



**Report on the Kalgoorlie-Boulder
Community Baseline Survey, Comprising
Readiness for Change Interviews with Key
Informants and a Survey of Community
Members**

Andreia Schineanu

Fredrik Welander

Richard Midford

Kalgoorlie Alcohol Action Project

2007



Executive Summary

This is a mixed method baseline survey of how the Kalgoorlie-Boulder community deals with alcohol. Detailed, structured information from key community informants was obtained through interviews, using an instrument called the Readiness for Change Interview. Information from community members was gathered in the form of a Community Survey. Both these activities were carried out in the period July to October 2006.

The overall Readiness for Change score for Kalgoorlie-Boulder, in terms of its ability to tackle local alcohol problems, suggests “Vague Awareness” of the issue of alcohol related harm.

Approximately two thirds of drinkers reported drinking at least once a week and 1 in 5 do so everyday, a rate which is twice the state average. Furthermore, men in Kalgoorlie-Boulder binge drink at almost twice the state average, but more worryingly, women in Kalgoorlie-Boulder binge drink at almost three times the state average and more than twice as much as Kalgoorlie men.

The majority of respondents usually drank alcohol at home (65.4%) and/or at the pub (37.3%), with just over half of the sample consuming the most alcohol at home. Approximately half of respondents usually drank the most alcohol on the weekends with a quarter spreading their drinking evenly over the week.

Alcohol related violence, public drunkenness and drink driving were the three main alcohol related problems in the community, and most respondents indicated that these issues have got worse or much worse in the 12 months prior to the survey.

Respondents were generally unsure of what services and information resources related to alcohol were available in the community or whether local drinking establishments served alcohol responsibly.

Community support for measures designed to reduce problems associated with excessive use of alcohol was varied, with the least intrusive measures receiving the greatest support.

The Community Baseline Survey found that awareness of alcohol as a local problem was low among both general community members and key informants, and there was a similar lack of awareness of the interventions that are currently operating in the community. This is a critical finding as it indicates that to increase readiness, and ultimately the capacity of the community to deal with alcohol, it will first be necessary to create greater awareness of the local alcohol issues and possible responses.

Introduction

Background

Alcohol is widely used and enjoyed all over Australia. However, it is also a factor in a range of health and social problems. It is well established that high alcohol consumption increases the risk of heart, stroke and vascular diseases, liver cirrhosis and some cancers. Alcohol is the main cause of deaths on roads and the second largest cause of drug-related deaths and hospitalisations in Australia (AIHW 2005). At community level, the misuse of alcohol has cost the Australian Community an estimated \$7.6 billion (1998-99) through crime and violence, treatment costs, loss of productivity and premature death (Collins and Lapsley 2002).

In Australia concepts of individual disease and addiction and cultural notions of autonomy and choice tend to cast alcohol problems as the responsibility of the individual drinker. Within this paradigm treatment is the response of choice. However, treatment is not enough. Providing for individual problem drinkers will not result in a reduction of alcohol-related harm at the community level, if the community dynamics that contributed to these problems are left unchanged. There are powerful advantages to community level prevention: it attempts to remove or modify the underlying cause of the problem; it has considerable potential for change because of the large numbers involved; once behavioural change has been achieved it is likely to be self sustaining because a new community norm has been established.

The Kalgoorlie Alcohol Action Project (KAAP) is a 3.5 year, whole of community initiative that seeks to prevent problematic alcohol use and remediate associated harm in a community, which historically has had high levels of both. The project was initiated as a partnership between the National Drug Research Institute (NDRI) at Curtin University of Technology and the City of Kalgoorlie-Boulder. Ongoing local direction is provided by the Investing in Our Community committee, made up of key local decision makers and community representatives, and the project collaborates with local community organisation and government agencies to carry out interventions. Funding for the project has been provided by the Alcohol Education and Rehabilitation Foundation (AERF).

This report discusses the findings of the first phase of the project which involved collection of pre intervention information on how the community deals with alcohol from community key informants and the community at large. Information from community informants was obtained thorough interviews using an instrument called Readiness for Change Interview, developed by the Tri-Ethnic Centre faculty and adapted to the Kalgoorlie context (Plested, Edwards & Jumper-Thurman, 2003). Information from community members was gathered in the form of a Community Survey. Both these activities were carried out from July to October 2006.

The Readiness for Change Interviews

Prochaska and DiClemente (1986) identified the importance of readiness to change in individuals with alcohol and other drug problems, as this determines the most appropriate intervention, and the same is likely to apply to communities. Accordingly an initial consideration in establishing KAAP was gauging community readiness for change. As a way of identifying what this community considered its greatest alcohol problems and its level of readiness for preventive intervention, key informants were interviewed using a series of questions derived from the 'Community Readiness Model'. This theory based model, developed at the Tri-Ethnic Centre for Prevention Research at Colorado State University, provides a broad framework for characterising and assessing key community level factors that determine the community's level of readiness to take action on an issue (Slater et al, 2005). It integrates measures of available resources, community culture and the current level of readiness to effectively address issues such as alcohol related harm. It can be used as both a research tool for community analysis and as a tool to guide community mobilisation (Slater et al, 2005). The Community Readiness Model also assists in maximising chances of success for an intervention, as it offers a set of tools to determine what problems would be best targeted in a particular community (Plested, Edwards & Jumper-Thurman, 2003).

The questions in the interviews with key informants assessed the level of community readiness along six dimensions: community effort; community knowledge of effort; leadership; community climate; community knowledge of issues; local resources committed to prevention. In addition, these responses were then used to calculate the overall stage of community readiness. This qualitative assessment allows the

prevention intervention to be matched to community readiness, both in terms of overall level and focus of concern.

The Survey of Community Members

The purpose of the Community Survey, a quantitative instrument, specifically designed for this project, was to gather information regarding consumption levels, to identify local drinking patterns and alcohol related problems in the community. In addition, it collected information on the awareness of respondents about any local initiatives currently being used to reduce alcohol related problems in Kalgoorlie-Boulder and on their opinions as to what constituted beneficial interventions. This information is considered important in determining the target of interventions and the level of community support particular approaches are likely to receive in the local context.

The results from this community survey, together with the outcomes of the Readiness for Change Interviews will be used to guide interventions throughout the project period and provide a basis for comparison in terms of change over time.

Methods

Readiness for Change Interview

Data collection

Key informants were chosen from community opinion leaders, government and non-government service agencies and retail alcohol outlets in order to get a broad spectrum of 'insider' views on where the problems exist in the community. A cross referenced 'snowball' method was used to identify stakeholders most connected to the issue. This process continued until the same names consistently reappeared on the list of potential key informants. The stakeholders most frequently identified were contacted and interviewed.

Interviews were carried out in a place each interviewee considered suitable, ranging from their office to the local café. Interviews lasted, on average, one hour. A standard set of questions was asked of each interviewee, although elaboration was encouraged

when it fleshed out detail on community readiness issues. A structured response sheet was used to collect information on each of the community readiness dimensions. Responses were recorded by hand during the course of the interview.

Data analysis

Data analysis for the Readiness for Change interviews involved the Evaluation Officer and the Project Coordinator individually scoring each response in the response sheet according to criteria specified in the Readiness for Change Manual. When the independent scoring was completed, the two scorers discussed their decisions, adjusted scores to best match criteria and then used these adjusted scores to calculate a community readiness score for each of the six change dimensions. This procedure acted as both a validity and reliability check on the interpretation of the interview information in terms of the Community Readiness Model change scale.

The scores of individual interviewees were then collated for each change dimension. To get the community readiness score for each dimension, the sum of all the scores for that dimension from all the interviews was divided with the number of interviews conducted. This procedure was repeated until scores for all dimensions were obtained.

In order to determine the overall stage of readiness, the sum of all the dimensional scores was divided by the number of dimensions, i.e. 6. This gives the final score, which in turn determines the overall stage of readiness of the Kalgoorlie-Boulder community. The final step in determining the readiness for change was to select particularly salient comments and qualifying statements from the interviews as a way of providing fine grained detail on the circumstances in Kalgoorlie.

Survey of Community Members

Data collection

An instrument was specifically designed for the purpose of this project. The draft was pre-tested using expert review whereby several experienced survey developers compared candidate questions with questions from similar instruments, and against standard terms and concepts and international best practice so as to ensure that the questions probed salient local alcohol issues.

The survey instrument was also pilot tested with a representative sample of 10 community residents. The instrument was refined in accordance with the feedback received from the pilot testing. The final questionnaire contained 19 items, comprising, multiple choices, Likert scale and open ended questions on alcohol use and problems in the Kalgoorlie community. In addition basic, non identifying demographic information was gathered. The survey took approximately 10 minutes to complete.

The survey was administered to a stratified, random sample of 405 individuals, segmented by age and gender in proportion to the Kalgoorlie-Boulder community. The Indigenous population was over sampled on purpose to ensure sufficient numbers for meaningful analysis of their perspective. The survey was administered at focal points in the Kalgoorlie-Boulder area, such as outside major shops, along well frequented shopping strips, at community events and in the central city, St Barbara's Square. A sausage sizzle was used in some cases during cold weather to attract people to the area where the survey was being conducted and in all cases free 'Scratch and Win' tickets were offered as an incentive to participate. The data collection process was designed so that the findings could be generalised to the Kalgoorlie-Boulder population.

Data analysis

Data from the collected questionnaires was coded and entered into an SPSS database for analysis. Types of analysis carried out included frequency distributions, cross tabulation, case matching and linear regression.

Results and Discussion

Readiness for change interviews

The readiness for change scale is an instrument that provides the researcher with an indicative scale of the level of readiness for change in a community by taking into account relevant knowledge, perceptions and activity at the local level.

Sixteen men and women in various key positions in Kalgoorlie-Boulder were interviewed over a period of two months and their responses have formed the basis of a set of dimensional readiness scores. The scores are between 0 and 10, with 0

indicating no readiness for change at all and 10 showing that there are sustainable efforts in place to address the issues.

Dimension A score: Community efforts currently in place

The resulting score for this dimension is 4.2 which indicates that some community members have met and have begun discussions on developing community efforts. From the interviews it became clear that the response to this question very much depended on whether the person interviewed was working for a service provider or not. In general those working for a service provider dealing with alcohol related issues indicated a higher level of readiness, in that they identified efforts currently in place. They did however suggest the need to further develop current efforts and implement new ones. A weakness that was consistently mentioned by respondents was the abundance of committees but little accompanying action.

Dimension B score: Community knowledge about current efforts

A score of 3.6 for this dimension indicates that the community's knowledge about what is going on in the locality in terms of preventing alcohol related harm is relatively low. A few community members have heard about various efforts but knowledge about the actual content and extent of the efforts are limited. Again this depended very much on who was the interviewee: people in organisations set up primarily to prevent or treat alcohol related harm were very aware of what efforts were in place. Interviewees who did not work directly with these issues had more limited knowledge.

Dimension C score: Leadership (including appointed leaders and influential community members)

A 3.7 for this dimension indicates that there is some recognition among community leaders of the need to do something about alcohol related problems, and some community leaders are even attempting address the issue, for example by supporting the Kalgoorlie Alcohol Action Project (KAAP). Interestingly, the majority of respondents were unaware that KAAP was in great part the result of efforts by community leaders.

Dimension D score: Community climate

The score of 3.9 indicates that there is a growing concern among community members about this issue and the need for it to be addressed in some way. However, there is an

underlying uncertainty of what should or could be done to deal with the effects of excessive alcohol use. There are still a significant number of people who have a neutral, slightly disinterested perspective on the issue. Their view is that this is the lifestyle of Kalgoorlie-Boulder; this is how it has always been and this is how it's going to be in the future. Furthermore, there is a belief that alcohol related harm is not an issue for the community at large but rather for a few individuals and they are the ones who should be targeted to solve the problem.

Dimension E score: Community knowledge about alcohol related harm

The community recognises that alcohol related harm is an issue and people in the community can identify the most visible signs such as violence and drink driving. However, with a score of 4.3 it seems that the community does not have an in depth appreciation of the issue. Multiple respondents have highlighted the fact that there is information available and that one doesn't have to look very hard to find it. Accordingly, the level of community knowledge may have more to do with a lack of interest in the issue, since it doesn't affect them personally.

Dimension F score: Resources related to the prevention of alcohol related harm (people, money, time, space, etc.)

With a score of 3.5 the results indicate that the community is unsure what resources they need or where the resources would come from to initiate efforts. However they are aware that there are some individuals and organisations that could be utilised as resources. Based on these responses and after meeting with the various agencies and organisations in this community, it is clear that that there are resources available, but that they could be better utilised, particularly if there was more collaboration between service agencies and various community groups.

Overall score

The overall Readiness for Change score for Kalgoorlie-Boulder on the issue of tackling alcohol related harm was 3.8. However, the developers of the Community Readiness Model advise rounding down the score to ensure that any interventions that derive from the Readiness Model do not overstep the community's capacity for change (Plested, Edwards & Jumper-Thurman, 2003). Efforts that are too ambitious are likely to fail because community members will not be ready or able to respond (Plested, Edwards & Jumper-Thurman, 2003). Therefore the overall Readiness for Change

score was adjusted to 3 which indicated “Vague Awareness” of the issue of alcohol related harm. This score indicates that to increase readiness, and ultimately the capacity of the community to deal with alcohol, it will first be necessary to create greater awareness of the issue and possible responses.

Findings from this research can contribute to this by raising general awareness about the issue and identifying a range of effective responses that are most likely to engender community support. Strategies suggested for this phase include: providing examples of how other communities have overcome similar challenges; supporting community events that target alcohol harm; and working with particularly disadvantaged or vulnerable groups to increase their capacity to reduce harm. It is particularly important that the project and its prevention message be visible in the mass media, for example by publishing newspaper editorials and articles that deal with topical local alcohol issues.

An important finding from these interviews is the overall lack of collaboration between various agencies and community groups. There are an abundance of committees, but there seems to be little resultant action. One explanation for this may be the territorial approach of various organisations. This may be due partly to competition for funding which leads agencies and community groups to become secretive and unwilling to share their resources with other groups. It could also be due to interpersonal differences, the effects of which are magnified due to the relatively small size of the Kalgoorlie-Boulder community. It is therefore quite possible that the overall readiness score is a reflection of boundaries between organisations and a focus on their own agendas. This suggests of course that there is considerable scope for a more whole of community approach to alcohol and a consequent increase in community capacity. Again this presents an opportunity for KAAP to facilitate such change.

Final comment

It is important to keep in mind that these results are only indicative and represent a guide to readiness for change; in order to accomplish change, the community itself needs to step up to the challenge and implement the interventions that lead to the changes they want to see, as no one else can do this for the community.

Survey of Community Members

Demographics

A total of 405 questionnaires were analysed. The majority of respondents were in the 25-44 years of age category (49.9%), roughly over half were female (50.4%) and they had lived in Kalgoorlie-Boulder for an average of 12.5 years. The sampling was designed to be representative of the age and gender breakdown of Kalgoorlie-Boulder as shown in the 2001 Census Data. Due to purposeful over sampling, more than 1 in 10 of the respondents (12.3%) identified as Indigenous or Torres Strait Islander. Table 1 shows respondent demographics. The slight discrepancy in the gender breakdown between the survey sample and the census data is due to a deliberate over sampling of Indigenous people.

Table 1: Demographics of sample population			
		% of sample (frequency)	2001 Census Data %
Age (years)	18-24	19.0 (76)	19.1*
	25-44	49.9 (200)	50.3
	45+	31.1 (125)	30.6
Gender	Male	49.6 (201)	54
	Female	50.4 (204)	46
Ethnicity	Indigenous	12.3 (49)	5.2
	Non-indigenous	87.3 (349)	88.2
	Don't know	0.5 (2)	6.6

*Census data refers to 15-24 year old while the sample data refers to 18-24 year old

Alcohol consumption patterns

Most of the respondents (88.9%) reported having drunk a full standard drink in the past year; and a break down by gender shows that 94.5% of men have had a standard drink compared to 83.0% of women. By comparison, the national average in 2004-05 was 84.5% with 89.4% of males and 79.8% of females reporting having had a standard drink in the past year (National Health Survey, 2004-05).

The next few items deal with alcohol consumption patterns and thus the sample population for these items consists only of those respondents who have had at least one standard drink in the past year.

Approximately two thirds (68%) of those who have had at least one standard drink in the past year, drink at least once a week and 1 in 5 consume at least one standard drink everyday. Table 2 shows frequency of consumption.

	% Total population	% Male	% Female
Everyday or nearly everyday	19.3	27.1	10.3
3-4 times a week	18.7	22.9	13.9
1-2 times a week	30.0	28.7	31.5
2-3 times a month	12.5	8.0	17.6
Once a month	5.4	2.7	8.5
Most months	2.3	2.7	1.8
3-6 times in the past year	7.1	4.8	9.7
Once or twice in the past year	4.8	3.2	6.7

A break down of these results by gender revealed that nearly a third of males drink at least a standard drink everyday, or nearly everyday, while only 1 in 10 of the women drink at this level. About twice as many males drink 2-3 times a week as women. Roughly about a third of both men and women drink 1-2 times a week, and this value most probably reflects weekend drinking.

Some of these values are almost twice the state average; for example 27.1% of Kalgoorlie males and 10.3% of Kalgoorlie females drink everyday or nearly everyday while the equivalent state figures are 14.8% for males and 5.6% for females (Draper and Serafino, 2005).

Respondents were also asked how many standard drinks they usually consume when they drink. Approximately one third of the total sample said 1-2 drinks, and another third drank 3-4 standard drink (see Table 3). For comparison purposes, the WA state averages taken from the 2004 National Drug Strategy Household Survey (Draper and Serafino, 2005) are provided in brackets next to the Kalgoorlie values.

Table 3: Number of standard drinks usually consumed per drinking occasion (WA state average)			
	% Total population	% Male	% Female
1-2 standard drinks	33.9 (50.2)	22.5 (38.3)	47.0 (62.7)
3-4 standard drinks	27.1 (27.2)	31.0 (30.8)	22.6 (23.5)
5-6 standard drinks	17.7 (11.9)	20.3 (15.1)	14.6 (8.6)
7-10 standard drinks	9.1 (6.1)	11.2 (8.5)	6.7 (3.6)
11-20 standard drinks	7.7 (4.5)*	8.6 (7.4)*	6.7 (1.5)*
More than 20 standard drinks	4.6	6.4	2.4

* The values in the brackets are for 10 or more standard drinks, therefore to get an accurate comparison, the Kalgoorlie data, values for '10-20 standard drinks' and 'more than 20 standard drinks' must be added, i.e. 4.5% vs 12.3%, 7.4% vs 15% and 1.5% vs 9.1%.

Almost a third of the total population (28.1%) reported binge drinking every time they usually drink with 26.2% of men and 37.1% of women doing so. Binge drinking is drinking 5 or more standard drinks for women and 7 or more standard drinks for men. By comparison, the state average for binge drinking for men was 15.9% and for women was 13.7%.

These results indicate that men in Kalgoorlie-Boulder binge drink at almost twice the state average, but more worryingly, women in Kalgoorlie-Boulder binge drink at almost three times the state average. Thus, even though women don't drink as often as men do, when they do drink, women tend to binge drink more than men.

To determine the local patterns of drinking, respondents were asked about the locations where they consumed alcohol. Table 4 summarises the results. The overwhelming majority of respondents said they usually drank alcohol at home (65.4%) or at the pub (37.3%), with half of the sample consuming the most alcohol at home (50.6%). This is an important finding as it indicates that efforts to reduce alcohol related harm should not target only drinking establishments but should focus on the 'at home' drinker as well.

Table 4: Usual locations for consuming alcohol						
	Where do you usually drink alcohol? (more than one location allowed)			Where do you usually drink the most alcohol? (more than one location allowed)		
	% total	% M	% F	% total	% M	% F
At home	65.4	69.2	61.8	50.6	50.6	50.6
The pub	37.3	37.3	37.3	28.2	26.7	31.3
At work (after work)	10.1	12.4	7.8	2.4	3.3	1.3
The sporting club	10.4	10.9	9.8	1.5	2.2	0.6
Outdoors	14.3	17.4	11.3	6.8	7.2	6.3
Others	14.1	14.4	13.7	10.0	10.0	10.0

The time during the week that alcohol was consumed by the sample populations was investigated. The results showed that half the respondents usually consume alcohol during the weekends, with slightly more women doing so (60.0%) than men (42.8%).

Over a quarter of the sample (26.8%) drink spread evenly over the entire week including the weekends. Similar values were obtained when the respondents were asked when they consume the most alcohol. A breakdown by gender showed little variation in the timings of alcohol consumption between the men and women in the sample. A summary of these findings is found in Table 5 below.

Table 5: Timing of usual alcohol consumption			
	% total	% male	% female
During the weekend	50.9	42.8	60.0
During the week	4.7	6.1	3.1
Spread evenly over the week including weekends	26.8	30.6	22.5
A little during the week, but more on the weekends	10.0	12.8	6.9
When time off work (shift work)	7.6	7.8	7.5

Alcohol related problems in the Kalgoorlie-Boulder community

The next phase of the survey investigated the respondents' opinions on issues associated with alcohol use in the community of Kalgoorlie-Boulder. Because respondents were asked to choose what they believed were the **THREE** main alcohol

related problems and they had a choice of 9 items, the percentages do not add up to 100%. Table 6 summarises these results.

Table 6: The THREE main alcohol related problems in Kalgoorlie			
	% Total respondents (number of respondents)	% Male (number of respondents)	% Female (number of respondents)
Alcohol related violence	45.4 (184)	45.8 (92)	45.1 (92)
Public drunkenness	44.0 (178)	43.3 (87)	44.6 (91)
Drink driving	31.9 (129)	31.8 (64)	31.9 (65)
Underage drinking	26.2 (106)	24.9 (50)	27.5 (56)
Domestic violence	24.0 (97)	21.9 (44)	26.0 (53)
Alcohol related crime	18.8 (76)	16.4 (33)	21.1 (43)
Liquor outlets not selling responsibly	5.2 (21)	4.5 (9)	5.9 (12)
Intoxicated people at work	3.5 (14)	5.5 (11)	1.5 (3)
Excessive drinking in sporting clubs	3.2 (13)	3.5 (7)	2.9 (6)

Almost half of the sample population thinks that alcohol related violence (45.4%) and public drunkenness (44.0%) are the two main problems associated with alcohol consumption, with drink driving identified in third place (31.9%). There were only minor differences between the proportions of men and women who identified the alcohol related issues, with more women identifying underage drinking, domestic violence and alcohol related crimes as problems than men. By comparison, in 2004, in Western Australia, 45.4% of respondents said that they had been a victim of alcohol related harm such as verbal and/or physical abuse or put in fear of violence, with more men (50.7%) than women (40.1%) responding so (Draper and Serafino, 2005).

When asked whether these problems have got worse, got better or stayed the same, underage drinking (72.9%), domestic violence (60.9%) and alcohol related violence (59.8) were the top three problems that were rated as having got worse or much worse in the 12 months prior to the survey (see Table 7). Depending on the issue, one fifth to one half of those who identified a particular problem as being one of the three main

alcohol related issues in Kalgoorlie-Boulder responded that the problem has stayed the same when compared to the previous 12 months.

Table 7: Persons who identified a particular problem as one of the three main alcohol related issues and responded that it had got worse or much worse in the last 12 months			
	% Total persons	% Male	% Female
Underage drinking	72.6	70.0	75.0
Domestic violence	60.9	59.1	62.3
Alcohol related violence *	59.8	48.9	70.6
Alcohol related crime	56.6	48.5	62.8
Public drunkenness	47.2	43.7	50.6
Drink driving	45.7	40.6	50.8
Liquor outlets not selling responsibly	38.1	33.3	58.3
Excessive drinking in sporting clubs	30.8	28.6	50
Intoxicated people at work	28.6	18.2	66.7

*Values in bold indicate a statistically significant difference to $p < 0.05$

A break down of the responses by gender showed an interesting result, with more women categorizing every issue as having gotten worse or much worse than men. The proportion of male to female respondents differed by 10% or more on changes in alcohol related violence and alcohol related crime, liquor outlets not selling responsibly, excessive drinking in sporting clubs and intoxicated people at work. The large percentage differences between males and females on the last three items are probably an artefact of the low number of respondents who have identified those issues; for example 11 men and only 3 women have identified liquor outlets not selling responsibly (see Table 6). Linear regression analysis, did however indicate, that there was a statistically significant difference between men and women in terms of their perception of change in alcohol related violence 95%CI (-0.172 to -0.015); $p=0.05$. Significantly more women than men perceive alcohol related violence to have got worse or much worse in the past year.

Community knowledge on alcohol related issues

In this section, the respondents' knowledge about various local alcohol related harm reduction initiatives and preventative measures in pubs was collected. The results show an overall lack of awareness about local initiatives. When asked whether

respondents' knew if anything was being done locally to reduce alcohol related problems, 78.9% said no, with men (84.7%) less knowledgeable on the issue than women (73.4%). Those who responded positively were then asked to list three examples of local initiatives or measures. Most commonly mentioned measures were police presence or activities that reduced or prevented alcohol related harm such as:

“Increased police presence”

“More police patrols on Burt Street Boulder”

“Police are moving on people who drink in public”

“Road side police doing breath tests”

The second most frequently mentioned measures or initiatives are related to the liquor industry's actions or legislation related to alcohol such as:

“Alcohol Accord”

“Not selling 4 litre wine casks before 1.00pm”

“Stopped 24hr of pubs (you couldn't go from one pub to another)”

Media campaigns, both local and state/federal, as well as education programs run by Population Health and in schools were the third most commonly mentioned measures, followed closely by local community measures such as the existence of a Local Drug Action Group, the Library Information Unit and counselling services.

Respondents were then asked 4 questions on whether local pubs sell alcohol to people who are already drunk, provide free drinking water and bar snacks or have a breathalyser on the premises. The results are summarised in Table 8 below.

Table 8: Knowledge of service practices in pubs?				
		Yes	No	Unsure
Not sell alcohol to people who are already drunk	% Total sample	39.3	23.7	37.0
	% Male	42.6	23.7	33.7
	% Female	36.2	23.6	40.2
Provide free drinking water	% Total sample	47.4	17.5	35.1
	% Male	46.1	17.8	36.1
	% Female	48.7	17.3	34.0
Serve free bar snacks	% Total sample	28.9	37.1	34.0
	% Male	34.0	34.6	31.4
	% Female	23.9	39.6	36.5
Have a breathalyser on the premises	% Total sample	24.7	25.5	49.9
	% Male	29.9	26.2	43.9
	% Female	19.7	24.7	55.6

Once again, for each item, more than half of the respondents were either unsure or negative and there was little difference between males and females. While the unsure response rate suggests that community is uninformed on these issues, it is possible that these respondents are people who do not frequent pubs and thus are unaware of their alcohol serving practices. It is also possible that pubs do not publicise their serving practices sufficiently: for example, even if a pub provides free drinking water, a customer may not know this without specific advertising of the service. These findings suggest that to accurately assess the extent of responsible alcohol serving in the pubs and drinking establishments of Kalgoorlie-Boulder, an observational study should be undertaken.

Participants were asked about their knowledge on the availability of information on alcohol use in their community, and the results are in Table 9.

Table 9: Knowledge about the types of information on alcohol use available in the community				
		Yes	No	Unsure
Library Information Centre	% Total sample	35.7	7.0	57.3
	% Male	30.2	9.5	60.3
	% Female	41.0	4.6	54.4
Alcohol information on drink coasters	% Total sample	35.2	16.3	48.4
	% Male	32.1	18.4	49.5
	% Female	38.3	14.3	47.4
Breathalysers in pubs	% Total sample	26.2	18.7	55.2
	% Male	30.5	23.7	45.8
	% Female	21.9	13.8	64.3
Media campaigns	% Total sample	67.0	7.7	25.3
	% Male	65.3	9.8	24.9
	% Female	68.7	5.6	25.8
Alcohol education in schools	% Total sample	38.2	8.0	53.7
	% Male	36.1	7.3	56.5
	% Female	40.3	8.7	51.0

Roughly half of all respondents were unsure and a further 10-20% was not aware of any information in the community. 'Media campaigns' was the only category where almost 70% of the total sample population responded positively, indicating that they were aware of the TV ads informing on various aspects of alcohol use. The results once again demonstrate a lack of awareness about information on alcohol use in the community. This is indicative of a lack of ongoing 'advertising' of the various local interventions, considering some of these interventions have been in place for quite a while. It is well known that the population of Kalgoorlie-Boulder is highly transient, and this suggests the need for continuous promotion of an intervention to ensure through coverage, especially for the newly arrived.

Community support for various interventions

Respondents were asked to indicate their support for a series of measures designed to reduce problems associated with the excessive use of alcohol. Females are more supportive than males of the majority of measures including reducing the number of

outlets where alcohol is sold, reducing trading hours and disallowing 'Happy Hours' (see Table 10). Furthermore, compared to the state average, a higher proportion of respondents from Kalgoorlie-Boulder support reducing the number of outlets where alcohol is sold and reducing trading hours (21% state average vs 36.1% in Kalgoorlie-Boulder support reducing the number of outlets where alcohol is sold and 22.5% state average vs 38.1% support reducing trading hours).

Overall, and in line with national and international findings, the results indicate that the people of Kalgoorlie-Boulder are very supportive of interventions that require little effort on a personal basis or have a direct impact on them and put the majority of the responsibility on a third party such as the pub owners or the police. For example 70% support the idea of the owners of drinking establishments being responsible for preventing patrons drinking to excess. One measure that has very strong support from the community, with 93.9% of males and 98.5% of females agreeing, was that liquor outlets should always ask young people of proof of age. However, a recent study conducted by the Injury Control Council of WA indicated that almost 80% of liquor outlets do not do ID controls on customers that look young (ICCWA, 2007)

Table 10: Community support for various interventions				
		Strongly agree or agree	Unsure	Disagree or strongly disagree
The number of places where alcohol is sold should be reduced	% Total sample	36.1	13.1	50.7
	% Male	28.2	11.8	60.0
	% Female	43.8	14.4	41.8
Liquor outlets should always ask young people for proof of age	% Total sample	95.9	1.5	2.5
	% Male	93.9	3.6	4.1
	% Female	98.5	0.5	1.0
Opening hours for liquor outlets should be reduced	% Total sample	38.1	16.5	45.5
	% Male	23.8	19.0	57.2
	% Female	51.5	14.0	34.5
Owners of establishments should be responsible for preventing patrons drinking to excess	% Total sample	70.2	14.3	15.6
	% Male	69.3	16.7	14.0
	% Female	71.0	12.0	17.0
Police should put more effort into catching drink drivers	% Total sample	72.1	14.1	13.8
	% Male	68.0	14.7	17.3
	% Female	76.3	13.4	10.3
Establishments that serve alcohol should serve free snacks with drinks	% Total sample	81.4	7.5	11.1
	% Male	79.8	7.3	13.0
	% Female	83.1	7.7	9.2
Establishments that serve alcohol should provide free drinking water	% Total sample	90.8	6.7	2.6
	% Male	95.0	5.0	0.0
	% Female	95.9	2.1	2.0
Breathalysers should be available in establishments that serve alcohol	% Total sample	90.8	6.7	2.6
	% Male	88.7	6.6	4.6
	% Female	92.7	6.7	0.5
There should be no “Happy Hour” in pubs	% Total sample	33.5	14.6	51.9
	% Male	23.0	15.8	61.2
	% Female	44.1	13.3	42.6
Sporting clubs should be more responsible about serving alcohol	% Total sample	26.2	18.7	55.2
	% Male	30.5	23.7	45.8
	% Female	21.9	13.8	64.3
Applications for new liquor licences should be better advertised	% Total sample	57.3	34.4	8.2
	% Male	56.1	36.2	7.6
	% Female	59.2	26.2	9.7
Council should be able to limit the number of liquor outlets in town	% Total sample	49.1	24.5	26.4
	% Male	43.9	25.5	30.6
	% Female	54.4	23.6	22.0

Not surprisingly, respondents of this survey were less supportive of interventions that have a direct impact on their drinking such as the end of “Happy Hours”, or reducing the number of outlets that sell alcohol, with only about a third supporting such

interventions. National and international research has, however, shown that such interventions can be quite effective in reducing alcohol related harm.

When planning interventions for the community of Kalgoorlie-Boulder, it is not enough to reproduce interventions that were successful elsewhere because this community is quite unique in its socio-economic makeup and the high rate of population turnover. In fact one of the reasons why the long term effects of excessive alcohol consumption are not visible in Kalgoorlie-Boulder is due to the short term local residency and high population turnover. For example, in the Northern Territory the price of cask wine was increased by a small amount and the number of casks sold decreased noticeably. While such an intervention would likely reduce harm among those, predominantly Aboriginal, drinkers who have limited funds and consume a lot of cask wine, it would not have a great impact on the more affluent drinkers in this community, as they have the ability to switch money from other purchases. Therefore the local context needs to be taken into account when designing interventions.

Community opinion on local alcohol related issues

Respondents were asked to indicate whether they agreed or strongly agreed, disagreed or strongly disagreed with several statements regarding alcohol related issues in Kalgoorlie-Boulder. The results for this section were quite varied and are summarised in Table 11. Most respondents agreed that young people should be taught about alcohol (94.4%) and that alcohol plays a central role in the social life of the community (79.9%). A large proportion of respondents were unsure whether people in Kalgoorlie drink less now than 12 months ago (61.7%) or whether alcohol is less of a problem now than 12 months ago (61.2%). However, in both cases a third of the respondents disagreed with the statements, indicating that they believe people are drinking the same or more compared to 12 months ago and that alcohol is a problem to the same or more extent than 12 months ago.

Table 11: Respondents' opinion on local alcohol related issues				
		Strongly agree or agree	Unsure	Disagree or strongly disagree
There are too many drinking establishments in this town	% Total sample	44.9	8.5	46.7
	% Male	34.5	8.4	57.1
	% Female	54.9	8.7	36.5
Alcohol is a bigger problem in Kalgoorlie than elsewhere	% Total sample	36.5	29.5	33.9
	% Male	29.3	30.9	39.8
	% Female	43.5	28.3	28.2
The community is involved in preventing alcohol problems	% Total sample	42.0	40.5	17.5
	% Male	44.8	36.2	19.1
	% Female	39.2	44.9	15.8
How much a person drinks is a private matter	% Total sample	50.8	19.2	30.0
	% Male	55.3	19.3	25.4
	% Female	46.1	19.2	34.7
People in Kalgoorlie are drinking less now than 12 months ago	% Total sample	11.3	61.7	27.0
	% Male	14.6	60.2	25.1
	% Female	7.9	63.2	29.0
Alcohol plays a central role in the social life of our community	% Total sample	79.9	12.1	8.0
	% Male	78.4	12.9	8.7
	% Female	81.5	11.3	7.3
Alcohol is less of a problem now than 12 months ago	% Total sample	7.1	61.2	31.6
	% Male	9.2	57.7	33.2
	% Female	5.1	64.8	30.1
It's safe to walk home from the pub in the evening	% Total sample	28.2	17.4	54.3
	% Male	41.1	19.0	40.0
	% Female	15.3	15.9	68.7
Information on alcohol and alcohol related harm is readily available in our community	% Total sample	43.7	40.8	15.6
	% Male	44.7	40.1	15.2
	% Female	42.6	41.5	15.9
There is a lot being done locally about alcohol problems	% Total sample	22.2	57.1	20.7
	% Male	20.9	54.8	24.4
	% Female	23.6	59.5	16.9
Young people should be taught about alcohol	% Total sample	94.4	3.0	2.6
	% Male	92.4	4.0	3.5
	% Female	96.4	2.0	1.5

There was almost an even split between those who think there are too many drinking establishments in this town and those who do not (44.9% and 46.7% respectively), however a break down by genders shows that 20% more women than men agree with that statement. The statement “Alcohol is a bigger problem in Kalgoorlie than elsewhere” drew a similar response, with approximately a third agreeing and another

third disagreeing with the statement, but almost 15% more women than men agreed with it.

Approximately half of the respondents were unsure whether to agree or disagree with whether the community is involved in preventing alcohol problems, whether information on alcohol is readily available in the community and whether there is a lot being done locally about alcohol problems. This finding is similar to the earlier results on knowledge about types of information on alcohol use available in the community, where roughly half of all respondents were unsure and a further 10-20% was not aware of any information in the community. These results further emphasise the lack of awareness about local interventions and sources of information.

The statement relating to whether it is safe to walk home from the pub in the evening drew very different responses from men and women. Overall, 28% of respondents agreed or strongly agreed that it is safe to walk home from the pub in the evening, however almost half the men responded so, compared with 15.3% of the women. This finding concurs with the earlier results whereby more women than men indicated that alcohol related issues such as violence and crime have got worse or much worse in the 12 months prior to the survey. These are significant indicators that women in this community are either victims of, or fear being the victims of alcohol related violence a lot more than men, and these issues have become worse in the past 12 months.

Finally, a statement was included on whether the amount of alcohol a person consumes is a private matter. Half of all respondents agreed that it was a private matter, with only slightly more men than women agreeing with it. While alcohol is very much a part of our society and a part of our daily life it is interesting to note that alcohol is a very sensitive subject in the sense that we don't like to discuss our own drinking habits, or the drinking habits of someone we know. However the effects of excessive alcohol use are a public concern whether it is in the health care costs to the tax payer for people with alcohol related illnesses, in the increased costs of insurance premiums we all have to bear, the costs of police and the justice system that deal with drunk drivers, the antisocial behaviour fuelled by excessive alcohol use and the lives lost due to drunk people getting behind the wheel. So, despite all the effects of excessive alcohol use being extremely public and affecting us all, it is unfortunate that so many people still perceive the amount of alcohol a person uses as a private matter.

Perhaps if more people were able to discuss alcohol use, including their own use, and accept that it affects everyone one way or another, people would be more willing to take action to reduce the harm associated with excessive drinking.

Conclusion and Recommendations

Conclusion

The results of this Baseline Community Survey have shown that the Kalgoorlie-Boulder community is lacking awareness about the issues associated with alcohol related harm, in particular the long term problems. There is also a lack of awareness about services and information sources in the community related to alcohol issues. Furthermore, while there are people who believe alcohol related harm is a problem for the community and that these problems have worsened in the past 12 months, they do not recognise alcohol related harm as a problem that affects them personally.

Alcohol consumption by the community is above the state and national average, and binge drinking patterns, especially in women are extremely worrying.

Not surprisingly, and in line with national and international findings, community members support interventions that would not have a major impact on their lifestyle and were against more intrusive interventions that research suggests to be effective.

Recommendations

Based on the results of this survey, the following recommendations are suggested for future community action:

1. Ongoing awareness raising at a local level about alcohol related harm due to excessive drinking and how it affects everyone, drinkers and non drinkers, and not just those with perceived alcohol problems. Awareness should be promoted in a positive way, for example by encouraging healthy drinking behaviour rather than just pointing out the negative side effects.

2. Ongoing awareness raising of local services and sources of information in relation to alcohol – for example, the Library Information Unit may have been promoted heavily when it was first opened, but there has been no mention of it since, so residents who moved to Kalgoorlie after its launch would not be aware of it.
3. Conduct community events to raise awareness about alcohol and the effects on the community.
4. Encourage and reward responsible serving of alcohol in licensed establishments – encourage all pubs to serve free drinking water and bar snacks to customers, and provide training to all staff on responsible alcohol serving; reward the uptake of such activities, perhaps have a list of ‘responsible pubs’ that can be published in the newspaper on a regular basis.
5. Develop a partnership with local media to raise community awareness about alcohol related problems and possible solutions.
6. Conduct observational studies to determine if and to what extent local drinking establishments follow responsible serving practices.
7. Develop intervention campaigns to target the ‘at home’ drinkers.
8. Support schools in the provision of alcohol education and facilitate community involvement through organisations such as LDAG and HYPE.
9. Create interventions for young women (18-24 years) who are currently drinking in a risky way for short term and long term harm. Carry out focus groups with local women to find out what would encourage/prompt responsible drinking. For example, most young women may not worry too much about the increased risks of breast cancer later in life due to excessive alcohol use, however they could be more worried about the decreased chances of having children.
10. Carry out ‘sting operations’ in order to determine whether licensed premises do ID check of young people or serve alcohol to those who appear intoxicated.

References

AIHW: Australian Institute of Health and Welfare (2005). 2004 National Drug Strategy Household Survey: Detailed findings. AIWH Cat no PHE 66. Canberra, AIHW.

Collins, D. and H. Lapsley (2002). Counting the cost: estimates of the social costs of drug abuse in Australia in 1998-99. National Drug Strategy Monograph Series No 49. Canberra, Australian Government.

Draper, G. and Serafino, S. (2005) 2004 National Drug Strategy Household Survey: Western Australian Results. Australian Institute of Health and Welfare

ICCWA: Injury Control Council of WA, (2007) The pseudo underage liquor sales project. ICCWA Newsletter: February: 1-3

Plested, B.A., Edwards R.W. and P. Jumper-Thurman, (2003), Community Readiness: the key to successful change. Tri-Ethnic Center for Prevention Research, Sage Hall, Colorado State University.

Prochaska, J. O. and DiClemente, C. C. (1986). Towards a comprehensive model of change. In: Addictive Behaviours: Processes of Change, W. R. Miller & N. Heather (Eds.), New York: Plenum Press.

Slater, M., Edwards, R., Plested, B., Thurman, P., Kelly, K., Comello, M. and T. Keefe (2005) Using community readiness key informant assessments in a randomised group prevention trial: impact of a participatory community-media intervention. Journal of Community Health: 30(1): 39-53