



Kalgoorlie Alcohol Action Project: Working with a Community to Prevent Alcohol Problems

Over recent decades state control of alcohol in most western countries has progressively lessened in the name of free trade, greater competition and consumer benefit. However, there is a fundamental incompatibility between greater access to alcohol and public health. Countries that have typically managed alcohol problems at a population level by judicious control of availability have also experienced lower rates of harm, but this has not proved a barrier to the tide of market deregulation. The experience of Scandinavian countries is particularly illustrative in this regard.

Powerful state monopolies on the production and sale of alcohol have existed in all Scandinavian countries since the beginning of the 20th century, keeping alcohol consumption relatively low in comparison to other western countries. In Sweden for example, per capita alcohol consumption during the 1980s ranged from 5.2 to 5.7 litres, compared with between 8.5 and 9.8 litres in Australia (World Advertising Research Center, 2005). However, as the populations of Scandinavian countries began to downplay the problems associated with alcohol use, they wanted easier access (Kurzer, 2001). Control on availability was progressively relaxed and as a consequence consumption rose. In 1968, Finland allowed the sale of medium strength beer from grocery stores as well as from state monopoly outlets. The result was a 46% rise in alcohol consumption the following year, and a corresponding increase in alcohol problems (Makela et al, 2002). In 1995, Finland and Sweden joined the European Union (EU). In compliance with the EU's one market policy, consumers got progressively better access to cheaper alcohol in neighbouring member countries. In 1994 Finnish tourists imported 3.5 million litres of beer. In 1995, the first year of membership, the figure rose to 30 million litres (Kurzer, 2001). In Sweden, in 1996, when quantity limits were still relatively restrictive, 1.1 litres of alcohol consumed by the average Swede, aged 15 years and older, had come into the country as a tourist import. By 2004, when all quantity restrictions had been lifted, tourist imports contributed 2.6 litres to per capita consumption. Increased levels of acute alcohol related harm accompanied this rise in consumption. The assault rate, for example, increased from 608 per 100,000 in 1996 to 682/100,000 in 2002 (Holder et al, 2005).

Liberalisation of the alcohol market in these Scandinavian countries was part of a world wide trend driven by substantial popular support (Drummond, 2000). This has made it increasingly difficult to deal with population level alcohol problems by altering state policies and regulations. In this new environment of reduced government involvement, other mechanisms for taking action at the population level are needed and community action has emerged as the most promising alternative.

The Benefits of Community Prevention

There are powerful advantages to community level prevention. It attempts to remove or modify the underlying cause of the problem. It has considerable potential for change because of the large numbers involved. Once behavioural change has been achieved it is likely to be self sustaining, because a new community norm has been established (Rose, 1985). A number of research studies have shown that community action can change norms about alcohol use and alcohol harm (Casswell, 2000). This can facilitate structural change within the community, which in turn works to reduce actual harm. A few studies, such as the 'Preventing Alcohol Trauma: A Community Trial', conducted in three American communities, have also been able to directly demonstrate a significant change in patterns of local consumption and harm (Holder et al, 1997). In Australia, the COMPARI project showed that a community based prevention intervention was able to initiate and institutionalise cultural and structural change in the management of local alcohol problems. This was associated with a decrease in local alcohol consumption and a relative improvement in alcohol harm that was maintained over a ten year period (Midford et al, 2005).

Rural and remote populations in Australia consume greater amounts of alcohol and suffer higher levels of associated harm than metropolitan populations (Chikritzhs et al, 1999; Midford et al, 1998). At the same time effective prevention is more difficult: community amenities are generally poor; the population in many cases is younger and more male dominated; family and social networks are often limited; local social norms and established drinking patterns can encourage high levels of consumption. On top of this AOD services are likely to be thinly spread and focussed on individual treatment, because this is always a more immediate need. In these circumstances it is not surprising that very little community based alcohol prevention work has been undertaken in non metropolitan settings (Midford & Boots, 1999). However, this is exactly the type of approach that needs to be developed if the level of alcohol related harm in these communities is to be reduced in the long term. Providing treatment for problematic drinking is important as it is likely to benefit treated individuals, but it is not enough. As Holmila (2000) asserted, curing or removing the individual problem drinker will not result in a reduction in alcohol-related harm, because the community dynamics that contributed to these problems are unchanged. In order to change the aggregate level of alcohol-related harm, long term environmental and structural changes are essential.

The Kalgoorlie Alcohol Action Project

Kalgoorlie-Boulder is a well known mining city, and the major population centre in the Goldfields/Esperance region of Western Australia. The city was established in 1893, as a result of gold

being discovered in the area, and grew rapidly over the following decade. Two of the legacies Kalgoorlie-Boulder inherited from its frontier past are a tradition of heavy drinking and the greatest number of hotels per head of population of any regional centre in Western Australia. These are likely contributors to the substantial population level alcohol problems. In 1997/98 the per capita consumption of alcohol in Kalgoorlie-Boulder was 13.99 litres, substantially above the state average of 10.3 litres for that year. In the same period Kalgoorlie-Boulder experienced 84.89 hospitalisations per 10,000 residents for acute alcohol problems, whereas the state average was only 52.95. Alcohol related violence has been a particular problem. Rates of night-time assaults, a proxy measure of alcohol related violence, were 83.24 per 10,000 residents in 1997/98. The equivalent state figure was 5.91 per 10,000.

The Kalgoorlie Alcohol Action Project (KAAP) is a 3_ year whole of community, alcohol harm prevention intervention that aims to reduce alcohol related harm in the Kalgoorlie community. At one level it is designed to have a beneficial impact on a community with clear needs. However, the broader aim is to provide a practical demonstration of how rural and remote Australian communities can take action to reduce alcohol related harm at the local level. To fulfil this aim the project will develop, evaluate and disseminate an integrated range of local interventions that address the individual, social and structural determinants of alcohol consumption and harm at the community level. This comprehensive approach is designed to achieve concordant change at all levels of the community and thereby maximise reductions in alcohol harm. There is also likely to be collateral benefit in terms of broader social problems, such as family functioning, crime, mental health and retention in education.

Thompson and Kine (1999) stress the 'principle of ownership' in change, which means that effective and lasting change is most likely to occur when the people affected are part of the change process. Accordingly a considerable amount of time was spent negotiating a local partnership. This resulted in a joint application by the National Drug Research Institute (NDRI) and the City of Kalgoorlie/Boulder, which was successful in obtaining project funding from the Alcohol Education and Rehabilitation Foundation. Ongoing local direction will be provided by a committee comprised of key local decision makers and community representatives.

A menu approach will be used to increase local ownership, whereby the community is involved in selecting the mix of interventions best suited to local circumstances. Local agencies will be provided with expert training enabling them to better assess local conditions leading to alcohol-related harm and to

¹ The alcohol consumption and harm data presented were provided by the National Alcohol Indicators Project at the National Drug Research Institute

Kalgoorlie Alcohol Action Project: Working with a Community to Prevent Alcohol Problems

make choices regarding suitable intervention strategies. The potential interventions would include parent education, family intervention, support for school programs, media marketing, community education, skills training, greater enforcement and high risk group programs. Community and key informant perspectives on local alcohol issues will be gathered during the course of the project, as will objective measures of consumption and harm. Data will also be gathered from a community in the Pilbara region of Western Australia to control for background influences.

Institutionalisation of changes brought about during the course of the project will be sought in a number of ways. Most importantly KAAP will seek to demonstrate the success of prevention initiatives in terms that are locally meaningful. This is likely to build community efficacy, which in turn would act to support continuation. In addition the information gathered during the course of the project will increase the evidence base of what works in remote rural settings and provide a resource that other communities can draw upon. Undertaking a rigorous Australian demonstration project to underpin dissemination of novel prevention practices is important, because not only does this provide tested, culturally salient procedures to guide similar interventions, it also provides the legitimacy of evidence as to effect.

Richard Midford

References

- Casswell, S.** (2000) A decade of community action. *Substance Use & Misuse*, 35, 55-74.
- Chikritzhs, T., Jonas, H., Heale, P., Dietze, P., Hanlin, K. & Stockwell, T.** (1999) *Alcohol-Caused Deaths and Hospitalisations in Australia, 1990-1997*, National Alcohol Indicators Bulletin No. 1, Perth: National Drug Research Institute.
- Drummond D. C.** (2000) UK Government announces first major relaxation in the alcohol licensing laws for nearly a century: drinking in the UK goes 24-7. *Addiction*, 95, 7, 997-998
- Holder, H. D., Andreasson, S., Norstrom, T., Osterberg, E. & Rossow, I.** (2005) *Estimates of Harm Associated with Changes in Swedish Alcohol Policy*, National Institute of Public Health.
- Holder, H. D., Saltz, R. F., Grube, J. W., Voas, R. B., Gruenewald, P. J. & Treno, A. J.** (1997) A community prevention trial to reduce alcohol-involved accidental injury and death: overview. *Addiction*, 92 (Supplement 2), S155-S171.
- Holmila, M.** (2000) Lessons learned about the community initiatives in preventing alcohol and drug-related harm. In K. Elmeland (Ed.) *Lokalt Alkohol-Och Drogförebyggande Arbete I Norden*, Helsingfors: Nordiska namnden for alkohol-och drogforskning (NAD).
- Kurzer, P.** (2001) Cultural diversity in post Maastricht Europe. *Journal of European Public Policy*, 8, 1, 144-161.

- Makela, P., Rossow, I. & Tryggvesson, K.** (2002) Who drinks more or less when policies change? The evidence from 50 years of Nordic studies. In R. Room (Ed.) *The Effects of Nordic Alcohol Policies: What Happens to Drinking and Harm When Alcohol Control Systems Change?* Helsinki: Nordic Council for Alcohol and Drug Research.
- Midford, R. & Boots K.** (1999) COMPARI: Insights from a three year community based alcohol harm reduction project. *Australian Journal of Primary Health - Interchange*, 5, 4, 46-58.
- Midford, R., Stockwell, T., Daly, A., Phillips, M., Masters, L., Gahegan, M. & Philip, A.** (1998) Alcohol consumption and injury in Western Australia: A spatial correlation analysis using geographic information systems. *Australian and New Zealand Journal of Public Health*, 22, 1, 80-85.
- Midford, R., Wayte, K., Catalano, P., Gupta, R. & Chikritzhs, T.** (2005) The legacy of a community mobilisation project to reduce alcohol related harm. *Drug and Alcohol Review*, 24, 1, 3-11.
- Rose, G.** (1985) Sick individuals and sick populations. *International Journal of Epidemiology*, 14, 32-38.
- Thompson, B. & Kinne, S.** (1999). Social change theory. Applications to community health. In N. Bracht (Ed.) *Health Promotion at the Community Level 2. New Advances*, Thousand Oaks: Sage Publications.
- World Advertising Research Center** (2005) *World Drink Trends 2005*, Henley-on Thames: Author.

Drug prevention: A health economist's view

Dr Ric Fordham, Senior Adjunct Fellow from the University of East Anglia, UK recently spent five months at NDRI. During this time he worked on reviewing the economic evidence in the drug prevention field.

There is a growing amount of economic evidence of drug prevention programs showing positive 'returns on investment', making them comparable with drug treatment programs. However these studies are relatively new and the economic methodology that underpins them relatively underdeveloped. Nonetheless with a growing number of these studies it is important to assess whether any consistent results are emerging.

Estimates found in the current literature are quite variable but an analysis of 12 drug prevention programmes specifically in the area of behaviour modification (where more robust economic evaluation has been undertaken) has shown a positive BCR (benefit-cost ratio) in every case. The benefits realised at a whole programme level ranged from 2.4 to 19.64 per dollar expended. From this small number of studies the unweighted mean BCR was 7.2:1. In other words, for every dollar spent on drug prevention we might expect to save around \$7.

Obviously, these diverse programmes have impacts on different types of drug-users (actual and potential individuals) and on quality of life (from addict to occasional user) and their economic impact needs further consideration.

It is important to establish the efficiency of drug prevention because of limited resources available to do all that is desired. Whilst prevention remains under-evaluated compared to other areas without a proven cost-benefit track record, these will continue to be dominated by investment decisions. But high variability in claims for return on investment in prevention means that without a standardised economic framework, this is unlikely to occur. Additionally, design of cost-benefit analyses could be significantly improved to avoid merely the present 'cost off-setting' practices. Capturing the broader costs and benefits of drug prevention is essential and will only strengthen the case for such activities. In particular non-market assessment techniques and willingness-to-pay valuation methods used in other areas of economic policy are as applicable in the drug arena. Making such methodological improvements offers a promising way to conduct economic evaluations of drug prevention in the future. Unfortunately as Maynard (2001) has observed, governments still "blunder into expensive policies world-wide, asserting rather than evaluating their cost-effectiveness".

