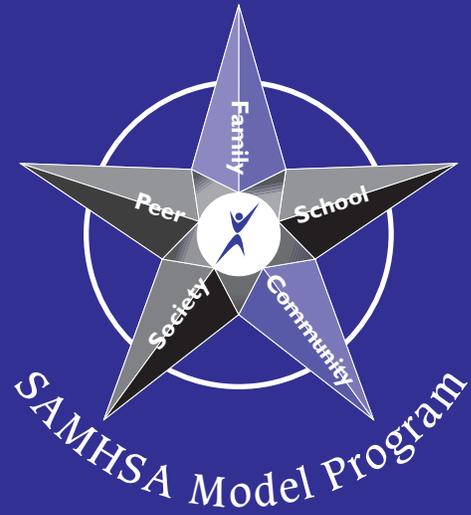




Also available
in Spanish



*Effective Substance Abuse and
Mental Health Programs
for Every Community*

Community Trials Intervention To Reduce High-Risk Drinking

Community Trials Intervention To Reduce High-Risk Drinking (RHRD) 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] and related problems. The program uses a set of environmental interventions including:

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

The program's aim is to help communities reduce various types of alcohol-related accidents, violence, and resulting injuries.

INTENDED POPULATION

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.

Proven Results

- 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

INTERVENTION

Universal

Selective

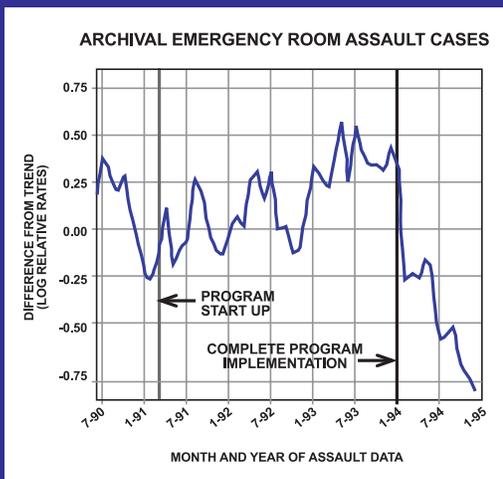
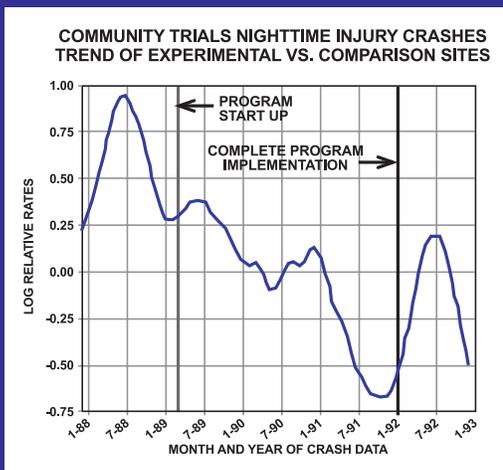
Indicated



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
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OUTCOMES

- 51% decline in self-reported driving when “over the legal limit” in the intervention communities relative to the comparison communities
- 6% decline in self-reported amounts consumed per drinking occasion
- 49% decline in self-reported “having had too much to drink”
- 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

The program brings about:

- Reductions in intentional and unintentional alcohol-related injuries (i.e., car and household accidents, assaults)
- Mobilization of community members and key policy makers
- Increased enforcement of drinking and driving laws
- Decreased formal and informal youth access to alcohol
- Responsible alcohol beverage service and sales policies

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.

IMPLEMENTATION ESSENTIALS

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 com-

missions, 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 are also 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.

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.

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 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

PROGRAM DEVELOPER

Harold D. Holder, Ph.D.

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 1 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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RECOGNITION

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