'own' the project, and in the extent and nature of the involvement of non-professionals. The recent rise of the 'capacity-building' model in the UK could be added to the list of action models. Frequently, programmes employ one or more of such approaches, both to inform overall design and to guide a 'community mobilisation' component.

Action theory tends to underpin many of the individual programme components and the conceptualisation of how programmes should be implemented and evaluated. Holmila (1997), for instance, describes the community as 'a system of everyday life' and sees action as directed towards altering the community structures and dynamics that give rise to the problems. At the same time, she argues the case for a naturalistic approach to community-based programmes, which:

*... develops meaningful involvement of local citizens and professionals in the design*

*and implementation of the community's development.*  
(Holmila, 2003, p. 82)

Using this approach, intervention aims to provide information and encouragement to communities rather than imposing a goal-oriented programme led from outside the community. Typically, local people are involved in identifying problems and in the design and implementation of programmes. A main aim is to encourage local ownership and facilitate long-term change. Control areas are rarely part of the design and more importance is given to process evaluation compared to outcome measures.

Box 10 provides an indication of the aims and theoretical models underpinning a sample of programmes initiated since 1996 and described in the literature. The 'Partysafe' programme (Midford *et al.*, 2003) in Australia provides a good illustration of a combination of a systems approach – in the conceptualisation of 'community' and of the programme – and a community action approach to inform the implementation process of the programme.

#### **Box 10 Aims and theoretical models: programmes post-1996 where there is at least one published paper**

*Operation Safe Crossing, USA (Voas et al., 2002)*

**Aim:** To reduce the number of youths crossing the USA/Mexican border to drink in Tijuana, their returning blood alcohol counts (BACs) and reductions in alcohol-

*Continued*

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related crashes – by: creating an environment that is less tolerant and facilitative of this behaviour, and increasing awareness of heightened enforcement at the border.

Model: Implicit – systems approach ‘Built on the procedures developed in the Community Trials Programme’.

*Florence (Scandicci) Community Alcohol Action Project (Allamani et al., 2003)*

Aim: To promote responsible drinking and to prevent alcohol-related problems in the sectors of health, school and possibly traffic – by: facilitating community interaction and activating local resources; planning training courses; awareness created from within the community and the programme, and through use of the media.

Model: Implicit – community action approach but initiated and led to some extent by professionals; described as a ‘down-top’ approach because of its focus on local resources and stakeholders.

*Stockholm Prevents Alcohol and Drug Problems (STAD) (Wallin et al., 2003a, 2003b, 2004; Wallin, 2004)*

Aim: To decrease problems related to alcohol consumption at licensed premises by: adopting a multi-

*Continued*

component strategy based on local mobilisation; training in responsible beverage service; monitoring alcohol service at licensed premises regulated by the alcohol laws.

Model: Explicit – systems approach based on Holder (1998).

*Auckland Regional Community Action Project, New Zealand (Casswell et al., 2003)*

Aim: To reduce alcohol-related harm for young people by: engaging organisations across the Auckland region in collaborative, evidence-based activity.

Model: Implicit – systems approach; environmental and policy action approaches favoured – reflecting research evidence (e.g. Holder and Reynolds, 1998).

*Carnarvon Partysafe Project, Australia (Cooper et al., 2001, 2003; Midford et al., 2003)*

Aim: To prevent alcohol harm in high-consumption rural communities associated with drinking in non-licensed settings by: awareness activities and linking into Christmas collaborative campaign, which included community mobilisation and other action to alter drinking contexts/settings.

*Continued*

Model: Explicit – systems approach (conceptualisation of the community); community action approach (programme implementation):

*The methodology deliberately emphasised local involvement in decision-making and flexibility in responding to local concerns, rather than research control of the implementation process.*

In the UK scoping sample, theoretically informed conceptualisation of the programme as a whole was rare but there was a greater tendency to use theoretical frameworks to determine how strategies and activities should be implemented.

### Conclusion

Arguing the case for a sound logic model, Giesbrecht and Rankin (2000) suggest that project teams should provide a conceptual perspective about:

- the nature of communities
- the nature of organisations, systems and their operation
- perceived causes of problems related to alcohol use
- social change and prevention.

Action plans should draw on available evidence of effectiveness of interventions in developing components but recognise that a fundamental element of a multi-component approach is the synergistic effects of components working in parallel or sequentially to secure positive changes. Different theoretical frames may be appropriate in designing the programme as a whole, in informing programme implementation, and in guiding individual components and sets of activities.

An explicit conceptual and theoretical framework for the development of initiatives and for evaluating the programme is a key factor in understanding why some components, activities or programmes may work and others may not.

## 5 Key factors influencing programme development and implementation

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### Policy tensions: national–local contexts

The influence of national, and increasingly international, policy clearly impacts on action at local level (e.g. Giesbrecht and Rankin, 2000; Holmila, 2000; Larsson and Hanson, 2000). As mentioned earlier, the increasing lessening of state control mechanisms, and devolution of responsibility for action to regional and local authorities, brings problems as well as the possibility of greater local powers to identify needs and develop appropriate responses.

In the UK, the opportunities afforded by the decentralisation of policy development and implementation have been welcomed, but tensions within national alcohol policies and their effects on local action have been widely debated in the literature (e.g. Room, 2004). In particular, critics have highlighted a perceived imbalance between population-level measures to address alcohol consumption and policies that emphasise harm reduction, which, it is argued, focus attention on criminal justice responses and the visible public health aspects of harm, to the neglect of broader health concerns. The impact on local policy was discussed by scoping respondents and provided examples of perceived policy tensions.

It was felt that national priorities are not always relevant to local concerns and that there is confusion in policy aims. The effects of a perceived bias towards criminal justice responses were felt to impact on local efforts and on resource allocation:

*Violent crime has been the primary focus of where the Government is heading in the next few months because it's the quick-win situation. If you reduce binge drinking in city centres you*

*can reduce violent crime by 70 per cent plus, but it won't tackle the long-term cultural need to shift. And it won't touch chaotic offenders at all.*  
(Alcohol lead for DAAT, Midlands)

Criticism was levelled particularly by health professionals and those concerned about the treatment response:

*With the development of the national Alcohol Harm Reduction Strategy ... alcohol is largely absent from anyone's strategic thinking ... We have some treatment programmes but what you'll often find is that there's a real emphasis or there's an increasing emphasis on enforcement because of the anti-social behaviour agenda, but there isn't a concomitant prevention or social care response.*  
(DAAT co-ordinator, London suburb)

It was also felt that the failure to include an action plan was unhelpful and would make it difficult to prioritise alcohol – especially health aspects – at local level:

*I think the Alcohol Harm Reduction Strategy sets out all the stuff that needs to be done and I think that in itself it is quite a good document. It says what we need to do, but it doesn't do any of it ... there are no action words in the strategy – it's all about research ... collecting information, in other words it's still a strategy, not an action plan. One of the things about an action plan is that it needs to say, because this is the way the world works, that health needs to be told 'you will be measured on the number of alcohol-related deaths that occur in your area'. If they're not measured, they will not give priority to it. It's the same for everybody.*  
(Community safety co-ordinator, South West)

Critics have also pointed out that constant reviews from central government, particularly with respect to community safety targets, have created competing and additional demands on local agencies (Alcohol Concern, 2004; Jayatilaka, 2004). This was commented on in scoping interviews:

*Historically, I think the way that local government, and probably central government, too, has worked, has been to have far too many targets and priorities, which ultimately have the capacity to nullify one another. Because there are so many you can't keep track of them and different ones contradict others.*

(DAAT co-ordinator, London suburb)

The extent to which national policy and guidance frameworks constrain local developments, and how different local authorities respond to national frameworks, is an area for further research. Clearly, programme development requires a considerable effort to map out the national–local interface, profile the target community and consider the specific needs of the community in relation to national frameworks and targets. However, current development of local alcohol strategies and action plans could draw on a multi-component approach both in conceptualising the problems and in designing implementation and evaluation. Inclusion of components targeting health and treatment issues could also be considered as part of a more comprehensive approach.

### **Transferring multi-component approaches**

The transference of policy, service or other response models is neither new nor unique

to the alcohol field. Temperance, Alcoholics Anonymous, drug courts and peer education are examples of models that have spread internationally in response to social problems.

Examples given by scoping respondents illustrated that drawing on apparently successful projects or initiatives (rather than whole programmes) was commonplace, but we have no information on how frequently this occurs or about the experience of transferring project ideas from area to area. Scoping sample respondents reported a tendency for projects and activities that appear to work in one local setting to be taken up and applied elsewhere, sometimes without any specific evidence that the model would transfer successfully. A typical response to the development of new initiatives was:

*'Beg, borrow or steal' – a pragmatic approach.*

The approach rested on an assessment of the situation informed by available data, local knowledge and the development of a local alcohol strategy or action plan. Decisions often depended as much on consultation and visits from local officials to other areas or countries as on any research evidence. The Manchester City Safe project and the Niterider scheme in Leicester were specifically cited as excellent role models because of achieving extraordinary reductions in alcohol-related violent crime. In 'borrowing' these models, there was mutual collaboration in the exchange of ideas, with advice being given on how programmes might be adapted. However, there was sometimes unforeseen local activity detrimental to the transferred schemes. One example was the Niterider scheme, a late-night bus service established to address the problem of dispersal.

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This had been adopted in another city centre but bus fares were undercut by local taxis, which meant that bus companies risked losing their profits and the service risked closure; taxis could then increase prices.

Borrowing also took place from responses to other social problems; experience from the drugs field was mentioned in particular. Existing partnerships and structures were familiar and could be adapted for alcohol, and the obligations regarding accountability for resources were already known.

### Transferable principles

Given that communities and local areas vary enormously, it would be difficult to formulate guidelines to assess the viability of specific approaches and actions in transferring programmes from one local context to another. However, a number of *transferable principles* emerge from the literature, which can be used in 'borrowing' initiatives or components to develop multi-component approaches in any area.

- Develop a sound theoretical base for the programme, which considers the problem, the community and the rationale for the programme.
- Take account of available research evidence and what has worked elsewhere.
- Have a clear profile of the community, taking account of diversity of population groups, values, knowledge and interests, and the potential for gaining support for the initiative.

- Consider the possibilities and limits of community involvement and the possible unexpected effects.
- Look at local resources, priorities, capacity to take on the initiative (component or new programme) and opportunities to link with existing partnerships and coalitions.
- Develop an action plan, an implementation strategy and an evaluation plan.

In sum, the multi-component programme model has been transferred already across national boundaries, but the extent to which programme models, components and evaluation designs can be 'imported' from one national context to another – or even from one local context to another – requires further investigation. General principles and key approaches that are based on theory and research evidence are likely to be relevant but need to be reviewed in relation to local needs, structures and perceptions on the problem and adapted accordingly. In this respect, the results from the AERC programmes, built on Holder's community systems model, will be important.

### Alcohol-focused or embedded programmes?

There appears to be a difference of opinion regarding the value of mounting alcohol-focused programmes compared to embedding a response to alcohol within other initiatives. Both approaches offer advantages and disadvantages.

Embedded within other initiatives, alcohol problems can be framed in a variety of ways

that may help to 'sell' the importance of tackling alcohol-related harm to local communities and preserve perceptions of *issue relevance*. It may help to prevent *issue fatigue* – the feeling that the problem has been dealt with already, nothing more can be done or, quite simply, boredom. In the current UK context, this approach may also provide better opportunities to secure resources. As one respondent commented:

*I think there are going to be tremendous openings for people embedded in the alcohol field to actually bid to various partnerships to develop this work for them, to develop partnerships, strategies – there are tremendous opportunities. I'm very keen on developing this approach. I just think we need a partnership and enable-all approach that encompasses everything from awareness raising through to detox and rehab.*

(Health promotion specialist, Home Counties)

Allocation of resources is likely to rest on perceptions of *issue status* in relation to other local concerns and priorities. While embedding may enhance issue relevance by demonstrating the important links between problem alcohol use and other harms, it could be seen to reduce issue status, with possible longer-term implications for sustaining action on alcohol as changes occur in community agendas.

A further danger is that embedding of alcohol issues may miss dealing with some important elements of harm. For instance, some agendas – such as community safety and 'safer cities' – focus on more visible public health aspects of problem alcohol use, to the neglect of chronic alcohol problems and more hidden problems such as alcohol-related domestic violence.

The 'embedded' approach seems to be occurring with increasing frequency; but we do not know whether this will result in a higher profile for alcohol on local policy agendas, with a better chance of developing long-term, stable policies and community structures that will result in cultural change and a decrease in alcohol-related harms.

Again, prior to mounting programmes, community profiling requires analysis of existing policies, partnerships and implementation structures, and an assessment of the viability of 'focused' compared to 'embedded' approaches. Access to resources is a major consideration and it has to be kept in mind that most of the multi-component programmes reviewed were at least partially supported by additional funds.

### **Mobilising communities**

#### **Community diversity**

Consistent with the community action (or community organisation) approach that informs most multi-component programmes, community 'mobilisation' is a central part of the programme, sometimes reported as one of the components. However, a major issue running through community action programmes is the extent to which mobilisation is based on an assumption that a community is a homogeneous population moving towards agreed goals and shared values, or on the understanding that community is a complex mix of people with different values, knowledge and interests. Underlying assumptions about the community are likely to steer mobilisation efforts, for instance, towards gaining the support and involvement of all members, or towards a focus

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on identifying and mobilising leaders and groups already sympathetic to the proposed interventions (US Department of Health and Human Services, 2000).

Typically, programmes in the literature and those identified in the scoping sample employed an area definition of 'community' and provided examples of the importance of community diversity in developing mobilisation. Different approaches were needed in areas with stable populations compared to areas with a high proportion of transient population; some communities were more 'bounded' and self-contained, and others more 'diffuse' and less easy to separate for implementing and evaluating action; some local groups were easier than others to engage in alcohol-prevention activities; rural communities had different social and environmental drivers of alcohol problems compared to urban communities.

- The Partysafe Project (Midford *et al.*, 2003), for example, was located in an isolated, discrete community with well-established community structures and relatively low population turnover where contact between the project officer, local networks and citizens was frequent and informal.
- By contrast, Operation Safe Crossing (Voas *et al.*, 2002), concerned with youths involved in crossing to Mexico for binge-drinking sessions, was dealing with a transient group, scattered throughout and outside the San Diego area.
- Commenting on the Metropolitan Suburbs Project, Holmila (2003) drew attention to the loose social structure of

the suburbs and the rapidly changing population, which made it difficult for the municipality to operate through informal community structures.

- What Holder (1997, p. 35) calls 'invented communities' – defined specifically for the purposes of the intervention or inherently unstable because of the nature of the population – will pose different and possibly more intractable problems of mobilisation, and of sustaining support for and involvement in interventions.

Scoping sample communities were also based largely on area definitions with 'city centres' frequently defined as a priority for action. City centres tended to be characterised by transient populations: employers and employees, students in temporary accommodation, visitors in general and visitors specifically to the night-time economy. Because the community is not cohesive, specific populations had to be identified and addressed.

- In one city centre, safer drinking information was disseminated via email to organisations, many of them businesses, with the expectation that messages would be cascaded to employees, reaching an audience of up to half a million people.
- By contrast, in one rural commuter area, there were tremendous problems in identifying and reaching communities, largely because of the complexity of its geography and administrative boundaries. This area in the Home Counties was officially classified as a rural area, with 70 per cent of the

workforce commuting to London and neighbouring towns, leaving behind the school population and older people as the resident communities. Extremes of wealth and poverty co-existed within this five-mile radius of 'manicured suburbia', and motorways traversing the area provided easy access and escape routes for criminal activity. Because of its status as metropolitan green belt, affordable housing development was highly restricted, which limited community sustainability.

- There was no direct initiative to tackle alcohol-related crime in this area as yet, although it was partially addressed through the domestic violence agenda.
- The needs of minority groups were not specifically targeted in the UK projects. Two respondents in the Home Counties commented on alcohol-related violence associated with travellers whose needs were being addressed largely via education measures. Due to the transient and less organised nature of the travelling community, these measures were expected to have limited effects.

Factors other than area diversity also influenced the extent and nature of community mobilisation. For instance, the aims of mobilisation differed. In the Community Trials Project, mobilisation was seen as a means of supporting other strategies and was not an end in itself (Treno and Holder, 1997a). Other programmes (e.g. the Kirseberg Project, Sweden) identified community mobilisation as a legitimate end goal for action, helping

to 'empower' communities, develop a sense of ownership and build capacity to develop longer-term, sustainable policy and strategy to tackle alcohol misuse (Hanson *et al.*, 2000).

The extent of citizen involvement also varied from working through community gatekeepers or leaders as opposed to involving citizens more directly; involving the 'community' (or some part of it) in decision-making processes and in implementing strategy, or confining involvement to consultation alone; using 'awareness campaigns' to gain support for policy action without requiring greater citizen engagement.

For the scoping sample respondents, community involvement typically meant public consultation, mostly concerning community safety issues; it was less about creating strategies and structures for community participation in projects – as in many of the international programmes. Consultation generally provided data in order to prioritise local objectives and helped to identify solutions to alcohol-related problems. For example, a suggestion to expand non-licensed premises to provide alternative places to socialise had emerged from a young people's conference. Raising awareness and providing advice and information about alcohol were aspects of broader alcohol strategies that linked into more targeted initiatives. The role of communities in the UK programmes was, therefore, a limited one.

### **The risk of disrupting communities**

There are many examples of the difficulties and limitations in trying to implement the ideal of gaining and keeping community support and involvement (e.g. Casswell, 2000; Allamani *et al.*, 2003; Shiner *et al.*, 2004). Such problems include:

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- the tensions that are likely to arise between the expectations and understandings of different groups regarding, for instance, the major aims of the programme
- the role of 'the community' in relation to professionals, power sharing and decision making
- conflicting priorities in allocating resources
- taking account of the possible effects of interventions on social cohesion, social capital and existing structures and networks
- the possibility that action may increase the exclusion of some groups (e.g. the young and most disadvantaged)
- assessing the limits of community willingness and ability to participate.

Two examples from the scoping sample illustrate the common difficulty of negotiating action taking account of competing interests within the community.

- In an area in the Home Counties, a lack of youth facilities was identified and youth activity provision was incorporated into an action plan; but, simultaneously, the fear of crime in the local community needed to be addressed and action had to be taken to ensure that the youth project did not increase local fears.
- In the North West, only a third of licensees in one town had signed up to Pubwatch schemes and there was a continuing problem of service to under-

age drinkers. This was explained by the respondent as due to the fact that many pub and club owners were not local residents and were employed by large corporate companies.

As earlier UK research has shown (Shiner *et al.*, 2004), initiating change in local communities may have unexpected and unwanted effects. This is acknowledged by Moore and Holder (2003, p. 43) who comment on how community prevention is:

*... inherently disruptive to existing social and economic arrangements in the community because it disturbs the system.*

The risk of disruption from community prevention projects to existing coalitions and governance structures emerges from the findings of several programmes.

- Treno and Holder (1997c), reporting on the Community Trials Southern California site, found a breakdown of relationships between an existing alcohol and drug coalition and the incoming alcohol trauma prevention programme.
- In Finland, Warpenius (2003, p. 128) described how a national initiative to establish a network of municipal prevention workers created difficulties because 'municipal professionals were likely to guard their own professional interests or to be limited by their scholarly perspectives'.
- It has been suggested that the effects of system disruption may be greater, or more feared, in some communities than in others – for instance, in smaller

communities or suburban areas, especially if action involves risk or confrontation. This may make it more difficult to mobilise and involve citizens (Perry *et al.*, 2000; Holmila, 2003).

- Action programmes may also risk damaging the 'social capital' of some groups more than others by destroying or disrupting opportunities to communicate and participate socially without providing viable alternatives (Casswell, 2000).

The effects on communities of treating 'the community' as the unit for intervention and of adopting multi-component alcohol programmes to tackle harms are still unclear. Concerns, relevant to the current UK situation, have been sketched out by Casswell (2000, p. 70) and these could form the basis of further investigation.

- How do the programmes impact on different sectors of the community, particularly the most disadvantaged?
- What is a realistic level of citizen involvement and how is this influenced by the structures and the investments in human and social capital that are made in the project?
- Can the tensions between institutional/professional goals and those in the project be resolved?
- How do the projects affect, if at all, the social cohesion within the community? And does it matter?

While arguments have been made for mounting demonstration programmes in

communities that are already supportive of change, it is possible that the development of *community readiness to change* might become part of the initiative. Drawing on Prochaska and DiClemente's (1982) cycle of change theory, we could then ask how communities can be moved round the circle from a state of non-contemplation where alcohol policy has low priority to a point where communities are willing to support sufficient and appropriate action to tackle alcohol-related harm. It may be more difficult to come to terms with the recognition that problems are, at least partially, generated from within the community itself, than to look for solutions to problems seen as generated from without or from isolated individual behaviour.

Issues of gaining programme legitimacy and credibility – an important factor in programme success – are contingent on the process and means of involving local people and, above all, of finding ways to initiate and sustain communication, to resolve tensions between different groups and to align the research/action agenda with local interests and concerns (Allamani *et al.*, 2003; Moskalewicz and Zielinski, 2003).

### **Institutionalising change**

Overall, a consensus emerges from the literature that ensuring the sustainability of successful initiatives requires that changes in norms, behaviours and social structures become 'institutionalised' or embedded in local policies, cultures and practices. The emphasis placed on developing local policies is indicative of this aim. A useful definition has been provided by

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Moore and Holder (2003, p. 42):

*Within community prevention, institutionalization can be characterized as the dynamic process of integrating or embedding into the natural structures of institutions within a community strategic programmes designed to reduce or prevent local problems.*

While charismatic leaders, committed volunteers or skilled professionals might be crucial in initiating and implementing projects, 'institutionalisation' increases the chances that initiatives and changes will endure beyond the involvement of specific individuals or groups.

Some programmes have been set up with institutionalisation as a focus for action, often closely allied with mobilisation efforts to ensure local commitment and ownership (e.g. Malczyce, Poland – Moskalewicz and Świątkiewicz, 2000). The sites for a number of multi-component programmes were chosen specifically because the programme organisers felt that the local community was supportive of the initiative (e.g. Community Trials Project – Holder *et al.* 1997a, p. 160).

Stewart and Conway (2000) describe the problems of gaining community support for local committees to tackle drinking and driving, and the 'community battle fatigue' that sets in when too much is expected from local involvement. A shift of focus to sustainable policy development, which entailed preserving and enhancing existing efforts by the police and other authorities, proved more successful. Casswell (2000) draws attention to a further factor, that issue-based action – such as responses to concern over drink-driving or binge drinking – is unlikely to be sustained over a number of years, especially if dependent

on voluntary effort. Alcohol programmes that seek alliances, and possibly become embedded in wider issues such as community safety, may increase the chances of maintaining changes long term. This suggestion is pertinent to considering the development of programmes in the UK context.

### Perceptions on 'institutionalisation' – the scoping sample

*We've begged, borrowed and stolen from local structures, local economy, local ecology where robust partnership arrangements already existed. We have just tried to build on them instead of inventing anything new.*

(Head of DAAT, East)

There was little evidence of preventive initiatives and activity targeting policy changes being aimed directly at alcohol within a 'single-focus' programme. Alcohol misuse was perceived to be a multi-disciplinary problem and therefore rightfully tackled through being embedded within other strategies and action plans. This approach was seen to facilitate negotiation with, and involvement of, partnerships and to ensure that alcohol remained on local agendas:

*It's a difficult one for a partnership. My role is building partnerships. The partnerships all bring their own problems and their own ideas to the table, so for me to turn round and say 'we'll go for just one problem' ... I think you have to get the balance right because they all overlap. Life is too involved, we are talking big issues ... I don't think we could do that one single thing because alcohol-related crime brings through ... domestic violence, children's issues, crime. It brings in one of the major things that everyone forgets ...*

*and that's victims.*

(Community safety officer, North West)

*This isn't just about delivering targets. This is about sustainability of approaches that do get bedded down into the core programme of what people do and I think that is a really positive factor of this way of working.*

(Head of DAAT, South)

Alcohol-related activity currently embedded in other strategies and action plans – notably, community safety, health and education – was sometimes separated out to give it a focus and clear priority setting, and then subsumed back within the broader strategies. By 'reframing' alcohol-related harm as part of a broader concern, it may be possible to avoid or delay a decline over time in public and professional interest in alcohol issues. However, these issues require further research to examine the possibilities and limitations of the approach.

A programme focused on a single issue was perceived to be problematic because of the obligation to address the raft of aims and government targets within the community safety agenda. While there was some belief that the current infrastructure would support a single-issue focus, and the drugs field provided examples of this, the question was whether the key partners would be able to prioritise it within their hierarchy of goals:

*Bits of that [multi-agency work] are going on but without the focus ... in various different districts, written into their action plans in varying degrees, but there's not this single-issue focus. In present climates it's quite difficult to have a single-issue focus because of government targets that are reasonably specific for the anti-social*

*behaviour of the crime and disorder agenda, that you've got to cover all of them, which means of necessity ... it's going to be quite thin. I think that's a difficulty. It's a good thing in a way because it does keep everyone involved ... when it comes to let's say young people's anti-social behaviour, alcohol is only one of the issues within that. Even I would have difficulty in saying we should look at the alcohol aspects of it solely.*

(Health promotion specialist, Home Counties)

One respondent identified timing as a critical factor in UK studies not opting for the single-issue approach; he believed that the alcohol agenda was in a transitional state and the Government would prioritise it to the same extent as drugs within the next few years. In the meantime, especially in some areas with limited resources, alcohol had been included within headings identified within the drugs strand of community safety: enforcement, education, supply and young people, which overlapped with the aims of the national Alcohol Harm Reduction Strategy.

For changes to become institutionalised, there is a need for sustainability mechanisms to be built in as an integral aspect of project development. This requires a commitment to dedicated alcohol resources, in terms of both funding and agency staffing. In some UK projects, lack of continuity of funding was identified as a problem impacting on sustainability. Furthermore, funding for alcohol services is confusing, as services are not funded directly but via DAAT monies or procured indirectly from other sources such as domestic violence funding:

*A while back we got some money from health*

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*to do a youth diversion thing about encouraging young people to play football and we got it from health on the basis that it contributed to the work on preventing heart disease. As soon as the money dried up that was it ... the priority changes and what you're measured on changes your priorities.*

(Community safety co-ordinator, South West)

In terms of staffing, dedicated alcohol workers and a commitment from agencies to alcohol-related responsibilities were perceived to enhance project sustainability. A key professional alcohol worker could act as the centre of umbrella co-ordination that was needed. He or she could maintain existing partnerships, create new alliances and initiate a forum for exchange of ideas, together with providing an overview of work in the field and identifying opportunities for development. Building key responsibilities within the roles of agency staff was needed:

*With any multi-agency sort of work and problem-solving work where you are working with a problem that's happening right here, right now, you are asking agencies to work beyond their remit to a certain extent. You are asking people to work beyond their job description ... so you are asking for a culture change within some agencies.*

(Project manager, Shire Counties local authority)

Two respondents advocated the role of voluntary agencies as mechanisms for institutionalising change within communities. Diversionary projects such as Saturday football clubs were promoted as making a real difference to the structure of community values and norms. However, the emphasis in the literature

on developing local policy and on mobilising communities was not apparent in responses from the scoping sample.

Further challenges to achieving sustainability involve both recognising the potential for alcohol programmes and keeping track of programme development. This was noted with respect to the SARA model, described earlier. The model has a dynamic aspect built into it – projects need to be revisited and revised. At the same time, its inherent flexibility can be problematic. As more local information becomes available and is acted upon, a project's original goals and the ability to maintain programmes can be lost from sight.

Respondents felt that minor temporary changes in perceptions of alcohol would occur almost incidentally through any harm reduction or community safety activity. However, while changing community structures and values was part of respondents' hopes and aspirations for longer-term change, there was also a belief that government directives were required alongside local activity to bring about enduring changes in community norms and values:

*I would say that that sort of change is more about national activity than local activity. I don't think there's very much that we in a city or in any local area can do to change the overall perceptions of alcohol when you're competing against television advertising, media, all that stuff. Unless there's a clear lead from Government that kind of thing can't happen to change local perceptions ... there may be some incidental community perception benefits as a result of success in anything we do but I don't think it will change societal attitudes to alcohol.*

(Community safety co-ordinator, South West)

This compares with the view emerging from the international literature that policy change at the local level is not only possible but also an effective method of achieving long-term changes in local structures and approaches to tackling alcohol-related harm, and in changing attitudes and negative aspects of drinking cultures.

### Pointers to institutionalising change

Based on experiences from the Community Trials Project, Moore and Holder (2003, p. 52) list a number of factors that they consider essential to institutionalisation:

- community leadership to endorse and legitimise the prevention programme (e.g. police chiefs, mayor, city council)
- use of local, indigenous staff known to the leadership and knowledgeable about the community
- building local alcohol policies into existing organisational structures and connected to existing patterns and preferences for action
- use of media advocacy as a tool to bring about change but also to support local ownership of the programme
- making use of local alliances, which recognises that there are other health and safety problems with their own coalitions and advocacy groups; joint action may be more effective
- accommodating staff changes in key organisations – institutionalisation may require repeat training and education of staff if, for example, there was frequent staff turnover

- seeking additional resources from local, regional and national sources
- working within local politics; support for the programme may depend on factors such as an upcoming local election or the internal politics of a police department
- incorporating and recognising local cultural values; recognise and manage possible tensions with the design of a scientifically based programme.

Results from the COMPARI project in Australia are also useful in considering the factors that may help to sustain positive change over time (Midford *et al.*, 2005). Follow-up interviews found that the original focus and core values of the project had not been fully retained and the original community prevention focus had been diluted, with more emphasis going on individual prevention through education and training. Nevertheless:

*The original project initiated cultural and structural change in the way alcohol problems are dealt with in Geraldton and this has produced an ongoing benefit for the community. (Midford et al., 2005, p. 3)*

Box 11 indicates some of the key factors that helped to ensure that the project endured and evolved to meet changing circumstances. As the researchers comment, it was 'sustained because it undertook to become an integrated alcohol and drug service agency for a region of the state'. While this inevitably brought costs (greater professional compared to community control), it also resulted in a culture of intersectoral collaboration, which contributed to better use of resources and sustained awareness of alcohol issues.

### Box 11 Factors in programme sustainability

- Influence of the COMPARI steering committee – set up the Community Drug Service Team (CDST).
- Able to secure resources.
- The COMPARI name was retained after the project closed – high profile and good reputation.
- Project brought skilled staff to the area and they set up other projects in the region.
- Established good community networks and greater interagency collaboration (but links are reported to have weakened over time).
- Increased community awareness of alcohol problems.
- Established ethos of community ownership/empowerment (deteriorating over time as professionals began to dominate the steering committee and CDST set up).
- Perceived (positive) changes in the way Geraldton dealt with alcohol problems.
- Ability to adapt to changing circumstances.

(Midford *et al.*, 2005)

### Conclusion

This chapter has illustrated some of the key issues in developing and implementing multi-component programmes and sustaining change.

The value of gaining the support and involvement of local people was recognised both in the literature and by scoping respondents. There is an extensive literature, which offers a variety of models for community engagement but which also highlights the problems and pitfalls that can act as barriers to successful implementation, result in tokenism rather than power sharing or disrupt existing systems and networks without necessarily achieving positive change. The constraints imposed on local action by national policy need to be taken into account, but reports from scoping respondents indicated a range of action already taking place to implement national goals. The literature provides a useful guide for local planning. However, a comprehensive area and community profile is also important and should be a key part of programme design and evaluation. While the programmes reviewed in the literature were largely focused on alcohol (single issue), programmes reported by scoping respondents tended to be based on 'partnership' approaches and action on alcohol was often part of programmes to tackle other local issues. An embedded approach may have disadvantages in removing the focus from alcohol but may be better suited to current UK local contexts, and may be more flexible and responsive to changes in community structures and resources. Embedding alcohol action within wider criminal justice, community safety and health agendas may result in more sustainable, long-term change.

# Endnote

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## Multi-component programmes: the potential for local action

As a reminder of the period of time over which we have been moving in the direction of developing a comprehensive, sustainable response at local level, we can look back at a 1986 publication on *Preventing Alcohol Problems: A Guide to Local Action* in which the authors commented:

*The effectiveness of any local prevention strategy depends on the cumulative impact of a wide range of prevention activities involving many different organisations and groups. Any integrated strategy should include a range of activities which covers each of the three basic prevention foci which were identified earlier – problem drinkers, drinking habits, and alcohol itself. Any strategy which emphasises one particular component – such as control over the availability of alcohol – to the exclusion of the other two would be unbalanced and would not draw on the full range of local prevention resources.*

(Tether and Robinson, 1986, p. 8)

There is a good case to be made for shifting the emphasis from individually oriented interventions to focus on policy-based interventions to initiate change at local community level. Although the politics of alcohol is likely to remain a contentious backdrop to addressing alcohol-related harm at both national and local levels, the recent publication of the *Alcohol Harm Reduction Strategy for England* (Prime Minister's Strategy Unit, 2004), the Licensing Act 2003 and the ensuing debates have raised the profile of alcohol and provided an impetus for renewed

effort to examine what can be achieved by local action. The involvement of local communities in implementing alcohol policy is a key part of national strategy that places *responsibility* for tackling harm on local authorities alongside the State, the industry and the individual.

International research provides considerable support for encouraging community alcohol intervention programmes. This report has highlighted some of the key constraints and difficulties in adopting multi-component community programmes as a mechanism for tackling problem alcohol use. However, examination of the literature suggests that multi-component approaches to prevent and reduce harm offer a promising way forward. While the outcome of action depends on many factors – not least the local context and available resources – the chances of success are improved through the creation of strong infrastructures to promote change. The latter includes the development of local partnerships and networks, the development of local policy and the appropriate mobilisation of local communities to support the programmes. Many of the programmes described in the literature (including the current AERC programmes) were based in areas where local interest and commitment (e.g. through joint funding) had been demonstrated. Although this is a relevant factor in area selection, especially where resources are limited, it would be worth exploring the extent to which communities with different levels of commitment could be 'shifted' towards greater awareness of the value of adopting a community prevention programme as opposed to mounting projects targeted at changing individual behaviour.

While the term 'multi-component

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programme' may not be widely used in the UK, many local areas appear to have developed, or are in the process of developing, local strategies and structures for tackling alcohol-related harm that employ similar approaches to multi-component programmes described in this report. Partnership and multi-agency approaches have been emerging over recent years and, in some local areas, these have resulted in both 'alcohol-focused' and 'alcohol-embedded' programmes to tackle local problems. Better use of explicit conceptual frameworks to inform the design, implementation and evaluation of programmes would be helpful in understanding what works and what does not. In particular, evaluation that incorporates a narrative description of the process of programme implementation would improve understanding of success factors and of the extent to which particular initiatives may be transferred to other local settings.

In mounting programmes, greater consideration of sustainability and 'institutionalisation' of change is needed. Many programmes are developed using limited, short-term resources; they sometimes rely on 'charismatic' leadership in the local community or on the input from research teams; few include evaluation of the programme as a whole as opposed to individual projects. These factors result in lack of knowledge about what happens once a research-supported (or non-evaluated) programme has ended. The question of sustainability is itself problematic. As communities and local areas change, some programmes or initiatives may no longer address local needs. To prepare for this, consideration of long-term action

should, therefore, include ways of developing flexibility in systems, partnerships, networks and responses, and consider how best to keep alcohol on the agenda.

In the wake of the *Alcohol Harm Reduction Strategy for England* (Prime Minister's Strategy Unit, 2004), new organisational structures have been emerging at local level. In future, Primary Care Trusts are expected to play a bigger role in prevention through the provision of screening and early intervention services. This is likely to have implications for priority setting and resource allocation, and may have an impact on existing power and decision-making networks. In some areas, alcohol co-ordinators have been appointed to forward the formulation and implementation of local policy. Based sometimes within local councils or as part of Drug and Alcohol Action Teams, they have a mobilisation role, aiming to ensure that alcohol issues are represented on local policy agendas. How they function appears to differ from one area to another. Equally, the Licensing Act 2003 has led to the formation of licensing teams, networks and partnerships centred around enforcement responses. In sum, local structures and networks are currently in a state of flux, with considerable differences emerging between areas in the types and structures of networks and in modes of working. The development of multi-component (or partnership) approaches within local areas offers a promising way forward in tackling alcohol-related harm; but such initiatives require monitoring and evaluation, especially in the context of changes and differences in resources, organisational structures and the needs of different areas.

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# Appendix 1

## List of multi-component programmes

**Table A1.1 Multi-component programmes identified from the literature and expert consultation**

Name of project	Country	Project duration
Saving Lives Program	USA	1988–93
Project Northland	USA	1990–95
California Community Planning Demonstration Project	USA	1990–95
Community Trials Program	USA	1991–96
Communities Mobilising for Change on Alcohol (CMCA)	USA	1992–95
Operation Safe Crossing	USA	1997–99
Sacramento Neighborhood Alcohol Prevention Project	USA	Five-year project
Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI)	Australia	1992–95
Surfers' Paradise Safety Action Project	Australia	1993–ongoing
Carnarvon Partysafe Project	Australia	1999–2001
Let's Talk – youth-initiated community forums about alcohol and other drugs (alcohol and drugs project)	Australia	2003–05
School Leavers' Project	Australia	Three-year project
Community Alcohol Harm Prevention Project, Kalgoorlie	Australia	Four-year project
Alcohol Action in Rural Communities (AARC), New South Wales	Australia	Five-year project
Maori Drink-drive Programme	New Zealand	1993–95
Waikato Rural Drink-drive Project	New Zealand	1996–98
Youth and Alcohol Project	New Zealand	1997–99
Midlands Community Action Project: reducing alcohol-related harm among young people	New Zealand	2000–04
Auckland Regional Community Action Project on Alcohol (ARCAP)	New Zealand	2001–ongoing (three years)
The Kirseberg Project (demonstration)	Sweden	1988–96
Kungsholmen Project	Sweden	1990–92/ongoing
Stockholm Prevents Alcohol/Drug Problems (STAD)	Sweden	1996–2006
Six Communities Project (alcohol/drugs)	Sweden	2003–05
Lahti Project	Finland	1992–95
Metropolitan Suburbs project	Finland	1997–2000
Local Alcohol Policy Project (PAKKA)	Finland	2004–08
Florence Community Alcohol Action Project	Italy	1992–98
Florence (Scandici) Community Alcohol Action Project	Italy	1998–ongoing

**Table A1.1 Multi-component programmes identified from the literature and expert consultation**

<b>Name of project</b>	<b>Country</b>	<b>Project duration</b>
Drinking and driving related injuries (alcohol / drugs) Florence	Italy	2004–ongoing
Community Action Project, Malczyce	Poland	1994–95
Reducing alcohol-related injury, violence, disorder in the city centre: Glasgow	Scotland	2004–ongoing (four to five years)
Multi-agency, community-based intervention to reduce excessive drinking in Cardiff city centre	Wales	2004–ongoing (two years)
Aquarius South Birmingham community alcohol action research project	England	2004–ongoing (three years)

# Appendix 2

## Programme evaluation

Table A2.1 Programme evaluation

Programme	Outcome measures	Results	Conclusions as reported by authors
Operation Safe Crossing (OSC), USA	<ol style="list-style-type: none"> <li>1 Had-been-drinking crashes.</li> <li>2 Public awareness of OSC programme.</li> <li>3 Population counts of individuals crossing Mexican border into US at weekends.</li> <li>4 Blood alcohol counts (BACs) of returnees.</li> </ol>	<ol style="list-style-type: none"> <li>1 A significant 45.3 per cent reduction in 16–20 year olds had-been-drinking crashes. No significant effect among 21–25 year olds.</li> <li>2 Overall, 50–60 per cent of bar-goers aware of increased enforcement.</li> <li>3 A significant 31.6 per cent reduction in late-night border crossers and a 39.8 per cent decrease in number of under-age drinking pedestrian returnees.</li> <li>4 A significant 29 per cent decrease in ratio of pedestrians with BACs at 0.08 (driving limit).</li> </ol>	Data from varied sources (including comparison sites) suggest that the media and enforcement events supporting OSC are significantly associated with reduced heavy drinking at the USA and Mexican borders.
Saving Lives Program, USA	<ol style="list-style-type: none"> <li>1 Fatal and injury traffic crashes involving alcohol/ not involving alcohol.</li> <li>2 Safety belt and speeding observations.</li> <li>3 Programme awareness.</li> <li>4 Perceptions of enforcement</li> </ol>	<p><i>Programme cities v rest of Massachusetts</i></p> <ol style="list-style-type: none"> <li>1 A significant 25 per cent decrease in fatal crashes and a significant 42 per cent decline in fatal alcohol-related crashes. Total injuries declined by a significant 3 per cent.</li> </ol>	The programme was successful in reducing traffic fatalities but less so in affecting rates of traffic injury, perhaps because of the greater likelihood of alcohol-impaired driving and speeding resulting in fatal crashes than in moderate/severe injuries. Alcohol-

*Continued*

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
	regarding speeding and drink-driving.		
	5 Monitoring of city traffic violations.	<p>2 Significant 17 per cent increase in safety belt use; a significant 43 per cent decrease in speeding vehicles.</p> <p>3 Fifty-four per cent of 15–19 year olds and 40 per cent of adults aware of programme, significantly higher in other areas.</p> <p>4 No change in perceptions of enforcement among adults, but significant increase among teenagers, from 61 to 76 per cent regarding drink-driving and 4 to 45 per cent regarding speeding.</p> <p>5 Speeding violations declined by 14 per cent compared with decrease of 6 per cent in other areas. Drunk-driving declined by 13 per cent but in other areas decreased by 16 per cent.</p> <p><i>Programme cities v comparison cities</i></p> <p>1 Significant 33 per cent decline in fatal crashes and 42 per cent decrease in fatal alcohol-</p>	<p>related fatal crashes also decreased in both other state areas and comparison cities, suggesting a programme effect. All programme communities demonstrated reductions in fatal crashes, attributable to community programme organisation rather than to specific interventions. This programme demonstrated that a community organisational structure that allows local initiatives to be developed can effect reductions in drunk-driving, speeding and fatal traffic crashes.</p>

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## Multi-component programmes

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		related crashes. No significant decline in all categories of injury.	
Project Northland, USA	<ol style="list-style-type: none"> <li>1 Annual student surveys including: (a) alcohol intentions and use of behaviour scales; (b) psychological measures, i.e. peer influence to drink, self-efficacy to resist alcohol, perceived access to alcohol.</li> <li>2 Alcohol purchase attempts by young-looking buyers.</li> <li>3 Parent telephone surveys measuring: acceptability of under-age drinking; permissive norms; alcohol control policy opposition; parental monitoring.</li> </ol>	<ol style="list-style-type: none"> <li>1a Students in intervention schools were significantly less likely to increase alcohol usage after Phase 1 (for tendency to use alcohol; past month use and binge drinking measures) than in reference areas. After Phase 2, students in intervention schools were significantly less likely to increase tendency to use alcohol and binge drinking. Past month alcohol use was only marginally affected. During the Interim Phase (minimal intervention), students in intervention schools were more likely to increase alcohol use and binge drinking.</li> <li>1b Students in intervention schools were significantly less likely to increase their perceptions</li> </ol>	<p>In Phase 1, most success was shown for interventions focusing on peer influence and social skills development among younger adolescents, most of whom were non-users at baseline. However the wider social environment was less affected during Phase 1 (as measured by access to alcohol). There are complex reasons why increases in alcohol use among intervention students were found in the Interim Phase. Multi-level targeting of high school students' access to alcohol and changing community norms is effective in reducing alcohol use. Typically, under-age young people engage in more binge drinking, therefore the reduction obtained in self-reported binge drinking is important. Significant changes across psychosocial measures were</p>

*Continued*

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		<p>of peer influence in using alcohol and perceived access to alcohol in Phase 1. During Phase 2, there was no difference between intervention and reference schools. In the Interim Phase, intervention school students were more likely to perceive peers to be influential in using alcohol and more likely to decrease their self-efficacy to refuse alcohol.</p> <p>2 A significant 46 per cent reduction in potential under-age purchases from all outlets and 82 per cent reduction in off-sales outlets in intervention communities after Phase 2. None achieved after Phase 1.</p> <p>3 No differences were found between parents in intervention and reference communities during the study, except that, by the end of Phase 2, parents in intervention</p>	<p>obtained for Phase 1, but were not sustained by the end of the study, suggesting that other factors or environmental influences may have been responsible for the initial changes. Important lessons can be learned for prevention work, in particular that change can occur among students in high-risk communities through sustained multi-level interventions. These must be age related, developmentally relevant and carefully planned to retain interest.</p>

*Continued*

## Multi-component programmes

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		communities had significantly less permissive norms than in reference areas.	
Community Prevention Trials, USA	<ol style="list-style-type: none"> <li>1 Self-reported alcohol consumption.</li> <li>2 Self-reported drink-driving.</li> <li>3 Alcohol-related crashes.</li> <li>4 Assault injuries observed in hospital emergency departments.</li> </ol>	<ol style="list-style-type: none"> <li>1 Alcohol consumption per drinking occasion decreased significantly by 6 per cent in intervention communities. Also self-assessed rate of 'having had too much to drink' decreased significantly by 49 per cent.</li> <li>2 There was a 51 per cent reduction in driving 'over the legal limit' in intervention communities.</li> <li>3 Drink-driving crashes declined by 6 per cent and night-time injury crashes (likely to be alcohol related) declined by 10 per cent.</li> <li>4 There was a 43 per cent reduction in assault injuries seen in emergency departments in intervention communities and all</li> </ol>	The findings suggest that comprehensive and co-ordinated community-based environmental programmes can effectively reduce risky drinking and alcohol-involved injuries, resulting from vehicle crashes and assaults presenting in hospital emergency departments or needing hospitalisation.

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Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		hospitalised assault injuries decreased by 2 per cent.	
Communities Mobilising for Change on Alcohol (CMCA), USA	<ol style="list-style-type: none"> <li>1 Surveys of ninth- and twelfth-grade students at baseline; twelfth graders at follow-up and 18–20 year olds measuring alcohol consumption, purchasing behaviour, drink-driving, access to alcohol.</li> <li>2 Telephone surveys of alcoholic beverage merchants.</li> <li>3 Alcohol purchase attempts using young-looking women, on- and off-sale.</li> <li>4 Annual arrests.</li> <li>5 Quarterly traffic crash data.</li> </ol>	<ol style="list-style-type: none"> <li>1 There was a significant overall effect on 18–20 year olds. A lower frequency of 18–20 year olds providing alcohol to minors and a lower likelihood of alcohol buying and consumption was found, but effects were not significant. No significant effects were seen for twelfth-grade students.</li> <li>2 There was a significant overall effect on the practices of on-sale alcohol outlets and a marginally significant effect for off-sale alcohol outlets. Merchants increased proof of age checking, were less likely to sell alcohol to minors and reported more careful control in selling alcohol to young people, but these were not significant effects.</li> </ol>	<p>The project successfully impacted on communities that were randomly selected and did not have any necessary prior interest in young people and associated alcohol issues. It was particularly effective in bringing about change in three of the four target populations. These effects were more significant than those usually found in other school-based interventions. While results for individual outcome measures were not significant, the authors reported that the intervention effects were almost all in the direction of the predicted effects. In the context of impacting on alcohol-related crashes, the authors suggest that a longer intervention period would increase effectiveness.</p>

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## Multi-component programmes

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		<p>3 There was a statistically significant decline in Driving Under Influence (DUI) arrests for 18–20 year olds and a decline approaching significance for DUI arrests and conduct violations among 15–17 year olds.</p> <p>4 There was a decline in traffic crash measures, which was not significant.</p>	
Surfers' Paradise Safety Action Project, Australia	<p>1 Internal environments: risk assessments, e.g. serving practices, alcohol policies, pricing, etc.; venue observations, e.g. physical and social environments, violence, alcohol consumption, etc.</p> <p>2 External environments: security observations; police records.</p>	<p>1 There were significant effects for 14 out of 16 items in Risk Assessment Policy checklist. Venue observation data suggested improvements in responsible hospitality practices; decreases in drunkenness and violence/aggression; attraction of more upmarket, better behaved clientele.</p> <p>2 Security data showed that there were significant declines in incidents (mostly drunk and disorderly</p>	<p>The findings suggest that the project was successful in reducing violence, crime and disorder especially after the introduction of the Code of Practice. Practices associated with irresponsible alcohol use also declined. However, the change to a more upmarket clientele suggested a displacement of problem patrons, which could have affected the impact of the project. Data collected two years later (after project implementation) confirmed that the project had only a</p>

*Continued*

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
Partysafe Project (including Christmas Collaborative Campaigns – CCC), Australia	<ol style="list-style-type: none"> <li>1 Resident survey collecting data on: alcohol consumption and behaviour; alcohol-related issues of concern; awareness and recognition of project-related activities including CCC; behaviour change.</li> <li>2 Key informant interviews, focusing on issues raised in survey.</li> </ol>	<p>behaviour) during development of and after implementation of Code of Practice. There was a 34 per cent decrease in overall assaults at Period 3 (end of project implementation), which approached significance and a significant decline in serious assaults. Drunk and disorderly incidents also declined after introducing Code of Practice.</p> <ol style="list-style-type: none"> <li>1 Survey data identified main target group as 25–45-year-old males. Alcohol consumption rates were significantly higher post-intervention, with females accounting for increase. Male consumption did not change. (Holiday period timing likely to have affected post-intervention results.) Awareness of CCC advertisements in</li> </ol>	<p>successful short-term impact, as violence levels reverted to those before project onset.</p> <p>The project was successful in creating a high level of awareness in the community, particularly via the use of a locally produced cartoon character, which could be adapted to suit different local community needs. The CCC radio advertisements were able to build on local personalities, who were important in highlighting prevention messages. Messages building on local content and</p>

*Continued*

## Multi-component programmes

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		<p>population was significant; 60 per cent heard radio advertisements and recall was significant among drinkers – 65 per cent heard radio advertisements. High recall of alcohol-related newspaper items. Ten per cent changed drinking behaviour. Significant decline in reports of street drinking, from 23 to 12 per cent, and violence, from 6 to 1 per cent, and violent/aggressive behaviour, from 13 to 7 per cent.</p> <p>2 Post-intervention there was greater awareness of alcohol as a serious health problem. There was greater awareness of local Partysafe and CCC campaigns than of state/national campaigns and also of alcohol-related harm prevention programmes in post-survey.</p>	<p>using local media were most salient. There are difficulties in demonstrating direct long-term effects. However, there is greater understanding of how local alcohol harm prevention effects can be developed.</p>

*Continued*

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
Waikato Rural Drink-drive Project, New Zealand*	<ol style="list-style-type: none"> <li>1 Monitoring of alcohol breath tests.</li> <li>2 Alcohol-related road deaths.</li> </ol>	<ol style="list-style-type: none"> <li>1 The number of drivers apprehended with positive alcohol breath tests decreased significantly from one in 35 tests to one in 216 tests. Prosecutions for drink-driving increased by 23 per cent.</li> <li>2 There was a decrease in fatal alcohol-related crashes from 22 to 14 per cent of all fatal crashes.</li> </ol>	Results from the impact evaluation suggested that combined activities resulted in collaboration that produced more effective strategies.
Lahti Project, Finland	<ol style="list-style-type: none"> <li>1 Media attention to alcohol issues as measured by content analysis of alcohol-related articles in newspapers.</li> <li>2 Surveys measuring project awareness.</li> <li>3 Surveys measuring perceptions of alcohol as a serious social problem.</li> <li>4 Surveys assessing public knowledge of alcohol.</li> <li>5 Measures of short-term effects in alcohol consumption and alcohol-related</li> </ol>	<ol style="list-style-type: none"> <li>1 Local media attention to alcohol issues increased, especially regarding preventative messages. One-third of preventative articles mentioned project.</li> <li>2 Campaign activities were remembered by their main target groups at height of their activity, but impact was reduced as activity declined. In March 1994, 42 per cent awareness of Lahti Project was achieved, compared with 30 per cent in</li> </ol>	The prevention activities resulted in a number of changes at the community level. Nevertheless, the findings suggest that the effects of the project were not clear. The economic recession confounded results for diminished alcohol consumption and related harm and official statistics were inadequate for evaluation. Suggestions are given for how evaluation could be designed to be less problematic.

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## Multi-component programmes

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
	harm, e.g. drunken arrests.	December 1994.	
	6 Surveys measuring drinking habits.	<p>3 Public perception of alcohol as a serious social problem increased from 63 to 75 per cent among men, and from 79 to 86 per cent among women, in 18-month period.</p> <p>4 Public knowledge of damaging alcohol levels and drink strength increased significantly. Both were messages featured in media campaigns. Thirty per cent gave correct answers regarding knowledge of alcoholic drink content, increasing to 40 per cent in final survey. No significant changes occurred in perceptions of adverse health effects of drinking, nor of alcohol breakdown rates in the body.</p> <p>5 There was a decline in alcohol consumption but other confounding factors may be influential. Results for alcohol-related</p>	

*Continued*

Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		diseases are based on too small sample sizes. Alcohol-related harm indicators showed declines. However, Finland generally showed declines across all measures.	
		6 Although self-reported heavy drinking showed a decrease, drinking patterns and problem drinking did not show statistically significant effects, but were in the direction of predicted effects.	
Kirseberg Project, Sweden	1 Alcohol consumption measures. 2 Alcohol consumption related problem measures. 3 Exposure to project measured by survey.	1 Alcohol consumption declined among males but not females. 2 Alcohol-related problems showed a statistically significant reduction for males and a decline for binge drinkers, but no reduction among females. 3 The project created high awareness (67 per cent) among the population and 30 per cent identified	The findings are inconclusive, as the project reduced alcohol consumption among the group with highest level of use, i.e. young and middle-aged males. Although these results were not statistically significant, this is the first time alcohol consumption has shown a city-wide decline. The authors discuss the use of quasi-experimental evaluation and measuring the effectiveness

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## Multi-component programmes

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Table A2.1 Programme evaluation (*continued*)

Programme	Outcome measures	Results	Conclusions as reported by authors
		alcohol as the main issue.	of community programmes, which are by nature complex and changing. While acknowledging the need for evaluation, they conclude that the complexity and cost of summative evaluation may be prohibitive factors in evaluating the effectiveness of community programmes.

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\* Results cited in Conway and Casswell (2003); Holder (2004).

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# Appendix 3

## Publications consulted, by programme

This is not a comprehensive list of all publications on multi-component programmes; we did not find publications for some programmes; all the programmes listed are not discussed in the report.

### **Saving Lives Program (USA, 1988–93)**

Hingson, R.W. and Howland, J. (2002) 'Comprehensive community interventions to promote health: implications for college-age drinking problems', *Journal of Studies on Alcohol*, Supplement 14, pp. 226–240

Hingson, R., McGovern, T., Howland, J., Heeren, T., Winter, M. and Zakocs, R. (1996) 'Reducing alcohol-impaired driving in Massachusetts: the Saving Lives Program', *American Journal of Public Health*, Vol. 86, pp. 791–7

### **Project Northland (USA, 1990–95)**

Perry, C.L., Williams, C.L., Veblen-Mortenson, S., Toomey, T.L., Komro, K.A., Anstine, P.S., McGovern, P.B., Finnegan, J.R., Forster, J.L., Wagenaar, A.C and Wolfson, M. (1996) 'Project Northland: outcomes of a communitywide alcohol use prevention program during early adolescence', *American Journal of Public Health*, Vol. 86, pp. 956–65

Perry, C.L., Williams, C.L., Komro, K.A., Veblen-Mortenson, S., Forster, J.L., Bernstein-Lachter, R., Pratt, L.K., Dudovitz, B., Munson, K.A., Farbaksh, K., Finnegan, J.R. and McGovern, P. (2000) 'Project Northland High School Interventions: community action to reduce

adolescent alcohol use', *Health Education and Behaviour*, Vol. 27, No. 1, pp. 29–49

Perry, C.L., Williams, C.L., Komro, K.A., Veblen-Mortenson, S., Stigler, M.H., Munson, K.A., Farbaksh, K., Jones, R.M. and Forster, J.L. (2002) 'Project Northland: long-term outcomes to reduce adolescent alcohol use', *Health Education Research*, Vol. 17, No. 1, pp. 117–32

Williams, C.L., Perry, C.L., Farbaksh, K. and Veblen-Mortenson, S. (1999) 'Project Northland: comprehensive alcohol use prevention for young adolescents, their parents, schools, peers and communities', *Journal of Studies on Alcohol*, Supplement 13, pp. 112–24

### **California Community Planning Demonstration Project (USA, 1990–95)**

Wittman, F.D. (1997) 'Local control to prevent problems of alcohol availability: experience in California communities', in M. Plant, E. Single and T. Stockwell (eds) *Alcohol Minimising the Harm*. London: Free Association Books, pp. 43–71

Wittman, F.D. and Biderman, F. (1993) 'The California Community Planning Demonstration Project: experiences in planning for prevention of alcohol problems in four municipalities', in T.K. Greenfield and R. Zimmerman (eds) *Experiences with Community Action Projects: New Research in the Prevention of Alcohol and other Drug Problems*. CSAP Prevention Monograph 14. Rockville, MD: Centre for Substance Abuse Prevention, US Department of Health and Human Services, pp. 102–13

### Community Trials Program (USA, 1991–96)

Grube, J.W. (1997) 'Preventing sales of alcohol to minors: results from a community trial', *Addiction*, Vol. 92, Supplement 2, pp. 251–60

Holder, H.D. (2000) 'Community prevention of alcohol problems', *Addictive Behaviours*, Vol. 25, No. 6, pp. 843–59

Holder, H.D. (2001) 'Community prevention trials: a respectful partnership', *American Journal of Public Health*, Vol. 25, No. 3, pp. 234–44

Holder, H.D. (2001) 'Prevention of alcohol problems in the 21st century: challenges and opportunities', *American Journal on Addictions*, Vol. 10, No. 1, pp. 1–15

Holder, H.D. and Reynolds, R.I. (1997) 'Application of local policy to prevent alcohol problems: experiences from a community trial', *Addiction*, Vol. 92, Supplement 2, pp. 285–92

Holder, H.D., Saltz, R.F., Grube, J.W., Voas, R.B., Gruenewald, P.J. and Treno, A.J. (1997a) 'A community prevention trial to reduce alcohol-involved accidental injury and death: overview', *Addiction*, Vol. 92, Supplement 2, pp. 155–71

Holder, H.D., Saltz, R.F., Grube, J.W., Treno, A.J., Reynolds, R.I., Voas, R.B. and Gruenewald, P.J. (1997b) 'Summing up: lessons from a comprehensive community prevention trial', *Addiction*, Vol. 92, Supplement 2, pp. 293–301

Holder, H.D., Saltz, R.F., Treno, A.J., Grube, J.W. and Voas, R.B. (1997c) 'Evaluation design for a community prevention trial: an environmental approach to reduce alcohol-involved trauma', *Evaluation Review*, Vol. 21, No. 2, pp. 140–65

Holder, H.D., Gruenewald, P.J., Ponicki, W.R., Treno, A.J., Grube, J.W., Saltz, R.F., Voas, R.B., Reynolds, R., Davis, J., Sanchez, L., Gaumont, G. and Roeper, P. (2000) 'Effect of community-based interventions on high-risk drinking and alcohol-related injuries', *The Journal of the American Medical Association*, Vol. 284, No. 18, pp. 2341–7

Roeper, P.J., Voas, R.B., Padilla-Sanchez, L. and Esteban, R. (2000) 'A long-term community-wide intervention to reduce alcohol-related traffic injuries: Salinas, California, *Drugs: Education, Prevention and Policy*, Vol. 7, No. 1, pp. 51–60

Treno, A.J. and Holder, H.D. (1997a) 'Community mobilization: evaluation of an environmental approach to local action', *Addiction*, Vol. 92, Supplement 2, pp. 173–87

Treno, A.J. and Holder, H.D. (1997b) 'Community mobilization, organizing and media advocacy: a discussion of methodological issues', *Evaluation Review*, Vol. 21, No. 2, pp. 166–90

Treno, A.J. and Holder, H.D. (1997c) 'Evaluating efforts to reduce community-level problems through structural rather than individual change', *Evaluation Review*, Vol. 21, No. 2, pp. 133–9

### Communities Mobilising for Change on Alcohol (CMCA) (USA, 1992–95)

Wagenaar, A.C., Murray, D.M. and Toomey, T.L. (2000) 'Communities mobilising for change on alcohol (CMCA): effects of a randomised trial on arrests and traffic crashes', *Addiction*, Vol. 95, No. 2, pp. 209–17

Wagenaar, A.C., Gehan, J.P., Jones-Webb, J.L., Toomey, R. and Forster, T.L. (2002) 'Communities mobilising for change on alcohol: lessons and results from a 15-community randomised trial', *Journal of Community Psychology*, Vol. 27, No. 3, pp. 315-26

Wagenaar, A.C., Murray, D.M., Gehan, J.P., Wolfson, M., Forster, J.L., Toomey, T.L., Perry, C.L. and Jones-Webb, R. (2002) 'Communities mobilising for change on alcohol: outcomes from a randomised community trial', *Journal of Studies on Alcohol*, Vol. 61, pp. 85-94

### **Operation Safe Crossing (USA, 1997-99)**

Voas, R.B., Tippetts, A.S., Johnson, M.B. and Lange, J.E. (2002) 'Operation safe crossing: using science with community intervention', *Addiction*, Vol. 97, pp. 1205-14

### **Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI) (Australia, 1992-95)**

Boots, K. and Midford, R. (1999) "'Pick-a-skipper": an evaluation of a designated driver program to prevent alcohol-related injury in a regional Australian city', *Health Promotion International*, Vol. 14, No. 4, pp. 337-45

Midford, R. and Boots, K. (1999) 'COMPARI: insights from a three year community based alcohol harm reduction project', *Australian Journal of Primary Health*, Vol. 5, No. 4, pp. 46-58

Midford, R., James, R., Oddy, W., Dyskin, E.V. and Beel, A. (1995) 'Alcohol consumption and harm in two Western Australian regional centres', *Australian Journal of Public Health*, Vol. 19, No. 1, pp. 41-5

Midford, R., Wayte, K., Catalano, P., Gupta, R. *et al.* (2005) 'The legacy of a community mobilisation project to reduce alcohol related harm', *Drug and Alcohol Review*, Vol. 24, pp. 3-11

### **Surfers' Paradise Safety Action Project (Australia, March-December 1993, intervention/1992-ongoing)**

Hommel, R., Hauritz, M., McIlwain, G. and Carvolth, R. (1994) 'Preventing alcohol-related crime through community action: the Surfers' Paradise Safety Action Project', *Public Intoxication and Injury*, Vol. 7, pp. 35-90

### **Carnarvon Partysafe Project (Australia, 1999-2001)**

Cooper, M., Midford, R. and Jaegar, J. (2001) 'Carnarvon Partysafe: designing a community mobilisation project in Western Australia's remote North West', *Australian Journal of Public Health*, Vol. 7, No. 3, pp. 63-9

Cooper, M., Midford, R., Jaeger, J. and Hall, C. (2003) 'Reforming Andy Capp? How a cartoon character was used in a community alcohol project', *Health Promotion Journal of Australia*, Vol. 14, No. 2, pp. 114-18

Midford, R., Cooper, M. and Jaeger, J. (2003) 'The Partysafe Project: working with an Australian rural community to reduce alcohol harm', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 69-80

### **Maori Collaborative Drink-drive Project (New Zealand, 1993–95)**

Conway, K. and Casswell, S. (2003) 'Riding the waves. The politics and funding context of twenty five years of research on community action to reduce alcohol harm in New Zealand', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 13–24

Moewaka Barnes, H. (2000a) 'Collaboration in community action: a successful partnership between indigenous communities and researchers', *Health Promotion International*, Vol. 15, No. 1, pp. 17–25

Moewaka Barnes, H. (2000b) 'Maori drink drive programme evaluation from a Maori perspective', Kettil Bruun Society Thematic Meeting: Fourth Symposium on Community Action Research and the Prevention of Alcohol and Other Drug Problems, Alcohol and Public Health Research Unit, University of Auckland, New Zealand

### **Waikato Rural Drink-drive Project (New Zealand, 1996–98)**

Conway, K. and Casswell, S. (2003) 'Riding the waves. The politics and funding context of twenty five years of research on community action to reduce alcohol harm in New Zealand', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 13–24

Stewart, L. and Conway, K. (2000) 'Community action to reduce rural drink and drive crashes in New Zealand: adapting approaches in dynamic environments', *Substance Use and Misuse*, Vol. 35, Nos 1 and 2, pp. 141–55

### **Youth and Alcohol Project (New Zealand, 1997–99)**

Conway, K. and Casswell, S. (2003) 'Riding the waves. The politics and funding context of twenty five years of research on community action to reduce alcohol harm in New Zealand', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 13–24

### **Auckland Regional Community Action Project on Alcohol (ARCAP) (New Zealand, three-year project – ongoing)**

Casswell, S., Huckle, T., Greenaway, S. and Conway, K. (2003) *Auckland Regional Community Action Project on Alcohol Evaluation Report. Progress Report One, December 2003*. Centre for Social and Health Outcomes Research and Evaluation, (SHORE) and Te Ropu Whariki. Auckland: Massey University

Conway, K. (2002) 'Booze and beach bans: turning the tide through community action in New Zealand', *Health Promotion International*, Vol. 17, No. 2, pp. 171–7

Huckle, T., Conway, T., Casswell, S. *et al.* (2005) 'Evaluation of a regional community action intervention in New Zealand to improve age checks for young people purchasing alcohol', *Health Promotion International*, Vol. 10, No. 2, pp. 147–55

### **The Kirseberg Project (demonstration) (Sweden, 1988–96)**

Hanson, B.S., Larsson, S. and Lindbladh, E. (1993) 'Experiences from the Kirseberg public health project in Malmo, Sweden: an alcohol prevention campaign', in T.K. Greenfield and R. Zimmerman (eds) *Experiences with Community Action Projects: New Research in the Prevention of Alcohol and other Drug Problems*. Rockville, MD: Centre for Substance Abuse Prevention, US Department of Health and Human Services

Hanson, B.S., Larsson, S. and Rastam, L. (2000) 'Time trends in alcohol habits. Results from the Kirseberg project in Malmo, Sweden', *Substance Use and Misuse*, Vol. 35, Nos 1 and 2, pp. 171–87

### **Kungsholmen Project (Sweden, 1990–92 and ongoing)**

Romelsjö, A., Andren, A. and Borg, S. (1993) 'Design, implementation and evaluation of a community action program for prevention of alcohol-related problems in Stockholm City: initial experiences', in T.K. Greenfield and R. Zimmerman (eds) *Experiences with Community Action Projects: New Research in the Prevention of Alcohol and other Drug Problems*. Rockville, MD: Centre for Substance Abuse Prevention, US Department of Health and Human Services

### **Stockholm Prevents Alcohol and Drug Problems (STAD) Project (Sweden, 1996– 2006)**

Wallin, E. (2004) *Responsible Beverage Service, Effects of a Community Action Project*. Stockholm: Karolinska Institutet

Wallin, E., Norström, T. and Andréasson, S. (2003a) 'Effects of a community action project on responsible beverage service', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 97–100

Wallin, E., Norström, T. and Andréasson, S. (2003b) 'Alcohol prevention targeting licensed premises: a study of effects on violence', *Journal of Studies on Alcohol*, Vol. 64, pp. 270–7

Wallin, E., Lindewald, B. and Andréasson, S. (2004) 'Institutionalization of a community action program targeting licensed premises in Stockholm, Sweden', *Evaluation Review*, Vol. 28, No. 5, pp. 396–419

### **Lahti Project (Finland, 1992–95)**

Holmila, M. (ed.) (1997) *Community Prevention of Alcohol Problems*. Geneva: World Health Organization.

Holmila, M. (2000) 'Introduction: The Finnish Case: community prevention in a time of rapid change in national and international trade', *Substance Use and Misuse*, Vol. 35, Nos 1 and 2, pp. 111–23

Holmila, M. (2001a) 'The changing field of preventing alcohol and drug problems in Finland: can community-based work be the solution?' *Contemporary Drug Problems*, Vol. 28, No. 2, pp. 203–20

Holmila, M. (2001b) 'Community initiatives as strategies for implementation of the European Alcohol Action Plan', in H. Klingemann and G. Gmel (eds) *Mapping the Social Consequences of Alcohol Consumption*. Dordrecht: Kluwer, pp. 161–70

### **Metropolitan Suburbs Project (Finland, 1997–2000)**

Holmila, M. (2000) 'Introduction: The Finnish Case: community prevention in a time of rapid change in national and international trade', *Substance Use and Misuse*, Vol. 35, Nos 1 and 2, pp. 111–23

Holmila, M. (2003) 'The evaluation of the Metropolitan Project: process and causality', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 81–90

### **Florence (Rifredi) Community Alcohol Action Project (Italy, 1992–98)**

Allamani, A., Forni, E., Ammannati, P., Basetti Sani, I. and Centurioni, A. (2000) 'Alcohol carousel and children's school drawings as part of a community educational strategy', *Substance Use & Misuse*, Vol. 35, Nos 1 and 2, pp. 125–39

### **Florence (Scandicci) Community Alcohol Action Project (Italy, 1998–ongoing)**

Allamani, A., Basetti Sani, I., Voller, F., Cipriani, F., Ammannati, P. and Centurioni, A. (2003) 'Experiences from a community alcohol action research in Scandicci, Florence', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 105–9

### **Community Action Project, Malczyce (Poland, spring 1994–summer 1995)**

Moskalewicz, J. and Świątkiewicz, G. (2000) 'Malczyce, Poland: a multifaceted community action project in Eastern Europe in a time of rapid economic change', *Substance Use & Misuse*, Vol. 35, Nos 1 and 2, pp. 189–202

### **UK**

Mistral, W., Velleman, R., Templeton, L. and Mastache, C. (2006) 'Local action to prevent alcohol problems: is the UK Community Alcohol Prevention Programme the best solution?', *The International Journal of Drug Policy*, Vol. 17, pp. 278–84