Community action to prevent alcohol problems
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Papers presented at the Third Symposium on Community Action Research
Greve in Chianti, Italy, 25 - 29 September 1995

A collaborative meeting of the WHO Regional Office for Europe and the Kettil Bruun Society
EUROPEAN HEALTH21 TARGET 12

REDUCING HARM FROM ALCOHOL, DRUGS AND TOBACCO

By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

This compilation of papers is the result of the third international symposium on Community Alcohol Projects for the prevention of alcohol problems, which was held in Greve in Chianti (Florence), Italy, from 25 to 29 September 1995. It follows the symposium held in March 1989 in Scarborough, Ontario, and the symposium which took place in San Diego, California, in January–February 1992, both under the title of “Experiences with Community Action Projects for the Prevention of Alcohol and other Drug Problems”.

In keeping with the ideas of the previous symposia, the organizers of the Greve meeting encouraged participants to take a reflective and process-oriented stance. The following criteria were suggested: describe the community research project; present interaction of research and programme components; discuss process experience: analyse the problems or challenges encountered.

Keywords

ALCOHOL-RELATED DISORDERS – prevention and control
ALCOHOLISM – prevention and control
CONSUMER PARTICIPATION
COMMUNITY HEALTH PLANNING

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Preface

This compilation of papers is the result of the third international symposium on Community Alcohol Projects for the prevention of alcohol problems, a collaborative meeting of the WHO Regional Office for Europe and the Kettil Bruun Society. The meeting was held in Greve in Chianti (Florence), Italy, from September 25 to 29, 1995. It follows the symposium held in March 1989 in Scarborough, Ontario, and the symposium which took place in San Diego, California, in January-February 1992, both under the title of "Experiences with Community Action Projects for the Prevention of Alcohol and other Drug Problems".

In keeping with the ideas of the previous symposiums, the organisers of the Greve meeting encouraged participants to take a reflective and process-oriented stance. The following criteria were suggested: describe the community research project; present interaction of research and program components; discuss process experience; analyse the problems or challenges encountered.

Though the meeting was attended by a majority of European participants, who furnished us with updated information on the current situation in Europe, the US, Canada and Oceania were also represented. Unfortunately the organisers were unable to provide enough support to allow participation of presenters from other regions.

As with the 1989 and 1992 symposiums, this one was designated as a Thematic Meeting of the Kettil Bruun Society for Social and Epidemiological research on Alcohol. The WHO European Region and the Regione Toscana sponsored the meeting. The "Società Italiana di Alcologia Sezione Toscania", and the "Centro Alcologico Integrato", Florence, looked after the organisation, which was my privilege to coordinate. Plans went back to 1994, and the planning committee was constituted by: Peter Anderson, Sally Casswell, Amedeo Cottino, Norman Giesbrecht, Harold Hølter, Marja Holmila, Stig Larsson and myself, who had met a few times during other Kettil Bruun meetings and communicated through correspondence. Sally Casswell took on the substantial role of laying out design of the sessions.

Thus, the papers are substantially a review of existing experiences. It is divided into 5 sections, each of which ends with a reflection. It is structured in the following manner:

The first section especially concentrates both on methodological issues and on the description of some European Community Programs. It also includes some work and studies done in Scandinavia, that is, those countries which in Europe are traditionally very sensitive to community issues. Marja Holmila's opening paper provides an overview of the Lahvi WHO demonstration project, including methodological aspects of process and formative evaluation, and the relations between research and action. A second paper illustrates the evaluation of an educational project aiming at public information about alcohol and including collaboration with the media (Montonen). The introductory papers are followed by a paper by the Malmö group - Géransson, Lindbladh, Hanson and Östergren - which points out that, as the language and message of their project were influenced by the social class of the project team itself, only a few social groups within the community were really able to understand and become involved. The next two papers focus on models of community intervention or evaluation among adolescents in Norway (Bergan and Iversen). This section ends with a paper from Southern Europe, where the
beginning of an ongoing Italian project and its pros and cons are quoted (Allamani, et al.). The second section reveals a dichotomy between the advanced experiences in the USA (Holder and Reynolds; Salz; Klein) after years of action research programs in the communities, and the initial community projects in post-USSR countries (Krasovsky; Vyevsky). However, unlike the previous section, this one substantially deals with projects built around the interface between alcohol policies and prevention strategies. The evidence of the effectiveness of policy-oriented programs, their longer life and their actual connection with the population’s needs are maintained in both Holder’s and Reynolds’ papers, as well as in the other north American papers. On the other hand, the European papers emphasise that, in order for a policy to be consistent, a connection with a pre-existent official document such as the WHO European Alcohol Action Plan, signed by most European governments, is a necessary step.

It is not yet known to what extent new information technologies and prevention programs can interact, which is a special concern in times of scarce institutional funding. An innovative project by Liz Stewart in New Zealand explains how such technologies are used to keep a group of community health professionals spread over a large area in New Zealand and involved in implementing a prevention program, connected.

Papers in the third section again divide into two types of reports, two from New Zealand and one from Portugal. In the first paper Sally Casswell accurately treats the dynamics between the students embodying the research based knowledge and their epistemological status, and the citizens with their role in their own community and their part in a participatory democracy. A negotiation between researchers and community players would bring the latter to a clearer role in the project evaluation, with practical consequences on community organisation. These methodological aspects are described by Casswell, and by Barnes and Stanley through the experience of a New Zealand Community Project involving University Researchers in Auckland and the Maori population. The third paper (by Barrias, Duarte and Dias) reports on the start of a Municipal Action Plan in Oporto, Portugal, according to the European multi-city Alcohol Plan.

The fourth section begins with an in-depth paper by Geoffrey Hunt, which highlights the role of cultural analysis in the evaluation of community programs. He also points out how the different meanings of the concept of community are indeed culturally determined. The following five papers illustrate projects from different continents. The paper by Graham and Bois focuses on the complexity of roles in a Canadian project for the elderly, while the community preventive action experiences, already completed, from Western Australia (Midford, Boots and Cutmore), and from Stockholm in Sweden (Romelsjö et al.) are described as to be conducive to further local projects. The last two papers show interesting attempts at implementing a community-based treatment program in a large urban area in India (Sharma and Mohan) and an educational program among immigrants in Israel (Weiss).

The fifth section is constituted by two papers from Poland, whose target is illicit drug consumers. In this case the community program is built up through the collection of opinions of the general population (Swiatkiewicz). Children’s school drawings were used as a means to involve all the community people (Gajlewicz and Moskalewicz). The compilation ends with a "reflections on the 5 sections" by Marja Holmila and I would like to mention three of her comments. The experiences presented in this book demonstrated how community changes are aimed not only at the individual, but also at the environment; how qualitative analysis has come to stay in the field of prevention, taking its place alongside
quantitative research; and that while community projects need more consistent language, we must come to terms with political and cultural differences which are specific to each project and each country.

In conclusion, I hope that this compilation can contribute to further experiences in the community and encourage sound evaluation of prevention programs, along with an open exchange among people involved in different projects.

Allaman Allamani
Florence, Italy
Acknowledgements

This compilation is based on the Symposium on Community Alcohol Projects for the prevention of alcohol problems, held in Greve in Chianti (Florence), Italy, from September 25 to 29, 1995, which was made possible through financial support from the Regione Toscana, Social Security Department and the WHO, European Region (funding for Eastern European participants). The City of Greve provided the meeting site (the symposium was held in Greve's City Hall conference room) and two dinners for the participants. The Societa’ Italiana di Alcologia, Sezione Toscana, and Centro Alcologico Integrato, Florence, organised the meeting and contributed to the publication of this compilation. The planning and the organising Committee of the Symposium was constituted by: Peter Anderson, Sally Casswell, Amedeo Cottino, Norman Giesbrecht, Harold Holder, Marja Holmila, Stig Larsson and Allaman Allamani. We also thank Faye Nepon and Alona Hess for their secretarial work before, during and after the symposium.
FIRST SECTION

Experiences of the Lahti project

Marja Holmila

Introduction

The Lahti Project is a multi component community action programme aimed at the prevention of alcohol related harms. The project site is the city of Lahti in Finland. The project relies to a great extent on the work of local professionals. It includes work in developing local alcohol policy discussion, education and information, health care intervention for heavy drinkers, youth work, support for family members and server training. Formative, process and outcome evaluation research are being conducted in order to assess the impact of the project (Holmila 1992; 1995).

The programme is an experimental one, and its purpose is to obtain information about the feasibility and possibilities of local prevention. For that reason research has an important role in the project. The programme started during the autumn of 1992, and was mostly finished by the end of 1994, even if some parts are still being continued. The final report is currently being written, and will contain description of the processes, research results of the community's lifestyles, responses to alcohol use and evaluation of the project (Holmila 1996).

This paper will not be a comprehensive presentation of the Lahti project. The paper gives a short summary of the project’s main features, and discusses in more detail some issues related to the process of working and the relations between research and action.

Starting the project

The initiative to start Lahti project came from several sources simultaneously. When the wish to start such action had developed independently both in the city of Lahti, among alcohol educators and among researchers, the project began without difficulties.

A suggestion to formulate Lahti’s alcohol policy programme was made in the city council already at the end of the 1980's. This initiative was, however, not supported by the local decision makers, and the matter was left to rest. Two years later the same suggestion was made again and supported by the professionals in the city. This time a working group was set to write the programme. Lahti was the second city in Finland to make such a plan, the first one had been Tampere. A permanent drug and alcohol policy working group, which consists of civil servants and representatives of some citizens’ organizations was nominated in 1992. The working group’s tasks are to monitor the changes in drug and alcohol use and to make suggestions for the city government for prevention and treatment of drug problems.

The researchers’ involvement started also gradually. A study on community social response to
alcohol problems collected its data in Lahti during the years 1988 - 1990 (Holmila, Ahtola and Stenius 1989; Simpura 1991; Säilä 1991). Even if this study did not look at prevention, it provided useful information for the prevention project. Many civil servants, treatment personnel and citizens of Lahti became familiar with the researchers and vice versa. This influenced the choice of Lahti as the location of the community prevention project.

Interest in carrying out community based programmes had grown among health promoters, too. As a result, a pilot study on organizing a library based education campaign in Salo was started (Montonen 1992). This campaign was then repeated in Lahti.

Community action studies from other countries, international symposiums on community action were important sources for inspiration. WHO:s European Office’s Alcohol Action Plan which includes community action as one of its action areas, has been an important support in gaining and maintaining the interest of national and local actors.

A lengthy process had thus preceded the beginning of the project. By the time the researchers were ready to start the project in Lahti, we were very welcome. The city’s involvement was ensured by negotiations with the city leaders. The project was supported by the mayor in Lahti. All the chiefs in the city’s administration were also involved, even if individuals differed as to how actively they backed the project. An opening seminar in the autumn of 1992 marked the beginning of the project.

The goals of the project

The goals of the experimental community action organized in Lahti can be listed as follows. It is possible to make this list now, after the project has matured and developed into its full shape. There was no clear programme when the project started, only the general idea and gradually different areas of work were specified.

1. Influencing the knowledge, attitudes and use of alcohol among the inhabitants of Lahti
2. Influencing the knowledge and attitudes among the key persons in the locality
3. Developing the social response to alcohol problems in the city’s welfare services as well as in the citizens’ organizations. Social response means here both the supply of services and the overall willingness and ability to approach the alcohol problems from a preventive point of view.
4. Activating local alcohol policy discussion and planning.

Action in the project was divided into independent working modules. The most important modules were interviews of key persons, alcohol policy processes at the local level, education and information, health care intervention of heavy drinkers, youth work, heavy drinkers and self-help, influencing the alcohol supply and server responsibility, and family.

The researchers acted as promoters of the action during its first stages. In doing this, their role was of two kinds. Some of us had a prevention idea, a method and a ”package”. This was the case in the Library Weeks and the heavy drinkers intervention in the primary health care centres. Some of us had a pure research idea, as was the case in the interviews of the local influences (which
however then later also had an intervention impact). For myself and Kari Haavisto the method of working was that of an interpreter, listener, summarizer, and on the basis of that, also an active initiator of meetings and action.

There were lots of meetings and discussions, and it was natural to the researchers to use their skills in collecting and organizing speech texts, interpreting it and writing it up. In that capacity, the researchers actively directed the action in the locality. The local actors then usually developed the actual prevention methods. As the process developed, the local activists took a stronger and stronger hold of planning and carrying out all action whilst the researchers started to pull out back to their desks. All activities were from the beginning based on previous work and resources in the locality.

The organization of the project itself has been very light. There was no separate budget, and the funds came from the normal budgets of the different cooperating partners. The planning and information was coordinated by a project group, which consisted of the local coordinator Sirkka-Liisa Mäkelä, principal coordinator Marja Holmila, Leena Warsell and Pekka Olkkonen from the State Alcohol Monopoly’s information and education unit and all the researchers. The research work was funded by the Social Research Institute of Alcohol Studies and the Biomedical Research Centre in Oy Alko Ab and the Finnish Foundation of Alcohol Studies. The core of the actors in Lahti were the welfare professionals in the city. They are permanently engaged in responding to social problems, and formed the ”support-network” for the volunteer organizations and individuals in the project.

Research

The research in Lahti project is clearly a case study. Case studies can be defined as empirical inquiries that investigate contemporary phenomena within their real-life contexts, especially when the boundaries between the phenomenon studied and the context are not clearly evident (Yin 1994, 13). In other words, one would use the case study method when one deliberately wanted to cover contextual conditions - believing that they might be highly pertinent to the phenomenon of study. Important here is that in the Lahti project the action - the prevention project - and the context - the cultural and social structure of the community - are not to be clearly separated. The context of the action and the action itself are studied at the same time.

Case studies allow the use of qualitative data, which in the present study has been an important element, for instance in interpreting the thoughts and actions of the local people and by describing the preventive action alive in the context of everyday life and more than just a list of good intentions, plans and protocols.

Action research

Action research differs from other types of social studies in two basic ways. First, it takes an active approach to change. Action research aims at changing the social group or the society, at producing innovations. Secondly, the relationship between the researcher and those studied is different in action research than in other types of research. Traditional academic research stresses the
distinction between the researcher and those studied. The researcher avoids influencing the studied persons or groups in order to obtain as objective results as possible. Action research, on the contrary, tries to break down the barriers between science and the world outside it, to make research a part of a process and to build good communication networks between different actors.

The distinctive element in action research is the way it understands the process of knowledge formation. Action research basis its knowledge on the group’s or system’s characteristics on acts. It ”checks” the interpretations of the system in a straightforward manner, by engaging in action with it. It is this special dialogical and practical way of obtaining knowledge of the studied case that distinguishes action research from other kinds of studies.

The group has to agree in open and dialogical atmosphere about the action, its goals and main methods. Only when the planned action corresponds with the values and understanding of the group, will something happen. Practice will thus be the ultimate check of what the system can and wants to do and how: of what it is like.

Besides trying to understand the system in the light of its acts, action studies aim at describing and testing the planned action itself, the formation and implementation of programmes. Descriptions and theories are built within the practice context itself, and are tested through intervention experiments. Hence, action researchers are always engaged in some practice context (Argyris 1989, 612 - 613).

Contemporary forms of action research also aim at making change and learning a self-generating and self-maintaining process in the systems in which the action researchers work. It aims at helping systems to develop a higher degree of self-determination and self-development capability so that learning continues after the researcher leaves the system (Elden and Chisholm 1993, 125).

From outcome evaluation to process evaluation

Social relevance of evaluation research does not just depend on the methodological quality of the work and its ability to follow scientific rules (Albrecht 1991, 422). The utilization of the knowledge gained from evaluation research depends on a great number of other factors. One of the first tasks for such research is the identification of specific, relevant decision makers and information users and working with them (Patton 1980, 59). The most important part of designing a useful evaluation is not the technical aspect of collecting and analysing data; the most important part is asking the right questions and presenting the results in such a way that they can usefully inform important decisions. This naturally requires that the researcher understands the goals and institutional context of the action he or she is studying. The researcher also has to be able to project what kinds of decisions will likely to be made on the basis of the results (Pirie 1990, 208).

The elements of evaluation are usually divided in three parts: formative, process and outcome evaluation (Duignan, Casswell and Stewart 1992, 4 - 5; McGraw et al. 1989, 459 - 483). The three different areas of evaluation are usually present, and depending on the project being evaluated and the research approach used, there is more or less emphasis on each of these three types of evaluation. Process evaluation still has the role of the newcomer: although process evaluation is discussed as an essential component to be included in any program evaluation, there
is not very much discussion in the literature of how such evaluations should be designed. A remarkable exception is Michael Quinn Patton’s well-known book (Patton 1980). A system of process evaluation was also developed and described in Pawtucket Heart Health Program (McGraw et al. 1989, 459 - 483).

Recently the previously so hot debate between outcome and process evaluation and between quantitative and qualitative measures has turned into realization of the necessity of both, and the importance of developing multi method approaches (Aaro 1992; Albrecht 1991, 419; Duignan, Casswell and Stewart 1992, 4 - 5). Outcome questions are often the first questions posed to the evaluator, but they should be the last ones to be answered. Only if the program seems to be operating in a satisfactory manner can the answers to outcome questions be meaningful (Pirie 1990, 206; Rutman 1980).

Deciding what is meant by program ”outcomes” or ”effects” is often more difficult than it would first appear. The effects of any program can be conceptualized as a chain of events leading from the program to the ultimate outcome. Thus the ”outcome” of the program could be evaluated on any of these levels. The choice of which outcome to study is determined by several factors: the soundness of the scientific evidence linking the various events in the chain, the feasibility and cost of obtaining the measurement, the statistical power to detect effects at various levels and so on. The choice of which endpoint to measure is also dependent upon the needs of the audience for the evaluation (Pirie 1990, 205).

Qualitative studies have an important role in process and impact evaluation. One of the reasons for this is that one has to avoid taking the official program as a true guide to action and making the goals it contains the measure of analysis. For obtaining effects, it is the daily routine of the program, the reality of the program implementation, that is significant. The actual treatment varies from person to person, from setting to setting, and from time point to time point. With the usual techniques of standardized social research it is difficult to assess; although it may be possible through systematic, quantifying observation or research techniques of qualitative social research (Albrecht 1991, 421).

**Research methodologies in the Lahti project**

Both the action research tradition and the literature on evaluation methodologies have influenced the research carried out here. Intervention sociology and action research have given ideas to the overall organization and orientation of the research approach. Interpretative and dialogical methods are used, and the rigid borderline between research and action has been broken. Literature on evaluation studies, on the other hand, has given tools for studying goal-oriented work, and for estimating its efficiency.

Some parts of the research carried out aim at following up the community intervention, whilst other parts analyse the community culture, organization or prevalence of problems. The methodologies used include both quantitative and qualitative methods, and data has been gathered in various different ways. The research is a good example of a multi method approach.

**Describing the context and process**
Finland is one of those countries which has been witnessing a change as to the way alcohol problems are perceived. Public opinion has swayed, within a few years, from a relatively control oriented position to a position where almost no public intervention into the market and private consumption is thought to be justified. The Nordic alcohol monopoly system has been under attack by the press, and opinion polls indicate a clear shift towards ”liberalism” in demands for better availability of alcoholic beverages. At the same time individual responsibility is being emphasized in both prevention and cure of drinking problems. The welfare regimes are undergoing major difficulties during economic cuts and high unemployment. In Nordic countries the municipal authorities have had a central role in providing local services. An alternative way of organizing the social response to alcohol problems is to stress the role of voluntary organizations and the activity of the citizens. These tendencies have implications for how the society sees the task of responding to the increasing harms caused by drinking.
Figure 1. Research in Lahti project

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<th>TYPE OF RESEARCH AND DATA</th>
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<td>Intervention</td>
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<td>- restaurant personell and patrons</td>
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Outcome evaluation

- pre-post surveys in Lahti and in comparison sites | X | X |
- three telephone surveys                            | X | X |
- statistics                                          | X | X |

Process evaluation

- memos on observations and discussions, protocols, information and educational materials, interviews of the activists | X | X | X |

Formative evaluation

- reception studies, feedback discussions, special enquiries and surveys, activists’ reports | X | X |
Certain phenomena become problems for the community in a process where social actors give meanings to these phenomena, assess their severity and rate them in relation to other problems. What are the processes that define certain type of drinking as problematic in the community? What are the roles of the local media and the community residents in this process? It seems that local events or decisions seldom determine what is considered problematic or non-problematic. Rather, local events are interpreted within a more general, nation-wide or increasingly global perspective (Simpura 1991). The crucial question then is, whether the efforts of local actors could have a stronger role in these processes of interpretation.

Social intervention on people’s drinking requires special legitimation. In the Finnish society alcohol use is seen on the one hand as a transgression and on the other hand as a sublimated social pleasure. People who see drinking as a transgressive activity could be expected to be more willing to accept external control over it than people who see alcohol use mainly as a sublimated social pleasure. The former is often the case when adults talk about youth or the lower classes, the latter when new middle class people talk about their own drinking. Groups of influential local people in Lahti were discussing the images of drinking and alcohol problems, ways of treating these problems and the legitimation for the society’s interference in people’s drinking. There opinions could be classified in three dimensions: welfare state approach, classical liberalist approach and neoliberal individualism (Sulkunen 1993). The sociological intervention among the influentials included feed-back sessions, where analysis of the first discussions where presented and then discussed. A systematic evaluation of the impact of this intervention is being made.

The perspective taken in the educational campaigns in Lahti was that members of the public are conceived of as active co-producers of messages, not as passive objects of persuasion. They are seen as subjects who selectively use communication materials to satisfy their interests and needs. Educational campaigns were also connected to other forms of activities: personal advice, education in various social settings, for instance in the schools, and organizing community action. Local media was an important channel (Montonen 1992).

The prevention and management of alcohol problems is well within the role of primary health care. Despite the advantages, there are a number of barriers to early intervention in the primary health care setting, relating to lack of knowledge or pessimism felt by the personnel of the value of any intervention. The aim of the intervention in the health care centres in Lahti was to initiate this work in practice and to show its effects. Patients in health care centres, employee health service and an emergency room were screened with a short questionnaire and those classified as heavy drinkers are divided into an intervention and a control group. The three year evaluation measures to what extent the heavy drinkers can be influenced in this setting (Sillanaukee 1995).

The importance of empowerment and positive health promotion instead of prevention of some distant disease or risk became particularly evident in youth work in Lahti. Education, support and entertainment for young people needs to have a positive, protective and supportive air to it. The presence and self-reliance of parents and other adults was felt to be an important part of drug prevention among the youth. Some of the youth work in Lahti concentrated in helping adolescents in particularly difficult life situations, other parts of it were focusing on young people in general. Data on school children’s drinking was collected (Haavisto 1993). Schools were engaged to inform both the pupils, teachers and the parents. The experiences will be discussed in the study.
Families and other close networks are both resources for supporting the drinker, and in need of support for themselves because of the suffering caused by the intimate others’ heavy drinking. Qualitative interviews conducted among the family members have as such been a kind of intervention, increasing the understanding and visibility of these issues in the community (Holmila 1994). Networks for family members were also created in Lahti.

One of the most important ways of prevention is regulating the sales of alcohol. Local communities have only limited resources in influencing the legislation or markets of alcohol products. Restaurants and other licensed premises are of particular interest from the point of view of community action, because they are a part of the local culture and environment, which the residents can influence. Data on occurrence of alcohol related violence and disorder in public places was collected together with the local police (Holmila and Haavisto 1994) and together with the students in the server training school (Holmila and Haavisto 1994b). The intervention included server training courses for restaurant personnel and some attempts to promote non-alcohol beer and wine.

**Some outcome results**

The analyses of the outcome of the project is not yet completed, but the following results illustrate the impact the project has had:

**Media impact**

During the period between January 1993 and December 1994 all alcohol- and drug related articles in the two local newspapers were coded. In the articles coded as having a preventive message, the project’s impact was noticeable: about a third of them mentioned the project directly. The major events caused a clear peak in the number of preventive articles.

**Reaching the audience**

The inhabitants of Lahti were asked in a telephone survey, had they seen or heard of several of the major happenings and forms of activity in the project. The results show that activities were rather well known, and also that the types of activities differed as to which groups of the population they could reach. The results are in a logical relationship with what could be expected to happen, and thus confirm the conclusion that the numbers tell about some real effects.

For instance, awareness ”ads” (in the form of a rhythmic poem) in the local radio had best reached young men (48 %) and working class men (52 %) presumably listening to the radio when driving their cars, whilst the Crazy Girls project was best remembered by white collar women (63 %) and young women (50 %) whom one could expect to be most interested in issues of female identity and drinking.

Importantly, the frequently drinking persons had been reached as well as those drinking less often. The campaigns had in that sense met their most important target group. Newspaper information on the limits of risky drinking was remembered best by the frequently drinking women (67 %) and frequently drinking men (48 %).
The Gallup results also show, that the effect of campaigns wares out rapidly. March 1994 was the "high time" of the project and since then its visibility and also impact in media and people's minds decreased. In the telephone survey in March 1994 42 % of the respondents knew what was "Lahti Project" and in December 1994 the corresponding figure was only 30 %.

Changes in alcohol policy opinions and perception of alcohol as a social problem

The proportion of those citizens who considered drinking to be a serious social problem grew during the project. The results are statistically significant. The change was in the same direction in all age groups and among men and women, as well as among the frequent and less frequent drinkers.

A majority also gave their consent in using the public funds for prevention projects. When asked "is it sensible to use public money on prevention projects like the Lahti project?", 87 % (90 % women and 84 % of men) answered yes. The oldest respondents were less enthusiastic (73 % of those over 65 years of age supported the prevention projects) and also the private entrepreneurs were more reserved than people in other professions.

Changes in alcohol-related knowledge

It seems that the project did have an impact as to how well people knew the content of alcohol in medium beer, and how well they knew the limits of risky drinking. The number of correct answers had grown, and as a similar change had not happened in some other areas of knowledge which were not included in the educational message of the project, it is likely that the change in knowledge achieved can be attributed to the project (Montonen 1995).

Changes in heavy drinker’s drinking

The mini-intervention for heavy drinkers in the health care centres started in one community health care centre, and one occupational health centre, but then spread to all of the health care centres in the city. According to the participants’ replies to the questionnaire, the initial suspicion and reluctance among the doctors and nurses was changed into interest and voluntary participation. The experimental follow-up on the drinkers’ behaviour is not yet completed. All in all about 21 % of the male and 10 % of the female patients were classified as heavy drinkers. Taking into account also the physician’s estimation, the proportion of heavy drinkers was smaller, giving the prevalence of 13 % for men and 6 % for women (Sillanaukee 1995).

Changes in social response to alcohol problems

The project created new permanent forms of social response in the city. Mini-intervention for heavy drinkers in the primary health care was carried out as an experimental study. The goal is to make such action as a permanent part of the health care centre’s normal work.

Consultation and support for alcoholics' family members was organized as a series of "mini-interventions” in the form of open consultation meetings which were usually attended by about 30 - 40 persons.
The vocational school for restaurant personnel in Lahti arranged two sequential courses on responsible serving for those working in the bars and restaurants. The two day course was well received, and about 120 waiters and waitresses took part in the course (Haavisto 1995). A second course will be arranged next autumn.

Changes in drinking behaviour

Data on the drinking behaviour of the residents of Lahti and two comparative sites been gathered before and after the project. The data is not yet available, but on the basis of some smaller data sets a few observations can be made. It seems that the drinking habits of the whole population of Lahti have not changed during the project. This was to be expected, as the changes in drinking habits are usually very slow, and radical changes are required to produce visible changes (Simpura 1995).

Dissemination of the project experience

The project experience has been widely disseminated among the different professional groups interested in local prevention of alcohol problems in the whole of Finland. Often the information has come from the local actors in Lahti rather than from the researchers. They have been telling about their work within the project in their own network meetings. On the 16th of May 1995 a national seminar was held in Lahti to discuss the project. This meeting gathered 200 participants from different parts of the country, and produced a seminar report with preliminary research results.

Changing the paradigm of alcohol prevention

The traditional temperance movement started the anti-alcohol campaigns in Finland in the beginning of the century, leading to prohibition in the 1920's and later to the State Alcohol Monopoly from 1932 onwards. The temperance ideology had dominance in alcohol education until the 1960's.

Temperance ideology became unpopular during the 1960's. Consumption of alcohol grew rapidly as a result of urbanisation, change of values and the liberalization of alcohol laws in late 1960's. The same tendency has continued; liberalism in alcohol policy has dominated the discussion especially during the 1980's. When Finland joined European Union in the beginning of 1995, the state alcohol monopoly was reduced to a partial retail monopoly, and a new alcohol law with considerable changes towards free alcohol trade was accepted in the parliament (Rosenqvist and Tigerstedt 1995).

From the point of view of prevention of alcohol problems this has created a new kind of vacuum. The concept of alcohol prevention is new and not very well understood in Finland. This is due to the history of alcohol field. For quite a long time the field was divided into state controlled alcohol policy with a strong state monopoly in production and sales on one hand, alcoholism treatment and individual-oriented education on the other. Now that alcohol policy has lost a great deal of its possibilities, education sometimes seems to be the only method of prevention left if the concept of prevention is not formulated in a new way.
Alcohol education in municipalities has been taken care of by "temperance secretaries", underpaid mostly female civil servants with a vaguely defined task of promoting the idea of temperance or controlled drinking. Since the early 1970's it was in many circles difficult to imagine a less popular word than "temperance". The temperance secretaries have gone through a major crises in reformulating their identities towards something that sounds more positive. For some this reformulation has meant focusing on high risk groups and forming closer links with treatment (early intervention), for others it has meant concentrating solely on young people and their leisure time hobbies, and for some it has meant attempts to move away from alcohol-specificity towards general health education.

Lahti project developed a new insight into the potentialities of alcohol prevention for those who worked in the project. Especially the local coordinator Sirkka-Liisa Mäkelä has been expressing this idea. Prevention of alcohol problems has become to mean action in promoting both awareness and policy processes among the general public and the decision makers in order to reduce the use of alcohol. It means action that works at the same time both on the individual and on the community level, and which uses various methods and bases on cross-sectoral cooperation. In order to underlay the new way of seeing her work, Sirkka-Liisa Mäkelä suggested a change in her title (to be "drug prevention worker" instead of "temperance secretary"). The city authorities could not be bothered with the process of changing the job title, and of course, the mere changing of the name of the post may not have produced the change that is required.

Research and action

In a community action project a researcher cannot be an emotionally "objective" and "free" bystander. This causes a double dilemma for both the research and prevention work. It seems that in order to carry out a community prevention project, there is a real challenge in keeping two parallel "realities" alive and equally strong at the same time:

- planned, goal-oriented, methodical and documented
- open, experimental, flexible, verbal and emotional

The researcher is dependent on the actors: if they don’t get anything done, the project is a failure, and especially at this stage of affairs, it means lost time and energy for the researcher too. Reporting of failures may sound like a good idea of critical research, but if all you can prove is that some individuals (yourself included) did not manage to work together, such a report is not going to be very useful.

The actors are dependent on the researchers: without their reports the project would not take the shape of a documented project. This relationship is not without risks for the actors, either. The increased publicity increases the actors risk of failure and risk of creating new conflicts among one’s old close-by allies and friends. The actors may feel that they are too much in contact with the researchers and other "outsiders", because if the project fails, they will have a major task in regaining their position in the local community, maybe even in maintaining their jobs and careers. They may be faced by feelings of envy and potential revenge of their colleagues because the project gives them new interesting contacts and gives them new visibility in the locality.
When carried out properly, a project needs persons with commitment: it must have an address, a face and lots of caring and emotional support. People must subsequently commit themselves to the success or failure. This commitment must come from both the actors’ and the researchers’ side. Personal commitment increases the feeling of mutual dependency.

There is nothing wrong with commitment, of course. The problem lies in the difficulties of combining two different work cultures and traditions together. The problem is usually discussed from the point of view of the researchers, but similar problems are faced by the prevention activists.

Scientific tradition stresses independence and objectivity as its main values. The role of a non-committed outsider is taught to us in our training and cherished by the culture of the research communities. Also, the skills taught to researchers do not particularly underlie the abilities in sharing or risk-taking over issues one cannot control; on the contrary, good research bases on intellectual control over the phenomena studied. The ”object” of research is clearly defined, conceptually controlled and grows from a strong theoretical base. Aims like these may be useful in writing up the report of a community action study, but do not make it easier to live through the mess of real life situations during the action period and risks taken there.

Building the action to suit the need of research values is one possibility of avoiding the tension. Strictly defined goal-oriented approach allowing for clear measurement of results can, however, kill all creative development of prevention work and make the project for that reason a useless and a rather boring repetition of something one already knows, even if it has not previously been sanctified by evaluation research. A preplanned top-down approach also requires either money or power for the work to get done. Voluntary engagement of local activists requires a different approach, and the most creative people will only work in settings they have control over.

The researchers live in their own reality with the necessity of gaining funding, and obtaining scientific merit. It is important to notice, that the content of community action in the locality can indirectly be determined by research funders. For instance in Lahti there were initiatives to create action in the work sites, which did not lead to any action because the research didn’t get started. The local A-clinics were willing to see themselves as a part of this work, there was a researcher with a research plan and there were negotiations in order to obtain money. However, for various reasons the research did not get support, and this lessened the eagerness of the local people. Another factor here was that the economic depression started at the same time, and led to huge unemployment (27 % in Lahti). As a result, the project did not include any work in the work sites.

Similarly, the local coordinator was most eager to develop school based education on alcohol issues. The half-hearted interest of the researchers, who did not see the traditional school based education as the most important field of a community project, did not kill this initiative, but clearly a lot more could have taken place had the researchers wanted to work more in the schools. ”Compromising” didn’t lead to very good results either: a hastily done survey looking at parents’ and their teenagers’ opinions, conflicts and attitudes was conducted due to the persistent requests of the actors, but had such a low response rate (about 30 %) that the results have not been used.
In summary

"Community" in this project was defined as a system of everyday life. Even present day communities have several features which make them useful in developing the prevention and in trying to understand how prevention can work (Holmila 1995b). In a case study like the one conducted in Lahti the understanding of the community structures and the ways of thinking is important and possible. The research methods were multiple, and a number of different approaches were applied. The overall frame of the study is to look at the community in action - bound by context and traditions, but yet in motion.

The research results are thus two-fold: on one hand the study will mediate a picture of the community engaged in prevention work. The qualitative description will give ground for understanding and judging this work and its possibilities. On the other hand the study will use both qualitative and quantitative data to assess the outcome of the project.

It seems that one of the many challenges of community action projects is developing the research methodology towards interpretation of processes instead of describing stable structures. Is it possible to understand social processes whilst they are happening, or only afterwards?
References


"Liquor Weeks": Local cooperation to inform the public about alcohol

Marjatta Montonen

"Liquor Weeks", alcohol and drug information exhibitions arranged in public libraries in Finland started as an experiment in 1992, and developed into a combined public relations and information dissemination event. The core of the Liquor Weeks consisted of a selection of information materials placed at the public’s disposal either as give-aways (booklets and magazines) or as items that could be borrowed for a week or two (books and videos). The topics ranged from product information to health information, drinking problems, treatment, and self-control of drinking - in practice from glossy wine magazines to the Big Book of Alcoholics Anonymous. Around the core, other displays and public events were arranged. Each Liquor Weeks event was unique, shaped by the ideas and resources of its organizers.

The chief organizers were the libraries and the national alcohol company’s education unit. The organizing team usually included an out-patient clinic and/or the municipality’s temperance/prevention workers, and an alcohol retail store. Other participants ranged from problem drinkers’ self-help groups to hotel and catering vocational schools, and beer and wine clubs.

Background

One point of departure for developing the Liquor Weeks was a disillusioned view of the effectiveness of public education about alcohol. A conclusion that can be drawn from evaluation studies is that, although the public’s awareness and knowledge levels may improve, education in itself is not sufficient for changing behaviour. Two main themes - "responsiveness" and "comprehensiveness" - can be discerned in the proposals for improvement that have been presented in current literature (Montonen 1996). "Comprehensiveness" means that something more than communication is needed. Educational campaigns and programs need to be supported by interpersonal interaction, or to be embedded in broader interventions aimed at affecting environmental factors that have a bearing on alcohol-related behaviours. "Responsiveness" means that people’s pre-existing knowledge and interests need to be taken into account. The chances of success will be greater if educational interventions are based on audience segmentation and use messages that match the target group’s orientation. Comprehensiveness and responsiveness may not be easily reconcilable in practice. Problems may

1 The Liquor Weeks events described here were arranged between March 1992 and May 1994. The author planned and organized the Liquor Weeks in Salo, and participated in the planning of the Liquor Weeks in Lahti. Organizers of three other events contacted the author and received some advice; two of these events were visited by the author. Organizers of five events have been interviewed by telephone. Other sources of information include circulation statistics, surveys and feedback forms, minutes of planning committee meetings, press releases, press clippings and a tape-recorded sample of radio programs.
arise when alcohol education is to be embedded in a community-wide prevention project. Communicating universal messages to the general public is not likely to be too effective but, on the other hand, available resources may not allow to tailor interventions to a large number of subgroups. The Liquor Weeks were an attempt to solve this dilemma.

There is good reason to assume that alcohol-related interests among any given population are varied. One key idea of the Liquor Weeks was to offer something to everybody. There exists a wealth of alcohol information materials produced by statutory agencies, voluntary organizations and commercial publishers; the exhibition displayed what was available, in the hope that members of the public might be able to find those materials that best match their interests. The materials varied not only in “breadth” but also in “depth”: booklets, magazines and videos offered more general and easily approachable content, and books offered detailed information for those who would be willing and able to concentrate on them.

**Information seeking in everyday life**

Dissemination of information can be considered in the frame of research on information-seeking (Wilson 1994). Empirical studies have examined the information needs that arise in the course of ordinary people’s daily life, and the strategies people use to satisfy these needs (Dervin 1976; Chen 1982; Piukkula 1990; Tuominen 1992; Savolainen 1995). The findings suggest some ”general principles” of everyday information seeking. For most people, family members and friends are the most frequently used sources of information on most topics. When people turn to institutional sources, the most familiar and easily accessible ones are given priority.

Information about alcohol should therefore be made available at places located by the public’s habitual paths of daily life. In Finland the public library is such a place. The network of municipal libraries covers the whole country, and it has been estimated that around 60 percent of the population use library services. Although data on the social-demographic background of library users is limited, it is evident that the libraries serve a broad cross-section of the population. A survey conducted in the capital area found families with young children, and active middle-aged people to be among the most regular library users. Groups that tended not to use the library included elderly people with only elementary education, and economics-oriented people, who were better served by other information channels (Myllylä 1992). A survey conducted in Lahti, one of the country’s bigger cities with a population of 94 000, found that the share of library users was greatest among students, and among people working in education or in health and social services. Library use was only slightly less common among homemakers, and among people working in commerce or industry (Piispanen 1990).

**Both sides of the coin**

The public library is generally seen as a nonpartisan mediator of information, and as such it has the advantage of being "neutralized ground" with regard to alcohol. It was hoped that setting up an alcohol information exhibition in the library would play down the moralism often associated with alcohol issues. People who are reluctant to contact alcohol agencies might be able to reach for information in the library, without fear of embarrassment or negative labelling. The Liquor Weeks exhibition was extended to cover also non-problematic aspects of alcohol use.
Product information and health information are normally kept apart: they are produced by different agencies, and distributed through different channels. In the Liquor Weeks exhibition, information about beer brands was placed side by side with practical advice for cutting down one’s drinking. The idea of showing “both sides of the coin” was emphasized as the key principle of the whole event when it was presented to the media, and through them to the public.

The idea of presenting both sides of the coin was broad enough to form a common ground for the different actors involved in organizing the event. The Liquor Weeks were meant to provide local actors with an opportunity to meet each other and to work in a joint project. The library provided the venue and the literature for the exhibition. The national alcohol education unit provided most of the give-away materials and videos. The contribution expected from the other participants was expertise and labour rather than monetary resources - which was more than acceptable in times of economic stringency.

History of the Liquor Weeks

The first Liquor Weeks (Montonen 1992; 1993, 3 - 19) were organized as an experiment and research project in Salo, a town of 22 000 inhabitants. As the main research task was to gather data on the public’s interest in the materials, it was important to arrange the exhibition in a place where it would not fail to attract visitors. The library of Salo seemed an ideal venue: the percentage of borrowers of the population (78 % in 1992), as well as the number of library visits and loans per inhabitant (19 and 39 per year in 1992) have for years been highest in the country (Kaupunkien kirjastotilastot 1993).

The library manager and other participants were contacted by a researcher on behalf of the national alcohol education unit. The Liquor Weeks exhibition - booklets, magazines, books, videos, thematic catalogues and leaflets carrying information on local services - stayed in the library for two weeks. Components that might have distracted the public’s attention from the information materials were kept at a minimum. A “conversation booth” was arranged by the local out-patient clinic and by a self-help group. When rumours about the preparations spread in the town, the local temperance association brought to the library some items relating to its history. On one Sunday, a couple of computers with educational games were set up, and educational videos were shown in the library. A display using bottles, sugar lumps and butter packages to illustrate the calory content of alcoholic beverages was set up in the local alcohol retail store.

A variety of channels were used to promote the Liquor Weeks. Posters and postcards were distributed to social and health agencies, pubs and restaurants. Publicity materials were mailed to schools and to large companies. Press releases and personal contacts were used to inform local and regional media. The local cable television station run a couple of alcohol-related videos accompanied by Liquor Weeks advertisements. The library manager made use of the city’s weekly 30-minute slot on the local radio to promote the event.

In terms of public attention, the Liquor Weeks were a success. Besides news reports, the leading local media run special articles/programs on alcohol-related topics. Around 18 600 visits were registered in the library during the exhibition period. The exhibition was visited by groups of students led by their teachers, and by a number of teenagers on their own. Roughly 7 000 copies of booklets and magazines were distributed, and more than 200 books and videos were borrowed.
The ball starts rolling

The next Liquor Weeks events in Raisio, Anjalankoski and Kotka (towns with 19 000 - 57 000 inhabitants) were arranged on the initiative of the libraries. The manager of the library of Raisio heard a radio report on the Liquor Weeks arranged in Salo, and passed on the idea to Anjalankoski. A librarian working in Kotka got the idea from a report published in a library journal.

In Raisio, a great deal of attention was paid to setting up attractive decorations and displays. The local out-patient clinic, as well as AA, Al-anon and Narcotics Anonymous groups brought their own materials to the library. An opening ceremony was arranged, with drinking songs performed by a local group and presentations by the manager of the out-patient clinic and by the manager of the alcohol retail store.

The events in Anjalankoski and Kotka were modelled on the Raisio Liquor Weeks. New features added in Kotka included public lectures on women’s use of alcohol, and classroom visits by local policemen who talked about drinking and driving.

Liquor Weeks as a component of the Lahti project

In the city of Lahti, the Liquor Weeks were organized as one component of a community-wide project (see Holmila, p. 1 - 21). After the head of library services had been contacted by the Lahti project’s representatives, a broad-based planning committee was established. The eight-month planning work was led by the library’s public relations official and by the city’s temperance secretary. Other participants included an out-patient clinic, a hotel and catering vocational school, and alcohol retail stores. Efforts were made to involve also schools, youth workers, social service agencies, and occupational health service units, but without too much success.

The Lahti Liquor Weeks, arranged in the main library, were designed as a high visibility event. To stimulate media coverage and to attract a large attendance, a variety of thematic exhibitions and public lectures were arranged. Also the opening ceremony was a high-profile event, including a speech by an assistant mayor. Alcohol-free beer was served to library visitors throughout the opening day. The themes of the lectures ranged from pub culture, and modern methods of winemaking to drinking problems, and the effects of alcohol on the brain. The thematic exhibitions focused on health effects of drinking, the calory content of drinks, treatment services, the era of prohibition and early temperance movement, and the art of serving drinks. Guided tours and video shows were provided on request for visiting groups of students.

During the two-week exhibition period around 50 000 visits were registered in the library. Roughly 10 percent of the city’s secondary school students visited the exhibition in groups, and a multitude on their own. The visitors took back with them approximately 34 300 copies of booklets and magazines, and borrowed over 300 books and videos.
The second generation

The subsequent events, the "second generation" of the Liquor Weeks, were modelled on the Liquor Weeks arranged in Lahti. The events included high-profile opening ceremonies, thematic exhibitions, public lectures and sampling of alcohol-free drinks.

In Helsinki, the capital, Liquor Weeks were organized on the initiative of the city’s drug prevention bureau; the bureau’s public relations official picked up the idea from Lahti. Helsinki has a population of over 500 000, and more than 30 municipal library units. Liquor Weeks were arranged in two of the biggest units, for a period of two weeks in each. A new attraction was an opportunity to have one’s GGT-level measured anonymously in the library. More than 1 200 people participated in the testing, sometimes after queuing for hours (Ollikainen 1994). Although more resources were spent on advertising the Liquor Weeks in Helsinki than in any other place, the attendance was smaller than expected: a total of 48 000 visits were registered in the two libraries, and approximately 44 000 booklets, leaflets and magazines were distributed.

In Kuopio and Imatra (with 82 300 and 33 000 inhabitants, respectively), the Liquor Weeks were again organized on the library’s initiative. Characteristic to the event in Kuopio was a wide variety of thematic exhibitions, including collections of beer cans, beer and wine labels, posters and postcards provided by members of beer and wine clubs. The consumer clubs also participated in organizing public lectures. GGT-testing in the library was organized by a heart disease prevention association.

In Imatra, the range of organizers was broadened again: lectures on wine and winemaking were given by the owner of a local restaurant, and by the owner of a winemaking equipment shop. High-profile public events were the speciality of the Imatra Liquor Weeks. The library commissioned from a local amateur group a musical on the theme of young people and drugs. On one night, students from a hotel and catering school, dressed in carnival costumes, served alcohol free cocktails and offered practical advise for arranging parties.

In Lohja, a town with 15 000 inhabitants, it was the chair of a local home-wine makers’ club who took the initiative in organizing Liquor Weeks; he had brought the idea back from a business trip to Kuopio. In the event arranged in Lohja, alcohol-free beer was served by the out-patient clinic, and GGT tests were taken by the occupational health service unit of a local firm. Small scale exhibitions were set up in three library units of a rural community surrounding Lohja; these seem, however, to have been too low-profile to have been a real success.

In Lohja, the lecture program was even more varied than that of previous Liquor Weeks, including themes such as modern winemaking, home-made beer and wine, champagne and eroticism, and current trends in alcohol policy. One of the speakers of the alcohol policy event, the chairman of a newly founded farm-wine producers’ association, focused on the future of fruit-wine production, a topic of special interest to local apple farmers.
Organizers’ perspectives

The libraries

Although reports on the Liquor Weeks appeared in regional and even national publications, the mass media played a minor role in disseminating the idea. Information and experiences were communicated from one library to another through librarians’ informal networks. Geographical proximity played no role: in some cases the idea was adopted from a library located at a distance of hundreds of miles, the organizers being unaware that a similar event had been arranged in a nearby community.

For several libraries, the Liquor Weeks provided the first opportunity to work in a joint project with the municipality’s health and social sector. For all libraries, as well as for the out-patient clinics and temperance/prevention workers, vocational schools and alcohol retail stores were completely new partners. The librarians involved in organizing the Liquor Weeks considered the event a worthwhile exercise. Making new acquaintances and working together with people who had different kinds of expertise was interesting, and sometimes fun. The Liquor Weeks interrupted routine work and was a project in which something visible was achieved. By pooling their resources the participants created an event that was more prominent and attractive than could have been anything organized by one agency alone.

Talking about “libraries” or other agencies as organizers of the Liquor Weeks is partly misleading: the events’ success seems to be far less accounted for by institutional resources than by people’s ideas and enthusiasm. In Imatra, for instance, the library staff seems to have put their heart and soul in making the Liquor Weeks a success. The idea was that everything that could be done would be done, starting with delivering publicity materials on foot, on bike and by private cars.

The work seems to have gone smoothly when the library manager took the lead, or when the staff in charge of the preparations had the full support of the management. In one library the management seems to have been a bit slow to grasp the idea of the Liquor Weeks, introduced by a rank and file librarian; by the time the management realized the event’s publicity potential, some opportunities had been missed.

The Liquor Weeks involved a variety of practical problems. All library buildings were not well suited for major exhibitions. There were also logistics problems. The volume of booklets and magazines that had to be transported to the library was remarkable - from hundreds to thousands of kilos. The popularity of the materials varied from one event to the next, and the demand was never accurately predictable. In each exhibition some titles ran out, and acquiring additional copies tended to involve complications. Sometimes library staff seem to have felt a bit uneasy because they were not familiar with all of the materials and could not give enough assistance to visitors.

Timing and duration were problematic aspects. In some cases the Liquor Weeks were arranged in a period when the public was less likely to visit the library - a couple of weeks before Christmas holidays, or in the first warm weeks of spring. Some events seem to have suffered from a too short period devoted to planning. Although the basic idea of the Liquor Weeks was simple, it took time to convene a planning committee, to agree upon the division of tasks and to design the local application. The Liquor Weeks typically lasted two weeks. In Kuopio, a one-week event was arranged, which was afterwards considered too short a period, considering the event’s popularity.
and the energy devoted to arranging it.

The practical problems seem, however, to have been minor deficiencies that did not prevent the Liquor Weeks from being a success. Most of the interviewed organizers were so pleased with the event that it required some thinking to remember flaws.

For the libraries, the Liquor Weeks were a welcome opportunity to get publicity. Because of the economic depression, which hit Finland hard in the early 1990s, public services have been faced with cuts in funding and even the existence of some services has been questioned. Cuts in funding have forced libraries to shorten opening hours, reduce acquisitions, and close down some units.

Other participants

Treatment services, too, have been affected by cuts in public expenditure. The out-patient clinics that participated in the Liquor Weeks welcomed an opportunity to make themselves visible in the community beyond the range of their clients.

Almost one year before the first Liquor Weeks event, the out-patient clinic of Raisio organized a high-profile open doors event called the "Liquor Fair" (Heino 1992); the event included exhibitions as well as blood pressure and GGT-measurements. The idea was quickly adopted by other clinics, and during a couple of years Liquor Fairs were arranged across the country. Some of the clinics that participated in the Liquor Weeks had previously arranged Liquor Fairs, and were thus experienced in organizing events for the general public. For the staff of other clinics, it may have been more difficult to foresee what kind of event the Liquor Weeks were going to be; one clinic manager admitted that, had he known how popular the event was going to be, he would have invested more in the clinic’s contribution.

Municipal temperance work has also been affected by cuts in funding, which has pushed toward reorganization of the work. There has also been a more long-term trend from traditional temperance work toward more broadly defined prevention of alcohol and drug-related problems. Temperance/prevention workers’ involvement in the Liquor Weeks varied from half-hearted participation to acting as chief organizers, depending on whether or not they saw the Liquor Weeks as one way to widen the scope of their work.

For the self-help groups the Liquor Weeks provided an opportunity to present themselves in a neutral, everyday context. Some groups just put their materials on display, others also provided the public an opportunity to discuss with group members. Even if the public was not always eager to enter into conversation, some group members thought that their mere presence in a neutral public place had the potential of reducing mystification and negative labelling often associated with drinking-problems.

The participation of the winemaking-branch in two of the latest Liquor Weeks events was evidently motivated by commercial interests. For the beer and wine clubs, the event was an extension of the hobby, both in the sense of being able to contribute to the event, and in the sense of benefiting from it as a source of information.

One feature that distinguishes the second generation Liquor Weeks from the earlier ones, is the difference in the nature of the citizens’ groups that participated in the event: self-help groups were
involved in the first events, consumer groups in the second generation events. The Liquor Weeks concept seems not to have been broad enough to accommodate both types of groups simultaneously.

For the vocational schools the Liquor Weeks provided publicity, and an opportunity for practical training: the students set up displays, acted as caterers, and advised the public on alcohol-free drinks, and on the art of serving drinks and dishes. Students also made use of the lectures and information materials. The Liquor Weeks frequently attracted individual students and groups also from other vocational schools, particularly from schools in the health and social service sector.

The alcohol retail stores’ participation in the Liquor Weeks was partly based on the national alcohol company’s obligation to carry out its activities in a way that would entail the minimum of harm to public health: it was the local stores’ duty to give assistance to the company’s education unit. The stores helped in transporting the education unit’s materials to the libraries, distributed publicity materials to pubs and restaurants, and sometimes detached staff to act as exhibition guides, but were in general not willing to set up any special Liquor Weeks displays within the stores. In several events, the manager of the local store or the chief of the sales district gave a speech in the opening ceremony. The extent of retail sales people’s involvement in the Liquor Weeks seems to have depended largely on their personal views on public health and alcohol policy issues.

For the national alcohol education unit the Liquor Weeks were a first step toward community-oriented prevention work. One idea behind the experiment carried out in Salo was that the exhibition could be developed into a “package” that could be circulated in libraries across the country. In practice the Liquor Weeks developed as a “natural” process rather than through systematic planning. The education unit was unprepared for the interest shown by libraries immediately after the first exhibition in Salo. It took some time to designate one staff member as the liaison, and to establish some continuity in working methods.

**Liquor Weeks in the media**

The Liquor Weeks’ publicity strategy aimed at generating media coverage. Posters and short notices in the media function best as attention-catchers or reminders. Reports by the local media were needed to give the public an idea of the content and of the spirit of the event.

In the seven towns from which press clippings were available, local and regional papers carried on the average six Liquor Weeks-related articles, often half-page stories with illustrations. Particularly the Liquor Weeks arranged in Lahti received some coverage also in national papers and magazines. Common types of coverage included news reports, and interviews with lecturers, some of whom were nationally renowned experts. Although the attendance of lectures and other public events was not always impressive, they served well the purpose of keeping the Liquor Weeks on the local media’s agenda.

The newspaper stories presented the Liquor Weeks as an event focusing on both ”positive and negative sides” of alcohol use, ”without glamorizing or condemning” and in a ”balanced manner”. The Liquor Weeks were said to offer ”a basis for making informed decisions” and ”guidance for controlling one’s alcohol consumption”, and to be meant for ”everyone” - although some articles
pointed out young people as the group most in need of education. The idea of combining alcohol and the library was characterized as "new", "surprising", "unprejudiced" and "showy".

The opening ceremonies, public events, and thematic exhibitions were - as expected - among the most newsworthy aspects of the Liquor Weeks. Sampling of alcohol-free drinks, which never passed unnoticed, tended to figure in photographs and headlines: "The Liquor Weeks were launched toasting with light champagne"; "The A-clinic’s staff served alcohol-free beer." Some articles contained quite nice "educational inserts". For instance, an article reporting on beer sampling included an interview with a visitor: "The taste is good, it tastes quite like real beer, said --- who told she had started a beer-fast. - Beer is not good for your liver, she reminded."

Data on the coverage of the Liquor Weeks on local radio is limited to a 65-hour sample of programs broadcast by one public service station and two commercial stations in Lahti. The Liquor Weeks accounted for almost half of all instances in which alcohol was mentioned. On the public service channel, alcohol appeared typically in news reports. On the commercial channels alcohol and drinking tended to appear as the subject of jokes, and in advertisements for local events. Liquor Weeks-related reports, interviews and short notices were much more frequent on the commercial channels than on the public service channel, and seemed to have brought some "balance" - albeit short-lived - to alcohol-related content on these channels.

A liberalist stance toward alcohol policy has been characteristic to the Finnish press during the past decades (Piispa 1994, 249 - 266). The gist of this liberalism has been a rejection of state control for the benefit of individual freedom and responsibility. Public education about alcohol has been the only policy tool that has received visible endorsement in the press. In this perspective, the positioning of the Liquor Weeks seems to have been almost too successful: the liberal image appealed to journalists, the event got the coverage it needed but, with a few exceptions, the focus remained on questions of individual choice - environmental and structural aspects related to alcohol use received little attention.

Liquor Weeks and the public

Data from Salo and Lahti suggest that the majority of people who visited the Liquor Weeks were regular library users, a similar cross-section of the population as library users in general. Only few respondents had come to the library expressly to see the exhibition. Women and young people were the most eager to give feedback on the event. One teenage girl wrote on the feedback form: "I think this kind of exhibition is a good thing, because how would we, particularly the young, get this kind of information from anywhere. And it is important for us."

Feedback from visitors was overwhelmingly positive. The exhibition was typically found "good", "interesting", or "useful". Particularly the "many sidedness" of the materials was appreciated. In Kuopio, a couple of visitors were so enthusiastic that they donated to the library photographs and a video-film depicting the exhibition.

The booklets and magazines

The booklets and magazines had some "novelty value" in the library context, at least because of
the unparalleled abundance of the supply. There were typically around ten different magazines and more than 30 different booklets to choose from. People tended to wander among the materials, pick up and browse different items, and put back the less interesting ones - the library context may be particularly conducive to selectiveness.

There seems to exist among the public, if not a loud demand for, at least a willingness to receive both product information and health information. Product information accounted for 43 percent of the give-aways distributed in Salo, and 32 percent of those distributed in Lahti. Items such as a "Beer Magazine" or a "Cocktail Guide" featured among the "best-sellers". In both sites, health information accounted for more than 20 percent of the distribution. General information about the health effects of drinking, the effects of alcohol on the brain, and the calory content of alcoholic beverages were among the most popular topics.

Interviews conducted with visitors suggest that in some cases the materials taken from the exhibition were read, in others not. While a middle-aged man interviewed in Lahti told that the booklets he took from the exhibition "are still unopened someplace", a teenage girl from the same city said: "I didn’t take thick ones, because I can’t manage them, but I did read --- the few that I took.”

The books

Alcohol and drug-related books are available in libraries’ own collections throughout the year. A factor that may limit their use is that the bibliographic classification system disperses them into different sections of the library. In the Liquor Weeks exhibition, the visitors had an opportunity to see on one occasion the variety of books that are available. In several events, thematic catalogues, produced by library staff, were distributed in the exhibition. The Liquor Weeks may thus have facilitated the use of alcohol-related literature in the long run.

While the distribution of give-away materials was counted in thousands, the book and video-loans were counted in hundreds at best. To get an idea of the popularity of alcohol-related literature in normal circumstances, circulation figures for some 70 titles were gathered in Salo (for the years 1986 - 1991), and in Lahti (for 10 weeks in 1993). Both in Salo and in Lahti, the books were borrowed more actively during the exhibition than normally in a two-week period. The exhibition did not seem to have affected much the popularity of different topics. Product information, drugs, and cultural aspects of alcohol use ranked high both during and outside the Liquor Weeks. Alcohol and traffic, a topic that normally receives little interest from the public, did not fare any better during the Liquor Weeks. The exhibition seems to have slightly increased the salience of books on drinking problems, self-control methods, women’s use of alcohol, and alcohol in the workplace.

The videos

Alcohol-related videos were something new in the library context. Video-lending started in Finnish libraries in 1985 and expanded rapidly. Today a total of over 100 000 videos are available in around 280 municipal libraries (Myllylä 1994). Documentary and know-how videos account for more than one fourth of the collections (Videokysely 1991). Alcohol-related videos are, however, a rarity. For example the otherwise well-furnished library of Lahti had no more than a dozen
To get an idea of how alcohol-related videos might circulate if they were available in normal library collections, some 30 titles (one copy of each) were left in the library of Salo after the exhibition. The number of video-loans taken from the two-week exhibition was not exceeded until after four months. There were no marked differences in the popularity of different topics between the exhibition and the period of "normal" lending arrangements. Videos focusing on drugs or on young people, as well as videos providing information about health effects of drinking were among the most popular titles.

A "two-step flow" of information

The Liquor Weeks were visited by a number of teachers and health or social service workers. For these professionals, the exhibition provided a rare opportunity to see on one occasion the variety of materials that are available. The thematic catalogues were considered useful sources of information. The Liquor Weeks seem thus to have served the public also indirectly by assisting some intermediaries in their work.

This "two-step flow" of information seems not to have been limited to professionals. It was not uncommon that visitors took materials back to their workplace, or to family members. Some parents were looking for materials for their children, or materials that would assist them in guiding their children. A bit surprisingly there were also teenagers who took materials back home for their parents.

The use of alcohol-related videos seems to be to some extent a "social" exercise. In Salo, Lahti and Helsinki, feedback forms were distributed to borrowers. Although the response rate was low (the pooled data accounts for just 15 percent of video-lending in the three sites) it gives an idea of how alcohol-related videos may be used. In half of the cases, the video had been borrowed for the benefit of the respondent’s family member or friend, or because it had some relevance for the respondent’s studies or work. Roughly half of the videos had been viewed in the company of other people.

Some of the thematic displays seem to have generated discussion among the public. One example is the calory display, which was of special interest for a middle-aged woman interviewed in Lahti: "I thought it was really good, and I have told about it to dozens of people, like, can you guess how many lumps of sugar there were beside a bottle of liqueur for instance ---; I went back there the next week, I went to check these calories, you know, that’s how interested I was ---."

Individual-level responses

Public events such as the Liquor Weeks may contribute to raising the public’s awareness of alcohol-related issues and to shaping public views about alcohol, but such effects are not likely to be marked or long-lived unless the events are part of a continuous effort to influence the
community. However, even single events can sometimes be gratifying or stimulating at the individual level, as illustrated by comments from Lahti. A woman in her thirties wrote that "the posters of the Finn Health exhibition really ‘hit home’, for instance the internal organs spoilt by boozing ---. I stopped to think about the drinking problem and about the health of a person close to me.” A man of the same age, who gave "unemployed drunkard and gambler” as his "occupation”, was interested in materials focusing on the brain, “related to my own symptoms”. The man had borrowed two books from the exhibition, one for a friend, and another one for himself. About the latter he wrote: ”After I read the book I dreamed about drinking and when I woke up I was glad that I hadn’t messed up everything again! The book ‘worked’.”

In a small town the staff of the public library tend to know their customers; the attendance of Liquor Weeks in Salo was characterized by a librarian as consisting of ordinary people, of professionals, and of people whose drinking habits are on the heavy side. A small peak was noted after the Liquor Weeks in the number of new customers coming to the out-patient clinic; the staff thought that the stir around alcohol issues was the most plausible explanation. Nevertheless, even if the Liquor Weeks may have stimulated some people to seek help, the event is likely to have been just one in a long series of incentives.

**Liquor Weeks and the community**

The Liquor Weeks were characteristically a local event. Only the Liquor Weeks organized in Salo seem to have been a regional event: one in four of those who borrowed something from the exhibition, and nearly half of those who filled in a feedback form lived in neighbouring communities. The figures are in line with the town’s position in the region: Salo is the only cultural and commercial centre within a radius of over 50 miles, and a major concentration of workplaces. Helsinki, on the other hand, may have been too big a place for the Liquor Weeks. Despite heavy advertising, and despite the fact that the two library units chosen as venues could be easily reached by public transport, the Liquor Weeks seem to have been two neighbourhood events rather than one city-wide event.

The Liquor Weeks events can be divided into those that were popular beyond expectations and into those that did not quite come up to the expectations. Some features that may have reduced the chances of success - too little time for planning, bad timing, inadequate support from the national alcohol education unit, and a deconcentrated town structure - are shared by some of the not-so-good Liquor Weeks, but not by all of them. The events’ relative success does not seem to be in any systematic manner related to population size, age structure, general level of education, or to the community’s economic structure (Suomen tilastollinen vuosikirja 1994).

In contrast to this, a certain pattern is discernible when commonly used quantitative measures of library efficiency are examined (Videokysely 1991). In the libraries, in which Liquor Weeks were successful beyond expectations, the percentage of borrowers of the population, the number of loans per inhabitant, and the operating expenditures per inhabitant were usually above the national average. In the libraries where the Liquor Weeks fell short of the expectations, the figures were usually below the average. It seems that the better functioning the library, the more chances of success there were for the Liquor Weeks.
Messages to the community

The organizers of the Liquor Weeks seem in general to have found palatable the content and spirit of the Liquor Weeks. A rare instance of criticism is expressed in a letter from the temperance association that volunteered to participate in the Liquor Weeks in Salo. Besides praising the event, the association’s representative also criticized it for leaving it to the visitors to assess the veracity of the information that was presented: “It was confusing that true information was presented side by side with commercial propaganda.” One library manager expressed some doubts about the appropriateness of one lecturer’s stance toward alcohol, which she considered to have been almost too positive. Nevertheless, she thought that, although some components might have been a bit biased, the Liquor Weeks as a whole functioned well as an information dissemination event. A different view was expressed by a librarian from one of the small libraries in the community surrounding Lohja, where low-profile exhibitions were arranged. She felt that distribution of health information was a lost cause: in her library unit the public had been more interested in product information.

The ”messages” attached to the Liquor Weeks in press releases and other publicity materials were very general in nature: ”risks and pleasures are located on the same continuum of alcohol use”, or ”decisions relating to alcohol should be based on information rather than on myths”. The participants could, if they wished, to raise other issues, for instance in opening speeches or in interviews given to the media. With the benefit of hindsight, and considering the strengthening liberal trend in the alcohol political climate of the time, there might have been room also for more explicit messages aimed at justifying the continuation of public health-oriented alcohol policy.

From a one-off event toward continued cooperation

The Liquor Weeks concept did not include any strategic plans for developing local partnerships. In most cases the Liquor Weeks took just one small step toward local cooperation around alcohol issues: the event brought together different local actors and demonstrated some benefits of pooling resources. In several cases - even in small towns - some members of the organizing team had never before had the opportunity to meet each other. The new contacts made in conjunction with the Liquor Weeks seem in general not to have led to further cooperation or alcohol-related action in the communities. In most cases the Liquor Weeks remained a one-off event. Usually the organizing team did not even reconvene after the event to share experiences.

Exceptions include the city of Lahti and the town of Raisio. In Lahti, where Liquor Weeks were the Lahti project’s first operation directed to the general public, the success of the Liquor Weeks prepared the ground for subsequent public events. The working relationships established between the project and the library and vocational school were continued. In Raisio, the Liquor Weeks were one instance in a series of major events, preceded by the Liquor Fair, and followed by an event focusing on the problems experienced by drinkers’ family members, in which cooperation between the outpatient clinic and the library was continued.

Evidently more would have been needed to encourage continuation of broad-based local action. The participants might have benefitted from an introduction to the rationale of community action, and to potentially fruitful working methods. There also seems to exist a need for a repertoire of models for practical action. In one small town, a group of local actors interested in organizing Liquor Weeks were left empty-handed. The temperance worker had made preliminary
arrangements with the national alcohol education unit, and contacted a variety of agencies that were willing to participate. All that was needed was the cooperation of the local library, which the planning group failed to secure. To their disappointment, the national education unit felt that the Liquor Weeks could not be detached from the library setting, and was unable to suggest an alternative model for local cooperation.
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Knowledge and attitudes towards local alcohol preventive project in different socio-economic groups

Experiences from the Kirseberg public health project in Malmö, Sweden
Magnus Göransson, Bertil S. Hanson, Eva Lindbladh and P.-O. Östergren

Introduction

Community-based public health interventions has become increasingly important as a strategy for health promotion, most notably in the prevention of cardiovascular diseases, but also in the prevention of smoking, accidents and alcohol-related problems (Matarazzo 1984; Bracht 1990). It is based on a ’principle of partnership’, meaning that the community should become involved in defining problems and priorities, in planning action and in the maintenance of the preventive activities (Bracht ibid; Thompson 1993). This approach has been considered appropriate also in addressing socio-economic differences in health. Little is known about socio-economic differences in the perception of health as a community issue, although differences in attitudes to health have been studied as an individual concept (Calnan 1987; Blaxter 1990; Worsley 1990; d’Hotaud 1984). Ong (1991) reported differences in priorities of local health issues between professionals and lay people in a local community, but differences between subgroups in the population were not studied.

The Kirseberg Project in Malmö is a community-based alcohol preventive project aimed at reducing the per capita alcohol consumption in the general population, in order to decrease the incidence of alcohol-related problems. It is located in Kirseberg, a district in the city of Malmö in southern Sweden. The district has about 10,000 inhabitants, compared to the 230,000 inhabitants of the city. The population of the district does not differentiate demographically from the city as a whole, but it has higher morbidity and mortality rates, also in alcohol-related diseases (Hanson 1991). The project combines an individual high-risk strategy for early detection of inhabitants at risk of developing alcohol-related problems with a community organisation approach where partnership with local public service organisations and citizen groups has been emphasised. This model has been described as ”a planned process to activate a community to use its own social resources and any available resources (internal or external) to accomplish community goals, decided primarily by community representatives and consistent with local values. Purposive social changes interventions are organised by individuals, groups or organisations from within the community to attain and then sustain community improvements and/or new opportunities” (Bracht, ibid). The project was initiated by the Department of Community Medicine (which will here be referred to as ”the agency”) and supported by the City Council.

Three channels were used for promotion of reduced alcohol consumption to the population:
• Health examinations at the primary health care centre, in order to identify riskful alcohol consumption levels, were offered to all inhabitants between the ages of 20 and 45.
• Newsletters and brochures have been distributed to all households as well as to selected target groups. Other local media such as local radio, teletext, bulletins from local organisations have also been used, and information has been distributed at the annual local festivals.
• Representatives of leading socially and politically significant community groups have been
educated about alcohol and alcohol prevention. A local resource group was created, with more than 30 representatives from the local public services, voluntary organisations and citizen’s groups, in order to:

- provide the agency with information about local issues
- live information about the project to the community
- transfer the responsibility for the preventive programmes to the community

As a result of discussions with local participants a number of issues mainly relating to local and environmental issues were added to the project focus. These issues will be related to as the expanded focus in contrast to the core focus of alcohol prevention.

Aims

The aim of this paper is to report the results of two studies on socio-economic differences in response to the local community-based preventive project. The first study analyses how community representatives from different socio-economic backgrounds have participated in the project and their attitudes towards the local resource group. The second study analyses differences in the general population as to knowledge about the project, as well as how the project was perceived in groups of different age, gender, national background and socio-economic status.

Methods and definitions

The preventive activities started in the autumn of 1989. The study on participants in the local resource group was performed from the autumn of 1989, when the group was started, until winter 1992/93. It is based on interviews with the participants, observations, notes and proceedings from the local resource group’s meetings and other meetings between the agency and the participants, and on memos and notes by the agency’s co-workers, compiled in a project diary. In all, forty-six interviews were made with twenty-six participants in the local resource group. The interviews were semi-structured and performed face-to-face. Also three focused group discussions on working methods and the impact of the project in the local community were performed with the researchers participating as group discussion co-ordinators. Nineteen formal meetings were held by the local resource group during the study period, with the researchers present. Proceedings and research notes from these assemblies were used to get data about the activity and attitudes of the local participants. Data about attitudes were analysed with an inductive method that Taylor (1984) has described as a three-step process. First, the material was re-read several times and discussed by the research team. Second, a tentative typology of themes, regarding types of participants, types of behaviour in assemblies and participants strategies for the participation in the project, was then created on the basis of the discussions.

The themes were sorted into empirically based categories. This was repeated until all data had been satisfactorily categorised. Finally, the data was interpreted by the use of these categories. The general population study was performed in the spring of 1992. A randomised sample of 400 persons in the area, limited to one person per household, were telephone interviewed. A questionnaire was mailed to those in the sample who were not available on telephone (37.3 %;
n=141). In total, 221 persons were interviewed by telephone and 56 persons answered the mailed questionnaire. Data on age, gender and national background was obtained from the national register. A study of non-responders were carried out with data from the national register and from the Swedish 1990 Census. In this study knowledge has been defined as having knowledge about at least one of the aims or the activities that the project was involved in. Attitudes were assessed by an open question (“According to your personal opinion, what are the most important things to do in order to improve health and well-being in the area?”) that were analysed with the inductive method described above. Answers from respondents who did not give any suggestions were labelled as ‘negative attitudes’. 'Positive attitudes’ were answers containing positive responses such as support to ongoing activities or suggestions about issues that should be acted upon, either through the project or by other agencies. In the population study, socio-economic status (SES) was categorised, according to the classification of Statistics Sweden (1982). Low SES is here defined as blue collar worker or white collar worker with not more than two years of education after completed nine-year compulsory education. High SES is defined as at least white collar worker with more than two years education after compulsory education. Retired people, housewives, students and the unemployed were not classified.

Results

The study of the participants in the local resource group

Based on our observations of the participants, and on the participants’ experience as reflected in the interviews, we found it incorrect to talk about one process of participation. Instead we found several processes developing. We set our task as categorizing different types of participants and mapping the development of their respective participation.

Although representing aspects of the same local community, the representatives of the professional organisations (such as the local health and social services) and the representatives of the voluntary associations had quite different means and motives for acting on health in the local public sphere. The means and motives of the representatives of the professional organisations were based on a professional belonging and had a defined field of activity, well within the scope of the project’s core focus. They were, in varying degrees, controlling resources such as budget and staff. The laymen organisation was based on shared everyday experience, as for example a parent or as a resident, and on shared interests, beliefs or opinions. Their fields of activity were mainly within the area of the project’s expanded focus. They had their strength in being rooted in local networks and having the potential of forming local opinions.

Within both categories of organisation there were clear differences between representatives with high and low status, which gave us a matrix of four types of participants (figure 1). Here we will only discuss status differences between the laymen representatives.

Figure 1. The four groups of local participants
The high status layman participant was typically a middle-aged person with a university or high school education who was closely associated with the local social movement. In this group there was a well-defined agenda for participation, based on the local social movements program: "The local social movements activities are health enhancing in themselves. What it is all about, is creating a local social context and a spirit of community". They had good contact with local decision-makers and others, which made them valuable as local gate-openers. They were also important as opinion-makers in the local public debate. They were negative to the focus on ill-health and alcohol consumption in the area, since it gave a bad impression of the community. But the project’s concern for general wellbeing in the area opened up for co-operation about issues for local improvements that the local social movement was already working for: "We were very sceptical at the beginning. It was when you supported our action to keep the local post office that we began to change our attitude". The high status layman developed good contacts with the agency and was able to get his demands onto the agenda of the project. They did not involve themselves with the core focus of the project, but the expanded focus of the project was to a large extent inspired by the local social movements agenda. They were able to use the assemblies as a media for spreading information about their activities and as an opportunity to make new contacts with local keypersons.

The low status layman was typically elderly and working class. He represented a local residents organisations which lacked an agenda to act upon in the group and which was without significant political influence in local politics. His concern for health improvement was not for local community nor about health promotion, but for the quality of the curative health care: "It is health care it is all about. We elderly must get better health care!" He had problems in finding his role in the project. He was not associated with the local social movement and its agenda and despite his concern for the health care he had no cooperation with the professional representatives. It was difficult for him to make himself heard in the local resource group: "We belong to the rank and file. The others (in the local resource group) they belong higher up. They can grab opportunities and take advantages in a completely different way than we can. We do not belong to them".

The general population study

The overall response rate was 73.3 % (n=277). Sixteen people, responding to the mailed questionnaire, did not answer the question about attitudes. The response rate was lower among younger respondents (68.6 %, compared to 78.3 % for older; p=0.03) and immigrants (54.4 %
compared to 76.6 % for Swedes; p<0.001). There were no statistically significant differences in response rates regarding sex or marital status. Participation rates for different SES-groups could only be estimated indirectly, by comparing the proportion of the low SES-group of all socio-economically classified among responders with the proportion of the low SES-group of all socio-economically classified inhabitants in the area, 20 - 64 years old, according to the Swedes 1990 census. The low SES-group was under represented among the respondents (65.4 % among responders compared to 74.3 % in the population; p=0.001).

Knowledge about the project was demonstrated by 38.5 % (n=107) of the participants (table 1). Most respondents perceived the project as associated with the local primary health care centre and the general health examinations.

Attitudes: Forty-six percent (46.0 %; n=120) reported negative attitudes towards health prevention as a local community issue. We have distinguished between three sub-groups of negative answers. Each negative answer may have been referred to more than one category but categorisation as "no opinion" excluded the possibilities of being referred to other negative categories.

- Those who did not want to express any opinion on this matter (29.1 %; n=76)
- Those who did not want to express any opinion (29.1 %; n=76)
- Those who perceived health as a strictly private matter (10.0 %; n=26)
- Those who saw no need for local health prevention but defended the area against the presumed accusation of being particularly unhealthy (9.6 %; n=25)

Fifty-four percent (54.0 %; n=85) reported positive attitudes towards health prevention as a local community issue. A broad range of issues were brought up as suggestions about what a local community-based health preventive activity should be about. We could define four main categories (where each positive answer may have been categorised into more than one category) for what was perceived as essential to act on for improved local health and well-being (table 2):

- Improvements of the physical environment, like heavy traffic or pollution (32.6 %; n=85)
- Improved local community spirit (15.3 %; n=40).
- Improved health and social services (16.5 %; n=43).
- Offerings of more local health promotion activities (11.5 %; n=30).
Table 1. Associations between knowledge about the Kirseberg Project in the population (n=275) and age, gender, nationality and socio-economic status (SES), expressed as percentage (%), crude and adjusted odds ratios (OR) and 95 % confidence intervals (95 % CI).

<table>
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<tr>
<th>Knowledge</th>
<th>n</th>
<th>%</th>
<th>Grude OR</th>
<th>Adjusted OR*</th>
<th>95 % CI</th>
<th>95 % CI</th>
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<tr>
<td>(n=275) old</td>
<td>(144)</td>
<td>34.0</td>
<td>1.5</td>
<td>0.9 - 2.5</td>
<td>1.6</td>
<td>1.0 - 2.6</td>
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<tr>
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<tr>
<td>(n=275) immigrant</td>
<td>41.4</td>
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<td>2.4 - 9.7</td>
<td>4.1</td>
<td>2.0 - 8.6</td>
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* Adjustments made for age, gender and nationality in a logistic regression analysis

Knowledge about and attitudes towards the project were different in different population groups:

- **Knowledge** about the project was more common among women (43.9 % compared to 32.2 % among men), persons born in Sweden (41.4 % compared to 19.4 % among immigrants) and in the high SES-group (64.5 % compared to 36.5 % in the low SES-group) (table 1).
- **Attitudes** tended to be more positive in the high SES-group (65.0 % compared to 51.3 % in the low SES-group and 50.6 % in the unclassified SES-group; p=0.08).
- The high SES-group expressed more concern for community spirit (25.0 % compared to 9.6 % in the low SES-group; p=0.006) and for offerings of local health promoting activities (21.7 % compared to 7.8 % in the low SES-group; p=0.009) (table 2).
Table 2. Association between socio-economic status and different local health issues (n=277). (Each answer could be coded under more than theme). Internal missing=16

<table>
<thead>
<tr>
<th>Suggested local health issues</th>
<th>% in the total population</th>
<th>Distribution in different SES-groups n %</th>
<th>p-value (high/low SES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvements of physical environment (n=61)</td>
<td>23.4</td>
<td>High 14 23.3</td>
<td>p=0.69</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low 30 26.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unclassified 16 19.5</td>
<td></td>
</tr>
<tr>
<td>Improvements of social environment (n=40)</td>
<td>15.3</td>
<td>High 15 25.0</td>
<td>p=0.006</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low 11 9.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unclassified 14 17.1</td>
<td></td>
</tr>
<tr>
<td>Improvements of health and social services (n=43)</td>
<td>16.5</td>
<td>High 9 15.0</td>
<td>p=0.91</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low 17 15.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unclassified 16 19.5</td>
<td></td>
</tr>
<tr>
<td>More health promotion activities (n=30)</td>
<td>11.5</td>
<td>High 13 21.7</td>
<td>p=0.009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low 9 7.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unclassified 7 8.5</td>
<td></td>
</tr>
</tbody>
</table>

Discussion

In the study of local participants, we found differences in the participation between the laymen representatives which were related to the social status of the participants, and we found that only the representatives with high social status succeeded in developing a partnership with the agency. The high status laymen had a defined agenda for their participation where support for the local social movement and strengthening of the local community spirit were important elements. In the population study, we found that the high SES-group was better informed about the project and that the high SES-group more often perceived improved social environment and health promotion activities as important for improved health and well-being in the area. The findings common for both studies were the socio-economic related differences in relation to the local health promotion project and the project’s higher affinity with the high SES-group.

The overall response rate in the population study was 73.3 %. It was lower among young people, immigrants and the low SES-group. Since these groups knew less about the project, we cannot exclude the possibility of having somewhat overestimated the knowledge about the project.

An important problem of precision and validity in the qualitative analysis in both studies is the risk of misclassification. In order to decrease this risk, observations and statements were coded several times and repeatedly checked against the actual interviews and notes, as suggested by Taylor (ibid.).

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Knowledge about the project in the population study was assessed with a self-report method. Studies in social psychology have demonstrated that respondents who have little or no knowledge about the topic asked about are more likely to give affirmative than negative answers (Ray 1983). Some persons claimed knowledge about the project, but identified it with activities to which the project had no connections. These individuals were classified as not knowledgeable. There was also a tendency to give more affirming answers in telephone interviews than in the mailed questionnaires, but the differences were not statistically significant.

In order to adjust for potential confounding factors in the population study we made multivariate analyses where age, gender and nationality were included in a logistic regression analysis. The adjustments slightly increased the socio-economic differences regarding knowledge.

Our findings in the population study about socio-economic differences in knowledge about the project are in agreement with a number of studies on public education campaigns in many different fields, including health education (Gaziano 1983; Rogers 1971; Viswanath 1990).

We suggest that the differences in attitudes; towards participation among the community representatives and towards health promotion as a local community issue in the general population; should be interpreted as a key factor for understanding the socio-economic differences in knowledge about the project.

We argue that in Kirseberg, the idea of taking action on health at the local community level is a socio-economically related phenomenon. One might say that the concepts of a local community spirit and of the local community as an arena for action is meaningful for the high SES-group, who were already involved in the local public sphere, but not so for the low SES-group. Therefore, a part of the explanation of the socio-economic differences in knowledge about the project is, that the project has been designed and marketed with concepts that are rooted in the everyday life of the high SES-group.

Our conclusion is that, in the design of community-based projects, it is important to carefully investigate how the explicit notions and the implicit premises of the health promotion campaign corresponds with central attitudes and values in different population groups in the target community.
References

Community organisation - A basis for preventing substance abuse amongst teenagers and young adults

Tone Bergan and Erik Iversen

Abstract

The project to be presented includes five municipalities in the Hordaland County, Western Norway. The participating municipalities were selected by application and have a population varying from about 1,000 to about 14,000 persons. In total the communities comprises approximately 43,000 persons. The National Directorate for the Prevention of Alcohol and Drug Problems is financing the project, and it is co-ordinated by a project leader situated at the Department of Health and Social Welfare, Hordaland County Administration. A team at the Department of Psychosocial Science, University of Bergen, is responsible for the evaluation. The project period is lasting from May 1994 throughout 1996 and the project is mainly based on the tradition of ‘community organisation’. The project develops through five more or less overlapping stages (Bracht and Kingsbury 1990): 1. Community analysis, 2. Initiation and design, 3. Implementation, 4. Maintenance and consolidation and 5. Reassessment and dissemination. (Bracht and Kingsbury 1990). The target group is young persons between 16 and 25 years of age. The aim of the project is reducing the prevalence of alcohol- and drug related problems and influencing factors contributing to these kind of problems. Furthermore, there is an object to obtain information about feasibility and possibilities of local prevention. After being selected for participation, each community chose a local project co-ordinator. Local boards were then recruited from diverse areas of community life. By September 1995, the local project groups had completed the major part of the initial community analysis (stage 1), ’stage 2’ initiation and design, was nearly brought to an end and the implementation phase (stage 3) had started. A progress report will be presented.

Introduction

The paper describes some of the first experiences from a community based prevention project. The project is financed by the National Directorate for the Prevention of Alcohol and Drug Problems. The start was May 1994 and the project period endures throughout 1996.

The aim of the project is preventing drug abuse among young persons between 16 and 25 years of age in order to decrease substance related problems. Furthermore, the objective includes obtaining information regarding feasibility and possibilities of local prevention at a community level.

The site of the project is Hordaland County, Western Norway. The county has approximately 420,000 inhabitants which amounts about 10 % of the population in Norway. Bergen, the second largest city in Norway, is the regional centre of Hordaland and Western Norway.

Hordaland is almost divided in two by the 179 km long Hardangerfjord and comprises 34
municipalities governed by district councils. The majority of the population lives in the coastal areas and on the low-lying narrow strip farming land along the fjords. The largest sector in the economy is oil-related industries. There is also more fruit growing in Hordaland than in any other county in Norway. Moreover, Hordaland is the leading county in fish farming. Tourism is another industry of major importance. The level of unemployment in Hordaland has traditionally been low, but there are some local variations.

Background

By request from the National Directorate for the Prevention of Alcohol and Drug Problems, the Department of Psychosocial Science at the University of Bergen, prepared a plan for a community based substance abuse prevention project among older adolescents and young adults (Klepp, Aarø and Skutle 1990). This plan formed the basis for an application to the Directorate for financing a programme consisting of two projects, implementation and evaluation of a community based health promotion and preventive model in selected local communities.

A team at the Department of Psychosocial Science at the University of Bergen is responsible for the evaluation of the implementation of the project model. The evaluation consists of both qualitative parts and quantitative parts. The qualitative parts are conducted in a close collaboration between the project leader and the evaluator.

The following describes the implementation project from the start in May 1994 until September 1995. For a more extensive description of the evaluation project, is referred to the paper presented by Iversen, Bergan and Skutle 1995: ”Community-based substance use prevention among older adolescents and young adults in Western Norway: An evaluation model”.

Organisation

The implementation project is organised with a principal project leader situated at the Department of Health and Social Welfare, Hordaland County Administration, and a steering committee consisting of representatives from:

- The National Directorate for the Prevention of Alcohol and Drug Problems
- Dept. of Psychosocial Science, University of Bergen
- Dept. of Cultural Affairs, Hordaland County Administration
- Dept. of Education, Hordaland County Administration
- Dept. of Health and Social Welfare, Hordaland County Administration

The committee has about 4 meetings each year summoned by the project leader that holds the secretary function. The evaluator attends the meetings. The steering committee has a superior responsibility for the project and shall according to this contribute to the quality of the project and act as a support for the project leader. The project leader is responsible for the co-ordination and the management of the implementation project. According to the job description, the project leader ”..shall inspire and support the local project groups and for co-ordinate the activities in the communities, as well as see to that the project is progressing according to what is planned”.
Philosophy of the project

The project is mainly based on the tradition of 'community organisation' defined by Bracht and Kingsbury (1990) as:

A planned process to activate a community to use its own social structure and any available resources (internal and external) to accomplish community goals, decided primarily by community representatives and consistent with local values. Purposive social change interventions are organised by individuals, groups or organizations from within the community to attain and then sustain community improvements and/or new opportunities (p. 67).

Many definitions of 'community' have been suggested, here it is understood as in Thompson and Kinne (1990, p. 47): "... a group of people sharing values and institutions. Community components include locality, an interdependent social group, interpersonal relationships, and a culture that includes values, norms and attachments to the community as a whole as well as its parts”.

During the project period it has been an aim to attain a combination of action and research, with a close collaboration between the researcher at the evaluation project and the leader of the implementation project.

Project model

The project model has an emphasis on empowerment and control to local agents. Community based preventive intervention can be described in terms of community development or community involvement, and is based on an active partnership strategy between local authorities and citizen groups. In short, citizen action is a key to realising social goals. The participation of the target group is crucial.

The concept of 'participation' can be defined as: ”The social process of taking part in either formal or informal activities, programmes and/or discussions to bring about a planned change or improvement in community life, services and/or resources” and 'community involvement' as: ”the active participation of people living together in some form of community in the process of problem definition, decision-making and action to promote health” (Hanson, B. et al. 1992).

When applied on community health projects, the community organisation model provides a structured five phase guide or process for achieving community intervention goals. According to this guide, the project is progressing in five more or less overlapping stages as described by Bracht and Kingsbury (1990):

1. Community analysis:
Assessing community culture, resources and problem areas. Identifying key organisations and persons, and potential barriers for success. The purpose is to give a picture of the local community’s history, culture, geography, demography, health and health risks, as well as its resources.

2. Initiation and design:
Mobilising community support and recruitment of key persons to local board and supplementary groups. Planning and designing preventive measures.

3. Implementation:
Turning plans into action. Making necessary adjustments. Generating broad participation in the community.

4. Maintenance and consolidation:
In order to maintain some of the substance use preventive and health promotive activities as integrated parts of the local authorities’ and associations’ ordinary activities after the completion of the project, these activities must be planned and incorporated as ordinary activities from the beginning.

5. Reassessment and dissemination:
Summing up experiences. Assessing successes and failures. Drawing up lines for future efforts. Summarise and report results in administrative, popular and scientific media.

**Participating municipalities**

In 1993 four counties in Western Norway were invited to apply for participation in the project, on the basis of application Hordaland County was selected.

Hordaland comprises 34 municipalities governed by district councils. In February 1994 they were all invited to apply for taking part in the project. Twelve municipalities sent their applications, and in May (1994) five were selected.

The selection criteria set were: variety in geographical location, population size and established inter-sectional co-operation as well as commitment and quality of applications.

*The following municipalities were selected for participation:*

**Eidfjord:** Population about 1,000. Fjord-bottom inland community. Water power, tourism and agriculture.

**Bømlo:** Population about 10,000. Island community. Fishing, smaller industry and agriculture.

**Kvinnherad:** Population about 13,000. Coastal community. Aluminium industry, shipyard, agriculture and tourism.

**Meland:** Population about 5,000. Island community. Small industry, fishing and agriculture. Suburb settling.

**Voss:** Population about 14,000. Inland community. Public services (higher education, hospital), tourism, agriculture and small industry.

Each municipality is unique, but the processes to be followed in the analysis, design, organising and implementation are similar. In total about 43,000 persons are living in the municipalities. The primary target group comprises about 7,000 persons.

**Progress of the project**
On the initiative of the project leader, meetings were held in each community immediately after the selection. Representatives from the municipal administrations (to a large extent from top level), the project leader and the evaluator attended the meetings. The intention of the meetings were rather informal ("get-to-know-each-other"), and information-exchange. The project leader and the evaluator presented the project model and the planned time schedule of the project, and the representatives from the communities put forward their expectations to the project.

At the meetings the five communities formed interim project groups (consisting of 2 - 3 persons) that started collecting material for the community analysis. The groups defined a local project co-ordinator that was the project leader’s local contact. In June 1994 a broad baseline survey amongst the target group in the communities was carried out. The survey has evaluative purposes as well as it served as an element in the community analysis.

During the autumn 1994 the project leader and the evaluator had more meetings in the communities. The local project co-ordinators summoned relevant persons and this time the meetings had a more formal character than the initial ones. They also comprised more people and was the first step in mobilising participants to the local project groups. About at the same time the district councils in the communities considered and approved the project.

According to Giesbrecht and Ferris (1993) community action projects are likely to be faced with a number of issues related to purpose and outcomes, philosophy and orientation e.g., and controversy or disagreement may arise with regard to a number of such key issues. It was therefore found important to enlighten some of these issues relatively early in the project period, and competence building seminars were arranged in each of the participating communities.

The themes of the seminars were the project model and community based philosophy regarding ‘health promotion’. Furthermore, substance use prevention was discussed, and information regarding the results from the baseline survey given. In addition, work shops concerning local aims and local organisation of the preventive measures were arranged. The participants represented social/human services agencies, the church, the police, medical/health professionals, schools, local newspapers, local politicians, voluntary public organisations (e.g. sports, cultural, religious), business sites and of course, the target group.

At the end of 1994, the communities had formed broadly constituted local project groups with intersectoral representation including the target group.

During the project period the National Directorate for the Prevention of Alcohol and Drug Problems allocates funding to be used for preventive measures, about NOK 500,000 each year. There is no specific forms to be filled in, and the steering committee appraises the applications from the local project groups according to the objective of the activity, duration, involvement of the target group, way of organisation and feasibility. Immediately after the consideration of the applications, the project leader informs the community project co-ordinators about the result. The local project groups have established specific bank accounts for the funding and the money can not be reallocated. The steering committee considered the first applications for funding of preventive measures in May 1995.

**Status, September 1995**
The first and the second ”generation” of the community analysis are completed or under completion (phase 1 of the model). Local project groups have been formed in all the five communities. Four of them have planned and applied for funding for specific preventive measures (phase 2). Some of the measures are implemented (phase 3).

*The impression so far is that:*

- There are good correspondences between the intentions of the community-based model and the way the community officials wish to work,
- There are emerging inter-sectional fora and arenas in the municipalities,
- There is genuine awareness of the need for health promotion and prevention in the municipal administrations, and some frustration over "how to do it"
- There is a healthy amount of enthusiasm over being part of the project.
References


Community-based substance use prevention among older adolescents and young adults in Western Norway: An evaluation model

Erik Iversen, Tone Bergan and Arvid Skutle

Abstract

A community-based substance use prevention project is under implementation in five municipalities in Hordaland County, Western Norway. The project is being evaluated throughout the implementation period by a team based at the University of Bergen. Evaluation is planned consisting of four elements: Process evaluation and effect evaluation of selected preventive measures in the various municipalities, qualitative evaluation of the implementation of the project as a whole in co-operation with the project co-ordinator situated at the county’s health administration, registrations of substance use related incidents by police and MDs in the municipalities, and a quantitative prospective survey of behaviour, attitudes, norms and self-efficacy expectancies related to alcohol use among 16 to 25 year old inhabitants of the municipalities. The baseline questionnaire for the prospective survey was administered in June 1994, and follow-up is planned in June 1996. An outline of the evaluation plan, it’s theoretical basis, a progress report and some results from the baseline survey is presented.

Program background

By request from the Norwegian National Directorate for the Prevention of Alcohol and Drug Problems (NNDPADP), the Department of Psychosocial Science in 1990 prepared a plan for a community based substance abuse prevention project among older adolescents and young adults (Klepp, Aarø and Skutle 1990). This plan formed the basis for an application to the Directorate for project financing. The Directorate has allocated approximately 1.2 million NOK yearly between 1994 and 1996 for the project.

The project has two parts. One part will try out a community based health promotion and prevention model in five selected local communities in Hordaland County in Western Norway (Bergan and Iversen 1995). The other part will evaluate the implementation of the model.

Program implementation

The prevention model (Bergan and Iversen 1995) is based on principles of community psychology, with emphasis on empowerment and control to local agents (Green and Kreuter 1990; Heller et al. 1984). It draws on experiences from community based heart disease prevention projects like the Stanford 5-city Project (Farquhar et al. 1985), the Minnesota Heart Health Program (Mittelmark et al. 1986) and the North Karelia Project (Puska et al. 1985) and other community based prevention programs (Bracht 1990; Hyndman et al. 1992; Giesbrecht and Ferris 1993). The
project is planned in five more or less overlapping stages as described by Bracht and Kingsbury (1990): Community analysis; initiation and design; implementation; maintenance and consolidation; and reassessment and dissemination.

A project co-ordinator situated at the Hordaland County health administration is co-ordinating and guiding the implementation effort in the local communities. The NNDPADP will supply funding for selected local preventive measures, for which local project groups will have to apply specifically. For a more extensive description of the design and progress of the implementation of the program the reader is referred to the paper presented by Bergan and Iversen at this symposium.

Program evaluation

The Department of Psychosocial Science at the Faculty of Psychology (UiB) is carrying out the program evaluation part of the project. Evaluation is designed to consist of four parts:

1. **Quantitative effect evaluations of selected measures in selected communities.** As local measures are implemented, some will be selected for limited pre - post surveys among the target groups, trying to measure effects of the implementations. These surveys will consist of simple questions measuring the impact of the measures undertaken, and a short "Readiness to change"-scale (Rollnick, Heather, Gold and Hall 1992), based on Prochaska and DiClemente’s (1986) Transtheoretical model of change processes.

2. **Qualitative implementation evaluation.** Throughout the project qualitative data will be collected in the forms of documents, interviews with program participants, recipients (user group representatives) and other local observers, and participant observations of proceedings and meetings of the local groups (King, Morris and Fitz-Gibbon 1987; Patton 1987; Pirie 1990). This part of the evaluation will be conducted in close co-operation with the county project co-ordinator.

3. **Data from police and acute wards.** From first half of 1995, records from police and acute wards in the areas will be obtained. Records of relevance for the project are alcohol or drug related incidents like MD or police call-outs, arrests, and acute treatment at emergency clinics. Such information is not routinely kept in Norwegian police-records or doctors’ records, except where the seriousness of an incident results in recorded consequences (pressing charges, person injury, hospitalization, death). In all five municipalities police authorities (state employed) and medical authorities (municipality employed) have agreed to participate in this registration. Police and MDs on duty are registering incidents as they occur. Registrations are made on simple forms (A5 format) and sent quarterly to the researchers at UiB (see appendix).

4. **Quantitative prospective surveys among selected year classes.** This prospective survey covers in all five communities the on start (1994) age groups of 17, 19 and 22 years. However, two municipalities are so small that the number of subjects are extended to include the nearest older, and in one instance, the nearest younger, age groups. The baseline
questionnaire was sent by mail to the participants in June 1994, and 1170 were returned (also by mail), a response rate of 51.2%. Apart from constituting a baseline for the prospective purposes, this study supplies information for the planning of preventive measures by the local project groups, and so serves as an element of the community analyses. It may further constitute a pre-pre data point for the limited measure evaluations mentioned in (1) above.

5. The baseline questionnaire includes standard demographics, measures of lifestyle, substance use and intentions of alcohol use, leisure activities, and optimism/pessimism regarding health, family, friends, living conditions, work and economy. It further includes scales for

- drinking attitudes and subjective norms, based on the theories of reasoned action (Ajzen and Fishbein 1977) and planned behaviour (Ajzen 1988),
- self-efficacy, based on Bandura (1977), de Vries, Dijkstra and Kuhlman (1988), and Wilhelmsen, Laberg and Klepp, (1994), angled towards drinking situations,
- readiness to change, based on Prochaska and DiClemente’s (1986) model and the short scale developed by Rollnick et al. (1992), and translated into Norwegian by ourselves,
- positive and negative affectivity, measured by the PANAS-X (Watson and Clark 1984, 1991), and
- sensation seeking, based on Zuckerman (1979, 1984) and modified into an 18-item scale for Norwegian conditions (Pedersen, Clausen and Lavik 1988).

The theory of planned behaviour (Ajzen 1988) was chosen as a guiding model for the quantitative effect evaluation, because it offers measurable behaviour antecedents such as intentions, subjective norms, attitudes, and outcome expectancies. Changes in these antecedents can serve as indicators of effects of the prevention efforts even if there should be no measurable effects on actual behaviour. The ”Readiness to Change”-questionnaire is constructed as a short and uncomplicated tool for measuring the precontemplation, contemplation and action stages of change in Prochaska and DiClemente’s (1986) model. It’s purpose in this context is to serve as an index (or three indices) of alcohol-use intentions, to supplement two simple and straight-forward questions about such intentions.

Follow-up surveys will (subject to funding) be conducted with the same respondents in 1997, at the same time of the year as the baseline survey. Questionnaires will be identical to the baseline on each occasion, with the addition that the follow-ups will contain measures regarding the project’s impact.

Current status

Program implementation

The program, which started in May 1994, is now (August 1995) in the beginning of its second year. All municipalities in Hordaland County were invited to send their applications for participation in the program. Twelve municipalities (out of 34 in the county) applied for participation, and the municipalities of Bømlo, Eidfjord, Kvinnherad, Meland and Voss were selected in May 1994, on the basis of quality of the applications, commitment, established inter-
sectoral co-operation, and variety in geographical location and population size.
Initial meetings and follow-up meetings have been held in each municipality, attended by
representatives of municipality administrations (to a large extent from top level), and by the county
project co-ordinator and the evaluation researcher from the university. The meetings confirmed
our impression from the initial applications, namely that
- there are good correspondences between the intentions of the community-based model and
  the way the community officials wish to work,
- there are emerging many inter-sectoral co-operative fora and arenas in the
  municipalities,
- there is genuine awareness of the need for health promotion and prevention in the municipal
  administrations, and some frustration over ”how to do it”, and
- there is a healthy amount of enthusiasm over being part of the program.

We also had indications that the municipalities to some extent had underestimated the scope of the
model and the research effort, both by direct expression that so was the case, and by the fact that
during the initial meetings, two of the municipalities shifted the level of the proposed interim local
co-ordinator from medium or low echelon to sector leader level.

Seminars addressing the project model, principles of primary prevention and health promotion,
principles of attitude change, and substance use data from the baseline survey have been arranged
in all municipalities, attended by a broader mix of municipality officials, police, voluntary
organizations, business representatives and youth from the ”target” age group.

All face-to-face contacts with local agents have taken place locally.

First and second ”generation” community analyses are completed or under completion in the
various communities, incorporating results from the baseline survey.

Local boards have been formed in all five municipalities, and task forces planning preventive and
health promotion measures are at work in most of the communities, which has resulted in several
proposed preventive and health promotive measures, many of which have been granted partial
funding from central project means, while others have been started on the basis of local funding.

Program evaluation

As specific measures at this point in time are in the process of being implemented in the
communities, work in relation with the first element of the evaluation plan are also in its starting
phase.

Concerning the second element (qualitative implementation evaluation) the processes taking place
in the five municipalities are constantly being monitored as thoroughly as possible given the
available resources. It is evident that there are differences in how the project is handled and
progressing in the various communities, both as to who are ”main operators” locally, as to the
amount of work going into the community analyses, as to what is selected as geographical areas
of focus within the municipalities, and as to how far the recruitment of active participants outside
the municipal official system has come. For instance, while all communities initially have chosen
a broad strategy emphasizing a community-wide approach, resource orientation and multi-
topic/multi-arena measures, three municipalities have selected specific village-areas as specific “local communities” to focus measures, and two municipalities wants to focus on the entire municipal community. It is yet too early, however, to draw any conclusions about consequences of such differences. What is apparent is that the processes are well under way in all communities, and that the ways are somewhat different.

As described above, MD and police registrations of substance-use related incidents (third element) are in effect. Registration seems so far to function as intended, except for one police department, where they for internal practical reasons register events post facto at the end of each month. The importance of keeping registration routines constant during the entire registration period has been thoroughly stressed, and seem to be well understood.

Results from the baseline survey (element four of the evaluation plan) are ready. One of the findings was, as expected, that alcohol by far is the preferred “drug” among the respondents. While 6.9% reported that they had tried hashish (most of them only once or a few times) and only a very few had tried harder substances like cocaine, heroin or amphetamines, 80% had used alcohol, and mean consumption during “the last three months” for those who used alcohol were 63.4 standard alcohol units (SAUs) for girls and 126.4 SAUs for boys. Figure 1 shows mean alcohol consumption last three months by age and gender (ages 17, 19 and 22 years). The elevation of the middle age group are most likely due to traditional celebrations in connection with the finishing of high school (after 12 years of schooling).

Furthermore, 50.3% of all the girls and 63.3% of all the boys reported having been inebriated twice or more the last three months (see figure 2), and 18.8% of the girls and 34.3% of the boys had been ”really drunk” twice or more during the last three months (see figure 3). Consultations with local MDs and police confirmed this picture. As a result, alcohol use will be the most important focus for interventions in the local communities.

Other results from the baseline study

Figure 4 shows most used type of alcohol consumed, for each of the three age groups. It is interesting to note the percent preferring liquor decreases with increasing age, and that as many as 37% of the 17 year group most usually drinks spirits. In Norway the legal age limit for buying beer and wine is 18 years, and for buying liquor 20 years. Even more interesting, in rural Bømlo, which has no off-license wine or liquor retail, and which is the only of the five municipalities without ordinary off-license beer retail (one can by a crate of 24 bottles of beer if one has ordered 4 days in advance, but not one bottle over the counter), the percentage of the 17 year group most often drinking liquor is as high as 45.4%, and highest of the municipalities.

Data from the survey show further differences between the municipalities. Figure 5 shows that Bømlo has a particular high percentage of non-drinkers among both sexes, while Eidfjord has a very small group of abstainers, particularly among men. Voss is the only community where there are a higher percentage non-drinkers among men than among women.

Figure 6 shows total alcohol consume in standard alcohol units the last three months, by gender and municipality. Again Bømlo and Eidfjord seems special. Both have a quite high average
consumption among men, about 160 SAUs, and the difference between women’s consumption is noteworthy. The situation among young women in Eidfjord, where they average almost as high as the men, is indeed worrisome.

The special case of Eidfjord seems also to come through in figure 7, comparing the communities with respect to the percentage having been “really drunk” more than four times during the last three months, and in figure 8, comparing them with respect to the norm pressure against alcohol use experienced by the respondent, from peers, parents, and other adults like relatives and neighbours.

Concluding discussion and comments

The differences in alcohol use data between municipalities in the same country, even the same county, point towards important cultural differences across small distances, and underscores the importance of taking into account local conditions and traditions, when seeking to implement effective preventive or health-promotive measures in local communities.

The design of the evaluation entails a close collaboration between the researcher on the evaluation part and the project co-ordinator on the implementation part of the project. The co-ordinator is instrumental in collecting most of the written material from the participating municipalities. The co-ordinator and the researcher are both attending many of the meetings with the local groups. Observations are shared and discussed immediately after such meetings. When one of them has contacts with local actors, information is immediately shared with the other. Likewise, during the start-up phase both have been instrumental in explaining and “selling” the ideas behind the project at the meetings and seminars. The work so far has been a practitioner/researcher team effort, but where co-ordinator and researcher have had the main responsibility for different tasks. So far this has been a satisfactory arrangement, and is likely to be carried on. The co-operation increases the probability that local events and processes are observed for evaluation, and that observations quickly can be checked out as more or no more than one person’s impressions.

The project has the marks of action research. Both qualitative and quantitative methods are emphasized in the evaluation design to counter the inherent control problems involved in research on community-based programs. In a project such as this, practical compromises or trade-offs usually have to be made. The very concepts “community-based” and “empowerment” means giving a substantial amount of control over events to the local participants (Mittelmark 1990; Wagenaar and Wolfson 1992). The aim of the evaluation design for this project is to describe events and processes thoroughly, to try to assess short-term effects of specific interventions, as well as to assess longer-term effects of the implementation of the model as a whole. Equal weight is put on qualitative process description and quantitative and qualitative effect assessment.

The evaluation part of the project is confined by limited resources. Because of this it was decided not to include control municipalities in the evaluation effort. This clearly can be a severe weakness. However, municipalities suited for such control would be hard to find. Within the county in question matching would only be possible in degrees, and then be neighbouring or geographically very close municipalities. “Overflow” of ideas and activities between implementation communities and control communities would in such cases be impossible to prevent. If control communities
should be selected in other parts of the country, cultural differences would threaten control validity severely. This is even likely to be the case when communities quite near each other are concerned, as shown above. By concentrating the resources within the project communities, and comparing different processes and changes in these communities, we hope that there is a good possibility to gain insights in how a community-based health promotion and substance use prevention model can work among young people.
References

1987.


Figure 1. Total alcohol consume last 3 months, by gender and age. Drinkers only.

Figure 2. Gender and times felt inebriated last 3 months. Percent.
Figure 3. Gender and times "really drunk" last 3 months. Percent.

Figure 4. Most usual type of alcohol, by age. Percent.
Figure 5. Respondents not drinking alcohol by gender and municipality. Percent.

Figure 6. Total alcohol consume last 3 months, by gender and municipality. Drinkers only.
Figure 7. Drunk more than 4 times last 3 months by gender and municipality. Percent.

Figure 8. Experienced norm pressure against use of alcohol, by norm senders & municipality. Drinkers only.
Appendix

**Lensmannen i Lindås og Meland**

Registrering av rusrelaterte hendingar

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Early experiences of the alcohol community project

Allaman Allamani, Patrizia Ammannati and Ilaria Basetti Sani

Frame of Reference

Prevention is part of an ecological approach promoting individual, family and social welfare. The concepts of "harm prevention" and "health promotion" have often been used in community program literature. According to the Ottawa Charter, health promotion aims at enabling people to increase control over, and to improve their health (WHO 1986). On the other hand, alcohol-related problems which have to be prevented actually are the expression of the concerns of both individuals and social groups in a certain community area.

According to the system model, the community is seen as a complex system of social, cultural and economic relationships. As far as alcohol is concerned, "some of these relationships contribute to alcohol-related problems, some have a protective or preventative contribution, and many have little or no contribution. Alcohol problems are system problems, and alcohol consumption can be problematic for any drinker, depending upon the situation or environment" (Ryan and Reynolds 1990, 325 - 343).

Some alcohol community projects, i.e. those in Kirseberg and in San Diego, draw upon the Public Health approach: they are oriented towards the development of community training activities, and focus community interests on alcohol as well as other interventions in keeping with public health principles (Ryan and Reynolds 1990; Hanson et al. 1991). However, seeing health as a collective issue enhances the attention on scientific assertions and overlooks individual benefits and the attitude of underprivileged people. It thus favours an "inoculative" or top-to-bottom approach (Lindbladh and Hanson 1993). Integrating a top-to bottom with a bottom-to-top approach would mean focusing "systematically on identifying issues, anchored in everyday life, which coincide with the public health aim defined by the "system", concentrating on developing the process of active participation of community members.

Alcohol problems and the preventative approach: the Italian context

In Italian and particularly Tuscan culture, wine is the main alcoholic beverage, and it is drunk especially during meals and in family or social contexts. Drinking of spirits, and especially of beer, is also widespread. People drinking alcohol are at risk of physical and/or behavioural problems related to alcohol. Risky drinking denotes a risky lifestyle and may be associated with other risky behaviour in eating, smoking, and licit and illicit drug consumption.

According to national statistics, alcohol consumption decreased by 35 % between 1981 (when per capita consumption of 100 % alcohol was 13.0 litres) and 1991 (when it was 8.4 litres). In the same period wine consumption in particular decreased by approximately 39 %; liquor intake decreased by 47 % and beer consumption increased by 27 % (litres per capita of beer intake being 17.9 in 1983 and 22.5. in 1991). In spite of the decrease, Italian alcohol consumption still ranks
high in comparison with other countries. Tuscan people are among the highest consumers of alcohol in Italy: in 1989 overall alcohol consumption per capita per day in Tuscany was 23.6 grams of 100 % alcohol, wine contributing 88 %, beer 8.9 %, and liquors 2.9 % of the total alcohol intake (Cipriani and Innocenti 1993).

In the face of this notable situation, public alcohol policies are lacking in Italy. For a long time, and still today, the public has viewed alcoholism as a personal problem, not a social one. A noticeable exception is the wealth of alcohol education programs for middle- and high- school students promoted during the late 80's and the early 90's by various health units and school authorities through national health education funds (Monarca et al. 1992). Those programs have been uncoordinated, and have hardly been evaluated, so it is difficult to ascertain their effectiveness.

The Background of the Florence Alcohol Project

In spite of a long public debate on the issue of Community by social psychiatrists, sociologists and politicians, there has been little documentation of any actual Community action project in Italy. However, one of the few known published studies concerned two small towns - Subbiano and Capolona - 60 kms south of Florence. This study describes the involvement of the citizens in expressing their priorities of health needs when the Local Health Unit was instituted in the 70s (Cecchi et al. 1984).

Florence and the region of Tuscany has a tradition of democratic involvement of citizens in public debates, and more recently in grassroots movements, on issues such as air pollution, cycling routes and mothers against illicit drugs. Political parties have sometimes incorporated these issues into their policies.

The Florence Community Action Project refers to the Community area called District no.3, situated in Rifredi, a neighbourhood on the North-West side of Florence, the capital of Tuscany. In the 70's and early 80's it was the seat of cultural events and of the building up of a self-help psychiatric group (Pini 1994). An ‘avant-garde’ District facility was also built there in the 80's. In 1987 the local District representatives applied to the Health Authority in order to obtain out-patient programmes to treat alcoholics. A reformulation of this request in terms of alcohol- related problems prevention was made two years later, when the first ideas for a Florence Community Alcohol Action Project were generated among local alcoholists. It was conceived as an experimental one, and one of its purposes is to collect information on the feasibility of its model. Research and evaluation have thus been stressed in the context of the action project.

The Florence Project was started through the stimuli of the Kirseberg Public Health Project in Malmoe, Sweden (Hanson et al. 1991). It is also indebted to the Lahti World Health Organization Demonstration Project in Finland (Holmila 1992). It has also tried to incorporate some of the principles of the European Alcohol Action Plan after its appearance in 1992 (European Alcohol Action Plan 1992). It was initially funded through a grant from the Regione Toscana Administration. After a few years, it became quite difficult to get any funding, and work has been since processed through District and Center professionals, volunteers, and the contribution of a few generous students devoted to this project.
The Florence Community area

Our community is an administratively defined geographical area, but it is divided into four culturally distinctive sub-areas. The district is inhabited by 16,900 citizens living on 2.77 square kilometres. Females make up 53.4% of the population, and the population is quite stable and elderly (24.0% of the people are over 64 years old). Two small groups of Balkan refugees, who came after World War II, live there. This area, previously rural, developed since the beginning of this century as part of the industrial area of Florence. Throughout the years, a technical school as well as apartment houses were built for factory employees. The City Council provided a few residential housing blocks for the poor. During the 70s a set of residential and commercial blocks of good quality houses was built in "Firenze Nova" (2,000 inhabitants), a middle/upper-class sub-area in the District. The latter encloses three other sub-areas: "Ponte di Mezzo" (7,500 inhabitants), a middle/low class site, equipped with a few health and welfare centres, reasonably socially active through both political and volunteer organizations; another middle/low-class sub-area, called "Lippi" (2,500 inhabitants), which is characterized as a village, and where there are several small size, and four medium/large-size factories with high technology products; and "Macelli" (4,500 inhabitants), a residential middle-class sub-area, with loose boundaries with the rest of the city, where a large dairy serving part of Tuscany is located.

The extension of public green areas has been greatly reduced over the last decades due to building speculation, and now covers as little as 20,000 square metres.

Meeting sites such as "houses of the people" (case del popolo) once attended by many persons, nowadays seem to attract mainly the elderly, while young people usually meet in bars, in squares and in gardens. There are practically no entertainment centres, such as movie-theatres or dance-halls, in the district.

Alcohol consumption: risk and harm in the Community

Some estimates (Allamani et al. 1988; Allamani et al. in press) allow us to hypothesize that in the District at least 3,000 people drink more than 60 grams of alcohol per day. About 1,500 individuals are affected with at least a minor liver disease, related with high alcohol consumption. Also we might suppose that there are about 1,000 alcohol-dependent people in the District.

As far as the mortality rate is concerned, 36 persons (19 men and 17 women) were estimated to have died during the period between 1985 and 1992 in the District due to alcohol-related causes. These data are calculated on the basis of the conservative estimate that 2.3% of all deaths in Italy are attributable to alcohol use. Thus the figures mentioned before are too low to permit any sound comparison with alcohol-related mortality in a control Community (Cipriani 1993).

Two other series of figures come from information collected directly in the Community. In March 1993 a sample of customers of the local Cooperative Supermarket were interviewed by Supermarket interviewers. 121 interviewees - 75% women and 25% men - lived in the District. Among those, 68.6% drank wine, and 32% bought it directly from the producer, or made it at home. The daily average per capita consumption of wine in families was as much as the equivalent of 20 grams of 100% alcohol. The figures are in keeping with the average figures in Tuscany,
However the sample is not representative of all the customers in the Supermarket.

In 1991 - 1992, 77 children aged 12 - 13 in the Middle Schools in the District were interviewed about their alcohol drinking practices, as part of a food education project. Results indicated that 29% of interviewees drank wine or beer at least once a week.

**Community Resources**

As in other areas of the town, several care, treatment and prevention units are distributed in the District. Some interviews were conducted with key professionals working in 20 Community Units in four districts, including District 3, as well as in nine Hospital Units by interviewers from the Alcohol Center, between November 1991 and April 1992. The majority of interviewees identified approximately 4 - 8% of excessive drinkers among their patients, which is surely an underestimation.

Other Community resources were identified in the District: (a) two nurseries and four pre-schools, three elementary, two middle and three high schools; (b) three catholic parishes (one of them gives daily hospitality to some “clubs” of alcoholics and their families; it is also the seat of one branch of “Charitas”, an active catholic organization devoted to support poor people and immigrants); (c) one local branch of the Florence association of volunteers for emergencies; (d) one sports association; (e) two politically left-oriented meeting “Homes of the People/ of the Culture”; (f) one private catholic basic school; (g) one Center for the Aged; (h) one left-wing “Cooperative” Supermarket.

**Objectives and Methods of the Alcohol Community Project (Allamani et al. 1992)**

The objectives of the Community Action professionals/researchers are: (a) to identify the dimensions of high-risk alcohol consumption and of alcohol-related problems among the population, through the opinion of Community people, and through an epidemiological survey of a sample of the population; (b) to activate human resources in the Community in order to build up a Community educational program; (c) to implement a network among Primary Health Care Professionals, teachers, policemen, volunteers, and other professionals; (d) to identify, educate and/or treat individuals with alcohol-related problems and their families.

The objectives of the Community population are: (a) to participate in the planning and implementation of Project actions; (b) to change attitudes of people towards risky alcohol intake and reduce the overall alcohol consumption in the Community.

The methods planned for the Community Project professionals/researchers to reach the objectives concerning the general population are: (a) meeting with Community key people to identify problems; (b) defining the intervention; (c) implementing the intervention; (d) process and outcome evaluation.

The methods planned for the PHC professionals to reach the objectives concerning people at high-risk of alcohol drinking are: (a) defining a Primary Health Care network to intervene when
individuals/families drink excessively or are affected by alcohol-related problems; (b) activating the network.

A multidisciplinary staff has been constituted on four levels: District professionals; Alcohol Center professionals; volunteers; consultant researchers. There is an open attitude towards new health care professionals, researchers and volunteers who would like to join the Project. Some of the planned educational courses will in fact try to interest their participants to participate in the Project and share their knowledge and energy. There are two types of Project meetings: (a) operative meetings, for discussing practical issues and research results among professionals, once or twice a week; (b) meetings with consultants, every 2 - 6 months, to adjust the project for new needs and to further planning.

Evaluation

As far as the Community Project is concerned, and following the indication of the European Alcohol Action Plan, the Community programme should significantly decrease overall alcohol consumption and reduce alcohol-related harm in the population (European Alcohol Action Plan 1992). Since there is already a trend towards a decrease in alcohol drinking in our country, prevention intervention should enhance such a trend.

A mail questionnaire was prepared to cover a sample of 400 inhabitants representative of the Community District population, with questions on drinking (quantity/frequency and attitudes), eating and smoking habits, as well as opinions about the quality of the health service in the District, concerning the individual and his/her family. The questionnaire will be sent again at the end of the Project. The other District areas in Florence where no special preventive alcohol intervention has been planned are considered a ”control” area, and a similar questionnaire will be sent to a sample of that population.

However, due to repeated failures, less importance has recently been given to large-scale outcome evaluation indicators because of the many variables intervening in the social context of a Community during a certain period of time. Therefore, more importance has been given to small preventive intervention projects, with expected goals and evaluation indicators (Holmila 1992).

The Community Project development: Analysis of the Community

In keeping with the 5-phase process through which the Kirseberg Public Health project was structured (Hanson et al. 1991), this paper presents the first three phases.

The main part of the Community Analysis, from June 1992 to June 1993, entailed 36 interviews personally carried out by the Project staff personnel with key persons, or groups of key persons in the District. Interviewees were asked to give their opinion about the features of the District, and about the present relevance of some health and social problems, and of alcohol problems as well as of alcohol drinking habits. Interviews lasted 30 minutes on average, and they were generally held at the interviewees’ work sites. They were announced with a letter signed by the Alcohol Center and the person responsible for the Local Health Unit.
According to our expectations on social drinking, a common opinion was that while adults drink wine during meals within the family, young people drink beer together with their peers; it was also noticed that wine drinking “for company” in local clubs is becoming more common among older people. It would seem that ”normal drinking” is considered to be between 30 and 90 gms per day. According to current medical literature this amount, on the contrary, should be understood as substantially risky. The tolerance of a high drinking level is confirmed by the observation that, according to the opinion of the manager of the local Cooperative (COOP) Supermarket, the amount of alcoholic beverages sold in this area is unusually elevated, low-quality wine and high-quality liquors being often purchased by citizens. This opinion differs somewhat from results elicited from the already-quoted interviews conducted on COOP premises, which are however certainly not representative of people attending the supermarket. The group of Greek immigrants are said to drink large quantities of alcohol, usually the traditional ”ouzo”.

Alcohol abuse is said to be one of the problems in the Community, affecting both young people and adults. Young people have their own special way of getting intoxicated: drinking beer, mixing liquors with psychoactive drugs, especially on weekends. Many interviewees in different contexts said that they were acquainted with alcoholics in the Community. Some District physicians indicated that approximately 2 % out of 650 cases who applied to local ”health mobile units” for emergency intervention were diagnosed as overtly alcoholic. One of the two chemists interviewed claimed that out of his 150 customers 10 % were “strong drinkers” and 10 % were alcoholics. A few sites - some public gardens and bars - were said to be attended by people with addictive behaviour; on one occasion the director of the local Volunteers for Emergencies decided to close its inside bar because some of their customers drank too much. Even if heavy drinking is stigmatized, there is a general tolerance towards alcoholics among the population, and to call the Police or other Public Forces is generally a second choice after calling Public Health intervention services. However it seems that alcohol problems are generally hidden within the families; according to one Police Officer, the Florentine trend is ”to keep quiet” even if alcohol problems are as great as in Northern Italy. Also, the middle lower class sub-areas are said to have the majority of District alcohol problems.

Interviews showed that illicit drug use and commerce is felt to be the greatest problem in the Community; alcohol problems scored as second, together with problems of older lonely people in need of some care. Also abuse of psychoactive drugs was mentioned. Eating too much meat was another issue mentioned by some physicians. Loosening of family ties and education, and lack of leisure-time areas suitable for young people, old citizens and women, were claimed. Poor interactions among institutions was noted. For example, the Police complained that some few social workers did not cooperate in the care of alcoholics; the Misericordiae volunteers criticized the general practitioners because they were not always available by telephone.

The Community Project development: the design-initiation

In 1994, after the main part of the Analysis of the Community was completed, the project staff met in order to process the appropriate feedback to the interviewees, and to establish the Project’s connections with the Local and Regional Administrative and Political levels. An effort was made to reframe the proposals mentioned before in ”modules” or preventive action components, which
may interact (Holmila 1992). So far, four modules have been built: (WHO 1986) Public Information for Community people (Ryan and Reynolds 1990) Primary Health Care professional training (Hanson et al. 1991) Health Education for young people (Lindbladh and Hanson 1993) Intervention for alcohol-related emergencies.

(1) Following the suggestion of the President of the District Council, as a first step in Community action a public information program with debates in theatres in the District was arranged, in cooperation with the local committee. The aim was to share the results of previous research with the people in the District, and to modify their knowledge and attitudes concerning alcohol drinking, so that they could relate to alcohol as a traditional Mediterranean dietary component, as well as a risk factor.

(2) An alcohol training programme for Primary Health Care professionals would be divided into 3 components: (a) early identification of hazardous or harmful alcohol consumption; (b) communication with the patient/ family; (c) information/ motivation of patients and their families.

(3) Some studies show scarce efficacy of educational intervention during late adolescence (Fossey and Miller 1994), while behaviour and values about lifestyles are well-absorbed during the early childhood in the family context. It is therefore sensible to start with the families at quite early stages of school. The Public School system in Italy generally requires families to enroll their children in schools in the Community where they live, and this keeps the District school users within the District Project. One effective strategy would thus be to involve teachers and families together with students, rather than just students.

(4) ”Volunteers for emergencies” is a well organized nationwide group of associations which covers the majority of the Community emergencies. District ”3” is endowed with about 200 volunteers enrolled in the Florence ”Misericordiae” (‘Mercy’) association. Since they traditionally come from different socio-economic classes in the town, their education varies. They apply first aid to a person’s urgent health or social needs. They generally go to the site of the emergency, and transport the patient to the hospital emergency room. The aim of this module is for volunteers to identify alcohol-related harm when they are called in for an emergency; to inform health professionals at the hospital or at the Community level, and to inform/motivate the patient and his/her family to change their alcohol practices.

The implementation phase: public information conferences

In autumn 1994 two public information conferences were held in the two houses of the People. The first one was arranged to feed back on the Prevention Project interviews previously carried out in the District. The second one was about the pros and cons of drinking alcohol; this conference made specific audio-visual materials available, so that people could get appropriate information in order to make their own choices. Two regional newspapers, which already gave some notice on alcohol services in the city during the previous year, advertised the events visibly. One newspaper, however, published an article in which the District was dramatically depicted as a high-risk area for alcohol problems. Most of the invited speakers, who were Local and Regional Authorities, came, as well as representatives of the Medical Association, of the Public School
Education System, of the Regional Committee for Consumers, of Producers. There was not a large audience, even if more people than usual were present. There were some of the interviewees, a number of persons from the Houses of the People, and a few recovered alcoholics. The conferences were possibly held too late after the District interviews, and the mass media was not completely involved, since the main local newspaper did not give notice of the events. Another problem was that in one of the conferences the public was not allowed enough time to express its opinion because of the lengthy talks of the experts.

In the meantime the mailed questionnaire sent to 400 sampled individuals in the District got a very high percentage of respondents: 45 % after the first mailing, and 70 % after the second invitation through telephone and mailing. These figures, which are higher than the average response rate with similar mail questionnaire, may mean an especially high awareness on health issues within the population, possibly through the other District initiatives already described.

The next step for the Public Information Module Project group will be to work out a few messages concerning information about one’s alcohol intake, and about how to help an alcoholic, as well as spreading the results of the District research and of the mail questionnaire through small groups such as young and old people’s associations, Catholic parishes, local and ”very” local newspapers and radio programmes which have to be better informed of and involved in the Project. This selected activation should raise issues which may go beyond alcohol themes, e.g. licit and illicit drug addiction, eating disorders, loneliness of the older people, and other problems expressed through the District studies. New persons volunteering for the Project, as well as other professionals of specific competence are expected to be part of the future strategy of the Project Group, which if able to activate this new movement, may give rise to new problems and new solutions through small group debates.

A further public information conference is scheduled for the end of 1995.

The implementation phase: training of the general practitioners

The Medical Association in Florence showed interest in a 3-day alcohol educational course. Twenty-eight out of forty-two physicians in the local health unit participated during the first of 3 days in January 1994, 18 on the second day in June 1994, and 18 on the last day in January 1995.

At the beginning of the Course general practitioners said that among their patients alcoholics numbered 0.83 %. Three physicians reported no alcoholic patients and one said that 7.4 % of his patients was alcoholic. High-risk drinkers were said to be 6.07 % (17 physicians, i.e. 58 %, reported less than 2 %, and three 20 % or more), out of 26,633 enrolled clients. The participants’ pre-test showed that: the majority (92 %) of respondents were unable to correctly figure out the grams of alcohol present in half a litre of wine; 2 participants thought that a small quantity of alcohol was safe for a patient affected with chronic hepatitis.

The educational objective of the first day was to enable participants to identify high risk drinkers among their clients. The second day educational objective was to enable participants to choose the more useful indicators and agree as a group on an instrument to identify the prevalence of high-risk drinkers and of alcohol-related harm among their clients. Five of them agreed to fill in a quite
simple quantity/frequency alcohol intake questionnaire with some information on biological indicators on a sample of their own patients. On the third day the educational objective was for the participants to become acquainted with their own health education tasks when facing patients with alcohol problems and their families.

The post-test showed that according to the participants high-risk drinkers on a whole constituted 7.25% out of 20,909 enrolled clients, and that the variance was smaller than at the beginning of the course - i.e. a smaller number of respondents (29%) indicated that high-risk drinkers among their clients are less than 5%.

A general comment to the course is the following. First of all the frequency GPs attending to the 3 days has been superior to expectancies. According to the pretest’s results, their information about alcohol issues was poor. Secondly, the idea of high-risk drinking seem to be especially hard to be incorporated by the professionals since the concept of alcoholism is pretty pervasive in the medical practice whenever the subject of alcohol is touched. Thirdly, a brief and simple q/f questionnaire may help physicians to observe better the drinking patterns of their clients when they pay a visit to the office.

The implementation phase: educational programmes in the schools

The School module began in September 1994 with a two-day course with twenty four Pre-school, Elementary and Middle School Teachers. This Course was planned within the framework of a broader Educational Project for Teachers in Health Community Units in Florence ("Let’s Learn to Feel Well", "Impariamo a Star Bene"), which aims at informing people about topics such as health, sickness, body and self-consciousness, diet, lifestyles. The Course concentrated on the issue of alcohol values and risks in the family, and its aim was to promote both maintenance of so-called “responsible drinking” whenever the case, and educational change in the presence of a risky lifestyle in the family. Its objectives for teachers were to activate family awareness of responsible and risky drinking in family members, and developing communication skills so as to involve parents and pupils in planning and implementing an educational project.

Afterwards, from 9 to 24 teachers met for five 2.5-hour meetings with the Project group and built up a questionnaire to be distributed to parents, and to older students in December 1994. The questionnaire was inspired by Fossey and Miller (Fossey and Miller 1994), particularly on exploring early experiences with alcohol and expectations about a possible alcohol educational program. It underwent major modifications through the incorporation of questions concerning eating, since lunchtime for the younger students is an issue often debated between parents and teachers. Three hundred and eleven parents of the pre-school, elementary and middle schools, i.e. more than 80% of all the parents (1/3 of them fathers, 2/3 mothers), and 133 middle school students, i.e. 90% of all the middle school students, answered the questionnaire. Parents perceived themselves to be determinant figures in their children’s choice of different kinds of food, while friends and, to a lesser extent, advertising were perceived important factors in the drinking behaviour of adolescents. On a whole, there was a traditionally permissive attitude towards tasting or drinking wine in the younger ages, even if middle-upper class parents seemed to be more restrictive. Most parents and students indicated that they would appreciate an alcohol educational program in their school. The alcohologists discussed such results of the survey and its implications
for a future educational alcohol program with the teachers. Subsequently a meeting with parents or middle school children and teachers and alcohologists was held in each of 6 schools sharing the Project, between March and May 1995. Eventually the Project group met with the 6 different groups of teachers in order to begin planning the specific programs for the next autumn. Participation both of teachers and of parents in the discussion and planning meetings was limited but lively and the planning work initiated for the next months is promising.
We thank Elisabetta Forni, Francesco Cipriani, Amedeo Cottino, and Canio Lomuto for their ideas and suggestions. Thanks also to Gianfranco Bozza, to Alberto Centurioni, and the many colleagues and friends in the Florence Alcohol Center and in the District n. 3.
References


Reflections on the day

Sally Casswell

Setting goals and planning strategies

The projects presented in this section illustrated a range of goals and action components which are included in contemporary community action projects. However, it was not always made clear in the presentations what exactly were the objectives of the projects and what was the plan of action, or programme logic, which underpinned the projects’ strategies and was expected to lead to achievement of the projects’ objectives.

The discussants’ comments and questions illustrated these gaps. For example, Robert Reynolds asked Allaman Allemani what problems the Florence project was setting out to prevent. Alleman’s response identified the types of problems they are responding to: first, dependence among older and isolated people and second, the problems perceived related to the drinking of younger people who are spending their time drinking in parks and other open spaces.

Similar questions were asked about the project from Western Norway. Elisabetti Forni, the discussant on Eric Iverson’s paper asked for more information about the specific problems found in the Norwegian context and also about the drinking context which preceded these problem experiences. In discussing Tone Bergen’s presentation on the community action programme in Western Norway Liz Stewart asked the question whether the project was based on research-based evidence? In other words, was the choice of strategies based on the evidence of what was likely to reduce harm?

These questions, posed by the discussants, showed that the presentations had not shown clearly what the objectives of the intervention were and how they were grounded in the researcher’s understanding of the community context. The lack of an explicit set of objectives and consequent strategies of community action was also suggested by the comment in Bergen’s paper that among the community participants there was a commitment to problem prevention activity but ‘some frustration over “how to do it”.

Action strategies illustrated by the projects

A number of strategies are common to the projects described in this section, and common to many community action projects focused on alcohol issues. One such common strategy was the raising of awareness of members of the community about alcohol issues. While the perception of this as an appropriate strategy is very widespread, the messages differ and were, appropriately and necessarily, a reflection of the cultural setting.

The Lahti project illustrated an interesting innovation which used the libraries as participants. This strategy used the idea of libraries as credible and neutral information sources, providing a mix of information. This strategy, in the Finnish context of the early 1990s, illustrates that the perception
of which strategies are appropriate is shaped by the political and social context of the project. In the context of the rapid liberalisation of attitudes and policy in relation to alcohol in Finland, which had occurred prior to the Lahti community action project, the need to acknowledge an acceptance of alcohol as the marker of a sophisticated liberal society was acknowledged in the use of a neutral institution of public information, rather than staying within the confines of the temperance or health sectors.

This strategy also illustrates the way locally developed strategies reflect (and are constrained by) the available infrastructure: in this case the high density of libraries in Finland, as was pointed out by the discussant on Montonon’s paper, Michal Gajiewiez from Poland.

In the Swedish Kriseberg project the information campaign was focused around the exhortation that ‘everyone should drink less’. This kind of approach was obviously deemed as inappropriate to the Finnish context but its use in Sweden reflected the project workers’ perception that a sufficiently high level of societal concern over alcohol still remained in Sweden, despite some changes, such that this approach would be acceptable.

A third illustration of the way the information messages are shaped to fit the context was shown in the Florence project. Reflecting the Mediterranean wine cultures’ emphasis on alcohol as a normal part of daily life the project simply attempted to raise awareness of the harms associated with its use from a very low baseline: ‘alcohol problems are an issue’.

Given the lack of a clear policy focus in the projects presented in this section it is not surprising that the public information strategies did not take the form of media advocacy, that is the utilisation of media to directly support policy change.

One policy focused strategy which has been adopted in a number of community action projects in Canada and New Zealand has been to enhance and facilitate local input on controls on the availability of alcohol. However, there was very little evidence of that strategy in the projects from the Mediterranean and Scandinavian countries. The exception was the project in Lahti which did have some focus on availability issues. There was also a mention that certain outlets were problematic in Florence and a hint that availability of alcohol was important in relation to youth drinking in West Norway. It is likely that the reasons for the absence of an availability focus in these projects from Scandinavia and from the Mediterranean region are somewhat different. In Scandinavia the responsibility for controlling availability has been a national one with little need or possibility for local input; in the Mediterranean countries drunkenness has only recently seemed to gain increased recognition as a potential problem and it is this aspect of alcohol-related harm which seems to call for work on local availability.

Another strategy which was part of the Florence project was the early identification of problem drinkers. This strategy was seen as very relevant for Italy where the alcohol-related problem recognised by the community was that of dependence. In the context in which alcohol is seen primarily as part of the diet and alcoholism as the only recognised need for intervention then a major community action strategy was identification and treatment.
Process of deciding the goals and strategies

The important issue of the process of deciding the shape of the community action was addressed in some of this section’s presentations. There was an acknowledgement that the notion of community action requires something more than a top-down direction of decision and energy.

The extent to which this can be achieved in practice may vary between different projects depending upon their initiation and structure. For example, if a project is initially set up by a University department of community health sciences it may not be easy or even possible to reverse the top down direction. In relation to this issue of power relations a useful comment was made by a participant from Poland who described what had happened once community actors were asked to run the meetings: they 'took over' quickly and there was greater involvement by them in public meetings.

While some of the projects described still give a feeling of a 'top down' process it is not entirely clear on what basis the 'experts' dominate. This does not necessarily depend on the extent to which the project relies on research-based knowledge. In some way the experts may have prestige because of their association with science but this does not depend on their utilisation of science for the development of the project.

The projects presented in this section also illustrated a process of negotiation over the nature of the projects such that the top down influence was challenged. In Norway, for example, there was negotiation over the objectives of the project. The professionals were happy with the focus on the core objectives on alcohol; the high status lay participants were more concerned with expanded goals, such as reducing loneliness and enhancing community spirit. They felt that the focus on alcohol gave the community a bad name, and were more interested in a positive focus.

Role of research and researchers

Holmila discussed the philosophical underpinnings of the relationship between researchers and communities and the role of research in social change. As she said, evaluation is one research approach which is in the service of the community and is predicated on a notion of knowledge which is contextualised versus a notion of knowledge which is universal. Montonen, in her discussion of the Kirseberg project commented that the use of qualitative methods in the process evaluation gave more insight into what had happened than a purely quantitative analysis would have. However, the Western Norwegian evaluation which had utilised qualitative research methods had apparently had difficulty with finding a funding source perhaps illustrating some of the constraints evaluation of community action are faced with.

Some of the projects described illustrate the focus placed on needs analysis as a legitimate role for researchers in the area of community action. Unfortunately there is a danger that the analysis of community and their needs may be carried out at a rather broad and abstract level and therefore result in little useful information being made available for the planning and implementation of community action projects. What is required is quite detailed and specific information about the local situation. To give an example from the Norwegian project, research was needed to determine what was the mechanism of access to spirits among 17 year olds in Bomlo (which was the
community without ordinary off-licenses). There was a need to focus on the specifics of the local situation to plan change to meet the stated goal of reducing alcohol consumption among young and this is a role for research.
SECOND SECTION

Alcohol policy and community action: Experiences from a national prevention trial to reduce alcohol problems

Harold D. Holder and Robert Reynolds

Introduction

Public policy reflects the priorities, processes and structures concerning matters of public concern. Alcohol policy has historically referred to public approaches to alcohol availability (including production, distribution and economic and physical access) and public responses to alcohol-involved health and safety issues such as treatment, emergency medical care, or drinking and driving enforcement. Alcohol policy has traditionally been formed and implemented at the national or state/provincial level. Communities have not always recognized policy at a local level as a means to prevent alcohol problems. See Edwards et al. (1994) in a recent review of alcohol policy effects.

This paper describes a community prevention trial to reduce alcohol-involved injuries and deaths resulting from acute events and drinking, such as driving, boating, swimming, falls, etc.

Alcohol policy at the local level

Local prevention strategies have typically been program based, not policy based (Greenfield and Zimmerman 1993). Some examples of community efforts to use alcohol policy to affect the drinking environment or the availability of alcohol are given by Holder 1992; Casswell et al. 1989; Giesbrecht and Ferris 1993.

There are positive benefits of locally applied policy:

In general, alcohol policy (which usually addresses environmental strategies) has scientific evidence of effectiveness. This includes such policies as retail price, availability of alcohol, location and type of alcohol outlets including hours and days of sale, retail and social access of alcohol to young people, enforcement and sanctions against high-risk alcohol use, e.g., drinking and driving (Edwards et al. 1994, for a review). Thus alcohol policy approaches to prevention have a substantial base of science on which to rest.

There are few cases in which the actual cost of prevention programs or policies has been documented. However, on the average, alcohol policies as they involve changes in rules and regulations or increased emphasis for existing activities are likely to be lower in cost than specially funded local prevention programs which require investment in staff, materials, and other resources.
For example, the cost of teacher and school administrator time, curriculum materials, and other costs for a school-based educational program likely exceed the cost of a local policy of reduced retail sales of alcohol to underage persons via such techniques as increased enforcement to prevent such sales by retail establishments. Increased retail price of alcohol implemented at a local level through local special-purpose taxes both generate increased revenue as well as being a low-cost prevention strategy.

Policies have a longer life, once implemented, than prevention programs which must be maintained and thus funded each year. A policy of required training for alcoholic beverage servers through an existing adult education system has a longer life of potential effectiveness than a mass media campaign which must be planned, funded, and implemented each year. Even when the potential effectiveness for any policy decays over time due to lower compliance or lowered regulation or enforcement, policies continue to have sustaining effect, even without reinforcement.

Local policies within one community prevention effort

This paper describes a subset of local policies which were implemented as part of a community prevention trials project at the Prevention Research Center in Berkeley, CA. This program has as its goal the reduction of alcohol-involved injuries and death at the community level in three experimental communities.

The alcohol policies selected as prevention interventions for this project were grouped into four areas for convenience but have clear interactive and mutually supportive relationships. None of the alcohol policies is isolated from the specific effects of the others. The four policy areas are the specific policies implemented by local communities:

1. Drinking and Driving--Establish highly visible drinking and driving enforcement.

The evidence of the effectiveness of DUI enforcement as a deterrence (rather than a means to only punish offenders) of drinking and driving comes from a number of studies which have demonstrated that such behaviour is reduced and alcohol-involved crashes are lowered (Ross 1982; Voas and Haas 1987; Homel 1988). The evidence is clear that the perceived risk of detection for drinking and driving is a primary intervening variable. Thus community members should be informed about increased enforcement and have it confirmed in direct experience with frequent enforcement checkpoints. This policy requires a policy commitment within local law enforcement to carry out frequent and highly visible DUI enforcement checks and that routine DUI enforcement is a priority among competing law enforcement activities. The second aspect of this policy is continuous mass media attention to the increased DUI enforcement and the new DUI detection capability of local law enforcement via advanced officer training and the use of new technology for detecting drinking drivers, e.g., passive BAC sensors.

2. Responsible Beverage Service--The establishment of alcohol serving practices by bars and restaurants which will reduce the level and frequency of alcohol impairment by customers.

The evidence for this policy comes from studies of the reduction in alcohol-involved traffic crashes from mandatory server training (Holder and Wagenaar 1994) and controlled studies in local
communities (Saltz 1987; Saltz 1993). Thus studies have shown that licensed establishments with an alcohol serving policy which (a) encourages servers to intervene with customers who are at risk of becoming intoxicated and (b) discourages high-volume consumption on the average results in customers leaving with lower levels of alcohol impairment. A responsible beverage serving policy of a bar or restaurant can also be reinforced through local government policy of required server training (e.g., via zoning or business licensing requirements) and local law enforcement of laws against service to intoxicated patrons (local police policy) (McKnight and Streff 1994).

3. Underage Drinking--The establishment of retail sales practices and limitations on youthful social events to reduce drinking by underage persons.

The evidence of the effectiveness of a higher and enforced minimum age of alcohol purchase comes from studies of the effectiveness of higher ages of purchasers in reducing alcohol consumption and alcohol-involved traffic crashes (Wagenaar 1987; O’Malley and Wagenaar 1991). Local policies can include a routine sales practice by on- and off-premise alcohol outlets of age identification and refusal of sales to underage persons. Such a local policy approach can be reinforced by parent, adult, and/or law enforcement practice of actual sales to underage persons. Other local policy alternatives include parent and law enforcement checks on alcohol availability at youthful social events. The first policy can be reinforced via local requirements (business license or zoning), training of sales clerks for age identification, and law enforcement checks about such sales, e.g., using "sting operations.” The second policy can be reinforced, for example, by a local keg registration ordinance which registers the name of the person who rented a beer keg used at a social event in which underage persons were drinking. The policy can also be supported by parental and other adult mobilization and training concerning enforcement of drinking practices at social events in which underage persons are present.

4. Alcohol retail access--The reduction of density of alcohol outlets and their concentration in certain areas of a community.

The evidence to support this policy comes from studies of the relationship of alcohol availability, alcohol consumption, and alcohol problems. Some of these studies have examined changes in forms of alcohol availability (Holder and Blose 1987; Blose and Holder 1987; Mäkelä 1980) and density of alcohol outlets by population or geography (Wilkinson 1987; Godfrey 1988; Watts and Rabow 1983; Gruenewald et al. 1993). This policy is created by local land use planning and zoning capabilities which, when available by state law, enable communities to establish local limits on the number of outlets in certain areas of the community (or the entire community), distances between outlets as well as distances from schools and churches and other locations and alcohol outlets.

Research Design

The primary distal outcome indicators for the community trials project described in this paper are alcohol-involved traffic crashes (specifically single vehicle nighttime crashes between 8 pm and 4 am which have a large number of drinking drivers), emergency room cases and hospital admissions for alcohol-involved injuries, and alcohol-involved fatalities.

Three experimental communities were selected as test sites for a local policy-driven prevention
trial. Each of the sites has a matched comparison community. A longitudinal design has been used in which the pre-intervention period of each experimental community served as a control for the intervention period as well as data from a matched comparison community. The matched community provides a control for historical effects or confound.

The experimental communities were selected because there existed a coalition or group or organization with an expressed interest in preventing alcohol-involved injuries and deaths in their community but they had no existing program for this objective. This was an efficacy trial (Flay 1986), i.e., testing for changes which can be accomplished in outcome indicators under ideal conditions. Thus, experimental communities were selected, not because they had above- or below-average levels of alcohol problems, but because of an expressed interest and commitment to such a prevention effort.

Descriptions of the three communities are:

Oceanside, CA (experimental) is located 35 miles north of San Diego, in San Diego county, in the southern end of California. Its comparison city, Orange, is 30 miles southeast of Los Angeles, in Orange county. Both represent non-manufacturing, non-agricultural communities with diverse light industry, tourism, and office centres, and both have a large (over 20 %) Mexican-American population.

Florence County, SC (experimental), lies in the northeastern part of South Carolina in the Great Pee Dee River area. Its comparison, Sumter County, is located in east central South Carolina. Sumter County lies approximately 50 miles east of Columbia, the state capital. Florence County is moving from an agricultural-textile base to light and medium industry. Sumter County is also dominated by manufacturing and retail trade activities. Both counties have significant African-American populations (approximately 40 %) which are actively involved in current local alcohol prevention activities. In terms of local economics, population size, and racial composition, Sumter is the best comparison county in the state for Florence.

Salinas, CA (experimental), is located eight miles inland from Monterey Bay in Northern California and is a part of Monterey County. The comparison site, Modesto, CA, is located 90 miles from San Francisco in the northern part of the San Joaquin Valley and is the county seat of Stanislaus County. Since its incorporation in 1874, Salinas has served as a commercial and agricultural centre. Modesto has a similar development pattern which was contemporaneous to Salinas. Both Salinas and Modesto have major farming influences. The major minority population in both communities is Mexican-American, which represents approximately forty percent of the population.

The first year of the five-year project focused on base-line data collection and community organization and planning. The second through the fourth years were concerned with gradual and systematic implementation of the policies described previously. Each community program implementation team was composed of local residents, hired and trained by the researchers. Each community worked from the same intervention protocol but was encouraged to develop the most locally relevant application, timing, and sequencing for the policies described above. More detail on community differences will be described later.
The five basic operational principles below have guided the relationship between the research team and the local community program organizing teams:

1. While community level interventions are often characterized as "top down" or "bottom up" in their structure, the relationship in this project is perhaps best described as a "respectful marriage" between scientific knowledge and community experience.

2. All media and mobilization activities must be derived from specific and well-defined intervention objectives.

3. "Customized" or "tailored" program materials for each site will follow from common intervention objectives and specifications.

4. While initial program implementation may require external training and technical assistance support, resources for on-going program implementation should be generated from within the community to the fullest extent possible (e.g., server training, media production).

5. This project will channel/focus on existing community resources, skills, and interests rather than only introducing them from outside.

V. Community-Specific Policy Interventions

The following describes each of the three experimental communities and the level of implementation achieved for each of the local policies above.

**Oceanside, CA:** The community alcohol trauma prevention program began as one of the projects of a federally-funded alcohol and drug coalition in the community. The project staff of the alcohol trauma prevention project (community organizer and data collection coordinator) were located with the staff of the local coalition. These existing coalition staff were primarily developing the membership of the coalition and conducting community-wide public awareness efforts, e.g., Alcohol Awareness Week. The coalition was not involved in any programs which were designed to reduce alcohol-involved trauma. During the baseline year, disagreements between key coalition members and the staff of this coalition resulted in a breakup of the coalition and the subsequent cancellation of the coalition’s federal grant. A new coalition was created in partnership with the alcohol trauma prevention program which sought the most representative community group. The program coordinator of the trauma prevention program became the key staff support for this new coalition, which received an official designation by the Oceanside City Council as the city’s representative for alcohol and drug prevention.

**Salinas, CA:** The City of Salinas did not have any existing officially-organized coalition. A group of concerned citizens with the organizational support of the County Alcohol and Drug authority established the relationships with the alcohol trauma prevention project. The first task of the alcohol trauma prevention staff was to develop a functioning coalition. Within three months, the PARTS (Preventing Alcohol-Related Trauma in Salinas) coalition was organized. During the first year (baseline data collection) this coalition became familiar with the general design of the project (specifically a policy-driven approach to prevention) and established plans for implementation which reflected local priorities and approaches. The membership of PARTS contained a mixture of local institutional representatives as well as interested citizens from the community.

**Florence County, SC:** The county authority for alcohol and other drugs in Florence County is a quasi-governmental organization, Circle Park, which provides treatment and prevention services
to the entire county. Circle Park is designated by the State of South Carolina as the local county authority. PRC entered into an agreement with Circle Park for it to accept organizational leadership in developing the alcohol trauma prevention program in Florence County. Subsequently, Circle Park received a federal (CSAP) partnership grant to establish a City of Florence (representing about 60% of the county population, not the entire county) drug coalition. Therefore, for approximately one year, two coalitions existed, the Florence Coalition for Alcohol and Drug Abuse Prevention and the Florence County Committee on Alcohol-Involved Trauma Prevention. After one year, as a result of the local needs assessment process, alcohol-involved problems were identified as the major drug-related problem for the entire county and a merger of the two coalitions into a county-wide Florence County Coalition on Alcohol and Other Drugs Abuse Prevention was recommended. As a part of this merger, a key staff member for the Alcohol Trauma Prevention Project became the Program Director for the Prevention Services Office of Circle Park and the key staff for the County coalition.

**Drinking and Driving:** Through cooperation with local law enforcement, all three communities have been successful in implementing regular and highly visible DUI checkpoints, on at least two week-ends per month. All three police departments have acquired and instituted use of Passive Alcohol Sensor (PAS) flashlights by both regular and special patrol officers. Salinas and Oceanside police have also been equipped with pocket sized active alcohol sensor units for enforcement of zero tolerance legislation for underage drivers - this law does not exist in South Carolina. All three communities have established special, dedicated DUI enforcement units. The police in all three communities have been enthusiastic participants in coalition DUI media advocacy activities. DUI media activities have been intense over a sustained period of time, usually averaging a feature print or television story every two weeks with letters to the editor, editorials, or commentaries during intervening periods. The press has demonstrated a consistent interest in stories created for it through media advocacy. In all three communities the police have reported that this visible expression of public support has been instrumental in decisions to sustain enforcement efforts.

**Responsible Beverage Service:** Implementation of the responsible beverage service (RBS) component was delayed in all three communities awaiting specification of the intervention and subsequent selection of a training consultant by the scientific staff of the project. During the summer, 1995, all three communities organized RBS constituencies and began to implement RBS training, with priority given to manager training and development of management policies over server training independent of policy development. Recruitment of alcohol outlet participation in policy development and training has emphasized “high volume sales” establishments independent of identification of “problem” outlet reputation. By Fall, 1995, all three communities will have instituted special police undercover operations for enforcement of laws regarding sales to obviously intoxicated patrons. In Oceanside this enforcement preceded R’S training. Alcohol retail outlets have been notified in advance that these special enforcement are commencing, and police in all three cities have committed to one such special enforcement effort every other month. The results of these enforcement efforts are also being shared with the press and with outlets owners directly. Police in all three cities have again stated that the visible public support provided by coalitions was central to their willingness to initiate and sustain enforcement operations.

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In Salinas, public ordinances or cooperative agreements have been implemented concerning standards for sale and service of alcohol in all public facilities, including recreation facilities (rodeo grounds, Big Hat Bar-B-Que, city parks).

**Alcohol Retail Access**: Surprisingly, the jurisdictions have initiated (Oceanside) or implemented (Salinas and Florence) land use ordinances to require a minimum distance separation between new alcohol retail establishments, both off-sale and on-sale. In addition to distance separation, the ordinances also govern, in greater or lesser degree, standards of business operation for outlets such as limits on shelf space, window advertising, hours of sale, training of personnel, maintenance and lighting of exterior space, and bans on sale of certain alcohol products (fortified wine, 40 oz. containers, etc.). These ordinances were initiated by coalition advocacy efforts.

**Underage Drinking**: The underage drinking component has been the last component to be implemented in each of the three communities, for two reasons. First, policies impacting the relatively small number of youthful drinkers would not reduce project outcome measures (injuries and deaths) as significantly as would policies impacting the much larger volume of adult drinkers. Secondly, citizen support for policies to reduce youthful drinking are so overwhelmingly popular that it was feared that initiation of these activities would jeopardize focus on the less familiar R’S and Access components.

To date, Oceanside has initiated police ”stings” for merchant sales to minors on a bimonthly basis. These ”stings” have been highly publicized, both through direct notice to retailers and through ”exclusive on the scene” television coverage. Similar ”sting” operations and media efforts will be initiated in Salinas and Florence County in the last quarter of 1995. Like R’S, policy training for managers and seller training have been delayed pending specification of the training curriculum by research staff. It is anticipated that policy development and training will be initiated in all three communities in the last quarter of 1995.

**Advantages of Alcohol Policy Approaches in the Community**

Alcohol policy has a number of advantages at the local level. First, local citizens and the effects of an alcohol policy are close to the ”scene of the action.” While alcohol policies have been typically set at the state or national level in the US, direct personal experience with alcohol problems and responsibility for the consequences of drinking access are at the local level. The community must deal with drinking drivers, injuries and deaths from crashes involving alcohol-impaired drivers, provide hospital services and emergency medical services, conduct autopsies, work with personal rehabilitation and recovery, etc. Alcohol problems are personal experiences for community members and efforts to prevent or reduce future problems are also a personal matter. For example, increasingly across the US (and in the experimental communities for these trials), parents’ groups are being formed around a concern about underage drinking. Such groups have been, and in the future can be mobilized to create public pressure against retail alcohol sales to underage persons, as well as access to alcohol in youthful social events. The consequences of such policy, if it places constraints on local retailers or establishes priorities for local police enforcement, are also experienced locally. When policy advocates advance such positions, they also encounter those who may oppose such policies (also members of the community). This means that alcohol policy can create, in a local forum, both debate and confrontation between opposing
community groups and individuals.

Second, there are limited or no local funds to support long term community alcohol prevention service programs. If the implementation of an alcohol policy and its maintenance can be low or no cost, then local leadership, especially elected officials who have a number of competing demands for tax revenue, are especially receptive. Local leadership wishes to show that they are finding solutions or approaches to problems which require little local funds. It helps with elections, increasing power and influence, and makes a real contribution to the community. An alcohol policy can be shown to the community to (a) have the potential to reduce alcohol problems, (b) be low cost to implement and maintain, and (c) have local citizen support (even if there is special interest opposition, e.g., local alcohol wholesalers). These three elements are especially attractive to local leaders.

Third, alcohol policies have evidence of effectiveness which can be presented to local citizens. Evidence of potential effectiveness within a real community appeals to citizens and their leaders. In current times, prevention programs are being increasingly asked to demonstrate that they work or have benefit. The research base for many alcohol policies demonstrates what can and cannot work.

Lessons From Implementation

While the sample is limited to implementation in three US communities, it is interesting that the following were experienced in each of these communities.

First, during the first year of the project (while baseline data was developed), community coalitions were organized in anticipation of a need for community groups to complete needs assessments as a prerequisite for motivation for action. This certainly would have been necessary a decade earlier. This turned out not only to be unnecessary, but potentially harmful to the project. Today it is doubtful that there is a community in America that would not acknowledge that it has four serious alcohol problems-- underage drinking, drinking and driving, drinking and violence, and drinking and social disorder. No further specification is necessary to convince communities that action is necessary to address these problems. In fact, needs assessment activities to further specify how large a particular problem is, lead to discussions about which problem is the most serious, and therefore most deserving of action. Such discussions threaten coalition unity as it jeopardizes the enthusiasm of those dedicated to resolution of problems of "secondary" importance. As policy based prevention interventions impact positively across the board on all four generally accepted problems, it is not necessary or fruitful to engage in this effort.

Second, it has become almost an axiom in the US that community members are not interested in what science might have to suggest about effective efforts to prevent alcohol problems. In our three communities, coalition members quickly wanted to move beyond problem definition to discussion of what works. Members embraced the contribution of project scientists and were quick to understand the utility of project data collection for mid-course correction of intervention efforts. As discussed below, communication between project scientists, staff, and coalition members was not always easy, but there was certainly lack of interest by community members in opportunities to learn about strategies promising effectiveness. We speculate that over the last decade
communities have not only come to recognize and give high priority to alcohol related problems, but they have also experienced a healthy dose of frustration and failure in responding to these problems. The "simple" answers selected previously were not effective, and community members are very interested today in the prevention science base.

Third, most prevention efforts involve the delivery of prevention "services" to individuals--students, high-risk youth, alternative activities, etc. These activity based prevention efforts require organizational structure, philosophy, and resources very different from the organizational base of policy focused interventions. Policy based interventions require a coalition to be much more thoughtful, strategic, and purposeful than do activity and service based interventions. In our experience, attempts to combine these efforts sabotage policy based initiatives. In Salinas, the project coalition contained several alcohol and drug service providers, including those providing prevention services. The Chair of the coalition stated that members were able to unite behind policy initiatives because "members leave their programs at the door" when they attend coalition meetings. In Florence County, policy based interventions could not be initiated until the host agency restructured to create two prevention divisions, one exclusively service oriented and one exclusively policy oriented.

Fourth, media advocacy, the strategic use of news to advance policy goals (Wallack 1990), is essential. Without skilful media work it is very difficult (impossible?) to create structural or policy changes within a community. When our project began, community leaders absolutely did not believe that they could get even a letter to the editor printed. Today, after providing staff and community members with media advocacy training and initial technical support, project personnel know that they can absolutely ensure that their issues and positions receive widespread media coverage. In Salinas, after project staff were out of the community for week of training, representatives of both print and electronic media walked in to project offices to ask where they had been - they were looking for stories.

Fifth, a respectful marriage is one in which each partner truly appreciates the attributes of the other. This does not come easily when the marriage is between scientists and community activists. One major barrier is that there is a natural power imbalance between the research scientist and community member. It is simply assumed that the scientist knows more about everything, than does the community member. This works to the disadvantage of both. Community members become fearful of offering what they know from their experience, and the scientists overcompensate for the silence by offering suggestions (often misguided) about areas beyond their formal training. A respectful marriage is much more likely when scientists limit themselves to discussion of what will work (have effect), and when community members are authorized to determine how to implement the intervention. Researchers and community members also think in different ways. Researchers are very skilled at disaggregating problems--at taking things apart. Community organizers are very skilled at finding commonalities--at putting things together. It is not surprising that each finds discussions with the other extremely frustrating, at least until they learn to appreciate the perspective each brings to bear. As good marriages often require the help of a marriage counsellor, science-community partnerships often need facilitator and management assistance to work harmoniously.
Limitations of a Local Alcohol Policy Approach and Expected Problems

Problems and limitations for alcohol policy at the local level include the following. Alcohol policies are rarely highly visible with accompanying lapel pins, balloons, posters, etc. Public activities which bring attention to alcohol problems have a valuable place in a spectrum of prevention strategies, but they are almost certainly never sufficient. However, these public activities, e.g., “Alcohol Awareness Week,” produce personally satisfying experiences for citizens and leaders. Such programs generate enthusiasm and public recognition. Alcohol policies, by their very nature, do not necessarily generate public spectacles or news events. However, coupled with news media coverage using media advocacy strategies (Treno et al., under review) public attention to the need for and support of specific policies can occur. In general, the point here is that alcohol policies are not in themselves guaranteed to provide immediate personal satisfaction to its advocates, in the way that a campaign or visible service program can. Alcohol policies can generate controversy. Unless the local citizens who are supporting and leading efforts to implement special policies are prepared for opposition, the enthusiasm of local groups for policy strategies can be reduced. As opposition grows (or can grow) in response to a local alcohol policy, e.g., restrictions on new alcohol outlets, local volunteers can be in conflict wanting to be ”good neighbours” and wanting to reduce alcohol problems in the community. This can arise particularly in cases of restrictions on local alcohol retail outlets, stores, or bars and restaurants.
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The use of evaluation data in intervention program design and implementation: A case study in a responsible beverage service program

Robert F. Saltz

Introduction

Responsible Beverage Service (RBS) refers to the steps that servers of alcoholic beverages can take to reduce the chances that their patrons (or guests) become intoxicated. It has traditionally also comprised intervening to keep intoxicated drinkers from driving (e.g., by calling a taxi for them or arranging accommodation). In an article reviewing the evolution of RBS evaluations and research, Saltz (in press) argued that the focus of research in this area has been shifting from efficacy studies (usually small-scale evaluations of whether the strategy holds promise) to effectiveness studies (which attend to issues of implementation). This paper is representative of the trend in that it reports on the design and implementation of a community-wide Responsible Beverage Service Program at three sites. As we are currently in the implementation phase, the emphasis here is in describing how data collected in support of the evaluation was also influential in program design and implementation.

One of the advantages of the programs (one for each of three sites) described here is that they were embedded within a larger, comprehensive set of interventions as part of a community trial (see Holder, in press). The larger ongoing project has as its goal the reduction of alcohol-involved trauma (deaths and injuries) via interventions that, besides RBS, included enhanced enforcement and public awareness of DUI laws, strategies to reduce minors’ access to alcohol, and the use of local zoning regulations to alter alcohol outlet densities within the communities, all supported by a multi-faceted community mobilization effort.

The Community Trials Project involves more extensive data collection and data sources than would be found even in well-funded RBS program evaluations, and thus forms an ideal case study in the exploration of the relationship between research and program. By way of background, I will start by describing the treatment communities themselves, discuss the relationship of data collection to both the evaluation and program components of the larger Trials project, and then present the data that were generated to deal with anticipated objections to an RBS program. The paper concludes with some general commentary on the value of research data in these situations based on our experience in implementing the RBS program itself.

Treatment Communities

Of the three treatment communities, two are in California and one is in South Carolina. For each community, a comparison site was chosen of similar size and demographic characteristics. For this report, and in others while the implementation and evaluation of the prevention programs are underway, we will be using fictitious names for those communities to reduce the chances that the
reports produce some unplanned reaction within either the treatment or comparison sites.

"Socal" is a distant suburb of a Southern California metropolitan area and a resort community in its own right. Its population is approximately 128,000, comprising about 64% whites, 23% Hispanics, and about 7% each Asian and African-American. Per-capita income is approximately $14,500. About two-thirds of the working population commutes to other cities. "Nocal" is located several miles inland from the ocean with a population of about 110,000. It has served as a commercial and agricultural centre and comprises a large Spanish-speaking population (about 45% of the total). African-Americans, Asians, and whites make up an additional 2.2%, 6.2% and 44.8% of the population. Located near the centre of South Carolina, "Carol" is moving from an agricultural-textile base to light and medium industry and has a significant African-American population (about 40%, whites make up nearly all the remainder of 60%). Total population for the city and surrounding county area is approximately 115,000. Agriculture is still a sizable part of the economic picture -- major farm crops being soybeans, tobacco, peanuts, and corn.

The Community Trials Project

The Community Trials Project was designed from the beginning as evaluation research; which is to say that priority was given to measuring the effect, if any, of a comprehensive community-level prevention program on alcohol-related injuries and deaths. In a different funding environment, proportionally more resources may well have been given to program design, materials, and implementation. Nevertheless, the project was committed to integrating the evaluation components of the project with programming, and to avoiding the artificial and often counter-productive separation of program and evaluation that was once considered the desideratum of "rigorous" evaluation. That commitment was not always fully maintained, but we designed all data collection to simultaneously serve both evaluation and program functions. For this paper, I limit my attention to only those aspects relevant to the RBS component of the Community Trials Project, but similar objectives and concerns arose for the other interventions as well.

Data collection, then, was designed for two broad purposes: to evaluate the impact of the interventions themselves; and to aid in the design and implementation of the RBS program. For the evaluation, primary outcome data were being collected to determine any change of level in trauma from hospital discharge data, emergency room interviews, and automobile crash data (as motor vehicle crashes were responsible for the great majority of serious injuries). These same data were being collected at comparison communities selected for their similarity to the treatment communities.

But merely knowing whether those indicators changed would not suffice, particularly if they failed to show a significant decrease. So, to be able to explain what facilitated or impeded the program’s desired impact, we also wanted to include data that would help uncover and interpret the underlying mechanisms or process by which the interventions are believed to function. In the case of the RBS intervention, process data included a telephone survey of senior bar and restaurant managers with items assessing their attitudes and current policies with respect to RBS (as well as descriptive data on their businesses), post-training questionnaires for employees participating in the manager or server training sessions, and a "heavy drinker" survey in which a research assistant entered an establishment and ordered a sufficient number of drinks in succession to have evoked an intervention from a responsible server. The heavy drinker survey checks to see if, in fact, any
change in serving practices can be observed in light of the RBS program.

Data collection was also intended to support RBS program design and implementation. Data for these purposes overlapped with those just described, of course, but derived from a different set of questions. First, we tried to anticipate potential barriers to adoption of RBS policies and then imagined what data could serve to overcome these obstacles.

**Anticipated Barriers to a Responsible Beverage Service Program**

There may be innumerable possible obstructions to implementing an RBS program, many of which might not be addressed by data (e.g., bars having difficulty in finding money to pay for staff training). But others may be overcome by the kinds of data the project was collecting. In particular, we anticipated several major arguments that might be raised against an RBS intervention, which could be organized as follows:

I. Alcohol-involved injury is not really a problem
II. The public is not concerned with it as a problem
III. Bars and restaurants are not a practical site for dealing with this problem
IV. Bars and restaurants are not a legitimate target for intervention

The data we collected in anticipation of these objections is summarized as follows:

**Is alcohol-involved injury really a problem?**

Random digit-dial surveys were conducted in each of the communities. The interviews were approximately 25 minutes long and included items related to the respondent’s alcohol consumption, exposure to risk of alcohol-related injury, attitudes regarding alcoholic beverages, perceived risk of injury when drinking, awareness of the interventions, and self-reported injury. The interview also comprised items related to driving after drinking, and driving when the respondent thought that he or she may have had “too much to drink and drive safely” and/or would have been in trouble if stopped by the police. For the cities of Socal, Norcal, and Carol (N=4467, 4481 and 4501), the proportion who drove within four hours after drinking (in the previous six months) was 27.9 %, 25.7 %, and 17.8 %. The proportions reporting one or more instances of driving when it was “unsafe” or likely “over the limit” were 8.6 %, 7.5 % and 8.4 % of those same cities. For communities with 100,000 people over 18 years of age, this means that between 7,500 and 8,500 fell into this group of impaired drivers (by self-report).

It turns out that those who reported driving when probably over the legal limit for alcohol did so an average of 4.6, 5.6, and 5.6 times in the prior six months (in the three communities). Thus, as a rough estimate, one could say that in a six-month time frame, Socal (population 118,000 over 18) had approximately 46,680 occasions of self-reported alcohol-impaired driving over a 6-month period, or a little over 250 occasions per day on the average. For Nocal and Carol, the rough average daily rates are 230 and 210, with differences mostly due to the size of the base population. Though some people undoubtedly considered themselves impaired when they were still under the legal limit, it is more likely that these figures underestimate both the proportion of impaired drivers in the population as well as the frequency of impaired driving.

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An alternative perspective on alcohol-impaired driving can be obtained from roadside surveys of drivers in each of the communities. These surveys were (and are) conducted on every-other weekend (Friday and Saturday nights) continuously over 8 to 12 sites per community (usually three on any given night). The survey was run from 9 p.m. to 2 a.m. with scheduled breaks while the site was being changed. On the road leading up to the scene were signs stating what is ahead. Drivers were stopped by off-duty but uniformed police officers at the survey sites. The police officer had no direct contact with the drivers, but rather signalled the driver to pull into the survey site. The site was typically a parking lot that allowed the use of traffic cones to designate lanes and interview "bays" into which the drivers pulled in and were then approached by civilian interviewers. The police officer was well out of hearing distance (from 50 - 100 feet) and monitored traffic along the road attending to the interviewing only to notice when an interview bay became available for the next car to be selected.

The stopped vehicle was immediately approached by a research team member and given the information card describing the research and saying that the driver’s participation was voluntary. They were then asked to participate in the research. Upon agreeing to participate, their breath alcohol concentration (BAC) was collected using a breathalyser. The driver was then asked to fill out a brief questionnaire. Along with basic demographic questions the survey contained items concerning drinking that night and during the previous 28 days, the drivers’ estimation of their current BAC, their knowledge of drinking and driving legal limits, and recent drinking and driving episodes. The entire process required 5 to 7 minutes.

The sample sizes at the time of this report were 10,323, 9,121 and 5,298 for Socal, Nocal and Carol (total N=24,742). Overall, the percentage of drivers who had a positive BAC was 18.9 %. Drivers whose BAC put them over the legal limit (.08 % in California and .10 % in South Carolina) comprised 2.2 % of the total sample. There was some variation by community, here, in that the same two proportions for each of the three communities were 23.3 % and 3.1 % for Socal, 13.8 % and 1.6 % for Nocal and 18.0 % and 1.1 % for Carol. The proportions of positive and illegal BACs are typically higher for drivers stopped later in the evening.

As the probability of any driver being selected into the sample cannot be known, we would not want to use these figures to represent the proportions of all drivers on any given night in these communities. Likewise, though the refusal rate is very low for this survey (6.9 %, 5.2 %, and 7.8 % for Socal, Nocal, and Carol), drivers with elevated BAC may well have been more likely to refuse than others.

**Is the public concerned with alcohol-involved injury as a problem?**

We were concerned that some community leaders (including those in mass media) might argue that their public considers other problems of much greater concern than alcohol-involved trauma. In the general population telephone survey, we included a series of items asking the respondent how "concerned" he or she was with a number of possible problems in their own community (responses were coded "1" for "not concerned" to "5" for "very concerned"). The list of problems, eleven in all, included drug abuse, cancer and heart disease, drinking and driving accidents, AIDS, teenage pregnancy, drowning, burns or fall involving drinking, unemployment, young people and drinking, homelessness, crime, and dirty streets.
The rank ordering of these items (using the mean level "concern") was fairly consistent across the three communities. In Socal and Nocal, greatest concern was expressed for crime, drug abuse, drinking and driving, and youthful drinking (in that order), with alcohol-related "drowning, burns, or falls" lower than all others except for "dirty streets." Carol results were similar, except that crime fell to #4. In all cases, then, we were able to show that alcohol issues, at least with driving and youth, were high in priority for the public. Absolute differences in mean scores were not great, and all problems scored better than 3.0 (the middle category). In Nocal, for instance, the mean score for crime was 4.65 and for youth and drinking (#4) it was 4.51.

Are bars and restaurants a practical site for dealing with this problem?

Those who reported driving while impaired from the general population telephone survey were also asked where they had been drinking prior to driving. The proportions coming from licensed establishments (bars, taverns, restaurants, and very few from private clubs) were 48.5 %, 46.1 %, and 52.4 % for Socal, Nocal, and Carol. These figures are consistent with results reviewed by O’Donnell from studies of places where impaired drivers drank (1985). In conjunction with the estimates above, they would mean that there are about 3,500 impaired driving occasions a month in each community in which the driver had left a licensed establishment.

Interestingly, for the roadside survey respondents, the proportion of legally-impaired drivers coming from licensed establishments is lower than the 50 % figure above. Overall, 28.9 % of those drivers came from those places, whereas 18.7 % came from their own homes, 31.8 % came from someone else’s home, and 20.7 % came from somewhere else (e.g., a park, church, work, or other type of business). The proportions of legally-impaired drivers from licensed establishments for each community (Socal, Nocal, Carol) are 34.3 %, 18.4 % and 22.9 %.

These data are not directly comparable to those from the telephone survey, however. Not only is the roadside sample biased in unknown ways due to sample sites, times, and protocols, but the question asked of drivers concerns where they had just come from and not where they may have been drinking. Thus, someone who drank at a bar and then went to a movie would report having come from the movie. Likewise, someone who was out drinking and stopped to pick up a friend would report coming from the friend’s home. Finally, the telephone survey data on location of drinking does not weight the locations by frequency of impaired driving (as we only ask about the location of the most recent occasion). If those who drive impaired more often are more likely than others to drink at locations other than licensed establishments, our "snapshot" of impaired drivers on any given night may show higher proportions coming from those other places.

The telephone survey of the general population asked respondents if they had driven between 9 p.m. and 3 a.m. on either of the last weekend evenings (or both). About a third of the population reports having done so. By the same rough extrapolation from the roadside survey data to the population as a whole, we can estimate that each of the communities would have approximately 8,400 legally-impaired drivers a month coming from licensed establishments (a little over twice as many as estimated from the telephone survey, but in the same ballpark). The roadside figure is probably an over-estimate, given that the survey sites were more likely to be in commercial, rather than residential districts.
There remains, finally, the "heavy drinker" survey, in which we were able to assess how well a sample of bars and restaurants in each community were doing in guarding against service to intoxicated patrons. Here, research assistants posing as customers entered a bar or restaurant, sat down and ordered an alcoholic beverage. They were shortly joined by a confederate whose main task was to record all interactions between the drinker and the server(s). The drinker ordered the same alcoholic beverage every 20 minutes until, at the sixth order (an hour and forty minutes after the first drink), he ordered two drinks simultaneously. All drinks except the last double order were consumed by the drinker, who would typically be at the legal limit or over it by the time he ordered the two drinks (which were not consumed).

The confederate recorded all server comments verbatim and was to code any overt behaviour related to refusal to serve, arranging alternative transportation for the drinker, etc. The verbatim comments and recorded behaviour were later reviewed and coded on a 0-to-5 scale representing the servers reaction from overt refusal (0) to positive encouragement to drink (5). A score of “3” was given when the server did nothing more than take the order and deliver the drink.

Given the time-consuming nature of this protocol, our sample was limited in size, with Socal, Nocal, and Carol samples of 23, 23, and 20. The three comparison communities were also involved in the heavy drinker survey to form a baseline for the evaluation data.

From the perspective of the RBS implementation, we considered these data useful in addressing the objections we have often heard from bar and restaurant owners that they are already doing a good job in dealing with intoxicated patrons. In the heavy drinker survey, however, there were only three overt refusals to serve (two in Nocal and one in Carol) in 66 visits (about 5 %). Clearly, there was quite a bit of room for improvement.

**Are bars and restaurants a legitimate target for intervention?**

We approached this question as an empirical, rather than philosophical one, which is to say, we decided to look at how both the public and senior managers of licensed establishments viewed the basic tenants of responsible beverage service. In addition to the telephone interviews of the general population, we conducted a telephone survey of a randomly-selected sample of on-premise outlets, in which we asked to interview the senior manager (or owner if he or she actually worked at the business). Call backs were made if that person was not present at the time of the initial call.

While many anticipate opposition to RBS by managers in the hospitality industry, Figures 1 and 2 show that, in each of our three communities, managers were more likely than the general public to support the primary tenants of RBS – that servers should prevent customers from becoming
Figure 1. Alcohol servers should take steps to prevent customers from becoming drunk.

Figure 2. Alcohol servers should prevent intoxicated customers from driving.
Figure 3. Alcohol servers should be required to take a course.

![Graph showing opinions of public versus those of premise managers.]

 drunk and should prevent intoxicated customers from driving. Managers are even supportive of mandated server training (Figure 3) where cost and logistical issues could have played a more significant role in their willingness to agree. It appears then that a community-level RBS program does not have to overcome hostility to the concept of server responsibility.

The actual functions served by research data in RBS program implementation

As we have seen, some thought had been given to the kinds of arguments that might be posed in opposition to the RBS program by some hypothetical people or organizations. We have focused on those points that could be addressed by the data the evaluation project was collecting (or could add to data collection), but there were other issues we anticipated as well for which our local data collection was irrelevant. As an example, for those who might worry that an RBS program might lead to a drop in a bar or restaurant’s income, we had testimony from managers who had implemented programs in other places that their profits were not harmed, and in some cases, income grew as a result of an overhaul of house policies and serving practices.

So how did these results come into play with respect to program implementation? First, our general population survey showed that drinking and driving accidents and youthful drinking were already high on the public’s list of concerns for their community (higher even than the concern for crime in one community). The priority did not extend to alcohol-involved falls, burns, and drownings, however, most likely due to the public’s ignorance of how large a proportion of those injuries are also alcohol-related, but perhaps also because they perceive less chance of injuring or killing an innocent (non-drinking) person in those other circumstances. Obviously, it was better to present the prevention interventions as a way of reducing drinking and driving crashes and

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1 Support is high among both groups. We do not know if the two groups have separate operational definitions of "drunk" or "intoxicated", which may disguise underlying differences of opinion.
youthful drinking than to prevent a wider assortment of trauma (though the interventions would, of course, carry over to those injuries as well).

Likewise, though youth make up only a small proportion of the population at risk of alcohol-related injuries, public concern is very high. So, although interventions aimed at youth would be expected to have a relatively low impact on an entire populations rate of injury and death, the Community Trials Project nevertheless comprised a visible component aimed at restricting youth access to alcohol (via enhanced enforcement of laws prohibiting sales to minors and publicity aimed at parents, etc.).

The results of the roadside and general population surveys also supported pursuing an RBS program in these communities, given the significant proportion of impaired driving occasions originating in licensed, on-premise establishments.

Perhaps the most significant, and surprising, impact of these results, however, was the effect of the survey data on the public and licensee’s support of RBS principals (summarized above). Surprising because with all of our anticipation of possible ”external” opposition, these results proved critical in overcoming an ”internal” resistance or reluctance on the part of staff and supporters that may not have even been recognized were it not for their reaction to the data.

To state it simply, while the design phase for the RBS implementation was underway, it seems that project program staff and members of the community task force were anticipating hostility and opposition to the program from the hospitality industry. There really was no basis for this expectation at the local level (some state or national trade organizations were on record opposing specific elements of RBS programs, e.g., mandatory training), but the ”news” that the public and especially the owners and managers of bars and restaurants were behind server intervention and server training moved the RBS program onto the ”fast track.” Prior to this time, I think it is fair to say that the RBS program was being pursued with some degree of apprehension and reluctance, not because of any lack of commitment to its value as an intervention, but rather in an understandable hope to stave off direct confrontation with overt opposition.

Of course, some of this apprehension could have been ameliorated via early and wide contact with members of the hospitality industry. It is common, though, for a project to develop at least the outline of an intervention before recruiting a wider circle of participants. It was especially difficult to recruit bar and restaurant managers early in the project, too, for they had difficult businesses to run which demand close supervision which left them little free time to attend general ”task force” meetings. Even assuming some level of licensee participation in the project, however, the staff would have assumed their support to be atypical of the larger population of bar and restaurant owners and managers.

I think there are at least two general lessons from this experience for the evaluator or researcher who may be operating in a similar environment. First, to be mindful of the fact that the ”audience” or ”client” for project data includes the project staff itself (and by extension, their allies in the community). All the attention paid to hypothetical external sources of opposition may, in fact, have been counter-productive to the extent that it contributed to the program staff’s level of anxiety in dealing with members of the hospitality industry. It is important to anticipate some opposition and to be prepared to turn that to an advantage for the program, but it may well be as important to
anticipate the data that will motivate and encourage the project staff as well. Results may also serve to settle any disputes among staff as to what they are likely to run into when implementation begins.

The second lesson is that it may be difficult to predict or appreciate what kind of data will prove to be valuable. To be frank, ”attitudinal” data on the respondent’s level of agreement with RBS goals (e.g., intervening to prevent someone from becoming intoxicated or requiring training for all servers) was not viewed as particularly significant by the research staff, who were more interested, for example, in estimating the proportion of impaired drivers coming from bars and restaurants. Yet these data have proven to be more helpful in the course of this intervention than the more classic epidemiological data the project was pursuing.

In this connection it is interesting to consider the parallel to a strategy being used today with school-based adolescent prevention education (c.f. Hansen et. al. 1988). In the school setting, the youth often assume that their own abstinence is somehow ”deviant” from the norm, and are shown that their behaviour is, in fact, common to the large majority of youth in their class. This changes their perception of norms with regard to drug and alcohol use, thus strengthening their own decision against use. In a similar vein, it is common for prevention advocates to see themselves as running ahead of popular opinion in that arena, but they, too, can be surprised to find that their (our) views are shared by a great many others, including those who constitute the target of our interventions.
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Experiences from the California perinatal substance abuse prevention and research initiatives

Dorie Klein

Introduction

This paper describes researcher experiences in a project that differs in scale and scope from most community action research: a series of policy, action and research initiatives by the State of California to address problems related to perinatal substance abuse. The substantive issue of perinatal substance abuse lies at the intersection of two major current trends: the emphasis on women in alcohol and other drug (AOD) prevention and research, and the concern over adequate parenting and the welfare of children raised by single mothers. At a more abstract level of community action research, tracing the experiences of this initiative responds to the larger question of how research can affect policy or programs in a large and politicized environment, since the state initiatives can be thought of as a massive multi-site action project. My discussion will address, first, the social shaping of action on this particular AOD issue; second, the context, opportunities and limitations of the state-sponsored research; and third, the potential for relationships between researchers and communities in this situation to effect action.

Pressures for action

Although women’s maternal role has always been central to discussions of their drinking and drug-taking (Fillmore 1984; Gomberg 1979; Rosenbaum 1981), action to address perinatal substance abuse is relatively recent in the United States. Perinatal AOD use came to be defined as a major concern by the late 1980s in association with several perceived consequences. These included the physiological consequences of prenatal maternal substance use for the fetus; the psycho-social impact of maternal substance abuse on the child; the fiscal and organizational effects of the problem on public institutions; and the social consequences of all of these factors for the most deeply hurt groups and communities. Discussion of these consequences and pressures to act came from a number of sectors or systems: scientific and medical research and technology; mass media; public health, social and penal institutions; and women’s advocacy and community activist groups. These consequences and pressures are briefly outlined below.

Impacts of scientific and medical research and technology

Concern over the possible physiological effects on infants of prenatal maternal substance use was sparked by the clinical research identifying a Fetal Alcohol Syndrome (FAS) (Jones and Smith 1973). More limited clinical and laboratory research was conducted beginning in the 1970s on potential harms of other substances, such as nicotine and opiates, and in the mid-1980s early results of the first clinical work on the possible effects of cocaine were reported (Chasnoff 1986). These research findings struck a responsive chord in the new middle-class health and consumer movements. For example, new laws were passed requiring pregnancy warning labels on alcohol,
comparable to the warning labels about driving under the influence or the cigarette label health warnings. In much of America, drinking during pregnancy, like driving under the influence or cigarette smoking, has become a deviant behaviour. Clinical and laboratory research on the effects of prenatal substance exposure has expanded enormously.

Another factor has been the explosion in prenatal genetic testing, fetal surgery, and neonatal intensive care. Obstetrical medical technology and availability have advanced considerably in the last decade or so in the US, placing emphasis on medically managed healthy pregnancies and monitored birth outcomes. Screening of pregnant women for prenatal defects has become routine (Stanworth 1987).

Social scientific research increasingly has focused on the relationships between parental substance abuse and child abuse. While this association had been made in earlier eras by temperance and children's advocates, it had historically addressed the father, alcohol, and physical abuse (Gordon 1988). Now increasingly the emphasis was on the mother, illegal drugs, and child neglect. Of particular concern were the psycho-social effects on children of maternal use of crack cocaine (Child Welfare League 1990).

Epidemiological research was hampered in shaping perinatal substance use concerns by lack of generalizable data. Early estimates of prevalence and distribution were drawn from anecdotal reports, clinical studies, and records of demographically unrepresentative institutions (e.g., big city public hospitals). More recently, probability samples of delivering mothers have been surveyed using anonymous urine toxicology testing (Vega et al. 1993) or anonymous self-report (US National Institute on Drug Abuse 1995). These studies suggest that the most common substances used are nicotine and alcohol, and, among the far rarer illegal drugs, the most widespread is marijuana.

Media coverage

A crucial pressure for action arose from mass media coverage of the innovation of the crack form of cocaine and its rapid dissemination in the mid-1980s (Reinarman and Levine 1989). Unlike the use of alcohol, marijuana and powder cocaine, use of crack cocaine has been heavily concentrated among the urban poor, particularly among African-Americans. This has meant that the mass media and mainstream public policy coverage -- which is slanted toward middle-class whites -- has socially constructed crack cocaine use as outside the norm for the American citizenry. Crack cocaine has also marked the first "epidemic" of use of a heavily stigmatized illegal drug in which large numbers of women are involved. Many of these women are young and have small children.

The media reported emotional stories of sick or damaged "crack babies". Of equal media interest were the mothers, portrayed as recklessly getting pregnant, injuring innocent fetuses, neglecting or abandoning their children, and doing anything to obtain drugs. Outrage was expressed on behalf of the children and the taxpayers.

Responding to the "crack mother" stories, some proposed criminalization of perinatal drug users, while others opposed the penal approach and advocated health care and treatment. The media carried reports and commentaries on drug-using women being singled out for prosecution or
incarceration because they were pregnant or parenting (Gomez 1994; Klein 1992; Noble 1992). These debates were part of the general media coverage of the "war on drugs" of the period.

**Pressures from public health, social and penal institutions**

Inner-city public health institutions reported growing numbers of crack-involved women giving birth beginning in the mid-1980s. Hospitals reported toxicology results showing prenatal drug exposure rates as high as fifteen percent (US General Accounting Office 1990). Concern was expressed on two levels: for the infants’ health and development, although largely in the absence of scientific research on actual effects, and for the public costs of caring for these indigent babies, focusing mostly on the rare but expensive neonatal intensive care.

At the same time, child welfare agencies experienced dramatic caseload increases of neglected or abused children attributed to maternal crack cocaine use. Large numbers of infants and small children were being removed from their mothers’ care and placed with relatives or in foster homes. City clinics and hospitals that served publicly insured (i.e., poor) patients worked out cooperative procedures with the child welfare authorities. Hospitals would routinely test new mothers’ urine for illegal drugs (far less frequently for alcohol), and report positive toxicology results to the authorities for investigation (Noble 1992; 1988). This coordination contributed to further strain on child welfare resources.

In addition to the intervention of child protection agencies and the special perinatal prosecutions, the criminal justice system expanded to process crack cocaine users to an unprecedented extent. The overall numbers of drug arrests rose dramatically, with women’s drug arrests increasing by 89 percent from 1982 to 1991. Jails, prisons and correctional agencies experienced surges in female wards, with the "per capita criminal justice control rate" increasing for women by 78 percent from 1979 to 1994. Of the explosion in female institutional inmates (which rose for state prisons alone by 433 percent from 1986 to 1991), nearly all the new admissions were drug-involved, mothers of small children, and of whom up to ten percent were admitted while pregnant (Bloom and Steinhart 1993; Mauer and Huling 1995). Criminal justice agencies were caught unprepared to provide health or social services for these women.

**Community activism and women’s advocacy**

In the communities most affected by both AOD problems and the war on drugs, groups of activists and service providers began to call for public attention and funding to address the unfolding problem of perinatal substance use. Local task forces and coalitions came together, often with some government moneys, to initiate local prevention campaigns, or to provide prenatal health care to pregnant women at risk for substance use (US CSAP 1993). These movements were most common in African-American urban communities, but could be found to a lesser extent in affected rural areas, including those with sizable American Indian, Latina or low-income Anglo-European communities. In American Indian communities, the focus was most commonly on drinking and on prevention of FAS.

Advocates for women’s legal and medical rights also coalesced around demands for perinatal
AOD services and general prenatal care. They successfully fought the criminalization of perinatal substance use in California (Noble 1992). Like the ethnic community activists, many had social change agendas far broader than prenatal substance exposure prevention. However, given the exploding interest, it seemed an opportune strategy to use the perinatal issue to press for resources for programs for women and minority groups. Furthermore, to advocate expanding treatment was also the strongest argument they had against punitive approaches.

**Author’s involvement**

I became directly involved in perinatal substance abuse research in 1992 when I and several colleagues responded to a request for proposals from the State of California’s Department of Alcohol and Drug Programs (ADP). As a research criminologist and policy advisor, I had been concerned about the criminalization of women for drug use. I had also written about the apparent special punitiveness recently being shown toward lawbreaking women who had children (Klein 1992). My understanding of perinatal concerns was at a beginning stage at this point, and benefited from the work of Amanda Noble, an early student of the problem.

Our proposal to conduct a Perinatal Needs Assessment (described below) was funded by ADP. This study was extended at different points to include a follow-up Pregnant and Parenting American Indian Study, and a preliminary policy survey of implementation of a state law to structure perinatal substance abuse intervention. A more in-depth longitudinal policy study of this law is now underway, but this is not state-sponsored.

Over three years, I and my colleagues met frequently with ADP officials and stakeholders from around the state to discuss perinatal substance abuse policy; we reviewed documents from ADP and other interest groups; and we continually spoke with other researchers, service providers and advocates in the field.

Conducting independent scientific AOD research under contract to the State of California can be difficult (Room 1990; Wallack and Barrows 1982 - 1983); however, one side benefit is the opportunity for participant-observation in projects on a grand scale, which in this case has been my close involvement with the state perinatal substance abuse initiatives. The perspective to be presented here is naturally shaped by my role and vantage point as a researcher on the ”alcohol and drug” side; it is likely to differ from that of a community advocate or service provider, or a health care or child welfare researcher.

**The California initiatives**

In response to the pressures to address perinatal substance abuse and its consequences, public sector agencies in California organized a network of programs to do treatment, outreach, coordination, prevention, planning, and research. The overall objective of the initiative has been...
to change social mores, environmental risk factors, and protective factors with respect to perinatal drinking and drug use, and to provide early intervention with those involved in substance use or exposure. The new programs have included legislative mandates to guide interventions, media prevention campaigns, expanded substance use treatment, and innovative service delivery models. The Governor of California, Republican Pete Wilson, made an announcement in 1991:

A plague is sweeping California and all America. It threatens to strain our hospitals and foster care system beyond capacity, and leave our schools struggling to cope. Nationwide, this epidemic will impair hundreds of thousands of innocent infants before they are even born....I won’t mince words: Drug and alcohol abuse by a pregnant woman is nothing less than child abuse through the umbilical cord....For the brief artificial high enjoyed by their mothers during pregnancy, these children are condemned through their lives to pay a fearful price in suffering and diminished lives....

That’s why I put $23 million in the state budget to expand treatment and recovery services for addicted pregnant and postpartum women and their babies. These services will expand residential and outpatient treatment. Treatment for substance-abusing mothers is only part of the solution. We must take preventive action....We must begin prevention by graphically showing our young people the horrifying, tragic consequences of substance abuse during pregnancy. So I’ve asked the legislature to fund a special drug education program for junior high and high school students (California Governor’s Office 1991).

Treatment and outreach

Many of the earliest treatment and outreach responses were initiated locally. For example, a number of counties instituted committees to develop protocols for addressing prenatal substance exposure through inter-agency coordination (e.g., public hospitals, child welfare authorities, and alcohol and drug treatment); some of these received small state planning grants (Noble 1992; Conrad et al. 1990). In urban communities experiencing the impact of crack cocaine, providers began hospital- or community-based perinatal programs. These programs, while locally developed, could not survive on local county moneys alone, but had to generate state and federal financial support to thrive. Some of these were extensions of earlier programs to reduce infant mortality in poor African-American communities. An example was a ”healthy infant program” in the public hospital in Oakland, funded through combined public maternal and child health moneys (Thompson 1990). In this program, new mothers found to be positive for drug use would be offered the services of social workers, public health nurses, therapists and drug counsellors. Outreach and follow-up was done via home visits to clients, with an impetus for participation being that refusal to participate could result in a report to child protective authorities.

A campaign for more ”woman-oriented” AOD treatment was initiated by feminist-identified local recovery advocates. Thanks to sympathetic state legislators, it resulted in a new statewide network of perinatal treatment. The earliest pilot programs, known as ”options for recovery,” were funded in 1989. These consisted of day or residential treatment for pregnant and postpartum women, the latter with some limited room for their newborns or small children. They also included case management for clients, that is, coordination of services in addition to treatment by an assigned case worker: housing, health care, access to welfare benefits, liaison to child welfare, and, less
frequently, school assessment or assistance, or job training and placement. Most of the women participating in this publicly funded treatment were low-income and (except in the more rural areas) disproportionately African-American (46 percent); much of the emphasis in the programs (except, again, in the rural areas) was on use of crack cocaine.

By the end of its second year, these pilot treatment programs had been established in ten out of California’s 58 counties, and had admitted 850 women. By the end of the third year, over 2,600 women had been served in the original programs.

The perinatal programs were later expanded to nearly every county, which was an impressive state commitment in a fiscally strained time. Some of these programs were funded in part by federal treatment dollars passed through the state that were specifically allocated for perinatal programs. A few were also funded directly as federal "demonstration" projects (US CSAP 1993). Each county also had to develop a coordinating council to oversee the services. In some counties, these funds were hailed as a response to local agitation for perinatal and women’s treatment; in other places, county and program administrators resented being forced to implement specific programs (and some refused). Generally speaking, state money was welcome; state control was not.

Prevention and coordination

At the state level, the earliest planning by the Department of Alcohol and Drug Programs (ADP), interestingly, had been oriented toward prevention of alcohol-related birth defects. A committee on alcohol-related birth defects had been instituted in 1986 (Conrad et al. 1990; Select Committee 1991). The first prevention campaign using the media focused on alcohol. The policy position and public message was that since there was no scientifically established level of prenatal drinking safe for the fetus, pregnant women should abstain.

But the emphasis was to change: in 1989, the committee was renamed the select committee on perinatal alcohol and drug use. By 1991, when the committee's report was completed (and the Governor’s above-quoted statement made), drugs and treatment took precedence over alcohol and prevention. ADP, the committee, participants in state conferences, and other concerned policy makers and advocates worked hard and successfully to keep a focus on alcohol as well as on drugs, on prevention, and on a public health rather than a criminal justice orientation. (This latter fact did not mean, however, that from a perinatal client’s viewpoint there was no punitive or coercive element in the emerging system of care; indeed, there was, but it was largely centered in the child abuse system.)

Numerous proposals by state legislators in 1989 and 1990 were made to address perinatal substance use: out of seventeen, eleven became law (Gomez 1994). The emphasis of the legislation was on crack cocaine and other illegal drugs rather than on alcohol, and on serving infants (born or unborn) rather than adult women. However, the orientation of most of the successful legislation (unlike that of most of the failed bills) was from a child welfare perspective rather than from a penal or criminal orientation. Treatment and prevention for the women, although not directly the major focus, were implicitly part of this orientation in that these efforts were acknowledged as benefiting children, albeit indirectly.
One major new law, Senate Bill 2669, attempted to coordinate the relationship between prenatal substance use and child abuse reporting, by requiring that women and infants identified as prenatally using or exposed be assessed by health care providers for risk levels and service needs prior to any reporting to child welfare authorities. The law was based on advice from a cross-disciplinary statewide committee of agency administrators, service providers and women's advocates. However, implementation was guided by the state office of child abuse prevention, which had a mandate to do child protection, rather than by an office mandated to provide women’s treatment or services. Thus the law’s implementation became child abuse-oriented in flavour.

The new laws of 1990 also created an office of perinatal substance abuse in ADP to coordinate statewide treatment, research, evaluation and policy. The creation of this perinatal office was the opportunity for ADP to solidify its policy and programmatic leadership in this area, advocating treatment and prevention for women as the major emphases, rather than following in the lead of the state child abuse prevention office or the state offices of maternal and child health or development, which were more baby-focused. Through a strong, committed and well-funded team of managers at its new perinatal office, ADP became very visible in all perinatal AOD activities around the state.

As part of the activist planning and advocacy support process, rich technical assistance was offered by ADP’s new office to its constituency of community AOD treatment and prevention caregivers. Funds supported trainings, writings, and advisory groups for different ethnic groups (Latinas, African-Americans, Asian-Americans, American Indians) and other advocacy groups (for the disabled, for gays and lesbians). Assistance was provided with other public moneys to local perinatal councils and networks of nurses and social workers. University of California teams drafted models of care for substance-involved new mothers and infants that stressed the continuum of identification, assessment, referrals, appropriate levels of services, and follow-up (Brindis et al. 1991; Soman et al. 1992). At the same time, federal activity to design guidelines for perinatal substance abuse management, along with federal perinatal prevention and treatment, took off at a fast pace.

Research

Research comprised a considerable portion of the ADP perinatal initiative. From the beginning, full-scale evaluation was undertaken. ADP funded an evaluation of the pilot treatment programs beginning in 1991, and continuing for the entire statewide program in 1993, at the University of California. The pilot evaluation indicated that the perinatal treatment programs were by and large successfully serving the targeted women as planned, with high client satisfaction (Brindis et al. 1994).

An ambitious statewide prevalence survey was also initiated by ADP in 1991, conducted by a University of California-led team. This survey was designed to provide estimates for infant substance exposure at the time of delivery for the state, twenty regions and the ten largest counties, and for all the major ethnic and age groups. It was felt that this data would be crucial to justifying a large commitment of resources to perinatal substance abuse activities. Anonymous urine toxicology results were obtained from 200 hospitals for nearly 30,000 delivering women for nine drugs, including alcohol. The results, reported in 1993, were that the overall point-prevalence
rate was 11.35 percent overall, 6.72 percent for alcohol, and 5.16 percent for other drugs (Vega et al. 1993). Of the 5.16 percent positive for drugs, 3.49 percent were positive for an illegal drug, and 1.88 percent of this was for marijuana. Thus a very small share of the exposure was to the more stigmatized illegal drugs. There were significant differences in these rates by region, ethnicity, and other demographic markers, including public vs. private insurance and married vs. unmarried.

The Perinatal Needs Assessment, the first study in which I was involved, was to complement the prevalence survey by providing qualitative data on perinatal substance users. It was intended to guide prevention, outreach and treatment service implementation and improvement. As designed by our team, it generated information on the AOD use patterns and problems and on the service and treatment needs of a sample of 400 pregnant women recruited at public health care, social service and criminal justice agencies in two counties (Klein et al. 1995). An AOD use and problem threshold was developed to screen women into the study who would be at risk for AOD-related problems. Agency clients were chosen because they were likely to be eligible for publicly funded programs (i.e., low-income). The major findings included high proportions of recruits screening into the study (i.e., high rates of AOD use among this agency client population); consistently decreasing use reported during pregnancy; high levels of problems, particularly at the community and family level; high levels of expressed service needs, particularly for socioeconomic assistance (jobs, education, housing, income support, child care, transportation); and little experience with and even less interest in entering AOD treatment or counselling. Needs, use patterns and problems were assessed separately for each region and for three major ethnic groups (African-American, Latina, and Anglo [i.e., European-American]), with some differences found (Klein et al. 1994).

Our follow-up Pregnant and Parenting American Indian Study was conducted in 1994-95 at the request of ADP’s Native American (i.e., American Indian) advisory group, to generate comparable information on women in an ethnic community known to have heavy alcohol use. This time, both pregnant and parenting women were recruited, and agencies were those serving the American Indian community in the two regional sites. This study yielded information similar in many instances to the first, multi-ethnic Needs Assessment, including high screening rates, high service needs, and low treatment demand. The researchers and community advisors hoped that the data would be useful in efforts to develop resources for American Indians.

Finally, another set of ADP-funded studies were preliminary policy analyses of the consequences of the major law described above, Senate Bill 2669, in selected counties and hospitals. Our team conducted the hospital survey, complementing child welfare data being collected from counties. Hospital nurses were surveyed in a number of counties and queried about institutional protocols and practices; the child welfare study surveyed county social service managers. Data were generated on the extent of implementation of the law and on the local perceptions of its purpose and effectiveness.

**The relationship between state research and action**

These extraordinary levels of local and state activity and funding created what appeared to be an opportunity for research that would be sensitive to community needs and that would in turn
influence the direction of action. ADP declared itself committed to "data-driven policy" in numerous presentations of its projects and programs. Political interest in the research was sufficiently high that a press conference announcing the results of the perinatal AOD prevalence survey was held by the state Governor, Pete Wilson, in 1993.

Nor was interest confined to politicians, ADP and AOD stakeholders; there were numerous community, organizational and professional stakeholders. Given that the issue crossed many institutional and disciplinary lines, it was an issue that many had stakes in. Different sectors were committed to protecting abused children, enhancing treatment for women, getting tough on drugs, improving prenatal health care, limiting hospitals’ liability and costs, reducing infant mortality, and so forth. At the state level alone there were a number of players in designing the treatment programs, the SB 2669 law, the prevalence study, and other projects: the state department of social services encompassing the child welfare and abuse offices, the department of health services in charge of maternal and child health, the department of developmental services for children needing special care, state professional associations, educators, county and nonprofit health care pressure groups, advocates for women, advocates for children, and minority group lobbies. These exchanges were replicated at each county level, in considering program and legal implementation. Thus the likelihood for thorough community-policy-research exchange appeared to be promising.

**Difficulties of state-level community-research interaction**

In needs assessment studies such as those we undertook, participation from an advisory group comprised of community leaders can be extremely beneficial and important. They can be successfully involved in conceptualizing and planning the project, facilitating data collection, reviewing findings, and acting on results.

Our Perinatal Needs Assessment inherited an advisory group which had been state-assembled for the prevalence study. The group had relatively little interest in agency-based qualitative research, being oriented toward the (larger) prevalence survey. Even more problematically, it had been called into place by ADP to retroactively endorse the prevalence survey and facilitate its acceptance by the hospital sites. The committee, naturally, did not always relish its rubber-stamp role. Its members were diverse and spoke from numerous viewpoints. Group tensions reflected ongoing, longstanding fights over power and money between the state and the counties, and between communities. ADP was always battling local officials for control over legislative appropriations, and feared any challenges to its funding priorities. The state managers’ reaction to committee dissension was to further minimize its role. In one case, a meeting was called two weeks in advance, which is hardly adequate notice for busy professionals coming from all over California.

At the same time that the state appeared to want to minimize community input, the managers at ADP were sensitive to any local criticism of the research projects. We researchers often had to respond in detail to every comment by any stakeholder. An example was my assignment to reply in writing to an advisory group spokesperson who objected to our compensating research respondents because they might use the money to buy drugs. There appeared to be an unfortunate dynamic in which the occasional criticism, whether reasonable or not, would only reinforce the state’s determination to avoid any further input, an attitude which in turn would stoke the fires among angry community stakeholders. Another dynamic was that it seemed that the more ADP
cared about a research project, the tighter its control. Apparently only the less prioritized projects (e.g., our follow-up American Indian study) were left to researcher and constituent communities to direct.

**Barriers to the state applying the research**

A number of factors worked against achieving the stated objective of research-driven state policy. First, it must be acknowledged that the interests of local providers and politicians in obtaining funds can always mitigate against acting on research findings. For example, a major initial reason to do the prevalence survey was to guide regional allocation of perinatal AOD moneys within the state depending on the objective need. Hence regional prevalence rates were generated in addition to statewide rates, at considerable expense. However, early in the course of this project it became clear that the results would not be used to reallocate resources. Not surprisingly, an influential region like Los Angeles was not going to lose funding because a study found that Los Angeles’ per capita rates of perinatal substance exposure were lower than those in many sparse rural regions.

Another impeding factor was that, as noted, the issue did affect so many stakeholders. They all saw the perinatal substance abuse problem and its solution differently. On the one hand, as noted, this made for lively and enlightening exchanges among people. On the other hand, in order to achieve anything, the political and organizational hoops one had to jump were considerable. Where the goal was funding, interest groups could make sure those hoops were jumped: e.g., the expansion of perinatal treatment. But where the goal was applying research findings, there were no powerful interest groups to advocate for action. Hence an objection by an individual or group could hold up progress indefinitely. For example, our SB 2669 preliminary report findings were buried by ADP apparently due to vague objections by persons unknown that they might stir some waters and negatively affect the agency’s position.

The state bureaucratic process can also create unbelievable research and reporting delays, which diminishes the likelihood of implementing results, since interest in projects fades quickly. The routine contractual arrangements for our studies each took nearly a year to complete. Our first Needs Assessment final report was submitted to the state at the end of 1993. It was initially reviewed by the ADP perinatal office and by spring 1994 it had been submitted to the agency managers “above” ADP and to the Governor’s office. Then matters stalled due to the electoral campaign, more urgent political work priorities by those in charge, and changes in top personnel. Hence by spring 1995 -- a year later -- the review had not resumed. Concurrently, publication of a state-funded book on all the research and service components was also indefinitely delayed, apparently cancelled.

A related obstacle to applying research to action was the timing of research in relation to action planning. Programs were put into place long before numbers had been counted, needs assessed, or models mapped out. This is often the case when pressure to act is great because an issue is politically urgent. The prevalence survey data was not available until 1993, by which time every county already had either a program or a plan. The selection of the pilot treatment sites in 1988 was based not on independent epidemiological research, but on institutional data (e.g., one hospital collected toxicology results to highlight its needs). The design of the treatment and service
components preceded not just the Needs Assessment data on at-risk women’s needs, which was not available until late 1993, but also the models of care that were drafted by experts who also served as ADP consultants (Brindis et al. 1991; Soman et al. 1992). The state’s development of a model Senate Bill 2669 protocol for county/hospital management of prenatal substance exposure was completed as legally required by mid-1991, but SB 2669 also required each county to develop its own model by the very same deadline! Thus over the course of the entire perinatal initiative from the late 1980s to the mid-1990s, expertise applied to program planning could rarely call upon completed research findings for guidance, but had to rely on preliminary or anecdotal evidence.

The final and most decisive barrier to using research for state action was the changing political climate. By the time the prevalence survey’s implications were analysed, the Needs Assessment reviewed, and the first treatment evaluation nearing completion, the mood was fast evolving away from the perinatal prevention focus. This was due in part to the worsening state fiscal situation, and in part to the politicization of policy due to the Governor’s various election campaigns in 1993 - 1995. After the routine bureaucratic delays noted above, our Needs Assessment final report was finally taken up again by Governor’s appointees in spring 1995. These were different individuals from those who had reviewed it on his behalf a year earlier. This time they questioned the study’s scientific character; we were informed privately that there was no chance politically of the study being publicly released. In late summer 1995, it was finally ”approved” (to be available to the public only upon special request), but in actuality buried. No press conference at all would be held to announce its results. This did not surprise me, since one of its major findings -- that low-income substance-involved women need and prioritize basic socioeconomic assistance (e.g., income supports, education, job placement, transportation, housing) over other services (e.g., treatment, therapy, self-esteem promotion) -- certainly did not fit the new political lines: crime control, welfare cuts, and lower taxes.

**Consequences of state’s inaction on research**

More tragic than the hold-up of one study were the results for the women and children at risk for AOD problems. The changing political climate ended their chance in the near future to receive appropriate assistance and information. Two cases indicate this failure to implement ”data-driven policy.” First, a legislative proposal to do preventive education targeting pregnant Latina women, who had been found by the prevalence survey to have unexpectedly high levels of alcohol use, was vetoed by the Governor. Second, a bill based on the Needs Assessment findings to broaden formal treatment to include socioeconomic services and agency-based outreach was also vetoed. These vetoes came after ADP’s perinatal managers worked intensely on developing initiatives based on the research, and even invited statewide providers to design pilot proposals. These setbacks and the general conservative climate triggered backlashes. Projects which might not fit the politics du jour were cancelled. The strong team of perinatal managers at ADP broke up, and leadership and influence appeared to wane. The perinatal office, which had prided itself on doing women’s advocacy within ADP, was disbanded in 1995.

I would summarize the overall state initiative by concluding that windows of opportunity for state action research do occasionally swing open, whereby the interests of a community-oriented project may coincide with the political winds, money, and having the right persons in the right places. The perinatal state alcohol and drug office, the innovative treatment programs, the prevalence survey
of infant exposure, the women’s needs assessments, the new laws and state-funded examinations of them, all show how the state can in some instances quickly fund, implement and complete projects that are large, multi-site, and community-oriented. In the best case, the scientific rigor of the prevalence survey was carefully preserved and its findings unfiltered. Its findings may be useful for local planners. However, even in this scenario, the researcher had little control over the state’s political use of (or failure to use) the work. Our Needs Assessment reports and reports on the SB 2669 law, as I write, still await official release in the future, or until they are irrelevant. In brief, by the time the research was ready to inform state action, for various reasons the window was slamming shut. This suggests that researchers signing on for state-funded projects who want to have an impact on programs should design studies and demand contracts that allow quick release of data, at least in preliminary form, before changing winds blow shut the window of opportunity.

The local community-research relationship

An important outcome for our team with implications for community action research has been the extremely positive local response to our work. This has been true for both the needs assessments and the SB 2669 study, all in regionally and ethnically diverse sites. Regardless of the state’s occasional embargos on the findings, as many local presentations as possible have been made. In the Needs Assessment regions, health, treatment and social service providers’ meetings were held to review findings, which were lively and fruitful. Nurses and social workers have responded with great concern to the preliminary findings on SB 2669 protocols, and have welcomed us to their meetings. Other providers and professional groups have circulated findings. In designing our most recent state-funded study, the American Indian needs assessment, our team has increasingly viewed its primary collaboration, constituency and accountability as centered in the state’s American Indian community, rather than the State of California. Building on the American Indian advisory group to ADP which requested the study, we assembled a consulting committee that helped design the study, communicate with providers and community leaders statewide, and review the results for accuracy and utility. This group was committed and invaluable.

Not only was this researcher-community relationship more vital to the study than was the researcher’s direct relationship with the state, it may also be more productive of state action as well. If it is in their interest, local advocates can use scientific data to pressure the state for appropriate responses. In the politicized crisis-oriented climate of government, aroused community groups are likelier than researchers to effect policy change. Furthermore, community groups are likelier than researchers to advocate and accomplish grass-roots or “bottom-up” change. Hence the state’s failure to apply research can be a mixed blessing if it allows community advocates to step into the vacuum and assume leadership.

This experience underscores the importance of some form of community “ownership” of state-sponsored research, and suggests that community-oriented researchers should try to build into state contracts ongoing community collaboration and structured local dissemination of results. Control over project purpose and design should be shared as much as possible, and, again, preliminary results should be released quickly, responsive to local planners.

My concluding words must be about the effects on AOD action research of the substantive social and political environment. On a fundamental level, any internal dissension or incoherence among perinatal service advocates (including ADP and its constituents) may recede in significance next
to the influence of broader sociopolitical trends. The initial focus by scientists and policymakers on fetal effects of alcohol was drowned out by the “crack baby” uproar, thanks to the war on drugs. The campaigns against street criminals, drug-using mothers, welfare payments, and the burdens on taxpayers have grown louder and more negative over the past years in the U.S. These indiscriminate discourses increasingly depict all single parenting as undesirable, all poor unmarried mothers as undeserving, all illicit drug use as indecent, and all prisoners as indefensible. This context places severe constraints on anyone’s ability to implement projects that benefit low-income single mothers with illegal drug-related problems. Unless advocates and scientists can reverse the political marginalization and stigmatization of this population, there will be little opportunity for action research in their communities.
References


Perspectives of the local alcohol actions and research in the post-USSR countries

Constantin S. Krasovsky

One of the strategic objectives of the European Alcohol Action Plan is encouraging, strengthening and supporting local actions to prevent and manage the harm related to alcohol use at the local and municipal level. In the countries of Western Europe the experience of local actions on alcohol and the relevant research is not so great as in North America, but nevertheless provides significant information for the future development of such actions. Russia before 1917 and the USSR since were very centralised states and local authorities had limited rights and resources for specific alcohol actions. So research on the evaluation of local actions is practically absent. Now the situation in post-USSR countries makes local action possible. The aim of the report is to consider perspectives and provide some guidelines for these actions and research.

Some historical features of local alcohol actions in Russia and USSR

It cannot be said that all alcohol activities in tsarist Russia and the USSR were only done by central government. Some of them, such as care for alcohol-dependent persons and their families, education and others were provided by local authorities according to the regulations of the central government. But all these activities were on the demand side. As to the supply side the actions were practically identical for the whole country. The alcohol monopoly of 1893 was tested first in some regions and then spread to the rest of Russia. The ”prohibition” of 1914 was issued as a Tsar Decree that gave the right to all communities to ban the sale of alcohol during war time. And all communities used this right. The same situation occurred in 1985 in the USSR, when local authorities greatly reduced the number of alcohol outlets. The extent of the reduction was different: from moderate in Georgia to prohibition in Badahshan (a mountain region of Muslim Tajikistan). The main feature though, was that local authorities never initiated significant alcohol actions. They only enforced the state alcohol policy to different extents.

An example of strong enforcement of the state alcohol policy was that of Ulyanovsk (mid-Russia) region. In 1984, Gennady Kolbin was appointed first secretary of the regional Communist Party committee. He greatly criticised drunkenness of local officials and party members. His approach was mainly moralistic and repressive but in 1985 1987 the level of alcohol consumption and relevant problems in the region was reduced to a greater extent than in neighbour regions. After Kolbin was moved to Kazakhstan the local alcohol policy did not differ much from the policy of other regions.

Even the public involvement in alcohol actions was often organised by the central government. At the end of nineteenth century the government proposed the establishment in communities the ”Concerns on people sobriety”. In some places where committed persons were involved they played significant role in alcohol prevention and education. But in many other places they were very formal and their leaders, as described by one newspaper, fought with alcohol by drinking it. In 1985 the All-Union Voluntary Society of the Struggle for Temperance (AVSST) was created.
This organization was built from above. The AVSST Central Council was actually appointed by the Communist Party Central Committee. Within the year in all districts of the USSR the branches of the AVSST were established with a full-time executive secretary. In Baltic countries which had strong traditions of temperance movement these branches actively participated in local alcohol actions, but in such wine-making countries as Moldova and Armenia they were considered as ridiculous organisations and disappeared with the start of collapse of the USSR.

Research of local alcohol problems mainly reflected the alcohol situation and sometimes compared the situation in different regions. But the general political conclusion of such research was not a proposition for some specific local actions but a recommendation of better enforcement of the state alcohol policy.

We must also mention research on alcohol education that was undertaken at the local level. Usually the authors described their own educational programs as successful but these programs were mainly short-term and without strict criteria of evaluation. It is very hard to estimate their impact on the local alcohol situation.

**On the way to decentralisation - first attempts of local alcohol policy**

After the collapse of the communist regime and the first free local elections in some places local authorities could be encouraged to undertake alcohol actions. And we have examples of such actions; in Riga (Latvia) alcohol advertising was prohibited while on the country level such a law was not adopted.

We consider the complex local alcohol policy taking as examples two cities which are the participants of the WHO Multi-City Alcohol Action Plan: Saint-Petersburg in Russia and Kiev in Ukraine.

Saint-Petersburg is a rather unique city for the USSR. The average level of education and culture is possibly the highest in Russia. Sankt-Petersburg was the first CIS city that joined the WHO Healthy Cities Project. The description is based on the article of Borodkin, Vasiliev and Korchagina ”Alcohol and drug policy in Sankt-Petersburg”. The main features of development of the alcohol policy are the following.

1. The initiative is taken by the representatives of the city alcohol treatment service. So strengthening of the service was the first priority of the city alcohol policy. As a development of the treatment service to a more broad approach special educational programs for medical and educational students and social workers were started.

2. The involvement of primary health care into alcohol actions was the second priority of the city alcohol policy.

3. As to political actions, the commission on health of the City Council adopted a resolution which requested the national government to establish an alcohol monopoly and ban alcohol advertising. At the city level, it calls for establishing a special commission and program on alcohol actions, strict control of the alcohol market and providing more resources for
rehabilitation.

4. An informal alliance was formed which mainly consists of medical organizations supported by women, self-help and other organizations.

In Kiev in 1995 the Plan of actions against alcohol and tobacco consumption was adopted by the executive committee of the City council. It appeared by the initiative of the Kiev Corporation "Sociotherapy" (a city alcohol treatment service) and under the influence of the national alcohol program. It consists of three parts: organising and legal actions; actions on reducing the alcohol and tobacco demand; treatment and rehabilitation of alcohol dependent persons. It is a rather comprehensive program and the main problem now is it possible to implement it in a full scale or it will be left on paper as many such plans, which have good ideas but practically no resources and responsibilities for implementation.

Some guidelines on community and municipal action on alcohol

The whole political history teaches the local leaders not to propose any significant initiative on alcohol policy. They are also not ready for a strong enforcement of the state alcohol policy. First, because this policy can be changed very soon, and, second, this policy often ignore specific features of communities.

These obstacles make the development of local alcohol actions rather difficult.

I would like to propose some recommendations for the people interested in the development of the actions which can encourage the local authorities to start the actions.

1. To study the alcohol situation in the community and its main trends in recent years.

The reliable statistic information is one of main problem for such study, but the range of problems is so braced that it is always possible to get some information. It is very useful to prepare a brief report of the study which shows that alcohol problems of the community are not only problems of "alcoholism".

2. To show the role of alcohol related problems among the whole range of the local problems.

Local authorities usually underestimate the role of alcohol problems and often provide resources to problems that are not so dangerous but attract general public attention. We provide the following example to illustrate the issue.

After the Chernobyl disaster everybody knows that radiation is dangerous for health and this issue is one of main priorities for local health policy. To estimate the rate of radiation and alcohol problems we compare two regions of Ukraine: Zhitomir and Poltava. They are approximately equal in population size, rate of urban population and other indices. Social, economic and cultural differences are rather moderate. The main difference is the level of radiation. North-east part of Zhitomir region is a part of Chernobyl zone from where the population was withdrawn. The neighbouring areas are considered as dangerous and have special status. As for Poltava the food
products from the region usually were considered at Kiev markets as those that have the lowest level of radiation. We compare the mortality rates in the regions in 1988 - 1992 and it occurred that only for respiratory diseases was the mortality rate in Zhitomir region higher. The general mortality and mortality rate of cardiovascular diseases, cancer and external causes was higher in Poltava. We compare the figures of alcohol sale in the regions and in Poltava it was much higher. The mortality rate from alcohol poisoning in Poltava region is 2 - 3 times higher than in Zhitomir. The rate of crimes was also higher in Poltava. All these figures show that alcohol consumption and alcohol related problems are at a higher level in Poltava and the impact of alcohol on general health conditions exceeds the impact of radiation.

This example also shows the importance of research for preparation and encouraging local actions on alcohol.

3. To study carefully the alcohol legislation of the country and responsibilities of the local authorities in enforcement.

The Kiev city alcohol plan was made under the influence of the national alcohol program that includes some items which made local authorities responsible for some alcohol actions. It is easier to persuade local authorities to develop actions if they are part of national policy and the national programs indicates some guidelines.

For some directions of alcohol actions such as age limits, restrictions on alcohol outlets, advertising, the main problem is enforcement at local level. In times of social and political changes it is not easy even for local leaders to follow all the changes in legislation. For example some anti-alcohol regulations of the Gorbachev campaign legally still act and we have good examples in some places where local leaders have managed to restrict alcohol trade using these regulations. A good knowledge of national legislation enables one to press local authorities for better enforcement of alcohol regulations.

4. To propose the list of definite actions for which local authorities have enough power.

The general answers of local authorities to the proposition of action on alcohol are: ”Yes, alcohol problems are very serious, but: 1) they are out of our control; 2) we should wait for the improvement of the general economic, social and cultural situation; 3) only at national level it is possible to do something.”

We can hardly expect that local leaders know better what to do with alcohol problems than the initiators of the actions. They should have the list of actions based on local, national and international experience. To complete the list the role of researchers is very important. Sometimes the main action is enforcement of the national legislation but sometimes it is possible to undertake a special action which is based on experience of the foreign community. For these activities international cooperation such as the WHO Multi-City Alcohol Action Plan has great importance.

5. To form alliances of forces interested in the development of local alcohol actions.

The cases of Saint-Petersburg and Kiev show that the main force of such alliance is a local
treatment service which traditionally operates on community basis and has enough influence and resources to start the actions. Sometimes treatment services overestimate the dependency aspects of the alcohol problems. For more comprehensive approach the alliance should include non-governmental organisations but not only self-help groups of alcohol-dependent persons. Committed persons from different sectors: education, social welfare, criminal justice and others are very Important counterparts even if they do not represent their organisations. Above we stress the role of researchers. It is not necessary to involve workers of scientific institutes. Educated people using the relevant information from national and international sources are able to undertake local research themselves. Formalization of the alliance is useful but sometimes informal alliance can be even more powerful.

6. To initiate local mass media campaign.

The necessity of local mass media coverage of alcohol problems is obvious. The main topics of organised campaign should be: alcohol problems significantly affect the community and must get more priority; alcohol problems are problems, of whole population, not only of alcoholics and drunkards; the actions can improve the alcohol situation; all citizens can participate in the actions.

Conclusions and perspectives of research

Special local and community actions on alcohol were practically absent during the Soviet and pre-Soviet times. At present the process of democratisation and decentralisation creates the background for development of the actions at local level. We have first examples of such actions which should be strengthened and supported.

Research is an important part of development of local and community actions on alcohol. The main topics of further research are: experience of local action in the past; evaluation of the present actions; the interaction of local, national and international alcohol policy; examples of good practice (including international experience).

It would be rather useful to undertake comparative research of western and eastern European community. We have the successful example of cooperation on alcohol problems between Dublin, Glasgow and Lodz (Poland). Such cooperation can provide more argument and resources for development of local actions on alcohol in the post-Soviet countries.
Prevention of health damage resulting from alcohol in the city of Kiev
Anatoliy M. Viyevsky

Alcohol and Statistics

The city of Kiev has more than 2.7 millions of inhabitants. Approximately 40 thousands of them are registered like people with alcoholism. In general, more than 80 thousands have alcohol-related problems. More than 1940 alcohol psychoses and 800 severe alcohol intoxications were registered in 1994. During 1989 - 1995 the number of crimes connected with alcohol consumption, total quantity of accidents with drunk drivers has been growing from year to year. The male/female proportion among people with alcohol problems is stable and is equal to 8.5 to 1. The most part of these people is between 22 - 49 (90.5 %). The average age of being alcohol consumption among people with alcohol-related problems is equal to 12.8 years. Six years ago - 14.1 years. In more than 60 % of cases the first drink was proposed to them by parents. More than 60 % of people with alcohol problems prefer strong alcohol beverages (vodka). More than 27 % of kievites (according to the results of survey) use self-made vodka, the so-called samogon not less than 3 times per year. During relapse drinkers used to consume not less than 3.5 or even 8 litres of vodka per day. Approximately 4 thousands of children are living of families of heavy drinkers and in general more than 130 thousands of children are living in the families of people with alcohol-related problems.

The Peculiarities of Alcohol Situation in Kiev

It is traditional for the post-Soviet society to locate the problems of inner realization of people at the very last places. The alcohol problem is not an exception from this rule. Diminishing of the scale of damage, the search of easy decisions, neglecting of people with alcohol-related problems are absolutely normal for the majority of population. Historically repressive attitude to persons with alcohol problems, alcohol ”prevention” which means first of all multiple social, administrative and economical limitations for these people, weakness of the conunon psychological net are combined with such general problems as extremely high level of neurotization of inhabitants, crisis, quick changes in society and undetermined position of political establishment about alcohol-related problems.

Treatment and Rehabilitation

In 1972 the special so-called ”narcological” service was created for treating people with alcohol problems. Till 1979 this system had been slowly constructed. In 1980 it included 2 in-patient facilities for 180 patients, few out-patient facilities for biologically oriented methods of treatment, one methodical facility. At that time more than 80 % of patients (and all patients with alcohol intoxications and psychoses) received treatment in non-specialized medical facilities. During 1980 - 1989 this system was slowly growing especially in 1985 - 1986 when Gorbachov’s anti-alcohol
company had started. The anonymous survey provided among registered narcological patients showed that more than 35 % of them did not seek help in narcological city of them reported about their negative position to the service and more than 80 % of them reported about their negative position to the existed narcological service. At that time the re-organization of the city Kiev narcological service was started and the Kiev Corporation was created. Now it consists of different in-patient and out-patient treating and rehabilitative facilities. For example, two of them are resuscitative detoxification clinics for 35 beds each. The KC Sociotherapy has a special facility for the in-patient part of psychological rehabilitative program, the clinic with ideology of therapeutical communities, different out-patient facilities for patients and their relatives, 3 phone hot-lines, clinical and toxicological laboratory, special ambulance, centre for legal rehabilitation of patients, two centres for vocational rehabilitation etc. The most part of the facilities is working round the clock. The survey provided among registered patients with alcohol related problems in 1994 showed that 37 % of them had stable voluntary and systematical relations with KC Sociotherapy like rehabilitative system and approximately 87 % of all registered patients expressed their trust to this organization.

The Psychological Rehabilitative System Like the Possibility for Prevention

The humanistically oriented rehabilitative system developed in the KC Sociotherapy has created a good basis for the much deeper secondary prevention of damage resulting from alcohol in the city of Kiev than it was earlier. From 1990 till 1995 the quantity of registered people with alcohol-related problems involved in different crimes fell down in 3,7 times. The new atmosphere of trust between the client and personnel created the ground for the appearance of the social workers. It had happened for the first time on the territory of the former Soviet Union. Now more than 50 social workers from the patients, relatives or formally healthy people are working in different facilities. This gave a possibility to start the construction of the city-wide system for the so-called ”social therapy”. The out-patient centres of the social therapy are situated in the different districts of the city and have two objectives:

- to give clients the additional possibilities for convenient contacting out-patient rehabilitative program; and
- to provide the primary prevention alcohol- and drug-oriented activities.

The special educational centre for training specialists according to the ideology of brief interventions has been created. It trains not only the specialists of the city narcological service but the specialists from the primary health care system, the school teachers, policemen. In general during 1995 - 1997 more than 200 of trainers have to be educated in the mentioned educational centre.

The Prevention of Drunk Driving

During 1994 approximately 20 thousands of drug and alcohol surveillance of drivers have been done in the four facilities specially created for such purposes. In 57 % of cases the surveillance gave positive results. The law does not foresee the normal level of alcohol in the blood, and the condition is evaluated due to the clinical observation. The big transport enterprises have their own
system of pre-route observation of drivers. The sphere of drunk driving is possibly the own sphere where the general attitude of the population to the preventative work could be evaluated as supporting. More than 93% of participants of the survey in Kiev considered drunk driving as a crime. Since 1991 the managing staff of transport companies has been educated in alcohol-related problems. Since this year the obligate control of the quality of the pre-route observations of drivers is implemented. Such control is provided by the traffic police and the personnel of the KC Sociotherapy. The program of educating drivers during driving courses is creating.

The Kiev City Alcohol Action Plan

During 1990 - 1995 there was no city anti-alcohol program in Kiev. These were the years of preparatory work. At the same time with the re-organization the information had been gathered and new international contacts appeared. Since 1994 Kiev is a participant of the Multi-City Action Plan of WHO and Ukraine in general is an active participant of the European Alcohol Action Plan. In the beginning of the 1994 the work for affirmation of Kiev City Alcohol Action Plan had started. It was hard one year and a half job with the dozens of meetings with the representatives of the political parties, invisible for other kievites movement of Alcohol Action Plan through bureaucratical pyramid and at least on the 4th of August of this year it was signed by the mayor of Kiev city. The superficial view shows the deep connection between WHO activities in alcohol field and Kiev city Alcohol Action Plan. There is a lot of notions about WHO activities in it. The future alcohol activities in Kiev have got a good legal basis at least for the nearest three years and some hopes for the financing in 1996 and 1997.

The Conclusion

The hard social and economical situation in transition period in Ukraine in general and in Kiev in particular have not become the obstacles for realization of the significant volume of work done in the alcohol field. Essential quantity of possibilities for the primary and secondary prevention of damage resulting from alcohol was created. During next three years the emphasis would be done on the alcohol education, implementing of the brief intervention technologies the development of rehabilitative facilities for the people with alcohol-related problems. The general direction is to reduce the health damage resulting from alcohol.

Kiev - Florence, 1995
City Kiev

Concerning the approval of Plan of Actions Against Alcoholism and Tobacco Consumption in the city of Kiev in 1995 - 1997 years.

Taking into consideration the increase of alcohol consumption, frequency of alcoholism and alcohol psychoses in Kiev, the increase of quantity of traffic accidents and crimes caused by drunk individuals, and also the general necessity to improve the effectiveness of work of institutions and organizations of health care system, systems of culture and education, mass-media, sport and youth organizations concerning actions against alcohol and tobacco consumption:

1. To approve the Plan Actions Against Alcoholism and Tobacco Consumption in the city of Kiev in 1995 - 1997 years according to the addition attached

2. To recommend the executive committees of regional Soviets of people deputies and to the Kharkiv regional state administration of city Kiev to decide the questions described by the items 3.3. and 3.4 of this Plan

3. The realization of this order is a subject of control of deputy chiefs of The Kiev City Soviet of People Deputies according to their responsibilities

The Chief of City Soviet

L. Kosakivskiy
Plan of Actions Against Alcoholism and Tobacco Consumption in 1995 - 1997 years

General Background

During last years the significant experiences of alcohol actions were gained in Kiev. These experiences and common affairs with international countries became a basis for implementation of new forms of alcohol actions. The city narcological service had been re-organizing. The city become an active participant of the international alcohol projects of World Health Organization (WHO), particularly European Alcohol Action Plan, Multi-City Action Plan, the Healthy City Project. The background for creation of the whole city system of actions against alcohol, drugs and tobacco consumption, has been developing.

The creation of such a system in Kiev is very actual because during 1989 - 1994 years the quantity of alcohol consumed and, as a result, quantity of drunk crimes and traffic accidents, traumas, alcohol intoxications and alcohol psychoses has increased. The problem of drinking of youngsters became more acute.

But the systematical preventional alcohol work in the city is absent. The majority of institutions, teachers stay far from the work with this problem. The existing possibilities to control the situation in the city are not used, the sale of alcohol beverages has been growing. The financing of alcohol actions is absolutely Unsatisfactory.

The situation with tobacco consumption is almost the same. The most effective directions of alcohol and tobacco work are the activities that maintain the constant reduction of alcohol and tobacco consumption by different layers of population on the work places, in the public places etc. This goal could be achieved when realizing wide complex of legal, social, economical, treatment, rehabilitative and other measures.

Organizing and Legal Measures

2.1 During 1995 to create and to propose for approval of Government of city Kiev the project of long-term Program of actions against alcoholism and tobacco consumption; aiming to maintain the methodological coordination and provide economical background of the Program to provide such actions as:

2.1.1 To establish The General Department of Health Care (GDHC) as the coordinating body to prepare this project

2.1.2 To create a conception and basic statements of city system of actions against alcohol, drugs, tobacco consumption, and consumption of other substances that can cause addiction, including care, treatment and rehabilitative approaches

GDHC, General Department of Ministry of Internal Affairs in Kiev (GDMIA), General
Department of Education (GDE), General Department of Culture (GDC) the second quarter of 1995

2.1.3 To prepare the propositions concerning creation of city committee for drug addiction and city narcological foundation as well as the questions of financing their activities

GDHC, the Financial Department
the first quarter of 1996

2.1.4 To prepare the propositions concerning development of technical background and staff potential of city agencies and services related to the work in the frameworks of the Program of actions against alcohol, drugs, tobacco consumption and to count the expenditures necessary for its realization

GDHC, GDMIA,
GDE, GDC
the third quarter of 1995

2.2 To create and to implement the city model of work for prevention, treatment, psychological and psychotherapeutic care of people with the signs of chemical dependency and their families

GDHC, Kiev Corporation Sociotherapy
the fourth quarter of 1995

2.3 To re-organize existing system of drug and alcohol surveillance, to determine the list of agencies designated to provide this work

GDHC, GDMIA,
the fourth quarter of 1995

2.4 To maintain the creation of system of medical monitoring of the alcohol and drug city situation

GDHC
1995 - 1996 years

2.5 According to the aim to integrate the city alcohol program into the international projects of WHO: The Health Cities, the European Alcohol Action Plan, Multi-City Alcohol Action Plan etc. to prepare a proposition for the Cabinet of Ministers of Ukraine concerning organization of some international WHO workshops in the city of Kiev: the workshop for national counterparts of countries of Eastern and Central Europe in the frameworks of European Alcohol Action Plan; the workshop for participants of Multi-City Alcohol Action Plan.

GDHC
1995 - 1996 years
2.6 To improve the work to reveal people with alcohol problems, to determine the group of people that have to be coerced to treatment and to direct them into appropriate care facilities

GDMIA, GDHC  
the third quarter of 1995

2.7 On systematic basis, not less than 2 times per month, to provide on the city level the evaluation, how the alcohol regulations including rules for beverages' sale are fulfilled

GDMIA  
1995 - 1997 years

2.8 To prepare the propositions concerning measures to prevent drunk driving

GDMIA, GDHC  
the third quarter of 1995

2.9 To maintain the systematic, not less than 4 times per year, surveillance of quality of beverages produced in Ukraine and abroad that are sold in the city

GDMIA, GDHC  
1995 - 1997 years

The Measures to Reduce Alcohol and Tobacco Consumption

3.1 To create the system of primary medical and psychological preventive actions aimed to prevent the chemical dependence and tobacco consumption and, for this purpose:

3.1.1 To organize in the Kiev Corporation Sociotherapy the educational centre that would be a basis to educate school and police staff, medical personnel of child care, educational, treatment and care institutions

GDHC, Kiev Corporation Sociotherapy  
the third quarter of 1995

3.1.2 To create and to approve the appropriate plans and programs of education

GDHC, Kiev Corporation Sociotherapy  
the third quarter of 1995

3.1.3 To create propositions about the sources and order for financing this educational centre and to support services and institutions directing personnel to this educational centre

GDHC, GDMIA,
3.2 To provide prohibition to sell alcohol beverages, tobacco brands in the educational, cultural and sport facilities

GDHC, GDMIA, GDE, GDC, Department of Justice, Committee of Youth and Sport Affairs
the third quarter of 1995

3.3 To maintain the current legislative regulations concerning sell of alcohol beverages

GDMIA
1995 - 1997 years

3.4 To increase the quantity of free days for museum’s and exhibition’s attendance (including family attendance) throughout the city. To support the appropriate cultural, educational affairs that are provided for people of different ages and social positions

GDC
1995 - 1997 years

3.5 To organize on the basis of Orbita cinema the systematical demonstration of popular science movies, that popularize the healthy style of life. To organize attendance of this cinema by schoolchildren not less than once a year according to the timetable

GDC, GDHC
1995 - 1997 years

3.6 Using counselling trust service of the Life Choice of Kiev Corporation Sociotherapy to provide ongoing counselling of population in the field of alcohol, drug, tobacco consumption

GDHC, Kiev Corporation Sociotherapy
1995 - 1997 years

3.7 According to the existing regulations to create in the Kiev Corporation Sociotherapy the informational centre for creation of popular scientific materials (printed editions, radio and TV broadcasts) that are directed to prevent alcohol, drugs and tobacco consumption, and to create propositions concerning the question of financing this work

GDHC, GDMIA, GDE, GDC, State TV and radio
the first quarter of 1996
3.8 To create propositions concerning implementation of the course of valeology in the secondary schools, secondary schools with professional training etc.

GDE, GDHC
the third quarter of 1995

3.9 Every year to maintain the organization of propaganda measures connected with WHO World Day without Tobacco

GDHC, GDE
1995 - 1997 years

The Treatment, Medical and Social Rehabilitation of People with Signs of Alcohol and Tobacco Dependence

4.1 To increase the effectiveness of treatment and rehabilitation of narcological patients and their families and for this purpose to continue the implement into the practice the special programs of medical and social rehabilitation in the Kiev Corporation Sociotherapy and another institutions related to narcological assistance; to continue the creation of original programs for coping with drug dependence

GDHC, Kiev Corporation Sociotherapy
1995 - 1997 years

4.2 Aiming to solve the problems with qualified personnel, development of material and technical basis of city narcological service to decide questions of financing such activities and actions as:

- to buy in 1996 the necessary equipment for Kiev Corporation Sociotherapy
  GDHC, the Financial Department,
  Kiev Corporation Sociotherapy
  the second quarter of 1995

- to create the project of re-construction of building situated on Schmidt Street, 2 to create the treatment and rehabilitative centre of Kiev
  GDHC, the Financial Department
  1996

- to provide all the necessary to start the work of the Centre of vocational rehabilitation and the medical supply department of Kiev Corporation Sociotherapy in the building on Collectornaya Street, 3a
  GDHC, the Financial Department
  1996

- to provide on the basis of educational centre of Kiev Corporation Sociotherapy the course of education for social workers in the field of narcology and license them in the
appropriate departments of Kiev-Mohila Academy or Kiev State University
GDHC, Kiev Corporation Sociotherapy
1995 - 1997 years

4.3 To decide the question concerning possession of facilities that are used as treatment and rehabilitative ones of Kiev Corporation Sociotherapy

GDHC, the Department of Community Possession, the Reconstruction and Manufacturing Corporation, Regional Executive Committees of the city
the third quarter of 1995

4.4 To decide the question concerning the organization of the special centre for child care and rehabilitation for work with children, adolescents and their families. This centre has to be organized Kiev Corporation Sociotherapy in the building of one of the former kindergartens

GDE, GDHC, Regional Executive Committees of the city, the Department of Community Possession
the third quarter of 1995

4.5 According to the requests of Kiev Corporation Sociotherapy to direct the graduates of nursing educational facilities for further work as well as doctors (not less than 8 doctors-interns) for internship in this organization

GDHC
1995 - 1997 years
Using computer conferencing to encourage action on alcohol issues: Implications for research and communities

Liz Stewart

Introduction

Nancy Milio has asked the question can the use of information technologies (IT) significantly improve community involvement in health and if so under what organisational conditions and policies? (Milio 1992). What are the applications of IT in the alcohol field and how might it change our perceptions of community, and community action? What are the implications for alcohol researchers interested in community action. This paper will attempt to explore some of these issues by examining the use of computer mediated conferencing (CMC), as one form of IT, for encouraging community action on alcohol issues and the implications for community action research. In doing so it will draw on findings from a demonstration project that set up and evaluated CMC for a group of alcohol community based workers in fifteen different geographical communities throughout New Zealand.

Information technology refers to a wide variety of computer and telecommunication technologies, for example electronic mail, computer conferencing, multimedia presentations and videotext services. Use of the Internet to exchange information and ideas through such means as news groups, list serves, electronic publishing, and world wide web sites has expanded enormously in the past two or three years. In looking at the application of such technology in health, Milio points out the exchange of information in a two way flow or many to many flow has communal uses, such as the expression of ideas and mobilization for collective action. She argues it can bind people, foster cohesion through developing common perspectives, finding common interests and engaging in joint endeavours towards shared goals. All of these are beneficial to the welfare and health of individual members of communities and also essential if health professionals are to be effective in working for environments conducive to health.

It was these issues and the research from our own evaluated projects indicating the value of collective planning and discussion in encouraging community-based action, which lead us to start exploring some of the questions around the use of IT to encourage community action on alcohol issues. A project was developed in 1993 to establish and evaluate a computer bulletin board service (BBS) for alcohol health promotion workers. The context of the Alcnet (Alcohol Network) project is important because it is embedded in the context of alcohol community action and research New Zealand style (Casswell 1995a). Community action as it has evolved in the New Zealand evaluated projects (Casswell and Gilmore 1989; Casswell 1993; Duignan et al. 1993; Stewart and Casswell 1993) has the theoretical underpinning of social learning theory in its broadest sense (Bandura 1986), which acknowledges the importance of environmental supports to initiate and maintain behaviour change. It is premised on the theory that achieving change in the development and implementation of local level alcohol policy is necessary for change to occur at the level of the individual drinker. Such an orientation was derived from research which has shown the importance of the availability of alcohol to the experience of alcohol-related problems (Bruun et al. 1975; Edwards et al. 1994); research which has focused on the conditions shaping drinking
in public drinking environments (Jeffs and Saunders 1983; Mosher 1983; Saltz 1987); the impact of the minimum drinking age (Moskowitz 1989; Ashley and Rankin 1988; O’Malley and Wagenaar 1991) and on research demonstrating the effectiveness of mechanisms to reduce alcohol-related traffic crashes (Homel 1988). The implementation of all of these public policies can be enhanced by local level activity.

One of the main underpinnings to the evaluated community action projects over the past thirteen years, has been a focus on encouraging local community sector support for and action on policy-oriented objectives, particularly in the broad areas of availability, management and enforcement of drinking environments and alcohol advertising and promotion. (Casswell and Gilmore 1989; Duignan et al. 1993). A second feature is the figure of the catalyst, the community worker or health promotion worker who is resourced to work with their geographical community on addressing alcohol issues, including working with a broad range of sector groups at a structural level. Each of the evaluated projects has featured these individuals as a key to enabling and supporting a community to act on these issues.

A third feature is the emphasis on formative evaluation, albeit not to the exclusion of resources into process and impact evaluation. Most evaluation effort has however traditionally focused on assessing whether a programme has achieved its aims - in other words, measuring outcomes. Formative evaluation is equally important, designed to constructively modify and improve a programme or activity during its planning and implementation so that it has a better change of achieving its aims (McClintock 1986). It is an interactive and dynamic process that implies partnership between researchers and community, and is particularly congruent with working in or along side dynamic community settings (Casswell 1993).

The Liquor Licensing Project

These elements combined in a successful evaluated community action project in the early 1990s involving community action on liquor licensing. The findings and circumstances of it helped shape the aim of the Alcnet computer conferencing project. The Liquor Licensing Project’s (LLP) research design focused on formative evaluation to assist the development and spread of effective strategies in relation to public health input into a new liquor licensing system (Stewart et al. 1993). It involved a series of meetings at six monthly intervals, bringing together 18 community workers from difference geographical communities to strategies for the project’s objectives. These were to discuss the opportunities for a health related focus in implementing the new Sale of Liquor Act and to plan specific activities to facilitate that. In addition to this, the project disseminated a considerable amount of information covering relevant research and documentation of local experiences to the community workers via newsletters.

The community workers worked with representatives from the key sectors of police, health and territorial local authorities who had a direct responsibility in the licensing area. Strategies were developed collectively by the formative evaluators and the network of community workers which encouraged a public health perspective. These included development of licensing liaison committees made up of local key sector representatives. A second initiative used information police collected from alcohol-related offenders about their last place of drinking in order to identify and intervene with problem premises. These 'last drink surveys' were a strategy developed during the planning meetings and other feedback components of the formative evaluation project.
As a result of the coming together of the eighteen workers, initiatives such as these which developed in one community could quickly be picked up and encouraged in other communities.

The process evaluation of the LLP indicated recognition of the community workers’ efforts and significant appreciation of the value of the initiatives which the workers established or encouraged (Stewart et al. in press). With the end of the research in early 1992 the planning meetings stopped. Subsequently there were occasional national meetings around licensed drinking environments and licensing issues organized by the Alcohol Advisory Council (ALAC). Although attempts were made to use the task oriented meeting model from the LLP, they were not very successful. The meetings involved a wide range of sector group participants, each of whom had different agendas. They were less focused on community level licensing policy and practice and more on interventions on licensed premises. They were too large for effective task oriented planning. There were also no effective mechanisms for ongoing feedback discussion, networking and strategizing, essential components to the success of the LLP.

Researchers in the Unit were becoming increasingly aware of IT and it was decided to investigate and evaluate the use of computer mediated communication as a medium for facilitating communication and information exchange and in turn, community action with the alcohol health promotion field. It was hoped a networking model similar to the LLP would develop, but using computer communication rather than face to face meeting.

**The Alcnet project**

The participants

- The community workers

The aim of the year long demonstration Alcnet project (1993 - 1994) was to set up a computer bulletin board service (BBS) and evaluate its perceived effectiveness in improving the quality of communication and information flow to and between a group of 15 alcohol community workers. Most of the group who were asked if they wanted to participate in the Alcnet project, had worked together in the earlier Liquor Licensing Project. This group was chosen because it was considered it would be easier, in terms of setting up the network, if the participants already had some sense of knowing and working together. It was thought if they had a sense of being a community of interest, rather than people who were unfamiliar with each others’ work, they would share information and ideas more easily.

In the written invitation, electronic mail and BBS systems were explained and the possible benefits of such communication were outlined, as were the evaluation activities the community workers would be asked to undertake. A prerequisite was to have an IBM compatible computer to meet the system’s operating requirements. All of the community workers contacted agreed to participate. While some were unsure about how the technology would apply to their work, the large majority of participants were excited by the potential for better communication. One or two were worried that the project would take a lot of time with little perceived benefit resulting from it, but again were keen to have enhanced networking. The previous favourable research/community worker relationship that had been established between the participants and
the research staff in the Liquor Licensing Project (Stewart et al. 1993) was influential in gaining acceptance.

Most of the fifteen were employed by regional health authorities directly or thorough a local community trust. They worked in fifteen different locations throughout New Zealand, ranging from major cities to small rural towns. In general they described themselves as health promotion advisers working on a variety of issues at a community level, primarily in the areas of public policy, community action or community development. None had experience of using personal computers for CMC, prior to the Alcnet project. About half used a computer every day, with most of the remainder using it less than twice a week. Two had no previous experience of using a computer.

• The research unit staff

Research and librarian staff involved in the project all used computers for word processing and other functions on a daily basis and could be described as conversant with computers to varying degrees. None had used E-mail or other forms of CMC prior to the development of the project.

The evaluation

Formative, process and impact evaluation were carried out. The aim of the formative evaluation was to optimise the technical and associated aspects of computer conferencing amongst the community workers. Activities included selecting and designing appropriate e-mail and bulletin board software and forum options in association with NZ Online. This was a business set up on the initiative of Telecom New Zealand and Learning Link, a company from the United States. It had set up computer bulletin board services for education and social service agencies in that country and had recently established a base in New Zealand. The final Alcnet bulletin board structure comprised a conventional BBS format of a news and announcement section, a public discussion section where anyone with online access could read or insert messages into a discussion and a private discussion centre limited to Alcnet project participants and accessible by password. There was also a file library where information (e.g. newspaper clippings, research articles) could be electronically scanned into the system by the forum managers and downloaded by individuals onto their own computers.

The formative evaluator also designed and implemented a one day, hands-on training workshop for the participants to learn the bulletin board system. This was conducted at the research unit’s premises in Auckland, using computers from the unit’s computer assisted telephone interviewing (CATI) system. The research project paid airfares and accommodation for the workshop and supplied each participant with a modem, the appropriate software, a manual and fifteen hours of online time, which is the time when users are linking into the system. The participants took these home with them from the workshop and then proceeded to install the software and go online.

Technical assistance was available through contact with the formative evaluator, an 0800 number and an E-mail help desk with NZ Online company.

The formative evaluator kept in touch with the participants through E-mail, phone, fax, and snail
mail or post, monitoring technical difficulties and assisting the community workers to install and establish the system. Questionnaires were sent out over E-mail or by post asking for feedback on how the community workers were using it, or if they were striking problems and so on. He then followed this up with suggestions to overcome them and hints to encourage the participants to try new elements (Benseman and Stewart 1994; 1995).

The process and impact evaluation was undertaken by another researcher to maintain a level of detachment from the formative evaluation. It aimed to monitor the usage patterns and content of the network, to assess the response of the users to it and to document the impact they perceived participating in the system had on their work individually and collectively.

A baseline questionnaire before the training workshop, a second at six months and a third at the completion of the project were sent out and answered either through E-mail or by postal mail. These included questions on how the community workers perceived the status of communication with each other before and after using CMC. Other questions were on their satisfaction levels (on a scale of 1 to 5) on, for example, keeping in touch with colleagues, keeping up to date with day to day developments on alcohol-related issues, having access to up to date information and having a sense of being able to contribute to alcohol-related developments locally and nationally. A telephone interview lasting approximately an hour was conducted with each participant at the end of the project.

Computer logs which recorded E-mail and BBS transactions for each participant were also analysed for patterns of communication. Each participant recorded the subject matter and reason for communication for each E-mail, following a code sheet from the evaluation. These codes were recorded automatically by each individual’s computer in its maintenance log. The process evaluator periodically asked the community workers to E-mail the logs in for analysis. Participants were also asked to manually record all other communication with each other (fax, telephone, mail, meetings) on a code sheet, for three time periods of three weeks each during the course of the project. This attempted to quantify whether use of the E-mail and BBS was affecting the choice of other means of communication with members of the group. However this procedure was discontinued after the first two periods when a random sample of forms were cross-checked to reveal insufficient reliability and validity.

Other Unit staff acted as forum managers for Alcnet which included scanning research-based information into the bulletin board’s file library, deleting out of date information, and informing participants about alcohol-related developments. It was suggested that participants include the forum managers in their E-mail addressing so we could read and keep up with the discussions and then send out research and other information as appropriate. It was stressed that we were not interested in evaluating the content or style of the messages. Throughout and after the project had officially ended, the Unit was included in all group E-mails which formed most of the E-mail communication. A relationship of trust between APHRU and the community workers which had been established during past community action projects, particularly the LLP, facilitated this occurring (Stewart et al. 1993).

Use of the network
All but one of the original fifteen community workers who attended the workshop in September 1993 went on line and began to use the system. Two thirds were on within two weeks and the remainder connected over a four month period. Only two did not experience technical difficulties in coming online. Problems included needing pieces of installation equipment (there were sometimes delays in obtaining it in small towns) and needing the help of a computer expert. The fifteenth community worker had considerable technical problems, unbeknown to the research team, in spite of efforts to contact her, and she was also unable to secure reasonable access to a computer. She returned the equipment to the Unit, which was eventually allocated to another health promotion worker, following lack of success in persuading her to reconsider. (During the course of the project, four of the other fourteen left their jobs and their equipment was then given to other workers who participated in evaluation activities).

Partly because of the small size of the group and the technical ease of using the E-mail component of the system, the group tended to be an E-mail group. It did not venture into the bulletin board components such as the discussion centres and news and announcements, even though the formative evaluator and forum manager attempted to encourage this. This is discussed in more depth further on. Some use was made of the file library. E-mail communications from participants were in the main sent to the entire group (one to many), as well as to one to one or one to few. In terms of E-mail use, the group divided into three categories of similar size. Firstly there was a small group of five who sent E-mails to and fro on a regular basis, and a second group of similar size who tended to send E-mails in short bursts of activity, with periods of inactivity lasting several weeks. The third group sent very few E-mails during the project and were largely E-mail readers.

The most frequently discussed topic was alcohol advertising by a significant margin, followed by availability/licor licensing issues and then concern over the disproportionate funding and attention given to alcohol and other drug education programmes compared to health promotion. The use of CMC on alcohol advertising is discussed in more detail later.

**Community worker response to using computer mediated communication**

The process and impact evaluation questionnaires and interviews revealed the community workers thought CMC had made a significant difference to their work individually and collectively in a range of ways. On an individual level, all participants indicated using Alcnet had significantly improved their ability to communicate with other health promotion workers. It helped them to keep up to date on alcohol-related developments in New Zealand, to discuss ideas and to plan and develop strategies to implement in their local communities and at national level. Most participants thought CMC had broadened their horizons on alcohol issues and increased depth of understanding. Those that did not rate it as highly for this, were either working on specific topics and did not have the capacity to expand or felt they already had a reasonable depth of experience. Many reported other benefits too, such as feeling more supported in their work, gaining in confidence and knowledge and realizing the benefits of networking. One of the greatest gains they felt they had achieved was feeling less geographically and professionally isolated.

Collectively, the participants also felt there was a considerable improvement in communication and liaison between the group and therefore alcohol health promotion as a whole, which they
attributed in large part to CMC. They thought it had contributed to better networking within the group and more awareness, consultation and coordination of approaches and strategies on alcohol-related issues. Some considered however, that face to face meetings were essential in generating momentum on an issue.

Several workers said the ease of the E-mail and its informal, conversational nature meant they were more inclined to share and pass on information than previously. As one said it made her think beyond the confines of her own organisation's work and that previously it "never would have occurred to me to communicate on mass with other health promotion workers.” Group E-mail addressing facilitated the quick distribution of information to many and was considerably less time consuming than writing letters or faxing. The community workers thought CMC was a cost effective use of communication: the equivalent cost of toll calls in reaching as many people would have been considerable.

Using CMC for action on alcohol issues: Alcohol advertising

During the year long project, the issue of brand alcohol advertising on television and radio was a significant topic of discussion and activity amongst the participants. Such advertising had been introduced in early 1992. In April 1994, seven months after the Alcnet project began, a national consensus development conference (CDC) was organised by the Alcohol Advisory Council to hear the results of research on the impact of the introduction of brand advertising in these media. A conference panel was expected to write a consensus statement on the findings and make recommendations regarding the future of brand advertising. As well as this debate, two bodies, the self regulatory Advertising Stands Authority (ASA) and the government agency the Broadcasting Standards Authority (BSA) conducted their own review processes and called for public submissions shortly after the conference ended.

During the six months lead up to the CDC E-mail exchanges between the group discussed how to deal with the conference. They included information about the CDC process, and who was on the panel which included strong representation from alcohol advertising and media interests. A discussion was held on whether to boycott the CDC because of growing concern about the process marginalising the public health voice, and instead to hold an alternative forum at the same time and gain media attention. This concluded with members of the group deciding to attend the CDC, because it was felt better to be a voice at the conference itself. Arrangements were made through E-mail to hold a planning meeting at another general alcohol conference held two months before the CDC. At that meeting it was decided that Alcohol Health watch, a health promotion group, would develop a kit on the advertising issue. This would have a format of questions and answers, a review of research, information about the upcoming CDC and reviews and how to write submissions. The content of the kit was further discussed through E-mail and was then sent out to a wide range of groups by the workers. Just prior to the CDC, further arrangements were made. It was decided to write an alternative consensus statement to that of the official panel if necessary, and to put out media releases. A suggestion was made if someone had a laptop computer available, to take it to the conference to expedite this. At the conference the workers held other meetings during the proceedings. The panel’s final conclusion was that ‘the research findings were not strong enough to warrant a ban’ (Consensus Statement 1994). The community workers wrote a joint media release immediately after the panel’s press conference which received coverage and set up a national radio interview with one of their number.
Following the CDC, workers concentrated on writing submissions and encouraging others to do so as well. Again there was E-mail discussion about the worth of participating in the review process and on what arguments to stress in submissions. Should the bottom line be to call for a ban, or should there also be a fallback position of making changes to the current self-regulatory system? Most included the latter in their submissions.

The ASA review received approximately 1200 submissions, which was likely to be considerably in excess of what was anticipated. During the months the review was considering the written and oral submissions, E-mail discussion and information flow continued between the health promotion workers. It included information on the position held on alcohol advertising by Members of Parliament. Individual community workers lobbied their own MPs and reported the information back to the others. Unable to find out from the ASA how many of the submissions were in support or opposition, Alcohol Health Watch, with the support of other Alcnet colleagues, counted the submissions themselves. At least ninety three percent clearly wanted a ban. Two percent, from alcohol, media and sporting bodies wanted it retained. In an attempt to publicly force the review to be mindful of the opposition to brand advertising, this information was released to the media a few weeks before the anticipated review release date. The press release was sent via E-mail for community workers to use it how they wanted and several achieved local press coverage. The ASA review findings were eventually released three days before the major Christmas and summer holiday break. Drawing on the CDC panel’s statement the review concurred research evidence did not justify removing alcohol brand advertising from the broadcast media, but wording of the voluntary codes was to be tightened and other measures taken. This result was not unexpected. The lobbying the workers had done with opposition politicians on the issue contributed to one putting forward a private member’s bill to remove advertising. He continued to seek advice from the community workers.

What was the influence of CMC as used by the health promotion workers on this issue and was it illustrate in terms of the potential for community action on alcohol issues? Obviously greater forces than the collective efforts of the workers meant alcohol advertising has remained on television and radio (Casswell 1995b). In the interviews at the end of the project, the participants were asked to categorise their involvement in the alcohol advertising debate (very active, occasionally active, not active). They were also asked if they thought the health promotion workers as a whole had made a difference in the debate, and what were their perceptions of the role of the BBS and its influence. No matter what they rated as their level of activity and in spite of the outcome, all thought they had made a difference to the discourse on the issue and using CMC had made a significant contribution.

The participants thought they were much more organised on working on this issue than on others. One said “we were very clear about what we were going to do, very clear about what our feelings on the whole issue were. There was a hard core who were very, very focused”.

The exchange of information about the CDC and review process had enabled the workers to keep up to date and to act quickly when necessary, and also to feel they were working with others on it, which increased morale. They felt they had contributed to encouraging a community voice on advertising through organising community groups to put in submissions. One participant from a small rural town thought the E-mail exchanges had played an important role in alerting him to the
alcohol advertising debate about which otherwise neither he nor his community would have
known. He encouraged people in that community to write submissions and got letters published
in the local newspaper.

**Using CMC as a tool for community action on alcohol: findings from the project**

Friedner Wittman has made the point that "a lot of prevention planning at the local level is not
about money but about organisation - how organisation occurs." (Greenfield and Zimmerman
1993, 289). Tenets of effectiveness in undertaking social action or action for change include access
to information, timing, collective approach, shared beliefs about the approach to take, resources,
flexibility and a well developed plan of action (Milio 1992). Efforts which can facilitate this
effectively result in action and change.

Technical constraints on use

In the Alcnet project the health promotion workers did use CMC as an organising tool to act on
alcohol advertising and, to a lesser extent, on other issues. This experience suggests there is
significant potential for encouraging effective action in this area. However there were also factors
which constrained its use. Some of these related to the different role of the research team in the
Alcnet project compared to the previous Liquor Licensing Project. Some related to the specific
conditions in using CMC by a group with the characteristics of the Alcnet group. These are likely
to be in common with other similar community based organisations or individuals wanting to use
CMC. These may have implications for its sustainable use as an organising medium for community
action.

The aim of the Alcnet project was to evaluate the use of CMC and not to specifically provide
evaluation resources to assist planning and action on a particular issue, as occurred in the LLP.
However, the researchers hoped that elements of the LLP approach to organising action would
be integrated in the use of CMC. It was anticipated that E-mail and the BBS components, such
as the discussion centres would be used for ongoing discussion, planning and strategising on
particular issues. In other words, they would play the role of the planning meetings and feedback
mechanisms such as the newsletters used in the LLP (Stewart et al. 1993). To this end, at the
bulletin board service training workshop in September 1993, a day was set aside for the
community workers, forum managers and other research staff to discuss alcohol issues, including
alcohol advertising, availability and liquor licensing, with the aim of facilitating planning and
strategising on them. It was intended to have specific tasks and activities for which the workers
would start using the BBS. This would thereby quickly encourage use of and integration of the
BBS into their work individually and collectively. Individual workers agreed to a number of
specific tasks, for example finding out specific information about the organisation of the
advertising conference. This information was to be sent back to the forum manager who would
then insert it into a section on alcohol advertising in the BBS's discussion centre for others to read.
They would then insert their own comments and plan further.

For several reasons using the BBS in this way did not occur. For the discussion centres to work
well, several people needed to be participating. However, it quickly became clear that it was going
to take much longer than anticipated for the group to come online and to become confident in
using the system. Another problem which could not have occurred at a more unfortunate time, was a major technical hitch about six weeks after the workshop. This was outside the researchers’ control. The NZ Online company running the system switched it over to another host computer in another city. For some weeks this caused many technical glitches for the sending and receiving of E-mails for the participants (e.g. failed mail, wrong addressing). The formative evaluation revealed this severely affected the participants’ confidence in their technical ability and in the system at a crucial time when they were still learning to use it. By the time the majority of the users were online, Christmas was drawing close and the participants were busy attending to the usual end of year rush and going on leave. The formative evaluator decided to leave instructions about using the discussion centres until February, after the summer holiday period. However we found even then, there was little response to the suggestions on using these components, partly because E-mail was working well for the group. Also using the BBS components were more technically complex than the e-mail system, and did require greater computer confidence. It was necessary to go ‘on-line’ to insert messages which members of the group who did try reported they found nerve wracking, as they struggled to follow the text-based instructions (the system did not have a more easily used windows software environment) aware of the minutes ticking by and using up their online hours.\(^1\)

It was also clear that several found it difficult to find time in their daily jobs to sit down at the computer and learn the new skills involved. Some were out in the field and rarely in their office, or when they were, were only able to have access to their computer at particular times of day. Not surprisingly, those who had more computer skills and a computer next their desk which they could turn to anytime, used CMC more frequently, and consequently were a more dominant voice. These are experiences in common with other groups of first time users of computer technology in a variety of settings and with a range of equipment, skills and access (Rubinyi 1989; Mantovani 1994) and indicate some of the organisational, social and technical complexities involved. With rapid technological and software developments in this field there are increasingly user friendly interfaces and increasing computer literacy, so these Alcnet experiences are likely to diminish as a barrier to greater use. Nevertheless it has been suggested that computer technology will differentially benefit the resource rich (large corporations and government) and resource- poor (small business and non-profit organisations) (Rubinyi 1989).

Influence of socio-political and research context

Another factor which affected how CMC was used in this project was the broader socio-political and research context within which the project took place, specifically the role of the research unit. The previous Liquor Licensing Project arose because of an opportunity - a new Sale of Liquor Act -with potential for significant impact on the availability and control of alcohol in communities. The research unit in that project was engaged, through the role of formative evaluation, in a partnership with the community workers to achieve the goal of encouraging public health in the new licensing system. In contrast to traditional conceptions of the evaluator as a neutral, detached observer, formative evaluation requires that the evaluators work closely with personnel involved

\(^1\) However by the end of the project most participants had half their fifteen hours left in spite of encouragement from the forum manaer and formative evaluator to have a go at learning new functions.
in decisions about the planning, development and implementation of the programme (Fitzpatrick 1988; Rossi and Freeman 1989). In the LLP the research team had been actively engaged informing discussions from a substantive research perspective, assisting the setting of objectives and strategies, and continuing to feedback progress and further resource the workers.

In the Alcnet project, the Unit stepped back from that issue-based formative evaluation role. This was partly because the aim of the evaluation was quite different as mentioned previously. However there was also a potential conflict of research roles in the controversial area of alcohol advertising, in which the unit was under considerable scrutiny from vested and other interests. Alcohol advertising was an issue of opportunity for the community workers, with a major review process occurring. Input into liquor licensing had been a similar opportunity, in the early 1990s with the introduction of the Sale of Liquor Act. However, at the time of the Alcnet project, the Unit was a major research participant in the alcohol advertising debate. It undertook several research projects on the impact of broadcast advertising, which were to be presented to the Consensus Development Conference in April 1994. The research team working on the advertising research projects did not include researchers engaged in the Alcnet project. However, in the climate surrounding such a highly contested policy area (Casswell 1995b), the Unit decided it was inappropriate for it to be engaged in a similar formative evaluation role to what it had undertaken in the LLP. Even so, the forum manager did keep in close touch with the workers on this issue, sending out information where relevant and attending the CDC conference and the community workers’ strategising meetings.

The interviews at the end of the project indicated that some members wanted more of a organised focus, and coordination similar to that which occurred with the previous Liquor Licensing Project. They missed its task oriented discussions at meetings, feedback from each region, and specific planning, with a range of options available for community workers to undertake in their local regions. There were local level and national level strategies. They thought there had been more coordination of discussion and activity around licensing than there had been around alcohol advertising. They thought consequently the community workers overall had greater collective impact working as part of that project than they did with Alcnet. In other words, organisational conditions in the LLP had been instrumental in facilitating action on licensing issues in the health promotion workers’ communities. On the other hand, there were more opportunities for local action around licensing and drinking environments in the LLP, than there were in the advertising debate.

The evaluation also pointed to management factors in the use of CMC for the group. Again these are not confined to this type of group and are likely to be common to others using CMC in other jurisdictions. Time management and information overload were two with which the workers had to learn to deal. For example, initially several participants reported feeling swamped by the amount of E-mail communications and felt guilty that they were not able to respond or work on issues that were raised. Some said it had increased their workload because they saw and thought of areas and strategies on which they would like to take action. On the other hand they found E-mail communication also helped prioritise work through reading other participants’ experience of whether an activity was worth the effort. It also was perceived as saving considerable time because of the quick access to information and help on strategising.

If the system had been managed with more discussion taking place in the BBS components, there
may have been less feelings of overload. This would have enabled users to categorise topics and choose what they would read and discuss rather than be sent all E-mails. On the other hand people enjoyed reading E-mail - when the formative evaluator asked the group their opinion on the volume of E-mail, because of some grumbles over E-mail overload, there was ambivalence. The consensus was that while it was sometimes annoying, they would miss not reading them, which seemed partly related to feeling part of the group and not wanting to miss out on anything. A further element to the perception of time constraints concerned individual users learning to manage and integrate use of the BBS into their work, much as telephone usage is integrated, rather than seeing it as an activity used only if time permits. By the end of the project some individuals had developed simple procedures to enable them to cope, including setting aside a specific time of day to concentrate on E-mail. This is also a matter for effective forum management in responding not only to E-mails but in actively encouraging participation. In the project this role took more time than expected and was not able to be done as efficiently as would be required for an ongoing, effective and active group.

It seemed clear that, as for any other mode of communication, in order to make use of its potential there are skills to be learnt in using it efficiently and effectively. This is particularly important the more users there are and information sharing and discussion increases. As CMC communication becomes more common and integrated into work practice, practices and procedures for this will become more commonplace.

Frustration in users of CMC can be produced by time lag in responses, which can be unpredictable, particularly when conventions about responding to E-mail are lacking (Mantovani 1994). Some of the workers were concerned about this, finding it frustrating when they "put ideas out and nothing comes back or the comment [back] just is 'this might be a good idea' but does not go further than that". In educational environments the success of networks among discretionary users of CMC was found to be contingent on the time delay in waiting for an answer (Riel and Levin 1990; cited in Mantovani 1994).

Out of the fifteen participants only four to five were routinely and actively engaged in discussing issues. Some of the less active members did not feel engaged in the discussions, particularly about advertising. They noted that while interesting the subject was outside the work they were doing. There was some perception within this group that there was a clique of those active in the advertising area. These members were 'old hands', had been part of the LLP and knew each other well. It was more difficult for 'newcomers' to join in. Some of those who did not actively participate in the discussion felt they did not have sufficient knowledge to contribute and were "self conscious about venturing an opinion knowing it was going out to a lot of people". These experiences indicate the historical context of CMC groups can influence the group members' perceptions and use of CMC in many ways. The context included norms governing a wide range of factors such as how members expect to be treated by each other, how group co-operation and conflict should be manifested, the mechanisms for socio-emotional support among members, processes of mentoring and collaboration, expectations regarding information sharing and patterns of interpersonal interaction (Levine and Moreland 1990 cited in Fulk et al. 1992).

The community workers thought that while CMC had many benefits, it was important to have meetings as a group, along the same lines as those in the LLP. They thought well facilitated, task oriented meetings enabled effective discussing, planning and strategising and allowed people to
get to know each other which would make it easier for people to continue collaborative work using CMC. Meetings facilitate and maintain a process of developing group norms, including processes of negotiation which assist further collaboration and action. Mantovani (1994) suggests the process of negotiation, an important part of democratic tradition and practice tend to disappear in CMC decision-making, and therefore CMC and especially E-mail are of little use in the first stages of the formation of a group or of the earlier development of a new project. Computer networking has been shown to work better when participants already had a history of interacting through conventional methods and when there was a general, well defined need for it (Rubinyi 1989).

Conclusion

The Alcnet project indicated clear usefulness in using CMC for action on alcohol issues within community settings in a number of ways. It enabled quick access to information and to ideas about taking action on alcohol related issues. In turn this increased confidence for some to tackle new areas. Most workers thought using e-mail had improved their effectiveness in working on alcohol issues. Importantly too, geographical and professional isolation was decreased, and a corollary was a perception that CMC contributed to some sense of the development of a community of support, which of itself can be regarded as health promoting (Milio 1992). While there were technical, contextual and organisational factors in using CMC which limited its use for participants, these are not insurmountable issues for resourced groups, particularly as familiarity with computer and ease of Internet usage increases. Milio has also pointed out health-related policy development, agenda setting, coalition and support building and advocacy can be strengthened through a broad electronic web (Milio 1995). Using such technology is becoming increasingly an everyday tool for communities working to reduce alcohol-related harm, but resources must be dedicated to enabling groups to use it. There will be increased collaboration between researchers and between community organisations and professionals. There will be increased and quick access to information on international and national policy development, as well as on research and stories of community action. There should be improved opportunities for effective advocacy, because of early alert to developments, affecting alcohol use, global and local industry marketing initiatives and government policy moves. Researchers working in the community action field will need to consider the implications of use of such communication, not only in terms of their research design but also in assessing their own roles.

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Reflections on the day

Robert I. Reynolds

I think that the six papers presented today, taken together, are very helpful to our understanding of several major issues confronting community action research. These issues seem to me to be related to three major themes: the definitions of relationships, the nature of power, and the need for mutual support.

Definitions of relationships

Community action research always involves relationships between researchers and prevention practitioners, but there are multiple options for how these relationships can be defined. These relationships are quite commonly defined as 'top-down', as 'bottom-up', and as 'mutual-benefit', although other definitions also exist. The papers presented today not only exemplify two of these definitions but, perhaps more importantly, provide insight into the factors and forces which influence the definition of these relationships.

The paper by Dorie Klein illustrates how political forces and funding availability can impose 'top-down' programs and services on communities and how the community action researcher may in fat be as much a victim of this 'top-down' relationship as is the prevention practitioner. The researcher is indeed at peril when the research outcomes are contrary to the political correctness demanded by political leaders.

In his discussion of the Klein paper, Paul Stanley astutely pointed out that commercial interests, often interests of the alcoholic beverage industry, can be as controlling as political interests in directing and limiting the intervention focus and in defining the researcher-practitioner relationship. The paper by Anatoly Vievskiy additionally touched on how alcohol industry marketing initiatives can serve as a counter-force to prevention efforts, and how this influence poses important measurement and analysis challenges for community action researchers.

Today’s participant discussion about the distinction between ‘cutting edge’ research and ‘bleeding edge’ research was interesting. The California perinatal substance abuse project reported by Klein is certainly an example of how prevention services and research can be directed to highly visible public problems and away from problems of greater societal impact.

The Holder paper discusses a project which sought a ‘mutual-benefit’ relationship between researchers and practitioners. This project characterized its structure as a "respectful marriage" between research and practice, with researchers helping community practitioners understand ‘what’ environmental intervention is likely to be effective and with practitioners helping researchers understand ‘how’ and ‘when’ a strategy can best be implemented. The core of this relationship involves a mutual dependency on information exchange throughout the life of the relationship.
The paper by Liz Stewart helps remind us that the mechanisms of communication between researchers and practitioners is not a substitute for the effort which is necessary to define the project relationship between researchers and practitioners. Communication systems can help to sustain working relationships, but only after working partnerships have been developed and defined.

Interestingly, none of the papers presented today illustrate a ‘bottom-up’ relationship between practitioners and researchers. While this may in large measure be a simple reflection of the membership of the Kettil Bruun Society, it is also a challenge. Organizers of future meetings on community action research will hopefully make special efforts to recruit presentations from practitioners who have sought out and initiated working relationships with researchers.

**Nature of Power**

In seeking to define relationships between community action researchers and prevention practitioners, it is impossible to avoid confronting the reality of power - what is it, who has it, and who wants it.

As noted, much of today’s discussion acknowledged the influence of political power and of commercial power. These influences were discussed in the papers by Klein, Krasovsky, and Vievskiy, and by several of the paper discussants and conference participants. While these political and commercial influences are certainly important, they are also largely ‘external’ influences beyond the control of researchers or practitioners. At best we are able to accommodate these influences, but we are seldom able to modify them.

Of perhaps greater interest is the ‘internal’ issue of how knowledge and information are sources of power, and how this power should be distributed and used. The paper by Bob Saltz provides an example of how research survey data can be used to empower intervention actions by practitioners. Constain Krasovsky’s paper likewise identifies the importance of epidemiological information, and discusses how this information should be shared to support prevention activities. Harold Holder’s paper illustrates how formative evaluation can be used to guide community action.

The Holder paper likewise identifies how prevention practitioners can provide information to influence the course and timing of research efforts. By knowing what, when, and how specific interventions are scheduled, researchers are better able to design sensitive change measures and better able to time data collection activities.

The paper by Liz Stewart, and comments by Sally Casswell, provide an important reminder that the design of project communication systems is indeed a function of power. In a ‘mutual-benefit’ relationship, all parties must have access to the communication system and authority to make content contributions. There must be a balance between information receipt and transmission in order to sustain equitable and productive working relationships.

Additionally, participants today recognized that communications about data is not as powerful as communications about strategy. In fact ‘data overload’ by researchers may distract and even divert
actions by practitioners. When information exchanges focus on strategy implementation it is far easier to identify what data is useful to the intervention and when it is needed.

**Need for Mutual Support**

A major theme in today’s presentations and discussions was the need by researcher’s and practitioners alike for support, from and for each other. The Holder paper discussed the reciprocal dependency of research and practice experience to achieve successful project and research outcomes. Dorie Klein shared with us how she provided her research results to project participants, and Liz Stewart advised us that this exchange is especially important for those involved in implementing environmentally focused change strategies.

Although the cultural, political, and economic conditions in post USSR countries vary considerably from those of the United States and Australia, Constantin Krasovsky and Anatoliy Vievshkiy also reinforced the common desire for better working relationships. We are more alike than we are different.
The dynamics of research and community action in the context of a bicultural project in Aotearoa/New Zealand

Sally Casswell

Community action projects, with some kind of research involvement, have become a popular response to societal concern about alcohol-related problems. A number of examples have been published from different countries (Casswell and Gilmore 1989; Boots and Quinlan 1994; Walley and Trindall 1994; Mathrani 1993; Wallack and Burrows 1983; Schatz et al. 1993; Wittman and Biderman 1993; Hingson et al. 1993; Giesbrecht et al. 1990; Douglas 1990; Romelsjo et al. 1993; Larsson and Hanson 1990; Holmila 1993). These have varied in the precise nature of the relationship between the community actors and the researchers. The nature of the relationship between researchers and community actors has been acknowledged as problematic in some of the earliest writings on the topic (Room 1990; Giesbrecht et al. 1990).

Related issues which have been discussed are the sustain ability of the community activity once the evaluated project has finished. It has not been clear in many projects the extent to which the purpose of the project was to establish and institutionalise changes in the practice of community organisations in the participating community, aimed to reduce alcohol-related harm on an ongoing basis, or the extent to which the primary focus was on gaining scientific knowledge which was generalisable to other areas, both geographically and substantively. Somewhere between these two ends of a continuum of research aims is that of providing a model of good practice for local emulation.

The funding agencies which have provided funding for the evaluation component of the exercise have presumably often required the projects to fit within traditional positivistic paradigms of science and required a focus on generalisability. Some researchers have been very clear that was the primary focus of their project (e.g. Holder 1995). Because of this focus in some projects the resources put into the evaluation component have outweighed the resources put into the community action.

In many, if not most, of these evaluated projects the exercise has been initiated by the research organisation and this will have had an influence on the subsequent relations between the researchers and the community actors. Related to this and other structural aspects of the projects, concern has been expressed about the power relations between researchers and community actors with it being described as often a ‘top down’ process (Hunt 1990 cited in Hyndman and Giesbrecht 1993).

Many of these issues are part of larger debates, for example about the role of citizens and representation in participatory democracy (Boyte 1990; Larsson 1990) and about the epistemological status of research based knowledge, whether it is privileged over...
ordinary knowledge and should therefore dominate in deciding community action (Silverman 1985).

**New Zealand Community Action Research in the 1980s**

These issues have also been of concern for us in New Zealand as we have carried out evaluations of community action projects. In each of the three studies in which we have participated we initiated the project. However, the three projects, which have spanned the 1980s and into the 1990s have illustrated developments in the relationships between the researchers and the community actors which have been shaped by the changing circumstances of the participating communities, awareness of the academic debates and the conscious attempt by us as researchers to reflect on these issues.

The first project, which was a quasi-experimental design evaluation of community action and mass media campaigns, was carried out in the early 1980s and took place in an environment in which there was little contemporary experience of community efforts to reduce alcohol-related harm. Our research unit, APHRU, raised the funds for both the evaluation and the action component of the project and was involved in the recruitment of local people to take on the role of community workers. However, the structure which was established was designed to minimise the perceived danger of researcher domination as much as possible. The community actors were employees of local (educational) institutions, rather than the research unit, and were responsible to these institutions on a day to day basis. They and their employing institution agreed to the general objectives of the project, as established by the research organisation, prior to agreeing to participate. The actual activities of the community workers was then a matter of negotiation between the researchers, a representative of the funder and the community workers; the latter group were very cogniscent of the demands and perceptions of (some sectors of) the community of which they were a part (Casswell and Stewart 1989).

The concept of the community worker aiming to reduce alcohol-related harm, as modelled in this project, was well received and in 1990, at the time of the second evaluated community action project, there was a network of 20 of such community workers throughout the country. The existence of such an established network made possible and appropriate a somewhat different approach in the next evaluated community action project in which we participated. In this situation the community workers were approached to invite their participation; the project funding was over and above their salaries and provided only for dissemination of information and collective development of the community action strategies in regular meetings. The evaluation approach which was taken was chosen as appropriate to this specific situation; a quasi experimental design was not feasible and much of the role of the researchers in the project centred upon a formative evaluation role which provided research based information and feedback to assist the formation of the project (Stewart et al. 1993).

The next foray into community action research took a different direction again. In previous situations the Pakeha research unit had been operating with predominantly Pakeha community workers who in turn had been located in communities which varied in the ethnic mix but who had worked primarily with Pakeha sectors. What contact there
was with the indigenous people of Aotearoa was within a Pakeha framework. In 1991 an opportunity arose to work with Maori on a community action project and an effort was made to try to create a partnership structure for the project in keeping with the terms of the treaty under which New Zealand was established and the circumstances of the early 1990s.

The Circumstances

Maori commentators have described themselves as the most researched people in the world (Jackson, S in Metro cited by Smith 1995; Teariki and Spoonley 1992). As part of the early and more recent colonial history of New Zealand, Pakeha researchers have observed and interpreted Maori to other Pakeha and, inevitably, to Maori (Teariki and Spoonley 1992; Smith 1991). Research has been seen as of more value to the researcher’s career than to Maori themselves (Smith 1995, 1991; Awatere et al. 1984) and therefore as an intrinsically exploitative activity. This view of research was in keeping with the perception of the colonial and postcolonial situation as generally exploitative of Maori.

In the late 1980s the determination of Maori to take control of their own affairs was enhanced by changes the New Zealand state enacted which began a process of redressing some of the wrongs of the colonial period.

In 1991 the APHRU was approached to request us to carry out some research into drinking and driving among Maori. We were told that a number of Maori researchers (who are few in number) had been approached and had not felt able to respond. At this time, through the good offices of our then secretary, Naina Watene Hayden, the Unit had a kaumatua, Nau Epiha. Nau took a major role through the early stages of the project and has continued with ongoing support and advice.

Two aspects of the project development process which occurred simultaneously in the early stages were a reframing of the research approach differently from that expected by the funders, and initial discussions of the funder’s approach at a hui on a nearby Marae. Both of these led to a proposal to develop, in partnership, a community action project aimed at the reduction of alcohol-related traffic injury among Maori. It was somewhat unusual in terms of typical research practice in that this action-oriented approach was taken despite the absence of quantitative data on rates of alcohol-involved traffic injury among Maori or any research material on attitudes to drink driving, collection of both of which had probably been anticipated by the funders. The preferred approach responded to the concern expressed by Maori at this initial hui about the damage occurring in their community, our perception of the need for research conducted in partnership with Maori to have immediate practical significance, and the history of community action research by APHRU.

The Projects

The initial development of the project took place in collaboration with the Huakina
Development Trust which had responded to our approach at the initial hui. In keeping with the partnership approach we wished to pursue, our next step was to raise funds to employ a Maori researcher to develop the proposal for project and evaluation funding and this person, Paul Stanley, was recruited jointly by Huakina, APHRU and our kaumatua. The proposal which was submitted for funding was successful and the project began in 1993.

The project proposal was written by a number of APHRU researchers, including Paul Stanley, and reflected three major strands of knowledge: first, tikanga Maori, including the concerns and needs as expressed by Maori informants relating to alcohol and traffic crashes and kaupapa Maori research; second, the empirical research on what strategies were likely to reduce alcohol-related traffic crashes; and third, the literature on evaluation practice. The sources of these knowledge bases, over and above the researchers’ life and work experiences were literature review and a large number of interviews carried out by Paul Stanley with Maori stakeholders.

The proposal for the community action project laid down four broad objectives. These objectives reflected our understanding of the need to focus on environmental change in order to reduce alcohol-related traffic injury and the collective nature of Maori ideology. They also acknowledged the need expressed by Maori informants to raise awareness of traffic crash injury in traditional Maori settings and utilising Maori media. The objectives were:

- to develop and implement a marae focused programme aimed to raise awareness and support among Maori for culturally appropriate strategies to prevent alcohol-related traffic crashes;
- to develop and implement a co-ordinated mass media strategy including media advocacy and paid Maori mass media to raise awareness of and support for culturally appropriate strategies to prevent alcohol-related traffic crashes;
- to develop and implement strategies aimed to reduce drunkenness and drinking environments in which Maori drink;
- to develop strategies aimed to increase the mutual supportiveness of random breath testing (RBT) and the programme components.

It was stated in the proposal that while the overall broad objectives could be agreed to at this stage the strategies by which those objectives would be sought could not since this would be a matter for the participating communities to decide. (There were now two participating communities as during the course of the consultation process carried out by Paul Stanley a further organisation, Te Whanau o Waipareira, had joined the project).

**The Evaluation**

The evaluation design drew on the strands of research practice which emphasise a naturalistic approach (e.g. Guba 1978) and the value of formative evaluation (e.g.
McClintock 1986). The naturalistic approach stresses the need for the evaluation to create minimal disturbance to the intervention and often relies on qualitative research to document the process and impact of the project. Formative evaluation is the focus on collecting research-based information in the planning and early development stage of the project to provide feedback to assist the formation of the project.

The evaluation design was selected following a thorough review of the feasibility and appropriateness of different evaluation designs to the specific situation. A number of factors militated against the possibility of establishing a quasi-experimental design to assess the outcome of these projects. These were the strong networks and degree of sharing of information and resources among Maori, making the likelihood of keeping control areas clear of the project extremely unlikely even if appropriately matching areas could be found. There was no opportunity to carry out a time series analysis on existing data as ethnic specific data did not exist; furthermore the nature of the data that might have been available would have been measures of traffic fatalities or injury. Given the time period covered by the funded project (two years) it was not felt likely that the project’s outcomes would be reflected in those measures within the time period.

Instead the orientation adopted was to accept an emphasis on intermediate measures which were judged relevant to the long term objectives of the project within the terms of the programme logic (Chen and Rossi 1981). This programme logic was drawn from existing research data which had demonstrated the potential impact of measures of environmental change to reduce alcohol-related traffic injury (Ashley and Rankin 1988; Mosher and Jernigan 1989; Casswell 1986; Casswell et al. 1990; Holder 1989; Partanen and Montonen 1988; Mosher 1983; O’Donnell 1985; McKnight 1991; Jeffs and Saunders 1983; Vingilis and Coultes 1990; Stockwell 1992; Stockwell et al. 1991; Homel 1988; Homel and Wilson 1987; Saltz 1987; Moskowitz 1989; Wagenaar and O’Malley 1990; The Advocacy Institute 1991; Wallack 1990). In other words, the research literature was used to help guide the intervention measures and the evaluation goals were to monitor how well the strategies adopted were put into practice and to assess the response of key stakeholders to them, partly with a view to improving the project (formative evaluation) and partly to document the process of the project and to allow some assessment of the likely impact of the project.

The tensions inherent in the project

The tensions inherent in this project are likely to be similar to those found in many evaluated community action projects but the particular circumstances of the New Zealand situation of the early 1990s and the bicultural nature of the project may be seen to highlight some aspects.

Who is the research for?

One of the major issues implicit in the development of the project was the underlying question of what is the purpose of the exercise? While the project clearly operated under a general public good philosophy, as do all community action projects, the degree
to which good was seen to accumulate to the different sectors participating in the research was an issue. Traditional western research practice is predicated on the (implicit) belief that scientific knowledge is intrinsically more valuable than other forms of knowledge and the process of collecting and analysing such information, particularly when carried out from an academic setting, is, for many participants, justified as an end in itself (Silverman 1985). In the new paradigm research-based knowledge is seen as less intrinsically privileged over other forms of knowledge (Silverman 1985). Within this paradigm research must be justified more in terms of its immediate relevance to the participants. Such new paradigm approaches are found in developments in post-positivist evaluation research which stresses the utilisation of findings by the stakeholders (e.g. Patton 1986), in feminist research (e.g. Jayaratne and Stewart 1991) and these approaches have some shared qualities with kaupapa Maori research (Smith 1995).

The values of new paradigm research were reflected in the design of the research project in a number of ways. One was the decision to move immediately to an action orientation relying on (unquantified) community perception of a problem. The second was the decision to proceed with an evaluation design which fell short of the gold standard of positivist science in that no experimental design was possible; despite this it was felt that evaluation could play a valuable role. The research emphasis was less on the provision of new information in pursuit of a universal truth (the traditional focus of positivist science) and more on making apparent new associations between research-based knowledge and a particular context. In terms of evaluation research this fits with the generalisable explanation approach (Chen and Rossi 1981; Weiss 1976; 1978) in which it is accepted that the effect of interventions will be contextual and the aim of the evaluation is to look for understanding of complex interrelationships between multiple causal determinants in order to facilitate transfer of models of good practice to similar contexts (Shadish et al. 1991).

Given that this is a somewhat different emphasis from the goal of generalisation it requires fewer constraints to be applied to the evaluation exercise; there was no attempt to utilise an experimental design or to define the exact parameters of the programme before it began. However, the evaluation did require the use of scarce resources, including the time of Maori researchers and Maori community informants, and some of the value of this, particularly the process and impact evaluation, was seen as going beyond the immediate project; furthermore the advantage could be perceived to be greatest to the researchers themselves, including the Pakeha researchers. In this context every use of resource, including time, to collect and to disseminate information about the research project to a wider audience became, of necessity, a matter for critical reflection and whereas participating in a Maori hui may seem appropriate, writing for academic journals may not.

**Control Over the Research Process**

While APHRU’ s evaluation research practice had moved towards an approach more in keeping with a critical relativist approach we had nevertheless in our previous projects maintained control and ownership over the research process. In this collaborative
One of the tensions between the community and the researchers was the somewhat detached and critical nature of the research process which was assumed appropriate by the researchers. Our previous practice, which was also followed in this project, was to have different people operating as formative and process/outcome evaluation researchers in any project. This reflected the belief that the role of formative evaluator necessarily entails a level of commitment and involvement in the project and that while the formative evaluator is the project’s ‘critical friend’, occupying that position over a period of time may make it difficult to also play a process evaluation role which requires a greater level of detachment and critical reflection (Fitzpatrick 1988; Rossi and Freeman 1989).

Such detachment and outside observation is likely to be difficult for any community to warmly accept but it is particularly counter to traditional Maori ethos in which acceptance as a member of the community is necessary to carry out research and yet this precludes adopting a detached and critical role, particularly if the product of that critical detachment is likely to be seen by outsiders to the community. Therefore the researchers access to community informants had to be discussed with the community players and our reasons for wishing to interview community informants, individually and privately, justified to them.

The delicate state of the relationship between Pakeha and Maori at this time in New Zealand puts an extra layer of complexity over the involvement of Pakeha researchers in this research process. The first two years of the project entailed a very fast learning curve for the Pakeha researchers involved, in order for us to understand the limits of our useful knowledge and reasonable input. At times this was an uncomfortable process (and one that is not yet over).

From the perspective of the traditional Western scientific tradition it follows ‘naturally’ that the research will be reported by the researchers and disseminated widely. However, from the perspective of the participants in the research, in this case both community players and community informants, they also have some ownership and responsibility for the information disseminated. Some agreement about the way agreements on publication would be sought between the two Maori trusts involved and the research unit was reached before the project began but the details will be negotiated as we go.

**Shaping the Community Action**

In APHRU’s community action research the principle from which we have operated in regard to the development of the intervention itself was that research provided one of a number of legitimate and valuable voices in the development of the community action, but only one, and a process of negotiation was needed to achieve the balance between this and other voices which would allow the project to proceed.

Given the loss of an intrinsically privileged status as researcher the research-based
knowledge will only be reflected in the project to the extent the researcher is able to persuade the participants of the value and likely relevance of the research perspective. This is, of course, an element in any community action in which the researcher does not have control over the project but the uncertainty facing the researcher is greater when participating in a cross cultural situation and acknowledgement of cultural ignorance and humility are essential components of good research practice in this situation, ones that are not necessarily well developed in successful Western research practitioners.

Having acknowledged that research input was only one of the valuable and legitimate voices in the development of the intervention it was our position that it, nevertheless, was a legitimate and valuable voice and this position had to be defended against those that sought to privilege the community voice above all others. In this project we observed the (understandable) tendency for the intervention to move away from the somewhat more challenging policy approaches and to more popular children-oriented educational activity in much the same way as had happened in a previous Pakeha project (Casswell and Stewart 1989). Part of the researchers’ role was therefore to continue to promote the existence of research evidence to support an approach of changing the drinkers’ environment as the one most likely to achieve change.

Conclusion

In conclusion, from the perspective of Pakeha researchers involved in the planning and funding of this community action project, the primary aim was to facilitate and legitimate local action by our treaty partner which was focused on the implementation of environmental strategies to reduce alcohol-related harm. The evaluation component of the project enabled the focus on environmental strategies by grounding the planning of the community action, in part, in the research literature of what had been shown to be effective in the past. The evaluation component also provided for documentation of the project to allow some assessment of impact and to allow for transfer of the project into similar contexts.

The role of the Pakeha researchers was to provide a funding conduit and some technical assistance on research methods. After playing a relatively major role in the early setting up phases of the project, particularly in regard to the research planning, the project has been characterised by a process of letting-go by the Pakeha researchers involved. This process has been ably facilitated by the active process of taking-over by the Maori researchers.

Many of the tensions inherent in this project were probably similar to those found in most evaluated community action projects and were simply highlighted for the participants by the cultural differences between the Pakeha researchers and the Maori community players. These included differences in emphasis on the value and legitimacy of those aspects of the research project which aimed to evaluate and to disseminate findings beyond the immediate participants; how many resources should go into that part of the project; who owned the project and who had responsibility for the data gathered as part of the project.
While these tensions existed and were part of the process of the project they have not, to date, from a Pakeha perspective, undermined the project. There have been and will, no doubt, continue to be a number of issues which will require debate and consideration. From our perspective, participation in this project has opened a window on to new experiences and opportunities and has shown us different ways of seeing the world and our work.

Our ongoing struggle in any future projects will be to achieve the appropriate balance between carrying out research in the service of the immediate community with which we are working and the critical reflexivity which is the characteristic which sets research apart from other endeavours.

**Vocabulary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Marae</td>
<td>meeting house and associated grounds and buildings</td>
</tr>
<tr>
<td>Hui</td>
<td>assembly, gathering, meeting</td>
</tr>
<tr>
<td>Kaumatua</td>
<td>elder</td>
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<tr>
<td>Pakeha</td>
<td>white New Zealander, a person of predominantly European descent</td>
</tr>
<tr>
<td>kaupapa Maori</td>
<td>Maori philosophy, principles, practice, knowledge, language</td>
</tr>
<tr>
<td>kaupapa Maori research</td>
<td>research undertaken by Maori for Maori and with Maori</td>
</tr>
<tr>
<td>tikanga Maori</td>
<td>Maori customs and traditions</td>
</tr>
<tr>
<td>Aotearoa</td>
<td>Maori name for New Zealand</td>
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References


Berlin 1990.
Kia Mau te Mana

Helen Moewaka Barnes and Paul Stanley

Introduction

The title of this paper which literally asks the reader to hold on to ones honour, prestige and culture. An outline of the context of Maori people in New Zealand and their history with alcohol as first nation people will be given. In addition using some experiences from a tripartite research and project between the Alcohol and Public Health Research Unit and two Maori Trust boards will be used to describe a method of evaluation in these two Maori communities.

History of Maori and Alcohol

Alcohol was unknown to Maori before its introduction by non-Maori in the 18th and 19th centuries. Often deliberately given or sold cheaply to them by unscrupulous land dealers as part of the process of acquiring vast tracts of Maori land, alcohol as a tool of colonisation had a devastating impact; physically and spiritually (Awatere et al. 1984).

In 1820 the then New South Wales Governnor appointed Robert Kendall as a justice of the Peace with three Maori assistant. Their task was to reduce the quantity of alcohol being landed in the Bay Islands by non-Maori. Similarly early objectors against alcohol were Maori who had already witnessed the devastation that alcohol had on the unruly colonial population at that time. Sometimes Maori were involved in controlling the availability of alcohol in their communities working alongside a Justice of the Peace. Other examples cited by Sutch; (1969) and Ward, (1974) where Maori people helped through an informing process of those who were illegally selling alcohol in their Northland communities during the early 1830s. In 1847 whilst one in eight pakeha people had a conviction for drunkenness, an ordinance was passed that prevented Maori from purchasing alcohol.

A review of the literature reveals consistent yet different focus between Maori and non-Maori writers. maori writers often draw attention to the Kaupapa of the programmes that they were working on (Paul 1989; Spooner 1990; Stanley 1992a; Te Maori News 1992). In addition Maori writers often highlighted the difficulties experienced through under funding (Paul 1989; Spooner 1990; Stanley 1992; Stanley and Casswell 1993; Stanley and Casswell 1994a; Stanley and Casswell 1994b). Other writers focus upon Maori as either genetically or statistically the cause alcohol problems. These interpretations are difficult to sustain culturally because they do not offer an explanation that is consistent with a public health perspective. To utilise such an approach in 1995 would not only be inappropriate but also shallow in analysis.

In addition maori writers concentrate on how Maori programmes use prevention methods that are culturally significant, whilst non-Maori writers identify either the symptoms of alcohol misuse and Maori, or the reasons as to why Maori are abusing alcohol. It is argued here that a perspective that seeks to blame the symptom on the victim is not really addressing the complex issues that
perpetuate the problem but makes it easier for a vested colonising interest group whilst at the same time saving money for the coloniser as well. Powerful interest groups have much to benefit from Maori people either being blamed of blaming themselves in this way the focus of criticism is not directed at them.

**Maori alcohol consumption**

Little recent research exists on Maori drinking patterns. A 1978 general population survey found that on average both Maori men and women reported drinking greater amounts on their last drinking occasion than did non-Maori respondents but drank less frequently. More Maori abstained from drinking compared with non-Maori respondents (Casswell 1980). The impact (and consequential) outcomes of heavy male drinking on Iwi has been described (Awatere et al. 1984; Murchie 1984).

Motor vehicle crashes are the second most common cause of admission for Maori people to hospital (Pomare and De Boer 1988). Approximately 45% of all driver fatalities (all ethnic groups combined) involved alcohol and around 29% of hospitalised motor-vehicle injuries had been in an alcohol-related crash (Bailey and Carpinter 1991). Department of Health statistics from 1980 - 1989 indicate a disproportionate number of Maori dying in traffic crashes, including single vehicle crashes, often used as an indicator of alcohol-related traffic crashes (Richmond 1985).

Alcohol has been used throughout history by many groups of people for enjoyment. The pleasure from the effects of alcohol and the amount of socialisation that alcohol is involved in, creates a potentially addictive quality (PHC 1994). Alcohol is the second most used drug after caffeine (Health Department 1992) in New Zealand.

From a report commissioned by the Alcohol and Liquor Advisory council in 1992 they highlighted the following concerns in regards to Maori statistics:

*During the 1970's the estimated Maori alcohol related death rate was 75% higher than non-Maori.*

Alcohol is the commonest cause of admission for young Maori Males to mental hospitals and rates have increased four fold since 1970.

The gazetted assessment Centres in Auckland have cited a significant increase in the number of older (that is 45+) Maori male presenting under section 32A, Ministry of Transport referrals. (Maori Working Party 1992)

**Community Action**

Research in this country has been dominated by researchers who have a captive audience with little regard for the needs or expectations of Maori. part of the Maori critique of research has been based on the perception that research itself has not practically worked for them.
Maori perceptions and expectations around community action has centred around the Maori concept of Tino Rangatiratanga. Basic components of this perspective suggest that those to whom the initiative is aimed at should have a wide level of control. It also suggests that these individuals or groups have a role to play in the development and implementation of the initiative. Durie (1994) adequately describes this in his analysis of cultural implications in the health field in New Zealand. He further detailed indicators of maori development, they being; Kawanatanga, Tino Rangatiratanga, Oritetanga, Partnership, Participation, Active Protection.

Demands by Maori for control over their programmes and their health are indeed not a new phase, neither is it new in the field of research for indigenous peoples anywhere in the world. Maynard (1974) in commenting on non-American Indian researchers studying Indian communities as,

"... a predator who is using the Indian to further his (sic) career ..."

For Aborigine communities the message is quite clear (Love 1993; McGregor 1992) communities desire to have people from their own ethnic group working alongside them.

In community action research the major focus is not only seeing projected outcomes coming to fruition, but just as importantly ensuring that what the community sees as outcomes also evolve. Beauvais and Trimble (1992) stress some important points for consideration when working with Native American groups stating that there is

"... little or no understanding of the multiple points of possible incongruence or conflict that can arise at the conceptual level of programme development and of the inappropriateness of bypassing the many levels of protocol. This also helps to perpetuate among Indian people that they are being used for research purposes."

Knowing what some of the implications of various projected research or programme strategies are very important. Mostly because the researcher is able to short cut any perceived problem before they arise. The positive implications are obvious.

**Evaluation Research**

As a methodology, the multi-disciplined approach that was implemented in our research project has enabled a wide use of experienced personnel from education, sociology, psychology, and the like which is obviously part of the founding intent of evaluation research (Shadish and Reichart 1987). This has ensured that the research has not been narrowly focused but instead allowed a wide data collection and analysis approaches to come to the fore. The incorporation of such fields has allowed the development of evaluation to be less narrowly focused and at the same time utilising wide data collection and analysis approaches.

Two important milestones in the development of evaluation research were recorded by Patton moves away from scientific. Although there was an original emphasis on quantitative research, Patton (1987) reported a deliberate move away from that approach. This is seen as a more favourable development particularly for Maori approaches to evaluation. Although quantitative approaches are extremely helpful, identifying Maori needs through qualitative approaches are seen
as desirous methodologies because the views and the whakaaro of the interviewees are accepted through the process as significant.

A second important feature of the development of evaluation research was extension of the field from the concentration on outcomes of the programme to one of implementation and developmental issues.

With the model of concentration on the implementation and development of the programme it is considered to be a more acceptable to Maori. This process helps to inject operational information into a programme thereby making the evaluators role directly useful. Secondly whereas the programme is designed to focus on a particular group, the ones who would really benefit are those that follow on from the project. In effect the project would be seen as a pilot for other maori programs.

**Naturalistic approach to evaluation**

To meet the aspirations and expectations of Maori a more naturalist approach was adopted in evaluation. Attractive in this approach are its roots in social anthropology with a philosophical base in phenomenology rather than positivist approaches. As its name suggests Naturalistic Evaluation concentrates more on description and understanding of social phenomena and has a more qualitative approach to its field. Grounded discovery is central to naturalistic evaluation and this is based on the view that evaluation issues emerge from “... intensive on-site knowledge, rather than being formulated prior to data collection” (Dehar 1991).

Suelzle (1981) highlights some of the tools of a naturalistic being that of;

"participant observation, depth interviewing, case studies, content analysis of documents, and oral history."

This later challenge to quantitative evaluation through a naturalistic approach or more qualitative strategies has enabled evaluation to broaden its application. Patton (1987) described the outcome of the challenge to quantitative evaluation approaches through naturalistic evaluation as an integration of both through the term ”paradigm of choices”.

**Advantages of formative evaluation for Maori**

The Formative Evaluation process of using data to directly influence the programme and its development in a way that would raise the potential for the programme to reach its designed purpose (Edward’s 1987; Fitzpatrick 1988; McClintock 1986). As highlighted earlier one of the milestones of evaluation was the deliberate move away firstly from qualitative methodologies and then from Summative evaluation that concentrated more on the outcome of the programme (Rezmovic 1984).

One of the difficult areas to address in Maori health is that of being able to give something back that is immediately useful. With formative evaluation the evaluator is able to work closely alongside of the programme implementors whilst at the same time feeding back a variety of
information and data that would be directly useful for its implementation and development. Compared to outcome and process evaluation, the majority of the data and information collected is virtually at the end of the implementation cycle. There have been many instances where Maori organisations and individuals have expected immediate help. It is difficult sometimes for them to see that evaluators in the process and outcome evaluations are also directly helping even though the results are not tangibly evident at that time.

However formative evaluation is also a process that allows the evaluator to overtly have a vested interest in the community and their programme succeeding. Other positive factors in this field are that one does not enter the community with preconceived ideas on what will be done, but they enter with a lot of background information and research. This simple process at one level sends definite messages:
1. suggests that the evaluators bring some knowledge
2. suggests that the community also have valid knowledge
3. suggests that the evaluator is a contributor to the programme and not the implementor or the controller
4. respects community answers to any perceived problem.

Project background

In February 1992 Te Whanau O Waipareira Trust board, Huakina Development Trust Board, and the Alcohol and Public Health Research Unit from the University of Auckland entered into a three year tripartite collaborative research project to implement strategies to lower traffic related injury amongst Maori. The role of the Alcohol and Public Health Research Unit was to provide formative and process evaluation.

The funding was obtained through two major sources, the first was for the research component the second for the purpose of the project itself. The funding for the project is in direct control of both Waipareira and Huakina. in this way the researchers are not in a position to influence the direction of the project by holding financial control of these organisations.

Both organisations were involved in the original development of the research proposal, as well as the introduction of their own preferred strategies to deal with alcohol related injury in their communities. Important in this sector is the ability of both organisations to develop and implement strategies that they felt were appropriate. It is also noteworthy that in order to work with any community organisation the research that seeks to capacitate those communities must realistically allow them to develop in their own way.

Four programme aims were decided upon at the proposal stage and were used in the programmes at Huakina and Waipareira. The four programme aims are;

1. to develop and implement a marae focused programme aimed to raise awareness and support among Maori for culturally appropriate strategies to prevent alcohol related traffic crashes,
2. to develop and implement a coordinated mass media strategy including media advocacy
and paid Maori mass media to raise awareness of and support for culturally appropriate strategies to prevent alcohol-related traffic injuries,

3. to develop and implement strategies aimed to reduce drunkenness in drinking environments in which Maori drink,

4. to develop strategies aimed to increase the mutual supportiveness of Compulsory Breath Testing (CBT) and the programme components.

Initial developments for Huakina and Waipareira Trust Boards was the selection of the person that they wanted to run their programme. The Formative Evaluator worked alongside both organisations with these decisions but tried more to keep out of the trust board resolve. It should also be noted that the selection of the formative evaluator in this project originally had Maori representation on the panel.

Features of Huakina / Waipareira Project

Although the writer considers the Huakina / Waipareira Project a way of conducting evaluation in a community, it is neither considered THE WAY or THE ONLY WAY, it is tendered as A WAY. Key features of the operation of this project and the research component are contained in issues of autonomy and negotiation. The role of the formative evaluator is to bring the wealth of experience couched in academia and strategic planning. What is brought to the project by the Kaimahi who were employed was the expertise and experience of their community. The knowledge and experience brought by both of these parties are acknowledged through equal levels of power on the project as well as equal remuneration in pay.

Kaupapa Maori Research

The term Kaupapa Maori research alerts us to the view that we are striving to assert Maori processes and considerations to the field of research. It is also important to note that we are commenting on some of the wider aspects of researching in our own Maori communities from either a tribal perspective or from a wider generic one. Just as important is the acknowledgment that Maori health research is in its relative infancy and we are merely contributors to this new field. We could not be so bold as to describe our Modus Operandi as being THE Maori health research format. But it is significant in that we are all in a time of dynamic change with regard to maori health research, and being on part of that frontline allows us some unique contributions and opportunities.

Like many other indigenous peoples in the world who have been colonised by a white skinned race, maori people have an employment problem, an alcohol problem, a dug problem, a nutrition problem, a suicide problem, a homicide problem, a well being problem, and more importantly a disenfranchisement from their land problem. It is the return of Maori land that is often prominent in the perception from Maori in the 1990s.

Essentially we see ourselves as Maori academics trained in a non-Maori institution. The purpose
of such self identification is clearly in line with the expectation of our culture. It is about knowing who and what we are and who and what we represent in terms of work and our personal direction. The ability to locate oneself (as a researcher) within this schizophrenic environment is not only challenging but also critical in addressing the obligations to academic institutionalisation of research as well as obligations to the communities.

We know that there are times when we are mistrusted by our own because we are seen as collaborators with the oppressor. Unfortunately we have no real verbal response to those situations, what we do have to offer though is active participation that can be accepted in both the professional academic world and the professional cultural world.

Like any other business deal, one of the first things that we have learnt as Maori researchers is to identify what everyone is getting from our participation in research. Now we know that there are a number of altruistic (and non-altruistic) reasons why Tauiwi research Maori, and it comes down to simply knowing what they’re getting. Secondly of course we have to also identify what we are getting from this professional relationship. And thirdly what communities are getting from (or participation in) this field. It may seem a little contradictory to say that we aspire to be alongside Maori communities yet in the same paragraph say that there are three different group considerations, of which we are on our own in one of them. However that is one of the contradictions and dilemmas that we have to get used to in our world.

We believe in a tautoko (in a powerment context) model rather than an empowerment model. Because if people truly believe in ensuring others enter into self help mode, then how come this is often based on out group terms, using the out group tools, out group processes, and out group time-lines, it would appear quite prudent to describe this method as quite paternalistic. Whereas in the tautoko model we are seeking to identify where the community ideas are coming from and how important it is. In addition this model allows for a process of community self help to occur unimpeded. In some situations we have found that the best thing for a researcher to do is actually not to do anything, in fact to get out of the way.

Although we acknowledge that we have a multi-disciplined approach to evaluation, we still work majoritively within a qualitative framework. The reliance on a qualitative focus and how it interfaces with Maori processes is indeed intriguing, particularly where interviewing is concerned. The term whakapapa is one that speaks of genealogy and more specifically with regards to research how close one is related to the interviewee. Under this principle, the closer the researcher is related to the interviewee the high the quality of the information from that person. It would seem logical that your great aunt would feel a lot more comfortable talking to her great grand daughter than she would a complete stranger.

Yet the experience that Maori as a group have had to endure suggest that they should be mere captive audiences for the manipulation of the researcher. In other situations Maori are seen as vessels or tools for the coloniser and essentially take over the role of self colonisation through spreading the world and the words of the coloniser. All in all Maori have often been seen as recipients of research and passive players in the development of their own health.

We look to community action as a means of Tino Rangatiratanga - a process of self determination. The ability to have complete control over one's environment. The ability to define, design and
implement one's own world and reality.

Like many indigenous peoples Maori have been the subject of work initiated and - carried out by non-indigenous researchers. There has been little Maori ownership and at best token consultation. As a result Maori researchers have inherited distrust and suspicion that years of abuse have left. A positive aspect of this fairly negative outcome has been through the accountability of the researchers to their communities.

Often in the past pakeha have been viewed as the norm and also as the benchmark, the advent of maori researchers in the field has literally challenged this perspective to a level that has been questioning of many years of pakeha dominated research and research methodologies. Understanding the effects of colonisation and some of the dynamics that are symptomatic of a colonising process is critical when working with Maori people. Just as importantly of course is the ability to understand the place that one has in Maori society as an evaluation researcher, and the relationship that is implicit and explicitly defined by your work as well as your tribal peers - there are times when this relationship is at logger heads with each other.

Further to the colonisation process and intrinsic in the Ottawa Charter, are issues that suggest that Maori are not healthy if they do not have control over their language, resources and their environment. Because maori have not had effective control over these areas they become complacent in accepting the control over their environment. Often maori are not in control over their environment, they are not in control over their health initiatives and they are not in control over their research. Paternalistic research methodologies that perpetuate pakeha domination over Maori world interpretation and reality are still rife but are becoming increasingly unacceptable. Taking control of this high ground is also part of reorientating outcomes. Success in our program is not just that the road toll was lowered but also that Maori were in controlling positions to help reorientate their environment. Maori take pride from the knowledge that they can implement programs and that they can do it on their terms.

Questioning the pakeha way of doing things and constantly checking out what use it is to Maori and what is not of use must also include questioning ourselves as Maori researchers. We are maori working within a pakeha university where methods of pakeha research dominate. We cannot look critically at these methods if we do not also look critically at ourselves and the work that we do.

As Maori we identify with family and whakapapa. ”Where are you from?” is a commonly asked question. When working with community action projects these same processes are carried out.

We know that participants agree to take part in the evaluation because they believe in the value of the project, but they also make decisions based on the credibility of the researcher. This relationship and credibility affects the quality of the research through the quality of the data gathered from the participants. Through the lack of real control of research Maori have resisted through limiting or strategically restricting differing portions of information. Maori know well the pakeha cliche of knowledge is power. In addition Maori have learnt the difference between power and the illusion of power.

Just as there is no universal approach for all people, there is of course no universal approach for Maori. As intimated earlier, we are proposing one approach that has achieved an element of
success for us and argue that it should merely be one of many.

There are several areas that can lead us to be complacent, one of them is assuming that we are experts. It is easy to be seduced into this belief when there are so few Maori health researchers about and you are in a pakeha dominated institution.

The assault of the new right regime which assumes that it is those that hold the purse strings who have the control over the overall bearing of projects, certainly makes a mockery of community development and community aspirations. mostly because this process interprets needs before hand through the eyes of those from outside of the group.

Questions arising either directly or indirectly from community people seek a level of understanding that even if you are a Maori person does not necessarily mean that you will automatically respect the needs of Maori community people. This level of mistrust build on a heritage of misapplication of community action research from out groups have made it very difficult. If a Maori ethos is centred around respect for each other and of working towards uplifting Maori well-being simply having to work as a detached and neutral researcher brings an array of complex issues for the researcher. The researcher is confronted with the problem of having to be associated and supporting the project but at the same time having to work in a world of seemingly secrecy through being neutral and detached. How can one possibly be detached from your culture when your culture expects you to be firmly attached to them through the project.

How can one record with an audio tape whilst at the same time be requested to maintain confidentiality. Even when we consider the amount of oral tradition intrinsic in Maori culture, we are still concerned about the degree of misinterpretation of information when that is transformed to paper, especially with respects to analysis. When issues are very clear to you as a Maori researcher, you sometimes feel that the audience whom you are writing for is not, and therefore have to write in such a way that you know that they will understand whilst at the same time sacrifice the depth of Maori knowledge. The risk here is that when information threatens to become superficial it runs the risk of being too broad and far too open to be interpretable and misunderstood by those who seek to reinforce prejudice.

This is an exciting time for maori, marked by increasing maori participation in the a wide array of fields in health. The developments that are taking place in Aotearoa as a whole are also similar to those that are taking place in Maori health research. There is increasing awareness of the obligations that pakeha have as treaty partners. maori are more actively breaking away from constraints placed on us by a system, and in addition examining the roles both partners have to play.

Conclusion

In this document we have outlined some of the positive aspects of working in the world of research for maori people. It has an element of challenge and sometimes it has an element of contradiction. Being able to deal with aspects of contradiction and making situations win for both sides is indeed advantageous, however just as important is the ability to recognise this and work alongside other maori people in actively supporting Maori well-being through interpretation of
maori reality through real Maori eyes. The title of this paper Kia mau te Mana, suggest that the identification of the expertise and of all stakeholders in research and the project are critical. It suggests that every person has something to offer. That every person is an expert and has an experience or experiences that are directly applicable and credible to our world of evaluation.
References


Captive Audience those who are seen as vessels of information or data in which they have no say. In this process the researcher "surgically" removes information or data for the "greater good" of others.


Martin, H. Personal communication 1994.


<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Aotearoa</td>
<td>Maori name for New Zealand</td>
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<tr>
<td>Kaupapa</td>
<td>Ethos, Philosophy</td>
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<tr>
<td>Maori</td>
<td>First nation people of Aotearoa</td>
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<tr>
<td>Pakeha</td>
<td>White New Zealanders</td>
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<tr>
<td>Tauwi</td>
<td>White New Zealanders or other immigrants</td>
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<tr>
<td>Tautoko</td>
<td>Support</td>
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<tr>
<td>Tino Rangatiratanga</td>
<td>Absolute control over resources</td>
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<td>Whakaaro</td>
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**Appendix**
THE UNIVERSITY OF AUCKLAND
POLICY ON OUTSIDE ACTIVITIES UNDERTAKEN BY ACADEMIC STAFF

Background

The University understands and accepts that there are many kinds of outside activities undertaken by members of the academic staff which rely on the special knowledge and expertise of the staff member and which enhance the academic status of the individual concerned and the reputation of the University.

Council accepts the value for the University and its staff to be obtained from staff undertaking outside activities, including public service and professional work which is non-routine and at a high level. The University encourages entrepreneurial activities consistent with its objectives.

Summary policy statement

Members of the academic staff may undertake a limited amount of professional activity and public service outside the University, provided such activities are supportive of University duties. Contracts for all activities from a commercial or government source must be actioned through Auckland UniServices Ltd.

The staff member must report on the nature of the activities undertaken and the time spent on them to the Head of Department. As a general guideline a commitment of up to twenty percent of a staff member’s time spent in outside activities may be acceptable, provided such activities are not detrimental to the staff member’s duties in teaching, research and administration.

Heads of Department must report annually to their Dean of Faculty on the outside work undertaken by staff in their Department. The Dean, in turn, will report to the Vice Chancellor.

1.0 Policy

Outside activities will generally be approved if the following conditions are met:

i) The activities are of an appropriate nature as stated above.

ii) The activities are conducted in such a way that the responsibilities to the University always remain paramount. Members of staff should be available for consultation by staff and students on a basis which satisfies the need for the smooth running of their department and also the need to be available to students on a reasonable basis as agreed with their Head of Department.

iii) The activities are not detrimental to the efficient and effective discharge of the staff member’s duties in teaching, research, and administration.

iv) Approval for continued involvement in outside activities shall be dependent upon evidence of an acceptable performance in teaching, research, and administrative
duties and may be amended or withdrawn if that evidence is unsatisfactory. Such evidence will form part of the performance review. Heads of Department will monitor the performance of members of their Department, Deans of Faculty will monitor the performance of Heads of Department and the Vice-Chancellor will monitor the performance of Deans.

v) The extent to which academic staff members are involved in outside activities shall be considered as part of their annual performance review.

2.0 Procedures to be followed

2.1 Teaching by full-time academic staff for another institution within New Zealand (with the exception of isolated lectures) must be arranged with the approval of the University and with the appropriate transfer of funds to the University, as may be required to cover the service provided.

2.2 Staff undertaking occasional lectures of radio, television, or kindred performances, preparation of books or articles, refereeing of articles in learned journals examining and minor opinion work may do so without permission. All other outside activities and the time required to carry them out must be discussed with the Head of Department, and specific written approval sought from the Head of Department where the work involves the use of University facilities and where there are potential costs to the University. The Head of Department must take into account the potential risk to the University of the outside activity.

In exceptional circumstances and with the approval of the Head of Department teaching duties may be rearranged to accommodate outside activities.

Similarly, Heads of Department must have the prior approval of the Dean of Faculty and Deans the prior approval of the Vice-Chancellor.

3.0 Responsibilities of the staff member

3.1 A staff member undertaking paid consultative and related outside activities in a personal capacity may not use the University name, letterhead, identity or facilities for offering a professional opinion and the University assumes no responsibility for the opinion offered. It is the staff member’s responsibility to make clear to the employing party that the University has no responsibility or liability in the matter.

3.2 All sponsored work of a commercial nature, performed by university staff, that uses University facilities must be actioned through Auckland UniServices Ltd. Facilities include offices, telephones, faxes, library, computers and computer networks, secretarial assistance, etc. When consulting work involves the use of university facilities, the arrangements for this work must also be made through Auckland UniServices Ltd. Auckland UniServices Ltd may at its discretion advise the employee that the work may be carried out in a private capacity.

3.3 As part of their performance review, all members of the academic staff shall summarize the nature of and the time spent on any outside activities, including consultative or other paid
outside work, undertaken during the preceding twelve months.

4.0 Policy on avoidance of conflict of interest in teaching

4.1 Teaching by full-time academic staff for another department (with the exception of isolated lectures) must be arranged with the approval of the Head of Department from which the teaching is being provided and with the inter-departmental transfer of funds or EFTS credit, as appropriate. Full time staff may not receive payment for teaching within another department.

4.2 Part- or full-time members of staff may not accept fees for giving private coaching in any course for which they have teaching or examining responsibilities.

4.3 Case books, laboratory manuals, study guides and other handouts which are prepared during a staff member’s employment within the University and are sold through the Faculty and/or department are to be charged at a price that covers only reasonable costs of reproduction and distribution. Proceeds from the sale must be administered by the respective faculty or department for faculty or departmental use.
Community and municipal action on alcohol in Oporto city

José Barrias and Zélia Duarte and Paola Dias

The inclusion of Oporto in the M.C.A.P (Multi-City Action Plan on Alcohol)

The history of the involvement of The Oporto Alcohology Regional Centre into a project of Alcohol Related Problems Prevention at municipal level, started in the early eighties (1981), when a group of mental health technicians from a Mental Health Centre analysed the frequency of alcoholism cases registered, and decided to constitute a group whose main purpose was to study and to investigate the real dimension of the problem.

The developments of the work of this small group culminate into the creation of the Alcohology Service of Hospital Magalhaes Lemos (1985).

Brief description of the city:

The surface of Oporto is not very large - 43 km² - corresponding to the third smaller municipality (in what concerns its dimensions) among the nine that constitute the Metropolitan Area of Oporto (M.A.O.).

The present data were collected during the last general census (1991).

The difference found between the resident population and the present one (about 7000 individuals) reflects in a considerable part the number of people working at the city, without living there. The resident population is distributed by 15 parishes, with a population density of about 7052 individuals by km², corresponding to five times higher value when compared with the average numbers for the M.AO.

The population distribution, according to the group ages is the following: 51,200 individuals for the group among 0 and 14 years old, 49,950 for the group from 15 to 24, 156,500 for the one among 25 and 64 and 44,700 for the older group. These values show that about 51 % of the population can be found in the group from 25 to 64 years old, and that only 17 % is less 17 year old. In what concerns birth and death rates we don’t find significant differences.

The birth rate is 11.5 and the death one is 11.3.

The unemployment rate is about 7 %, and the illiteracy rate it is close to 6 %.

In the domain of urban construction it is important to sign some factors: nowadays the construction is essentially made in height, due to the rareness of the building sites, and to the natural limits of the town (the river, the sea, and the other neighbour towns). For these reasons the building of residences has been mainly made at the suburbs, and the hart of the city has been converted from ancient residences to new commercial and services spaces.
This situation provoked a problem that is a main concern to the Town Hall: during the night and the week-end the hart of the city is almost dead, and the security what used to be a special characteristic of Oporto is now quite reduced.

Consequently, the dynamization of the city is now being made through the creation of amusement places, pubs, bars, "concert-cafes", art galleries, etc.

One of the aspects of Oporto’s economic life may be described by some examples of the enterprise’s distribution: the global number is about 36,000 and more specifically there are about 4,000 industries, 3,600 related to services, 8,000 banks and only 197 dedicated to agriculture, forestry, hunting and fishing.

The presented figures show a clear predominance of the enterprises linked to services and industry, but specially the ones related with finances. This may be partially explained by the important role played by Oporto in the business domain. Is also evident the reduced number of enterprises dedicated to agriculture, and the main justification is probably the absence of lands appropriated to the agriculture.

However in 1984, and at the Metropolitan Area of Oporto the main permanent culture was the vineyard, in 8 of the 9 municipalities, which corresponds to near 1,600 hectares of cultivated surface, producing mainly the well known "green wine".

The exception is the municipality of Oporto, due to its strictly urban characteristics.

In the domain of Education, the town of Oporto presents, when compared with the average of A.M.O. 20% of the institutions dedicated to basic education, but as we climb in the level of specificity we find 49% of secondary level schools (high-schools), 58% of the institutions dedicated to professional and artistic education, and the high majority of the superior schools (colleges) what implies a strong movement of young people from the suburbs to Oporto, in order to be able in continuing their studies.

In what concerns the health domain, its primary structures and its indicators Oporto has 11 official and 14 private hospitals, 7 health centres, 30 health posts and about 121 pharmacies.

It is important to refer that the town of Oporto is a main centre for health care, that supports the neighbour municipalities, too.

The number of beds by 1,000 inhabitants is 15.8 (almost three times the average value of Metropolitan Area, which is 5.1). The number of medical doctors practising in Oporto is about 3500, corresponding to the average of 11.4 for thousand inhabitants.

These are some of the reasons that contribute to the overload and to the long waiting lists registered in the main health structures for consultations and surgical interventions.

At Oporto the child mortality rate is decreasing since 1985 in 7.8 by thousand. However, the value was still 12.8 against the average value of 10.3 registered in the Metropolitan Area.
Some other indicators such as the numbers of traffic accidents place the town of Oporto in the top of Metropolitan Area, presenting about 37% of the global number of accidents.

The victims that result from the previous data may be a departure point to estimate the global costs of alcohol related morbidity.

More specifically, and in what relates with alcohol problems, we can say that the District of Oporto presents about 44,330 alcoholics, calculated with the Jellineck formulae, which represents about 2.7% of the district population.

In the Metropolitan Area we found about 32,700 alcoholics (corresponding to 2.8%) and in the town of Oporto the value was about 10,500, corresponding to 3.3% of the population, the highest one.

Continuing with the numbers we can point out the frequency of people asking for help in our Centre. In 1994 38% of our patients were from the town of Oporto (754 - 596 men and 158 women).

To understand the incidence of alcohol related problems in a town like Oporto, and, consequently in a country like Portugal, it is not possible without knowing the political and legal context beyond these issues.

Firstly it is important to point out the absence of a clearly defined policy about alcohol. It is also needed to register the lack of tradition near the municipalities, specially near the Town Halls, in making investments in the areas of education and health, because it is a common believe that these issues are strictly addressed to the central government, and not to autarchies.

About the regulation of alcohol related issues, and facing the lack of clear and objective orientations about the access to alcohol, its distribution and consumption, we need to say that the responsibilities of making those rules are attributed to the local representatives of the government. The results are the existence of different rules for different districts.

It is also significant the fact that the inspection of the local rules' accomplishment is in practice inexistent, and that the exclusive responsibility of the control is addressed to the police, giving the idea of an essentially punitive and not educational policy, to the changing of population’s life styles.

Nevertheless these obstacles, the prevention of alcohol related problems in Oporto, as we have said before, started in 1985, in an informal basis, but the development of our work has had since then, the orientations proposed by WHO.

At this is the description of the activities developed in this aim, that we are going to initialise, although in a very summarised way, and mainly dedicated to the involvement of our Centre with the Municipality.
Intervention actions with the municipality of Oporto

In 1993 the City Hall of Oporto and the Oporto Regional Alcohology Centre established a protocol of co-operation, in order to prevent alcohol related problems in this area.

The protocol was established with two different departments from the City Hall, specifically with the Department of Health and the Department of Social Intervention, and reflected the acknowledgement presented by both institutions in developing collaborative interventions, summarised in the following description:

- To know the needs of the parishes, specially the ones with more evident social problems, making at the same time the situation diagnosis.
- To involve the social agents (specially the technicians charged with the social support to each parish) in order to make the planning of the activities near the general population, as well as near the risk groups such as children and youngsters, pregnant women, and the elderly.
- Development of the adequate answers, that may include information and sensitisation sessions about alcohol related problems, as well as the constitution of community groups constituted by significant local members, and representatives of local institutions.

Taking in account those general purposes, the expression of the preventive actions may be very extended, and specified for each situation. Some examples will be described as follows:

- Firstly we collected basic information in order to have a specific characterisation of each one of the 15 parishes that constitute the municipality of Oporto (quite different among them), from the social and demographic point of view;
- Secondly we initialised, in each parish, the sensitisation of the autarchies, and of the significant institutions;

After those preliminary contacts, and taking in account the answers to our proposals, we made several sensitisation actions about Alcohol Related Problems, namely in the parishes that already had running projects for intervening in the social blockhouses, having as major purpose the promotion of healthier life styles, as well as the improvement of their living conditions. In those actions have been involved medical doctors from the local health centre, social workers, sportive and cultural associations’ members, dwelling’s associations, teachers and kindergarten elements.

Simultaneously we have developed informative sessions addressed to group risk, like youngsters, and women.

The need for specialised training in alcohology has been requested specially by clinicians, and Alcohology Courses have been promoted by our Centre assured by our staff. It is scheduled a specialised course addressed to all the clinicians from one of the health centre that provides health care to two of the parishes (in a global number of 60,000 individuals), and a more global one dedicated to general practicians (May 1995) These clinicians will continue their intervention near the population above referred.

After a few years of negotiation the Alcohology Training is now considered an important module of the G. P’s Course curriculum.
We also participate in the I Health Meeting dedicated to the Elderly and organised by the City Hall Health Department, which has been extinguished in January, 1995.

Nevertheless our co-operation with the Oporto Municipality continued, more specifically with the Social department. In the aim of the concerns felt by the team, the alcohol issues had been approach specially in the most "hard" blockhouses, where alcohol and drugs abuse are major problems.

Considering that the working context is a specially important place to organise preventive actions, we are starting now a few programmes about alcohol related problems at the enterprises. Specifically a programme has been implemented at the City Hall itself (with a range of about 4,000 workers), at the strongest economic group in Portugal (SONAE) and at SOPETE, an economic group which main activities are the tourism and gambling.

The programme prepared to SONAE will reach only the enterprises connected with nourishing products distribution, attaining a global number of 10,000 workers, while the one prepared to SOPETE, will reach 1,000 workers.

These interventions are based under the principle that the ”organisations” reproduce somehow the problems of all society, and simultaneously that the those problems can be detected at the enterprise, namely the alcohol related problems.

First of all we try to know the dimension of the problems, and after that we make the design of the intervention (taking in account the enterprises’ strategic structures and their availability to attain the purposes of the programme). The intervention usually includes three stages: the control of the offering of alcoholic drinks, the information / education, and the promotion of healthier alternatives.

Those purposes obligate the existence of explicit rules that stipulate whether the worker can drink or can not drink during the working period, the development of the information actions addressed to all the workers and concerning the damages provoked by immoderate drinking of alcohol, which are usually organised and presented by workers’ groups previously trained, and finally the production of posters and the distribution of diverse informative material.

Taking in consideration the indications of WHO, specially addressed to the Multi-City Action Plan on Alcohol it is important to know that:

- The actions and the community programmes constitute an important measure to promote healthy life styles;
- Schools and working places offer opportunities to promote healthy behaviours and to strain the attitudes that rely on the moderate use of alcoholic drinks;
- The Health Care System has an important role in the detection and in the prevention of the prejudices related with alcohol consumption, specially at the level of health primary cares.

For that it is our concern to define (beyond the ones that we already have) several indicators, that will allow not only a better ”diagnosis” of the situation, as well as the future evaluation of the e preventive programmes.
To make this possible it’s necessary to get the following data (as reliable as possible):

- Number of liver cirrhosis at the municipality of Oporto
- Number of cases of liver chronic disease
- Number of cases of alcoholic psychosis
- Number of cases of violent deaths attributed to alcohol
- Number of cases of legal and illegal alcoholemies registered at the non fatale cases
- Collection of the traffic accident registers linked to alcohol consumption
- Register of the hospital admissions dues to alcohol.

At the same time we have scheduled preventive actions in the following domains:

**Education:** through educational actions addressed to the students but specially to the teachers, whose training in alcohology is a major purpose of ours; development of specific actions dedicated to young people under professional education.

**Primary Health Care:** Through the systematic training of general clinicians, and training sessions dedicated to health professionals, specially the ones working with children, youngsters, and women.

**Working place:** through the enterprises’ effort’s conjugation, specially the ones that were involved in previous programmes, in order to establish a reflection group at communitary level about alcohol problems at the enterprises. Within this process it is our desire to include the trade-unions.

**Alcohol and driving:** we are preparing a proposal to the main enterprises’ producers and distributors of gasoline, with the aim of elaborate an alcohol and campaign in the media.

**Mass Media Involvement:** this involvement implies a better knowledge from the media professionals, not only about the consequences of alcohol problems, but also in what concerns their role in the prevention.

**Conclusions**

Strengthening the relationship between both organisations it became possible a structured intervention aiming to optimise the available resources. The sensitisation of the several participants through the training of quite diverse professional that are working in the field, specially with risk groups made possible the identification of alcohol related problems and the design of adequate answers. At the same time it provided us the conditions for an integrated research that begins with the epidemiological essential data’s collection, which is a specially difficult issue.

It is also important to remark that a wider impact of this action is quite limited by the existing centralisation of the Health and Education issues by the global policy.
A Wednesday morning in Greve witnessed presentation and discussion of three papers. Two of them "Kia Mau te Wehi" by Sally Casswell and "Kia Mau te Mana" by Helen Moewaka Barnes & Paul Stanley presented experiences from an alcohol action project carried out in Maori communities in New Zealand; a third one by Jose Barrias dealt with action research on alcohol implemented in northern Portugal.

In spite of cultural specificity of both settings, or perhaps thanks to it, all papers highlighted dilemmas, conflicts and contradictions which have to be faced in any community action projects, although with a different intensity. As phrased by Sally Casswell: "Many tensions inherent in this project were probably similar to those found in most evaluated community action projects and were simply highlighted... by the cultural differences between the Pekeha researchers and the Maori community" (page 7) or as noted by Geoffrey Hunt this ... is not solely about doing research on the Maori people in New Zealand, it also raises key issues for conducting research and evaluation both in general (italic mine) and more specifically for evaluating prevention programs geared to minority people”.

As it came out from presentations, comments and discussions community action projects must not be reduced to technical or research level. They constitute a political process. Community action requires legitimacy which can be increased by support from international organizations or from academic institutions of recognized reputation. However, the relationship between researchers and the community reflects in fact the power structure within this process. Information which is collected in a community is very likely to become an instrument of exercising power ("Maori know well the pakhea cliche of knowledge is power") (page 9).

Interventions, especially in traditional communities may be perceived as a manifestation of cultural superiority of modern public health values over culture of the community. Contradictory values are very likely to lead to conflicts of interests between researchers and the community. The list of potential conflicts covers a variety of questions. The main one is what should have priority - interests of the community or interests of research. In other words should a major portion of resources be allocated to meet the needs of the community or to supply expansion of the research side of the community project. The next interrelated question regards the major aim of the project - whether the project should serve the interests of the community in point or ought to be oriented towards more general public good, namely towards a collection of information and experiences which later on could be scientifically analysed and applied perhaps more successfully in other communities. If a latter approach dominates, community becomes in a way an experimental rabbit which is hardly to be accepted by its members.

Overtly expressed interests of science or of the others may mask (and often do) vested interests of researchers who, in addition to a direct income, tend to possess the project to utilize it in their own professional careers. A very real question of ownership of information and findings of the
project seems to be of crucial importance in solving problems inherent in evaluated community projects. Feedback from research appears to be the major gain for the community both in terms of formation of the project and in terms of better insight of the community. Confrontation of research reports with the community has also fundamental significance for research, reducing a risk of biased interpretations and of possible misunderstandings.

A community, however, does not constitute a homogenous entity. Even in relatively egalitarian cultures distinct differences may exist and some people may have better access to benefits and information of the project while others be deprived of this. That is why, as suggested by Geoffrey Hunt in his comments: “supplying feedback should be done to all sectors of the society”. Adoption of this approach may reduce tensions among different groups in the community as well as offer valuable input to research aims of the project.

In addition to more general reflections, papers presented in this session raised a question of more specific nature of potential damage or harm which can be induced by preventive projects aimed at cultural and perhaps also to economic minorities.

As noted by Helen Moewaka Barnes & Paul Stanley ”Powerful interest groups have much to benefit from Maori people either blamed or blaming themselves...” 11 (page 2). Community action projects are very likely to reinforce stigmatization and further marginalization of traditional communities or cultures by increasing concern in society of harmful effects of their drinking habits. Blame put down perpetuates the power structure of society and gives it moral as well as scientific legitimacy.

Finally, a researcher should be aware that preventive programs on alcohol may shift attention from other more important problems of the community and overshadow claims concerning e.g. health, poverty or education. Perhaps, in an unintentional way, alcohol projects can stay in sharp conflict with fundamental interests of the community.

All these political and ethical issues have strong methodological implications. Important shifts take place in community action projects - from research oriented towards change oriented, from positivist evaluation to post-positivist, naturalistic evaluation with focus on its formative role, and finally from social planning and community development towards direct community action. Paternalistic relationship between external researcher and community are slowly being replaced by more partnership. Often, as seen in projects from Portugal and New Zealand, members of the community acquire a role as researchers of their own people. This in turn has further impact on the project. Research instruments become less imperialistic in terms of culture and interpretation of findings is more culturally sensitive, at the expense however, of scientific values of ”objectivity” and ”impartiality”. Interviews conducted by a researcher from the community may be more pleasant and the interviewer better received by the interviewee. On the other hand, external interviewers offer feelings of anonymity which can increase frankness and reliability of responses.

Methodology can be a source of yet another conflict of interests between research and action. As demonstrated by many action research projects, comprehensive community actions prove to be more efficient in meeting a variety of needs of a community than actions limited to single interventions. On the other hand outcome evaluation is a lot more difficult, if possible at all, in projects covering various aspects of life in a community. As phrased by Eric Ivarsen in his
comments to the Portuguese paper: "Sustained efforts, on different arenas, towards different objectives, and in different modalities gives a better chance of success, but this is also a lot more difficult to evaluate in a meaningful way."

Considering the amount of tensions, contradictions and conflicts that are inherent in any action research and which were only highlighted by three papers discussed today it can be conflicts reflected that community action research make us aware of a fundamental repositioning of science in the society from a positivist, apparently neutral position to a new conflict-prone interaction of life and science which can be as much creative as destructive.
FOURTH SECTION

Ethnographic evaluation and cultural analysis: The case of the community partnership program

Geoffrey P. Hunt

Introduction

In spite of ethnography’s long history as a major research approach within the social sciences, only relatively recently has it begun to receive attention in disciplines outside anthropology and sociology. This recent attention is apparent within the field of alcohol and drug research. Ethnography is now considered an important additional approach to understanding the culture of drug use and abuse. One possible reason for this has been the apparent failure of more standard survey research methods to collect information on what has been described as "hard to reach populations" for example, drug dealers and IV drug users.

As an anthropologist, I am indeed pleased to see this interest, which will hopefully lead to a more serious consideration of anthropological issues in the alcohol and drug fields. Unfortunately, as occurs in many cases where a perspective becomes the "flavour of the month", what passes for ethnography or for that matter qualitative research, may have little to do with what anthropologists would consider to be ethnography. In fact, I would argue that ethnography has been adopted with little or no understanding of what is involved either in terms of ethnographic fieldwork methods or the ethnographic imagination.

Given the absence of ethnographic work in much of the alcohol and drug literature, it is not that surprising that ethnography should be largely absent from evaluation studies of substance abuse programs. However, when we consider the recent development of community prevention programs, it is surprising that ethnographic evaluation has been overlooked. Given the defining focus on encouraging and developing social change at the local community level, one might have expect that evaluators would have turned their attention to the dominant method used by anthropologists and sociologists in conducting community research. In order to begin to remedy such an oversight, this paper explores the potential role of ethnography in assessing community prevention programs. Much of the discussion is based on my experiences as an evaluator in assessing the impact of two prevention programs in northern California.

What is ethnography?

For the purposes of this paper I shall deal almost exclusively with ethnography as developed within anthropology. I do this for two reasons. First, Malinowski, a British Social Anthropologist, is considered by many to be the founder of ethnographic research especially for fieldwork conducted in alien or "exotic" cultures. Second, anthropology, especially in the US, since the 1960's, has been
involved in reassessing both its subject area and its research methods. Consequently, a copious literature now exists which examines ethnography as theory, method, and written text.¹

With this in mind, let me begin by defining ethnography. This may appear, at first glance, to be a straightforward task, and yet, as is to be expected, the field is littered with different definitions which emphasize different aspects of the ethnographic process. However given these difficulties in defining ethnography, most ethnographers, especially in the U.S., agree on the importance of ethnography as a way of attempting to understand other cultures. This cultural component separates ethnography from other research styles and also emphasizes the point that it is not merely a set of research methods, but instead a way of conducting research whose purpose "...is to describe and interpret cultural behavior". (Wolcott 1987, 43) Ethnography uses a series of methods to reconstruct the culture of the group by uncovering and delineating patterns of meaning which shape and give expression to social forms. This reconstruction has to be a comprehensive account, rich in detail and providing a "thick description" (Geertz 1973) which situates the cultural behavior within its own context. In other words, in addition to reconstructing culture, the ethnographer attempts to situate this culture within a particular social situation thereby producing a holistic account. This task of examining culture within a larger social context is a distinguishing characteristic of ethnography and can be retraced, in part, to Durkheim’s approach of seeing the society as a whole greater than the sum of its parts. In this way, the ethnographer "...attempts to treat the group’s life as a whole - not to isolate some artificially abstracted aspect.” (Peacock 1986, 19)

In reconstructing a culture, the ethnographer must interact personally and extensively with the group under study. Unlike other research styles, where the researcher remains aloof or detached, the ethnographer "...distills his ethnography from his own experience” (Peacock 1986, 67) interacting with his or her subjects. In fact, as some have noted, the ethnographer is the research instrument (Wolcott, 1987). In addition, to recording all that he or she observes, the ethnographer must record his or her own reactions to the group. These initial perceptions may form the basis for preliminary analytic categories and constructs. (LeCompte and Goetz 1984, 44)

What methods are used to reconstruct a culture? Ethnographers use extended participant observation. This technique was given its first and most elaborate development by Malinowski when he conducted fieldwork among the Trobriand Islanders.² By the 1920's, anthropologists had begun to realize the importance of gathering information first hand, rather than depending, as before, on information from laymen, missionaries or colonial administrators. Once in the field, the ethnographer begins the task of observing all the activities and conversations that take place. This observation and recording enables the researcher to collect what Malinowski called the "imponderabilia of actual life and typical behavior” (Malinowski 1922, 18), and "...provides information unlikely to be given in direct answer to a question.” (Sanjek 1990, 212) This practice,

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¹ See Hammersley and Atkinson 1983; Marcus and Fischer 1986; Clifford and Marcus 1986; and more recently Hastrup 1992.

² Mallinowski did not invent participant observation nor was he the first anthropologist to use this method, what he did do was to use this method to generate specific anthropological data. See for example ellen (1984).
which became known as "speech in action", (Richards 1939) emphasized the importance of not just recording what was said but also what was done. By doing this, the researcher can discover the extent to which the participants are doing what they say they are doing.

The extent to which an ethnographer should participate or should observe varies and is largely dependant on the individual ethnographer. Moreover, the extent to which an individual ethnographer uses observation as opposed to participation will also depend on the extent to which he or she feels that culture is contained more in action than words or more in what is said than what is done. (Wolcott 1987) However, it should be noted that the purpose of participating is not only to allow the researcher to observe the behaviour of others, but also to facilitate the use of ”...all other possible research techniques.” (Ellen 1984, 23) By participating, it is hoped that the researcher will become increasingly accepted by the group, thereby allowing the ethnographer to collect information normally hidden from outsiders.

Given the fact that ethnographers spend a considerable amount of time watching, listening, and participating, how is this data to be collected? Although some ethnographers use recording devices, the traditional mainstay is the use of field notes. Unfortunately, in spite of its centrality, it is not exactly clear what ethnographers do when they take field notes. The particular information recorded is as likely to be inspired by intuition as by plan or design. Unlike other professions in which the apprentices are trained to do A followed by B followed by C, trainee anthropologists are generally told little or nothing about how to record social situations. In a recent survey of anthropologists, (Sanjek 1990) the vast majority of them said that they had received no formal instruction in field note taking and basically learnt as they went along. As Nels Anderson once remarked: "the single instruction I ever received was: Write down what you hear and see, you know like a newspaper reporter”. (quoted in Kirk and Miller 1986, 40)

To a large extent, what one does when taking field notes depends on the research setting, the research problem and the interests of the researcher. Ethnographic note-taking is a selection of information within a particular social situation which is governed by the individual researcher. As noted above, the ethnographer should be a finely tuned and sensitive research instrument constantly adapting to the particular social situation. Field notes are thus both a reflection and an extension of the researcher and his or her interests.

Evaluating the community prevention programs: the role of cultural analysis

The most significant development in alcohol and drug prevention research had been the gradual acceptance of what came to be known as the public health, community prevention model or the environmental risk-reduction approach. This model saw primary prevention not as an individual issue but instead as a social and environmental issue. The model proposed a more holistic approach which encompassed three components - the individual, the environment and the substance or agent.3 In confirming this shift from the individual to the community, prevention research began to examine the possibility of doing community wide prevention. The development

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3 See Wallack and Corbett 1987.
of community based prevention to combat cardiovascular disease prevention especially in Finland⁴ and the U.S.⁵ had stimulated researchers in the alcohol and drug area to investigate its effectiveness.

However, it took a number of years for this alternative and more comprehensive way of looking at prevention to infiltrate mainstream prevention thinking (Cahalan 1991). Much of the prevention thinking was still centered around the idea of school-based prevention and specifically around prevention curricula. Gradually, an expanding evaluation literature began to be published which cast serious doubts on the efficacy of school based prevention.⁶ Consequently, researchers within the prevention field began to accept the limitations of school-based prevention and emphasize the importance of community-wide prevention.

According to Benard, this new prevention model had to have the following components: First, it was important that community-wide prevention be comprehensive; "that is it targets multiple systems (families, schools, workplaces, media, governmental institutions and community organizations) and uses multiple strategies.” (Benard 1990, 126) The proposed strategies include providing information, developing life skills, creating alternatives and training community leaders. Second, the prevention program should be collaborative and bring together representatives from all the different social systems and sectors of the community. By bringing together these individuals, prevention experts believed that the community would ensure that there were sufficient resources for the program and that "community ownership” had occurred.

Evaluation has been divided into two separate but overlapping tasks - process evaluation which documents the project’s day to day activities and impact evaluation which provides an ”objective and reliable judgement of the effect of the program.” (Goldberg 1984, 157) In assessing the efficacy of community prevention programs, ethnography can play a crucial role in both process and impact evaluation. In process evaluation, by using participant observation methods, it can produce not only a detailed chronicle of the activities of the project, but also important insights into the thinking of the key participants. Within impact evaluation, it can examine the extent to which the program’s goal of community-wide social and normative change is achieved and its ability to encourage community residents to rethink their views about alcohol and drug use. The extent to which community prevention programs are successful cannot be understood solely by examining such features as community based indicators on substance abuse problems, (in fact some may argue that it cannot be understood at all by such methods) but instead, must be accomplished by the painstaking task of day to day observational work. Only then can we know the extent to which the prevention culture has been adopted by the community, in whatever way this is defined. Moreover, by utilizing a holistic approach, ethnographic evaluation can assess the impact of the program within a broader social and cultural context. For example, an important and necessary task of evaluating the substance abuse prevention program is to place it within a wider context of societal changes in attitudes, norms and behaviours, and social reactions to substance

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⁴ See Salonen et al. 1986.
⁵ See Balckburn et al. 1984.
⁶ For a fuller discussion see Tobler 1986; and Kerst and Springer 1991.
use and problems. Only then can we accurately assess the local impact of this particular prevention program.

Reconstructing the culture of prevention.

The focus of ethnographic evaluation is primarily on the issue of culture within an overall perspective which argues that everything is cultural. Such a position carries with it two possible implications. First, there is no "hot line to some reality external to cultural perception" (McDonald 1994, 12). In other words, the notion of a social problem, in this case drug and alcohol abuse and suggested solutions, are culturally and socially constructed. This is not to imply that drug and alcohol problems do not exist, but instead to assert that the way that the problems and their solutions are conceptualized is determined by social and cultural factors. As Heath has noted "...problems are in no way inherent in an inert substance but emerge in an interaction between it, the user, and the context” (1992, 278). Second, the fact that drug and alcohol problems are socially and culturally constructed means that notions of what constitutes a problem will vary across time and space. Consequently, an examination of contemporary ideas about drug and alcohol problems can be used as a window through which we can explore, or illuminate contemporary culture. As a result of this perspective, the focus of work is less on whether or not the program has been a success, judged by some notion of an objective assessment, and more on examining different individuals’ perceptions, whether at the federal or local level, of the problems and their solutions.

This shift of focus leads inevitably to examining the culture of the program, the culture of its practices, and the culture of prevention. More specifically, the underlying structures, meanings and rituals of the meetings, the activities proposed, and the vocabularies used are examined. In exploring these elements from a cultural perspective, the aim is not to diminish their importance, but to highlight the taken-for-granted assumptions that lay beneath the surface. In "anthropologizing" the culture, and examining the "cultural other" within what could be described as mainstream society, the aim is to point out that the unusual is not only located in the cultural practices of the other but is within our own cultural practices. As Marcus and Fischer (1986) have noted, while anthropology has fulfilled its role of salvaging distinct cultural forms of life from the process of global Westernization, it has been less successful in serving as a cultural critique of our own practices. It is this latter feature which is the basis of the crucial uniqueness of ethnography and ethnographic evaluation, and it is from this perspective that I would suggest that evaluators, especially in the alcohol and drug fields, have too often forgotten a key element of their social science training which is to be "critical”, not in the sense of criticizing but in the sense of asking critical questions. Instead of questioning the basic ideas of, for example prevention programs, evaluators have been quick to celebrate the ideas. In fact so much so that evaluators have often embraced the accepted notions of the problem and then reproduced these notions within their research and evaluation findings.

In order to illustrate the use of such an ethnographic evaluation approach, let me now examine the Community Partnership program. In assessing this prevention program it is possible to identify two separate but inter-connected levels of analysis, which can be conveniently described as the macro and the micro. At the macro level a cultural analysis of the program will involve an examination of the ideological premise of the program and at the micro level will entail an investigation of the
program’s day to day activities.

The community partnership program: the partnership’s intellectual roots.

In 1990, the Office for Substance Abuse Prevention (OSAP) began funding a series of community prevention projects. The projects, known as the Community Partnership Program (hereinafter known as the Partnership), eventually totalled 251 nationwide. Broadly defined, the purpose of this grant was to encourage the formation, development, and, thereafter, the on-going existence and vitality of grass-roots, community-level organizations and initiatives aimed at preventing alcohol and other drug-related (AOD) problems within local communities.

The overall program was described as a new and radical departure in the field of alcohol and drug prevention - a program that was based on the latest developments in prevention research. CSAP itself defined the program as a “paradigm shift” from a model based on an outdated service delivery approach to that of a “community empowerment” model. By proclaiming the start of a new way of thinking, CSAP set up the expectation that significant steps forward were about to take place in confronting alcohol and drug abuse. In one way, CSAP’s claim to newness was correct - the Community Partnership Program was the first large scale federally funded demonstration program in drug and alcohol prevention planning. Furthermore, many of the ideas contained in the Partnership program were clearly taken from recent developments in prevention research. In developing a new community wide prevention program, CSAP has clearly followed the current research literature and recent developments on effective alcohol and drug prevention. This literature had encouraged a comprehensive approach to prevention, that focused on the key groups and organizations in the community. The basic premise of the Partnership program was that meaningful, long-term reductions in alcohol and other drug (AOD) problems will be won only when the concerns, energies, and commitments of local communities are focused on this problem territory. Partnership’s supporting funds were to be used for a variety of prevention-related ends and a wide array of possible community activities were described in CSAP’s application package, which represented their commitment not to fund and support prevention activity by means of CSAP’s own resources but instead to expand, strengthen, and otherwise invigorate the community’s prevention-related infrastructure. Such expansion and invigoration, CSAP hoped would provide, in turn, a multiplying effect on the community’s subsequent ability to prevent AOD problems.

But this, in fact, is only one side of the coin, for there was much within the program that was neither new nor for that matter based strictly on social science research. In fact, as I hope to illustrate, the Community Partnership project contains a veritable potpourri of ideas - some of which come from the alcohol and drug prevention field, some have their historical and intellectual roots in the late 1950’s, early 1960’s, and 1970’s, some have been taken from popular conceptions of the family and society, some from writings on management and organizational techniques and some have even been culled from liberation theories of the third world. Many of these ideas have intellectual pedigrees which would seem to be in opposition with each other and yet some how

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7 The name of the agency was subsequently altered to the Center for Substance Abuse prevention (CSAP).
Community and Community Lost

The most basic idea in the partnership project, in addition to that of prevention theory, is contained in the title: "Community Partnership". This is important because it reflects both CSAP’s interest in the idea of community - references to community are riddled through CSAP’s literature including "community empowerment", "community systems", "community prevention", "cultural diversity of the community", "community assessment", "community building", and "community awareness" - as well as at the same time portraying a particular image. It is instructive that CSAP chose to use the word community and not, for example, society which could have been used to refer to the same issues. However, using the word society would not have conjured up the same images.

As many writers have noted the word community has two important characteristics. First it is symbolically rich and evocative and second it lacks any negative connotations. According to Cohen the term receives much of its symbolic power "from a profound sense of nostalgia". (1985, 117) As a result of this symbolism, the use of the word ceases to be merely classificatory, describing how life is led in particular geographical areas and instead becomes a moral quest, suggesting how life should be led. This is what Nisbet called the "Quest for Community", a quest which sprang from the "need for a clear sense of cultural purpose, membership status and continuity." (Nisbet 1990, vii) Community is therefore the opposite of individualism - communality the opposite of separateness.

The quest for community is a call to a mythical time - a lost world and a lost order - when people lived in self-regulating communities, where central government was absent, where everyone knew and helped each other, where everyone knew their place, where crime and delinquency hardly ever took place and stability reigned supreme. The theme of community lost has a long theoretical pedigree and many of our ideas today can be traced back to the 19th century when the concept became mobilized, especially in the early sociological writings which sought to explain social change. During this period, Toennies and Durkheim were the two most important writers to attempt to conceptualize the impact of industrialization and urbanization on society. Following on from these early attempts to theorize the effects of rapid social change on social relations, later

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8 An example of this nostalgic pull can be clearly seen in the recent discussions of the family in which we are berated about the "collapse of the family" and urged even by our presidential candidates to reaffirm "traditional family values." And yet as Stephanie Coontz (1992) notes in her book "The Way We Never Were" these calls to a by-gone era are not in fact based on too much reality but are instead based on an idealized memory of times passed, probably located somewhere in the 1950's. As Coontz pointedly remarks "Contrary to popular belief, Leave it to Beaver was not a documentary", nor was Ossie and Harriet the way people actually lived. However this is not to suggest that people’s anxieties about the family today are delusions, but calls for a return to a "golden era" which in fact never existed is not constructive in our attempt to address the current problems in our society.
writers have further developed the idea that increasing urbanization, industrialization and specialization leads to an inevitable loss of community.9

Today, contemporary life and especially the urban environment is portrayed as the antithesis of communal and cohesive life. In fact modern life is seen as the absence of community and because of its absence social disorganization and social dislocation thrive. Urban life is seen as encouraging within its boundaries social problems - poverty, crime and unemployment, its buildings are dilapidated, its services overstretched and its residents alienated, deprived and frightened. In sharp contrast to these images of the city, the suburb represents a haven, a place where well kept houses, well controlled schools, personal safety and a sense of civic pride exist, in fact a place where community must exist. And yet in recent newspaper accounts, it would appear that all is not well even in the suburbs. In this haven of peace, far away from the urban problems, children are still raised in ”dysfunctional families”, families still disintegrate, parents still get divorced, and substance abuse still occurs. It is therefore not surprising given the angst created by all these problems that the search for a lost community still thrives.

But how are these developments to take place? According to CSAP this must be done through a process of ”community building” and empowerment. Contained in the notion of community building is the idea that community is absent and must be re-created. Following on from this premise it is clear that something has to be installed if prevention is to be successful.

**Community Building**

According to CSAP, ”Community building” refers to the Partnership’s endeavors (1) to broaden the base of agency and citizen involvement and action in this problem territory and norm- changing enterprise, (2) to choreograph and coordinate that broadening so that the resulting diversity of membership, thought, and action does not, in turn, bring divisive or even self-defeating results in its wake, and (3) to leave behind a self-sufficient infrastructure for on-going community initiatives in respect to AOD problems after the CSAP support has left the scene. In order to begin to build community, the first task is to begin community organizing.

The ideas contained within the Partnership on community organizing incorporate two different strands of thought - that of community development and that of social action. Community Development or locality development emphasizes a process whereby a wide spectrum of people at the local level come together to achieve a particular goal (Wellman and Leighton 1988). Within this approach, the local community is seen as overshadowed by the larger society and by urbanization and industrialization ”the process of urbanization have almost destroyed ”man’s feeling of belonging to a community.” (Rothman and Tropman 1987, 9) To correct this situation, the community development approach advocates the importance of people getting together to talk about their needs and set about solving their problems. The process by which these themes are to be developed is that of consensus through small group discussion and fostering communication

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9 For example, much of the work done by the Chicago School sought to understand the ”urban way of life” in which there has occurred ”the substitution of indirect secondary ofr direct face to face primary relations” (Wellman and Leighton 60, 1988).
and collaboration. This process of consensus also includes members of the power structure who are seen as collaborators in a common effort.

In contrast to this perspective, within the social action approach, as exemplified in the writings of Saul Alinsky, the community is conceived of as a hierarchy of power and privilege. It presupposes a disadvantaged segment of the population which is exploited by the power structure. The power structure, therefore, far from being incorporated in the process is seen as a key target and the aim is to organize and overthrow the oppressor. The process advocated conflict and confrontational tactics.

The Community Partnership philosophy incorporates both these models. For example in using the term Partnership in the title, the consensus view found in the social development approach is emphasized. In fact, one of the training sessions offered by CSAP is centred on ”consensus decision making skills” which prescribes a highly regularized mode of operation whereby areas of dispute are subjected to increasingly detailed attention and examination, leading eventually to resolution. CSAP wishes to encourage not only a collegial and joining together quality but also equality relationships between local community participants, whether they be senior bureaucrats within local government, law enforcement officers, representatives of non-profit agencies or volunteer citizens. However, at the same time, a rhetoric was adopted which has overtones of a much more strident position. Terms such as grassroots and empowerment have their philosophical origins in the social action approach of Saul Alinsky (1972) and liberation theories of the Third World.

**Federally Inspired Community Change.**

A key element within the Partnership philosophy is the belief that federal resources can be used to stimulate or encourage community in order to solve the problem of substance abuse. As noted above, one of the key factors to be identified in the decline of community has been the increased involvement of government in people’s daily lives. And yet in spite of this belief, here we find a situation where a federal government grant is meant to develop community. In order to do this it is necessary for a group of local participants with the assistance of federal funding to overturn and halt a whole range of social forces - many of which have continued since the start of industrial revolution and some have even been occurring for much longer. And yet in spite of these obstacles, these individuals are meant to re-create a sense of community. This approach suggests, as Lewis has noted in another context, a definition of human nature in which our communal nature is in some ways seen as independent of social and cultural forces. (1988, 136)

What is never made clear in this clarion call for a return to community bonding is whether people really wish to return to a social structure which could be described as deeply communal. As noted above, the nostalgic quality of community fails to specify the exact nature of the community that one yearns to return to. People who live in what are known as tight knit communities frequently complain about the oppressive nature of this type of society, the rigidity of the system, the lack of opportunity, the control by tradition and the refusal to allow any questioning of the status quo. In fact, many socialized in a modern urban or suburban society want social attachment but do not want social imprisonment. Therefore it may be that what is implied in this call for a renewal of community, is merely a way of feeding ”our desire for attachment” (Lewis 1988, 138), without
providing us a "blueprint for how we might go about changing the structure of society or the institutions which, by definition are seen to "breed our individualism.” (Ibid)

The Transmission of a Partnership Culture: The Program’s Day to Day Activities.

According to CSAP’s training manuals, prevention was a "proactive process which empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviours and lifestyles". The purpose of the Partnership program involves an attempt, not merely to discourage people from abusing alcohol and drugs, but to create a new way of thinking which would allow people to handle contemporary problems and maintain a more healthy way of living.

Examination of these views and their effect is important in assessing the impact of the program. For example, an important indicator of success is the extent to which the Partnership program is able to encourage the participants within the various projects to accept this model of prevention. In spite of prevention’s long history in the alcohol field, only recently has prevention gained a foothold in the substance abuse arena. Funding treatment programs has dominated available budgets; only with the development of CSAP has prevention become an important player. Thus, an important part of CSAP’s role and of the Partnership program has been to educate people on prevention. By examining, through cultural analysis, CSAP’s ability to encourage people to accept the prevention model through the use of a cultural analysis, we can assess its ultimate impact.

The Transmission of a Partnership Culture

Because of its commitment to a locally inspired project, CSAP chose not to impose a step by step regimen on grant recipients or leadership. To ensure some sort of oversight capacity over emergent projects, a national training program was devised. The program sought to transmit a common perspective on the prevention of AOD problems, a common conception of process, a common view of action, a common world view and a common language. The development and incorporation of the latter - a new and common language - was important if the possessors of the new prevention model were to be distinguished from other players in the field. Although much of the vocabulary was taken from other unrelated arenas, the terms were given a new life and identity within CSAP’s prevention community. For example, paradigm shift, a concept taken from the realm of scientific discourse, became a key term within the Partnership literature and was used to identify a new way of thinking about prevention. The concept came to represent CSAP’s new and radical way in thinking about prevention. Empowerment, adapted from the political arenas of the Third World and struggles around race, became de-politicized and neutralized. No longer was it associated with struggles of the disenfranchised or attempts to create social change, but instead became encased in notions of individual change.

Individual change versus social change
Earlier attempts at eradicating social problems, for example the War on Poverty, focused on the importance of structural inequalities, today the focus in the War on Drugs has shifted from concentrating on structure to concentrating on the individual. Whereas the War on Poverty architects pinpointed the importance of unemployment and inadequate housing, the prevention experts today look to the individual and normative change as the key elements. Instead of social change arising from attempts to alter the basic structure of the society and its inherent unequal distribution of goods, social change now becomes equated with individual change. Even the literature on community prevention remains instead firmly focused on the individual. The community is analyzed as though it were merely the individual writ large. This approach and ways of viewing the community is not merely reflected within the prevention literature, but also within CSAP’s training sessions.

One by-product of CSAP’s community-based orientation in the Community Partnership program is the unusually flexible, open-ended, and locally-controlled character of the grant’s provisions. (Obviously, one could not attempt to field a federal program intended to stimulate local interest, creativity, and responsibility regarding AOD problems and at the same time design one that imposed a step-by-step, item-by-item regimen on the program’s grant recipients!) Indeed, only the broadest features of recipient’s obligation to CSAP are described in the Partnership program’s grant award. These include (1) that the activity the grantee undertakes is oriented toward prevention (rather than treatment or law enforcement approaches), (2) that the activity is community-based, and (3) that the activity is accompanied by a thorough and independent program evaluation.

Nevertheless, in order to maintain some sort of directive capacity over the emergent project CSAP developed a training program and through the trainings began to develop a Partnership culture. "Culture", here, is intended to convey the notion of a common perspective on AOD problem prevention, a common conception of process, a common vocabulary, a common view of action and a common world view. In building this new culture of prevention a major task was to create, within each program, a new community. To do this the Partnership program developed a nationwide training program whose major goal was to “build community”, to develop the participants community-building skills, and strengthen the communitarian and egalitarian sensibility of Partnership participants.

Within these sessions, the role of the individual was strikingly emphasized. For example, in one training on "Community Organization and Community Change", the trainers emphasized the idea that to change society, one first had to change oneself. In an effort to encourage this view, participants were asked to repeat such slogans as "it will be different, because I will be different". Participants were further instructed that "community organizing” was not really about strategies and it was not even about analysing, it was about people. They were told that they "should start thinking family” because "we were all one, there was no longer us and them". Consequently social change, was no longer structural change it was instead "establishing relationships with people”. Within this framework, it is therefore not surprising that "hugging” has become such a crucial element.

This view which sees social change resulting from a 'change of heart’, is not specific only to the partnership but can be traced to more general themes within US culture. For example Skolnick
argues these ideas result from a strong sense of religiosity which "promises that we can solve our problems through changes of heart rather than through the difficult and divisive route of political and social change". (1991, 203) Other writers have noted the importance of this view within the recovery movement. For example Kaminer in her particularly caustic and insightful analysis shows how the movement sees the process of reforming ourselves and our families as the way to reforming society. According to Kaminer, this view is the "movement's party line" - a point neatily captured in the quote from Bradshaw, one of the gurus of the codependency and recovery movement, who suggests that "recovery will save us as a society....you have only to recover and the world recovers with you". (Kaminer 1992, 94)

Ironically however, these training sessions while increasing a sense of shared experience, belonging, and togetherness also had the opposite effect of creating diversity and conflict. For those who went to the trainings a sense of camaraderie and bonding developed and they began to define themselves as part of a new community whose purpose was to transmit this community to others. They exhibited not only a new spirit and a new purpose but also a new feeling of togetherness. As one informant noted coming to the meetings was like going to church or going to a support group "because you know that everyone there is there for each other and that we all share the same ideas”. This new solidarity, however, also caused the trainees to see themselves as a group apart, not only because they had obtained a new way of looking at substance abuse prevention but also because they were now bonded together by their common "training experience”. According to one of the participants, the trainees were now the “chosen ones” who had gone through a "melt down”. Unfortunately, the participants who attended the trainings found themselves having to confront others who not only did not share this view, but also represented other sub-communities, with different memberships and different cultures. For example, there existed the culture of the administering agency which, in the case of the two projects where I was the evaluator, were local government agencies, which possessed clearly demarcated, hierarchical and bureaucratic structures. Within such structures, in-coming federal funding involves the responsibility of accountability for its use. This notion of accountability ran contrary to the spontaneous and egalitarian character of the Partnership program, especially as portrayed by the CSAP trainings. This created a tension between the culture of Partnership participants and the culture of local government administrators.

Because of the size and diversity of many of the targeted communities, the notion of an homogenous Partnership community as emphasized by CSAP has to be examined either as an example of bureaucratic nonsense or identified as a belief by the program architects of creating a unifying symbol. In fact in spite of clearly demarcated divisions within the Partnership community, participants within the Partnership programs would attest to their "community” membership regardless of their specific work or neighborhood affiliation. This allegiance to an often "fictitious” community reflects the potency of this particular symbol. For example, within one of the Partnerships a local County Supervisor called for the establishment of a "drug free community" by which she meant a drug free county. Forgetting for one moment the feasibility of such a goal, it was clear, by the frequency with which other participants adopted this clarion call, that the

10 For example one of the Partnerships that I was involved with targeted an entire California county encompassing approximately 800,000 people divided into five very different and contrasting administrative regions.
designation of the entire county as a single community fulfilled a symbolic role, at least for those within the Partnership, if not for others in the county.

Conclusion

We live within what Peter Berger has called "symbolic universes" (1967) and any federal government program, which attempts to promote social change by re-creating community, has to be seen both from the perspective of its formal goals as well as its more latent aims. Although the specific focus of the program is to reduce substance abuse problems, there exists an underlying focus which is reflected in the symbolism that is exhibited clearly in the language of the program. CSAP’s Community Partnership program is a major development in the substance abuse prevention field and as such it deserves an evaluation which considers its impact in the broadest of terms. Unfortunately, in many evaluation studies, there is a tendency to consider the notion of impact in a limited and narrow way. This tendency to limit the assessment to the Partnership specific goals should be avoided especially when the program’s focus is community wide. To consider the Partnership program solely in terms of substance abuse community indicators, is to ignore the extent to which the Partnership program possesses an important symbolic component.

Moreover, an evaluation which considers a community wide social program within a social and historical vacuum, cannot do justice to the program or its participants. The Partnership has to be evaluated within a holistic context which sees it as part of a contemporary societal view - a view which sees the society as experiencing some deep malaise. The Partnership program reflects some of these views and attempts to reduce substance abuse problems within the context of promoting healthy lifestyles. The notion of a healthy lifestyle is promoted as one way of re-creating a pre-existing or traditional social order, which currently appears out of control or under threat (Douglas 1966). If therefore, as evaluators, we are responsible for making pronouncements on this program success or failure, it is important that we consider both the program’s effect on substance abuse problems, and the extent to which it is able, within each of the local communities, to create a new sense of community, even if it is only for its participants.
References


The complexity of roles in community action projects: The example of the evaluation of "alternatives"

Kathryn Graham and Christine Bois

Introduction

The interdependencies of community action research

Unlike many other type of research, community action research requires more than just warm bodies who happen to have research skills. The involvement of the community involves minimally a mutual dependency between the researcher and at least one key community person. As described by Robin Room (1990) in the introduction to the monograph based on the First Symposium on Community Action Research: "Evaluated community action projects involve an inherently unstable mixture of two and usually three mismatched frames of reference and agendas: those of the community members, those of the change agent, and those of the researcher/evaluator" (p. 19). In the present study, it was three: the change agent was an ARF program developer (Bois) who worked in the communities involved in the project, the researcher an ARF Scientist (Graham) based in London, and the community members were represented on a formal community committee formed specifically to implement the project. Although there were a number of other roles on the project, including specific roles within the community, these three roles were central to the project. First, the developer facilitated entry into the community to do both the intervention and the accompanying research. The community committee was essential for at least two reasons - first the funder required the proposal to be sponsored by a community group! Second, they were the vehicle used by the developer to gain access to and support from those to whom the project was directed (in this project, local seniors). Finally, the researcher was also necessary to the project, bringing the relevant background and expertise to evaluate the project, as well as a prior relationship of trust with the developer based on collaboration on several previous projects.

The Present Project

The project was initiated by two program developers who approached the researcher with an idea for evaluating a community intervention package called "Alternatives". The goal of "Alternatives" is safer use of alcohol and depressant medications by older persons. The package includes health promotion (workshop training materials for older persons and for caregivers of older persons, pamphlets on alternatives to use of alcohol and depressant medications) and early intervention/treatment (a video on how to intervene with an older person who is experiencing alcohol and drug problems). The treatment aspects of the package had been evaluated in previous research (Graham, Saunders, Flower, Birchmore Timney, White-Campbell and Zeidman 1995) but the effects of the package as a community intervention had not been assessed.
The evaluation and research components

The project that emerged included both evaluation of the intervention and additional research components which were added to the base evaluation. The evaluation procedures had an impact on the implementation of the intervention; therefore, the evaluation is described first, before describing the intervention. The initial proposed evaluation included:

(a) workshop evaluations. This part of the evaluation involved immediate feedback following the workshops plus three-month follow-up to assess perceived effects of the workshops on participants.

(b) evaluation of the dissemination of the health promotion materials. This part of the evaluation involved a survey of older persons in the community to assess their awareness of the intervention. The survey included questions to measure the alcohol and drug use of the respondent in order to assess whether the intervention was reaching the target audience, namely, users of alcohol and depressant medications.

c) evaluation of the impact of the intervention. The impact of the intervention on use of depressant medications is being measured using data from the Ontario Drug Benefits Program which pays for all prescription drugs purchased by persons aged 65 and older. Because of the potential effects of the survey described in (b), this part of the evaluation includes the following design, comparing data from four sites: (1) the primary community receives the intervention plus the survey; (2) a nearby community receives the intervention only to serve as a control for the effects of the survey; (3) another community of comparable size where no similar intervention had taken place will serve as a no-intervention control community; and (4) claims for all of Ontario will serve as additional comparison data.

As part of the initial proposal, the following research components were added:

(a) inclusion of a complete drug review as part of the survey in order to ensure that depressant drug use was measured accurately. Typical survey approaches measure depressant medication use by asking the respondent whether they have consumed tranquillizers, sleeping pills, or narcotic analgesics (such as morphine or Tylenol 2!) (Graham and Vidail-Zabellos 1995). However, there is considerable evidence that older persons (as well as people of other ages) often do not know the kind of drug they are taking (Johnson and Volimer 1991; Landry et al. 1988; Rumble and Morgan 1992). Older people who are taking depressant medications without being aware of it may be particularly at risk of drug effects, drug-drug interactions, and alcohol-drug interactions, and, therefore, were an important target audience of the intervention. Accordingly, in assessing the penetration rates of the intervention, the actual use of depressant drugs by the person was important (not just the perceived use).

(b) inclusion in the survey of psychosocial, social and health measures in order to explore the correlates of use of alcohol and depressant medication by seniors. The unique situation of having highly accurate measurement of depressant drug use provided an important opportunity to study the correlates not only of alcohol use by seniors, but also of depressant medication use, as well as concurrent use of both alcohol and depressant medications. Inclusion of these measures, however, necessitated a much larger sample than would have been needed in order to measure the penetration rate of the intervention and precipitated the need to expand the project through external funding.

The evaluation affected the intervention in the following ways. First, it tended to reinforce the
intervention. The survey reminded people in a very direct way (i.e., one-to-one interviews about their alcohol and drug use) about the issues being addressed by the community intervention. Therefore, if long-term impact of the intervention alone was to be measured, the intervention had to be done in two communities, one that did not include the survey. Second, because there was no easy way to identify persons aged 65 and older living in the community (in order to survey them), identifying seniors for the research was done using a community networking process. To obtain the addresses of people aged 65 and older in the community, the project coordinator consulted with over 100 volunteer seniors who used the telephone book to identify other seniors. This procedure had two effects on the implementation of "Alternatives": (1) it provided an opportunity for a 100 persons in the target audience to become involved in the project and become more aware of the issues; (2) it provided addresses for door-to-door distribution of the pamphlets (without the need for addresses for the survey, this would probably not have been included as part of the intervention).

**The intervention**

The intervention began with visits by the program developer to key staff of agencies who worked with seniors, such as the District Health Council, the Public Health Unit, and the local hospital. These visits were intended to accomplish two goals: obtain support for the project and identify other key persons or agencies involved with seniors. Following these interviews, the developer invited representatives from relevant agencies to a planning meeting to discuss the project. These aspects of the project were done using special internal funding. Shortly after beginning this process, an opportunity for external funding presented itself, and the committee was asked to endorse a proposal for a project that was somewhat larger in scope than the one initially proposed.

At the start of the project, a project coordinator was hired by a subcommittee (including the program developer) of the local project committee. The coordinator’s first task was to send letters to all physicians and pharmacists explaining the project and requesting a meeting with them to discuss the project. While the local committee included a pharmacist, none of the physicians had agreed to be part of the committee. However, most of the physicians and all of the pharmacists agreed to meet with the coordinator and most agreed to display materials relating to the project. The coordinator also met with other independent health care providers such as chiropractors and obtained their support.

In addition to individual meetings held with health and social service workers, the coordinator conducted workshops for seniors and their caregivers using the "Alternatives" package. The first workshop involved training 15 key agency staff who then became trainers for their own agencies and conducted similar workshops with their own staff. Ultimately, nine workshops were held with caregivers in each of the two communities receiving the intervention.

The first workshops for seniors was also intended to be a "trainer of trainers" workshop. It involved members of the committee who were seniors and representatives from the Seniors Home Support organization. Although this plan of convincing seniors to conduct workshops for other seniors was not entirely successful, the workshop had some general impact since it was videotaped by the local cable station and broadcast several times.

In order to hold other workshops for the seniors, the coordinator obtained a list of community
associations attended by many seniors, for example, church groups, service clubs, social clubs, and apartment complexes containing a high proportion of seniors. The groups were contacted and offered a workshop or presentation held at a time and using a format that was convenient for them. Thus, the amount of material covered within individual workshops varied depending on the context in which the workshop was presented. Nine workshops were held with seniors in the primary community and 15 were held in the comparison community.

The committee had suggested that a poster be developed promoting the message of safer use of alcohol and medications through alternatives. Funding was sought and obtained from a seniors group of the local Legion to pay for printing of the poster. Committee members distributed posters to local grocery stores, banks, hairdressers, library, pharmacies, and doctors’ offices. Public information was also disseminated through pamphlets that were distributed to seniors’ homes in both communities by volunteers from the local home support agencies.

Several articles about the project appeared in local weekly papers. In addition, the video contained in the ”Alternatives” package (describing how to intervene with seniors who are experiencing problems related to their use of alcohol or medications) was shown frequently on the local cable channel during the three month period of the intervention.

**Community intervention versus ”Community Action”**

Previous research has made the distinction between interventions done to the community (”community-based interventions”) and interventions focused on changing community systems and structures (”community action”) (Holder et al. 1990). Technically, ”Alternatives” would appear to be the former - that is, workshops are ”done to” seniors and their caregivers, and public information materials are distributed. However, unlike a media campaign where you merely need people to turn on their TV sets, ”Alternatives” needs participants who will attend workshops in order to receive the information. This was done by developing a local committee of relevant agencies and seniors. Using this strategy, ”Alternatives” works best as community action, and, correspondingly, the developer must have the capability to modify ”Alternatives” as required for various uses determined by the community. ”Alternatives” also functions as community action in that sense that changes in the ways that professional caregivers deal with alcohol and drug use by seniors may well have systemic or structural changes. Finally, the present project actually did result in definable structural changes. Local agencies instituted ”Alternatives” training for staff and volunteers as part of their regular training. Another systemic change was that the community college serving the area began to include ”Alternatives” as part of the Health Sciences curriculum.

**The players and their roles**

In the following sections, the various roles on the project will be described, including how roles were coordinated. The three central roles will be described first: the local community developer, the community committee (including subroles), and the researcher. Then other roles in the community will be described: the project coordinator, the surveyor, volunteers, local service providers, and the media. Finally, additional roles on the ARF project team that initiated the project will be described, including: another developer who was not local, an evaluation specialist,
a pharmacological researcher, the general role of base funding provided by ARF, and the role of the external funder. Potential or actual conflicts and coordination issues associated with particular roles will be identified and highlighted by being italicized and set in indented paragraphs.

**The local community developer.** The pivotal role on the project was the local community developer. Not only did this person have to ensure that the intervention took place so that there was something to evaluate, but much of the evaluation research depended on local support. While the drug benefits data could be obtained and analysed without community involvement, the workshop evaluations and the community survey depended on community access and support in order to obtain high quality data - including a high response rate.

To accomplish this central role, the local community developer needed to have credibility - first, credibility with the researcher that she could deliver the community support to make the project happen, including the research components; second, she needed to have credibility in the community such that people would trust that the community would gain from the project rather than being used and abused by researchers. In the present project, the local developer entered the project with this credibility based on previous work in the community and with the researcher. The early stages of the project would have been more of a struggle and would probably have taken longer, if this credibility needed to be established. And as described in the following, because of the timing in applying for external funding, much of the project and the associated research might not have taken place, had the developer not entered the situation with high credibility.

**Having the key people at the table.** The local developer had worked in the community for a number of years in the addictions field. However, until the present project there had been little overlap between those involved in the addictions field and those who worked with older people. Therefore, many who were asked to the first committee meeting had not worked with the developer before. When it was observed that one of the key agencies working was seniors in the community was not represented at the table, this omission lowered the credibility of the developer (even though a representative from that agency had agreed to participate but was unable to attend the first meeting). Fortunately, the representative of one of the general health agencies who had worked extensively with the developer in other addictions contexts was able to vouch for the developer and convince the group to agree to proceed with the project.

**External deadlines preventing the community group from having the appropriate role in the initial planning of the project.** The deadline for obtaining funding was such that the proposal had to be prepared quickly (by the two developers and the researcher), and there was no time to involve community members in its preparation. At the same time, the funder required that the proposal be endorsed by a community group. The local developer had to approach the committee which had only been formed a few months earlier and, at a single hastily-convened meeting obtain their approval to proceed with the funding request. Basically, this involved asking local professionals and others to make a commitment of a substantial investment of their time, while having little say in the design of the proposed project (although they were promised control over the implementation of the project, as will be described in subsequent sections). That this agreement was obtained was largely attributable to the developers prior work in the community and preliminary work already done on the project.

**Handling complaints from the community about the research.** The survey did not cause chaos
in the community, but it did at times elicit suspicion and confusion, at least partly because of uncontrollable events that seem to plague community research! For example, just after the survey started the federal government enclosed a notice with every old age pension warning seniors to beware of people who were pretending to do a survey but were actually trying to sell them something or worse! In addition, cutbacks in the provincial government had seniors worried that some of the medications they depended on would be de-listed from the drugs benefits plan and would no longer be obtainable at no cost. Thus, in this climate and despite all the activities undertaken to promote the survey, some people telephoned the local police or the seniors support centre and one or two came to the local ARF office to complain that the survey involved invasion of privacy. Since the researcher was not on site, these complaints had to be handled by the developer or the project coordinator. Had the developer not been a partner in the research and strongly committed to it, these complaints might not have been handled so effectively. As it was, this was a fairly minor aspect of implementing the survey that did not cause major problems because they were handled well at the local level, including the developer or coordinator informing the relevant community agencies (police, seniors support centre, etc.) of the survey and obtaining their support.

The community committee. The community committee actually had a key role in the project, not merely fronting the proposal to the funder. In order to deliver this intervention, an audience was needed who would receive, ideally welcome it. The committee provided access to this audience - both among care providers and among the ultimate target (i.e. older persons who used alcohol and depressant medications). First, all relevant stakeholders were asked to join the committee, including both caregivers organizations and seniors groups. Thus, the committee provided access and expertise through its own membership. In addition, committee members also provided access through their contacts with other organizations who were not represented on the committee. For example, at various points in the project, seniors service clubs and church groups provided resources (e.g., meeting rooms, funding to print a poster) and support for the workshops and other events. Although these service clubs and church groups were not directly represented on the committee, these groups were accessed through seniors who were on the committee. The project received broad support from the community because of the committee membership and the role committee members played in supporting and promoting the project. This applied even to the research components, where the committee legitimised the survey among older persons in the community and encouraged participation. The committee also provided valuable expertise to the project, not only about local conditions but also about seniors generally. Their knowledge was important in guiding both the intervention and the research.

Conflict in the community regarding the project. An important group of stakeholders were less than fully supportive of the project - namely, the local physicians. This was a source of conflict for some of the members of the committee who had to interact with these doctors in various professional capacities. However, despite some pressure from doctors, none of the committee members withdrew support. In fact, some attempts were made to compensate. For example, a committee member who worked in a long-term care institution overheard a physician making negative remarks about the project. The committee member spoke up and confronted the physician about what he had said. She told him that she disagreed with him and informed him that this was an important project and engaged him in conversation about it for quite a while.

As alluded to in the above description, a subrole of some committee members was one of
protector. Certain people on the committee had such stature in the community, with both seniors and professionals, that their participation and commitment to the project provided a kind of "godfather/godmother" protection. Many potential crisis points have been long-forgotten by the project team because these people spoke up when needed and the crisis passed.

The groups on the committee included representation of: institutions that served seniors (e.g. hospitals, nursing homes), community-based services (e.g. visiting nurses, pharmacists), volunteer-based services (e.g. seniors support), and community seniors. All provided knowledge and access, but this varied somewhat by group. The institutions provided resources such as meeting rooms for training; the community-based services represented one of the key caregiver groups targeted by the intervention; the volunteer-based services and seniors on the committee not only represented the other main target group, but were able to mobilize volunteers to get things done on the project, as needed. While these are the groups most relevant to a project on older persons, similar groupings exist for other populations who might be the target of a community intervention. For example, a project targeting youths would probably need a committee of institutions (e.g. schools), community-based services (e.g. Children’s Aid Society), volunteer-based groups (e.g. community recreation groups) and so on. Active participants in each of these roles facilitated the project in numerous ways.

The researcher. The researcher also had a key role to play in making the project happen and could not merely sit in her ivory tower office and wait for the data to roll in. One of the major distinctions between community research and other types is that the researcher has to be available to explain and justify the research to the community in the beginning and during the project (as needed) and, in addition, must be prepared to report the results to the community in a timely way. (Given the age of some respondents in the present study, there was some urgency in reporting the results so that those who participated could hear about them!) This was the covenant entered into in this community project and presumably most community projects - namely, that the community members provide their time and resources to meet research needs and the researcher gives back to the community by reporting the findings in a form that the community can use.

Community control over research. In this project, the agreement with the community went even farther than justifying the research and explaining the results - the researcher was obliged to allow the community committee to screen both the survey and the community report. Although this process did not result in any substantive changes to the survey or the report (possibly because the local developer success in obtaining support for the research and because the researcher wrote the community report specifically to be read by non-researchers), it meant that some control of the research was given up by the researcher. In fact, the screening of the survey by the committee was seen by the researcher as more of an advantage than a loss of power, since this process provided a kind of protesting for community acceptability and applicability.

The developer defines the researcher’s role in community interactions. The control of the project that the researcher must give over to the local developer is another potential source of conflict. In the present project, the local developer controlled interactions between the researcher and the community - this was seen as particularly important since the researcher was from outside the community (people from Toronto are particularly resented, but even with the researcher being from a more 'friendly' location (London) there was still the potential for 'urban-centroism' and acting without regard for local needs and interests). An example of this
control was that the local developer actually instructed the researcher not to say too much at the first meeting with the committee! In fact, throughout the project, the local developer orchestrated all interactions between all project team members from ARF and the local community.

**Conflict over the results of the study.** The local physicians had not been strongly supportive of the project - particularly, the research component which included a survey monitoring use of prescription medications. However, because of their central role in use of prescribed medications by seniors, the local physicians were invited to pre-review the report of the survey and to meet with the project team on the morning of the release of the community report. They were very negative and defensive at the meeting and were critical both of the survey and of efforts to teach seniors alternatives to using alcohol and depressant medications.

The animosity of the physicians towards the project and the associated research was unfortunate and undoubtedly reduced the impact of the intervention. Previous research by a member of the project team (Joan Marshman) had found that many doctors feel pressured by their patients to prescribe tranquilizers and sleeping pills. The ‘Alternatives’ intervention could have been a resource to local physicians in resisting that pressure and directing their patients to safer alternatives. In addition, since the survey found that alcohol use and problems were higher in this community than in Ontario generally, the physicians could have used their ongoing health contacts with older persons to advise them of risks of heavier drinking. The physicians in this community, did not respond to requests to be on the committee and the local medical association did not acknowledge receipt of a letter inviting them to send a representative to the committee meetings. This conflict highlights the difficulties that can arise in obtaining support of key stakeholders. In the present situation, the project was strong despite their lack of support because of the broad and consistent support of all other relevant stakeholders.

**Other Community Roles**

**The project coordinator.** The project coordinator (Louise Dolinksi) was hired initially to implement the intervention and do the preparatory work for the survey (i.e., compile a list of names and addresses of all people in the community aged 65 and older). The person hired had a number of qualities that made her particularly suited for the job: she was a nurse who had worked in the community and with seniors; she was from the area and well-regarded by other professionals; she was imaginative, creative and personable. She was able to work with the local developer to maximize opportunities for implementing the intervention and obtaining media exposure for the project. She had the local connections to enlist many volunteer seniors and others in various aspects of the project, including identifying the addresses of local seniors and delivering pamphlets door-to-door. Because of her involvement in the project, knowledge of the issues, and good organizational skills, she was hired to coordinate the surveyors for the research part of the project, despite her lack of research experience or expertise. This provided a smooth transition from one phase of the project to the other. For example, she could be looking for potential surveyors while winding down aspects of the intervention. It also resulted in some conflict and communication problems.

**Combining the two roles of implementing the intervention and conducting the research.** The transition of the coordinator from the intervention to the research involved some conflict. In retrospect, this problem might have been expected. First, this particular person was hired
because her background made her well-suited for delivering the intervention. She did this extremely well and was reluctant to give it up when the focus of the project switched to doing the survey. In addition, her role as research coordinator was much more restrictive than her role had been in implementing the intervention. By the time of the survey, she was functioning mostly autonomously of the local developer. With the start of the survey, the researcher wanted to assume fairly close control over procedures.

Some problems were clearly attributable to the coordinator being hired to do one job for which she was well-trained (implementing the intervention in the community) and then being switched to a different job for which she was not as well-trained (supervising a large scale research survey). However, much could have been done to reduce the conflict of the two roles. First, it would have been better if she had had a greater role in the design of the survey instrument. This would have provided her with greater insight into the rationale for some of the survey procedures. Second, she should have had more personal training by the researcher who would ultimately supervise her. This would not only have provided her with more information regarding the survey and its procedures, it would also have helped to establish a relationship between the researcher and the coordinator that would have made communication easier (especially since the survey was being done in a community that was 500 kilometres away from where the researcher was located).

The persons who conducted the surveys. Much thought and care went into deciding the necessary attributes of the people who would conduct the survey and in choosing particular people for the role. The surveyors not only played a key role in the collection of high quality data by being able to gain entry into an older person’s home and collect fairly personal data, they were also emissaries of the project and as a by-product of that role tended to reinforce the message of the intervention (e.g. asking people questions about the pamphlet that was delivered to each senior causes the respondent to re-examine the content of the pamphlet). The inter-mingling of the intervention with the survey was partly a function of logistics, but also desirable from a research perspective. In most surveys, older people have lower response rates than younger people (Olsen and Mandel 1988; Herzog and Rogers 1988), and response rates tend to be especially low for surveys of older people about alcohol use and other sensitive topics (Campbell 1986). Previous research (Campbell 1986) has found that the more the survey was advertised and seen as a community project, the greater the participation rate. Therefore, the survey was packaged into the overall project and promoted in the community, and the credibility of the local interviewers helped to promote participation in the survey. The goal of the survey had been a full census of all persons aged 65 and older in the town and surrounding area (about 1,200 people). While this goal was not achieved, the personal and professional qualities of the surveyors were critical to conducting home interviews and collecting the necessary information - including a review of all medications. To ensure the necessary background and experience, it was decided to hire nurses to do the interviews. Some were local and some were from outside the community; all had worked with seniors before; all were women; and most were middle-aged or older. While hiring nurses had some distinct advantages, it also had some risks that the nurses would exceed the researcher role.

Clarifying the researcher-interviewer role from the nurse-interviewer role. Hiring nurses, while optimizing some aspects of the survey, raised important conflicts in terms of other aspects. First, while the nurses were trained interviewers, they were not trained research interviewers. Therefore, considerable training was done to stress the need for standardized data (e.g., not
rephrasing questions or response categories). In addition, a major focus of the training was on the difference between a community nurse going into a home and a researcher. In particular, while a nurse could offer advice and suggestions, a researcher could not. Because going into an older person’s home and asking personal questions, including questions about alcohol and medication use was likely to uncover some individuals in poor, possibly life-threatening situations, a good deal of time was spent in developing procedures for responding to these situations without overstepping the boundaries of a researcher-interviewer role. It was important to make the distinction between consenting to a research interview and consenting to an assessment by a nurse, given that the natural tendency of the interviewers would be to do what they had been trained to do (namely nursing, including health education). This seemed to be time well-spent. In the debriefing with the interviewers following completion of the survey, they reported that they did encounter situations where they felt some response might be needed and they were glad that this issue had been discussed and that they had procedures to address these situations.

**Volunteers.** Volunteers assisted in the project in various ways, as described in previous sections. They not only provided free labour, but they also helped to legitimize and publicize the project, as well as incorporating the message of the intervention into their own networks.

**Local service providers.** Local service providers such as pharmacists, physicians, chiropractors and others who had office or storefront space agreed to display “Alternatives” public information materials as well as announcements and other materials relevant to the project. When the results of the survey were printed in a community report, this report was distributed through local pharmacies. Even the physicians, many of whom were not supportive of the project, agreed to have “Alternatives” pamphlets and posters displayed in their offices. These distribution points were very important in making materials easily available to seniors and in legitimizing the materials.

**The media.** The local media were important in accomplishing several aspects of the project. The developer and project coordinator were able to obtain free coverage using various angles on the issues (and later even national coverage of the results of the survey). These stories formed part of the intervention - in that most of the stories repeated the “Alternatives” messages regarding safer use of alcohol and depressant medications. The stories also helped to obtain community support and increase participation in the workshops. The media were also used in paid advertisements to (1) inform the community that the survey was about to take place, (2) thank seniors in the community who participated in the survey (and remind those who did not participate that they still could), and (3) thank volunteers and others who had worked on the implementation of the intervention.

**Other roles on the ARF project team**

**The Program Developer from outside the community.** The ARF project team included several other members besides the local developer and the researcher and each of these members had important roles on the project. First, another community developer (Virginia Carver) was involved
in the original idea for the project. She had developed the "Alternatives" package and had a strong interest in having it evaluated in the community. She had a major role in developing the funding proposal and in helping with the implementation of the intervention, including aiding the local developer and the researcher in smoothing the transition of the project coordinator from development to research.

**The Program Evaluation Specialist.** An evaluation specialist (Cindy Smythe) had responsibility for the workshop evaluations. Her assuming this role helped to make this aspect of the evaluation less threatening.

**Separating the evaluation of the program from the evaluation of the person delivering the program.** The intent of the workshop evaluations was to obtain feedback on the 'Alternatives' package; however, in so far as the workshops were delivered or even organized by the project coordinator, they could also be seen as reflective of her work. Having someone who did not supervise the coordinator handle this aspect of the project reduced the extent that the coordinator would feel that she was personally being evaluated, as would have been likely had the researcher assumed responsibility for this aspect of the evaluation.

**The Pharmacologist-Researcher.** The project team included a pharmacologist who also had experience in community research and economic evaluation (Joan Marshman). She brought important knowledge to designing the drug assessment part of the survey, equipping the interviewers with a checklist of depressant drugs so that they knew when to ask the additional questions on the survey relating to depressant drug use, categorizing drugs for the report and for the analyses of drug benefits data, and addressing technical issues at the meeting with the physicians and at meetings with the public and the media the day the community report of the survey was released.

**The Project Research Associate.** As soon as the survey was begun, a part-time Research Associate was involved in checking all the surveys as they were returned, coding the open-ended items and generally preparing the forms for data entry. Through this process, she identified general problems in completing the survey and problems with data provided by individual surveyors which she fed back to the project coordinator who then corrected the problems. Thus, there were two levels of quality control of the data: (1) the project coordinator provided on site supervision and checked over the forms before sending them to the research associate; and (2) the research associate who was located in the same office as the researcher on the project then went through the forms very thoroughly as part of preparing them for data entry.

**Base funding from ARF.** ARF provided base funding for a smaller version of this project. Through this funding and in working towards this funding, much of the community development work (identifying key players and obtaining their support) was done before seeking external funding, much less receiving it. This meant that when the proposal went forward to the funder, the project was more viable and less risky than would have been the case had it not been possible to do this groundwork with base funding.

**The external funder.** The external funder, the Seniors Independence Program, provides funding for programming and associated evaluation research done in partnership with local communities. While the partnership requirement can be somewhat of an impediment, this requirement does
ensure that the project is community-based and involves community action.

Conclusions

As has been emphasized throughout this paper, the absolute minimum basis for community action research is the partnership of the researcher and the developer. This involves joint planning and mutual trust. In this project, the partnership also included a local committee with key representatives of the community. In addition, many other roles were very important in implementing both the intervention and the associated research. With the many parties involved in such a project, there are likely to be competing needs, goals and interests, despite overall agreement on a common goal. For example, the research component of a project is often seen as an inconvenience that is tolerated in order to obtain the intervention which is generally perceived as desirable. This paper has attempted to capture the complexity of community action research by describing some of the conflicts and issues that arose in the context of the various roles. In highlighting these conflicts and issues, it is possible to identify some of the attributes of each role that allowed the project to be completed successfully despite the conflicts and differing agenda inherent in such large scale collaboration.
References


Compari

A three year community based alcohol harm reduction project in Australia: What was achieved and what was learned

Richard Midford, Kevin Boots and Terri Cutmore

Abstract

The COMPARI (Community Mobilisation for the Prevention of Alcohol-Related Injury) project was designed to show that alcohol related injury could be reduced by community mobilisation. The project operated in a regional Western Australian city from January 1992 to February 1995. There were initial difficulties in gaining support for the project at the local level. However the project team developed a good local network and demonstrated the benefits of a community harm prevention approach by involvement in a number of high profile activities that had broad community support. The implementation and evaluation strategies employed by the COMPARI team are outlined. The mistakes, successes and lessons learned from the intervention are presented. Four major conclusions have been drawn from the project. These concern project initiation, project strategies, project impact and outcomes, and the evaluation methodology. A number of related recommendations are made. The COMPARI project did have a considerable impact on the way alcohol issues were dealt with within the community and the project was valued by its host community to the extent that at the end of the demonstration period, management and funding were taken over at the local level.

Introduction

The Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI) project commenced in January 1992 and finished as a demonstration project in February 1995. COMPARI, as originally constituted, sought to show that alcohol related injury could be reduced by community mobilisation. This approach involved changing the levels and context of local alcohol consumption through a range of strategies, including community development, environmental change, mass media campaigns, and health education.

The city of Geraldton in Western Australia (population approximately 25,000) was selected as the location for a community-based intervention project in 1991 because of its status as a regional centre, its proximity to the Perth based National Centre for Research into the Prevention of Drug Abuse (NCRPDA) and its match with another regional city, Bunbury, which could be used as a non-intervention 'control'.

COMPARI was a unique community based alcohol harm reduction project in Australia. It used a quasi experimental design. It was formulated to be comprehensive and integrated in its approach. It operated for over three years in its demonstration phase. It was located in a small, relatively isolated, rural Australian city, and yet was well supported financially and professionally. Extensive evaluation has also accompanied all stages of implementation and this provides an opportunity to
scrutinise both the work undertaken by the project and the fundamental concepts that guided decision making.

Evaluation strategies

During its three years of operation COMPARI undertook over twenty-two component projects and considerable evaluation (Boots et al. 1995a; Midford et al. 1995; Laughlin et al. 1994; James and Harrison and Laughlin 1993). Five strategies were used to evaluate the COMPARI project. The first of these was the collection and analysis of global alcohol-related harm data, available from various government agencies. The second involved interviewing key community members before and after the COMPARI intervention. The third strategy was that of measuring the level of community participation in the COMPARI project. The fourth strategy involved a pre and post intervention survey of community attitudes about alcohol issues. The final strategy comprised individual evaluation of some of the twenty-two COMPARI activities.

This array of measures was designed to assess how COMPARI changed the way its host community dealt with alcohol related injury and other harms. The evaluation results are reported comprehensively by Boots et al. (1995b). However, in the process of formulating, conducting and integrating these evaluation strategies a great deal was learned in a more abstract sense about what could be achieved by an intervention such as COMPARI.

Project conclusions

Four major conclusions have been drawn from the COMPARI project. These relate to project initiation, project strategies, project impact and outcomes, and the evaluation methodology itself. The first conclusion concerns the difficulties encountered by COMPARI in achieving community participation in the project due to its top down initiation and the effect this had on the institutionalisation of COMPARI’s goals within the community. The second conclusion comes from comparing the different health promotion strategies employed by COMPARI during the course of the project. The third relates to the overall impact of the COMPARI project on alcohol related harm in Geraldton and the relationship between community mobilisation goals and the outcomes possible in three years. The final conclusion concerns the difficulty of measuring the impact of a community mobilisation project implemented within a quasi experimental design framework. In concert the conclusions reveal both the shortcomings of COMPARI’s attempts at mobilising Geraldton to prevent alcohol related injury and its success in changing the city’s approach to this problem. A number of recommendations deriving from each conclusion are presented.

1. Evaluation of the Project Initiation

Community participation can be achieved using a ‘top down’ model but considerable time is required and the institutionalisation of project aims may be difficult.

The COMPARI Project was community based, clearly involved health promotion and used community development strategies to achieve its aims. However, it’s initiation could only be
characterised as external and top down. This occurred because it was Perth based health professionals who recognised the problems associated with alcohol in Geraldton and decided to formulate an intervention. COMPARI openly acknowledged this approach and the problems it caused and reflected the matter in the title of the project's first annual report "Problems With Parachuting In" (James, Harrison and Laughlin 1993).

The COMPARI Project, like similar top down interventions, had a number of inherent advantages (Sabatier 1986). It had a sound rationale, was well planned, well resourced and employed skilful and committed staff. This gave the project considerable local presence. However, dissonance between the alcohol harm prevention aims of the project and the perception within the community that illicit drug use was the major local drug problem did present an ongoing problem. This was handled initially by involving influential citizens and key local professionals in COMPARI and followed through with high profile projects which responded to community concerns (Harrison, Laughlin and Midford 1995). This approach, coupled with repeated emphasis on local data that illustrated the extent of alcohol harm, worked well in raising the salience of alcohol problems and the relevance of COMPARI (Midford et al. 1995).

The top down initiation of COMPARI meant that the project had to work hard to gain local acceptance. Overcoming this problem was time consuming. However, even with community acceptance, some consequences of top down initiation remained. Project staff, although seen as benefiting the community, were considered to be experts and there seemed a tacit assumption that their roles could not be adequately undertaken by community members. As a result little progress was made on the long term institutionalisation of the project until very close to its completion. This seems to be an inherent weakness of top down implementation. The fact that structures, expertise, resources and support are assembled by external agents at the start of a project tends to imply that the community does not have to do as much because that is the role of the specialised project.

The case for an integrated approach

It does seem to matter how a project is initiated, because that creates certain expectations in the community and has implications for the way resources, expertise, intersectoral support etc. are provided. However, the processes employed at various stages of implementation may be more important in determining the final outcome. Lane (1986) for example, in a study of the creation of a university in Sweden supported the bottom up emphasis on the behaviour and motivation of the community implementors, while indicating that policy enactment from the top was the starting point of the implementation process.

In the case of COMPARI, most of the difficulties inherent in its top down initiation were progressively overcome and funding support for community management of local alcohol harm prevention was forthcoming as a follow on to the demonstration project. In part, this transition was achieved because project staff recognised and compensated for the limitations imposed by top down implementation.
**Recommendations**

1) That active community involvement and ownership of local alcohol harm reduction projects be a recognised priority of funding agencies irrespective of whether such projects are top down or bottom up initiated.

2) That the development of partnerships involving local community members and groups and state or national support agencies, be encouraged.

2. Evaluation of the Project Strategies

The process of community mobilisation is more likely to be successful if community development strategies such as media advocacy are supplemented by health promotion activities which are positive, visible and effective.

As a project aiming to mobilise a community to reduce alcohol related harm, COMPARI undertook a range of health promotion activities. Some of these activities focused on the process of mobilising the community to achieve the desired outcome, while others focused on achieving the desired outcome and through doing so, mobilising the community.

The principle activities undertaken in the early part of the project were networking and support and community development. This involved participation in a number of local committees. The rationale for this involvement related to reducing the resentment towards the COMPARI project (James, Laughlin and Harrison 1993) and the desire to initiate a mobilisation approach congruent with Corrigall and Seebaham’s (1991) conceptualisation of a process, whereby local citizens bring about desired social and economic change, by getting the community to do something about issues of concern.

In hindsight there were a number of problems with the committee approach. One problem experienced by COMPARI staff was that it was easier to join local committees than it was to leave them. As a result, committee involvement continued in a number of cases beyond that originally intended. Secondly, identifying tangible benefits that resulted from committee participation was difficult.

The second category of activities undertaken by COMPARI involved general community development. In the first year these activities complemented the networking and support activities of committee involvement. In the second and third years they complemented the health education, health marketing, and policy institutionalisation activities. These activities also emphasised the participatory nature of community mobilisation and maintained a focus on process rather than outcome. Two particularly important strategies were media advocacy and coalition formation.

Media advocacy in the first year involved writing letters to the local newspaper regarding inappropriate alcohol messages, the availability of alcohol at local youth concerts, and misplaced concern about marijuana as the major cause of drug related harm in Geraldton. The benefit of this approach was that COMPARI got considerable free media coverage and succeeded in stimulating community debate. The cost was that COMPARI was seen as critical of local people and institutions and as being negative rather than constructive.
A similar strategy was employed in 1994 when the proprietor of a local hotel sought to relocate from the city centre to a purpose built suburban tavern - the ‘Utakarra Tavern Issue’. On this occasion however, COMPARI played a support role to a wider coalition of local organisations: assisting but not directing their opposition to the proposal. COMPARI utilised its resources and skills to create a media advocacy campaign that was successful in both process and outcome. It appears that media advocacy is more successful when the advocates are part of wider community action, and have already established their credibility within the community.

The second community development strategy used by COMPARI was coalition formation. This mainly involved the creation of the COMPARI community committee which was intended to provide local support for the project. For three reasons the development of the community committee was difficult. Firstly, top-down nature of the project created local resentment. Secondly, the existence of paid employees naturally resulted in community committee members leaving the bulk of the responsibility to the those employees. Thirdly, the committee members did not have formal power to direct or control COMPARI while it operated as a demonstration project, thus making ownership less likely. However, the community committee did eventually take control of the project. As such, the group must have developed over the three year period to the point where independence was possible.

As COMPARI gained more acceptance within the community, staff were able to conduct a range of health education activities that emphasised both reducing alcohol related harm and community mobilisation. Four activities classified as health education were undertaken between 1992 and 1994. An example was the ‘Operation Drink Safe’ program. This provided counselling and advice to regular hotel drinkers about their own drinking habits and was considered a success locally, not so much because of its direct impact on alcohol harm, but because it involved a considerable number of people, was seen as community based and attracted television and other media coverage.

Three activities, categorised as health marketing because of their use of the media, were conducted by COMPARI. An example was the ‘Partysafe’ host responsibility campaign. This obtained extensive radio and newspaper coverage during two, three week pre Christmas campaigns. Each of these activities also involved community development and health education and consequently community mobilisation aims were concurrently addressed.

The final group of activities were those classified as policy institutionalisation. The first activity involved the development and implementation of curriculum material in a responsible serving course for trainee bar workers. The second activity involved advice to Council on the responsible serving of alcohol. This resulted in a permit for the sale and consumption of alcohol on Council property which required harm reduction practices. Once again the process of mobilisation was an important component of these activities.

In conclusion it would seem that undertaking a range of activities is preferable to selecting and maintaining one strategy and that community mobilisation is more likely to be a by-product of an outcome oriented activity which is positive, visible, and effective, rather than coming from dedicated community development processes.
Recommendations

1) That community based alcohol harm reduction initiatives should employ a full range of health promotion strategies in order to both mobilise the community and to reduce harm.

2) That there be a balance between activities which provide public critical analysis and visible, positive action.

3. Evaluation of Project Impact and Outcomes

Harm reduction projects such as COMPARI can achieve a significant and measurable impact upon specific attitudes, knowledge and behaviours within a community, but more than three years is required to achieve and measure significant community-wide change.

The issue of central concern in the COMPARI project has been alcohol related harm at the community level. Consequently at the end of COMPARI it seems logical to pose the question: does such an intervention reduce alcohol harm? The answer to this is two-fold. Harm reduction projects such as COMPARI can achieve a significant and measurable impact upon specific alcohol related knowledge and behaviours within a community. However, a three year community based intervention is unlikely to provide a thorough answer to this question since many of the component campaigns aim to achieve long-term change.

Measurement of attitudes, knowledge and behaviour

Many of the individual activities of COMPARI resulted in changes in community knowledge and behaviour. For example, the ‘Partysafe’ campaign in its first year created an increase in knowledge of the safe partying tips in those who had been exposed to the campaign. By the end of the second campaign this change was large enough to be measurable community-wide and was complemented by an increase in safe partying behaviour (Boots et al. 1995a).

Other changes in knowledge and behaviour were identified by key informants and the community attitude surveys. Both sources revealed that there had been a considerable increase in the awareness of alcohol issues within Geraldton as a direct result of COMPARI. The key informants were very knowledgeable about the various campaigns and activities conducted by COMPARI and considered that this work was associated with an increase in the awareness of alcohol issues within Geraldton. This change was also reflected in the wider community. Surveys indicated that COMPARI has had an impact on Geraldton in a number of ways. There was a statistically significant increase in the level of support for the role that Councils should have in limiting the number of drinking establishments. This change could be related to the ’Utakarra Tavern Issue’ where a community coalition, including COMPARI achieved a high profile in lobbying against the transfer of a liquor license. Furthermore, the level of awareness of the project name was high, with 23 % of the Geraldton sample indicating that they had heard of COMPARI. Awareness of many of the project activities was even greater. A designated driver campaign with the title ‘Pick a Skipper’ was recognised by 83 % of Geraldton post-test respondents.

The global indices of alcohol-related harm generally confirmed that Geraldton had a higher rate of alcohol consumption and related harm than Bunbury. The indices were particularly useful in
providing an objective and reasonably comprehensive picture of how alcohol use was affecting the community. This increased local knowledge and gave COMPARI more salience as a community intervention. However it is not possible to claim that the COMPARI project has made an impact upon these long-term harm indices. This is not unexpected, since changes in most of the indices of alcohol-related harm will take many years to show in serial measures.

Community attitudes were also measured at various points throughout the project as part of the evaluation of certain high cost/high profile harm prevention activities, such as 'Pick-A-Skipper' and the 'Utakarra Tavern Issue'. Positive attitude changes were consistently recorded when there was elaboration of the issues in the media. In the case of the 'Utakarra Tavern Issue' for instance, those involved expressed positive attitudes about the community’s collective ability to recognise and pre-emptively act on a potentially harmful situation.

Measurement of Outcomes

While these results provide examples of the impact of COMPARI at the end of it’s three year intervention, identification of project outcomes is more difficult. Bandura’s social learning theory recognises that knowledge of new material is not sufficient to change behaviour, and that social norms and rewards play a large part in motivating individual change (Bandura 1977). In a community setting the influence of a comprehensive harm prevention program is likely to be particularly gradual and diffuse because it is targeting a heterogeneous population, often through action at the organisational, social or environmental level. In the case of the COMPARI study, sufficient time has not elapsed to allow meaningful quantitative measurement of community wide change in harm related behaviour. This is compounded by the fact that the objective consumption and harm data that can be used to indicate change have a lag period of almost a year. This obviously makes such data relatively insensitive to the COMPARI intervention, unless they can be tracked for several years subsequent to completion of the project’s implementation phase. Fortunately in this instance, funding for a two year follow on evaluation has been forthcoming. So, while COMPARI outcomes cannot be determined at the end of the demonstration phase there is the capacity to investigate how alcohol related harm subsequently changes in Geraldton.

Similarly, the transition processes involved in achieving institutionalisation of the project can now be followed over the next two years. These processes only gained momentum late in the project and community control is still embryonic. The transformation of an externally initiated public health project to a locally controlled community resource is in some ways the essence of community development and one of the most useful things to understand about the COMPARI project.

Recommendations

1) That large scale harm prevention projects such as COMPARI which aim to bring about community wide change be funded for a minimum of five years.
2) That the goals of externally initiated projects such as COMPARI should include the development of local decision making and implementation capacity and the institutionalisation of project strategies within the host community
4. Evaluation of the Evaluation Methodology

There is limited value in using quasi-experimental evaluation designs to evaluate community mobilisation projects which emphasise a community development approach

There exists a mismatch between community mobilisation goals when pursued within a community development framework and the design parameters of quasi experimental evaluation. The result of this mismatch in the case of COMPARI was the production of some poor quality evaluation data. This occurred because project interventions were chosen in response to community needs as the project proceeded, while various components of the evaluation strategy were predetermined and relatively inflexible. Such a mismatch has been discussed by many authors and is often described as a clash of paradigms (Guba and Lincoln 1981).

Evaluation Paradigms

The two paradigms that dominate social science inquiry, scientific and naturalistic, are based respectively upon positivist and phenomenological thought (Taylor and Bogdan 1984). Positivism seeks facts and causes of social phenomena, apart from the subjective states of individuals, whereas phenomenalism is committed to understanding social phenomena from the perspective of the participant.

The evaluation method associated with the positivist paradigm is experimental and generally seeks quantitative data, while the method associated with the naturalistic paradigm generally seeks qualitative data. Experimental method, based on positivist assumptions is a very well accepted research and evaluation tradition according to Nutbeam (1990). However the limitations of this approach in community settings need to be recognised. Nutbeam (1990) considers that the very nature of community based interventions denies experimental control of many variables.

The overall COMPARI evaluation design, with its pre and post-tests in both Geraldton and a control city, was clearly derived from the scientific paradigm and is similar to a number of other community mobilisation projects. For example, the Community Intervention Trial for Smoking Cessation (COMMIT) project employed a rigorous experimental design with baseline survey prior to randomised treatment (Thompson et al. 1993) and the Community Action Project (CAP) used a quasi-experimental design with untreated control groups and separate pre-test and post-test samples (Casswell and Gilmore 1989).

Despite these similarities, the difference between COMPARI and these projects was fundamental. Both the COMMIT and CAP projects included specific activity goals and directed their community workers accordingly (Thompson et al. 1993; Casswell and Gilmore 1989). The COMPARI project in contrast, was not designed to restrict its community workers in the nature or scope of community mobilisation activities. The aim of the project was not specified beyond that of reducing alcohol related injury in the community through individual behaviour and environmental change strategies. Accordingly staff were given a free hand to engage in whatever activities were deemed the most appropriate to mobilise the community towards this end (James, Harrison and Laughlin 1993). The emphasis on involving the community and being responsive to local needs meant that project activities were often determined from outside the project itself.
Analysis of the Evaluation Components

The five components of the COMPARI evaluation were intended to produce data which would allow a thorough evaluation of project activities and outcomes. However, an analysis of component data reveals the practical outcome of the mismatch between the project’s community mobilisation goals and the design parameters of quasi experimental evaluation.

The first component of the evaluation design was the collection of pre and post-test statistical data of alcohol related mortality and morbidity in both Geraldton and the control city, Bunbury. This component ensured the collection of data which could be used to identify long-term change in harm and consumption as a result of the COMPARI project. However, the data collected are of little value in identifying the impact of COMPARI in Geraldton at this time, because of time lag in data availability and insufficient data points to allow time series analysis.

The second component of the evaluation design, the survey of key-informants, resulted in the collection of some poor quality data, because of the quasi-experimental evaluation design. Firstly, the respondents were selected as key community members prior to the project commencement and not surprisingly a significant proportion of this original group was not subsequently conversant with COMPARI activities. Secondly, many of the original key-informants were unavailable at post-test and were replaced by people holding a similar position in the community. When the replacement informant was also new to Geraldton this again resulted in a lack of knowledge about COMPARI. Thirdly, many people who developed a lot of knowledge about the project were not interviewed because they were not originally identified as key-informants. As a result the data presented from key-informants in this report were not as rich as they could have been. Fourthly, data obtained from Bunbury proved to be of very little value for the same reasons as those noted above and the use of a control location in such a study needs to be questioned given the expense involved.

The third evaluation activity was based on a methodology developed by Rifkin, Muller and Bichmann (1988), designed to measure community participation by means of a web of relevant dimensions. Three major problems were identified with this approach. Firstly, the sample size was very small because few people had sufficient knowledge about the project to complete the task required. Secondly, projects such as COMPARI tend to involve professionals in their steering groups or as interested observers, but professional positions in country towns have a high turnover. To counter attrition and have any chance of identifying statistically significant change, a very large number of informants must be recruited at the beginning of the project, which is difficult in a small community. In practice, experimental tools such as the ‘web’ can only be used if one accepts pollution of the sample with new participants. Thirdly, some potential participants refused to participate because they considered that they did not know enough about COMPARI to make informed judgements.

The fourth and single largest component of the evaluation design involved a pre and post intervention survey of community attitudes to alcohol in Geraldton and Bunbury. The pre-test questionnaire was undertaken in 1991, prior to project commencement. However since the intervention activities were unknown at that time of writing the survey, it was pre-supposed that COMPARI would address certain issues. As a result, most of the questions were not related to the activities actually addressed by COMPARI.
The fifth evaluation activity was that of evaluating specific COMPARI activities. Only five of the twenty-two main COMPARI activities were comprehensively evaluated because of time and resource limitations. A range of evaluation methodologies were used, such as experimental and control group surveys in the case of the 'Partysafe' campaigns and a structured ethnographic approach in the case of the 'Utakarra Tavern Issue'. It became clear from actually conducting these evaluations that when the community development component of an activity was small, and where detailed impact objectives were specified, a quasi experimental intervention and supporting evaluation was most appropriate. However, when community development was an important objective in its own right, a more phenomenological action research approach produced better results.

Resolution of the Paradigm Dilemma

Projects such as COMMIT and CAP (Thompson et al. 1993; Casswell and Gilmore 1989) attempt to resolve the paradigm dilemma identified in this discussion by specifying the activities and activity objectives in advance of the intervention phase. While this may increase the appropriateness of a quasi-experimental evaluation design to such projects, the cost borne by such a proscriptive approach is a reduction in program flexibility and community involvement.

An alternative may be to undertake community alcohol harm prevention programs within a community development model that encourages an action/reflection cycle. This could incorporate evaluation based on an action research model (Wadsworth 1991). In the case of COMPARI, a more appropriate evaluation design would have emphasised evaluation and feedback of each activity (not just the high profile activities), and regular interviews with currently knowledgeable informants. Such an evaluation design would have been congruent with the community mobilisation goals of COMPARI and produced data which were more timely and of greater quality.

Recommendations

1) That evaluation remain a high priority in similar future projects.
2) That projects with a broad community development focus be evaluated within a design framework that emphasises naturalistic methodology, such as action research, rather than by using experimental or quasi-experimental design methodology. Such evaluation should seek to inform the community.
3) That individual activities be evaluated using methodology appropriate to the specific activity. For example, the community development activities should be evaluated using action research, while health marketing activities could be evaluated using quasi-experimental methodology.
Summary

The COMPARI demonstration project achieved considerable change in the way alcohol related harm is understood and dealt with in Geraldton and in turn a lot was learned about community intervention processes. In drawing conclusions many of the mistakes have been highlighted. However, the positive learning experiences should not be underestimated. While COMPARI did not rigidly adhere to a predetermined intervention plan, which made evaluation more difficult and somewhat fragmented, the flexible structure of the project allowed it to be responsive to community needs and capitalise on opportunities when they arose.

COMPARI developed a particular ability to respond to local alcohol issues and in the process build innovative programs that educated, mobilised and created capacity within the community to deal with its own problems. These approaches and techniques, individually and as a whole, can inform responses to alcohol related harm in other community settings. In summarising COMPARI’s achievements, perhaps the most telling outcome was that at the end of the demonstration period the project did not finish, rather management and funding were taken over at the local level.
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The Kungsholmen project - implementation and findings in a community action programme for prevention of alcohol-related problems in Stockholm city.

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ABSTRACT

Introduction

A community intervention project to reduce alcohol consumption and especially high consumption, has been going on during 2 years in an area in central Stockholm with about 45,000 inhabitants, financed by Stockholm County Council which implied fast actions but less time for scientific planning and evaluation.

Methods

The project have mainly included primary prevention, but also secondary prevention, with focus on young people, the health care and the social sector. Surveys to random samples of the population in the intervention and in a similar control area was conducted before and after. The project was met with considerable interest from local agencies and parties, facilitating cooperation. Three similar information campaigns targeted to the population in the ages 20 - 45 years have been conducted and partly evaluated. A central aim was to increase awareness about one’s own consumption by wide-spread distribution of posters with the slogan ”75 centiliters of spirits a week”, showing different pictures of social well adjusted people, whose consumption add up to high figures. Thousands of copies of a special self-device, the ”Alcohol Carousel” was also distributed in cooperations with shops, warehouses, the alcohol retail monopoly stores, health care clinics. Baseline surveys was conducted prior to the campaign to random samples of 800 subjects in the population, and also afterwards

Results

The evaluation of the second campaign in 1992 showed that 67 % of the responders hade noticed the campaign, that 82 % were positive to the use of tax money to prevent alcohol-related problems and that 40 % had used the ”Alcohol Carousel”, with a higher percentage among those who reported a high consumption. There were statistically significant changes in the replies to several of 19 questions about knowledge and attitudes to alcohol in the post-test questionnaire, compared to the pre-test questionnaire. Experiences from this project have contributed to a decision by Stockholm County Council to finance a 10 year community intervention alcohol program.
Introduction

During the last two decades various, often comprehensive public health projects have been initiated, especially to prevent heart disease, injuries and cancer (Salonen et al. 1986; Sanderson et al. 1988). However, the international experience from the alcohol field is rather limited (OSAP prevention Monograph 1990; Casswell et al. 1989a; Casswell et al. 1989b). This is a report of a community intervention project aimed at a reduction of alcohol consumption and alcohol-related problems in Kungsholmen, a metropolitan community with three parishes in the Swedish capital Stockholm. The project was called the FIA-project (FIA stands for ”Förebyggande insatser mot alkoholrelaterade problem” = Preventive intervention of alcohol-related problems) or sometimes the ”Kungsholmen project”.

Concepts and Ideas

Our way of using alcohol is influenced by people around us as well as from norms and values on the societal level and in the immediate environment. Figure 1 is an incomplete illustration of this complexity, possible too much focussed on medical problems and on a national level, but shows that alcohol problems can be seen in a systems perspective, as suggested by Holder and Wallack (Holder et al. 1986). This perspective implies activities from a broad societal and environmental perspective and also means that prevention of alcohol problems in a community must take various subsystems into consideration, in planning, implementation and evaluation. This means an active policy to build coalitions and partnership with other parties in small or big issues.

There is strong empirical support, i.e. from Sweden for a relationship between (changes in) per capita alcohol consumption, the proportion of high consumers and the magnitude of important alcohol-related problems in the population - the total consumption model (Bruun et al. 1975). A reduction of mean alcohol consumption is thus also an important objective in a community intervention project. There are several plausible ways to try to achieve this.

The concept "community" has been defined in various ways (Salonen et al. 1986; Sanderson et al. 1988; OSAP Prevention Monograph 1990; Casswell et al. 1989a; Casswell et al. 1989b; Barcht (ed.)). In this project, as in many others, a community is defined rather loosely as a geographical area were people live and can easily come in contact with each other, and have something in common - it may be on the historical, cultural or administral level. Community intervention work depends on a fundamental extent of factors in the local community but also on the role of the "change agents" and the interplay and co-operation between the change agents and the population. Despite local variations one can mostly identify various phases at least in the planning stage: community analysis, initiation, implementation, integration of the programs into the ordinary activities by people and organizations in the community and evaluation of processes and results. At least in the beginning many projects are “top-down”, i.e. developed outside the community and then introduced with some kind of official support, with an aim to replace this by “bottom-up” activities.

Our project was focussed on primary prevention, but includes secondary prevention and also aimed at improved cooperation between authorities who have contacts with people with more
chronic alcohol problems, i.e. the social welfare agencies, the Out-patient Clinic for Alcoholics and Alcohol Abusers, the Department of Psychiatry, primary care and voluntary organizations (Anonymous Alcoholics). This was considered to be of importance for the general credibility of the project.

Objective

The objective from the start of the Kungsholmen project was two-fold: to contribute to a reduction of alcohol-related problems in the population in the intervention area and to initiate, conduct and evaluate various prevention activities to gain experience for further alcohol prevention in the Stockholm metropolitan area. Not least considering the latter objective, the project can be considered as a pilot project. There are various conflicts embedded in such a twofold goal, which soon became obvious.

Planning and Implementation

Economic Support

The initial fundings for the planning of the Kungsholmen project were received in February 1990 from the Health Promotion Committee of Stockholm County Council. The project has been refunded by this committee, and has also received economic support from the Board of Social Welfare in Stockholm city, the National Board of Health and Welfare, by the Research Committee of the Center for Research on the Elderly in Stockholm and by the Research Committee of the Alcohol Retail Monopoly. The principal founder was the Health Promotion Committee of Stockholm County Council on a yearly basis. This called for rather rapid actions, to show activity, in order to get new fundings. On the other hand this meant less place for careful scientific planning and evaluation.

Study area

The community Kungsholmen in the central part of Stockholm was selected mainly as we knew that there was some interest in prevention of alcohol-related problems at the Social Welfare Agency, in primary care and especially at the Department for Treatment of Alcoholism and Drug Abuse. Secondly, the rates of mortality and inpatient care in alcohol-related diseases was somewhat above the average for Stockholm County with 1.6 million inhabitants, which includes the capital Stockholm with 0.7 million inhabitants. There are around 45,000 inhabitants living in Kungsholmen, which is the catchment area of both the primary care district and the social service district. The proportion of old age pensioners is high, approximately 27% at Kungsholmen while the proportion of children and youth is lower than the average for the county. However, the proportion of inhabitants in the working ages 20 - 64 years is the same as in Stockholm as a whole (62%). The socioeconomic structure is rather heterogenous. The proportion of the population with a college or university education is higher than averagely in Stockholm county, especially in certain areas. In other areas this proportion is lower and the mean income lower. The unemployment rate was low during 1990 - 1991 (around 2%) as in the Stockholm area as a whole, but then increased considerably during 1992 - 1993. 5 per cent
of the population have a foreign citizenship while the average for Stockholm county is 9 per cent. The number of paid sickdays is below the average for the county, while an age standardized index for disability pensions is somewhat increased. There is a considerable net influx of people to Kungsholmen during day-time, as some large enterprises are situated there.

One can wonder if there is any sense of community belonging among the inhabitants in this district with three parishes in the middle of the city. In a questionnaire survey (see below) 35 % of the responders admitted a strong sense of affinity with the area, while 40 % admitted a rather strong of affinity. 15% negated a sense of area kinship, while 11 % felt uncertain. 73 % of those who had lived in the area more than 10 years (approx 50 % of the sample) admitted a strong sense of affinity.

**Marked local initial support**

The first year, 1990, was used for theoretical and practical planning of the project:

- a project plan was worked with goals for various areas and evaluation. The overall objective is a reduction of alcohol consumption and alcohol-related problems in the community.
- four project workers were successively hired
- data collection as part of a community diagnosis started
- various organizations or local authorities were contacted. After 3 months we had been in contact with the bodies depicted in Table 1. We were generally met with great interest. It seemed necessary to start the work by contacting main authorities and organizations to get an idea about their interest. By this we have started to work “from above”. Our idea was that it will be easier to work and engage people at the grassroots level for a project with support from some important societal bodies, at least in the alcohol field in Sweden.

**Community and scientific reference groups**

Between the autumn of 1990 and the spring of 1993 - the last year with the project - we had five generally successful meetings with the local and two with the scientific reference group. The local reference group was composed by representatives for the high school, the social welfare agency, the police, primary health care, the Department for Treatment of Alcoholics and Drug Users and various parts of the health care sector. Project workers became influential members of ”the Kungsholmen working party for young people” based on collaboration between organizations and authorities working with young people at Kungsholmen. This can be seen as a second local reference group, and generally supported and/or participated in our activities. We used a separate four-page newsletter to reach about 70 contact persons, mainly at authorities and organisations.

**Concrete project activities directed to young people**

School education. We gained confidence at the high school to be responsible for an increased education about alcohol (predominantly), narcotics and tobacco, among pupils aged 14 - 16 years. Meetings have also been for the parents, in collaboration with the school and the youth
group at the social welfare agency. A special small text-book was worked out for this education. Some education was directed to the teachers. The education aimed at supporting the pupils not to start using alcohol, to avoid drinking to intoxication, to increase their knowledge about alcohol, and to stress their own responsibility in a choice situation. As part of the evaluation an anonymous questionnaire survey of alcohol habits was performed at the school in the spring of 1991, as this school was separately included in the repeated national surveys of use of alcohol, narcotics and tobacco in a sample of school classes for pupils aged 13 or 16 years. According to this survey a surprisingly high percentage of the pupils (aged 14 - 16 years in our school) had drunk home-made liquor. The reporting of this at meetings with parents and teachers during the autumn were met with great interest, worry and hot debates. As part of the evaluation the education at school has been evaluated with a test-retest study of alcohol habits and attitudes among the pupils, and also in a "control school". The results of this evaluation will be available at the oral presentation.

On request the project worker also arranged special education at a vocational school, as the teachers meant that too many pupils misused alcohol. This was done together a well known actor who was a sober alcoholic, was quite popular and brought about drawing exhibitions about alcohol by the teachers in collaboration with their teacher. We do not know if their alcohol habits changed. A local school survey before this education confirmed that a large proportion often drank themselves intoxicated, but we could not conduct a survey after the education.

A campaign directed against boot-legging to young people in connection with the school breaking-up was conducted in June 1991 in collaboration with the working party for local bodies working with young people and was rather limited. All restaurants in the area were contacted and asked to put up a poster saying "We love young people, but we cannot serve you alcohol when you are underage". The local alcohol retail stores have been asked to (and agreed to) put up a similar poster, and asked to increase their check of age limit. We have also contacted the main stores in the area with the request not to have beer sales during the period of school breaking-up. An advertisement in local newspaper carried a similar message.

The anti-bootlegging in the spring of 1992. In the spring of 1992 a more comprehensive campaign was undertaken, with participation of pupils and parents. An anti-bootlegging campaign to reduce the widespread "bad habit" to buy and/or to bring over alcohol to young people was going on with much greater force than the campaign one year ago. Pupils and parents were participating. They had i.e. taken the responsibility to ask local stores, post-offices etc to put up anti-bootlegging posters, while another group had the responsibility for reaching bars and restaurants with information and another poster with the text "We love young people, but we cannot serve you alcohol when you are underage". The largest amusement park in the area was hired for an arrangement with local youth music entertainment at the day of school-break up- an alcohol-free alternative to the usual boozing at those days, arranged mainly by school pupils aged 15 - 16 years, together with parents and "the Kungsholmen working party for young people". A few days after that the formal license to hire the park was given, a large organization for voluntary social work for and together with young people was allowed to hire the park for a 2 week arrangement in tents in the park, with serving of strong beer to soccer football fans in the park during the European championship in Stockholm in the beginning of June. This would clash with the planned alcohol-free arrangement at the day of school-break-
up. This aroused widespread and sharp protests from people at Kungsholmen, and a debate in TV and other mass media. The pupils and their parents started a "name collection" for support of their (and our) standpoint and protested to the politicians, written protests came immediately from the well-functioning "Kungsholmen working party for young people", the social welfare agency, our project, and also as a debate article in Sweden’s largest morning newspaper, by the project leader (AR). The rapid and strong protests probably contributed to decisions to move this beer-serving arrangement to a peripherally situated park. This was regarded as a victory among the pupils and other local people, and certainly contributes to an increased local support for the future.

The anti-bootlegging in the spring of 1993. The project was weakened during 1993. The economic support from Stockholm County Council was reduced, as was planned from the beginning. Two of the project workers gained steady jobs at the new National Institute for Public Health, in competition with hundreds of other applicants partly due to their merits from the FIA project. However, in the spring of 1993 a similar anti-bootlegging campaign was undertaken in collaboration with a minority of the local social welfare agencies in Stockholm.

Activities directed to parents of small children

These activities has developed in three steps. First we arranged two days of education for employees working at the day nurseries and at the leisure homes with children aged 1 - 10 years. The aim was to increase knowledge and awareness about the connection between the drinking habits of the parents and the well-being of the children and to increase the knowledge of how to find and support parents with high alcohol consumption. Almost 100 employees from our area attended this training. Together with other interested parties the work the planning of a short educational movie about the connection between adult’s alcohol habits and the well-being of children has started. We thought that a movie of this kind could be a means to reach the parents at the free child health examination, which is performed for children between the ages 0 and 7, with a participation of close to 100 % (about 100 people). The crucial task is how to convey the message that small children learn from the attitudes and the behaviour of parents, also in the alcohol field, in an interesting and acceptable way. The movie has been used in education here and there and has been regarded as useful. The next step was education together with the personnel at the public health centres for children. These are free of charge in Sweden since the 1930's and are visited by over 95 % of all children, together with their parents, after a schedule with regular visits up to the age of seven. This education, delivered by a child psychiatrists who had recently published a book about alcohol and youth was also highly appreciated, with a high participation. The next step has been to work out guidelines in local groups with participation of personnel from both the social and the health care sector. An anonymous questionnaire evaluation confirmed our impression that this education was regarded as very good and useful. The important ultimate goal is that he social and the health care sector in collaboration devote more energy with greater competence to identify children at young age, who have difficulties due to the alcohol use of their parents.

Other activities in collaboration with the social welfare agency
Representatives for the social services took part in the activities directed to parents and employees in contact with children, described above. One working group aimed at finding support for a new meeting place for young people, and attracted some youngsters, but did not achieve its goal. The goal for another group was to improve the work by the social welfare agency in collaboration with the health care sector among subjects who have been taking by the police for drunkenness. The idea was that some of those subjects may be at an early stage of alcohol abuse. However, these strivings were not successful.

One important goal was to stimulate the local social welfare board to adopt an alcohol policy act. This was also achieved.

**Activities in the health care sector**

A major goal was to increase the awareness among the physicians and other personnel for possible alcohol-related problems in their patients and to increase the secondary preventive activity. Education has been given, and the interest generally increased. A policy paper was worked out together with representatives for the main departments (internal medicine, surgery, orthopaedics, urology, psychiatry) at the St Göran’s university hospital, the only hospital at Kungsholmen on identification of high consumers, their treatment and for collaboration and has been accepted by those parties during the autumn of 1991. A similar policy paper has been accepted by the family physicians. A main task is to have those guidelines implemented in reality by the physicians and other personnel. At the hospital especially strong support have been received from the almoners. The project is participating in another project at the Department for Treatment of Alcoholism and Drug Abusers aiming at giving support to relatives to subjects with alcohol problems.

Approximately 100 % of pregnant women in Sweden attend the free maternal health care (MHC). Since a few years, the midwives are trained to ask all pregnant mothers about alcohol consumption. Advice is given (not to drink during pregnancy). We found considerable interest at the MHC to improve this alcohol interview and the advice about alcohol consumption and have conducted various training activities. A scientific study, testing a method with a more careful questioning of alcohol habits with a cross-over design was undertaken during 1992 - 1993. In this study, questions about consumption of each alcoholic beverage during each day of an ordinary week was be put, and compared with questions about consumption frequency after estimated conception, which are the ones used nowadays. Also questions about alcohol consumption before pregnancy will be put. This study went on very well due to the enthusiasm by the midwives, who meant that they really learned from this project. The initial planned project time of 6 months was extended to 12 months. Over 99 % of the about 600 pregnant women participated. Over 40 % admitted alcohol use during the previous week - with a mean consumption of less than 2 grams 100 % ethanol per day - which corresponds to one glass of wine per week. However, we did not find any who reported a high alcohol consumption during, or before pregnancy. We do not know if this is true, or due to an especially low validity in the self-reports of alcohol in pregnant women. There are no valid chemical test for alcohol use during pregnancy.

**Prevention campaigns directed to the local population**
We devoted considerable time to the difficult issue of how to reach the inhabitants in the intervention area and how to formulate a relevant message. A first more comprehensive campaign directed to those aged 20 - 30 and those aged 30 to 45 was undertaken during four weeks in the autumn of 1991. The general aim was to attract interest for the alcohol issue and to increase awareness about one own’s consumption without being moralising or condemning. Three main activities were conducted: A poster campaign in the community and at subways in the whole county, the distribution of the ”Alcohol carousel” made of coloured paper all over the community, and 3 arrangements at evening time directed to the public. The slogan of the poster campaign was ”A bottle of liquor a week”. ”Ordinary” men and women in seemingly good social conditions were portrayed (without face), and it was shown that their ”ordinary” drinking habits added to approximately 75 cl of spirits or more. The aim was to make people aware of their drinking habits and to reconsider them.

With the device the ”Alcohol carousel” one can easily calculate alcohol consumption, transform to cl spirits, and also to cost per year, calories per years, calories expressed as number of Danish pastries consumed per year etc. This ”Alcohol carousel” became very popular. 10,000 copies were picked up during a four week period by the public at various places in Kungsholmen, with an adult population of approximately 35,000 subjects. At the first public evening arrangement, a rather well-known author read her poems and talked about her experiences as wife with small children to a deceased alcoholic. At a second meeting a theatre group presented short provoking items around the theme ”Women and Alcohol”. Swedish alcohol policy was debated in ”The alcohol duel” at our last arrangement. Approximately seemingly quite interested 100 subjects came to each of those arrangements. The campaign was presented in the monthly community newspaper, which is said to be read by ”everyone”.

It was evaluated mainly with specific surveys before and after the campaign directed to random samples of 800 people in the population aged 20 - 45 years. (See below). In the autumn of 1992 a new campaign with a similar message was undertaken, directed to the same target group in the population. This time we worked out a special brochure ”Pleasures are to be taken seriously”, which was mailed to everybody in the ages 20 - 45 years who lived at Kungsholmen. This brochure informed about the results of the surveys of alcohol use at Kungsholmen, had articles about ”Women and alcohol” and ”Can I serve alcohol to my teenager” and also presented 10 warning signals for riskful alcohol use and informed about treatment facilities. The alcohol carousel was also made available. Also this campaign was evaluated with specific surveys before and after the campaign directed to random samples of 800 people in the population aged 20 - 45 years. In the autumn of 1993 we worked a special 4 page supplement to the local newspaper with various articles about alcohol, some with local issues and other more general as ”Alcohol- good or bad for the heart?”.

Evaluation

The goal was to evaluate both processes and results on a community level, and also to evaluate some of the specific subprojects. Some of these questions were too ambitious considering the short project period and the resources, amounting at most to 150,000 dollars a year, in 1992. A summary follows.
Some questions in the evaluation:

Will the knowledge about the project increase in the community? Will the attitudes become more positive to a restrictive alcohol policy?
Will self-reported alcohol consumption decrease more (or increase less) in the intervention area than on average in Stockholm county and more than in the control area?
How will different social strata (sex, age, socio-economic category) be affected?
Will there be any reduction of alcohol-related problems?
Will the prevention guidelines worked out together with personnel become implemented?

Measures at the community level

1. A questionnaire study of drinking habits and attitudes within a general health survey has been carried out in the spring of 1991 in the intervention area and in a similar area in another Swedish city. The mail questionnaire was addressed to random samples of 2,000 adults in each area. A similar questionnaire survey has been conducted after the project. Three results from this survey are especially interesting:

1) There is a strong opinion for a more liberal alcohol policy. 51% of the males were positive to sales of strong beer in ordinary grocery shops, and 43% to sales of wine and spirits in such shops, while the corresponding figures among females were 40 and 32%. In Sweden, alcoholic beverages are sold only at state-owned retail stores since the end of the last century, besides at restaurants (at high prices).
2) There was a clear association between high alcohol consumption and a liberal attitude.
3) In a methodological study within the survey, we found preliminary a very high coverage of questionning about the consumption of each alcoholic beverage during Monday-Thursday, Friday, Saturday and Sunday, compared to the usual volume*frequency questions. This study has been accepted as a paper in a scientific journal (Romelsjö et al. in press).

2. Surveys on the attitudes about alcohol in connection with the primary prevention campaign were undertaken. The design of these surveys is illustrated in Table 2. One survey to a random sample of 1,200 subjects aged 20 - 45 years was conducted before the autumn campaign in 1991, with a re-test survey directed to the approximately 700 respondents with questions also about project activities. A third survey of the attitudes in a new random sample in the same ages was also been conducted. Approximately 20% of the questionnaire respondents knew about the project after the campaign, conducted after less than one year of activities.

The surveys contained 29 propositions about attitudes, with five reply alternatives, ranging from "I agree completely" to "do not agree at all". Generally the differences before and after the campaign were small. However, we found a statistically significant decrease in the percentage of affirmative answers ("I agree completely or on the whole") to the following 9 questions:

- The age limits for alcohol serving at restaurants should be the same as at the Alcohol
Retail Monopoly, i.e. they should be increased from 18 to 20 years;
- It is a myth that young people drink too much;
- Only a minority in the population drinks too much;
- The drinking habits of the parents influence the drinking habits of their children;
- Nobody should tell me how much beer, wine or spirits I am drinking;
- Young people should not drink before attaining a mature age;
- Alcohol brings more pleasure than harm for most of us;
- The penalties for bringing alcohol to underaged should be increased;
- Information campaigns about alcohol are valuable (82 % affirmative answers before and 88 % after the campaign);
- Sweden’s joining of the European common market will probably influence our alcohol habits.

The results are thus not unambiguous. This should not be expected after such a short project period.

A similar pre and post test survey in 1992 showed that the information campaign was noticed by about 65 % of the responders, compared with 23 % after the campaign in 1993. Most people had observed the campaign in the direct mail brochure "Pleasures are to be taken seriously". About 40 % answered that they had used the "Alcohol carousel" and 4 % meant that they had reduced their consumption afterwards. If this figure were representative for Kungsholmen, then about 800 people would have reduced their alcohol consumption. A greater proportion of those with a higher consumption had used the "Alcohol carousel". Ninety percent were positive to information campaigns to reduce alcohol-related problems. About 85 % agreed to the proposition that tax money should be used for the prevention of alcohol-related problems. Between 25 % and 30 % suggested 1/2 dollar per month as appropriate, 25 % at least one dollar/month, while 30 % did not suggest a special sum.

3. A survey about alcohol habits at the high school has been conducted (see above).

4. Data on inpatient care, drunken driving, mortality and subjects taken into custody for public drunkenness for this area other areas in Stockholm county can be used.

5. Data on alcohol sales at the retail stores will not be used. Sweden has a state alcohol retail monopoly. Alcoholic beverages are sold at about 380 stores or can be picked up at another 550 locations for delivery, often stores in smaller communities. Kungsholmen had 3 alcohol retail monopoly stores. In a customer study the Alcohol Retail Monopoly which supports our project, found that roughly 50% of the customers at the three alcohol stores in Kungsholmen did not live in the area. Thus, sales data will not be useful in the evaluation. For similar reasons it seems very uncertain if data on sales at restaurants, which we have access to, will be of any use.

6. We had early planned to conduct repeated measurements of alcohol involvement among subjects aged 20 - 74 years attending the emergency room at St Göran’s hospital, to analyse the data with interrupted times series analysis (Cook et al. 1979) and to connect this to program activities. The measures would then be based on analyses of the blood test carbohydrate-deficient transferrin (CDT) (Romelsjö et al.), which is a new indicator of high alcohol consumption with a high sensitivity (approximately 80 - 90 %) to detect
high consumers of alcohol (60 - 80 grams 100 % ethanol/day during 10 - 20 days) and a high specificity (approximately 99 %). Our first measurement activities did not work well in spite of support from the hospital and the personnel who were to take the blood specimens. They found difficulties to present the study in an emergency situation and also to get support for blood tests, even if the study was anonymous, and took blood specimens only from a minority of the attenders.

Concluding remarks and reflections.

The FIA project has contributed to the decision by the Health Promotion Committee of Stockholm County Council in the spring of 1994 to support a 10 year local prevention project, which will be conducted at Kungsholmen, and in a neighbourhood area. This is perhaps one of the best results of the project and creates a quite different situation with a possibility to a more thorough planning and a more careful evaluation. Then the role of the FIA project as a pilot project becomes evident. And some of the authors of this paper will be engaged in the new 10 year project, in one way or another. It is then important not only to measure self-reported attitudes and drinking behaviour as in the FIA-projects, but also to develop and use measures for alcohol-related consequences. During the whole project period the contradiction between the need to show activities on one hand and the interest to conduct at least some scientific studies was obvious. The compromise could have been better, and there are different opinions among us what would have been the ideal. Another short-coming was our common experience with this kind of project. There were also different opines about priorities within the project group. This is understandable and was due to our lack of experience, but also to different values in some questions. Another short-coming was that the project leader (AR) had his office at another place 5 kilometres from the intervention area, and was busy with several other things.
References

Activities in 1992 and an assessment of the current project status.

During 1992 we aim at improving and enlarging our work in various fields. The project is probably widely rather known in the community and has been met with positive interest by various agencies, and contributed to increased preventive activities. However, we have so far to a too limited extent reached people in general in the community. For instance, in an one page advertising of the campaign in the local newspaper, we also asked for ideas, contributions and voluntary work, but did not receive any relevant answers. One important exception is that people picked up 10,000 copies of the "Alcohol carousel" at visits to shops, banks, health care and alcohol retail shops during the campaign month. There are very few influential local voluntary organisations. Some large organisations, i.e. sport clubs, have their office at Kungsholmen and are registered there, while their activity encompasses the whole city. It is very important for us to build up better support in the community and try to transfer project activities to a greater extent to bodies or subjects in the community.

We have also been funded from a Research Committee for a project indented to reach elderly people in danger of high alcohol consumption and have just formed a task force for this. We also intend to actively spread our experiences over the county more systematically and to cooperate and exchange viewpoints and experiences with our preventive projects in Stockholm county. Last but not least the valuable and inspiring cooperation with the Kirseberg project (Romelsjö et al.) will continue.

Viability of community approach in demand reduction of alcohol and other drugs in a developing society

H.K. Sharma and D. Mohan

Introduction

The community approach finds its prominence in primary health care, adult education, rural development and environmental protection in the country but has been least applied in the field of alcohol/drug dependence. It was only in late 1970's that the ‘camp setting’ approach was applied for the treatment of raw opium users in the western part of Rajasthan State. It gained popularity in 80's. The rationale for the ‘camp’ approach to detoxification is not based upon a ‘classical’ response of the hospital-like isolation of the drug user from the community but rather for animating both parties having more contact on a daily basis within a process of mutual empowerment, at an appropriate moment being provided with relatively short-term, intensive camp experiences to interrupt, if not fully extinguish addictive behaviour. (Kaplan et. al 1993) The camp approach proved an effective therapeutic measure for opium dependents in rural areas but for heroin dependents the programme met with limited less success. A study to compare and assess the outcome of patients dependent on opiates in different settings showed that drug dependence disorder treatment is not a single occasion intervention and requires complex after care facilities (Mohan and Sharma 1991). The emerging picture in alcohol/drug treatment is that of a broad-based process with intervention directed towards changing drug use/drinking behaviour pattern as well as social environment and other life problems in a way that would help to sustain abstinence status.

A few of these elements have been incorporated in a community based treatment programme for alcohol and other drugs (AOD) of the Drug Dependence Treatment Centre, All-India Institute of Medical Sciences, New Delhi for an under-privileged urban population in the capital. The present communication focuses on the experiences gained during this programme and explores viability of community approach to contain alcohol and drug problems in the hope that involvement of people at grassroots level can play and effective role in consolidating drug control efforts in a developing society.

Community-based programme

The programme was launched about five years back in an urban locality in the West Delhi, with a population of approximately, 100,000 spread over to many sub-localities. This locality came to the notice of the Centre due to high prevalence of heroin use and large scale drug trafficking and street peddling by an excriminal tribal community (Sansi). At the initial stage, the main purpose was to identify alcohol/drug dependent individuals and motivate them to avail treatment facilities of the newly established Centre, located in nearby general hospital. The subsequent interaction of the staff of the Centre (including one of the authors) with a cross-section of the people of the affected community, it was realised that unlike hospital based treatment programme that focus mainly on the individual (drug dependent), the community based intervention must address both
the individuals behaviour and the socii-cultural context that defines norms relating to that
behaviour. The programme also took into consideration the issues, such as assessment of AOD
problems at the community level (ICMR 1993), identifying strengths and weaknesses of natural
control mechanism and supportive factors (Sharma and Mohan 1993).

**Aims and objectives**

The community leaders from a sub-locality showed their willingness to provide infrastructure for
a community based programme for treatment and management of drug dependents. After
discussing the procedural aspect of the programme it was decided to extend community outreach
treatment services in the natural milieu with the following aims and objectives:

(i) To provide low-cost and short term drug dependence treatment services within the
community.
(ii) To identify majority of drug dependents in different sublocalities and to initiate the process
of pre-treatment counselling (clarify myths and misconceptions associated with drug
(ab)use).
(iii) To focus on health and social consequences of socially sanctioned drugs like tobacco and
alcohol and illicit use of heroin in their environment and possible remedial steps.
(iv) To mobilise community resources in strengthening of community-based treatment services
to facilitate formation of local support groups (youth, women etc.) as well as self-help
groups (AA, NA etc.).

The implicit objective of the programme was to develop a sense of responsibility on the part of
community so that the residents could take collective decision against the easy availability of
alcohol and heroin.

**Intervention package**

Prior to this programme, very few attempts had been made to reach to alcohol/drug affected
individuals/communities in their natural setting. The emphasis of the present work was to provide
low-cost treatment facility through a community clinic at the doorsteps of the community. The
treatment package comprised of home detoxification, free distribution of medicines and
individual/group counselling. Printed material on alcohol, tobacco and drug abuse consequences
was also used for education awareness campaign in the community.

**Programme implementation**

Community clinic

The community clinic services for treatment of drug dependents commenced in June, 1990 in a
temple premises of one of the sub-localities (an urban village). It was decided to run the clinic
twice a week to dispense medicine for home detoxification under the supervision of the family
member(s). The staff, consisting of a Psychiatrist, a Social Scientist, two Medical Social Workers
and a Nursing Tutor was provided by Drug Dependence Treatment Centre. They also carried out
responsibilities of Psycho-educational session, follow-up with the patients, family visits and facilitate resource mobilisation and identify social networking in different sub-localities.

The other steps taken in the implementation of these services were

a) **Identification of problematic users.** The snow-ball technique was adopted to identify problematic alcohol/drug (ab)user in different sub-localities. It was noticed that users of a sub-locality were known to each other as they often took alcohol/drug together in small groups. Once identified, the contacts were made with them individually and in small groups and rapport was established to get them registered at community clinic for treatment.

b) **Family contacts.** The family members of these identified problematic users were also informed about treatment procedure and objectives of the program. They were advised on the steps to be taken by them during detoxification and after care.

c) The sub-localities were divided into small pockets, consisting of 75 - 100 houses. The staff of community clinic and the local volunteers visited these pockets to ensure support of the family and resource persons in motivating drug dependents to accept detoxification and to maintain an abstinent status.

d) **Community based organisations (CBO’s):** The local community based informal organisations (CBO’s) like Youth Groups, Temple Committee, Educational/Welfare Committees were involved in both planning and implementation of these services. Their involvement was a necessary step to mobilise local resources to deal with the problems of drug trafficking, alcohol related violence and stigmatisation/marginalisation of youth in the urban conglomerate.

e) A few volunteers from localities were invited to join with the staff of community clinic to understand the process of detoxification and recovery under the supervision of a Psychiatrist.

To ensure community participation, meetings of resource persons and CBO’s were held from time to time and issues related to functioning of the community clinic were discussed.

**Process experience**

A record of daily activities maintained by the staff and ethnographic observation during the implementation provided basis for process evaluation through set of indicators. These were:

**Programme activities and accomplishment**

The functioning of the staff at the clinic was participatory rather than hierarchical to perform a wide range of activities. The medical staff, including a Psychiatrist, provided medical assessment, examinations evaluations, pharmacotherapeutic services and clinical supervision. The other staff members carried out assessments, individual, group and family counselling, education of patients and their families and also facilitated in making linkages with the community.
The team endeavour, collective decision making and open communication and informal setting at community clinic were a few significant factors helped in to establish the credibility of the programme and acceptance of these services at grass-root level. However, the community support in after-care and rehabilitation of treated patients remained one of the minus points in these services.

The receptivity of the target groups

The receptivity of the target groups varied from one sublocality to another and intensity of AOD problems. In the sublocality, where community clinic was functioning, there were a large number of problematic alcohol users. The alcohol related problems like drinking brawls, violence, family and marital conflicts were frequently reported. The staff of community clinic tried to reach to these users and their families with the help of local volunteers. At the commencement of these services, a large number of heavy alcohol users including community leaders got them registered for treatment and management of alcohol related problem(s). However, retention of these patients became a challenge to the outreach services. A large number of them reported that as soon as they leave the clinic, they are encountered with environmental factors such as alcohol sales outlets, group pressure, social setting of drinking etc. that increased their risk for alcohol consumption.

The reasons cited for dropouts from the programme were: lack of insulation from family, and job crises, under estimating severity of AOD problems and lack of family support for treatment and after care. some times, mere improvement in physical health was taken as ‘cure’ for drug dependence.

On the other hand, heroin dependents from neighbouring sublocalities took about six months to avail these services. However, their informal peer network helped them to remain in contact with these services for a longer duration.

Community responses

The community responses towards any programme is a good indicator of its credibility and the felt need. In this sub-locality the responses have varied from time to time. At the beginning of the programme, the community did commendable work in terms of providing human and material resources. The leaders, youth and the patients promised final ownership of the programme. They readily helped at that stage to identify the houses and individuals who were alcohol/drug dependents.

Later on, it became clear that the main interest of the community leaders was to utilise them for general health care and project it as an ’achievement’ for their basti (locality).

The community was heterogenous in nature i.e. people belonging to different castes or sub-castes and still affiliated to the place of origin and cultural groups and did not provide a normative social control mechanisms to check non-confirmatory behaviour like alcohol/drug abuse, gambling etc. In the community there was a lack of hierarchical leadership and command. Each group or sub-group had their own leaders. Here one witnessed the rivalry among them which affected the extension service and attendance. Some of the leaders were themselves long-term alcohol users, their own and community’s reactions towards their drinking became mixed after the entry of the
extension service. Hence the goal in practical terms had to be changed from total abstinence to preventing harmful consequences.

Impact of the programme

The efforts were made to study the cumulative effects of the programme on alcohol and drug use pattern and other aspects of the community. A few important observations in this regard were:

- Among the patients attending clinic, there appears to be a direct relationship of patients improvement and number of visits made and support extended by the affected family. The improvement was seen as positive upon discontinuation of primary drug or less intake in terms of frequency/quantity at a follow-up of 12 months period.
- In spite of indifferent attitudes of the community leaders, the majority of people admitted that illicit sales of alcohol declined considerably to almost 75%.
- Due to continuous efforts of the staff of outreach services, drinking of alcoholic beverages in the public places, and in open space outside the residence was less observable. One unauthorised place used by the local influential men for drinking of alcoholic beverages was closed down for fear of stigmatisation.

An enforcement raid to check on illicit drug trafficker in the neighbouring sub-locality gave a new shape to the programme as a large majority of heroin users from the other localities got registered themselves at the Clinic. The attendance at community clinic showed many folds rise but the participation of the local people where it was functioning, became minimum. The youth of this sub-locality, with indirect support of the self-claimed leaders encouraged a game play foul in the proximity but for my doorstep.

Shifting of the premises

There were two options left before programme implementors, either to discontinue these community based services or shift them to another place in the interest of the target groups. The second option was followed and the services were shifted to a neighbouring sub-locality in February, 1994, where heroin trafficking was the maximum and need for these services was felt for a long time. A few registered medical practitioners (RMP’s) and volunteers from the sub-locality extended their co-operating in the establishment of the community clinic. The shifting was a setback to the programme in view of massive input over three years on the part of clinic staff to mobilise the community resources to deal with AOD problems. The redeeming feature was that there was manifold increase in the registration of the patients seeking treatment and other help for substance use disorder. The community involvement was symbolic but the treated patients and a few ex-addicts played a key role in motivating and bringing new patients and helped them in recovery process. In the year 1994 when the community clinic was shifted, a total number of 201 patients was seen in comparison to 971 in the previous year. If this trend is taken as an indicator, then this programme proves to be cost-effective with modest success but still many steps away from the process of community empowerment and ownership.

Broad-based modality

The experiences gained in running these services helped in formulation of broad-based modality
to cover another vulnerable section of the urban population in Delhi. In this regard, a slum cluster (Kathputali colony) was selected in 1993 on the basis of severity of alcohol/drug problems and existing infrastructure of the Urban Basic Services, Delhi Government, for health and welfare programmes. A local non-governmental organisation, ‘Kalakar trust’, looking after the welfare of folk-artists families was also involved in delivery of these services. The slum cluster consisted of approximately 2599 huts of which one-fourth belonged to the folk artists. Besides shabby living conditions of the inhabitants, the problem also lay in the area of health, poor maternal and child care, malnutrition, tuberculosis and high rates of alcohol/drug abuse. It was also a paradox that the artist groups, hired by health and welfare agencies to participate in anti-drug campaign during festivals and other cultural events were heavy users of alcohol and cannabis. They rationalise the use of these psychoactive substances as a part of their life style and cultural ethos.

The intervention package, remained more or less the same as that of earlier programme. The treatment services were to be provided through community clinic once in a week to be run in the community Centre of the adjoining locality. The first step was to identify the decision making body for the slum locality involving both artist and non artist population, sensitising their leaders to work as community motivators, selection of youth and women groups to serve as animators and close co-operation with Kalakar Trust and Urban Basic Services (UBS). Besides identifying the problems of alcohol/drug abuse, the environmental factors associated with heavy alcohol consumption in both the artists and other inhabitants were also identified. An intervention package was developed accordingly. A male extension worker of the community was trained in counselling and mobilisation of existing resources and he worked closely with the community clinic staff.

The women’s support group (mahila mandal) involved by kalakar Trust in community development programme was in favour of closing of illicit sales out of alcoholic beverages, run by women and children of non-artist groups.

Instead of confrontational approach, the Panchayat leaders (Council members) as well as majority of men suggested approaches like awareness campaign against illicit drug (Smack/charas and ganja) through folk media, holding street corner meetings, inviting films/sports personalities and to carry out other developmental activities. The treatment of heavy alcohol users with physical health damage, psycho-social and economic problems was favoured but on voluntary basis. The role of family members in motivation and detoxification was visualised. Coercive methods were suggested for least motivated individuals. The programmes outcome is yet to be evaluated in this slum community.

Viability of community approach

The community approach has received considerable recognition in the treatment of substance use disorder in the South-East Asian countries. In India, community ‘camp’ approach gained popularity in 1980’s for the treatment of raw opium users in the rural areas of north-western states of the country but met with little success for heroin dependence in the urban population.

The present programme is an attempt to reach to this vulnerable population and develop a supportive environment for sustaining recovery through family enrichment and other outreach programmes. As a part of service delivery, community clinic was started. The experiences of the
programme remain mixed ones. The availability of treatment services at the doorsteps of the vulnerable population, open communication, informal atmosphere and free availability of medicines were the favourable factors in broadening the target group and even bringing street addicts, drug pushers cum users and persons with high risk behaviour.

The disappointment came from the level of community participation, although not surprising in the field of substance abuse. The problems of AOD use affect only specific groups/small population and it does not rank high in the value system of the people. There has been a tendency among the non-drug users to view this problem as an unpleasant condition which is not particularly dangerous, but which can perhaps, undermine the prestige of the community. The heterogeneity of the urban population with strong affiliations to either caste, language and place of migration and emergence of nucleated groups and their antagonistic attitudes toward each other fail to facilitate the process of collective participation and meaningful social action. However, these mixed responses suggest that viability of community based intervention programme in the field of drug dependence among the peripheral urban population is the need of the hour.
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Ethnic-oriented community project among immigrants in Israel - A model for other countries which absorb immigrants

Shoshana Weiss

Introduction

While visiting at the end of 1991 research and prevention institutions in Canada in the framework of faculty enrichment program - award from the Canadian government through its embassy in Tel Aviv, I arrived at the British Columbia Prevention Center in Vancouver, which serves as resource centre and provides an alcohol education service, especially for "ethnic communities" - immigrants from Eastern Asia (China, India, etc.). I found out that all prevention materials and activities were carried out in the immigrants’ languages and stemmed from their own values, norms and customs. Actually, the situation there was very different from the condition I had met in the USA, where Western-oriented prevention materials were offered to immigrants in English, or eventually translated into Spanish.

In 1991 - 1992 I was interested in immigrants because the immigration wave from the former Soviet Union started to bring to Israel, with its 4.5 million citizens, more than half a million newcomers. I knew that the prevalence of alcoholism and problem drinking was estimated to be very high in the former Soviet Union (The Globe 1992; Anderson and Hibbs 1992), which means - alcohol problems among the newcomers who consume large amounts of alcohol, especially Vodka, in comparison with Israeli-born Jews. What Israeli considered heavy drinking was the norm for most Soviet people. They drank at parties, at meetings, at family get-togethers, during holidays and whenever the occasion seemed to suit. Therefore, I decided in 1992 to adopt various valuable elements from the "Vancouver Model", and to plan a community prevention project aimed at Russian immigrants. In addition, many of the 50,000 newcomers from Ethiopia, who came in two waves (in the middle of the 80's and in the beginning of the 90's) have taken to imbibing large amounts of beer. They embarked on the habit after they had come to Israel. Beer reminds them the taste of a traditional drink - "Tela", which in Ethiopia does not contain 5 % alcohol (Weiss and More 1993). Therefore, I decided to include also this population in the community prevention project.

The first stage of the community action project encompassed investigation and collection of reports and studies pertaining to alcohol use among the immigrants. Research conducted in the winter of 1992 in the north of Israel revealed that beer is indeed the main alcoholic beverage drink by Ethiopian students (75 %). They reported drinking mainly at home (58 %), in order not to be exceptional (33 %), and to improve bad mood or forget troubles (25 %) (Weiss and More 1994). In 1991 and 1992 Russian immigrants constituted a third of new cases of Jewish alcoholics admitted to the centres for the treatment of alcohol dependency, and this was probably the tip of the iceberg (Bar-Am 1991; Ministry of Labor and Social Affairs 1992) because there were not statistics concerning the drinking problem among the newcomers. But if there were already a third - Russian clients, there were probably more to come, because there were several kinds of barriers to Russian immigrants entering treatment (Bar-Am 1991). Furthermore, according to the official statistical data published by the governmental statistical bureau, the local production of distilled
spirits (such as Vodka, Arak, etc.) increased from 2,148,000 litres in 1990 to 3,939,000 litres in 1992. In addition, an article (Manilowitz 1992) which explains in depth the reality of alcohol drinking among the Russian newcomers encouraged the purpose to decrease the amounts of alcohol consumed by the newcomers and reduce the impact of Russian immigrants’ Vodka drinking patterns on the Israeli population. Otherwise, the Israeli society can develop fairly rapidly, patterns of non-ritual drinking which are commonly found in East European countries. In addition, many reports on alcohol-related violent events among newcomers from the former Soviet Union and Ethiopia, as well as drunken driving cases among the Russians, were collected from the daily newspapers. All the above materials pointed out to an urgent need to carry out a prevention project in these two communities.

In order to cope with alcohol problems (violence, driving under the influence of alcohol, health damage) among these two populations of immigrants from two distinct parts of the world, which shared a common phenomenon - alcohol problems, the Jewish Agency for Israel supported in 1993 (by a generous grant in Israeli terms) the community project aimed at adult immigrants, which was carried out by the Israel Society for the Prevention of Alcoholism.

I would like to present selected characteristics of the project, which was unique in local terms, but may be very interesting for alcoholism authorities in the former Soviet Union, in Ethiopia, and in developed countries which absorb immigrants in general, and immigrants from those countries in particular.

**Description of the Ethnic-Oriented Community Project**

The superordinate objectives of this projects were to reach a lower level of beer consumption among Ethiopian Jews and to decrease the amounts of Vodka consumed by Russian Jews. The project’s main specific aims were as follows: (a) Enhance awareness both to alcohol problems in the community and to alcoholism authorities which provide assistance, and lead to attitudes which do not favour excessive drinking. (b) Encourage and motivate immigrants to seek help for themselves and for their relatives and friends concerning prevention and also treatment. (c) Establish a liaison between the immigrants’ communities and the alcoholism authorities (by providing prevention materials, resources, training, professional consulting etc. in relation to alcohol abuse). (d) Conduct formative (followed by summative) evaluation of the project’s effectiveness and extent of the attainment of the above specific goals and superordinate objectives.

In order to develop the contents of the prevention materials, as an Israeli-born researcher, I had an assistance from Dr. Ada Lichterov, a newcomer psychiatrist with years of experience in a Soviet hospital for alcoholics, who had gone through the difficult process of immigration herself, fully understood the problems of the Soviet newcomers and works as the principal professional who treats the newcomers in the governmental residential centre in Ramat Gan (which is operated by the Israel Society for the Prevention of Alcoholism). I had also assistance from social workers (Ethiopian and non-Ethiopian) who work among the Ethiopian immigrants.

**Project’s Unique Characteristics**

The project did not include translations of available Western-oriented Hebrew materials into
Russian or Amharic. It was an ethnic project, which included a development of materials for two ethnic groups, in their natural and cultural environments and in their own languages, in accordance with the "Vancouver Model" I had been acquainted with in Canada. It encompassed the design of new materials, which stemmed from the values, norms and customs of these populations, and dealt with their unique problems. For example, beer drinking patterns among Ethiopians, beer drinking during pregnancy, or alcohol and AIDS, were subjects discussed in the framework of the Ethiopian materials, whereas Vodka drinking patterns among Russians, Vodka and driving or Vodka and violence, were issues dealt with in the framework of the Russian materials. Thus, the contents were tailored to the target populations and provided in their languages.

The project included materials produced to a very high quality (posters and colourful, rigid and lustrous four leaflets in each prevention kit), which had never been seen before among alcohol prevention materials in Israel. This is expensive, but is necessary in order to attract the attention of the undeveloped population of Ethiopian Jews and even of the Russians, who have come to Israel from places with a very low standard of living, and to ensure that the four leaflets in each kit will be read, kept at home and not thrown away. Special pictures were planned and included in every leaflet in order to intensify the messages written in big letters in the headlines, and they occupied the largest part of the available space. The verbal part was, in comparison short, and it included a brief "personal story" connected to the leaflet’s theme and chosen from events among immigrants described in the daily newspapers. The verbal part is not the most important, because nowadays people have no time to read loaded texts. Furthermore, the sentences in the verbal part are relatively short. Therefore, emphasis was put on the headlines and the pictures. The headlines expressed the messages such as: "Ethiopian Jews have adopted in Israel excessive drinking patterns of beer", or "Vodka drinking impairs driving". Thus, prevention materials for immigrants have to be in a high quality, in an attractive format, in their language, and more descriptive than verbal.

Implementation

About 20,000 copies of the prevention kits were distributed in 1993 - 1995 among the immigrants. In the Ethiopian neighbourhoods they were distributed "from door to door" by social workers who personally gave them further explanations. The materials were distributed in Russian immigrants’ neighbourhoods and in "absorption centres" and were followed in most cases by educational activities among groups (40 - 80 people) of immigrants. The activities were conducted by the Russian staff of the Israel Society for the Prevention of Alcoholism (who had recently come to live in Israel) and mainly by Dr Ada Lichterov. The idea was that the immigrant would trust them more than the Israeli-born staff. Following implementation, a wave of Russian newcomers came to treatment/family therapy/counsel. The hot-line, which is available 24 hours a day, had more calls from the Russian community than before. More requests for materials and information came from newcomers.

Problems Encountered in the Process

Actually, the main problems were in the implementation stage among the Russian immigrants. The Ethiopian Jews were glad to receive the kit and the explanations. They were fascinated by its
technical quality and they really appreciated the efforts invested for their sake. However, male
Russians have in Israel a stigma of alcoholics - “All Russians are Alcoholics”. They try all the time
to eliminate and relieve this stigma. Therefore, the project caused some rejection. The main
Russian daily newspaper published an article against this project which “is not needed, because
there are no alcoholics among the immigrants. Israeli-born people invented this lie”. For public-
relation purposes, Russian immigrants denied the existence of the problem. In addition, they were
afraid from the “authorities” and from sanctions such as had been existed in the USSR. When
groups of newcomers in absorption centres were brought to attend the educational activities, their
responses were: “It is not for us”, ”We do not drink”, ”It is a waste of time”. Therefore, the title
of the implementation among the Russian immigrants was not ”Prevention of Alcohol Abuse”. The
title was ”Coping with the immigration crisis”. (Indeed, the idea was that there is a need to change
drinking patterns in the framework of changing all life styles in an extremely different new
country). In the framework of the lectures they faced a Russian staff (which of course was more
reliable than an Israeli-born staff) which made them aware of the fact that their reaction had been
characteristic of people who deny their condition and do not like to hear the truth. There were
discussions concerning “other people” drinking problems (not the “audience problem drinking”)
and information was provided concerning referrals to treatment centres of ”people who drink
daily” (because this situation can be dangerous) as well as about treatment methods. The main
issues of the prevention kits were discussed and kits were distributed among the families. Each
lecture was about 1.5 - 2 hours.

Future Work

The distribution of the Russian kits is continuing. There is an intention to evaluate the project
systematically by interviews and by questionnaires. There are two difficulties concerning this
intention: Russian immigrants, in general, refuse to answer questions concerning alcohol drinking
because of their stigma and fear, and previous efforts to investigate this issue have failed (Michaely
and Naor 1995). There is a plan to enlarge the project and to develop similar materials for young
immigrants. Funds are being looking for.

Notes

The prevention kits described in this paper won in December 1995 the first place in the
sings/posters/displays category in the framework of the 1995 International ”Markie” Awards for
Alcoholism and Addiction Education, sponsored by The American National Foundation for
Alcoholism & Addiction Communications (NFAAC). In addition, some colourful leaflets were
presented in WHO exhibition during the WHO European conference Health, Society and Alcohol,
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Reflections on the day

Harold D. Holder

The collection of papers which make up Section 4, reflect the rich diversity of setting, prevention strategy, and methodology which exists in community prevention efforts throughout the world.

The paper by Geoffrey Hunt provides an example of how qualitative approaches can be used in evaluating community programs. Here the evaluator is an essential partner in the overall project, i.e., of support to the project itself and not simply an outside, independent critic.

The paper by Kathryn Graham and Christine Bois provides a case study of a partnership between a community organizer and a researcher to design and evaluate a project to prevent substance abuse among the elderly in a community in Ontario, Canada. Here we see the effort to define alternative roles, to maintain credibility of the function of each role, and to find the most effective balance in working with the community.

The COMPARI project in Western Australia, written by Richard Midford, Kevin Boots, and Terri Cutmore, is an example of a comprehensive project designed to reduce alcohol-related trauma. This project demonstrates how community processes and research objectives must be integrated in order for the project to be effective.

The purpose of the Kungsholmen project in Stockholm, Sweden, described in the paper by Anders Romelsjö, Stefan Borg, Kerstin Hjalmarsson, and Jörgen Larsson, was to reduce high volume drinking in a community which actually was an island within the metropolitan capital. This project utilized a series of community and school educational strategies to increase citizen awareness of the risks of heavy consumption, and to provide tools which assisted drinkers in monitoring their own alcohol use.

The prevention project in Israel presented by Shoshana Weiss had the difficult task of dealing with differences in drinking styles between existing citizens and Russian immigrants who had recently reached Israel. This project was faced with the challenge of selecting words and images which communicated the risk of heavy drinking in a setting from which people came with high volume drinking traditions.

An important observation across these community projects is that each established a stated or implicit process model which guided local prevention interventions. The Kungsholmen project was based upon a systems model of the community which recognized the interrelatedness of various parts of the community in stimulating and supporting heavy drinking. The COMPARI project was based upon a harm reduction perspective in which the objective was not to reduce drinking per se but to reduce harm associated with drinking in the community. The Ontario project was based upon a health promotion and early intervention & treatment model to reduce alcohol and depressant medication abuse by older persons. This is similar to a model employed in the ethnic community prevention project in Israel, with the additional requirement of developing culturally appropriate images and approaches to health promotion.
The evaluation paper presents how an ethnographic approach to research, which was initially developed by anthropology, can be employed to evaluate community action projects in the United States. Since evaluation was required by the national funding source for these "community partnerships", there was the natural tension of being a required element in the project and a part of the project team.

Based upon these papers, as well as the other papers in this collection, there are at least two important observations which can be made. First, while general strategic or conceptual models are useful, they do not substitute for a research grounded causal model to guide the project design. This establishes an important role for research and science in the early stages of a community project. The initial requirement for any project is to identify the final outcome which is to be reduced or prevented. Usually this would be an alcohol-involved problem, but some community projects target high risk drinking (such as intoxication) as an intermediate variable. Therefore, in the next step, based upon the best available research, community project planners must identify those most critical intermediate variables which give rise to the final outcomes targeted. Within a community context, no alcohol problem is the result of a single behaviour, or situation, or setting. Rather multiple factors interact to produce any alcohol problem. For example, a drinking and driving accident can result from a combination of alcohol impairment of the driver, high speed, and unsafe driving conditions. High speed and driving conditions alone can produce a crash but a drinking driver has an additional increased risk via his/her impairment from alcohol.

Thus, a causal model of the variables which interact together to produce targeted outcomes is an essential scientific development for improving community prevention efforts. By identifying the key intermediate variables, the most appropriate strategies for intervention with these variables can be identified from evaluations of strategies which have attempted to change these variables. While none of the projects in this section presented such causal models, all could have benefited from such specification.

The second observation based upon these papers is the importance of a partnership of specialists in community organization with researchers in developing and evaluating local initiatives. Each of these papers presented cases in which researchers were involved in the project from its initiation. In this way, the opportunity for a true working and respectful partnership was created. In some cases, the project leader was a researcher. In other cases, the researcher was an important and central participant in the overall process. This is the basis of effective local prevention.

Overall, these papers provide excellent examples of local efforts to reduce alcohol problems in quite diverse cultural settings. Each of these cases demonstrate the robustness of community action as a means to integrate prevention into the full fabric of the community.
FIFTH SECTION

Usefulness of population survey methodology for planning and implementing preventive programs on community level - Experiences from Poland

Grazyna Swiatkievicz

Introduction

Despite the fact, that contemporary prevention programs more and more frequently offer broad range of activities of the early prevention character, they focus on a single substance. Manuals, advisers and so on, presenting methods of anti-alcohol programs construction and those, presenting programs of drug prevention are published separately. Despite many common elements, especially with regard to early prevention, separate institutional bodies coordinate activities with regard to alcohol and drugs.

Depleting of proved experience in early alcohol prevention may be justified, also in drug prevention program building. Such issues as approval and backing by local communities or establishing a local cooperation network to implement and carry on a prevention program can be resolved in a similar way, independently of the stimulant, which given prevention activities focus on.

On the other hand, there are some substantial reasons justifying existence of separate and specialized approaches. The social context of the illegal drugs abuse is somewhat different from the context of the legal substance abuse. The more ‘risky’ populations are approached the more specialized strategies are justified. In case of primary prevention, which focuses on young generation, reasons justifying specialized approaches are less convincing.

Community action research projects, whose popularity is increasing in many countries, are of incidental character in Poland.

Over the period 1988 - 1989 the Institute of Psychiatry and Neurology initiated the project to limit alcohol abuse related problems in the district of Mokotow, of the City of Warsaw and in a rural community of Sianow, located in the North-West Poland. The experience learned there, appeared very useful in preparing and implementing the ‘Prevention and Management of Drug Abuse in Poland’ project. The accomplishment of the project was possible thanks to the agreement reached by the European Commission and the Institute of Psychiatry and Neurology.

In the action research project of the late eighties, the questionnaire constructed in Contra Costa, California, was utilized. The original questionnaire was adapted to Polish circumstances. First, at the stage of translation. The verbatim translation of some paragraphs was senseless due to apparent cultural dissimilarities. Then second stage of the adoption process took place after the
pilot study. The sequence of questions regarding the relevance of drunk persons behaviour problem for the community members made the significant component of the questionnaire. The pilot study revealed, that the common sense understanding of the word ‘problem’ in Polish, significantly differs from its meaning in English. Consequently, further change of the Polish version of the questionnaire adaptation to the Polish context appeared strenuous and effected in the tool, which did not guarantee a satisfactory level of results comparability.

At the stage of a research tool construction the dilemma arises: Should given questionnaire be specific regarding a unique research endeavour, capable of grasping unique features of given population, or should it rather grant comparability of results with results of former studies within the country or even less specified results, granting however, international comparisons. It is worthwhile to underline, that in case of the action research studies, results intelligibility and clearness concerning local activists constitute additional, significant value of the studies. If the results are to serve for planning of a specific action in a specific area, priority should be given to tools grasping cultural uniqueness of the community.

A questionnaire employed to study two separate communities, where the European Commission funded program of drug prevention is implemented, makes a compromise between the attempt to secure inter-cultural comparability and grasp uniqueness of the problem in Poland.

On the ground of our earlier experience on action research studies, we know that submission of results to public debate is great significance. The results should be presented in the intelligible way both, to local activists and the broader audience. The second lesson learned during alcohol related activities is better comprehension of the need of regular contacts with local activists. Usually, such meeting fulfills the evaluative function regarding preventive activities and they make corrections of erroneous assumptions feasible.

**Basic assumptions of drug prevention program implemented in the city of Starachowice and Malczyce**

In Poland and in other countries in the process of political and economic transformation, the level of drug addiction spread out may be worded as a modest one. Some presumption however, justify the prediction concerning the eventual deterioration of the situation. The rapid increase of many social problems, namely unemployment, crime, poverty and so on, increases the likelihood of drug addiction elevation. The opening of the borders, which is followed by easier access to legal and illegal psychoactive substances, make additional promoting factor. The implementation of drug addiction preventive programs in two localities in Poland, was founded on this basic assumption.

As compared to the rest of the country, the City of Starachowice, inhabited by 60,000 people, can be said to have relatively small drug addiction spread-out. The basic problems there are unemployment and clearly perceived deterioration in living standards.

Malczyce, is a county (gmina) in South-West Poland, inhabited by 6,000 people, where drug addiction coefficient, is somewhat higher than in many other regions. The difficult economic situation experienced by the country affects these people in the significant way.

In the subsequent part of the paper I will focus in Starachowice. This is the place of low drug
addiction spread-out. For these reason it is more typical for Poland.

The general scheme of the preventive activities implementation in Starachowice, could be broke into three basic stages:

1. The stage of diagnosis, comprising of:
   A the questionnaire population survey of the representative sample of the inhabitants of Starachowice,
   B studies over available city statistics, regarding such youth related issues as alcohol abuse, psychoactive substances abuse, crime, school problems,
   C questionnaire studies of school youth,
   D interviews with drug dependent individuals.

2. The stage of the drug prevention program formulation:
The results of the investigation were presented during the extended local council meeting. The simple version of the study report was distributed among local activists. The results of the questionnaire survey served for the distinguished preventive activities formulation.

3. The action stage (May 1, 1994 - May 31, 1995):
   A activities within the area of the first line prevention, focusing on all youth,
   B activities within the area of the second line prevention, addressed to the risk groups,
   C activities within the area of the third line prevention - drug dependent individuals assistance system in the locality.

4. The evaluation stage:
   A the population survey of the representative sample of the inhabitants of Starachowice with the use of the questionnaire,
   B investigation of the available city statistics concerning such youth related problems as alcohol abuse, psychoactive substances abuse, criminality, school problems,
   C the questionnaire investigation of school youth
   D interviews in the milieu of the local drug abusers.

The evaluation of the process takes place over the entire activity period. Once a month, the Institute of Psychiatry and Neurology research team meets the local program implementors, reports on the course of the activities are presented on the run. The more general evaluation of the activities took place twice, during conferences participated by local activists, engaged into the program implementation and observers, who represented influential local educational and civic organizations.

At the diagnosis stage as well as the three remaining stages of the program we used several research and evaluative methodologies. The population survey methodology was one of them. For activities based on the early prevention theory, population surveys seem to constitute methodology of particular usefulness.

The stage of diagnosis
The questionnaire survey covered the randomly selected sample of Starachowice inhabitants. The sample consisted of 500 individuals. Inhabitants of 15 years of age coming from all social groups were represented in the sample. The intervenes then asked about issues, that make their life harder, irritate them or make uneasy, generally pointed out at unemployment. More than 80 % of them suggested unemployment on the spontaneous basis. The frequencies regarding other issues did not exceed 30 %. The fractions of 20 % verbalized the issues of low living standard, crime and alcoholism. Drug dependence was pointed out by less than 2 % of the inhabitants.

The awareness of the inhabitants’ opinions concerning significance and spread out of various social problems, substantially influenced the form of presentation of the offer, regarding implementation of drug prevention program activities. The survey results clearly proved, that the program will be implemented on the area, where people combat basic, everyday problems. One should not expect broad social approval for designating significant financial means to resolve drug problems, which are perceived as of marginal importance. The concept of early prevention, based on the broad approach to the prevention of problems among adolescents, in the light of the obtained results, seemed more appropriate.

Despite the fact, that everyday existence problems dominate, the inhabitants are aware of the present and coming threats to adolescents. The majority was of opinion that adolescent trouble makers equal half or majority of the city adolescents. Alcohol abuse, anti-social and aggressive behaviour were most frequently pointed out youth related problems. According to 7 % respondents drug dependence relates to local adolescents.

The threats of unemployment, poverty, alcoholism and neurosis were extensively perceived. Light potential problems were evaluated by the respondents. Drug dependence was concerned least jeopardy to adolescents in Starachowice. Probably, the social consciousness of Starachowice inhabitants accommodates a conviction that drug dependence is the phenomenon of substantially different causes than alcoholism, anti-social behaviour or neurosis. This result suggested the necessity of informative activities. It is known, that the foundation of drug dependence development may consist of the same factors that bring about alcoholism and other socially harmful attitudes and behaviour of adolescents.

The inhabitants of Starachowice generally confirmed the necessity of preventive activities of some sort, focusing on youth problems (79 %).

According to the decisive majority of respondents, the basis of many harmful phenomena among adolescent is simply boredom. This is why, probably, when talking about definite prevention activities to be undertaken, the inhabitants concentrated on the idea of better management of leisure time of adolescents. There were numerous proposals on youth clubs, after-school activities and so on. It makes sense to explain, that the availability of the abovementioned forms of leisure time activities was cut down rapidly, over few recent years, due to the severe economic problems experiences by the city.

Additionally, the questionnaire investigated opinions and attitudes of inhabitants regarding so-called troubled youth and drug dependents.

The outlook prevailed, that family and school, i.e., the closest milieu, are entities most suitable to
assist troubled youth.

The attitudes toward local drug dependents are not of repressive character. According to most of respondents, drug dependent individual is an indisposed person, who needs assistance.

The inhabitants generally supported the concept of early education on HIV prevention, however, they represent low level of HIV positive individuals tolerance.

Local press enjoys significant popularity. It is considered the reliable and appropriate source of information concerning, among others, HIV related problems.

The population surveys provided data on (a) the position of the drug dependence problem in the consciousness of the local community against other social problems, (b) public opinion on the spread out of socially harmful behaviour of adolescents, (c) the degree of social acceptance of the intended preventive activities, (d) information on the most suitable, according to the public opinion, methods of prevention and limitation of youth related problems.

The key problem, which emerged from the questionnaire survey, was the question of the marginal significance of drug dependence, as the present and the future matter of the youth related threats. The position of our program was based on the idea of early prevention, preventing the development of problems. It is hard to demonstrate however, that the applied preventive activities had whatever preventive effect, concerning the phenomenon, which had not developed on the given area. It is hard to acquire definite and quantifiable evidence to be presented for future sponsors of the eventually proceeded activities.

The dilemma and the nature of the early prevention activities are best illustrated by the story, which many people are familiar with, about a man, who used to walk around a town clapping his hands. When asked about the purpose of this behaviour, he explained that he frightened away big pink elephants. When told by one on the bypassing individuals, that even a single big, pink elephant had never been seen in the town, he said that they did not come, because he frightened them away.

The problem of drug dependence in the opinion of the Starachowice inhabitants is like this big, pink elephant, which has never been seen in the town, so it is not perceived as a potential threat.

The stage of the program formulation

The results of the questionnaire survey constituted the significant information source, during the formulation of definite prevention endeavours. Their simplified presentation during the joint meeting or the local control and local activists stimulated the discussion over the necessity of designing a prevention program focusing on youth. According to suggestions contained in the questionnaire, the proposed activities concentrated on the idea of betterment of leisure time management. Teams to organize various sporting activities for school youth, including swimming lessons, were established. Renovations and opening of formerly closed youth centres were planned. The graduate club, which attracted youth who could not find a job after graduating, was opened. The availability of interest circles, which existed for some time already, but on somewhat elitists basis, like the survival school, was increased.
Many one-time events to animate social and cultural life in the city, were scheduled. It was assumed that this type activities may stimulate youth’s own initiative.

Following the opinion of the inhabitants, no centre focusing on troubled youth was opened. According to the questionnaire data, family and school was considered the most appropriate to resolve the problem. In order to support both entities, psychological counseling centres for parents were set up. Also, the on-service training program for teachers was initiated in Starachowice.

The results of the population survey provided much lesser support for planning of the third line prevention, which focused on the small group of drug dependent individuals in Starachowice. The plan proposed to them was founded on the additional penetration of the group of local drug abusers. Nevertheless, the familiarity with social attitudes of drug dependents on the ground of the population survey, appeared to be useful also in this area. Helping drug users remained in full accordance with non-repressive opinions of the community. The decisive majority of the respondents defined the drug dependent individual as the indisposed person, who requires assistance. Both, people who provided such assistance and drug users were familiar with the results of our study. Thus they were aware, that activities on this area will not bring about hostile reactions or rejection by the community.

At the program construction stage, the results of the survey appeared the significant source of expertise regarding social and cultural context of the city, where the project was to be implemented. The inhabitants quite widely expressed their demand for preventive activities focusing on youth. They distinctly preferred activities directed to large youth groups, over the activities addressed to smaller groups of high risk. The idea of better management of leisure time of adolescents was almost entirely taken from the set of solutions proposed by the community.

**The stage of program implementation**

The results of the population survey were presented to the local implementors in the form article written in commonly understood language.

On the fall of 1994 the city council election took place. After the election many agreements and commitments of former city authorities had to be re-negotiated with the new authorities. According to the report of the local program coordinator, the results of the studies, facilitated the process. The city authorities alteration did not interfere the early project cycle, in a significant way.

Also, local media made use of the results. The wide circle of the inhabitants could learn that the drug dependence prevention project implemented in Starachowice embraces both, themselves and their children and was intended to prevent drug dependence as well as many problems of different nature.

During the program implementation, more intense statistical analysis of the data collected over the initial studies, were done. The information on the attitudes of city inhabitants toward HIV carriers provided to local activists, revealed distressingly low tolerance level regarding this group. This statement was particularly true in case of the elders. The discussed results served to supplement
formerly scheduled activities. Educational activities concerning HIV and focused on school youth were supplemented by adult education program. The special brochure written for the city inhabitants was distributed through the general health care centres.

The meetings of the Institute of Psychiatry and Neurology research team and local activists organized on monthly basis performed the function of regular program evaluations. In the debates, the results of the study were used to justify the necessary correspondence of activities and initial assumptions.

The final evaluation stage

The program officially expired on May 31, 1995. The evaluative studies were accomplished over June and July. Their results will be known in the Fall. Just as at the diagnostic stage, population surveys were only one of the methodologies applied. The questionnaire, after modifications and adjustments necessary in order to use it for evaluative purposes, was tested in the pilot study. The result of the pilot study proved its appropriateness for the measurement of social discernment of the entire program and some of its components.

The main target of the population survey methodology evaluation was the conclusion regarding the discernment of the program implemented in Starachowice, by local community. The social discernment of the drug prevention problem was the basic target of the program addressed to the general audience, i.e., entire city population. It does not seem feasible, that a program focusing on the early prevention and addressed to one group only, namely adolescents, could induce transformations, which could be assessed on the ground of the population survey method.

Table 1. Social problems at the community level pointed by citizens from Starachowice.

<table>
<thead>
<tr>
<th>The name of the problem</th>
<th>% of respondents pointing the problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unemployment</td>
<td>82</td>
</tr>
<tr>
<td>2. Low living standards</td>
<td>27</td>
</tr>
<tr>
<td>3. Crime</td>
<td>21</td>
</tr>
<tr>
<td>4. Alcohol related problems</td>
<td>16</td>
</tr>
<tr>
<td>5. Problems with infrastructure in the city</td>
<td>15</td>
</tr>
<tr>
<td>6. Bad relationships in the society</td>
<td>9</td>
</tr>
<tr>
<td>7. Problems with young generation</td>
<td>9</td>
</tr>
<tr>
<td>8. Lack of infrastructure for cultural spending of spare time</td>
<td>8</td>
</tr>
<tr>
<td>9. Criticism addressed to local authorities</td>
<td>8</td>
</tr>
<tr>
<td>10. Lack of optimistic perspectives for youth and adults</td>
<td>6</td>
</tr>
<tr>
<td>16. Drug abuse</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Table 2. Opinions on young generation.

<table>
<thead>
<tr>
<th>Category of the opinion</th>
<th>% of responses</th>
</tr>
</thead>
</table>

261
Vast majority of the young generation does not produce problems for the community

Majority does not produce problems

About half of young people produce problems for the community

Majority produces problems

Vast majority produces problems

Don’t know

Table 3. Youth related problems pointed by citizens.

<table>
<thead>
<tr>
<th>Name of the problem</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol related problems</td>
<td>50</td>
</tr>
<tr>
<td>Anti-social behaviour</td>
<td>34</td>
</tr>
<tr>
<td>Crime</td>
<td>34</td>
</tr>
<tr>
<td>Unemployment</td>
<td>13</td>
</tr>
<tr>
<td>School problems</td>
<td>11</td>
</tr>
<tr>
<td>Tobacco smoking</td>
<td>11</td>
</tr>
<tr>
<td>Boredom</td>
<td>10</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 4. Threatens of problems among youth.

<table>
<thead>
<tr>
<th>The name of the problem</th>
<th>Big threatens % of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment after school</td>
<td>95</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>59</td>
</tr>
<tr>
<td>Health troubles</td>
<td>38</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>14</td>
</tr>
<tr>
<td>Crime</td>
<td>42</td>
</tr>
<tr>
<td>Poverty</td>
<td>80</td>
</tr>
<tr>
<td>Neurosis and other psychological problems</td>
<td>60</td>
</tr>
</tbody>
</table>
Stimulating community participation: Posters on drug abuse prevention designed by children

Michał Gajlewicz and Jacek Moskalewicz

Introduction

In Spring 1994, an action-research project “Prevention and Management of Drug Abuse in Poland” was started in two local communities being “at risk” due to high unemployment, disruption of local economy, poverty and due to devastation of their cultural and recreational infrastructures. The project lasted about 18 months, until the end of 1995.

The project targeted two local communities: Malczyce and Starachowice. Malczyce are located 300 km south-west of Warsaw in Lower Silesia which for years has been known as a region of high prevalence of drug abuse. Having approx. 6000 inhabitants, Malczyce had between 20 and 30 addicts i.e. 0.5 per cent of its population (this ratio as calculated for one village, where virtually all addicts used to live, approached one per cent). Formerly small industrial town with big sugar plant, river shipyard, small harbour and paper factory, Malczyce had slowly drowned into economic crisis followed by unemployment and poverty as well as accompanying social problems.

Starachowice are located in central Poland, some 150 km south of its capital. It is much bigger town of 60,000 inhabitants with long industrial tradition. For more than forty years its economy has been dominated by big truck factory which used to employ more than twenty thousand workers. In addition to its economic functions, the factory performed a variety of social roles including provision of kindergartens, schools, industrial health care, cultural life and recreation. After recent transformations, employment has dramatically declined to about two thousands, unemployment reached 30 per cent level. Social and welfare activities of the factory were drastically reduced. As in Malczyce economic crisis was accompanied by other social problems. In contrast to Malczyce, drug abuse was not prevalent as a total number of addicts was less than twenty for the population 10 times bigger.

The project “Prevention and Management of Drug Abuse in Poland” was launched to demonstrate that drug prevention is possible and feasible in such a context. A preventive package or manual on how to prevent drug abuse at the community level at a potentially specific Eastern European context is a major outcome of the project (Moskalewicz 1995; 1996).

The project consisted of three phases: research - action - research. In addition to traditional outcome evaluation, continued monitoring of experiences from its implementation or process evaluation have been carried out.

Research phase composed of:
• the gathering and processing of existing statistics,
• a community survey,
• a school survey,
• investigating agencies involved in drug problems, and
• the interviewing of local addicts.

Within the action phase three major components could be distinguished:
• increasing public concern,
• primary prevention, and
• treatment and relapse prevention.

The poster campaign, we are dealing with here, constituted an important part of activities placed under the heading of "increasing public concern".

**Campaign**

1. Educational campaign versus commercial advertisement

In the educational campaign, the vehicles were applied that are typical for advertising. Advertising is mainly associated with achieving commercial goals (Sandage et al. 1979). But besides, there are other kinds of advertising or - speaking in a more general way - persuasive activities. Some of them are called noncommercial advertising. The discussed campaign undoubtedly belonged to this kind of activity. It is worthwhile discussing some main features of advertising since they pertain to the educational campaigns too.

First of all there is a formula known as AIDA that shows main features of advertising that ought to stimulate the recipients (Boveé et al. 1992):
A - Attention
I - Interest
D - Desire
A - Action

An advertisement understood as a published, broadcasted or otherwise disseminated units of advertising or the whole group of advertisements applied in a campaign must:
• Draw attention of a recipient,
• Arouse interest in the content of a message,
• Create the recipients' desire to possess something (a product, an idea, knowledge etc.),
• Convince the recipients to take action in accordance with the intention of the communicator.

Three of four mentioned above features or requirements pertain in equal degree both to educational as well as to commercial campaigns (first, second and fourth). As to the third requirement (desire) it fits better to the commercial than to the social sphere. Desire to possess something is more obvious when associated with products (less with services) than with typical goals of an educational campaign which not rarely persuades people to abstain from something (for instance drinking, smoking or using drugs). In such cases the objects of desire have to be defined in more general terms, first of all by means of involving values (health, self-satisfaction, happiness etc.). The commercial advertising also uses such approach but not so often.

Educational campaign possesses in a way some features of the so called institutional advertising - which aims at creating a favourable image of an institution in the minds of people who have or
may have contacts with it (Sandage et al. 1979). Using a concept from the commercial area - it is more an advertising of the producer than of the product.

Out of variety of advertisement approaches this campaign focused on outdoor display of posters. Because of its low budget, the smallest posters (format of the small theatrical poster) were used. Other means of outdoor advertising such as billboards, displays and spectaculars were not used though they could be more effective. In this kind of advertising only extremely condensed messages may be applied because of very short period of time devoted to them by the recipients: on average it amounts to only 5 - 8 seconds. So the content of a message (both verbal and graphic) has to be laconic enough to convey the whole idea to a potential spectator in this time. Besides the message has to be attractive in order to grasp attention. It is important for two reasons. Firstly, people must notice the message because it is the necessary and initial condition of exerting influence on them. Secondly, it is vital in such a case when a poster offers longer contents. Then attracting attention is a precondition for the eventual further act of communication. In this phase a spectator takes a decision concerning viewing.

The outdoor advertising has its advantages and disadvantages. The most important of them are listed below.
Table 1.

<table>
<thead>
<tr>
<th>Advantage</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The outdoor advertising reaches a high cross-section of population.</td>
<td>I. The outdoor advertising has limited time of perception by an individual. It demands more creativity from designers and copywriters.</td>
</tr>
<tr>
<td>II. Geographic flexibility - it reaches population in chosen regions.</td>
<td>II. Lack of selectivity in the sense of demographic characteristics of the population. As a rule the outdoor advertising reaches the whole society.</td>
</tr>
<tr>
<td>III. Visual attractiveness due to the quality of reproduction, especially by the illuminated exposition.</td>
<td>III. Extremely high cost when applied in the small-scale campaigns because of high cost per unit.</td>
</tr>
<tr>
<td>IV. Low cost. It is the cheapest advertising vehicle when applied in the large-scale campaigns due to low cost per unit (a single poster).</td>
<td>IV. The posters might be easily damaged, especially when they are placed within reach of the hands of people, fist of all children. They can spoil or change the message and its meaning.</td>
</tr>
<tr>
<td>V. The outdoor advertising is compatible with other media. It may additionally reinforce messages disseminated by other media (especially by television and radio).</td>
<td>V. Placement of posters is very important not only because of traffic. One should take into account also attractive power of other visual elements of the neighbourhood such as other posters, shop windows, monuments etc. which can diminish reception of posters.</td>
</tr>
</tbody>
</table>

2. Aims

The project was implemented in communities which suffer from variety of social problems that require an urgent solution. Against a background of epidemic unemployment, poverty and alcoholism, drug abuse was expected to be of secondary importance. This was confirmed by population survey. In an open-ended question concerning most important problems of the community, drug abuse ranked seven among other social problems in Malczyce and was mentioned by 12 per cent of its inhabitants while in Starachowice it was mentioned by less than two per cent of people. In both communities unemployment, poverty and alcoholism were perceived among most important problems (Świątkiewicz 1996). Also from the perspective of local agencies, drug abuse was not perceived as an issue of particular priority (Zielinski 1996). On
the other hand, more than 40 per cent of people in Starachowice and close to two thirds in Malczyce expressed opinion that drug abuse represent a danger for younger generation (Światkiewicz 1996). That is why the major aim of public campaign was to win popular support for the idea that drug abuse should be prevented before it becomes a major social problem. This was attempted by meeting local authorities, through local media coverage, and, last but not least, by a poster design competition.

3. Implementation

It had been planned to be not only a campaign reduced to poster competition and their display. The main idea was to make people take part in it, to do the campaign to be more interactive. Poster design competition was launched for children from the primary as well as the secondary schools in two localities. The organisation of such a big task was possible only in co-operation with teachers of those schools. At the beginning of the campaign it was necessary to discuss the main topics of the posters. The primary concern was not to restrict competition only to the problem of drug abuse but, on contrary, to broaden its scope in order to avoid presenting one-sided and rather gloomy character of the drug theme. It was vital to introduce something more joyful and to escape from stereotypes associated with such campaigns. The competition harvested several hundred of posters representing a great variety of ideas, concepts, points of view and ways of expression. Apart from this material results, an important benefit of the competition was that for several weeks, hundreds of children thought of drug abuse as a social question, had reflections on it and finally were kept busy with a creative, self-gratifying work.

Thirty children divided into three age groups were awarded during a ceremony associated with exhibition of all posters. This event constituted a preventive measure in itself. Several dozens children, family members, teachers met together and discussed presented posters, guessed their meaning, commented decisions made by the jury.

Twelve of posters were then selected to be printed and displayed every month in public places in both communities. Professional designer framed original children’s paintings and produced the logo for the project as well as designed its slogan "Take-off - Program of Drug Abuse Prevention". The logo took the shape of a small baby-bird standing ready to take off. The Polish noun "odlot" ("Take-off") stands in slang for a drug trip and it was taken as a name, a kind of the trade mark of the project. The logo has been placed on nearly every element of the campaign: on the documents, in the press articles, T-shirts etc. and of course on the posters (Werkman 1974). Apart from different paintings, all 12 posters were easily identified as a part of the same campaign, by identical frame, logo and slogan "Take-off - Program of Drug Abuse Prevention" crossing a bottom part of the frame. The displaying of such posters was neither intended to educate people nor change their behaviour.

A rationale of this campaign was formulated as follows:
• to increase public concern of drug abuse,
• to promote the project and its identity,
• to spread the message that drug abuse bothers youngsters from this particular community,
• to disassociate drug abuse from violence, crime and law enforcement at the level of public perception.

The latter aim was supposed to be achieved by selection of posters which stressed integrating
aspects of drug prevention as well as presented psychological and social context of adolescent drug abuse. It was hoped to strengthen attitudes already prevailing in both communities as most of their inhabitants perceived drug abuse as a question of treatment rather than of law enforcement (Swiatkiewicz 1996).

Evaluation of visibility

1. Methods

The method applied was typical for the evaluation of outdoor advertising. It consisted of three major steps:

- The representative samples of both places of exposition of posters and times of their displaying were drawn. They included places with the biggest and the smallest pedestrian traffic as well as with the traffic of the average intensity. As to time - three periods each lasting half-an-hour were taken during the daylight hours. They had also to represent different traffic intensity.
- All the people passing by and looking at the posters in the area with good visibility were counted and the time of viewing was recorded. Every person who was actually looking at it was defined as a poster viewer. Besides two variables were recorded that could be distinguished at a guess: sex and age.
- The data were computed and compared with background information, first of all with statistical data describing the entire populations of two locations. A unit of measuring viewing is called SHOWING. It means percentage of the population of the target area that is estimated to be in touch with an advertisement campaign. In other words it is a per cent of the entire resident population of a given area that every day sees posters, billboards and other media used in the campaign. People in this unit are of course understood statistically because SHOWING as a measuring tool is based on representative samples of places and time and extrapolation of the results for the whole population.

It has to be stressed that this study was conducted in a sixth consecutive month of continuous poster display in both communities. In spite of the fact that every month a new poster was displayed they could have aroused less interest than in the beginning of the campaign.

2. Results

According to earlier experiences the outdoor advertising reaches all demographic groups of the population of the locality (town, rural community etc.). When the number of viewers grows then they as a group tend to become a representative sample of a given locality encompassing a cross-section of population. This tendency was confirmed in this study with an exception of older teenagers which were clearly over-represented among those who were recorded as viewing posters.

It seems that such medium of outdoor advertising as poster is suitable for all campaigns when a target group is the whole community. But at the same time it is not proper to use this medium when a target group would have particular traits and it is necessary to reach it selectively. Length of perception time was measured for four categories. As indicated in the table, time of perception
was very short.

Table 2.

<table>
<thead>
<tr>
<th>Time</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 second</td>
<td>83.2 %</td>
</tr>
<tr>
<td>1-5 seconds</td>
<td>13.4 %</td>
</tr>
<tr>
<td>5-10 seconds</td>
<td>1.9 %</td>
</tr>
<tr>
<td>More than 10 seconds</td>
<td>1.4 %</td>
</tr>
</tbody>
</table>

Short time of perception may be partly explained by the small format of the posters which could be less attractive than bigger billboards. It can be guessed, however, that most viewers saw a poster or similar ones many times before, during the previous months of campaign.

At the same time the observed percentage of people who stopped while having a look on the poster was rather high - nearly 13 percent which suggest that those who saw the poster for the first time were quite interested in it. Especially its form and content totally different from commercial ones could increase interest of viewers

In two communities 43 posters were exposed at the same time (in Starachowice 25 and in Malczyce 18). The SHOWING (average reception expressed as the number of people viewing posters during a day related to the entire population of the community) in the course of the whole time of display is shown in table 3.

Table 3.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number of posters</th>
<th>Showing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starachowice</td>
<td>25</td>
<td>14.0 %</td>
</tr>
<tr>
<td>Malczyce</td>
<td>18</td>
<td>71.8 %</td>
</tr>
<tr>
<td>Both communities</td>
<td>43</td>
<td>37.0 %</td>
</tr>
</tbody>
</table>

Big difference between SHOWING in Starachowice and in Malczyce may be explained by the fact that in the former one the number of posters on display was disproportionally lower as compared to its population.

This data may also be used to estimate the cumulated number of people who had viewed the posters (in many cases counted more than once) during the whole period of the campaign.

Table 4.
<table>
<thead>
<tr>
<th>Locality</th>
<th>Cumulated number of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starachowice</td>
<td>90,969</td>
</tr>
<tr>
<td>Malczyce</td>
<td>62,866</td>
</tr>
<tr>
<td>Both communities</td>
<td>153,835</td>
</tr>
</tbody>
</table>

In other words an average inhabitant of Malczyce saw 10 posters during the campaign while that of Starachowice less than two times.

Other experiences

A crucial feature and limitation of this project was that it was initiated outside communities in point as well as financed from external sources. In the same time it assumed high level of community participation and involvement. In addition, an elevated amount of external control was required because of demonstrating nature of the project. It had inevitable led to some tensions which eventually resurfaced also in poster campaign, especially in one community with long tradition and know-how in primary prevention. Poster campaign presenting little masterpieces of painting of children from both communities which was meant to underscore local character of the action, did not get a particular priority there. Out of over hundred posters handed over to that particular community every month not more than 30 could be identified as displayed in the same time. Local team which developed and implemented the project quoted a great deal of technical difficulties including bad glue, stealing or destroying posters, thefts of boards which made it apparently impossible to carry out highly visible campaign.

It seemed that a new external invention was intended to be diluted in a variety of previous and current activities carried out by the local team which had enjoyed a good reputation because of its preventive work and experience. Keeping a separate identity of a project which came from ”outside” could overshadow personal merits and contribution of numerous local professionals.

This conflict of interest or rather status conflict was additionally reinforced by the fact that the selection of posters for display as well as logo of the project were designed without consultations in both communities. Thus poster campaign could have become a symbol of external domination in implementation of the project.

The poster campaign reflected also tensions among different components of the project. Such a comprehensive enterprise composed of research, education, leisure time alternatives, counselling and finally relapse prevention had to produce conflicts of interests. According to opinions quoted during co-ordinating meetings colourful ”luxurious” posters were perceived by some people as a waste of money in a community with extremely scarce resources and growing poverty.

Drug addicts who joined the project at the early stage of its implementation were also upset that funds for solving drug abuse are trifled away on posters, leisure time alternatives for children and adolescents rather than to be spent on ”serious things” like social aid or treatment. An idea to combine their interests with those of prevention by offering them money for sticking posters failed after several attempts due to low interest and negligence manifested by addicts who did that job.
It has to be stressed that most of the above discussed conflicts erupted in bigger community which had more professionals and more experiences with prevention and was less likely to eagerly accept non-local initiatives and external control as well as monitoring of their own work.

Summary

A role of research int his particular project is difficult to grasp in few sentences. A general knowledge cumulated for years by social and epidemiological research constituted a basis for drafting the project. A variety of studies carried out in two local communities where it was implemented aimed at confirming earlier findings, evaluating and monitoring the project, and, perhaps, to bring scientific legitimacy for its implementation.

General population survey as much as interviews in local agencies indicated a low position of drug abuse among other social problems in both communities. Poster campaign was offered a special priority in order to increase public concern and to promote the project among their inhabitants.

The campaign which applied posters designed by children was to show its focus on primary prevention among younger generation. This kind of prevention was expected to be socially accepted more likely than drug-specific secondary prevention in risk groups.

The poster campaign reflected some possible conflicts inevitable in local campaigns which are initiated outside a community and funded from external resources, especially status conflicts between local team and external one as well as tensions among different components of the project which consisted of education, leisure time alternatives as well as assistance for local addicts.

Routine methods developed in evaluation of commercial advertising proved again to be useful in educational campaigns. A simple study carried out in the middle of the poster campaign indicated that 14 per cent of inhabitants of bigger community and 70 per cent of people in small community saw drug preventive posters every day.
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Program zapobiegania narkomanii "Odlot": Raport kocowy (Drug Prevention Programme
Reflections on the day

Irmgard Eisenbach Stangl

The presentation of the two papers on a community action project against illegal drug abuse in two Polish communities stimulated a discussion on various topics, e.g.:

• The community action project was initiated and mainly designed, carried out and evaluated by researchers of the Institute of Psychiatry and Neurology in Warsaw using experiences of other countries and experiences collected in community action projects against alcohol abuse. Consequently the discussion concerned the character of research as action in itself and the tensions between the "external" (scientific) team and the "local” teams.

• In both communities drug related problems in relationship to other social problems were perceived as minor ones. But as one author pointed out: money was only available for a community action project against illegal drug abuse. Thus, the discussion focused on possible solutions to this dilemma and on the conflicts between different local interest groups consequently arising in the course of the project. Unspecified alcohol and drug related problems were discussed as one possible solution. Another discussed solution was a greater shift in the aims of the community action project: social integration of conflictious groups and their needs or even integration (solidarity) of the community instead of specified action against illegal drugs.

• One part of the community action project was the exhibition of posters drawn by school children. This measure stimulated a discussion on media of influence and on the possible superiority of pictures to words.

The papers, the comments and the discussion touched topics and questions which can be summarized as follows:

(1) The strong relationship of alcohol and/or drug related problems to other social problems become visible at the community level. This can either result in the formulation of an “integrative” community action project or the community action projects consciously single out alcohol and/or drug related problems or even single out special problems related to alcohol and/or drugs.

(2) On the community level different and often divergent and conflictious perceptions of alcohol and drug related problems become visible. Community action research has to deal with the different social constructions of alcohol and drug problems by at least:

• different (interest) groups / segments of the community
• different professional and semi-professional groups
• the research team itself
• actionists
• agencies financing research and/or action
(3) Community action projects against alcohol and/or drug related problems have to be seen in the context of international or national alcohol and drug policies:

- Do the community action projects enforce international or national alcohol and drug policy?
- Or are they a complement to them?
- Or are they a correction/criticism, as it seemed to be the case with the Polish community action project?
- Or do they aim to replace international or national alcohol and drug policy, that is, do they support the community to establish special measures against their special alcohol and drug related problems?
Reflections on the symposium

Marja Holmla

First of all I would like to say that I have found the symposium to be of a very high quality. The presentations have not been series of descriptions of what has been done in various projects, but people have reflected on their work, discussed the background assumptions or ideologies, presented analyses and taken a stand in relation to various strands of community action.

Sometimes there was a feeling of talking past each other. Cultural differences in using allegories or differences in values caused misunderstandings. The very challenging feature of this meeting was that escaping to statistical standards or formal quantitative academic language was not available as an easy means of creating apparent sense of understanding.

I found the following eight points of discussion of special interest. My comments are more from the perspective of research than methods of prevention.

1. There has been a wise consensus in all of the presentations and discussions that community projects aim at environmental change, not only at changing individual behaviour. In this connection the observation was made that we who are engaged in alcohol related community projects, may not have sufficiently used as our learning reference the experiences of community action on the other fields of social change.

2. The notion of community remains open to continuous discussion in these meetings. This of course may seem slightly odd as that word is a part of the basic terminology here. In this seminar the term has been used at least in the following four senses:
   1) community as a locality
   2) as an ethnic community
   3) as social classes within a community
   4) subgroups of a local population, as for inc. the elderly, the young or the high risk groups

It has become clear that it is important to use exact language, and to specify who are we actually referring to when we are speaking about community. There may have been too much unclear rhetoric around the very positive word "community" in many previous contexts.

In some projects a minority group was the focus of action, rather than the whole population of a locality. It was brought out that there is the risk of stigmatising and increasing the problems of a minority group rather than helping them; a possibility which should be taken into consideration and avoided.

3. Different projects had differing emphasis on either needs assessment or clear pre-set goals for community action. This dimension created a lot of debate during the week. It seems that the wider social and political context determines many of the choices here. The choices are
also influenced by the complexity or straightforwardness of the problem one is attempting to influence. The European projects stressed the need-assessment more than the US projects which on their part stressed the need for clear goals and plans. This difference may be reflecting the strong tradition of critical research in Europe on one hand and the greater awareness of science based knowledge on workable prevention methods in US on the other hand.

4. The projects also differed in their research emphasis on either being committed to the particular locality, helping it to understand what is going on, or commitment in producing information to the wider society. In the latter case the specific locality would be a case or experiment which to draw general conclusions from.

5. Several speakers attempted to develop the criteria of outcome measures. These range from behavioural or attitudinal changes to sustain ability or greater skills among the project activists. Many papers brought out important lessons in this field. It was also pointed out that the evaluation methodology and the use of different criteria might be worth a separate meeting or a working group.

6. During the week, a lot of discussion and innovative allegories were offered on the theme of the relationship between the activists and the researchers. This is naturally due to the special action-research oriented setting of these projects.

7. There were also discussions concerning the conflicts of interests inside the community. The economic interests of producers and sellers of alcohol were brought out especially in the context of the Eastern European countries, but also in US.

8. Qualitative research has a strong position in most of the studies presented in the seminar. Qualitative analyses has thus definitely come to stay on the field. On the other hand, the need for quantitative research was also stressed, and the need to develop the quantitative measurements and methodology of evaluation.
Community action to prevent alcohol problems

This compilation of papers is the result of the third international symposium on Community Alcohol Projects for the prevention of alcohol problems, which was held in Greve in Chianti (Florence), Italy, from September 25 to 29, 1995. It follows the symposium held in March 1989 in Scarborough, Ontario, and the symposium which took place in San Diego, California, in January-February 1992, both under the title of “Experiences with Community Action Projects for the Prevention of Alcohol and other Drug Problems”.

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