



An asset-based community development approach to reducing alcohol harm: Exploring barriers and facilitators to community mobilisation at initial implementation stage

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ABSTRACT

Globally there is a need to engage communities in actions to reduce alcohol harm. This paper reports on the initial implementation phase of an asset-based community development (ABCD) approach to reducing alcohol harm in ten pre-identified areas across Greater Manchester (UK). This qualitative study highlights the experiences of stakeholders responsible for, or engaged in, implementation. Findings show that it is challenging to recruit sufficient volunteers in a specific, small area/community, which may limit the ability to build health assets. Wider policy and organisational factors that should be understood prior to implementing a place-based volunteer-led health promotion programme are also identified.

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1. Introduction

Globally, harmful drinking remains one of the leading risk factors for population health (World Health Organisation, 2018). If the World Health Organization's (WHO) ambition to reduce alcohol harm by 10 per cent by 2025 is to be realised, multi-component, evidence-based approaches which mobilise communities are needed (World Health Organisation, 2018). Communities are defined as groups of people joined by a common interest or experience including factors such as geographical location, health need or disadvantage (National Institute for Health and Care Excellence, 2017). The assets within communities, such as skills, knowledge, social networks and physical assets (including community buildings and publicly accessible meeting spaces), are recognised as being building blocks for good health (Gov. UK, 2020; Foot, 2012; Foot and Hopkins, 2010). Despite the WHO's call to action, the evidence exploring community mobilisation in reducing alcohol harm in local areas is scarce (McGrath et al., 2019).

Evidence indicates that improving regulation, restricting the availability of alcohol, and scaling up alcohol 'Identification and Brief Advice' (IBA) are effective interventions (Burton et al., 2016; Babor

et al., 2010). Box 1 summarises different types of alcohol-related brief advice. IBA can reduce alcohol consumption at an individual level in traditional health settings (D'Onofrio and Degutis, 2002; O'Donnell et al., 2014; Kaner et al., 2018). However, there is not yet any evidence that lay people can be trained to deliver brief advice. In addition, although powers exist for local people to influence the regulation and availability of alcohol in their neighbourhood, such action is uncommon due to a lack of transparency, low awareness and lack of confidence that local views will be valued (Glasgow Centre for Population Health, 2014; Alcohol Focus Scotland, 2017).

Communities in Charge of Alcohol (CICA) is a novel asset-based community development (ABCD) approach to reducing alcohol harm in specific, targeted geographical areas through: firstly, engaging volunteers or 'alcohol health champions' (AHCs) and providing them with the tools, knowledge and capability to lead brief advice conversations with friends, family and neighbours; secondly, CICA provided volunteers with greater understanding of licensing processes to empower them to engage in conversations with licensing authorities to address local concerns and needs (Cook et al., 2018).

The key mechanism to achieve the reduction in alcohol harm,

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Box 1

Types of alcohol-related identification and brief advice (IBA) interventions (Heather et al., 2013).

'Brief intervention' is considered an 'umbrella' term for a family of interventions. Three types of 'brief intervention' are defined:

(i) Minimal Intervention (IBAlite)	Use of AUDIT-C screening tool (an alcohol harm assessment tool in the form of a scratch card that assesses alcohol consumption and potential harm), provision of a feedback statement and leaflet
(ii) Identification and Brief Advice (IBA)	A 'simple brief' intervention (one session) utilises AUDIT-C, provides structured advice, lasts approximately 5 min, delivered by non-alcohol specialists
(iii) Extended Brief Intervention (EBI)	Utilises motivational interviewing techniques typically lasting 20–30 min (one session) delivered by trained practitioners

identified in the intervention's logic model (Cook et al., 2018), was to build a sustainable resource of trained lay volunteers (assets) to increase community capacity to engage in issues related to alcohol harm; rather than relying long term on health promotion activities managed by provider services. CICA is a complex intervention, i.e. a "*deliberately initiated attempt to introduce new, or modify existing, patterns of collective action in health care*" (May et al., 2007). Previous evidence shows that the context in which interventions are implemented impacts on whether they are successful in achieving desired outcomes (Watson et al., 2018). The aim of this paper is to explore the factors that enabled policy and practitioner stakeholders to take up and support the intervention during the initial implementation stage (first three months) of CICA.

1.1. Implementation context

The intervention was set in Greater Manchester, an urban city-region in north-west England (population 2.8 m), which comprises ten local authorities (LAs). Each LA was required to identify local communities within their authority where the intervention would be implemented. The specific communities were defined by their Lower Super Output Area (LSOA) boundaries. A LSOA is a geographical area designed to facilitate the reporting of statistics in England and Wales (NHS Digital, 2021). The use of defined LSOAs therefore allows comparison of routine statistics between intervention areas and control areas; in this evaluation these were: emergency department admissions; ambulance call outs; crime and social behaviour incidents and alcohol-related hospital admissions. The statistical evaluation ends in 2022 and will be reported separately.

Each LA utilised their own assessment of the indicators of alcohol-related harm to identify which geographical areas might benefit most

from CICA, the characteristics of which are shown in Table 1. Nine LAs identified target communities and carried out the intervention. The tenth LA was initially committed to the CICA programme, but did not progress. Volunteers from these localities (population sizes ranging from 1600–5500) were recruited to train as AHCs. CICA local co-ordinators were provided with no specific guidance on who to recruit or how to recruit, other than volunteers were required to work or live in the LSOA area.

Volunteers attended a two-day training programme to become Royal Society for Public Health (RSPH) Level 2 accredited AHCs. At each course, two LAs paired to provide 'first generation' AHC training to volunteers from their areas. CICA local co-ordinators and licensing leads from each LA also attended. The intention was to build community capability to reduce alcohol harm by establishing an initial cohort (first generation) of five AHCs per locality. Utilising a cascade training model, this initial cohort aimed to train a further 30 AHCs (second generation) in each locality over the course of 12 months.

2. Methods

2.1. Design

This qualitative study, underpinned by a realist epistemology, involved semi-structured one-to-one interviews with stakeholders involved in implementing CICA. Ethical approval was granted by the University of Salford ethical approval panel (HSR1617-135).

2.2. Interview participants

Sampling was purposeful. All 22 stakeholders (Table 2) from ten LAs

Table 1
Intervention area characteristics.

Characteristics	Intervention areas									
	1	2	3	4	5 ^a	6	7	8	9	10
No of LSOA's	2	1	1	2		2	3	2	3	2
Deprivation decile (Department for Communities and Local Government, 2015)	1,1	1	1	1,1		1,1	1,2,2	1,1	1, 4, 4	1,2
Population: men (%) (Office for National Statistics, 2017)	48.7	56.6	46.4	45.7		47.6	48.3	50.7	49.5	53.0
Population: women (%) (Office for National Statistics, 2017)	51.3	43.4	53.6	54.3		52.4	51.7	49.3	50.5	47.0
Ethnicity: white (Office for National Statistics, 2011a)	94.0	64.0	90.0	96.3		81.0	80.0	96.0	82.0	89.0
Social housing (%) (Office for National Statistics, 2011b)	45.0	37.1	39.6	55.8		45.0	42.0	55.0	17.6.0	50.0
Home ownership (%) (Office for National Statistics, 2011b)	38.0	29.0	31.5	33.9		28.8	45.0	36.4	56.0	35.0
Access to health assets and hazards decile (CDRC, 2019)	6th,8th	10th	9th	9th,9th		8th	6th,7th,9th	8th,9th	7th, 9th, 10th	9th
No of licensed premises in intervention area ^b	8	59	0	3		20	17	9	22	20
No of first generation AHCs trained	8	5	8	4	0	5	5	5	5	3

^a This Local Authority did not identify appropriate LSOAs or roll out CICA within their area.

^b From process evaluation data, unpublished.

Table 2
Background and expertise of stakeholders.

Stakeholder	Background and role in implementing CICA
Commissioning leads	Extensive experience of working in local government. Invited to participate in regular meetings prior to implementing the intervention in their area. Commissioning leads could attend the RSPH Level 2 Understanding Alcohol Misuse training programme for AHCs.
Local operational co-ordinators	Employed by their local authority or by a service provider commissioned by their local authority. All operational co-ordinators had extensive experience as practitioners with expertise in working with individuals with moderate/severe addiction difficulties. All were invited to participate in three meetings in advance of the training rolling out in their area. All attended both days of the RSPH training programme in their area, supporting their prospective AHCs.
Licensing leads	Licensing leads, employed by their local authorities, had extensive experience in licensing. Eight of the nine licensing leads attended the RSPH training programme on Day 2 to provide input about the Licensing Act 2003 to prospective AHCs. They were invited to attend the pre-meetings prior to the training rolling out in their area.

Table 3
Framework analysis process.

Stage	Actions taken
Familiarisation	Sample of interview transcripts (n = 4) read and initial codes generated (SCH/MC).
Identifying a thematic framework	Initial framework themes identified from the interview guide and initial coding of transcripts (SCH).
Indexing	All transcripts imported into QSR International NVivo 12 and systematically coded line-by-line. Following indexing, a NVivo report was created, sorting quotes into themes by participant (SCH).
Charting	A matrix was created in Excel [Version 10] with columns representing themes/sub-themes and rows representing stakeholders. Quotes from the NVivo report were sorted into the matrix (SCH).
Mapping and interpretation	The matrix was used by the researchers (SCH/CU/MC/LB) to synthesise, establish connections and associations across themes, and interpret the data. Themes were refined during write-up of the findings.

who had committed to establishing the role of AHCs in their localities were eligible to participate. Two chose not to be interviewed.

Since this paper describes barriers to establishing the intervention, the key stakeholder from the LA that did not roll out the intervention was also included (area 5). All were known to the research team through conference calls prior to training rollout.

2.3. Data collection

All stakeholders were invited by email to participate in a telephone

or face-to-face interview within three months of the initial training session for AHCs. Nineteen telephone and one face-to-face semi-structured interviews were conducted with thirteen public health practitioners (commissioning leads and operational local co-ordinators) and seven licensing leads (n = 20). Consent was gained at the outset of interviews. The interview guide ([Appendix 1](#)) covered:

- A narrative of how stakeholders became involved in, and how their role fitted with, the CICA programme;
- Challenges in establishing CICA in the local area, including recruitment of champions;
- Description of reactions and responses to promoting the alcohol health champion (AHC) training and CICA programme;
- Knowledge and perceptions of the local area in terms of harms due to alcohol;
- Thoughts on current alcohol licensing activity within the community;
- Knowledge and understanding of any other programmes taking place in the local community aimed at reducing alcohol harm.

Audio-recorded interviews lasted between 13 and 50 min (mean = 26.5 min) and were fully transcribed. Data, including anonymised transcripts, were stored on a password protected computer. The Standards for Reporting Qualitative Research (2014) ([O'Brien et al., 2014](#)) guided the reporting of this study.

2.4. Data analysis

A thematic framework method ([Ritchie and Spencer, 1994](#); [Lacey and Luff, 2009](#); [Pope et al., 2000](#)) was used for data analysis. This approach enabled themes to develop both deductively from the research questions and inductively from participants' testimonies ([Heath et al., 2012](#)). Data were coded and analysed according to the five stages of framework analysis ([Table 3](#)). Researchers MC, SCH and CU held review meetings to reflect on thematic development and agree on recurring themes.

Member checking: The findings were presented back to commissioners, local operational co-ordinators, licensing leads and AHCs at a conference, led by the project team, to share and discuss early CICA project findings. The presentation gained verbal input from attendees, who were invited to comment, in order to check the trustworthiness of findings ([O'Brien et al., 2014](#)). The findings resonated with attendees and no recommendations for amending the themes were suggested.

3. Results

Eight themes ([Box 2](#)) report the barriers and facilitators experienced by policy and practitioner stakeholders within the initial implementation phase of CICA. These reflect factors that impacted on the setting up of the AHC role (Themes 1–4) and external factors impacting on the

Box 2

Thematic map: Barriers and facilitators at initial implementation stage of CICA

- **Factors impacting on setting up the Alcohol Health Champion role in the community**
 - Theme 1: Effective recruitment of AHCs
 - Theme 2: Effective delivery of appropriate training
 - Theme 3: Getting to grips with the AHC role
 - Theme 4: Addressing communication challenges
- **Wider external factors impacting on implementation**
 - Theme 5: Identifying useful assets
 - Theme 6: Attitudes to community engagement in licensing
 - Theme 7: Operational challenges
 - Theme 8: Alignment with strategic, political and policy context

wider implementation of the intervention (Themes 5–8). To protect participants' anonymity, we have created different, randomly generated, codes that do not relate to the area codes used in Table 1.

3.1. Barriers and facilitators impacting on establishing the role of AHCs in the community

3.1.1. Theme one: Effective recruitment of alcohol health champions

The requirement for volunteers to live or work within the specific geographical areas identified for the intervention (defined by LSOA boundaries) created challenges for recruitment. Many local co-ordinators described recruiting AHCs as *'being really hard'* or *'really difficult'*. Many appear to have misunderstood the intervention principle (Alcohol Focus Scotland, 2017) that the aim of CICA was to build capacity in a specific community as part of a place-based approach. Instead, they referred to the constraints of taking part in the research study:

"I think, one, because of the constraints of the areas for the pilot was a bit difficult" (Area H).

A second barrier reported related to low levels of existing engagement pre-intervention by the provider organisations in the CICA areas. One local co-ordinator described working with a local multi-agency team *'just to go onto the estate every week'* (Area F) while another described having to work through networks of individuals and organisations to access these communities:

"speaking to people as much as possible to connect us with people who can connect with people in the communities" (Area G).

In some areas, recruitment was facilitated by local co-ordinators investing time and energy by taking potential volunteers *'for a brew'* (northern English slang for a cup of tea) or by becoming a known face in the community where recruitment would take place.

Additionally, social attitudes to alcohol programmes were reported as a barrier to recruitment:

"no-one wants to talk about alcohol, nobody ever wants to talk about alcohol because everybody thinks oh just leave them alone, they're only having fun, or blah blah blah" (Area D).

Implementation was facilitated by enabling local co-ordinators to approach different types of people to become volunteers including people who had experienced alcohol and substance misuse themselves, and who understood the challenges:

"some of our participants are recovering alcoholics, they've also been kind of, they've three or four years some of them had not touched a drop erm, so they know the challenges themselves ..." (Area A).

While accessing potential volunteers through drug and alcohol services or through recovery housing services facilitated recruitment, two local co-ordinators described the challenges they faced working with volunteers drawn from these services. For some, this created additional pressure, anxiety and a sense of being out of their depth when implementing CICA:

"some of them are still battling with their own addiction. They're also still struggling with loneliness and getting a job and, the many things that happen, you know as a result of them going through a drug and alcohol service. It's really, I'm finding it really hard. That's not my, that's not my job, it's not my expertise either" (Area F).

Two areas developed links with people who wanted to get back into employment:

"we worked with the DWP [Department of Work and Pensions] for looking at people who wanted to get employment and who were interested in accessing courses and things like that" (Area G).

Some areas recruited members of local public health teams, or individuals who had prior experience of working in schools or for organisations such as the police, housing organisations or providers.

Social media, particularly Facebook, appeared to offer potential in facilitating recruitment. However, converting initial interest into actual engagement in training was experienced as far more challenging:

"But then social media being social media, when you started chasing people up and going, yeah, that'd be great, if you give me an email address and I'll get you some information, ...it turned out that people seemed to be kind of going, yeah, I'm interested in that but when it actually came to the reality of it they were a little bit less keen" (Area E).

Only one local co-ordinator raised early concerns about how to retain AHCs over the long term and embed AHC activity into local plans:

"I don't know, how do you keep them ... I don't know how the other teams are doing it, you know, the other areas are doing it, because if you're just asking people to just to speak to you once a month, twice a month, it's not gonna be, it's gonna die off quite quickly I would say" (Area C).

Retention of AHCs was reported as a potential barrier to successful implementation. When volunteers decided *'it wasn't for them'*, this often resulted in local co-ordinators having to *'start again'*.

3.1.2. Theme two: the effective delivery of appropriate training

In some areas, the provider was not RSPH accredited or they did not have access to an accredited RSPH training centre. This was a prerequisite for the training to go ahead, in order for AHCs to receive a formal qualification. Four local co-ordinators reported being unexpectedly required to commit resources to enable accreditation. Where the RSPH accreditation centre was *'all set up'*, commissioners still needed to become familiar with the accreditation processes prior to training roll out:

"so, it's been, it's one of those processes, it's like a getting, getting yourself familiar with it really" (Area E).

The training itself was described as *'intense'*, *'tiring'*, *'a bit of an overload'* and *'a lot to do in a short space of time'* by stakeholders but overall, they felt their AHCs responded well and benefitted from being *'challenged and pushed'*. Education and literacy levels were highlighted as potential barriers in three areas:

"... there was some people ... who, who hadn't been in education for such a long time and for some of those to feel confident in taking on board the training, I think the training was, there was a lot" (Area A).

The concept of cascade training was considered *'quite daunting'*. While some local co-ordinators were concerned that AHCs felt *'comfortable'* prior to carrying out cascade training and needed *'plenty of time to get them up to speed'*. Another expected the AHCs to cascade the training, including the licensing component, on their own with light touch support:

"I'm hoping the first lot of champions that were trained, initially, are going to be able to deliver that training, so I don't necessarily have to be involved and I can dip in and out if they need me to. But it is about empowering the community, so, once you've empowered them, you don't really want to carry on holding their hand if they don't need it to be held. But, I'm happy to be there if they need me" (Area E).

Other areas felt CICA would be facilitated more effectively if professionals, such as outreach and engagement workers, participated in

the initial training to enable them to lead cascade training and support AHCs:

“I thought, you know it’s gonna be really relevant to [name] to be on the training. She’s delivered training before so I thought [name] and maybe either [name] or [name] can support each other to deliver it” (Area J).

The licensing input was considered a significant factor in developing AHC interest in CICA:

“the part of it [that] was taking champions and volunteers seriously” (Area D).

Those licensing leads interviewed were energised and enthusiastic about the opportunities for AHCs to make a difference from a licensing perspective. They described the AHCs as *‘really positive’*, *‘enthusiastic’*, *‘keen’* and *‘passionate’*, showing significant interest in licensing. This was reflected by one licensing lead feeling:

“like a rabbit caught in the headlights because there was a lot of questions” (Area A).

Several licensing leads reported how focused the AHCs were in considering how to engage their communities in licensing issues and one commented on the good understanding participants showed regarding licensing and the Licensing Act:

“Yes, the discussions, they weren’t just sat in silence, they were asking questions of me in my role, they were sharing experiences and how they might engage with their community members, as to rolling the project forward” (Area F).

However, one licensing lead identified the training content as too dense, suggesting that more opportunities should be provided to increase relevance to AHCs by focussing discussion on the areas in which they live and making it easier for AHCs to deliver:

“but to make it more relevant to the actual champions. Just to maybe relate it to something that they’re aware of. You know, a particular premises, or an experience that they’ve had” (Area E).

Consequently, some local co-ordinators were keen to adapt and change the training content for training future AHCs. This included considering removing some of the licensing element of the training:

“So, I wonder if we could, I don’t know, prune it a bit or change it a bit or just give them what they basically need” (Area E).

3.1.3. Theme three: getting to grips with the AHC role

One local co-ordinator (area F) identified issues of ‘fit’ for the role and acknowledged that their *‘service user AHCs’* (i.e. those accessing alcohol treatment services) had little previous experience of volunteering. However, this view was not articulated by other local co-ordinators, with one describing their first cohort of AHCs as strong, confident people:

“the first cohort of champions were really strong people. There were people from [organisation] and there were a couple of strong individuals from within the community as well, who felt confident” (Area E).

Not knowing how or where to start with this new role was highlighted as a challenge for the local co-ordinator:

“... the challenge we faced was just understanding to start with where it all fitted in, I think” (Area A).

Local co-ordinators described some AHCs as being unclear about their role. Concern was also expressed that role boundaries were not always observed by volunteers from alcohol recovery services when

engaging with the local community:

“Try and work on things like boundaries, social skills, there’s a hell of a lot to cover because these people think that we are there to help them and sometimes they go back into talking about their experiences and that’s not what the community, you know the alcohol health champion’s role is” (Area F).

Despite these challenges, local co-ordinators valued their AHCs, and were committed to protect, develop, and encourage them in their roles:

“I want to get ‘em trained up, inducted, get them ID badges. They’ve now got t-shirts, got a full set of kit so I want them getting out there and getting ready for a bit of fun kind of thing” (Area C).

Local co-ordinators identified CICA as a stepping-stone for AHCs through gaining experience, an accreditation, access to the council’s job pages, and confidence:

“getting somebody that’s maybe doing nothing at the moment, to get them doing a little bit of voluntary work. They build up their confidence, they apply for a job, maybe working within a school, maybe doing something, you never know and before long, they’ve got a role and you know that, for us, that, that’s the win-win” (Area A).

3.1.4. Theme four: addressing communication challenges

Most local co-ordinators reported finding the right message to *‘sell’* CICA *‘quickly and succinctly’* as a significant barrier:

“it was about just having an understanding so we could then sell the product to people, that was the biggest challenge really” (Area A).

Local co-ordinators reported time spent discussing CICA with existing LA volunteers or potential volunteers who had indicated interest only to find that they had no connection to the intervention target area and therefore did not meet the recruitment ‘criteria’. Local co-ordinators also perceived communication challenges in how volunteers should provide brief advice:

“I think if we get too involved with having a conversation, sooner or later there’s either nervous laughter or there’s a sort of ‘oh no, just stop lecturing me, I have a hard job every week, I just want to enjoy myself at the weekend, just leave me alone’ ” (Area I).

However, one local co-ordinator suggested that working with a provider service which offered free personalised support to help improve health and well-being, including conversations around smoking, mental wellbeing and healthy eating, facilitated brief advice conversations as they took place in the wider context of a person’s wellbeing:

“... with the lifestyle-type service it’s well, we’re not talking about your alcohol today, we’re seeing how you feel about your family you know, or trying to get that motivation, finding the motivation” (Area D).

It became evident that different areas had different perceptions regarding what CICA ‘success’ would look like. One local co-ordinator believed the number of licensing reviews initiated in the intervention area would be the main indicator of whether the intervention worked:

“specifically from a licensing service point of view if we’re not getting any erm, reviews in from members of the public having been engaged with by an alcohol champion, then from that perspective I think then perhaps from ... it’s not been really beneficial on that part, but if we do then erm, obviously it shows that it’s working” (Area A).

In contrast, a licensing lead for a different LA felt that initiating reviews was not a key outcome. Rather, the training should lead to more emphasis on community-led mediation thereby preventing increases in

the workload of the local Licensing Committee (Area E).

3.2. Wider barriers and facilitators impacting on initial implementation of a place-based approach to reducing alcohol harm

3.2.1. Theme five: identifying useful assets

Local co-ordinators described contextual variables, including the availability (or otherwise) of local assets and services (i.e. existing hubs, cafés, networks) as having the potential to affect grassroots mobilisation of volunteers. Free local physical assets were reported as essential including a central area where people could meet at no cost (community centre, health centre, or community café):

“[Location] that’s got a community building, and it’s actually originally a pavilion for the bowling greens, but we have access to that at, and no cost to use it for us” (Area B).

In areas where *multi-agency* teams - comprising housing, antisocial behaviour teams, the police, community link workers, employment and welfare services, and voluntary sector organisations - worked together, AHCs benefitted by being given practical advice on providing brief advice to community members by these professionals:

“The multi-agency team, while they’re litter-picking with the champions say, ‘this is how you do it, this is how you have conversations’ because they don’t have those skills, the champions at the moment to be able to link litter-picking, picking up cans of lager with having a conversation around health or alcohol” (Area F).

The presence of established drop-in centres in the locality was seen to facilitate multi-agency and place-based working, enabling new networks and relationships. One local co-ordinator described it as a ‘*kind of fertile ground*’ within which the ABCD model sat well.

However, the range of activities multi-agency teams were asked to engage with was reported as making their roles extensive, with concern being highlighted by one local co-ordinator that they were being asked to do too much and this limited their ability to provide further support to AHCs:

“I think money is so tight that multi-agency teams are getting pushed by everybody to add on a bit of this and a bit more, do you know what I mean?” (Area F).

Some local co-ordinators reported poor formal assets including a ‘*seedy back room*’ or no central hub or coherent networks, creating barriers to initial implementation.

Besides the physical (more formal) assets, ‘informal assets’ such as the volunteers themselves, and community activists were considered key facilitators:

“it’s [local area] got a number of assets, the [name] centre, which is a former sort of housing office, and obviously [person’s name] is a brilliant community asset so she gets things going in that area” (Area E).

Furthermore, if local co-ordinators were known - ‘*it’s my patch*’ - in the chosen CICA intervention area, this was seen to be facilitative:

“I can make use of my contacts and because of my autonomous role out in the community I’m making many more” (Area D).

3.2.2. Theme six: operational challenges

At implementation, some commissioners were unable to commission an appropriate provider organization to deliver the intervention due to lack of available candidate services. Either relevant ‘service level agreements’ (the contract between the LA and the service provider) had terminated and new service providers were being commissioned - impacting on rollout - or there had been no scope to ‘add’ CICA into existing contracts:

“we’ve only got the drug and alcohol team who will be helping me to run this and they have recently been decommissioned and a new commissioner, a new provider is starting in April [three months after initial training]” (Area F).

Concerns about having the capacity to deliver the essential elements of CICA were frequently emphasised. Area I identified a lack of capacity to manage AHC volunteers:

“so even if we could recruit volunteers initially, we certainly couldn’t manage the volunteers, because there’s no post within our organisation as part of the new tender arrangements. So actually, even if you got ten volunteers, we still couldn’t manage them, we’d have to get someone else to manage them” (Area I).

One licensing lead was apprehensive that increasing the knowledge of community members might result in generating more administrative work, leading to Licensing Committee hearings, for which the department would not receive additional funding to manage.

Two stakeholders raised issues about funding for training, specifically in relation to implementing the cascade training, for which no prior funding had been made available:

“from promotion, to making leaflets, to delivery and so and forth” (Area G).

Similarly, a licensing lead indicated funding constraints would affect implementation despite the view that empowering the community to support preventative approaches was more appropriate than relying on enforcement or requiring the support of drug and alcohol services:

“... a further option is to get more areas rolled out, across Greater Manchester. I think that would be absolutely fantastic. But, as I say, we’ll have to see. [LA name] has its own difficulties with funding and I’m pretty sure it wouldn’t automatically happen here, in the scale it possibly needs” (Area F).

Despite meetings taking place prior to training rollout, some local co-ordinators remained confused about CICA until participating in the training (i.e. post recruitment of potential AHCs):

“Some of us would come away and actually still email each other and say ‘I don’t really know what we’re doing yet’ and I think for me yeah, I think for me it was only when we did the training I actually started getting a feel of everything” (Area A).

Similarly, licensing leads described being unclear about their personal role and responsibilities, feeling that they ‘*came to it cold*’ (Area B).

3.2.3. Theme seven: Attitudes to community engagement in licensing

Licensing leads acknowledged that at a neighbourhood level there existed a low base of involvement in licensing decision-making, despite expectations from licensing authorities that community members take a proactive investigatory stance to licensing issues. One licensing lead cited the non-reporting of issues which flouted licensing laws, including under-age drinking in licensed premises, as evidence:

“I am sure that people within the community would have known that that was probably going on but erm, nothing was reported to me in that regard, so we’re starting from zero information from the community” (Area D).

A reduction in funding to local authorities was acknowledged as contributing to reduced opportunities for community engagement around licensing:

“Things had happened in the past but it kind of all got stopped and lost when there was a lot of, when all the austerity measures were stepping in around 2015” (Area H).

For one local co-ordinator, low levels of community engagement

were attributed to a 'fear of reprisals', as any official representation to the licensing authorities become 'public':

"... and sometimes I have had conversations with members of the public 'but I don't want my name going in the public domain'" (Area A).

Encouragingly, licensing leads welcomed CICA as an approach that could improve the rate and type of intelligence received by the licensing team:

"... best information you can get is from community because they do know what's going on, on the ground" (Area D).

They reflected that building and enhancing new or existing relationships that could support licensing objectives was a positive aim for CICA:

"the idea of having local people with knowledge around the licensing system which typically they don't have as lay people. And then knowing how to effectively engage in the process, yeah, I think there are definitely benefits for that" (Area H).

Local co-ordinators and licensing leads commented on the gains that had been made in developing new relationships through the training and the potential for public health improvements through more partnership-based working in the future.

3.2.4. Theme eight: Alignment with strategic, political and policy context

Finally, stakeholders reported implementation as being affected by the extent to which CICA aligned with local alcohol harm strategies and the political and policy contexts of their local areas. Some stakeholders reported variable levels of support from their democratically elected local representative (local councillor) which impacted on perceptions of wider support for a place-based community led approach:

"I was kind of hoping I'd have a bit more support from the councillor" (Area C).

In contrast, some highlighted the significant role of LA Directors of Public Health (DPHs) in supporting CICA:

"... We've got [name of DPH]'s full sort of weight behind not only the alcohol health champions but also the health champion network in general" (Area E).

Some local coordinators reported issues with commissioning arrangements and others with key role vacancies at the time of implementation (e.g. no full-time commissioning lead) which created barriers in gaining 'buy-in':

"The problems you've got when you're not commissioned ... is, I have to try and get buy-in from that multi-agency team and it's difficult, one thing I don't have any influence ... it's different to, to areas where a commissioner is directly commissioning a provider service; and, which a community health promotion like this is embedded into what they do" (Area F).

4. Discussion

To our knowledge this is the first process evaluation study of the initial implementation phase of a programme to mobilise communities to act on alcohol harm. Given the complexity of this intervention, it is unsurprising that stakeholders experienced a range of barriers and facilitators to success during this phase, and these differed from place to place.

All areas found recruitment of volunteers who resided or worked in a specific, defined small area (circa 1600–5500 residents) challenging. Taking a place-based approach was based on the intervention theory

(Cook et al., 2018). The intervention was also tightly constrained to specific LSOA boundaries to support the outcomes evaluation (i.e. the comparison of LSOA-level statistical data from intervention areas with control LSOAs). This was the first time local commissioners and co-ordinators had been required to focus exclusively on delivering a health promotion activity within a limited geographical footprint and as such it required new ways of engaging with communities. In the absence of the need to take part in a formal, externally funded evaluation, it is likely that the volunteer pool would have been widened beyond the target areas. This may have led to a dilution of the place-based approach.

No specific recruitment strategies were employed universally for first generation champions and no 'centralised' direction was provided about how to recruit. Interview data suggested that no formal process of asset mapping took place to identify linkages already in place in each intervention area, and instead 'who to start with', such as a popular opinion leader (Kelly et al., 1991), relied on the knowledge of the local co-ordinator. Universally, local co-ordinators described a high level of personal involvement, which they had not anticipated, in recruiting to meet the needs of the programme. Different areas used different methods to identify potential volunteers to train as AHCs. Some local co-ordinators felt having a lead provider service with direct links to local alcohol treatment services, outreach work and recovery support, offered the potential to recruit volunteers from this community i.e. existing or past alcohol treatment service users. However, most local co-ordinators felt having a provider with existing volunteer contacts, an interest in community work and the capability to support volunteers was beneficial; suggesting that the predominant CICA 'work' required expertise in community-centred volunteering. As well as these considerations, local operational coordinators suggested the ability to develop local wisdom and to become locally 'known' in the target locality where limited relationships previously existed were more important than the day-to-day 'business' of the provider. The findings therefore show that commissioners and providers seeking to develop assets-based approaches need time to establish confidence and networks within local communities in order to develop a partnership-based approach prior to intervention implementation.

The findings also demonstrate that establishing a locally led alcohol health champion programme requires a robust local infrastructure to support it, including formal (free community centres or cafes) and informal (local volunteers) assets. Barriers, for some, included absence of a training infrastructure that could award the formal RSPH qualification. Honing the training content to reflect the specific needs of the AHCs, the local area and the licensing context within that area, were identified as beneficial for engagement and increasing individual AHC self-efficacy. This supports previous findings regarding matching the intervention to the needs of the target population and neighbourhood (Watson et al., 2018). Furthermore, given the concept of cascade training was considered 'quite daunting' by local co-ordinators, exploring whether they would have benefited from additional support to underpin the delivery of cascade training would be useful. For future work, it would be helpful to understand whether local co-ordinators and AHCs consider themselves to have the 'therapeutic commitment' to deliver IBA (Thom et al., 2016); i.e. the extent to which they feel they have adequate knowledge, training and experience to address alcohol issues within their communities, including perceptions of their role legitimacy.

From a licensing perspective, links between LA licensing teams and AHCs needed to be built from a low level. Fear of reprisals appeared to be a factor that could affect community engagement with the licensing process. While some licensing leads welcomed the opportunity to strengthen local intelligence within the CICA areas, CICA was also seen to foster proactive engagement in participatory licensing processes (McGrath et al., 2019; Reynolds et al., 2020) with the training events providing new opportunities for partnership working between local public health and licensing teams.

Local co-ordinators described grappling with understanding the role of an AHC due to its 'newness', and the requirement to set up novel ways

of working. They celebrated the social value gained by AHCs through gaining new experiences, accreditation and improved confidence. However, these personal successes added to AHC attrition as some subsequently took up employment within three months of training, leaving them with insufficient time for the role.

Stakeholders' testimonies demonstrate a lack of shared understanding across all areas and amongst leads locally of what CICA entailed. Overall, interviews demonstrated that a range of challenges arose when trying to communicate: the learning outcomes of the training; who the target population was for volunteer recruitment; and, the expectations of the AHCs post-training. The challenges around 'selling' CICA as a product suggested that, despite successfully securing volunteers to attend a two-day course, individual participants may not have known exactly what they had signed up to.

Additionally, consistent with previous findings (Watson et al., 2018), the extent of strategic and political support at a local area level impacted on the success of this phase of implementation. Policy climate was also influential as many provider services were experiencing change and changes were not consistent across areas. In fact, in one area, despite an original commitment, the intervention was not established. This was attributed to a challenging period regarding the changing of commissioning organization and lack of capacity to manage volunteers. However, while operationally, models of service provision varied, CICA was deliverable through all models. Efforts to establish and roll out CICA occurred at a time of scarce resources due to austerity measures imposed by central government (Gray and Barford, 2018), a known barrier to effective implementation (Watson et al., 2018). In areas where commissioners were unable to influence an existing or future 'service level agreement' (i.e. contract), the intervention either could not progress or creative workarounds needed to be found.

This study focuses on the barriers and facilitators experienced by policy and practitioner stakeholders within the first three months only of implementing CICA. Insights from CICA will be further developed by analysis of the experiences of the AHCs and by analysis over a longer follow-up period (12 months) with stakeholders, which will be reported in due course.

There were limitations imposed by the randomised order of the intervention roll out, staggered over nine months. This was required for the statistical evaluation, which uses a 'stepped wedge' design (Cook et al., 2018). Thus, the areas that started CICA later benefited from informal sharing of experience from those areas that introduced CICA earlier, and therefore the interviewees' experiences were not consistent in terms of their prior background learning. There were some limitations with the set-up of the intervention. These lead us to conclude that practitioners would benefit from clearer guidance on how to implement CICA or other place-based community development health promotion interventions. This finding is directly informing work currently underway to produce an evidence informed toolkit for use by public health practitioners and, service providers.

The findings of this research have led to several recommendations to support effective implementation of a place-based health promotion utilising community assets:

- Ensure all stakeholders have a clear understanding of the place-based 'role' being implemented, including its scope and purpose.
- Ensure providers or commissioned services have clear understanding of own role; anticipated outcomes; and, the skills and capacity to support inexperienced alcohol/health issue focused volunteer groups.
- Prepare the ground at community level, well in advance of a formal implementation period, to build community understanding, support, and involvement to aid recruitment at the appropriate time.
- Develop and resource a multi-pronged recruitment strategy utilising digital technologies, social media, community influencers, leaflets/posters and word-of-mouth.

- Be prepared for a longer/sustained period of supporting new champions—especially since the aim is to target areas of high need where existing levels of confidence and literacy might be low.

5. Conclusion

In summary, we identified eight themes which influenced the initial implementation phase of CICA. By evaluating the barriers and facilitators experienced by stakeholders at this stage, we can learn from practice (Delivering Alcohol, 2015) and make recommendations to improve future programmes. We believe these recommendations will have applicability for other ABCD volunteer-led champion programmes tackling health inequalities at a local level.

Authors' contributions

PAC, EJB, MC, SA and KA designed the project. SCH and EJB conducted the interviews. SCH carried out initial coding with MC. SCH indexed and mapped the data. SCH, EJB, MC and CU analysed the data. CU drafted the manuscript for review by all authors. All authors contributed to further drafts of the manuscript and approved the final version of this manuscript.

Availability of data and materials

The datasets analysed during the current study are available from the corresponding author on reasonable request.

Consent for publication

All participants gave permission for their comments to be published in an anonymised form.

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Ethics approval and consent to participate

This study was granted approval by the University of Salford Research, Innovation and Academic Engagement Ethical Approval Panel (HSR1617-135). All participants gave written informed consent.

Declaration of competing interest

The authors declare that they have no competing interests.

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Abbreviations

ABCD Asset Based Community Development
AHC(s) Alcohol Health Champion(s)

CICA	Communities in Charge of Alcohol
IBA	Identification and Brief Advice
LA(s)	Local Authority(ies)
RSPH	Royal Society for Public Health
WHO	World Health Organization

Appendix 1. CICA Key Stakeholder Interview Guide

1. Could you tell me about how you came to be a local lead for CICA?

[Prompts].

- Who suggested that you should become a local lead?
 - What was it about your current role that made you an ideal person?
 - How did you feel about being nominated as a local lead?
2. What have the challenges been (if any) to establishing CICA in your local area?

[Prompts].

- Willingness to establish the intervention (personal and/or colleagues)
 - Recruitment of champions
 - Any practicalities for roll-out e.g. funds, room hire, RSPH centre
3. Local Public Health and provider leads only: What reactions or responses have you had so far when promoting the Alcohol Health Champion training and CICA programme?
4. Can you describe the target area to me in terms of the harms due to alcohol?

[Prompts].

- Availability of alcohol – pubs, bars, clubs, off-licences
 - Noise, litter, any other anti-social behaviour
 - Crime, accidents, injuries
 - Alcohol sales to children/over serving alcohol to people who are already drunk
5. Thinking about current licensing activity in the area, to what extent have local community members been involved in licensing issues before CICA?

[Prompts].

- Active in reporting issues
 - Active in objecting to new applications
6. And finally, can you tell me about anything that is going on in the area to try to reduce alcohol use?

[Prompts].

Activities/projects/policies If none known, proceed to question 7.

7. Anything else further you want to add or consider further, which you haven't mentioned so far?

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