# Community-led and community-based prevention.

## What is it?

**Alcohol and other drug problems can impact the whole community and communities can play an important role in addressing and contributing to effective responses.**

Communities are often defined by geographical boundaries, such as Local Government Areas (LGAs) or ABS defined boundaries such as Statistical Local Areas (SLAs).

### Community-led or community-based

Community-led programs aim to initiate or strengthen the capacity of communities to identify and strategically prevent and respond to health and behavioural issues in a given population.[1]

A community-led approach is usually characterised by a community that identifies its own needs and is then mobilised to respond to those needs in order to help prevent further health and behavioural problems.

Community-led interventions, also known as *whole community interventions* and *community-driven interventions*, are grassroots projects, often funded by the communities themselves, or as a result of partnerships with research institutes, governments and organisations.

A community-based approach tends to be project oriented and most often driven by external people or organisations to assist a community to identify areas of concern or lead interventions to address specific community issues.

Community engagement methods used within community-based approaches may include facilitated formation of:

- community coalitions and committees
- peer leadership and educational groups
- volunteering groups
- community workshops
- health promotions councils.[2]

There is good evidence for a number of community-based programs including those focussed on preventing youth tobacco,[3] alcohol[4] and other drug use.[5] Community-based interventions are most effective where they target prevalent and important risk factors, use evidence-based components and are implemented with fidelity.

### Factors for success

Whilst the differences between community-led and community-based are mostly in the formation and initiation of a project, the two approaches share similar interventions and strategies when projects are implemented.

For a community to be effective in either a community-led or community-based initiative they usually form a governance structure that helps facilitate the approach. Such a structure

often comprises a coalition of individuals from a cross-section of sectors and services. The coalition actively participates in the planning, design and implementation of the evidence-based (tested and effective) programs, policies and strategies.

This 'bottom up' approach helps to ensure that the focus of the project is relevant to the needs of the community and that communities are engaging in – and with – initiatives in a way that is most suited to them.[6,7] Engaging community support is also critical to ensuring effective responses are embraced. The most effective responses don't always enjoy community (and thus political) support and vice versa.

Fostering a sense of community ownership is key to engagement and participation in community-led programs. Pooling resources and knowledge and multi-agency coordination are two important elements for achieving this. This broad-based approach also increases the potential for long term effectiveness.[7]

Programs are often organised and delivered in specific community-based settings and service delivery agencies such as:

- healthcare services
- educational facilities
- religious or community groups
- local businesses
- sporting facilities.[6]

Community engagement and involvement in project planning, design and implementation also works to increase awareness of the problem, which can help facilitate community readiness – an essential component in mobilising communities. Awareness also enables communities to actively advocate and lobby on behalf of their communities and their programs; a powerful tool that can and has been utilised by communities to influence policy makers and prompt the creation of more effective community-specific policies.[8]

Training community coalitions often results in increased understanding of public health and prevention approaches. It also can increase and improve the standard of evidence-based practice in the community.[9]

# Why?

**Alcohol and other drug problems are known to be influenced by a range of modifiable risk factors that operate at the community level (e.g. availability, marketing, community attitudes and norms, community disadvantage, prevalence, etc.).**

Where they work well, community programs support and promote the skills, confidence and competence needed within the community to organise effective, efficient and sustainable responses to a range of health issues.[10,11]

Utilising local knowledge and local skills and services can help to ensure that any project or programs implemented are relevant, appropriate and more likely to succeed.[2,12]

The cause of any behaviour is complex and is always linked to numerous factors. Thus, single targeted approaches to prevent or reduce prevalence of alcohol and other drug (AOD) use or other behaviours within a community are likely to have little or no effect.[13]

Nationally and internationally, there is evidence of the importance and the efficacy of community engagement and participation in AOD prevention. This is especially the case in high risk and marginalised populations.[2,11,12,14]

# Pros and cons of community-led and community-based programs

## Pros

- Evidence-based approach.
- Works with multiple sectors and agencies to strategically target greatest need.
- Encourages sectors and agencies to work together and reduces competition for funds and resources.
- Creates capacity and promotes best-practice.
- Educates and increases skill level across sectors and services.
- Creates a common language and framework so sectors and services can work together more easily.
- Strives to embed a prevention approach within the community system and thus strives for sustainability.
- Benefits are wide ranging – social cohesion, community connectedness, improved health and social outcomes.

## Cons

- It can be difficult to identify what is the most effective component of a broad scale community intervention as in most cases many different elements are included, such as education, health promotion, community awareness building events and targeted programs.
- There are few studies that can specifically delineate between the community-led and community-based interventions.
- A large proportion of the evidence base that demonstrates efficacy focuses specifically on the benefits of youth participation outcomes, not whole community outcomes. More detailed evaluation is needed within programs to assess the impact of programs on other at-risk groups and the community in general.[1,12]
- Prevention works best when it involves change from the bottom up, i.e. people and organisations acting for themselves, becoming more resilient and less vulnerable. But action at this level needs strong support to tackle the political, economic and cultural factors that have helped to cause the harm in the first place.[15] This means that the community acting alone without consideration of how they might influence change at high levels of the social and political system may not achieve intended outcomes.
- Communities may have sufficient readiness for change but may also have a poor understanding of risk factors and effective interventions. Finding the solution(s) that will make change happen is difficult for some groups. This could be due to lack of knowledge, set values and mythology, and/or being under-resourced for what they want to achieve (both financially and physically). Further to this, good intentions do not always lead to good outcomes and there can be unintended adverse outcomes when what is thought to be a good idea (often not evidence-based) leads to a negative outcome.
- The pace of community-led change can be slow. It takes time to mobilise communities, to determine the issue to target, to gather the resources required, and to sustain intervention over time.

# Evidence

**There is an ever-increasing body of evidence to support the use of community-led initiatives as a way of bringing together a diverse range of stakeholders to comprehensively address alcohol and other drug (AOD) use issues, especially in regard to prevention, early onset and health promotion.[1,16]**

A 2011 systematic review of community interventions to deter young people from starting to smoke found that there is some evidence to suggest that multi-component community interventions are effective in influencing smoking behaviour and preventing uptake of smoking in young people.[3]

Community members are involved in determining and/or implementing these programs that include education of tobacco retailers about age restrictions, programs for prevention of smoking-related diseases, mass media, school and family-based programs. These interventions use coordinated, widespread, multi-component tactics to try and influence young peoples' behaviour.

The authors concluded the following program characteristics could be considered by individuals planning future community programs:

- Build upon elements of existing programs that have been shown to be effective (rather than repeating methods that have achieved limited success), especially multi-component school-based interventions, parental involvement, intervention duration longer than 12 months and based on the social influences or social learning theory model.
- Programs need to be flexible to the variability between communities so that the different components of a given program can be modified to achieve acceptability.
- Developmental work with representative samples of those individuals to be targeted should be carried out so that appropriate messages and activities can be implemented.
- Program messages and activities should be guided by a combination of theoretical constructs about how behaviours are acquired and maintained.
- Community activities must reach the intended audience if they are to stand any chance of success of influencing the behaviour of that audience.
- Consider the use of community leader involvement in the planning, development and ongoing implementation of community programs, mass media as a source of message delivery, the use of peers as role models and specific program components for boys and girls separately.[3]

A systemic review of alcohol misuse prevention for young people suggested that certain universal multi-component prevention programs can be effective and could be considered.[4]

Programs that combined school, community and family interventions and that did not typically focus exclusively on the prevention of one behaviour appeared to offer advantages over alcohol-specific programs. Programs that have a psychosocial developmental orientation designed to impact on a range of health and lifestyle behaviours have greater effectiveness.[4]

# Australian evidence

**A 2018 Australian systematic review by Stockings et al aimed to investigate the effectiveness of whole-of-community interventions in reducing population-level harms from AOD use.[6]**

The review of 24 interventions concluded that a whole-of-community approach showed limited effectiveness in reducing population-level harms. There is some evidence that suggests some interventions may be beneficial in reducing AOD-related harms however, this is limited to youth samples.[6]

There was a wide variation in the types of interventions reviewed with most studies having poor methodology and an overall high risk of bias. Stockings et al (2018) reported that overall, interventions had limited impact on prevalence of substance use. Issues relating to sustainability of interventions, non evidence-based interventions being favoured by communities and the long time period that some interventions took to establish all contribute to the modest effect sizes found to date. It is also noted that community-based interventions may only affect a small number of AOD outcomes or may benefit only a select group within communities.[6]

There are many examples of community-based/community-led interventions that are in practice in Australia with variable results, some of these are outlined below.

### Violence and alcohol community-led program

A report published by the University of Western Australia, that focused on innovative models to reduce family violence in remote communities, provided strong qualitative evidence of the need to mobilise a local community-driven response to a community issue.

The report, based on qualitative research in three sites: Fitzroy Crossing (WA), Darwin (NT) and Cherbourg (Qld), supports the creation of a network of place-based Indigenous strategies owned and managed by Indigenous people. The research specifically called for a 'country-centred' approach to family violence, of which alcohol is a major contributor.

Prior to 2007, Fitzroy Crossing, a small community in remote Western Australia, had a significantly high level of alcohol-related harm, in particular alcohol-related violence. In response to the issue, a small number of Fitzroy community members came together to lead a comprehensive program of advocacy.

Community members lobbied local politicians and gained media coverage to raise awareness of the issue of alcohol-related harm. The coming together of the community led to an inquiry into alcohol-related harm in the area and in 2007 the sale of take-away alcohol beverages with an alcohol content of 2.7% or higher was banned in Fitzroy Crossing.

An evaluation of the impacts of the ban demonstrated alcohol sales dropped 88% in the months following the ban. A significant drop (28%) in domestic violence and a decrease (48%) in emergency department cases was also seen. The evaluation also demonstrated alcohol-related problems were not simply displaced to surrounding towns as there had been no significant increase seen in alcohol-related incidents in nearby towns.[8]

The success of the projects in Fitzroy Crossing demonstrates the need for a local community-driven, community-specific response.

### The Marulu Strategy

An international report of Indigenous community-based initiatives found that a successful Fetal Alcohol Spectrum Disorder (FASD) strategy required:

- strengthening and supporting families
- being community-led and culturally appropriate
- building capacity in community members and organisations
- engaging collaborative partnerships in a coordinated approach.[17]

In 2007, community leaders in the Fitzroy Valley became aware that many children in their communities displayed learning and behavioural difficulties. They came to believe that the practice of women drinking alcohol in pregnancy might be adversely affecting their children's ability to learn and develop.[18]

At a womens bush camp in 2007, discussions between senior women of the four main language groups of the area were held and the community-led initiative: the Marulu Strategy, was born.[18]

This project sought to develop individual treatment plans for children, as well as community education programs and support systems for parents, teachers and carers. The Human Rights Commission remarked that this community-led initiative resulted in 'transformative change' in the region.[8]

Following extensive community consultation, a successful appeal was made to the WA Director of Liquor Licensing to introduce restrictions. In the two-year period following the restrictions, rates of alcohol-related crime and injury decreased, school attendance increased and food purchases at the local stores increased.[18,19]

The Marulu Strategy demonstrates a community-led approach to complex and sensitive issues. An important feature of the strategy was that the community themselves identified FASD as a priority issue and then sought collaboration with research and service providers. Community leadership and ownership has ensured a relationship of trust and the ongoing success of the project.

Mobilisation of the community at Fitzroy Crossing also led to the partnership between the Nindilingarri Cultural Health Service, Marninwarntikura Women's Resource Centre, The George Institute for Global Health and The University of Sydney Medical School, allowing for the first Australian Study of FASD prevalence, known as the Lililwan Project.

### NSW partnership (community-based) project

In New South Wales, a community partnership project between the police, health professionals and the hotel and registered club industry was conducted with the aim of reducing alcohol-related crime.

The focus of this community-based project was problem-oriented police surveillance and educational feedback.

Police collected information about the last venue attended by offenders of alcohol-related violence, and reports were generated and sent to a group of 200 of these licenced venues. Audits were also performed on the venues' responsible service of alcohol practices.

At follow up, a significant reduction in alcohol-related incidents was demonstrated involving the interventions group of venues (32%) compared to controls (14%). These results indicate the potential influence of community-based coalition to influence the behaviours of law enforcement, orienting them towards education-based preventative practices, rather than reactive models of policing.[20]

### Communities That Care

Communities That Care (CTC) is a coalition-based comprehensive prevention approach for communities.

This community-led approach is conducted using a five-phase process that focuses on identifying local profiles of risk and protective factors (that modify outcomes for high risk groups) reported by young people within communities.

Once identified, these factors are tested and effective prevention and early intervention programs are planned to improve the community risk and protective factor profile.

No two CTC projects are the same as they are designed specifically for each community, by that community, to address their own individual needs. CTC assists communities to select and implement evidence-based practices that can address their local profile of risk and protective factors.

Examples of evidence-based programs that are listed as addressing CTC risk and protective factors include the Big Brother/Big Sister program that provides mentoring support to vulnerable young people. This program builds community protective factors for vulnerable youth. A 2009 study in Australia found this program had potential to reduce rates of high-risk behaviours amongst young people.[21]

Australian evidence is accumulating, suggesting CTC is showing promise as a way of improving health and behavioural outcomes at a community level.[22,23]

# International evidence

### Planet Youth (Iceland)

Planet Youth is an evidence-based approach to alcohol prevention that was developed in Iceland in the late 1990s to address the increasing levels of alcohol and other drug use amongst young people. It has now been actioned in communities in 31 countries worldwide.[24,25]

The prevention model is based on three pillars of success:

1. evidence-based practice
2. using a community-based approach
3. creating and maintaining a dialogue among research, policy and practice.

The prevention model that emerged from these pillars aims to maintain a continuous link between national level data collection, and local level reflections and actions.[25]

Local data is collected through school-based questionnaires and explores individual, social and environmental risk factors. This data is analysed and the scope of use is matched with the risk and protective factors identified. Findings are utilised by local stakeholders to plan and implement prevention responses. The impact and outcomes of these programs are measured through regular data collection, and effective evidence-based programs utilised on a national level.[25]

The Planet Youth approach acknowledges that peer group affiliations, family, and type of recreational activities available to young people are strong predictors of substance misuse. The model aims to emphasise these factors within communities to build social capital, creating social environments high in protective factors, and low in risk factors for substance misuse.[24] Annual cross-sectional surveys were performed on approximately 7000 adolescents with a response rate of >81%. The result being that substance misuse declined significantly between 1997 and 2007.[24]

#### Evidence gap

It is worth noting that many of the above-mentioned programs, and other community-based/community-led programs, have attracted criticism due to the propensity for self or internal evaluation.

## Success criteria

- Community-led change is most likely to be successful when coupled with legislative change.
- Programs must have clearly defined, focused, and manageable goals.
- Clear and consistent consultation with the community is essential.
- They must have adequate planning time.
- Prevention decisions must be based on empirical data about what needs to change in the community and on evidence from scientifically valid studies of what has worked to address those needs.
- They must implement prevention policies, practices, and programs that have been tested and shown to be effective.
- They must carefully monitor prevention activities to ensure implementation quality.[7]

## ADF position

- The ADF identifies the need for government to invest in and develop capacity of communities to lead evidence-based activities to prevent alcohol and other drug (AOD) harms.
- The ADF supports community-led interventions as a way to support AOD prevention and harm minimisation.
- The ADF supports investment in research into community-led AOD intervention being undertaken.
- It's important to note that the Alcohol and Drug Foundation views community-led prevention activities as part of a range of measures to prevent drug harms.

# References


1. Loxley W, Toumbourou J, Stockwell T, Haines B, Scott K, Godfrey C, et al. *The prevention of substance use, risk and harm in Australia: a review of the evidence.* Commonwealth of Australia; 2004.
2. Swainston K, Summerbell C. *The effectiveness of community engagement approaches and methods for health promotion interventions.* 2008.
3. Carson KV, Brinn MP, Labiszewski NA, Esterman AJ, Chang AB, Smith BJ. *Community interventions for preventing smoking in young people. Cochrane database of systematic reviews.* 2011(7).
4. Foxcroft DR, Tsertsvadze A. *Universal multi-component prevention programs for alcohol misuse in young people.* Cochrane database of systematic reviews. 2011(9).
5. Gates S, McCambridge J, Smith LA, Foxcroft D. *Interventions for prevention of drug use by young people delivered in non-school settings.* Cochrane database of systematic reviews. 2006(1).
6. Stockings E, Bartlem K, Hall A, Hodder R, Gilligan C, Wiggers J, et al. *Whole-of-community interventions to reduce population-level harms arising from alcohol and other drug use: a systematic review and meta-analysis.* Addiction (Abingdon, England). 2018;113(11):1984-2018.
7. Fagan AA, Hawkins JD, Catalano RF. *Engaging communities to prevent underage drinking.* Alcohol Research & Health. 2011;34(2):167.
8. Blagg H, Williams E, Cummings E, Hovane V, Torres M, Woodley KN. *Innovative models in addressing violence against Indigenous women.* Horizons Sydney: ANROWS. 2018.
9. Fagan AA, Hanson K, Hawkins JD, Arthur MW. *Implementing effective community-based prevention programs in the community youth development study.* Youth Violence and Juvenile Justice. 2008;6(3):256-78.
10. Dailly J, Barr A. *Meeting the Shared Challenge: Understanding a Community-led approach to Health Improvement.* Healthy Communities. 2008.
11. Wise M, Angus S, Harris E, Parker S. *Scoping study of health promotion tools for Aboriginal and Torres Strait Islander people.* Melbourne: The Lowitja Institute. 2012.
12. Shakeshaft A, Doran C, Petrie D, Breen C, Havard A, Abudeen A, et al. The effectiveness of community action in reducing risky alcohol consumption and harm: a cluster randomised controlled trial. PLoS medicine. 2014;11(3):e1001617.
13. Johnson K, Courser M, Holder H, Miller B, Ogilvie K, Moore R, et al. A community prevention intervention to reduce youth from inhaling and ingesting harmful legal products. Journal of drug education. 2007;37(3):227-47.
14. Anderson LM, Adeney KL, Shinn C, Safranek S, Buckner-Brown J, Krause LK. Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations. Cochrane database of systematic reviews. 2015(6).
15. Coote A. *The wisdom of prevention.* The New Economics Foundation, London. 2012.
16. Amato L, Mitrova Z, Davoli M, Ferri M, Burkhart G, Bo A, et al. *Communities That Care (CTC): a comprehensive prevention approach for communities.* EMCDDA papers: EMCDDA; 2017. p. 1-28.
17. FAS/FAE Technical Working Group. *It takes a community: Framework for the First Nations and Inuit FAS/FAE initiative and a resource manual for community based prevention of FAS/FAE.* Ottawa: Health Canada First Nations and Inuit Health Branch. 1997.
18. Fitzpatrick JP, Oscar J, Carter M, Elliott EJ, Latimer J, Wright E, et al. *The Marulu Strategy 2008–2012: overcoming fetal alcohol spectrum disorder (FASD) in the Fitzroy Valley.* Australian and New Zealand Journal of Public Health. 2017;41(5):467-73.
19. Kinnane S, Farringdon F, Henderson-Yates L, Parker H. *Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a 12 month period.* Mt Lawley, Western Australia, The University of Notre Dame Australia, The Drug and Alcohol Office, Western Australia. 2009.
20. Drug and Alcohol Office. *Introduction to Alcohol and Other Drug Prevention.* Perth; 2014.
21. Moodie ML, Fisher J. *Are youth mentoring programs good value-for-money? An evaluation of the Big Brothers Big Sisters Melbourne Program.* BMC Public Health. 2009;9(1):41.
22. Rowland BC, Williams J, Smith R, Hall JK, Osborn A, Kremer P, et al. *Social marketing and community mobilisation to reduce underage alcohol consumption in Australia: A cluster randomised community trial.* Preventive medicine. 2018;113:132-9.
23. Toumbourou JW, Rowland B, Williams J, Smith R, Patton GC. *Community intervention to prevent adolescent health behavior problems: Evaluation of communities that care in Australia.* Health Psychology. 2019;38(6):536.
24. Sigfúsdóttir ID, Thorlindsson T, Kristjánsson ÁL, Roe KM, Allegrante JP. *Substance use prevention for adolescents: the Icelandic model.* Health Promotion International. 2008;24(1):16-25.
25. Planet Youth [cited 2020 January 21]. Available from: planetyouth.org/get-involved/communities


Published: February 2020