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DrugInfo Clearinghouse
Australian Drug Foundation
409 King Street, West Melbourne, Victoria 3003 Australia
Tel: 1300 85 85 84 (Victoria only)
Email: druginfo@adf.org.au
Web: www.druginfo.adf.org.au

Any enquiries or comments on this publication should be directed to the Publishing Manager, DrugInfo Clearinghouse, at the above address.

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Paul Bourke, Alcohol Strategy, Policy, Planning and Strategy, Mental Health and Drugs Division,
Department of Health
Richard Colbran, National Innovation & Sector Support Manager, Australian Drug Foundation
Mark Durran, Manager, Information Services, Australian Drug Foundation
Chantelle Miller, Senior Policy Officer, Drugs Policy and Services Branch, Department of Human Services
John Rogerson, CEO, Australian Drug Foundation
Clea Smith, Program Manager—Sport, Australian Drug Foundation.

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Alcohol and community sporting clubs

Bosco Rowland, Senior Research Fellow, Australian Drug Foundation and School of Psychology, Deakin University, and **Professor John Toumbourou**, Chair in Health Psychology, School of Psychology, Deakin University

It is not hard to convince the Australian community that alcohol and community sport in Australia are intrinsically connected. The following scenarios are common in community sporting clubs across Australia:

- ▶ after the weekend game players drink alcohol into the night and several individuals drive their car home
- ▶ post training, club members enjoy playing competitive drinking games, such as skolling large glasses of beer or lining spirit drinks up for a public competition in quick consumption
- ▶ an “under-18” full-forward is given a six-pack of beer for his exceptional efforts on the ground
- ▶ the end-of-season celebration provides “all you can drink” beer and wine.

Unfortunately, most individuals who associate with sporting clubs see these scenarios as “normal” or expected practices. Given the physical exuberance and “attraction to risk” of people who are involved with sport, many assume it is inevitable that sport and alcohol misuse will be highly associated.

This paper examines the link between alcohol consumption and community sporting clubs. The paper argues that there are steps sporting clubs can take to reduce the link between alcohol and sport, and by so doing, clubs will create a setting that will cultivate and develop healthy individuals; sporting clubs will be more sustainable and attractive to the community; and there will be greater opportunities for recruiting new players and members. Drawing on published and unpublished literature, this paper begins by examining the prevalence of alcohol consumption and related harms in sporting clubs. It then explores the implications of these alcohol consumption levels. Based on published evidence, a framework is then suggested to guide sporting clubs and influential stakeholders about steps they can take to address the management and consumption of alcohol in their club. Interspersed through the document are case studies of sporting clubs from across Australia. These case studies highlight practical examples of reported evidence and best-practice. The paper aims to be relevant to

a variety of stakeholders associated with sporting clubs including board members, committee members, coaches, fitness staff, managers and patrons.

Is there evidence of a problem?

Organised community sport plays a significant role in the Australian community. In 2007, approximately 4.5 million Australians aged 15 years and over were involved with organised sport as players, officials, members or supporters.¹ There are substantial physical, mental and social health benefits of playing sport. Physical health benefits include greater muscle strength and bone density, reduced blood sugar levels and reduced blood cholesterol levels.^{2,3} Playing sport provides opportunities for social engagement, it encourages collective and strategic thinking and it may reduce the risk of depression and anxiety.⁴ Those who play sport also seem to be better able to deal with the stresses of everyday life.

Unfortunately participation in sport in Australia is also associated with harmful levels of alcohol consumption. Two studies of football, cricket and

netball clubs undertaken by the Australian Drug Foundation (ADF) reported that relative to the general population, club players and members had high rates of alcohol misuse. Approximately 37 per cent drank at levels that put them at risk of immediate harm (e.g. accidents or injury) or long-term harm to their health (e.g. cancers, liver cirrhosis and cardiovascular disease).^{5,6} A further study undertaken by the ADF replicated these findings for golf, cricket and bowling club participants.⁷

Larger Australian studies have reported similar findings. For example, in New South Wales, 50 per cent of males who participated in cricket, rugby or surfing activities were found to be more likely to drink at levels that increase risk of short-term harm.⁸ Similarly, in a sample of members from a variety of sporting codes across Australia, a substantial proportion of members consumed alcohol at levels that increased risk of short-term harm (16 per cent of men and 31 per cent of women), and of long-term harm (32 per cent of men and 58 per cent of women).⁹ The consumption of alcohol among sporting club members appears far higher than found in the community, where the population consumes alcohol at a level that puts 10 per cent at risk of short-term harm and 17–24 per cent at risk of long-term harm.¹⁰

Similar behaviour is reported to be occurring in community sporting clubs in countries around the world. In Britain for example, a household survey indicated that heavier alcohol consumption was associated with those who were sporting club members.¹¹ Studies in New Zealand report higher levels of harmful alcohol consumption among rugby players than community members generally,^{12,13} and studies in the United States of America report higher levels of harmful consumption among college athletes,^{14,15} and that playing sport was strongly associated with alcohol misuse.^{16,17} A recent study reported that similarly high consumption levels occur in elite Australian football clubs in Victoria at the end-of-season period.¹⁸

There is evidence that the link between risky alcohol consumption and sport is more than the aggregation of heavy drinking individuals and runs deeper to form broad cultural expectations for membership.^{19,20} In a large Australian study undertaken by the ADF, approximately 75 per cent of sport participants reported that drinking alcohol was important for club camaraderie, an important tradition at their club,

and an important tradition for celebrating after a game.⁹ Similarly, a number of studies have reported the prevalence of ritualised club behaviours associated with alcohol consumption such as long drinking sessions, drinking competitions, and end-of-season trips that focus on excessive alcohol consumption.²¹

What is risky drinking?

Recently the National Health and Medical Research Council (NHMRC) issued a revised set of Australian safe drinking guidelines.²² Overall, there are four guidelines; the first focuses on long-term risky drinking; another on short-term risky drinking; and the other two focus on children and pregnant women. Both long and short-term risky drinking levels apply equally to men and women, and it is these two guidelines that are most applicable to alcohol consumption in community sporting clubs. The long-term risk guideline states that healthy men and women are advised not to drink more than two standard drinks on any one day. According to this guideline, if an individual drinks no more than two standard drinks per day, the “probability” that they will suffer from long-term alcohol-related disease or injury is substantially reduced, compared to someone who drinks more than two drinks a day. Alcohol-related disease or injury includes things such as cirrhosis of the liver; stroke; hypertension; cardiovascular disease; cancers of the mouth, lips, throat and oesophagus; cancer of the stomach, pancreas and liver; bowel cancer; and breast cancer.

In the past decade there has been a growing concern about the level of drinking that is more acute and transient; that is, the type of heavy or above average alcohol consumption that often occurs at celebrations or special events on a semi-regular basis. This type of consumption is sometimes referred to as binge drinking, as it refers to the consumption of large amounts of alcohol in drinking sessions and is typically interspersed with days of no alcohol use. Binge drinking patterns are most common among young people and social drinkers, and are drinking patterns that are commonly identified in sporting clubs.²³ Binge drinking patterns are sometimes distinguished from chronic drinking patterns that are common among individuals with a problem of alcohol dependence.²⁴ The second national guideline has been developed to reduce the risk of injury on a single occasion of drinking, that is, to reduce harm from binge drinking. It states that for both men and women, drinking no more than four standard drinks

Table 1. Types of drinking.

Type of drinking	Level of drinking that causes harm
Short-term risky drinking ²²	More than four standard drinks in one sitting.
Long-term risky drinking ²²	More than two standard drinks every day.
Alcohol use by people less than 18 years of age and by pregnant women ²²	Low levels of alcohol use are harmful and should be discouraged.
Alcohol dependence (DSM-IV)	Usually regular and heavy drinking over a prolonged period. When drinking stops, withdrawal symptoms such as tremors, sweating and inability to sleep are experienced.

on a single occasion reduces the risk of alcohol-related injury arising from that occasion. Risk of injury includes physical injury or road accidents due to impaired cognitive performance and slow reaction times.

It is the short-term risky drinking that is most often associated with intoxication, and this type of consumption that seems to characterise the drinking patterns that the media often describe when reporting the antics of community sporting clubs. Short-term risky drinking, sporadic binge drinking and long-term risky drinking, are not the same as alcohol dependence. Dependence is usually characterised by heavy and prolonged drinking, preoccupation with alcohol, loss of control, and withdrawal symptoms such as tremors, sweating and inability to sleep when the individual stops drinking.²³ Table 1 shows the different types of drinking. The consequences of both long and short-term risky drinking have implications for the individual drinker and the broader community. It is important for clubs to understand these concepts and promote the notion of safe drinking levels if they are to change the amount of risky drinking occurring in sporting clubs.

Consequences of risky drinking

Risky alcohol consumption in sporting clubs has immediate health, legal, social and economic consequences. For example, in 1994, the police were called to the Diggers Rest football club at 3.30 a.m., where they found a 26-year-old man dead in the toilet. The man had played football that day, which concluded at 2.00 p.m., and began drinking alcohol soon after. The coroner's report stated that the young man died of alcohol poisoning, his blood alcohol content (BAC) was 0.31; he had literally drunk himself to death. The coroner suggested that the continuous supply of alcohol to the man while he was intoxicated

contributed to his death. The inquiry into the death of the man found that the football club had breached several liquor laws, such as serving outside its licensing hours, and serving alcohol to an intoxicated patron.²⁵

Worldwide, it has been reported that alcohol consumption is associated with 2.5 million deaths.²⁶ In Australia between 1992 and 2001 approximately 31 000 deaths were attributed to short-term risky drinking; that is, binge-type drinking associated with a particular setting, such as the type that occurs at a licensed venue or sporting club.²⁷ For Australian men, about 33 per cent of motor vehicle deaths and 25 per cent of motor vehicle injuries have been attributed to alcohol consumption; for Australian women, the figures are approximately 11 per cent for both deaths and injuries.²⁸

There is no published literature on the prevalence of drink-driving and other consequences associated with risky alcohol consumption in sports settings. However, there is a small amount of published evidence that focuses principally on alcohol consumption and whether individuals report driving to and from their club.^{6,29} For example, Snow and Munro found that 84 per cent of sporting club members reported spending up to three hours drinking, with 40 per cent of respondents drinking more than five standard drinks, and 15 per cent drinking between seven and 10 standard drinks on each occasion they were at their sporting club.²⁹ They also found that most respondents (71 per cent) reported living within 10 kilometres of their club and that 83 per cent of club members reported driving home from their club. While these studies do not explicitly examine the number of individuals who consumed alcohol at risky levels and the proportion of individuals who drove home from the club, the substantial proportion of individuals that report these behaviours indicates that

the community sporting club is a high-risk setting for drink-driving.

Unpublished reports produced by the ADF also support the conclusion that high levels of drink-driving are likely to be occurring in community sporting clubs. For example, the study mentioned above indicated that 33 per cent of community sporting club members reported driving their car from their club after consuming alcohol at levels that can be estimated to have taken their BAC over the legal limit of 0.05.⁷ In this report BAC was estimated by assessing the number of standard drinks consumed and the period of time the alcohol was consumed. Similar findings have been replicated by the ADF with cricket and football clubs.⁷

Can sporting clubs take action to reduce the problem of drink-driving? There is increasing optimism that the answer is yes. Although there isn't any strong published evidence about the need for drink-driving strategies in sporting clubs, and while there hasn't been an explicit national campaign targeting drink-driving in this setting, there are community sporting clubs that have acknowledged that drink-driving is an issue in the community sporting club setting and have decided to take a proactive approach to the issue. Case study 1 is an example of a community rugby club in Queensland that has tried to address the drinking culture—specifically drink-driving—at their club.

Sport, risky drinking and quality of life

The impact of risky drinking and its consequences on the health and hospital system are significant. Alcohol-related road trauma, accident and injury draw heavily on the Australian economy. The consequences for the workplace through absenteeism and workers being present but impaired (“presenteeism”), are also substantial. In some countries, excessive and harmful consumption has also been linked to premature retirement.³⁰ Taking account of these flow-on effects of excessive alcohol consumption, a conservative estimate of the economic cost to the Australian community has been in the proximity of 15.3 billion dollars per year.³¹ While there is no published evidence on the explicit relationship between alcohol consumption in sporting clubs and the burden on the health and economic system; given the levels of alcohol consumption in sporting clubs and given that alcohol consumption levels are

Case study 1

Club: Rugby league

Location: South-west Queensland

What were the problems/issues?

This rugby league football club is a central element of the community; on weekends it brings a large proportion of the community together.

Alcohol was a key feature of socialising at the club. The club ground was not fenced so individuals could bring and consume alcohol from any point on the ground. Underage drinking was occurring at the club. The club recognised that there were public liability issues to be addressed if the sale and consumption of alcohol was to be allowed at the club. It also acknowledged that the physical environment needed to change in order to manage alcohol consumption at the ground.

What did the club do?

- ▶ The club has built a new club house and separated the bar from the children's area.
- ▶ The club has erected a fence around the ground. This helps control alcohol being brought to the ground, and also provides space for sponsorship and advertising.
- ▶ The club has purchased a mini-bus so junior team members can be driven to “away” games. The bus is also used to transport patrons who feel they have consumed too much alcohol.
- ▶ The club only serves mid and light strength beer.
- ▶ Bar staff are trained in the Responsible Service of Alcohol (RSA); training that teaches bar staff about liquor licensing laws, and how to recognise and manage drunk and intoxicated patrons.
- ▶ Members' and players' partners cook and serve meals at the weekend.

Outcome

The fence around the ground generates revenue from advertising and has increased sponsorship for the club. The club is no longer heavily dependent on alcohol sales for revenue. The club's major sponsor provides senior players with sports drinks, water and food after the game. Members report that there is a general acceptance that drink-driving is not tolerated and there are strategies in place to ensure that this does not happen. Socialising and the sale of hot meals has increased. Membership of the club has remained steady.

Case study 2

Club: Community baseball

Location: Southern part of South Australia

Small rural town whose economy relies on agriculture, fishing, forestry and tourism.

What were the problems/issues?

A small community club whose membership, like most sporting clubs in the area, had been declining rapidly. The club recognised that it was not attracting new members, and that this was partly due to it having a poor image in the community (i.e. just a place to drink). The club wanted to find ways to attract new members, to be seen as a health promoting organisation, and manage the risk and liability issues associated with selling alcohol.

What did the club do?

- ▶ The club developed a policy that placed an emphasis on making families feel welcome and safe.
- ▶ The club developed a policy that placed an emphasis on attracting young people to play for the club.
- ▶ The club ensured bar staff were trained in RSA; training that teaches bar staff about liquor licensing laws, and how to recognise and manage drunk and intoxicated patrons.
- ▶ The club emphasised broader links to health by creating the opportunity for club members and visitors to sit down and enjoy a hot healthy meal, not just fast food (i.e. pies and pasties).

Outcomes

The club has become more clearly identified as a healthy organisation. Club members describe the club as a family-friendly safe club. They report an increased sense of community and say the club is a critical element of their broader community life.

A number of other sporting clubs in the area report they have declining membership, especially for junior members; however, this club has experienced an approximately 28 per cent increase in membership.

Canteen revenue has increased and while strategies to curb excessive drinking have been implemented, bar revenue has also increased. This has been partly because visitors and members sit down to enjoy a meal, and also feel that the club is a safe place to relax and socialise. The club is now spending \$20 000 to expand its canteen facilities.

greater in sporting clubs compared to the community, it can be reasonably extrapolated that risky alcohol consumption in sporting clubs is having a significant impact on our country's economy and health system.

Traditionally the health of a nation has been interpreted by the level of mortality (deaths) and morbidity (diseases), usually in respect to the overall population or in relation to certain populations (e.g. Indigenous). From this perspective, the statistics for alcohol consumption in sporting clubs reported above, suggests that there is a strong case to be argued for the existence of an alcohol-related health problem in sporting clubs. However, more recently, the definition of health has been changing. The World Health Organization (WHO) now defines health as not just the absence of disease, but as a state of complete physical, mental and social wellbeing.³² Health is not described as an end in itself, but a feature of life that is instrumental in improving the quality of living. Health for the WHO is to be understood as a "resource for everyday life"; a resource that enables individuals to have greater engagement in the community, and thus helps them contribute to the overall fabric of the community.

If we use the WHO definition of health, reducing consumption levels in community sporting clubs is not to be understood simply as an economic imperative; that is, it is not to be judged as a bad thing because it has a significant impact on the country's health and economic system. Rather, reducing alcohol consumption in sporting clubs is a human rights imperative; that is, reducing risky alcohol consumption in sporting clubs will ensure club members have the best opportunity for the highest quality of life.³³ Greater quality of life will fundamentally mean individuals will better engage with other club members and the broader community, feel healthier, and thus participate in a more substantial, meaningful and fulfilling manner. Greater quality of life for members of sporting clubs could include enhanced mental health, increased physical participation, and lower levels of obesity.

Recently the Australian Government's Preventative Health Taskforce identified alcohol and obesity as primary health issues that are a concern for the nation.³⁴ The taskforce also identified that these issues can not be addressed by the government alone, and that one way to address these issues is to engage key and influential community organisations. As sporting clubs already provide the opportunity for increased

physical activity and social development, and as the sale of alcohol is usually an essential feature of a community sporting club, there currently exists a platform to address both the issues of obesity and alcohol simultaneously.³⁵ Case study 2 demonstrates how a club addressed the way it managed alcohol, and how this management action has benefited the way members participated and engaged with the club. Overall the changes have increased the club's standing in the community; these changes have also been associated with increased membership, revenue and the number of individuals that participate in sport at the club.

The Ottawa Charter

By taking steps to reduce health and social problems in sporting clubs, club leaders (e.g. committee members, board members) align their organisation with current policies that seek to support organisations that improve and promote health. Using organisations and settings, such as sporting clubs, to change behaviour like alcohol consumption and thus improve the quality of life of communities and individuals has been advocated in the international health promotion movement. One of the first international documents to formally acknowledge the link between health and quality of life is the Ottawa Charter for Health Promotion. The Charter was launched in 1986 in Ottawa, at the First International Conference of Health Promotion.³⁶ Overall the Charter was the first document to be launched on an international stage urging for an "international call for action". However, the document also went a step further: it stated that health is determined by the interplay of human biology, healthcare systems, environment and lifestyle.

Fundamentally the Ottawa Charter stated that health (and therefore quality of life) is a product of how people live and the conditions they find themselves in; and that individuals and communities do not always have control of the conditions they find themselves in. By suggesting a need to create healthier environments, the Ottawa Charter stated that health promotion should take a settings approach; it suggested targeting behaviour change in organisations and social settings (e.g. sports clubs, licensed venues, schools). As a way forward, the Charter suggested that the objective of health promoters and program developers is to create conditions/programs that enable and empower

people to increase control over their lives and to improve their health and quality of life. From a sporting club perspective, it is the job of board members, committee members, coaches, fitness staff, and managers of community sporting clubs to create conditions that make healthy choices around alcohol the "easy" choice. The Ottawa Charter has had an important influence on state and national policies across Australia.

The development of theories in relation to the Ottawa Charter has principally focused on social and cultural conditions. These theories emphasise that if programs are to achieve individual behaviour change, the target of the program is not specific individuals, but mostly cultural and collective influences, systems and rituals that promote unhealthy individual choices.³⁷ As described in the opening paragraph and illustrated throughout this paper, cultural practices and rituals in sporting clubs include activities like alcohol-focused awards for the "under-18" best-on-ground, celebrating success with excessive alcohol consumption, or the pouring of alcohol into the premiership cup and emptying it over players. Allowing intoxicated individuals or underage individuals to be served alcohol or permitting intoxicated individuals to leave the premises without ensuring they are not driving home are systemic practices that occur in many sporting clubs. Case study 3 is an example of a sporting club that recognised that if it were to change the culture of alcohol consumption, certain practices and behaviours needed to change.

An evidence-based framework for alcohol management programs in sporting clubs

What are the steps and strategies that clubs can take to improve alcohol management? There are a number of frameworks designed to help practitioners develop programs that draw on the theoretical principles of the Ottawa Charter. One popular framework is the PRECEDE/PROCEED model.³⁸ There are currently over 950 applications of this model published in the research literature. Programs using this framework include interventions in specific geographic regions, occupational settings, educational settings, and health-care settings.³⁸ This model fundamentally states that behaviour is influenced by a number of variables and thus a one dimensional approach rarely works. It suggests that combinations of factors are needed to change behaviour and these are

Case study 3

Club: Rugby

Location: Coastal New South Wales, close to Sydney.
A popular holiday destination.

What were the problems/issues?

A relatively new club—only five years old. The club recognised that it was in an area that attracted families and holiday-makers. The club wanted to be seen to be responsible, and also wanted to be identified by community members as a safe and family-friendly environment.

Acknowledging that the sale of alcohol was critical for its revenue and thus its economic survival, the club wanted to find ways to help members enjoy alcohol responsibly while at the club and for them to travel to and from the club safely.

What did the club do?

- ▶ The club introduced low-alcohol and non-alcoholic drinks.
- ▶ The club ensured bar staff were trained in RSA; training that teaches bar staff about liquor licensing laws, and how to recognise and manage drunk and intoxicated patrons.
- ▶ The club banned drinking games (e.g. skolling, drinking competitions).
- ▶ The club implemented a “buddy system”.
- ▶ The club installed a breathalyser machine in the club rooms.
- ▶ The club offered a free courtesy bus to drive patrons home.

Outcomes

The club reports that it is now identified in the community as a safe and family-friendly place to socialise. The club reports an increase in sponsorship, as leading organisations/businesses in the community want to be associated with the club. It reports there is an overt acceptance in the club that drink-driving is unacceptable and fewer people report they want to drive home after consuming large amounts of alcohol. Club members report they are aware of the strategies in place at the club to help them get home after consuming alcohol at levels that may breach the legal limit for drivers.

best categorised into three domains: predisposing, reinforcing and enabling.

Predisposing factors principally focus on the individual. They typically examine the values, knowledge and attitudes of individuals. While the Ottawa Charter and its associated theory argue for cultural and setting change, these documents also acknowledge that a key strategy in achieving change is to influence key decision makers and that changing the environment often involves changing the values, knowledge and attitudes of people who control the environment.³⁸ Thus, when implementing a program in a sporting club setting it is important to convince key people, such as the club committee, of the need for the program. In addition, knowledge of safe levels of drinking in the context of strong environmental cues, such as Responsible Service of Alcohol (RSA) practices, signage of serving practices, and restrictions on cheap drinks (see enabling factors in Table 2), can be a strong combination of factors that influence behaviour.³⁸

Enabling factors facilitate healthy behaviour by individuals or groups.³⁸ As mentioned above, without enabling factors knowledge has minimal influence on behaviour. Enabling factors focus on social forces and systems, such as making healthy choices/behaviour more accessible. In the context of a sporting club, enabling factors would be making light-alcohol beer cheaper than full-strength beer, training bar staff in RSA and actively promoting and abiding by these practices. The RSA practices include not serving intoxicated individuals and people less than 18 years of age.

Reinforcing factors are usually social or environmental feedback cues that strongly influence whether behaviour is repeated. Social feedback could be recognition, appreciation or admiration by peers or leaders. In a sporting club setting this could be feedback from the local council, residents or families about the positive and well-behaved members of the sporting club. Environmental feedback could be a healthier and more vibrant sporting club or a club that is now less characterised by drunkenness and violence. Reinforcing factors are critical to programs targeting groups because they formalise new behaviour and systemic change; they also help initiate and promote new norms of expected behaviour.³⁸

Table 2 summarises the factors associated with alcohol-related behaviour change.

Table 2. Factors associated with alcohol-related behaviour change.

Predisposing factors:		
<i>Individual characteristics</i>	Description	Evidence and relevance for sports clubs
Knowledge	Provision of information aimed at encouraging healthy behaviours.	No evidence for direct link with behaviour; knowledge enhancement works best as part of a broader program. Clubs can ensure patrons have information about national guidelines for alcohol use.
Attitudes	Enduring disposition favouring alcohol use.	Evidence suggesting that favourable attitudes to alcohol use in adolescents is predictive of use in later years. Sporting club policies can show disapproval for adolescent alcohol use
Values	Guiding principles.	No direct link with behaviour change, but when included in a broader program can be influential. Clubs can incorporate values into club policy and use them to guide decision making around alcohol management.
Perceptions	The perceived level of alcohol use in the community.	No direct link with behaviour change, but when addressed as part of a broader program can be influential. Clubs can highlight the high levels of consumption in sporting clubs, compared to the general community.
Enabling factors:		
<i>Environmental factors: physical; social; economic</i>	Description	Evidence and relevance for sports clubs
Availability	Restriction in serving practices such as training of bar staff in RSA.	Evidence indicates that availability influences behaviour but must be implemented in conjunction with some type of enforcement. Clubs can ensure bar staff are RSA trained. Clubs may set a policy to not provide alcohol to people less than 18 years.
Accessibility	Defined times for selling alcohol (not selling on particular days/times or to specific groups).	Does not reduce consumption, but linked with a reduction in alcohol-related harms such as violence. Clubs restrict the sale of alcohol to particular times only and may refuse service to intoxicated patrons.
	Restrictions on discounting, such as "happy hour", or alcohol promotions.	When part of a broader program can reduce alcohol consumption and harmful alcohol-related behaviours, such as drink-driving. Clubs can choose not to promote alcohol promotions, discounting and "happy hour".
	Increase in price.	Strong evidence linking price with consumption. Clubs can make low-alcohol drinks cheaper, and provide soft and low-calorie drinks.
Laws	Laws enforcing minimum age of purchase and use.	Strong evidence linked with reducing harm in young people. However, often poorly implemented. Most successful when part of a broader community approach (see community mobilisation). Clubs can have a policy on not serving alcohol to minors and actively enforce the policy.
Community mobilisation	Coordinated community approach involving community members and key stakeholders in the community.	Resource intense, but evidence suggests it is effective in reducing alcohol consumption. Clubs can work with their local council, police and licensed venues, to ensure responsible alcohol management and consumption occurs consistently.
Advertising	Specific marketing campaigns explicitly aimed at young people.	Correlation evidence indicates that greater exposure to advertising is associated with risky consumption. Evidence is mixed on whether advertising directly causes greater consumption. However, clubs can choose to ban specific marketing promotions, and not to accept marketing merchandise from the alcohol industry.

Reinforcing factors: <i>Behaviours of individuals, groups or communities</i>	Description	Evidence and relevance for sports clubs
Favourable attitudes and behaviour of leading individuals	Perceived general consumption levels of alcohol in community.	Particularly with young people, consumption in the broader community is linked with personal consumption. Clubs can use high profile sporting celebrities or club members to promote reduced alcohol consumption.
Favourable attitudes and behaviour of peers	Perceived general consumption levels of peers.	Particularly for young people, alcohol consumption levels of peers is linked with personal consumption. Clubs can use high profile sports celebrities or club members to promote a healthy attitude to alcohol consumption.
Favourable attitudes and behaviours of community or group	Licenses code of conduct, such as Accords. Accords are negotiated agreements/policy positions between community stakeholders (e.g. police, licensees and council) covering standards of service and promotion, such as not permitting alcohol promotions.	Accords can be difficult to maintain, but with an enforcement element incorporated can be effective. Clubs can provide feedback to club members from local community members and licensed venues about the benefits to the neighbourhood and the increased standing of the club in relation to the way the club manages and consumes alcohol.

More details about these studies can be found in: *The prevention of substance use, risk and harm in Australia: A review of the evidence*,³⁹ *Alcohol: No ordinary commodity: Research and public policy*,⁴⁰ and *Restrictions on the sale and supply of alcohol: Evidence and outcomes*.⁴¹

While there is evidence supporting the multiple influences on behaviour, there is also evidence of factors that might impede or enhance the implementation of health promotion programs like alcohol management programs. The PRECEDE/PROCEED model suggests addressing or paying attention to those elements that will ensure smoother implementation of a program. In practical terms, this part of the framework is an assessment of the following questions:

- ▶ What organisational and club resources are required to implement the intervention?
- ▶ Does the program or club have the organisational, administrative capabilities and resources to implement and deliver the program?³⁸

Thus, it is the role of the program implementer to identify policies, regulatory procedures and organisational practices that will impede or hinder the implementation of the program. Problems that might impede a program in a sporting club could include not communicating clearly to others within the club, the objective, structure and length of the program. Another impediment might be that some members might not see any need for the program, and thus no

need to change their current behaviour. Clubs may also be obligated to service particular licensed venues, and changing this relationship might impact on sponsorship and other forms of fundraising.

Table 3 outlines a summary of the evidence relating to the organisational/group/club factors that hinder and impede the implementation of an alcohol management program in a community sporting club. It also identifies example questions that clubs might ask when assessing each of the listed factors.

Evaluation and research

Having identified a rationale and a framework for an alcohol intervention in sporting clubs and having also identified a theoretical framework that demonstrates factors that impede and enhance the implementation of population approaches to alcohol prevention it is time to ask: are there any programs that have been implemented and been thoroughly evaluated? While it is important to implement strategies that have been proven to be successful it is just as important to implement programs that use a combination of strategies that have also been proven to be successful.

Table 3. Impediments to implementing alcohol management programs.

Factor	Effect on implementation	Questions sporting clubs might ask in developing strategies and policies
Program plan		
Theory and evidence	Widely tested	Do we have a resource or expert we can seek advice from regarding policies and strategies that work?
Assumptions	Well defined	Are the terms and concepts used in our plan well understood by members and stakeholders?
Goals	Explicit and measurable	Do club members understand what will change, by how much and when?
Amount of change	Feasible	Have other clubs been able to achieve similar change?
Rate of change	Incremental	How fast do we need to implement strategies and will members be open to the rate of change?
Familiarity	Familiarity	Are the changes too extreme or radical for club members?
Complexity	Minimal components	Is the program too complex and does it have too many components?
Structure of program		
Scale of goal	Relevant to target group	Do our members see the relevance and benefits of the program?
Type of goal	Perceived as suitable	Do members see the outcomes of the program as realistic and purposeful?
Capacity		
Resources	Available	Does the club have the staff and/or financial capital that might be needed?
Target population disposition		
Values	Congruent	Are the values of the program consistent with the values of members?
Attitude	Favourable	Do club members have a favourable attitude to the program?
Belief	Faith in policy/program goal	Do club members believe that the program will be of benefit to the club?
Behaviour	General openness to change	Are club members open to the implementing of the intervention?
Political climate		
Political support	Present/tangible/palpable	Do the political and funding bodies support the program?
Strength of support	Strong	Is the political support for the program strong?
Environment		
Timing	Good timing for implementation	Is it a good time to implement the program at the club?

More details about these studies can be found in the following texts: *Reconciling concept and context: Community intervention handbooks for comprehensive health promotion programming*;⁴² *After the applause: Exploring multiple influences on application following adult education programs*;⁴³ and *Advances in health education and promotion*.⁴⁴

Table 4. The accreditation levels of the Good Sports program.

Level 1
<ul style="list-style-type: none"> Clubs comply with state liquor licensing laws.
<ul style="list-style-type: none"> At least one bar staff member on duty is trained in RSA.
<ul style="list-style-type: none"> Liquor is only served within specified hours.
<ul style="list-style-type: none"> People aged less than 18 years do not serve and are not served alcohol.
<ul style="list-style-type: none"> Drunk and intoxicated people are not served alcohol and are not allowed to enter the premises.
Level 2
<ul style="list-style-type: none"> Low and non-alcoholic drinks are provided.
<ul style="list-style-type: none"> All bar staff on duty are trained in RSA.
<ul style="list-style-type: none"> Bar staff do not consume alcohol on duty.
<ul style="list-style-type: none"> The club maintains an incident register.
<ul style="list-style-type: none"> Tap water is provided free of charge.
<ul style="list-style-type: none"> Substantial food options are available when the bar is open for more than 90 minutes.
<ul style="list-style-type: none"> The club implements a safe transport strategy, for example a designated driver program, taxi vouchers or key register.
<ul style="list-style-type: none"> The club does not conduct any of the following: "happy hour"; cheap drink promotions; drinking competitions; drink vouchers; all-you-can-drink functions; drinking competitions; and alcohol only awards or raffle prizes.
<ul style="list-style-type: none"> All indoor areas of the club are smoke-free and club does not sell cigarettes.
Level 3
<ul style="list-style-type: none"> The club has a Good Sports written policy which addresses the following: bar management; RSA; underage drinking; alcohol alternatives; food options; safe transport; smoking; club trips; non-compliance; promotion of policy; and policy review.

A recent Cochrane review of interventions in sporting clubs reported that no evaluation studies with rigorous designs could be located that focused on alcohol-related interventions.⁴⁵ However, in Victoria, a program called the Good Sports program has been piloted. An initiative of the ADF, the primary aim of the Good Sports program is to implement multi-level change within sporting clubs in order to reduce the incidence of alcohol-related problems. It does this

through a three level accreditation program (Table 4.) Consistent with the PRECEDE/PROCEED model, multiple strategies are implemented. Clubs progress through the program by gradually implementing agreed alcohol-related strategies. When clubs have implemented all the strategies they are classified as a level 3 accredited Good Sports club.

While there is no published evidence detailing the outcomes of the Good Sports program, two pilot studies have been undertaken by the ADF and the results from these studies are very promising. It can be said that these findings demonstrate that as clubs progress through the Good Sports program a reduction in alcohol-related behaviour is observed. The results of these findings are being prepared for submission to journals by the end of the year (2009). Clubs implementing the Good Sports program also report an improved standing in the community and an increased number of players, participants and members. For example, an analysis of the change in members and players for 48 clubs that progressed from level 1 accreditation to level 3 accreditation demonstrated that over this period there was a 25 per cent increase in the number of club members, a 10 per cent increase in the number of members and an increase in the number of teams (average increase of one team).⁴⁶

To build on this outcome and help create a more health-promoting environment for members and spectators, the Good Sports program is also trialling an additional component to the program that focuses on healthy canteens. This component encourages clubs to provide healthy food options in their canteens, such as fruit and vegetables, and encourages these options to be positioned prominently and to be competitively priced. Case study 4 describes a sporting club that has implemented the Good Sports program and some of the positive outcomes it reported from being part of the program.

To further enhance the evidence base for the Good Sports program, the ADF in collaboration with Hunter New England Population Health, Turning Point Drug and Alcohol Centre, and Newcastle University are undertaking a randomised control trial (RCT) of the Good Sports program. Randomised control trials are seen as the "gold standard" in evaluation and research; they are the best way to identify cause and effect. These types of studies are very expensive to

Case study 4

Club: Football and netball

Location: A Victorian town on the outskirts of Melbourne.

Sports clubs have been identified with the town since the establishment of the area in the late 1800s.

What were the problems/issues?

The club was never successful on the field as most of the players were concerned with the drinking and socialising after the game. A substantial proportion of underage drinking was occurring in the club. Alcohol was always the focus of any form of success (e.g. best-on-ground award). Community members reported that the club had a poor reputation, especially around excessive consumption of alcohol. Three years prior to implementing the Good Sports program the club did not win a game. With its poor reputation, the club found it difficult to find sponsors.

What did the club do?

- ▶ Joined the Good Sports program.
- ▶ Achieved level 3 Good Sports accreditation in three years.
- ▶ Reconfigured the club room to take the emphasis away from the bar.
- ▶ Developed policies for creating and emphasising a safe and inviting environment.

Outcomes

Club functions now always have a family-friendly focus and there is no longer an emphasis on “boozy boys” functions. There has been an overall reduction in alcohol sales and alcohol-related incidents. The club has now over 100 sponsors, which helps compensate for the reduction in alcohol sales and also promotes the club throughout the broader community. The community reports that the club has a more positive image and members that were part of the club simply because they wanted to just drink alcohol have now left. The club won two games in the last season.

implement and are not usually undertaken if pilot studies do not indicate that the program is having an effect. The trial is partly funded by the Australian Research Council (ARC), the ADF and Hunter New England Population Health. The trial will be undertaken over the next two years.

While there is a need for the efficacy of the Good Sports program and other strategies/programs to be rigorously evaluated, the case studies presented in this paper also suggest that there is considerable room for club leaders and stakeholders to advocate improvements to club policies and practices. There are many areas that can be feasibly examined including the impact of alcohol marketing and advertising in community sporting clubs and the efficacy of alternative revenue-raising strategies in relation to consumption. As most of the case studies indicate, clubs are heavily dependent on the sale of alcohol. Programs that aim to reduce the sale and consumption of alcohol also need to provide alternative revenue-raising models if they are to be sustainable and if clubs are to remain faithful to them. The above report suggests that it is feasible for sporting clubs to better manage alcohol and that by doing so the club is likely to position itself for a more successful future.

Conclusion

This paper has described behaviours and events that are indicative of an alcohol-centric culture in community sporting clubs. It has also outlined how key decision makers within sporting clubs can change this culture by developing better policies and practices in alignment with national health promotion policies that were first expressed in the principles of the Ottawa Charter.

Sporting clubs are well-placed to become leaders in health promotion by offering numerous health benefits to the community, especially in relation to obesity and alcohol consumption. With national and state policies supporting settings such as sporting clubs as a means to improving the nation’s health, it is hoped that this paper will enhance the confidence and knowledge of sports change-agents, sports program developers and sporting club personnel to actively contribute to improving the health and quality of life for a substantial proportion of Australians.

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DrugInfo Clearinghouse
409 King Street West Melbourne VIC 3003
Email: druginfo@adf.org.au