The University of Sydney

Broken Hill Department of Rural Health

A framework for supporting the implementation of community-based alcohol primary prevention and early intervention

This picture is included to indicate that an appropriate diagram reflecting 'assisting communities to reduce the burden of alcohol' may be appropriate.

Sue Selden

Broken Hill Centre for Remote Health Research

The Centre for Remote Health Research is a joint initiative of the University of Sydney Broken Hill Department of Rural Health and The Greater Western Area Health Service.

Funding for this project was provided by a grant from AER Foundation Ltd

Suggested citation: Selden S & Lyle D (2009). A framework for supporting the implementation of community-based alcohol prevention and early intervention programs. Broken Hill, Centre for Remote Health Research, University of Sydney.

Broken Hill University Department of Rural Health
Corrindah Court
PO Box 457 Broken Hill NSW 2880

Phone: 08 8080 1228
Fax: 08 8080 1258
Web: www.drh.med.usyd.edu.au

Contents

Executive summary

Why a framework for supporting community-based alcohol primary prevention and early intervention?

Alcohol is 'no ordinary commodity' (Babor *et al* 2003). It is a significant contributor to economies large and small as well as being a toxic substance that causes general health, psychological and social harm. Health services usually focus on the treatment of individuals with alcohol-related diseases or conditions, while the social problems, especially violence, are acknowledged, but are outside their brief even as they deal with its consequences. Governments and their public health policies focus on strategies and interventions to reduce alcohol-related harm with varying degrees of success. Increasingly, emphasis is being given to the importance of prevention and of developing strategies that will impact on the burden of disease and social dislocation associated with risky alcohol consumption.

This community guide presents a framework for supporting the development and implementation of community-based drug and alcohol prevention and early intervention programs, with particular relevance to Australian Indigenous communities. It is intended to inform those working in partnership with community members seeking to reduce the impact of alcohol in their communities.

Although there are a number of recent systematic reviews that identify the level of effectiveness of alcohol-related interventions, such interventions need to be considered in the context of each community and it is here that a number of themes intertwine. Broadly, these are:

- The 'health' of the community and its readiness to change
- Issues of time, person and place, which reflect the impact of culture and social determinants throughout life
- The many systems in play that determine alcohol's local availability and use; and
- Lessons learned from previous Indigenous programs.

Aspects of all of these come together when a community seeks to determine the best practice interventions it will embrace to reduce the burden of alcohol-related social and individual harm.

The framework represents elements that are explored with a community wanting to reduce the burden of alcohol. These are presented in the form of nine exercises community members are asked to undertake as they respond to a posed question.

- Exercise 1

How is your community affected by the larger society?

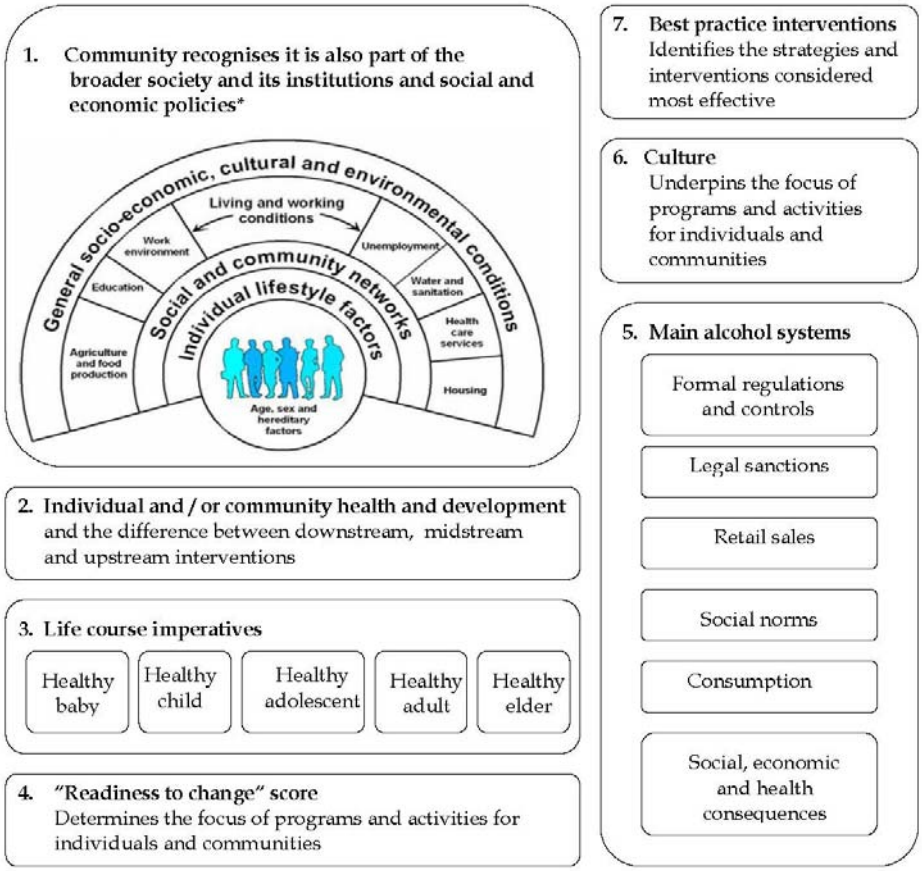
(Addresses inequity and structural barriers limiting opportunity and choice.)

- Exercise 2

Do you want to rescue or prevent the need for rescue?

(Addresses primary prevention versus secondary and tertiary prevention interventions.)

Figure 1 Alcohol primary prevention and early intervention framework



Exercise 3

What is the effect of alcohol on your vulnerable community members across the life course?

(The community considers the cumulative and long-term consequences of alcohol on both drinker and non-drinker.)

Exercise 4

Reconsider question 2: Do you want to rescue or prevent the need for rescue?

(Revisits primary or secondary and tertiary prevention interventions in terms of alcohols effects on the vulnerable next generation and asks if now willing to put the effort into long-term primary prevention activities, recognising that this will require significant changes in the community as well as a long-term commitment from them.)

Exercise 5

How ready are you for change?

(The community undertakes a Readiness to Change assessment along with an audit of community capacity to help identify existing skills and those that need to be developed if change is to be successful.)

Exercise 6

How are the six subsystems of alcohol interrelated in the community?

(Community members map out the interrelationships between the various subsystems of the 'community alcohol system' and in doing so find that no single alcohol prevention intervention is possible because many issues contribute to alcohol being a problem.)

Exercise 7

Have cultural considerations been fully addressed?

(Both the community and those working with them explores issues of cultural understanding as they relate to working with a community, and involving the community in the development of culturally appropriate activities and programs.)

Exercise 8

Have you considered the range of interventions and their effectiveness?

(The interventions to be considered are not just alcohol-related. They also include actions to reduce inequality. Whatever the intervention, the need for 'best practice' and effectiveness are required.)

Exercise 9

Have you made a final check of where you are to this point in time and what your next steps will be?

(Reminds communities, as they begin to think about developing their own programs, about learning from successful and not so successful programs, and to not repeat the mistakes of less successful ones.)

Finally, as the first-steps of an alcohol primary prevention intervention the resource has a five-fold purpose:

- To encourage primary prevention
- To highlight the complexity of alcohol and that there is no simple solution
- To highlight issues around change and make it clear that commitment is required
- To make it clear that a range of skills is required to guide a community through this process, and
- To highlight that if primary prevention is not possible at least any program they want to undertake is properly planned and evaluated.

Introduction

Review context

Alcohol is 'no ordinary commodity' (Babor *et al* 2003). It is a significant contributor to economies large and small as well as being a toxic substance that causes general health, psychological and social harm. Health services usually focus on the treatment of individuals with alcohol-related diseases or conditions, while the social problems, especially violence, are acknowledged, but are outside their brief even as they deal with its consequences. Governments and their public health policies focus on strategies and interventions to reduce alcohol-related harm with varying degrees of success. Increasingly, emphasis is being given to the importance of prevention and of developing strategies that will impact on the burden of disease and social dislocation associated with risky alcohol consumption.

This community guide presents a framework (Figure 1, page 26) for supporting the implementation of community-based drug and alcohol prevention and early intervention programs, with particular relevance to Australian Indigenous communities. It is intended to inform those working in partnership with community members seeking to reduce the impact of alcohol in their communities.

Although there are a number of recent systematic reviews that identify the level of effectiveness of alcohol-related interventions, such interventions need to be considered in the context of each community and it is here that a number of themes intertwine. Broadly, these are:

- The 'health' of the community and its readiness to change
- Issues of time, person and place, which reflect the impact of culture and social determinants throughout life, and
- The many systems in play that determine alcohol's local availability and use; and
- Lessons learned from previous Indigenous programs.

Aspects of all of these come together when a community seeks to determine the best practice interventions it will embrace to reduce the burden of alcohol-related social and individual harm.

Development of the framework

This 'first steps' community resource was initially intended to be a literature review of best practice and potential options for communities who identified alcohol as a problem and who expressed a desire to act. A community could then consider each option according to its effectiveness and appropriateness in line with identified community needs. During the initial literature search, however, a number of reviews relating to alcohol interventions were identified. While these presented the evidence for effectiveness of various interventions they also identified some common themes relevant to this evidence and programs in Indigenous communities. These themes included inequity and the need to address structural disadvantage, program elements that make successful outcomes more difficult to achieve, and suggestions for better evaluation processes to be developed. The literature search also identified other elements that were of importance to communities considering alcohol-related actions. These included determining the community's readiness to change and the need to have an in-depth

understanding of the complexities that make alcohol such a complicated issue to address: as a toxic substance, its impact on both non-user and user and its role as a commodity.

Rather than producing another review we felt that providing a framework for supporting community change with a checklist of issues that impact on the success of community-based programs, could be useful. We do not claim that this framework is comprehensive, but we do suggest that it identifies important areas that impact on the efforts of any community trying to 'make a difference' when it comes to tackling the effects of alcohol at the community level. The intended audiences are those working in partnership with communities considering change.

Local context

Slightly less than nine percent of Australians aged 14 years and above consume alcohol at levels that are risky or high risk in both the short and long-term. Indigenous Australians are less likely to drink alcohol but a higher proportion of those who drink, do so at risky and high-risk levels (AIHW 2008: 140; 79). Each Indigenous community is different and experiences with alcohol also differ but a common theme in the literature is that, while most Indigenous people do not have alcohol-related problems some communities or sections of communities are disabled by the problems associated with their alcohol use.

In Far Western New South Wales, local action plans developed by the Community Working Parties of the Murdi Paaki Region all identified drug and alcohol issues, either directly or in association with violence and dysfunctional behaviour, as 'a key health priority area'. There was also a high prevalence of mental health and drug and alcohol co-morbidity. Social factors such as household over-crowding, common in some Far West communities, also exacerbate alcohol use, violence and dysfunctionality (Battye and Hines 2007). The challenge of providing sustainable appropriate health services in these small and remote locations has meant that health services often focus on early intervention and treatment components of care and have limited resources available for prevention activities. These communities are beginning to ask what they can do.

If appropriate prevention and early intervention strategies are to be developed in these communities, understanding the complexity of ill-health and drug and alcohol use and misuse is required. As part of this a very real understanding of the context of historical colonialism, dispossession and alienation and resulting institutional racism, marginalisation and poverty is crucial (Trudgen 2000; Gray *et al* 2004; Brady 2008). In such a context prevention and early intervention strategies cannot be reduced to single strategies targeting individuals or groups of individuals in a community. Neither can they be delivered solely by a health service.

Just as culturally appropriate alcohol treatment guidelines for Indigenous Australians (Department of Health and Ageing 2007) have been developed for health practitioners to incorporate into their practice so, too, appropriate community-based multi-strategy prevention and early intervention programs may play a role in reducing the negative effects of drug and alcohol abuse on individuals and communities. However, a recent Australian review of substance use prevention programs and projects (Loxley *et al* 2004) emphasises that the appropriateness of many of these for Indigenous populations is not clear. Furthermore, there is an increasing awareness of the need to understand how community systems function, for any prevention or early intervention program or activity will be operating in those systems (Holder 1998). It is also recognised that

communities, like individuals, will be at different stages of readiness to bring about change and that different strategies are required at each stage if there is to be success (Plested *et al* 2006).

It is this context that has determined the four sections that follow.

The first section focuses on the context in which alcohol use and community alcohol prevention activities take place. Community members, and by extension community groups, interact with their physical and sociocultural environment in complex ways. It is these interactions that come together to make alcohol use problematic and how communities respond to these will determine the success of any intervention. A community 'acting' implies a community making changes. A community that understands its 'readiness for change' status is more likely to develop successful strategies to address big issues.

The second section focuses on prevention approaches that have been shown to work and those that are, theoretically, likely to work. Since any prevention activity is going to be about change, this section highlights current knowledge on readiness to change at both the level of the community (again) and the individual. The section also identifies alcohol harm reduction strategies that are essentially policy-driven and determined above the level of the community because many of these need to be implemented or enforced locally and will form some of the strategies a community may choose to strengthen.

The third section looks at the lessons learned from alcohol and other health-related interventions in Indigenous communities that have relevance to anyone considering a new program in these communities.

Finally, the fourth section provides a summary in the format of a checklist against a framework to support the development and implementation of community-based alcohol prevention and early intervention programs.

The focus here is predominantly on alcohol. Illicit drug use is still a major risk factor for ill-health and death in Australia (AIHW 2008: 143) and there is much in this framework that has relevance to the prevention of drugs and substance use specifically and more generally. However the focus is alcohol.

Prevention and a community ready for change

Choosing what to prevent

The essence of prevention is to stop something from happening, usually something with significant negative outcomes. The consequences of risky alcohol use are well established. Prevention requires that you somehow "anticipate", "take precautions against", "act in advance" or "forestall" (OED 2008) those things that contribute to its misuse. Preventing the consequences of its misuse is complex because alcohol is more than an addictive drug with significant social and health consequences. It is also a significant commodity for many communities. This means that any decisions made about controlling alcohol not only need to be based on good evidence but also need to take into account political and commercial interests, as well as reflect common sense and foster community safety (Babor *et al* 2003: 273).

Prevention is not straightforward. It implies acting today so that there will be positive results 'tomorrow', but 'tomorrow' may be this year or years away, depending on how a community chooses to deal with the problem.

Primary, secondary and tertiary prevention refer to different approaches for reducing the problems of alcohol. *Primary* prevention involves sweeping efforts aimed at a larger group of people, such as the whole community. At this stage it is not clear who will develop a problem or be exposed to the consequences of alcohol use. While it may not be possible to eliminate alcohol from the community it is possible to put in place programs that strengthen community health generally and help people be less vulnerable to the risks of alcohol. *Secondary* prevention consists of measures aimed at individuals at risk of developing alcohol-related problems or who are exposed to the adverse consequences of alcohol. Finally, *tertiary* prevention focuses on identified individuals who already have alcohol-related problems (Last 2007: 300).

Health professionals traditionally focus on secondary and tertiary prevention and lack the resources and training to focus on true primary prevention.

A community considering where to focus its efforts will find it useful to consider the parable of downstream and upstream interventions (Figure 2, page 28) and ask itself a question. Is it in the community's best interest to keep 'rescuing' individuals with alcohol-related problems or should it act on the environment and the issues contributing to the problem. It does not mean that the community does nothing for those needing 'rescuing', but it does mean that it also decides to stop people 'needing to be rescued' and begins to change the physical and social structures and policies that are contributing to the problem in the first place.

Such changes are never easy and it may help a community decide that action is required, even if difficult, if it takes the time to think about alcohol in a different way. Community members and those working with them should forget, for a moment, the usual statistics associated with alcohol, which, paradoxically, can hide the real impact of alcohol on the community. Instead, community decision-makers, influential members and elders need to thoroughly explore the impact of alcohol and how it affects the potential of those they care about.

The effects of alcohol across the life course

Individuals can often describe some of the effects of alcohol – on them and on others. It is less well known that exposure to alcohol and its consequences during critical periods of growth and development especially, have negative effects that are cumulative and long-term. An important exercise for community members to undertake is to explore the effects of alcohol not only on different age groups but also across the life course[1]. By doing this it is possible for them to see how the future potential of many are being affected now, and it is not only those who 'drink'. The ones most affected are the children and grandchildren of the community who then become adults likely to continue the cycle of alcohol-related problems.

The following summary of the impact of alcohol across the life course provides an example of the range of effects that community members should discuss. The information comes from a range of sources and you will find more detail in Stanley *et al* (2003), Kuh and Ben-Shlomo (2004), Watson *et al* (2005), Dodd and Sagger (2006), NSW Department of Community Services (2006), Turning Point (2006), Alcohol Working Group (2008: 16) and SDERA (2008: 165).

A baby exposed to alcohol during its development because its mother is drinking will never be able to reach what would have been its full potential. Alcohol affects brain development during the whole nine months of pregnancy. Poor memory, attention deficit, impulsive behaviour and poor cause-effect reasoning as well as other general disabilities are the result.

A child raised in a household with alcohol misuse is often affected by poor parental functioning. Emotional problems, deviant and aggressive behaviour, and violence displayed by the drinking parents or caregiver result in similar behaviours in the child. Child neglect is more common, and a younger child wandering the streets so as not to be at home and subject to the outcomes of binge drinking episodes is at risk and more likely to mix with older children, and then engage in age-inappropriate behaviours with them. A child exposed to substance misuse is at greater risk of becoming an early user itself.

An adolescent will experiment with alcohol, but is much more vulnerable at younger ages. Binge drinking is common, particularly when there is peer-pressure, boredom and 'nothing to do'. The adolescent's brain is also still developing so his or her potential can be adversely affected. They are more likely to be involved in motor vehicle accidents where alcohol is a factor in resulting death and disability. Violence, assault, malicious damage and accidents are all associated with alcohol misuse and have the potential to bring the individual and their family into interactions with the justice system. These young people observe the binge drinking role models of their elders and wonder what the future holds for them.

An adult caught up in the cycle of alcohol misuse is more likely to encounter the '4-L' consequences of that misuse: liver, lover, livelihood and legal problems. These translate into significant health problems, interpersonal relationship difficulties, employment issues and negative contact with the justice system. More broadly, the cornerstones of physical, mental and emotional health and well-being – spiritual, family and community - are impacted.

[1] The life course refers to an individual's life from birth (even pre-birth) to death as it plays itself out in social and historical contexts. It recognises that human development and ageing is a lifelong process, that individuals do have free agency, but that what happens to them is affected by when and where they live, that there are times when individuals are particularly vulnerable, and that lives are linked with the lives of those around them (Daaleman and Elder 2007).

An elder affected by the consequences of alcohol misuse is not only subject to all the issues highlighted for the adult, but can find that younger age groups reject their role as the respected elder handing down the traditions of a proud and long-existing culture.

With its far-reaching effects community members can see there is an imperative to reduce the impact of alcohol across the community and that this will require change at all levels.

Alcohol, change and community development

In many ways concern for alcohol issues is a concern for community development and a sustainable community. With changing economic times and changing demographics, small communities in particular are being challenged because community size reflects available resources, opportunities and choices. Although small communities may be under pressure, resilient communities can survive and revive (Kenyon and Black 2001). Resilient communities are those that can adapt and influence the course of social and economic change[2]. When researchers were reflecting on the future of Indigenous communities in Cape York they made a number of important points - what they called a "reality check"- noting that all are important for successful and viable communities (CYI 2005).

Firstly, the social determinants[3] impact on communities. Employment, income, health, safety, housing, basic infrastructure and education are important and when there is inequity, programs need to consider and respond to these. Demanding that individuals change their attitudes and lifestyles and *not* changing the environment in which individuals live and work and which gives them little choice or support to make changes is fruitless.

Secondly, when needs are great there will be constraints on programs, but communities, like individuals, can make choices. They may be strongly constrained choices but they are choices nevertheless.

Thirdly, governance, which at its most basic is about who in the community makes decisions or controls decision-making, is intensely political and there is high potential for conflict of interest, particularly in Indigenous communities.

Harnessing and developing community capability is fundamental to any change being successful.

Definitions of community development vary somewhat but the goal is about achieving lasting change in relation to issues that affect people's health and lives (Auer *et al* 1993: 163). Community development emphasises processes that are community centred, in which a community comes together to analyse its needs and develops strategies to address them. Through a process of assessment, activity and achievement, and in a continuing and cyclical process, the community (and its members) become increasingly empowered[4] and develop

[2] 'Resilience' is about capacity to adapt and refers to "intentional action to enhance personal and collective capacity of its citizens and institutions to respond to, and influence the course of social and economic change" (Centre for Community Enterprise 2000:2).

[3] The social determinants of health are the economic and social conditions under which people live and which determine their health. They are interconnected in myriad ways, producing illness and health inequity. If those aspects of the environment which are promoting ill-health are not changed, continuing to deal with its consequences – ill-health – has little impact long-term.

[4] The notion (or idea) of empowerment encompasses giving power, authority, qualities or abilities to someone or some group. At the community level it is about increasing the spiritual, political, social or economic strength of individuals and communities, which develops confidence in their own capabilities.

social capital[5], which at its heart is about social responsibility and community involvement.

The process of community development begins from the point where the community currently is and the community's needs define the boundaries. In today's complex interactions of government and non-government agencies and funding bodies, others from outside the community may be intimately involved in community development-related activities, but they should still be listening very clearly to the voice of the community.

This assumes that it is the representative voice of the community that is heard. Community development principles emphasise the need for *all* in a community to have their say and that those with the weakest voice, and who often are the most adversely constrained by societies pressures, are to be actively sought out and listened to (Ife 2002: 201-255).

Readiness to change

Just as individual behaviour change can only begin when an individual acknowledges they have a problem and wants to do something about it, so too, community change can only begin when a community acknowledges there is a problem and wants to do something about it. Just as successful changing of individual behaviour requires a combination of self-efficacy[6], positive factors in the environment combined with other individual factors, so too, successful community change requires that a combination of factors be met. And just as how an individual responds to a message or an intervention depends on how ready they are to change, so too, knowing how ready a community is to change helps determine the interventions likely to be successful.

The idea of community capability or community capacity is a positive one that is associated with readiness to change. It is a 'potential state' that reflects the characteristics of a community able to identify, mobilise and address the social and health problems it faces (Goodman *et al* 1998). It reflects the skills the community needs to do this, a sort of checklist. Areas requiring particular skills include participation and leadership, communication, resource management, social and inter-organisational networks, sense of community, understanding of community history, community power, community values and critical reflection.

Those working with communities wanting to change should encourage community members to take the time to consider their skills in these areas. Table 1 (pages 30-31) provides a checklist of questions they should respond to. Such a list may seem daunting but their responses will help highlight the skills community members already have, and areas where they need to develop further skills if they truly want to bring about community change and development.

How ready is the community to change? A 'Readiness for Change' model that has been applied in a range of cultural settings provides a useful guide for a community considering change (Plested *et al* 2006). In this model representative community members are asked set questions and their responses are scored and averaged to provide a community score. The questions focus on what the community is currently doing about a problem area and what community

[5] The concept of social capital involves the institutions, relationships, attitudes and values that govern interactions among people and contribute to the cohesiveness and economic and social development of a community. It is a useful term that encompasses the attitudes, spirit and willingness of people to engage in collective, civic activities to "add value" to their community. At its heart is trust: working collaboratively, with respect for each other's values and differences and resolving disputes civilly because there is recognition that people are working for a common good, not just factional interests (Cox 2002: 9).

[6] Self-efficacy: the confidence that action can be taken and barriers overcome.

members know about these efforts, what knowledge the community has concerning the problem and how positive they feel about doing something, as well as issues of leadership and resources. Take a moment to look at the figures on pages 29 to 31. These illustrate the process of using the model (Figure 3); the key factors that influence how prepared a community is for action (Figure 4); and the stages of change (Figure 5). Determining the stage of readiness is fundamental to any future program development because each stage requires different intervention approaches.

The checklist in Table 1 and the 'Readiness to Change' model are important for a community considering change. Each, in its way:

- Emphasises that change does not occur without effort and that it takes time
- Identifies skills that a community requires to help change happen, highlighting that if these skills are not present they be developed
- Emphasises, especially, the importance of leadership qualities and skills and how participation is encouraged and developed
- Recognises that 'readiness to change' is variable, because communities are unique
- Stresses that determining how ready a community is to change has to occur because it is this that identifies the interventions likely to succeed
- Stresses the importance of all the stages of planning: of knowing where you are at (assess), where you want to go and the best way or ways to get there (plan), making the changes (implement) and finally, determining what change is occurring and if it is what you want (evaluate and modify). It is this last step that is often done least well or not at all.

Community leaders and those working with them, who are focused on making real changes to the problems of alcohol in their community, need to have audited their capacity for change as an individual and their readiness for change as a community. Only by doing this will they identify the most appropriate steps for their community to take, including activities to strengthen the capability of individuals and interventions that are appropriate to their stage of readiness.

Alcohol: more than a single problem - more than a single solution

A system is an arrangement of parts that interact with each other within the system's boundaries. Systems can have subsystems and boundaries can change, but of importance to all systems is having an understanding of the interactions and interrelationships between the various components and a recognition that these can change over time and often in surprising ways. Alcohol problems result from complex interactions within the social, economic and cultural community systems in which people exist. An individual's decision about when and where to consume alcohol is not just a personal choice. Local customs, social behaviour and legal sanctions can determine frequency of drinking, how much is drunk and where alcohol is consumed, as can access to alcohol and its cost. Understanding the systems at play in any community is required if the community truly wants to develop good prevention interventions (Holder 1998).

Community members need to undertake a third exercise, to take pen and paper and start to draw the interrelationships between the following subsystems of their 'community alcohol system', as represented in Figure 1 (page 26):

- Who drinks, when and where, and the differences between different

groups and what affects these differences (consumption issues)

- How and where alcohol is available and how it is promoted (retail sales issues)

- The rules that affect alcohol's restriction and how these are enforced (formal regulation and control issues)

- Community values and the social influences that affect drinking (social norms)

- The legal actions aimed at detecting and deterring public intoxication (legal sanctions)

- How the community identifies and responds to alcohol-related problems, and has it identified **all** of them (the social, economic and health consequences)

Individual community members and organisations may not have all this information. One of the things that is clear about alcohol problems in particular, but also applies to most health-related prevention and early interventions, is the need for collaboration with other partners. What is clear from the literature, though, is that without real intent to make a difference, such collaboration in the past has not been as effective as it could have been (Brown *et al* 2008).

Notwithstanding the difficulties of collaboration, any approach to alcohol prevention has to address the interrelationships between, at a minimum, these six subsystems of a 'community alcohol system'. After such an exercise it should also be clear that more than one solution is required and that there will be different strategies and interventions required for each of these subsystems.

Before leaving the alcohol subsystems it is worth noting the blunt message one community-focused alcohol expert gives to community leaders and others involved in alcohol prevention:

> *"If community leaders or prevention planners are unable (or unwilling) to undertake the difficult thinking necessary to improve their understanding of their own community systems, then local prevention interventions selected will have limited (if any) long-term effectiveness"*(Holder 1998: 153).

Alcohol and Indigenous history

A common theme in the literature on alcohol and Indigenous health is the need for a greater understanding of Indigenous cultures, of their history since 'dispossession' and the role of alcohol in their stories. Those who have not experienced this, either personally or through the stories of their relatives, will not fully understand the impact and consequences of this history. However, developing a more holistic understanding of Indigenous history is critical for anyone working with communities addressing the problems of alcohol (Brady 2008).

Each Indigenous community is different and experiences with alcohol also differ. The Yolŋu people of Arnhem Land have a particular history, but their story has been described and so it serves as an important example. As in other groups, not everyone drinks, but for many, the combined effects of alcohol, despair and hopelessness that ends in violence results in a "crisis of living" and a "living hell" (Trudgen 2000: 59; 158-175). This is the consequence of a once proud culture being misunderstood, ignored and made to feel worthless by the dominant (Euro centric and White) culture. Importantly, it was only when alcohol became freely available in the communities (in the 1970s) that "real acts of violence" became a feature of these communities (Trudgen 2000: 174). Brady (2008) makes the point that drinking habits have been learned and can therefore be changed, but it is not a simple solution. Unemployment,

boredom, social and personal isolation and the effects of ongoing historical grief, combined with kinship and social obligations and associated group drinking, have reinforced current habits of drinking and behaviours associated with drinking. In such settings alcohol may serve as the trigger for violence and the consequences of violence have been acknowledged. We may be looking for solutions to address this physical violence, but what of the violence that "destroys a person's soul" (Trudgen 2000: 175), that is the result of over 200 years of dispossession and colonialism that has impacted on the physical, spiritual and social fabric of communities.

The intent of this 'alcohol and Indigenous history section' is to highlight the interconnectedness of themes to this point. The Far West NSW communities identified the association between alcohol, violence and dysfunctionality, and high levels of mental health co-morbidity, and that these were key health priority areas. However, targeting alcohol alone cannot lessen the effects of alcohol, violence (both physical and spiritual) and abuse. Primary prevention requires changing physical and social structures, and communities wanting to bring about change require specific skills and need to develop strategies that are in line with their level of readiness to change. And while communities may differ in their cultural and historical specifics, the majority of them face the consequences of decades of inequity, resulting in far fewer opportunities and choices than non-Indigenous Australians. Developing successful change programs is possible when communities want this, but addressing inequity is a challenge and requires potentially more resources and skills. Those who work with Indigenous communities to bring about primary prevention change require a deep understanding of the interconnectedness of all these themes.

What works and best practice in prevention

Will a community's interventions be successful? Those involved in improving a community's health outcomes want to see their actions have effect, yet research has shown that not all prevention and early intervention activities are effective. And often it is the popular choices that are least effective, so understanding how to determine what might work best for a community is important.

Two approaches are useful in choosing appropriate activities. The first focuses on using best available evidence, and the second on using health promotion theory and models for change when evidence is less clear.

What has been shown to work: evidence-based practice

Best practice represents an accumulation of knowledge of what works and does not work, and suggests strategies, activities or approaches that have been shown to work in another situation. If other people's experiences suggest there is more than one way of getting the same result, best practice also means that what is done is the most acceptable to the community, or is the most cost efficient, or the least stressful to all concerned.

Evidence-based practice helps you make sense of what has been shown to work elsewhere. Ideally, research evidence should be able to provide the community and those working with them, with a basis for making decisions about where to invest their efforts: in other words, what works best. Evidence-based practice guidelines provide a ranking of evidence. They look at evidence from a range of sources and consider the strengths and biases of methods used to answer specific questions relating to interventions (NHMRC 2008). These rankings are presented in descending order of credibility, from strong evidence, such as a systematic review of all the relevant and critically appraised studies on a specific topic, through to expert opinions, which may have a low level of scientific evidence, but may reflect views, particularly cultural views, on what is important. Take a moment to read through these rankings, in Table 2, page 34.

Recent systematic reviews on the prevention of alcohol use and harm (Babor *et al* 2003 and Loxley *et al* 2004) have been used by the Australian National Preventive Taskforce (Alcohol Working Group 2008) to provide current ratings on the effectiveness of strategies and interventions for communities to consider. The ratings, which are described in Table 3, page 35, are organised according to four major criteria: 1) evidence of effectiveness, 2) strength of research support, 3) extent of testing across diverse countries and cultures, and 4) relative cost efficiency of the intervention in terms of time, resources and money. They consider the range of current strategies in seven areas and rank them according to effectiveness. In general, for alcohol interventions, regulating its availability, focusing on taxation and pricing, having drink-driving countermeasures and providing treatment and early intervention strategies have been shown to be effective. However, interventions that focus on altering how and where drinking occurs, how it is promoted and

education and persuasion activities have been shown to be less effective.

Most effective interventions

1. Regulating the physical availability of alcohol
2. Taxation and pricing measures
3. Drink driving counter-measures
4. Treatment and early intervention options

Less effective interventions

5. Altering the drinking context
6. Regulating the promotion of alcohol; and
7. Education and persuasion activities.

Source: More detail on each of these interventions can be found in Alcohol Working Group (2008) pages 20-36.

Each of these seven major intervention areas also has a range of interventions, with some more effective than others. Table 4 (page 36) details the more effective interventions and Table 5 (page 37) those shown to be less effective. You should take a moment to look at each of these. You may have noticed that at least half of the interventions in these tables target the whole population and approximately half target high-risk groups. Tables 6 and 7 (pages 38-40), therefore, provide you with the target groups of each of the interventions. Generally, interventions targeting the whole population are more effective, but if you want the greatest population impact you need a range of interventions and the full spectrum would be the ideal. This last point is worth emphasising again but with a slightly different focus. Strategies that complement each other and seek to restructure the total drinking environment are more likely to be effective than single strategies.

When all of the ranking criteria are taken into account (see Tables 4 to 7), the following 10 options stand out as the "best practice" options for reducing harm associated with alcohol use.

10 best "best practice" options for reducing alcohol-related harm

1. Minimum legal purchase age
2. Government monopoly of retail sales
3. Restrictions on hours and days of sale
4. Outlet density restrictions
5. Alcohol taxes
6. Sobriety check points
7. Lowered BAC[7] limits for drinking-drivers
8. Administrative license suspension
9. Graduated licensing for novice drivers and
10. Brief interventions for hazardous drinkers.

Source: Summarised from Tables 4 to 7.

Alcohol reform will be a challenge in any Australian community, given Australia's drinking history. The majority of these 'best practice' interventions are the result of government policies that come from public health efforts to reduce the harmful effects of alcohol for the population as a whole and for those 'at risk', especially those who drink and drive. These policies then have to be implemented, reinforced or policed at the local level where such activities may not be popular. This is often the case in small rural communities where alcohol is a major commodity. Reduction in alcohol supply through liquor licensing restrictions has been a successful intervention in remote communities but is not an option for all communities, and can lead to other problems.

[7] BAC: Blood Alcohol Concentration

One remote community's experience with limiting access to harmful substances provides an important lesson. Their youth replaced one harmful substance (petrol-sniffing) with another (marijuana) and the older community members made their way to the nearest liquor outlet and either brought alcohol back to the community or created problems binge drinking in these other communities (Senior and Chenhall 2008).

It is the total environment of a community that has to be considered when appropriate strategies and interventions are being chosen, and why choosing interventions is the last step of the framework.

It is also why the emphasis of the framework is primary prevention. The effects of long-standing disadvantage and misunderstanding have to be addressed, not just the visible problems of alcohol.

There are no 'best practice' options currently identified for addressing disadvantage – governments and others are being encouraged to develop these now (Kelly *et al* 2007). This requires collaboration and partnership with communities, organisations working in partnership with them and the government, to redress the inequity reflected across all the social determinants.

What are available, however, are identified areas for attention if social determinants are to be improved. It should be noted governments are being encouraged to commit to comprehensive approaches that deliver better outcomes and reduce inequities in these areas (WHO 2009).

The list is also important for a community on a 'prevention and change journey'. If they can identify where there are current deficits they are in a stronger position to argue for the extra resources to address any disadvantage. The following list does not include essential services such as health, water and sanitation and food supply: these are important and any deficits also need to be identified.

10 areas for focused community action

Healthy start

Early childhood development and education

Opportunities of youth

Opportunities for adults

Flourishing older life

Affordable and safe housing

Employment in a safe environment

Good nutrition

Adequate income

Social inclusion

Sources: CSDH 2008; Global Health Equity Group (2009); WHO (2009)

You will notice that these 10 areas reflect not only the social determinants in the framework, but also the age groups of the life course imperative. It is about putting in place strategies that encourage healthy growth and development now and potentially lessen the risks of exposure to the negative impact of alcohol later.

What we need to know to assist change: some theories about supporting change

We have already made is clear that prevention and early intervention involves change, for individuals and for the community as a whole. The best interventions are those that are based on a sound understanding of the knowledge, beliefs and practices of those the intervention is trying to influence. These have been built on theories or models that attempt to explain health behaviour and change in individuals, at the community level and in organisations. Programs that do not reflect an understanding of how a community works, of what gets in the way of change or helps it, or what influences behaviour in general, will fail.

Just as there is evidence that communities are at different stages of readiness to change, so too, with individuals. The evidence suggests that behaviour change occurs in stages or steps and that movement through these steps is cyclical, involving a pattern of adopting change behaviours, continuing them for a while, relapsing and then beginning again or not. The experiences of the drinker, the smoker and the dieter provide common examples that illustrate this aspect of change behaviour. It is important to note that the same thing can happen with community change. If you accept this then you are less likely to be frustrated when relapse occurs.

The rationale for determining an individual's initial 'stage of change' was an understanding that the support they needed differed according to their point in the change process. There is a continuum of change: from not being aware of the need to change, not wanting to change, beginning to think about changing, through to being actively engaged in changing a behaviour. All the stages are outlined in 'stages of change model' and 'precaution adoption process model' in Table 8, page 41. Each of these stages requires a different counselling approach and other supports to assist the individual on their 'change' journey. The major limitation of the models – with their focus on the individual – is that if the structural and environmental issues that impact on a person's ability to enact behaviour change are not supportive, change is difficult or impossible, even if personally desired.

Other models of changing behaviour, such as the 'health belief model', 'theory of planned behaviour' and 'social cognitive theory' models also focus on the individual as well as key people around them, with the social cognitive theory model also playing particular attention to environmental influences. Key concepts of these models are outlined in Tables 8 and 9, pages 41 and 42.

Fundamental to each model is understanding an individual's ability, in the broadest sense, to change. This requires acknowledging how each of the following, singly and collectively, support or impede behaviour change:

- Attitudes, both positive and negative, related to particular behaviours
- Having an intention to change
- The influence that the thoughts and actions of those close to a person can have, and
- The positive and negative environmental and structural factors at play external to the individual.

The reality is that behaviour change does not happen just because an individual desires to do so or is advised to do so. This is one of the reasons why health education interventions, with the exception of brief interventions, are not very effective. Brief interventions, short personal sessions of information and counselling that encourage a person to think differently about their alcohol use and make a change away from risky drinking, have been shown to be

effective, if the person is 'ready for change'. However, external factors can still prevent or make change difficult.

Table 10 (page 43) describes community level change theories, including 'community organisation', 'diffusion of innovations' and 'communication theory'. Take a moment to look at the key concepts associated with 'community organisation' and note that these are the critical factors associated with determining community readiness to change and successful community development already mentioned. This is not surprising when the focus of the model is community-driven approaches to assessing and solving health and social problems. The other two models are useful for providing guidance for introducing new ideas and developing communication strategies. You can find the details for all of these models, and others that you will find useful when it comes time to develop programs, in *Theory at a glance* (Rimer and Glanz 2005), which is freely available.

The reasons for considering what works are two–fold. Firstly, if you are going to make a difference, you want to ensure that what you do is effective. The evidence tells you that both a whole of community approach and targeting those at risk are the most effective strategies. Secondly, if you want to develop programs that have an impact, the models of change reinforce the importance of understanding community knowledge, attitudes and practices and structural barriers that inhibit change.

Alcohol prevention interventions and Indigenous communities

Understanding the difficulties associated with determining best practice in community-based interventions, compared to ranking the effectiveness of interventions that have taken place in a clinical setting, with scientifically rigorous methods, is important.

There is a large literature on alcohol interventions in Indigenous communities. Many of the projects and programs described have been acute interventions to reduce harm, health promotion projects, activities developed as alternatives to substance use, residential and non-residential projects, support and referral services, staff development activities, and larger multi-service projects offering a range of services that are not discrete projects (Strempel *et al* 2004: 1).

While a prevention and early intervention focus has been part of these projects, the majority can be classified as secondary and tertiary prevention activities, rather than being primary prevention interventions. However, while primary prevention requires very different approaches and activities, the lessons learnt from these other programs should not be ignored. These lessons can be grouped into elements of good and not so good practice, but contributing to these elements are three areas that have continually challenged programs. These include the nature of community development and a realistic timeframe for change, issues with evaluation and the diversity of communities and organisations.

Firstly, the very nature of a community development program is that it can take a long time to demonstrate a successful outcome. The following problems were frequently encountered in such programs.

- Community needs and dynamics change during or as a consequence of the program and the program changes. It then becomes difficult to evaluate the 'old' and the 'new' program.

- Long-term change takes time and this can be difficult to see and evaluate when projects are funded in the short-term.

- When projects take place in communities with different cultural backgrounds and they fail to address appropriate cultural concerns, they fail the community.

The second challenge has to do with the programs themselves and the lack of evaluation. Time-frame issues are compounded when programs have poorly defined goals and evaluation mechanism at their outset. It is very difficult to determine elements of successful programs when overwhelmingly, the majority:

- Were poorly designed and implemented, and

- Did not having evaluation strategies in place from the beginning of the project.

The third factor that adds to the complexity of determining best practice for Indigenous communities is the very diversity of these communities, with their different local culture, history and present circumstances. Furthermore, the organisations implementing programs are also diverse. This means that culturally, what works in one community may not work in another, and organisationally, some aspects of

programs are done well, yet other activities are less well done or poorly done (d'Abbs and Jones 1996; Strempel *et al* 2004:1).

The literature identifies key elements for effective community intervention programs and those factors that consistently impeded the success of programs. It is worth noting how the elements for effective programs closely reflect those characteristics that foster community capacity (see Table 1). Each of these areas is summarised in the table that follows.

Lessons learned from existing alcohol-related programs in Indigenous communities

Key elements contributing to effective projects[1]

- Indigenous community control
- Clearly defines realistic objectives that meet community needs
- Good governance and social accountability
- Clearly defined management structures
- Recruitment of appropriate staff
- Staff development and support
- Strong managerial leadership
- Multi-strategy interventions
- Inter-agency collaboration
- Flexibility of approach
- Reporting, monitoring and evaluation systems and
- Adequate resource provision

Characteristics fostering community capacity[2]

- Effective citizen participation
- Sense of community
- Inclusive community power
- Inclusive community values
- Understanding of community history
- Skilled leadership
- Involved community developing skills
- Cooperative social and inter-organisational networks
- Critical reflection skills and processes
- Resources from inside and external to the community

Key factors for successful programs[3]

- Adequate funding and resources
- Skilled and committed personnel
- Functioning organisations and good project management
- Community control and respect for community protocols
- Community acceptability and involvement
- Strong partnerships
- Understanding the underlying factors relating to the identified problem

Factors consistently impeding success[3]

- A lack of funding, and vertical rather than integrated funding
- An inadequate skills base
- Organisational and family issues
- A lack of information to set priorities
- A lack of support structures
- Distance
- The competing interests created by multiple projects operating in one community at the same time

[1] Stempel *et al* 2004; [2] Goodman *et al* 1998; [3] Clapham *et al* 2007: 282-283

Anyone developing a primary prevention program should ensure that their program adequately addresses each 'lesson learned': not only the elements that have continually challenged all programs but also the good and not so good practices identified from other projects and programs.

A checklist for community action

Small and remote communities face many challenges yet resilient communities can adapt and influence the course of social and economic change if they have the will and skills to do so. The framework for considering alcohol prevention and early intervention strategies requires those concerned for their community to undertake a series of exercises. Each exercise asks the community a question as it explores an area relevant to their intent to develop successful change programs.

 Exercise 1

How is your community affected by the larger society?

Any community is part of a larger society. The broad social determinants – employment, income, health, safety, housing, basic infrastructure and education opportunities in that community – reflect the history of the community. Many communities with an Indigenous population face the consequences of decades of inequity. Structural barriers contributing to existing inequity need to be identified and addressed if disadvantaged individuals and groups are to be given greater opportunities and choices.

 Exercise 2

Do you want to rescue or prevent the need for rescue?

Does the community want to focus on those who have alcohol-related problems now or do they really want to make a difference to the community's overall health and well-being, and in doing so prevent much of the misery that is a consequence of alcohol misuse.

 Exercise 3

What is the effect of alcohol on your vulnerable community members across the life course?

Community members need to consider whether alcohol is a problem for only those who drink, or are others affected. They are particularly challenged to think about the effects of alcohol on the vulnerable in the community. The effects of alcohol across the life course are both cumulative and long-term. Both the effects of alcohol and the consequences of alcohol misuse are far-reaching and reducing its impact will improve the lives of everyone in the community.

 Exercise 4

Reconsider question 2: Do you want to rescue or prevent the need for rescue?

After considering the cumulative and long-term consequences of alcohol across the life course, the community should ask itself again if it is willing to put the effort into long-term primary prevention activities, recognising that this will require significant changes in the community as well as a long-term commitment from them.

 Exercise 5

How ready are you for change?

A community has to want to change. It is easy to talk about change, but the community needs to consider how ready it really is to initiate change. It needs to think about what it would take for change to occur. It needs to consider what skills the community and individuals in the community have and need to develop to assist in bringing about this change.

The community will need to complete an audit of community capacity and

readiness for change. Issues of governance and trust will affect the success of this exercise. Those involved need to understand that all are working for a common good and not for factional interests.

 Exercise 6

How are the six subsystems of alcohol interrelated in the community?

The interrelationships between consumption, retail and sales, formal regulations, social norms, legal sanctions and the full social, economic and health consequences of alcohol on the community need to be clearly identified, as do all the players. Unless the interrelationships of all the components of their 'community alcohol system' are understood, interventions will be selected that have limited effectiveness. Such an exercise should also make it clear that there is no single alcohol prevention intervention because many issues contribute to alcohol being a problem.

 Exercise 7

Have cultural considerations been fully addressed?

Our culture underpins how we think and act as individuals and in relationships with others. There are two aspects to this exercise.

Firstly, those working through these exercises with a community should clearly understand Indigenous history in general and the specific history of the involved community, not only with alcohol but also with the wider society. Just as the history of each Indigenous community is unique, so too there will be no single strategy or intervention that can be applied universally to all communities.

Secondly, are cultural attitudes, norms and practices that will need to be addressed in any intervention proposed being identified? Are the cultural guardians of the community being involved in developing responses to these, so that any proposed activity and its potential outcome are deemed culturally appropriate?

 Exercise 8

Have you considered the range of interventions and their effectiveness?

The range of interventions available for alcohol-related programs is considerable. The evidence for the effectiveness of these interventions is variable. Interventions with evidence supporting their effectiveness in a range of settings lack evidence of appropriateness and effectiveness in Indigenous communities. One of the issues with programs and projects that have been undertaken in Indigenous communities is the lack of evidence for their effectiveness. A major contributor to this has been a lack of appropriate evaluation procedures.

Many of these projects focused on secondary and tertiary prevention activities and for this exercise we are interested in primary prevention interventions. The community will want to be choosing interventions that are most effective and that target those areas they have identified as problem areas. Best practice options targeting alcohol will be only one group of interventions. Strategies that focus on the 10 areas of community action to reduce inequity are also required.

 Exercise 9

Have you made a final check of where you are to this point in time and what your next steps will be?

A community undertaking these exercises is one that wants to make real change and improve the future of its members. After completing all the components of the framework, community members should also reflect on the lessons learnt by those who have previously undertaken alcohol or other health–related programs in small communities. As they begin to formulate their own plans they would do well to

ensure their programs contain the identified elements of effective programs and do not repeat the lessons provided by less successful programs.

It is worth emphasising once more that poorly evaluated programs are not able to demonstrate their successes, are not able to identify lessons learned and are unable to determine where they could have improved their outcomes. The process of good evaluation begins during the planning stage of a project.

What now?

This framework provides a community with the first steps of an alcohol primary prevention intervention. It identifies the various components that need to be addressed if the community really wants to lessen the burden of alcohol. The intent of this community resource is five-fold.

Firstly, it encourages a community to consider the value of a primary prevention strategy.

Secondly, it highlights that alcohol is a complex problem and has no simple solution (or it would have been found by now!).

Thirdly, it highlights that change will be required, that this is always a challenge and that time and effort is required. Skills are also required and if these are not all present at the beginning of the process, their development needs to be built into the planning of any program.

Fourthly, it hopes to make it clear that in order for a community to work through the exercises linked to the framework it requires facilitators with the skills, experience and time to guide the process. If these individuals are not locally available, they need to be sought out. The local University Department of Rural Health or community development organisation should be able to provide assistance.

Experience with primary prevention, inequity issues, and alcohol - its effects and its subsystems - are required. An understanding of culture, both the effect of historical events and ensuring programs are culturally sensitive and relevant is also needed, as is knowledge of the effectiveness of the range of alcohol interventions and the theories behind them. Finally, skills in project development and evaluation are needed. A team may be required to provide this range of skills and managing a team requires its own skills.

Finally, even if a community decides that it is unable to commit to a primary prevention approach at this time, the hope is that community members begin to understand the complex nature of their alcohol issues. If this occurs they can then go on to develop secondary prevention programs that are not only realistic for them, but are also more likely to be effective.

References

Alcohol Working Group (2008). *Technical Report No 3: Preventing Alcohol-Related Harm In Australia: A Window Of Opportunity*. Prepared for the National Preventative Health Taskforce. Canberra, Australian Government Preventative Health Taskforce.

AIHW (2008). *Australia's Health 2008. Cat. no. AUS 99*. Canberra, Australian Institute of Health and Welfare.

Ashton J and Seymour H (1988). *The New Public Health*. Milton Keynes, Open University Press.

Auer J, Repin Y & Roe M (1993). *Just Change: The Cost-Conscious Manager's Toolki*t. Adelaide, South Australian Health Commission, South Australian Community Health Association, Commonwealth Department of Health, Housing, Local Government and Community Services.

Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, Grube J, Gruenewald P, Hill L, Holder HD, Homel R, Õsterberg E, Rehm J, Room R and Rossow I (2003). *Alcohol: No Ordinary Commodity - Research And Public Policy*. New York, World Health Organization and Oxford University Press.

Battye K and Hines J (2007). *Murdi Paaki Health Project: Analysis Of The Murdi Paaki Community Working Party Action Plans*. Orange, Kristine Battye Consulting; for the Australian Government Department of Health and Ageing and Greater Western Area Health Service.

Brady M (2008). *First Taste: How Indigenous Australians Learned About Grog*. Set of six resources. Canberra, The Australian National University; Alcohol Education and Rehabilitation Foundation (AERF).

Brown EC, Hawkins JD, Arthur MW, Abbott RD and Van Horn ML (2008). "Multilevel analysis of a measure of community prevention collaboration." *Am J Community Psychol* **41**(1): 115-126.

Centre for Community Enterprise (2000). *The Community Resilience Manual: A Resource For Rural Recovery And Renewal*. Port Alberni, British Colombia, Centre for Community Enterprise.

Cox E (2002). *The Social Audit Cookbook: Recipes For Auditing The Way We Connect.* Melbourne, For Lance Reichstein Foundation. Available http://www.communitybuilders.nsw.gov.au/download/social_audit_cookbook.pdf Accessed 16 December 2008.

Cape York Institute (2005). Can Cape York communities be economically viable?. *Viewpoint November 2005*. Cairns, Cape York Institute for Policy and Leadership. Available http://www.cyi.org.au Accessed 19 January 2009.

Clapham K, O'Dea K & Chenhall RD (2007). "Interventions and sustainable programs" in B. Carson, T. Dunbar, R. D. Chenhall and R. Bailie Eds. *Social Determinants of Indigenous Health*. Crows Nest, Allen & Unwin**:** 271-295.

CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization. Available http:// whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf Accessed 15 July 2009

Daaleman TP and Elder GH (2007). "Family medicine in the life cause paradigm." *J Am Board Fam Med* **20**(1): 85-92.

d'Abbs P & Jones T (1996). *Gunbang... or ceremonies? Combating Alcohol Misuse In The Kakadu /West Arnhem Region*. Menzies Occasional Papers No.3/96. Darwin, Menzies School of Health Research.

Department of Health and Ageing (2007). *Alcohol Treatment Guidelines For Indigenous Australians*. Canberra, Commonwealth of Australia.

Dodd J and Saggers S (2006). *The Impact Of Drug And Alcohol Misuse On Children And Families*. Perth, Centre for Social Research, Edith Cowan University for the Australian Research Alliance for Children and Youth. Available http://www.aracy.org.au Accessed 18 December 2008.

DrugInfo Clearinghouse (2006). "Individual intervention, structural intervention: what's the difference." *factsheet*: Number 5.2 September . Available http:www.druginfo.adf.org.au Accessed 28 April 2008.

Global Health Equity Group (2009). "Marmot Review". *Strategic Review of Health Inequalities in England Post 2010*. London, University College of London. Documents available http://www.ucl.ac.uk/gheg/marmotreview/Documents Accessed 15 July 2009.

Goodman RM, Speers MA, McLeroy K, Fawcett S, Kegler M, Parker E, Rathgeb Smith S, Sterling TD and Wallerstein N (1998). "Identifying and defining the dimensions of community capacity

to provide a basis for measurement." *Health Education & Behavior* **25**(3): 258-278.

Gray D, Saggers S, Atkinson D and Strempl P (2004). *Substance Misuse And Primary Health Care Among Indigenous Australians. Aboriginal And Torres Strait Primary Health Care Review*: Consultant Report No. 7. Canberra, Australian Government Department of Health and Ageing.

Holder HD (1998). *Alcohol And The Community: A Systems Approach To Prevention*. Cambridge, Cambridge University Press.

Ife J (2002). *Community Development: Community Based Alternatives In An Age Of Globalisation.* 2nd edn. Sydney, Longman.

Kenyon P and Black A, Eds. (2001). *Small Town Renewal: Overview And Case Studies*. Barton, ACT, Rural Industries Research and Development Corportation. Available http://www.rirdc.gov.au Accessed 20 December 2008.

Kelly MP, Morgan A, Bonnefoy J, Butt J and Bergman V (2007). *The Social Determinants Of Health: Developing An Evidence Base For Political Action. Final Report To The World Health Organization Commission On The Social Determinants Of Health.* London, Measurement and Evidence Knowledge Network, Universidad del Desarrollo, Chile and National Institute for Health and Clinical Excellence, United Kingdom. Available http://www.who.int/social_determinants/resources/mekn_final_report_102007.pdf Accessed 17 July 2009

Kuh D and Ben-Shlomo Y, Eds. (2004). *A Life Course Approach To Chronic Disease Epidemiology.* 2nd edn. New York, Oxford University Press.

Last JM (2007). *A Dictionary Of Public Health.* New York, Oxford University Press.

Loxley W, Toumbourou JW, Stockwell T, Haines B, Scott K, Godfrey C, Waters E, Patton G, Fordham R, Gray D, Marshall J, Ryder D, Saggers S, Sanci L and Williams J (2004). *The Prevention Of Substance Use, Risk And Harm In Australia: A Review Of The Evidence*. Canberra, The National Drug Research Institute and the Centre for Adolescent Health.

NHMRC (2008). *NHMRC Additional Levels Of Evidence And Grades Of Recommendations For Developers Of Guidelines. Stage 2 consultation. Early 2008 - end June 2009.* Canberra, National Health and Medical Research Council. Available http://www.nhmrc.gov.au Accessed 20 January 2009.

NSW Department of Community Services (2006). "Parental alcohol misuse and the impact on children." *Research to Practice Notes:* **October**. Sydney, Centre for Parenting and Research, NSW Department of Community Services. Available http://www.community.nsw.gov.au Accessed 16 December 2008.

Plested BA, Edwards RW and Jumper-Thurman P (2006). *Community Readiness: A Handbook For Successful Change*. Fort Collins, CO, Tri-Ethnic Center for Prevention Research, Colorado State University. Available http://www.TriEthnicCenter. ColoState.edu Accessed 9 November 2008

Rimer B and Glanz K (2005). *Theory At A Glance. A Guide For Health Promotion Practice.* 2nd edn. Bethesda, MD, National Cancer Institute, National Institutes of Health, U.S. Department of Health and Human Services. Available http://www.cancer.gov Accessed 16 September 2008.

Senior K and Chenhall R (2008). "Lukumbat marawana: A changing pattern of drug use by youth in a remote Aboriginal community." *Aust. J. Rural Health* **16**(2): 75-79.

SDERA (2008). "Background notes". School Drug Education and Road Aware, Department of Education and Training, Western Australia. Available http://www.sdera.wa.edu.au Accessed 21 January 2009.

Solar O and Irwin A (2005). *Towards A Conceptual Framework For Analysis And Action On The Social Determinants Of Health (Draft).* Geneva, Commission on Social Determinants of Health, World Health Organization. Available http://www.who.int Accessed 20 March 2007.

Stanley J, Tomison AM and Pocock J (2003). "Child abuse and neglect in Indigenous Australian communities." *Child Abuse Prevention Issues:* **19**. Melbourne, Australian Institute of Family Studies. Available http://www.aifs.gov.au Accessed 16 December 2008.

Strempl P, Saggers S, Gray D & Stearne A (2004). *Elements Of Best Practice: Five Indigenous Drug And Alcohol Projects*. Canberra, Australian National Council on Drugs.

Trudgen R (2000). *Why Warriors Lie Down And Die*. Darwin, Aboriginal Resource and Development Services Inc.

Turning Point (2006). *Bottling It Up: The Effects Of Alcohol Misuse On Children, Parents And Families*. London, Turning Point. Available http://www.turning-point.co.uk Accessed 16 December 2008.

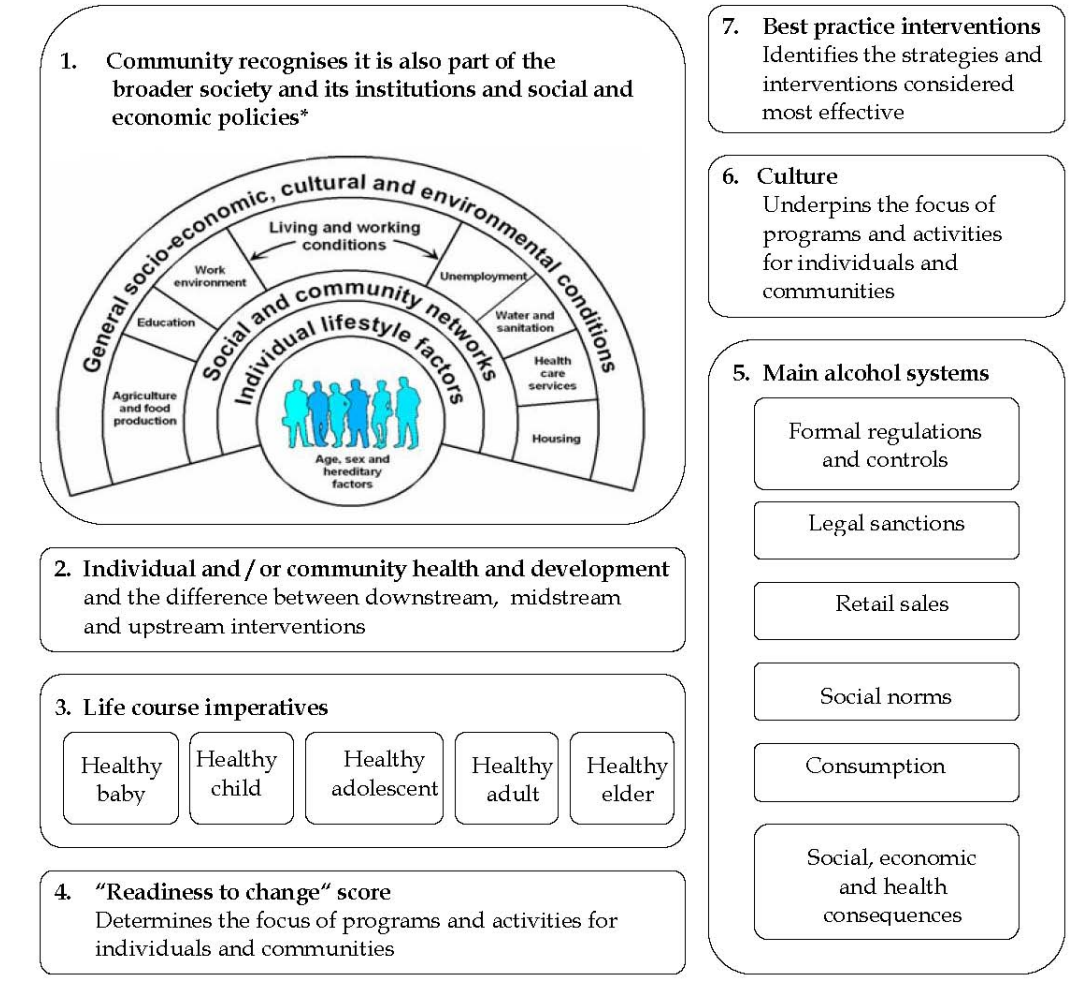
Watson J, White A, Taplin S and Huntsman L (2005). *Prevention And Early Intervention:*

Literature Review. Sydney, NSW Centre for Parenting & Research, NSW Department of Community Services.

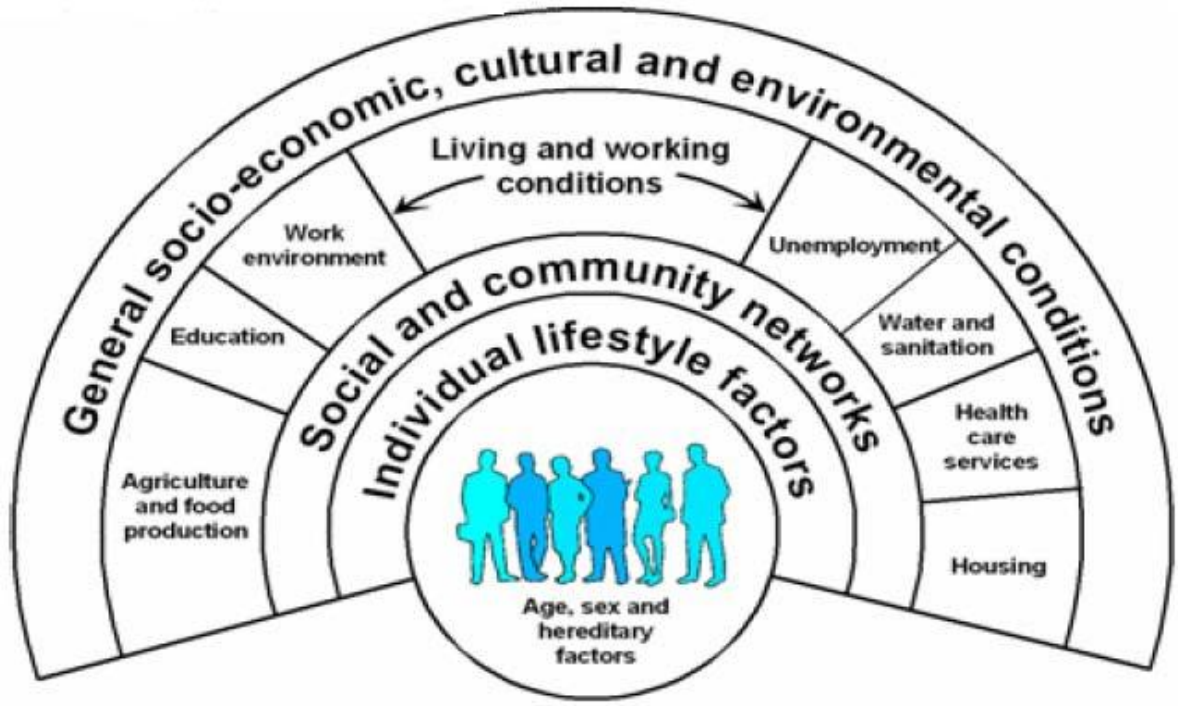
WHO (2009). *Reducing Health Inequalities Through Action On The Social Determinants Of Health. Sixty-second World Health Assembly agenda item 12.5. 22 May 2009*. Geneva, World Health Organization. WHA62.14. Available http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf Accessed 15 July 2009.

Appendix

Figure 1 Alcohol primary prevention and early intervention framework



A larger version of this diagram and its source is provided on the following page.

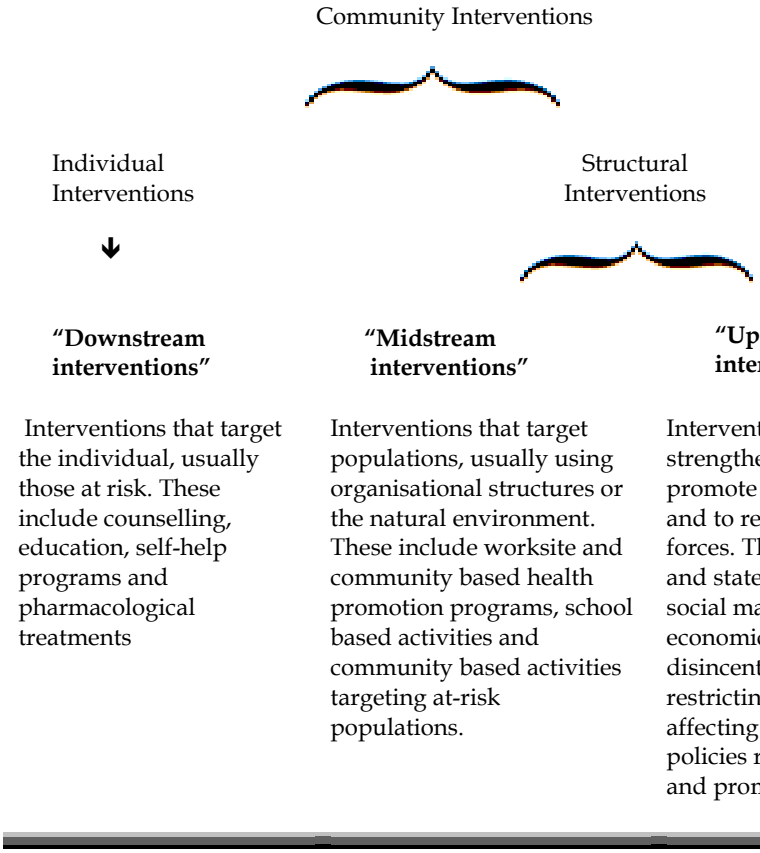


Source of Dahlgren and Whitehead's "layers of influence" (1991) is Solar and Irwin (2005), page 10.

Figure 2 Downstream, midstream and upstream community interventions?

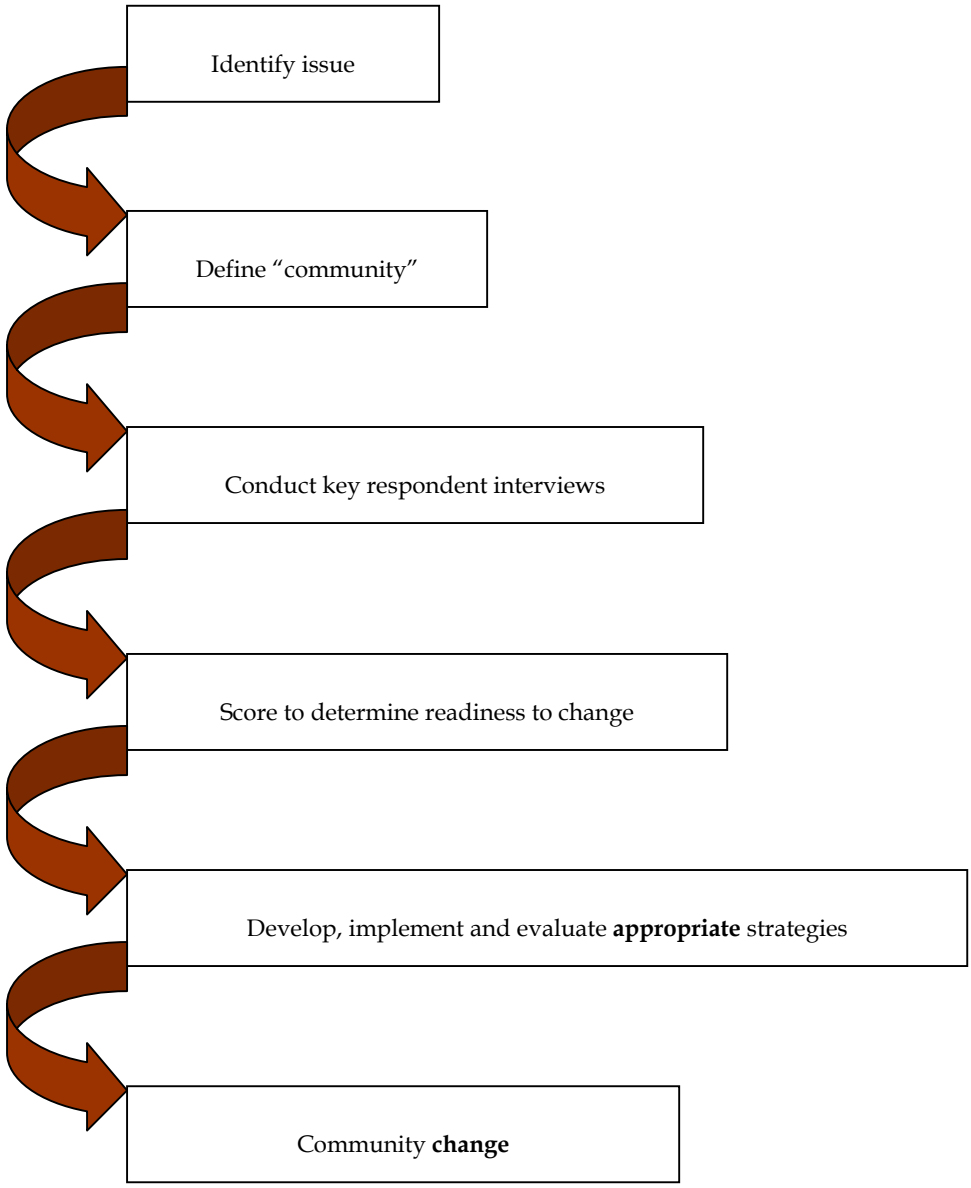
A parable about downstream and upstream interventions

There is a fast flowing river with lifeguards standing beside it. Every so often a drowning person is swept past them. A lifeguard dives in to the rescue, pulls the person out of the river and resuscitates them. Just as one person is saved another drowning person is swept past. The lifeguards are so busy and involved in all this rescue work they have no time to walk upstream to see why so many people are falling into the river and do something to prevent it from happening.



Source: Parable adapted from Ashton and Seymour (1988: preface), and figure from DrugInfo Clearinghouse factsheet 5.2 (September 2006).

Figure 3 Process of using the community readiness for change model



Source: Plested *et al* (2006).

Figure 4 Community readiness for change dimensions

Dimensions of readiness are the key factors that influence how prepared your community is to take action. Your community's status in each of these areas forms the basis for its overall readiness to change. There are a number of questions asked of a range of representative community members and their responses are then scored and averaged to provide a community score of readiness to change. Knowing your readiness level allows you to develop the most appropriate prevention-associated strategies. Questions cover:

A. Community efforts: To what extent are there efforts, programs, and policies that address the issue?

B. Community knowledge of the efforts: To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

C. Leadership: To what extent are appointed leaders and influential community members supportive of the issue?

D. Community climate: What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?

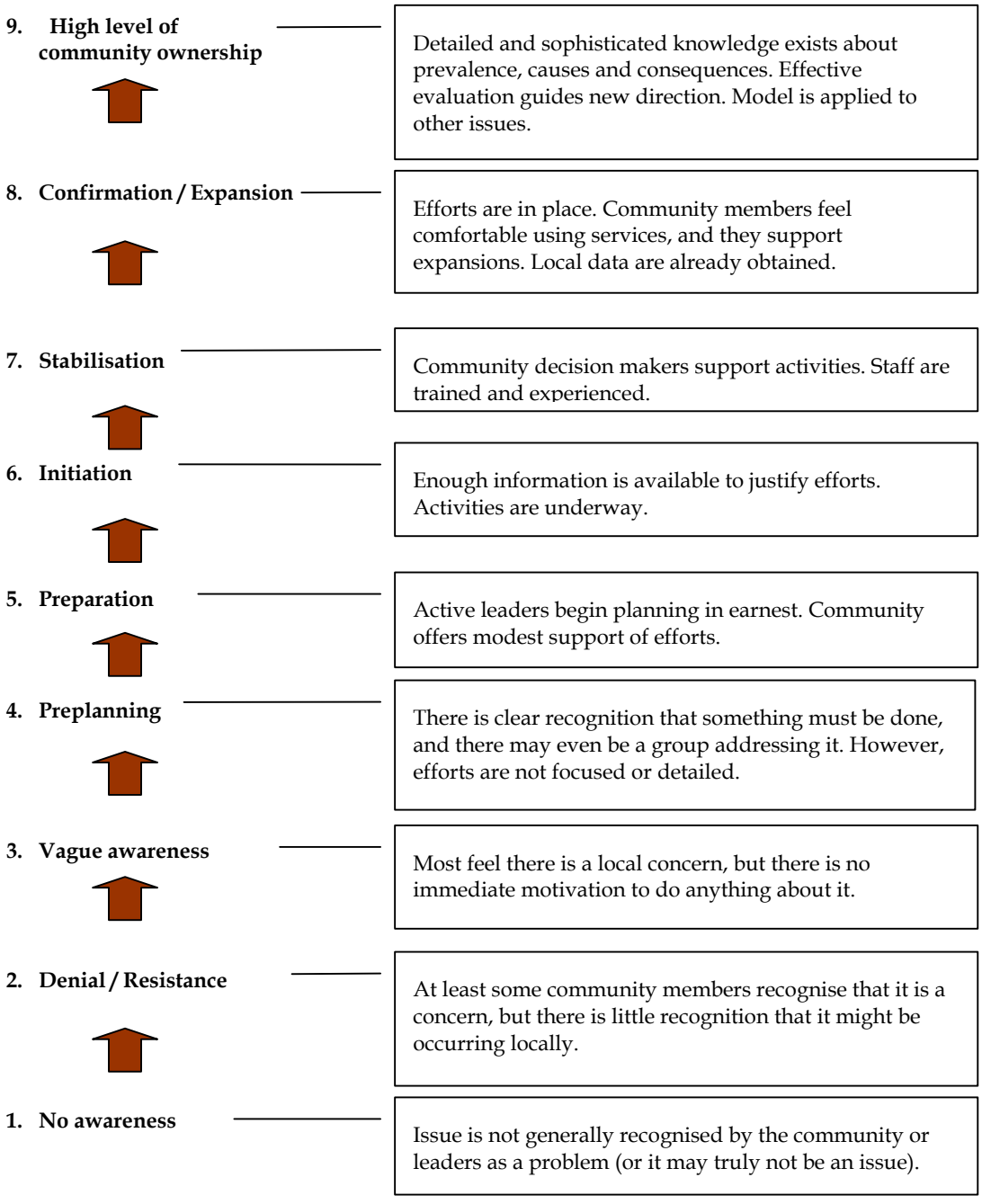
E. Community knowledge about the issue: To what extent do community members know about the causes of the problem, consequences and how it impacts your community?

F. Resources related to the issue: To what extent are local resources – people, time, money, space etc. – available to support efforts?

Source: Plested *et al* (2006). Page 9.

Figure 5 Stages of community readiness

When you have explored questions focusing on need or a problem and scored your community's readiness to change you will be able to develop appropriate strategies to progress the changes you want to make. Each level of readiness requires different interventions.



Source: Plested *et al* (2006). Adapted from pages 11 and 12.

Table 1 Characteristics that foster community capacity

Citizen participation that is characterised by

- Strong participant base
- Diverse network that enables different interests to take collective action
- Benefits overriding costs associated with participation
- Citizen involvement in defining and resolving needs

Leadership that is characterised by

- Inclusion of formal and informal leaders
- Providing direction and structure for participants
- Encouraging participation from a diverse network of community participants
- Implementing procedures for ensuring participation from all during group meetings and events
- Facilitating the sharing of information and resources by participants and organizations
- Shaping and cultivating the development of new leaders
- A responsive and accessible style
- The ability to focus on both task and process details
- Receptivity to prudent innovation and risk taking
- Connectedness to other leaders

Skills that are characterised by

- The ability to engage constructively in group process, conflict resolution, collection and analysis of assessment data, problem solving and program planning, intervention design and implementation, evaluation, resource mobilisation, and policy and media advocacy
- The ability to resist opposing or undesirable influences
- The ability to attain an optimal level of resource exchange (how much is being given and received)

Resources that are characterised by

- Access and sharing of resources that are both internal and external to a community
- Social capital, or the ability to generate trust, confidence, and cooperation
- The existence of communication channels within and outside of a community

Community values that are characterised by

- Clearly defined norms, standards, and attributes
- Consensus building about values

Sense of community that is characterised by

- High level of concern for community issues
- Respect, generosity, and service to others
- Sense of connection with the place and people
- Fulfilment of needs through membership

Table 1 (Cont.) Characteristics that foster community capacity

Social and inter-organisational networks that are characterised by

- Reciprocal links throughout the overall network
- Frequent supportive interactions
- Overlap with other networks within a community
- The ability to form new associations
- Cooperative decision-making processes

Understanding of community history that is characterised by

- Awareness of important social, political, and economic changes that have occurred both recently or more distally
- Awareness of the types of organisations, community groups, and community sectors that are present
- Awareness of community standing relative to other communities

Community power that is characterised by

- The ability to create or resist change regarding community turf, interests, or experiences
- Power with others, not control over them (non-zero-sum or win-win strategies)
- Influence across a variety of domains or community contexts

Critical reflection that is characterised by

- The ability to reflect on the assumptions underlying our and others' ideas and actions
- The ability to reason logically and scrutinise arguments for ambiguity
- The ability to understand how forces in the environment influence both individual and social behaviour
- The ability for community organisations to self-analyse their efforts at change over time

Source: Goodman *et al* (1998). Table 1, pages 261-262.

Table 2 Australian NHMRC* levels of evidence for interventions

Level*	Ranking of levels of evidence
I	Strong evidence from at least one systematic review of multiple well-designed randomised controlled trials
II	Strong evidence from at least one properly designed randomised controlled trial
III-1	Evidence from at least one properly designed pseudo-randomised controlled trial
III-2	Evidence from well-designed comparative studies with concurrent controls, including non-randomised trials, cohort studies, time series or matched case-controlled studies
III-3	Evidence from well-designed comparative studies without concurrent controls, including historical control studies, two or more single arm studies or interrupted time series
IV	Evidence from case series
Other	Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees

Source: Adapted from NHMRC (2008). Table 1, page 6. *Levels I to IV reflects the latest NHMRC rankings, and 'other' is from previous guidelines that ranks opinions, while recognising they do not have scientific rigour.
*National Health and Medical Research Council

Table 3 Key to rating scales in Tables 4 to 7

Rating	Evidence of effectiveness	Breadth of research support	Test across cultures	Australian evaluation
0	Lack of effectiveness	No studies undertaken	Not tested	Limited investigation
★	Limited effectiveness	1 well-designed study completed	Tested in 1 country	Evidence for implementation
★★	Moderate effectiveness	2-4 studies completed	Tested in 2-4 countries	Evidence for outcome effectiveness
★★★	High degree of effectiveness	5+ studies completed	Tested in 5+ countries	Evidence for effective dissemination
?	No evidence available			N/A
●				Warrants further research
✖				Evidence is contra-indicated

Source: Alcohol Working Group (2008). Table 5, page 18.

Table 4 Most effective alcohol strategies and interventions

Strategy or intervention		How effective	Breadth of research	Cross-cultural testing	Cost to implement	Australian evaluation
Regulating physical availability	Total ban on sales	★★★	★★★	★★	High	★★
	Minimum legal purchase age	★★★	★★★	★★	Low	
	Hours and days of sale restrictions	★★	★★	★★	Low	★★
	Restrictions on density of outlets	★★	★★★	★★	Low	●
	Staggered closing times for bars and clubs					✖
	Server liability	★★★	★	★	Low	★
	Different availability by alcohol strength	★★	★★	★	Low	
Taxation and pricing	Alcohol taxes	★★★	★★★	★★★	Low	★★
	Hypothecated tax to pay for treatment / prevention					★★★
	Setting floor prices / banning discounting					★★
Drink-driving counter-measures	Sobriety checkpoints	★★	★★★	★★★	Moderate	
	Random breath testing	★★★	★★	★	Moderate	★★★
	Lowered BAC limits	★★★	★★★	★★	Low	
	Administrative license suspension	★★	★★	★★	Moderate	
	Low BAC for young drivers	★★★	★★	★	Low	★
	Graduated licensing for novice drivers	★★	★★	★★	Low	
	Designated drivers and ride services	0	★	★	Moderate	★
	Ignition interlocks					★
Treatment and early intervention	Brief intervention in primary health settings	★★	★★★	★★★	Moderate	★★★
	Alcohol problems treatment	★	★★★	★★★	High	★★★
	Thiamine supplementation					★★
	Workplace interventions					●
	Mutual help/self-help attendance	★	★	★★	Low	
	Mandatory treatment of repeat drink drivers	★	★★	★	Moderate	

Source: Alcohol Working Group (2008). From Table 6, page 19. This table adopted from Babor *et al* (2003), Loxley *et al* (2004) and Toumbourou *et al* (2007).

★★★=High degree of effectiveness; ★★=Moderate effectiveness; ★=Limited effectiveness;
0 =Lack of effectiveness; ●=Warrants further research; ✖= Evidence is contra-indicative;
?=No evidence available (See Table 3). Grey shading indicates no information provided in original tables.

Table 5 Less effective alcohol strategies and interventions

Strategy or intervention		How effective	Breadth of research	Cross-cultural testing	Cost to implement	Australian evaluation
Altering the drinking context	Bans on serving intoxicated persons	★	★★★	★★	Moderate	
	Training staff to prevent intoxication / aggression	★	★	★	Moderate	★★ (✖ if not enforced)
	Voluntary codes of bar practice	0	★	★	Low	★★ (✖ if not enforced)
	Enforcement of on-premises regulations and laws	★★	★	★★	High	
	Promoting alcohol-free events	0	★★	★	High	
	Community mobilisation	★★	★★	★	High	★★
	Plastic or tempered-glass serving containers					★
	Food service					★
Regulating promotion	Advertising bans	?	●	●	Low	
	Advertising content controls	?	●	●	Low	●
Education and persuasion	Alcohol education in schools	0	★★★	★★	High	★
	College student education	0	★	★	High	
	Parent education	?	●	●	Moderate	●
	Public service messages / Mass media campaigns	●	●	●	Moderate	★
	Warning labels / National drinking guidelines	0	★	★	Low	★

Source: Alcohol Working Group (2008). From Table 6, page 19. This table adopted from Babor *et al* (2003), Loxley *et al* (2004) and Toumbourou *et al* (2007).

★★★=High degree of effectiveness; ★★=Moderate effectiveness; ★=Limited effectiveness;
0 =Lack of effectiveness; ●=Warrants further research; ✖= Evidence is contra-indicative;
?=No evidence available (See Table 3). Grey shading indicates no information provided in original tables.

Table 6 Target groups of most effective alcohol strategies and interventions

Strategy or intervention		How effective	Cost to implement	Target group (TG) and comments
Regulating physical availability	Total ban on sales	★★★	High	TG = General population. Substantial adverse side effects from black market, which is expensive to suppress. Ineffective without enforcement.
	Minimum legal purchase age	★★★	Low	TG= High risk or vulnerable groups. Reduces hazardous drinking, but does not eliminate drinking. Effective with minimum enforcement but enforcement substantially increases effectiveness.
	Hours and days of sale restrictions	★★	Low	TG= General population. Effective in certain circumstances.
	Restrictions on density of outlets	★★	Low	TG= General population. Requires a longer time course for implementation when drinking establishments have become concentrated because of vested economic interests.
	Staggered closing times for bars and clubs			
	Server liability	★★★	Low	TG= High-risk drinkers. Requires legal definition of liability; mostly limited to North America
	Different availability by alcohol strength	★★	Low	TG= General population. Mostly tested for strengths of beer.
Taxation and pricing	Alcohol taxes	★★★	Low	TG= General population. Effectiveness depends on government oversight and control of alcohol production and distribution. High taxes can increase smuggling and illicit production.
	Hypothecated tax to pay for treatment / prevention			
	Setting floor prices / banning discounting			

Source: The strategies and interventions are from Alcohol Working Group (2008), Table 6, page 19. Target group information is from Babor *et al* (2003), Table 16.1, pages 264-266.

★★★=High degree of effectiveness; ★★=Moderate effectiveness; ★=Limited effectiveness;
0 =Lack of effectiveness; ●=Warrants further research; ?=No evidence available (See Table 3).
Grey shading indicates no information provided in original tables.

Table 6 (Cont.) **Target groups of most effective alcohol strategies and interventions**

Strategy or intervention		How effective	Cost to implement	Target group (TG) and comments
Drink-driving counter-measures	Sobriety checkpoints	★★	Moderate	TG= General population. Effects of police campaigns typically short-term.
	Random breath testing	★★★	Moderate	TG= General population. Somewhat expensive to implement. Effectiveness depends on number of drivers directly affected.
	Lowered BAC limits	★★★	Low	TG= General population. Diminishing returns at lower levels (e.g., 0.05-0.02%), but still significant.
	Administrative license suspension	★★	Moderate	TG= Those with harmful drinking and alcohol dependence.
	Low BAC for young drivers ('zero tolerance')	★★★	Low	TG= High Risk drinkers
	Graduated licensing for novice drivers	★★	Low	TG= High Risk drinkers. Some studies note that 'zero tolerance' provisions are responsible for this effect.
	Designated drivers and ride services	0	Moderate	TG= High Risk drinkers. Effective in getting drunk people not to drive but do not affect alcohol-related accidents.
	Ignition interlocks			
Treatment and early intervention	Brief intervention in primary health settings	★★	Moderate	TG= High Risk drinkers. Primary care practitioners lack training and time to conduct screening and brief interventions.
	Alcohol problems treatment	★	High	TG= Those with harmful drinking and alcohol dependence. Population reach is low because most countries have limited treatment facilities.
	Thiamine supplementation			
	Workplace interventions			
	Mutual help/self-help attendance	★	Low	TG= Those with harmful drinking and alcohol dependence. A feasible, cost-effective complement or alternative to formal treatment in many countries.
	Mandatory treatment of repeat drink drivers	★	Moderate	TG= Those with harmful drinking and alcohol dependence. Punitive or coercive approaches have time-limited effects, and sometimes distract attention from more effective interventions.

Source: The strategies and interventions are from Alcohol Working Group (2008), Table 6, page 19. Target group information is from Babor *et al* (2003), Table 16.1, pages 264-266.

★★★=High degree of effectiveness; ★★=Moderate effectiveness; ★=Limited effectiveness;
0 =Lack of effectiveness; ●=Warrants further research; ?=No evidence available (See Table 3).
Grey shading indicates no information provided in original tables.

Table 7 Target groups of less effective alcohol strategies and interventions

Strategy or intervention		How effective	Cost to implement	Target group (TG) and comments
Altering the drinking context	Bans on serving intoxicated persons	★	Moderate	TG= High Risk drinkers. Training alone is insufficient. Outside enforcement essential for effectiveness.
	Training staff to prevent intoxication / aggression	★	Moderate	TG= High Risk drinkers
	Voluntary codes of bar practice	0	Low	TG= High Risk drinkers. Ineffective without enforcement.
	Enforcement of on-premises regulations and laws	★★	High	TG= High Risk drinkers. Compliance depends on perceived likelihood of enforcement.
	Promoting alcohol-free events	0	High	TG= General population. Evidence mostly from youth alternative programs.
	Community mobilisation	★★	High	TG= General population. Sustainability of changes has not been demonstrated.
	Plastic or tempered-glass serving containers			
	Food service			
Regulating promotion	Advertising bans	?	Low	TG= General population. Strongly opposed by alcoholic beverage industry; can be circumvented by product replacements on TV and in movies.
	Advertising content controls	?	Low	TG= General population. Often subject to industry self-regulation agreements, which are rarely enforced or monitored.
Education and persuasion	Alcohol education in schools	0	High	TG= High Risk drinkers. May increase knowledge and change attitudes but has no sustained effect on drinking.
	College student education	0	High	TG= High Risk drinkers. May increase knowledge and change attitudes but has no sustained effect on drinking.
	Parent education	?	Moderate	
	Public service messages / Mass media campaigns	●	Moderate	TG= General population. Refers to messages to the drinker about limiting drinking; messages to strengthen policy support untested.
	Warning labels / National drinking guidelines	0	Low	TG= General population. Raise awareness, but do not change behaviour.

Source: The strategies and interventions are from Alcohol Working Group (2008), Table 6, page 19. Target group information is from Babor *et al* (2003), Table 16.1, pages 264-266.

★★★=High degree of effectiveness; ★★=Moderate effectiveness; ★=Limited effectiveness;
0 =Lack of effectiveness; ●=Warrants further research; ?=No evidence available (See Table 3).
Grey shading indicates no information provided in original tables.

Table 8 Individual level health promotion theories and their key concepts

Theory	Focus	Key concepts
Health Belief Model	Individual's perception of the threat posed by a health problem, the benefits of avoiding the threat, and factors influencing the decision to act	Beliefs about the chances of getting a problem (perceived susceptibility) Beliefs about the seriousness of a condition and its consequences (perceived severity) Beliefs about the effectiveness of taking action to reduce risk or consequences (perceived benefits of action) Beliefs about the material and psychological costs of taking action (perceived barriers) Factors that activate 'readiness to change' (cues to action) Confidence in one's ability to take action (self-efficacy)
Stages of Change Model	Individual's motivation and readiness to change a problem behaviour	No intention of taking action in next six months (pre-contemplation) Intend to take action in next six months (contemplation) Intend to take action in next month and have begun some preliminary changes (decision) Has changed behaviour for less than six months (action) Has changed behaviour for more than six months (maintenance)
Theory of Planned Behaviour	Individual's attitudes toward a behaviour, perceptions of the norms, and beliefs about the ease or difficulty of changing	Perceived likelihood of performing behaviour (behavioural intention) Attitude (Personal evaluation of the behaviour (attitude) Beliefs about whether key people approve or disapprove of the behaviour; motivation to behave in a way that gains their approval (subjective norm) Belief that one has, and can, exercise control over performing the behaviour (perceived behavioural control)
Precaution Adoption Process Model	Individual's journey from lack of awareness to action and maintenance	Unaware of the issue Unengaged by the issue Deciding about acting Deciding not to act Deciding to act Acting Maintenance

Source: Rimer and Glanz (2005).

Table 9 Interpersonal level health promotion theories and their key concepts

Theory	Focus	Key concepts
Social Cognitive Theory	Personal factors, environmental factors, and human behaviour exert influences on each other	The dynamic interaction of the person, behaviour, and the environment in which the behaviour is performed (reciprocal determinism)
		Knowledge and skill to perform a given behaviour (behavioural capability)
		Anticipated outcomes of a behaviour (expectations)
		Confidence in one's ability to take action and overcome barriers (self-efficacy)
		Behaviours developed from watching the actions and outcomes of other's behaviour (observational learning)
		Responses to a person's behaviour that increase or decrease the likelihood of reoccurrence (reinforcements)

Source: Rimer and Glanz (2005).

Table 10 Community level health promotion theories and their key concepts

Theory	Focus	Key concepts
Community Organisation	Community-driven approaches to assessing and solving health and social problems	Empowerment (a social action process through which people gain mastery over their lives and their communities)
		Community capacity (characteristics of a community that affects its ability to identify, mobilise around and address problems)
		Participation (engagement of community members as equal partners)
		Relevance (community organising that "starts where the people are")
		Issue selection (identifying immediate, specific, and realisable targets for change that unify and build community strength)
		Critical consciousness (awareness of social, political, and economic forces that contribute to social problems)
Diffusion of Innovations	How new ideas, products, and practices spread within a society or from one society to another	Is the 'new' better than what it will replace (relative advantage)
		Does the 'new' fit with the intended audience (compatibility)
		Is the 'new' easy to use (complexity)
		Can the 'new' be tried before making a decision (trialability)
		Are the results of the 'new' observable and easily measurable (observability)
Communication Theory	How different types of communication affect health behaviour	Institutional factors and processes influencing how the media define, select and emphasise issues (media agenda setting)
		Link between issues covered in the media and the public's priorities (public agenda setting)
		Link between issues covered in the media and the legislative priorities of policy makers (policy agenda setting)
		Factors and process leading to the identification of an issue as a "problem" by social institutions (problem identification / definition)
		Selecting and emphasising aspects of a story and excluding others (framing)

Source: Rimer and Glanz (2005).