Empower and engage: tackling the social determinants of risky drinking in two deprived communities
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Introduction

High-profile issues like drug abuse and smoking can overshadow the issue of drinking, which is often perceived as a harmless and enjoyable social activity. People with alcohol ‘problems’ are thought to be in a minority. However, according to the World Health Organisation, just as much of the global burden of disease is attributable to alcohol as to tobacco.

Drinking too much can cause problems for individuals, families and whole communities. Consequences include accidents, violence, sexual and mental health problems, chronic liver disease, increased risk of other chronic diseases and, ultimately, avoidable deaths.

We wanted to co-create solutions with people rather than designing clever messages or ‘products’ for them because we felt that this would be a more effective way of supporting them through a change in their behaviour, given that we knew that there would be factors in their environment beyond their control that would make change difficult. We also believed that co-created solutions developed in collaboration with local people and stakeholders were more likely to be sustainable in the long-term.

Problem Definition

A Primary Care Trust (PCT) in England asked us to work with two communities that, according to the Index of Multiple Deprivation, are within the 5% most deprived communities in the country (the Index is a measure that combines over 30 indicators
like income, employment, social and housing issues into a single deprivation score for each area). The PCT wanted us to try and understand why many people drank more than the recommended limits and to work with local people to co-create strategies that would help them cut down.

We started the project with a hunch that the answer would be more complicated than just providing information about safe drinking levels or attempting to educate people about the dangers of heavy drinking (though it was important to recognise that this was just our assumption). Instead, we thought that many factors in the social, economic and physical environment would influence drinking behaviour. Consequently, we believed that even if people wanted to cut down, they might not be able to do so without some changes to their physical and social circumstances.

**Stakeholder Analysis**

Stakeholders (by our definition, these are typically service providers and community leaders) were involved in the project from the beginning and were vital to us in getting introduced to both communities. To launch the project, we held a workshop for stakeholders from the police, council, community organisations and charities. We asked these stakeholders to identify and prioritise what they thought the goals of the project should be. Overwhelmingly, stakeholders felt that improving self-esteem, feelings of competence and increasing engagement in the community needed to come before objectives related specifically to drinking.

Through the workshop and subsequent visits to community leaders, we began to build relationships with key stakeholders, including the Youth Centre manager (a
formidable lady with significant influence in the community) and the Reverend of the local church. Both these stakeholders had witnessed the effects of risky drinking on local families they were very engaged from the start, offering us a vast store of local knowledge, access to venues and introductions to other groups. We also formed links with the Children’s Centre’s family workers, the employment hub, tenants and residents associations, other churches and faith groups, service providers and housing associations. In one of the communities, we were fortunate to gain the support of a respected city councillor (another formidable personality) who became a very strong advocate of our work and opened many doors that would otherwise have been closed to us.

An awareness of local power structures and politics was vital. In most cases, stakeholders were open about their agendas (as we were about our own) but in others we found ourselves with privileged information that we knew was affecting decision-making. In one instance, a stakeholder took a personal dislike to a representative of another project and attempted to use their considerable influence in favour of our work. Our experiences demonstrate not only the importance of effective stakeholder analysis, but also how vital good relationships and trust built up over time are to the success or failure of co-created initiatives <reference relationships chapter?>.

**Aims and Objectives**

The goals of the project were to:

1. Understand the underlying causes of risky drinking in two deprived communities
2. Co-create value propositions with the communities that would reduce the levels of risky drinking and that would be sustainable in the long-term

**Value Co-Discovery**

We took inspiration from a methodology called Participatory Action Research. Rather than describing situations as they are or seeking out general rules and principles, researchers following this tradition seek to improve human welfare using methods of reflection and action. With this method, people participate in the inquiry at all stages, including design, data collection, analysis, application and dissemination of research findings (Ozanne & Saatcioglu, 2008). <reference participatory research section>.

We began co-sensing the problem by setting up ‘methods stations’ in a community centre, which encouraged people to experiment with different ways of expressing themselves about risky drinking. We persuaded people to try out visual methods like making collages or writing on large boards. We also tried out simple games and more traditional qualitative techniques like semi-structured interviews. We found that people were willing to share some very personal stories with us in this informal situation. However we noticed that literacy problems were common, so many people felt anxious about any method that asked them to read or write because they were worried about making mistakes in public. Many people we spoke to were concerned that they would lose control of their stories; that what they told us would become public knowledge or be passed to Social Services. People didn’t seem to have much confidence in authority or outsiders and whilst we had reduced this
somewhat by spending so much time in the community, the trust we had built didn’t extend beyond the research team.

In the end, we found that co-creating the methods merged seamlessly into the data collection phase. In fact, the approach that seemed to work best with our communities was closer to ethnography than anything else, with one of the authors helping at community events (the Youth Club bowling outing and a pantomime for example) and making endless cups of tea. Spending so much time with people informally gave us the chance to chat to lots of individuals, some for a few minutes but others for an hour or more. Becoming part of the community in a small way gave us a deep understanding of the problems that people face and the role alcohol plays in their lives.

Participatory Action Research starts with small groups of collaborators, but as the research progresses, the community of co-researchers should expand to include more and more people. It can take considerable time to get to know people and encourage those with less confidence or who are disengaged to take part. It took several months to build up enough trust to really start to work with ‘ordinary’ people (rather than the confident community leaders we were introduced to at the start of the project). In total, Lindsay conducted 64 semi-structured depth interviews with 23 males and 41 females in Community 1 and 58 semi-structured depth interviews with 19 males and 39 females in Community 2.

We found that we were correct in our initial assumptions that drinking was often a consequence of other factors rather than a problem in and of itself, though once people started drinking to excess, this did make their other problems worse. People
wanted us to know that there was good community spirit but that they were tired of outsiders pointing out the negatives. We were told that alcohol was readily available and cheap to buy. Even if it weren’t, people would make cutbacks in other areas so they could keep drinking. There was a general feeling that the NHS in particular and people from other areas in general don’t understand what life is like in these communities and shouldn’t think they know what should change. In summary, seven broad themes emerged from our analysis of the field notes:

1. **Family** can be a trigger (e.g. childhood experiences) and be part of the consequences of risky drinking. But family could also help people cut down and cope with less alcohol.

2. People feel **trapped** in many ways: by their responsibilities, because they can’t move away, by their financial situation and by what’s available locally.

3. People **worry** about the practical and the social consequences of seeking help: losing children, friends or benefits and the humiliation of others knowing about their problems.

4. People feel **powerless**, stuck in a rut. They may be suffering mental health or mood problems or simply be bored, de-motivated and feel they have no reason to get up in the morning.

5. People feel physically, emotionally and socially **isolated**: others are at work and they are stuck at home, no one else understands.

6. Men feel **shame** about admitting weakness and losing masculinity, women feel ashamed about not fulfilling caring duties. Consequently, people hide their problems.
7. People are **confused** by conflicting advice, what happens if they ask for help and what’s normal.

While people living in both communities had similar life experiences and reasons for drinking, the structures of the communities were quite different. Community 1 had many more facilities and services that ‘belonged’ to the community, i.e. they were located within the geographical area community members defined as theirs. However, there were some territorial issues, which meant that if a service or facility were located at one end, people from the other would feel unwelcome there and vice versa. People in Community 2 on the other hand felt that there was a severe lack of services, activities and facilities for them to use. In particular, they told us that they needed a local doctor, dentist and better quality shops. They’d had access to good services in the past, but these had all closed down due to lack of funding. Consequently, people in Community 2 were much more difficult to reach and to engage in co-creation activities because they didn’t like to leave their own territory (which may be as limiting as their home or street) and they felt let down and forgotten.

**Value Co-Design**

In partnership with social change agency Uscreates (www.uscreates.com), the next stage was to organise the value design process. In Community 1, we held a workshop where more than 40 ideas were suggested. Some ideas were quite specific to a particular age and life-stage (e.g. extreme sports could help divert groups of young men from organising all their social activity around alcohol) but with general principles that apply to all (e.g. provide activities that people will value and that
don’t revolve around drinking, reduce isolation and make people feel better). Ideas were both preventative and geared to help people already struggling with their drinking.

We asked the participants to visualise the idea that they felt was the most likely to make a difference. They created a vision for a ‘Community Hub’, located in the centre of the community (to mitigate the territorial issues). The Hub would host a range of services for all ages as well as being a venue for ‘positive’ (not stigmatising) reasons to visit, such as a café, evening social club and venue for short courses. The Hub would be promoted and supported by ‘Community Champions’, who would signpost residents and reassure them about what to expect from any services they might access there. Because the philosophy of our approach is collaborative, it isn’t possible to describe exactly how the Hub will develop; the people involved will shape it over the next few years.

As we knew that people would be very unlikely to come to a workshop in Community 2, we attended two community events, again helped by Uscreates, to try and engage people in mini co-design activities. We spoke to 33 people about our research findings and what ideas they had to make things better. Once more, a variety of suggestions were made and many fell under the broad themes of combating isolation and breaking down barriers. Specific suggestions included befriending or mentoring schemes and a community bus to allow people to access services and facilities more easily.

We connected ideas from the value co-design with the feedback we had received in the research about the lack of services and facilities to create the idea of a Mobile
'Hub’ that would work hard to engage people street-by-street. The advantage of this approach is that once established, the Mobile Hub can be used to deliver any intervention, service or enterprise. At its most basic level, we are attempting to get people out of their houses and talking to one another, even just for a few minutes. This Mobile Hub is currently being piloted with the support of a range of local residents and stakeholders, offering a street café, products from a local bakery and greengrocer, health and wellbeing services, youth and family support and ‘Have Your Say’ engagement events.

Discussion

We would like to be able to tell you about the difference these two initiatives have made in both communities, with statistics to back up our claims about increased community engagement, reduced isolation and better health. Unfortunately, projects that attempt to tackle the social determinants of health take years to evolve and the value co-delivery work is ongoing. Baseline data was collected at the start of the project using a survey designed to detect awareness and recall of any health and alcohol interventions; engagement with the community; knowledge of government guidelines about safe drinking and units in drinks; claimed alcohol consumption; attitude to health in general and socially desirable responding. The survey is being repeated in August 2012 and again one year later. Even then, we suspect that the changes detected will be relatively minor and this can be a significant challenge for social marketers advocating this approach in an age of short-term funding and political change.
A second challenge with this approach is the lack of generalisability in the findings, which runs contrary to the traditional ‘test and roll out’ approach common to many social marketing communications and health promotion initiatives. This means that technically, every time a social marketer wants to co-create with a different community, they can’t assume that the same solutions will have the same results; they need to start the process again from scratch. This takes time and costs money. Consequently, there is the temptation to engage in co-creation ‘lite’ (an approach that jokingly we sometimes call “faux-creation” amongst colleagues in our research centre). Taking this approach, social marketers would work towards outcomes that are somewhat pre-determined, taking communities along for the ride and allowing them only limited input to decision-making. There may be a pragmatic middle ground between the two extremes of co-creation projects that take years and those that offer pretend participation. Our friends and colleagues at Uscreates experiment with toolkits and shortcuts that can help to transfer learning from one project to another and this may be a way forward for this method for pragmatic social marketers.

Finally, we note that while participatory methods like co-creation offer a promising way to empower people to change, they have attracted some criticism as well. Particularly worrying is the accusation that they haven’t really shown that they can achieve meaningful change (for example, see (Cooke & Kothari, 2001). Critics worry that if we just assume any form of participation is superior to more traditional approaches without being sensitive to power dynamics and political issues, then we run the risk that people or organisations with disempowering agendas might divert the work in a way that suits their purposes rather than those of the community. This
problem adds an interesting dimension to the ongoing debate about the role of commercial organisations in social change initiatives because of their power and profit-making agenda. Would it have been appropriate to give Diageo a role in our project for instance?

References


Questions

1. Why didn’t we simply provide information about the government’s recommended alcohol intake?

2. What types of participation do you think were involved in the project? Did levels of participation vary between the two communities or change as we went through the process?

3. In what ways do you think that our process and methods might need to be adapted if, rather than people in deprived communities, we wanted to work with university students to co-create strategies to reduce drinking?