video clip

Community Trials Intervention to Reduce High-Risk Drinking

Program developers or their agents provided the Model Program information below.

BRIEF DESCRIPTION

Community Trials Intervention to Reduce High-Risk Drinking is a multicomponent, community-based program developed to alter alcohol use patterns of people of all ages (e.g., drinking and driving, underage drinking, acute [binge] drinking).

The program uses a set of environmental interventions including:

- Community awareness
- Responsible beverage service (RBS)
- Preventing underage alcohol access
- Enforcement
- Community mobilization

Its aim is to help communities reduce various types of alcohol-related accidents, violence, and resulting injuries.

Program Background

The Community Trials Project was originally inspired by the success of community-wide programs to address chronic health problems such as cardiovascular disease, results from natural experiments (e.g., reductions in the minimum drinking age), and earlier community-wide programs designed to reduce drinking and drinking-related problems. Additionally, it involved a careful collection of baseline data during the pre-intervention period, adopted well-defined community-level alcohol-related problems as targets, had a long-term implementation and monitoring period, was followed by a final evaluation of changes in target problems, and involved an empirically documented successful result in the target attributable to the intervention.

RECOGNITION

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services: Model Program

INSTITUTE OF MEDICINE CLASSIFICATION (IOM)

UNIVERSAL

Developed for a universal audience.

INTERVENTION TYPE

COMMUNITY-BASED

This program was developed for use in community-based intervention sites, which can vary greatly from community to community. The program needs a location to organize, collect and distribute data and information, hold community meetings, conduct community or targeted trainings and outreach, etc. These functions can be situated within a church, community center, civic organization or public building.

CONTENT FOCUS

ALCOHOL

This program targets alcohol.

PROTECTIVE FACTORS

INDIVIDUAL, FAMILY, COMMUNITY

INDIVIDUAL

- Perceived high risk of arrest for drinking and driving

FAMILY

- Parental supervision of alcohol access to youth within the home

COMMUNITY

- RBS training of alcohol establishments and related sales and service policies
- Enforcement of drinking and driving laws
- Publicity surrounding changes in youth alcohol access and drink and drive enforcement
- Media advocacy in support of alcohol policy change
- Decreased alcohol outlet density
- Decreased formal and informal youth access to alcohol

RISK FACTORS

INDIVIDUAL, FAMILY, COMMUNITY

INDIVIDUAL

- Low perceived risk of arrest for drinking and driving

FAMILY

- In-home alcohol access to minors

COMMUNITY

- Proliferation of alcohol outlets
- Alcohol sales and service to minors at on- and off-premise alcohol outlets
- Alcohol service to intoxicated patrons at bars and restaurants
- Lax enforcement of drinking and driving laws
- Little media coverage of community efforts to combat problematic drinking and associated outcomes

INTERVENTIONS BY DOMAIN

COMMUNITY, SOCIETY

COMMUNITY

- Education to alter perceptions of societal norms and expectations
- Multiagency activities and collaboration

SOCIETY

- Enforcement of tobacco and alcohol sales laws
- Increased taxes on alcohol and tobacco

KEY PROGRAM APPROACHES

COMMUNITY INVOLVEMENT, MASS MEDIA (USE OF), SKILL DEVELOPMENT, PARENT TRAINING

COMMUNITY INVOLVEMENT

Assists communities in using zoning and municipal regulations to restrict alcohol access through alcohol outlet density control

Through law enforcement sobriety checkpoints, it increases actual and perceived risk of arrest for driving after drinking

Provides communities with tools to form the coalitions needed to implement and support the interventions that will address restriction of alcohol access, responsible beverage service, risk of drinking, driving, and underage alcohol access

MASS MEDIA (USE OF)

Teaches communities how to enlist local media in awareness campaigns that may range from the risks of drinking and driving to warnings about sobriety checkpoints to alcohol service testing

SKILL DEVELOPMENT

Assists alcohol beverage servers and retailers in the skills of responsible beverage service, such as the development of policies and procedures to reduce intoxication and driving after drinking

Promotes and assists with training of alcohol retailers to avoid selling to minors and those who provide alcohol to minors

PARENT TRAINING

Note: The program interventions target youth and adults who consume alcohol, and the community norms and systems that support alcohol abuse and underage use. Depending on the community's needs, parent-focused interventions may be developed and implemented.

HOW IT WORKS

For the RHRD program to be successful, the implementing organization must first determine which program components will best produce the desired results for its community. The RHRD program uses five prevention components, including:

Alcohol Access. Assists communities in using zoning and municipal regulations to restrict alcohol access through alcohol outlet (bars, liquor stores, etc.) density control.

Responsible Beverage Service. Through training and testing, RBS assists alcohol beverage servers and retailers in the development of policies and procedures to reduce intoxication and driving after drinking.

Risk of Drinking and Driving. Increases actual and perceived risk of arrest for driving after drinking through increased law enforcement and sobriety checkpoints.

Underage Alcohol Access. Reduces youth access to alcohol by training alcohol retailers to avoid selling to minors and those who provide alcohol to minors, and through increased enforcement of underage alcohol sales laws.

Community Mobilization. Provides communities with the tools to form the coalitions needed to implement and support the interventions that will address the previous four prevention components.

Understanding the community's alcohol environment (e.g., norms, attitudes, usage locations, cultural and socioeconomic dynamics, etc.) and alcohol distribution systems (e.g., alcohol sales licensing, alcohol outlet zoning, and alcohol use restrictions) is key to the startup of RHRD. This requires gathering the data needed to determine which interventions to use and adapting them to the individual community.

Project staff are key to this information gathering and for working with a wide array of community components, including local community organizations, key opinion leaders, police, zoning and planning commissions, policy makers, and the general public. Though dependent on local conditions, staff generally includes the following:

Director—responsible for developing the initiative and its strategy, seeking funding, building coalitions with key community groups and leaders, and hiring project staff

Assistant director—responsible for day-to-day management of office operations and staff, recruiting and organizing volunteers, and implementing interventions/tactics

Data managers—collect information to track program trends

Administrative—assist with managing volunteers and processing information; the first line of information for public and other stakeholders

Volunteers—provide general support for program interventions; elicit support from the broader community and participation by key community leaders (e.g., police); assist in the "synergistic" application of program components, such as media coverage of program efforts; attend community meetings and hearings to speak or gather information on targeted topics; and assist with public education projects and other interventions as needed

Program Task Force—composed of key community leaders (e.g., police captains, zoning, public safety and youth commissioners); they can provide and further build coalitions to support program interventions

Staff can be employees of the lead agency endeavoring to implement the program or may be hired and separate from existing entities.

Training and Materials

Training and consultation target the specific needs and problems of the individual community. Consultation is available and is tailored to the individual site. Training manuals for RBS are available at a minimal cost.

Brochures also are available that offer strategies and tactics for reducing alcohol use within various areas of the community, such as on college campuses, in neighborhoods, within the high school population, etc.

OUTCOMES

DECREASES IN SUBSTANCE ABUSE, REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS

DECREASES IN SUBSTANCE USE

6% decline in self-reported amounts of alcohol consumed per drinking occasion.

49% decrease in self-reported "having had too much to drink."

REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS

51% decline in self-reported driving when "over the legal limit" in the intervention communities relative to the comparison communities.

10% reduction in nighttime injury crashes.

6% reduction in crashes in which the driver had been drinking.

43% reduction in assault injuries observed in emergency rooms.

2% reduction in hospitalized assault injuries.

BENEFITS

Decreased alcohol sales to youth

Increased enforcement of DUI laws

Implementation and enforcement of RBS policies

Adoption of policies limiting the dense placement of alcohol-selling establishments

Increased coverage of alcohol-related issues in local news media

Reductions in intentional and unintentional alcohol-related injuries (i.e., car and household accidents, assaults)

Mobilization of community members and key policy makers

Decreased formal and informal youth access to alcohol

Responsible alcohol beverage service and sales policies

EVALUATION DESIGN

The project evaluation used a longitudinal, multiple-time series design across three intervention communities. The matched comparison communities served as no-treatment controls. Within this design, the effects of project interventions can be determined by comparing outcomes to those from matched comparison communities.

Data collected as a part of the evaluation included:

- A community telephone survey including self-reported measures of drinking and drinking and driving
- Traffic crash records
- Emergency room surveys
- Intoxicated patron and underage decoy surveys
- Local news coverage of alcohol-related topics
- Roadside surveys conducted on weekend evenings

DELIVERY SPECIFICATIONS

0–4 WEEKS, 5–24 WEEKS, 25–52 WEEKS, 1–3 YEARS, 3–6 YEARS, 0–12 YEARS

Amount of time required to deliver the program and obtain documented outcomes:

The length and specifications of any intervention are determined by the needs of the individual community.

INTENDED SETTING

RURAL, URBAN, SUBURBAN

Developed for suburban, urban, and rural schools.

FIDELITY

Components that must be included in order to achieve the same outcomes cited by the developer:

The implementing agency or organization must gather data needed to determine which interventions to use and adapt them to the individual community. This requires understanding the community's alcohol environment, such as norms, attitudes, usage locations, cultural and socioeconomic dynamics; and the community's alcohol distribution systems, such as alcohol sales licensing, alcohol outlet zoning, and alcohol use restrictions.

BARRIERS AND PROBLEMS

NO INFORMATION PROVIDED

PERSONNEL

FULL TIME, PART TIME, PAID, VOLUNTEER

The implementing agency or organization should include the following staff, either as employees of the lead agency or as staff separate from already existing entities:

A project director who is responsible for developing the initiative and its strategy, seeking funding, building coalitions with key community groups and leaders, and hiring project staff.

An assistant director who is responsible for day-to-day management of office operations and staff, recruiting and organizing volunteers, and implementing interventions and tactics.

Data managers who collect information to track program trends.

Administrative staff to assist with managing volunteers and processing information.

Volunteers who provide general support for program interventions; elicit support from the broader community and participation by key community leaders; assist in the application of program components; attend community meetings and hearings to speak or gather information; and assist with public education projects.

Program taskforce, composed of key community leaders (i.e., policy captains, zoning, public safety, and youth commissioners), that can provide and further build coalitions to support program interventions.

EDUCATION

HIGH SCHOOL, UNDERGRADUATE, GRADUATE, SPECIAL SKILLS

Not specified by the developer.

PERSONNEL TRAINING

Location: ONSITE (user)

Training and consultation are available and are tailored to the individual site.

COST (estimated in U.S. dollars)

$0–100
$101–1,000
$1,001–5,000
$5,001–10,000
$10,000+

Cost considerations for implementing this Model Program as recommended by the developer:

Costs will vary by community.

MATERIALS

Training manuals are available and included in training costs.

INTENDED AGE GROUP

EARLY ADOLESCENT (12–14), TEENAGER (15–17), YOUNG ADULT (18–24), ADULTS (25–54)

This program targets people who are old enough to understand the public health effects of drinking and driving. An environmental, community-based intervention, it can reach and impact all ages.

INTENDED POPULATION

MULTIPLE ETHNIC GROUPS

This program has been delivered to communities that are racially and ethnically diverse.

Each of the six intervention and comparison communities located in northern and southern California and South Carolina had approximately 100,000 residents. The communities were racially and ethnically diverse and included a mix of urban, suburban, and rural settings.

GENDER FOCUS

BOTH GENDERS

This program was developed for both males and females.

REPLICATION INFORMATION

NO INFORMATION PROVIDED

CONTACT INFORMATION

ABOUT THE DEVELOPER

Harold D. Holder, Ph.D., is the principal investigator for the Community Trials Project, which was developed and implemented by the Prevention Research Center (PRC), Berkeley, CA, under a grant from the National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, U.S. Department of Health and Human Services. The PRC is one of 14 alcohol research centers and specializes in the development of and advocacy for prevention science and related research and is a project of the Pacific Institute for Research and Evaluation.

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