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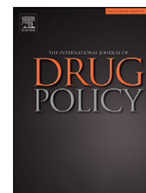

Research paper

How can communities influence alcohol licensing at a local level? Licensing officers' perspectives of the barriers and facilitators to sustaining engagement in a volunteer-led alcohol harm reduction approach

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ABSTRACT

Despite the World Health Organization's assertion that communities need to become involved in reducing alcohol harm, evidence of community engagement in alcohol licensing decision-making in England remains limited. The evaluation of the Communities in Charge of Alcohol (CICA) programme offers policymakers, Licensing authorities and public health practitioners, evidence regarding a specific volunteer-led, place-based approach, designed to enable community engagement in licensing with the aim of reducing localised alcohol harm. This study explored factors affecting the sustainable involvement of volunteers in alcohol licensing decision-making from six licensing officers' perspectives, through semi-structured interviews. Routinely collected crime, disorder, and hospital admissions data were reviewed for further context as proxy indicators for alcohol-related harm. Licensing officers perceived sustainable engagement to be impacted by: (i) the extent of alignment with statutory requirements and local political support; (ii) the ability of licensing officers to operationalise CICA and support local assets, and; (iii) the opportunity for, and ability of, volunteers to raise licensing issues. The perspectives of licensing officers indicate complexities inherent in seeking to empower residents to engage in licensing decision-making at a community level. These relate to statutory and political factors, funding, social norms regarding engagement in licensing decision-making, and the need for networks between critical actors including responsible authorities and communities. The evidence indicates that after increasing community capacity to influence alcohol availability decision-making at a local level, communities continue to struggle to influence statutory processes to affect alcohol availability where they live and work. More understanding of how to enable effective community engagement is required.

Background

A significant positive correlation between alcohol outlet density and alcohol consumption is reported in the literature (see for example Burton et al., 2017). Evidence suggests that local policies and decision-making to reduce alcohol availability and accessibility can reduce alcohol harm in different geographical settings including Australia (Coomber et al., 2021; Miller et al., 2014) and North America (Jernigan, Sparks, Yang, & Schwartz, 2013; Wagenaar, Gehan, Jones-Webb, Toomey, & Forster, 1999; Zhao et al., 2013). Multi-component community programmes in Stockholm (Ramstedt, Leifman, Muller, Sundin, & Norstrom, 2013; Wallin, Gripenberg, & Andreasson, 2005) have also shown small reductions in acute alcohol harm. Furthermore, in England, in areas where policies that managed the physical availability of alcohol were implemented and enforced, a 5% reduction in alcohol related hospital admissions was experienced (de Vocht et al., 2015).

The World Health Organization (WHO) sees a key role for communities in reducing alcohol harm at local levels (WHO, 2014). In England and Wales, the sale of alcohol is subject to the Licensing Act 2003, which explicitly recommends that there is community involvement in licensing decision-making (Home Office, 2018a). This can be achieved through statutory processes, consultation processes, representation or

Abbreviations: ABCD, asset-based community development; AHC(s), alcohol health champions; CICA, Communities in Charge of Alcohol; GM, Greater Manchester; LA(s), local authorities; RA(s), responsible authorities.

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Table 1
Intervention area licensing characteristics including number of alcohol health champions (AHCs) trained and licensing officer engagement.

Area characteristics	Intervention areas								
	1	2	3	4	6	7	8	9	10
Number of licensed premises in intervention area at the start of roll out	8	59	0	3	20	17	9	22	20
Number of first generation AHCs trained	10	8	13	7	6	7	9	7	6
Total number of AHCs trained during intervention period	16	20	13	11	9	7	22	15	10
Number of cascade training events held during intervention period	1	1	0	1	1	0	4	2	1
First generation training event attended by licensing lead	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cascade training event(s) attended by licensing lead	Yes	Yes	N/A	Yes	No	N/A	Yes	Yes	No

other relationship-focused initiatives at local level (Reynolds et al., 2018). However, a recent systematic review identified just one example of research into community engagement in licensing decision-making in the UK (McGrath et al., 2019). Furthermore, the authors noted that this UK dearth of published examples of community engagement corresponded with experiences in other contexts, including Australia and New Zealand.

Here, we examine local authority (LA) licensing officers' perceptions of a volunteer-led, community-based approach to reducing alcohol harm - Communities in Charge of Alcohol (CICA) (Cook et al., 2018). CICA aimed to increase the strengths, motivations and confidence of volunteers and their communities to enable them to influence licensing decision-making. Through completing a Royal Society for Public Health (RSPH) Level 2 Understanding Alcohol Misuse training course, supplemented by additional training focused on licensing policy in England, local volunteers became formal community 'assets' known as alcohol health champions (AHCs). These community-centred assets (PHE, 2015) were trained in two distinct roles: (i) to deliver alcohol advice to members of their community, and; (ii) to influence alcohol-related licensing issues in their localities. Given the limited published research regarding community involvement in licensing decision-making, the focus of this paper is the licensing element of the AHC role. Barriers and facilitators to the initial implementation of CICA have previously been reported (Ure et al., 2021). In this paper, we use empirical evidence gathered from licensing officers across nine different LAs to analyse the barriers and facilitators which supported or impeded community activity around licensing at 12 months post implementation of CICA. The aim was to: understand factors affecting sustainable community involvement from a licensing officer perspective; and identify recommendations to be considered in future interventions that use community-based volunteer assets to reduce alcohol availability and accessibility.

Methods

The intervention

CICA was developed as part of the Greater Manchester (GM) alcohol strategy (2014-17). Viewed as an asset-based community development (ABCD) approach, a collaborative agreement to deliver CICA was signed up to by the Directors of Public Health for all 10 of GM's LAs. In this agreement, the initial set up phase of CICA received financial backing, but this did not cover operational support at a local level. A half day training session on licensing was provided to an initial (first generation) cohort of volunteers. Further volunteers were trained using a cascade approach (Ure et al., 2020). The total number of volunteers trained (n=123), ranged across each of the 10 areas from seven to 22 (Table 1). Licensing officers, who had been delegated as the lead officer for the CICA programme for their local area (henceforth referred to as 'licensing leads'), were invited to attend and co-facilitate the training. Table 1 provides an overview of the licensing context by LA; number of AHCs trained and licensing officer engagement.

Box 1
Responsible authorities

The Licensing Act (2003) for England and Wales identifies the following agencies as 'responsible authorities' (RAs) at local government level (Home Office, 2018):

- police
- local fire and rescue
- primary care trust (PCT) or local health board (LHB)
- the relevant licensing authority
- local enforcement agency for the Health and Safety at Work etc Act 1974
- environmental health authority
- planning authority
- body responsible for the protection of children from harm
- local trading standards
- Home Office immigration
- any other licensing authority in whose area part of the premises is situated

Responsible authorities and the general public have a right to comment on applications for new licences to sell alcohol; to revisions of existing licences, and; to call for reviews of existing licences (Reynolds et al., 2020). Responsible authorities are notified of every application for a new premises licence or variation of existing licence (LGA, 2019).

Volunteers received training in: The Licensing Act 2003; the LA's Statement of Licensing Policy; the role of 'responsible authorities' (Box 1); the availability of public licensing registers of applications received and premises licences issued; and how to influence licensing decision-making through making 'representations' or objections that address at least one of the four licensing objectives: (i) the prevention of crime and disorder; (ii) public safety; (iii) the prevention of public nuisance, or; (iv) the protection of children from harm (PHE, 2019a).

The intervention's logic model (Cook et al., 2018) anticipated that community involvement in licensing activities would be measurable using 'formal metrics' including: the number of licence reviews requested, and representations made; and 'informal metrics' including the number of premises licences challenged, investigations initiated, and issues reported to local licensing authorities. These would act as a proxy measure for community engagement.

Design

This qualitative study involved semi-structured one-to-one interviews with licensing leads 12 months post implementation of CICA. Routinely collected data relating to alcohol harm and descriptive statistics of licensing applications were reviewed to understand context. Ethical approval was granted by the University of Salford ethical approval panel (HSR1617-135) on 30.05.17.

Data collection

a) Routine data

The local communities where the CICA intervention was targeted were defined by small geographic units of population, known as lower layer super output areas (LSOAs). Five LA licensing authorities were

asked to provide data on 'formal metrics' i.e. the number of representations made and licence reviews requested, relating to the electoral ward in which the target LSOAs were located (see Table 2). Wards were chosen as the geography because LSOA-level licensing data were not easily available; typically, there are four to six LSOAs in a ward. Four authorities cited lack of staff capacity for non-provision of data. Pre-intervention data for specific crimes and health outcomes were obtained from multi-agency groups, in line with de Vocht et al. (2020), to provide descriptive context of the intervention areas.

b) Interviews

Sampling was purposeful. Licensing leads involved in AHC training from nine LAs were invited by email to participate in a telephone or face-to-face interview 12 months after the first training session for AHCs. Licensing leads from Areas 1, 2, 6, 7, 9 and 10 participated. Licensing leads from Areas 3, 4 and 8 did not respond to interview requests. The intervention did not take place in area 5. The area numbers are consistent with previous publications on this intervention (Ure et al., 2021).

Five telephone interviews were conducted by SCH and one face-to-face interview by EJB. Audio-recorded interviews ranged between 14.6 and 38.3 minutes (average 22.18 minutes). Box 2 summarises the interview questions.

Box 2
Summary interview guide (See Appendix 1 for full interview guide).

- How licensing leads became involved with the CICA programme
- What they thought about the CICA programme
- Awareness of local commissioning arrangements in place at the start of the project
- Personal experiences of the strategic/managerial aspects of CICA
- Experiences of the first phase of training (first generation).
- Experiences of cascade (second generation) training.
- Experiences in respect of licensing, specifically with regard to:
  - Relationships that worked well
  - AHC involvement in licensing issues locally
  - Wider community involvement in licensing issues as a result of CICA
- Benefits (or otherwise) of CICA for those involved.
- Perceptions of how successful CICA could be if rolled-out into further areas within GM/outside GM.

Data analysis

a) Routine data

Crime rates (violent, sexual, public order offences and anti-social behaviour) per 100,000 population were calculated for each area by summing the number of crimes reported within the year preceding the intervention and dividing by the average mid-year population for the same time period. Crime data came from Greater Manchester (GM) Police and mid-year population data from the Office of National Statistics (ONS, 2020). Alcohol-attributable fractions for hospital admissions data, defined as "admissions to hospital where the primary diagnosis is an alcohol-attributable code or a secondary diagnosis is an alcohol-attributable external cause code" (PHE, 2020), were calculated for each area.

b) Interviews

Full transcripts of all interviews were subjected to the five stages of framework analysis (Box 3) (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Ritchie & Spencer, 1994; Ward, Furber, Tierney, & Swallow, 2013) as part of a framework analysis of a wider group of stakeholder interviews.

Results

a) Contextual information from routine data

The intervention areas ranged in size from 1600 to 5500 population and were distinct communities identified by each LA's Public Health team as having high levels of alcohol harm in comparison to the rest of the borough. Intervention areas varied in size from one LSOA to three LSOAs. Data on the numbers of premises licence applications, reviews and representations processed within 12 months prior and 12 months during the CICA intervention were incomplete. Four areas provided data that, to our knowledge, was complete. One further area (area 4) provided a full set of data with only one example of a new licence application but did not clarify which year the licensing application pertained i.e. the 12-month period pre-CICA rollout or the 12-month intervention period. Four authorities did not provide data due to COVID-19 related capacity issues. Data were at a larger geography (ward level) compared to the CICA intervention areas, but nevertheless showed that activity had been limited, even in the areas with more licensed premises (see Table 2). Alcohol-related hospital admissions varied from 572 to 1,359/100,000 (NHS Digital, 2020), and rates of major offences ranged from 1,545 to 14,477/100,000. Data at such a geographic granularity can be used to support scene setting when making representations at licensing hearings, or for more strategic considerations, such as cumulative impact policies (PHE, 2019b).

Despite a persistent context of alcohol related harm, Table 2 suggests that while all areas reported receiving new premises licence applications during the intervention period, only one area (area 8) recorded receiving any representations to raise concerns. Representations against new applications did increase in area 8 during the 12-month intervention period, though the licensing lead reported that these were made by LA councillors (elected representatives) rather than community members or public health teams acting as a responsible authority. Four areas recorded applications received for 'full variations' to an existing premises licence during the intervention period. A full variation is an application to significantly change a premises licence that could impact on the licensing objectives (e.g., to extend opening hours). However, only two areas (areas 6 and 8) recorded any representations. Information provided by the area 6 licensing lead indicated three representations were received objecting to one full variation, with one of these representations made by a resident. It is not known whether this resident was influenced by CICA/AHC's work. In area 10, the number of applications for a full variation increased from 1 to 13 during the intervention period, with no concerns or objections raised.

b) Interviews

Three overarching themes were identified regarding barriers and facilitators to operationalising and sustaining CICA in relation to community-based activity around licensing activity. Themes, definitions of themes and subthemes are provided in Table 3. Participants have been anonymised. As such, participant numbers do not relate to area numbers identified in Table 1.

Theme 1: extent of alignment with statutory requirements and political context

(i) **Fit with statutory requirements**

The interviews highlighted challenges for communities and responsible authorities (RAs) in addressing alcohol harm through the existing legal framework if local alcohol harm issues did not directly align with one of the four licensing objectives. Licensing leads highlighted how their practice is guided by statutory requirements which do not include taking a (public) health perspective in England and Wales:

> *"we have a statutory obligation to grant licences to premises or licence holders that have met all the criteria that is set out by the legislation. There*

Box 3
Using framework analysis.

Stage of framework analysis	Approach taken
Familiarisation	Audio recordings were listened to and interview transcripts (n=6) read to familiarise the first author with the content.
Identification of a thematic framework	An initial coding framework was identified using themes developed for baseline interviews (Ure et al., 2021); and, themes previously identified in the literature (Watson et al., 2018). New themes e.g. 'legacy' were added from the interview guide. New coding was identified inductively from the transcripts following line by line coding and added into the framework. Using this initial framework, four transcripts were independently coded by CU, MC and SCH. In MS Word, data were highlighted, and the comments function used to annotate text against pre-determined themes. New codes were assigned to new ideas and assigned to themes where there was a 'fit' or identified as 'other', enabling discussion, revision and refinement of codes, subthemes and themes.
Indexing	Following refinement of the coding structure within the thematic framework, the framework was systematically applied to all transcripts in Microsoft Word.
Charting	A matrix was created for each theme in Microsoft Excel by abstracting, summarising and charting data for each case (licensing lead) and each code within an overarching theme.
Mapping and description	Thematic analysis was carried out on the Excel spreadsheet dataset by establish connections and associations across the themes, and between cases. Preliminary findings were discussed and refined with the wider research team. These discussions facilitated the need for local contextual data to underpin the findings and provide greater understanding of each case site (local area) and supported more nuanced understanding of the data given. Data from case sites were compared to identify similarities and differences in the barriers and facilitators identified.

Table 2
Characteristics of CICA intervention areas.

Area Characteristics	**Intervention areas**								
	1	**2**	**3**	**4**	**6**	**7**	**8**	**9**	**10**
Number of LSOAs	2	1	1	2	2	3	2	2	2
Availability of a full[1] public licensing register	Yes	Yes	No	Yes	No	Yes	No	No	No
Licensing data[2]									
Number of new licensing applications made[3]	-	-	-	1[8]	2(1)	-	2(6)	9(4)	28(56)
Number of full variation[4] applications made	-	-	-	0(0)	3(1)	-	1(2)	1(4)	1(13)
Number of minor variation[5] applications made	-	-	-	0(0)	3(4)	-	1(2)	0(0)	0(17)
Number of reviews of licences	-	-	-	0(0)	0	-	0(0)	0(0)	-
Number of licensing representations made on new applications	-	-	-	0(0)	1(0)	-	0(4)	3(0)	-
Number of licensing representations made on full variation applications	-	-	-	0(0)	2(3)	-	0(5)	0(0)	-
Number of licensing representations made on minor variation applications	-	-	-	0(0)	0(0)	-	0(0)	0(0)	-
Number of representations/reviews requested made by AHCs during the intervention period	0	0	0	0	0	0	0	0	0
Crime rate per 100K pop. in the year preceding CICA rollout									
Public Order offences	712	4810	710	629	1155	785	467	324	1164
Sexual offences	441	416	376	126	141	109	55	76	58
Violent offences	1662	9251	2424	881	2334	1332	1483	1144	1600
Total Major offences[6]	2816	14477	3510	1635	3631	2226	2005	1545	2822
Anti-social behaviour offences	2070	6846	2507	1352	2405	2043	1895	1316	2182
Alcohol harm related hospital admissions per 100K pop.									
Alcohol-attributable fractions for hospital admissions[7]	976	1335	1359	572	726	591	1011	936	970

[1]Full public access is defined as an online public register containing details of the named Designated Premises Supervisor, Opening Times, Permitted Activities and Hours Granted, and Conditions attached to the licence.
[2]Licensing data are provided for the 12-month period pre-CICA rollout and (in brackets) for the 12-month intervention period at electoral Ward level, which typically encompass 2 LSOAs. Electoral wards vary in size, typically ranging from 1000-30,000 people (OCSI, n.d.).
[3] A dash [-] indicates no licensing data was provided.
[4] E.g. an application to extend hours of trading, adding other licensable activities or amending a condition (Cheshire West & Chester Council, 2018).
[5]For example, a variation to a premises licence that does not adversely affect the four licensing objectives (Home Office, 2012).
[6]Total Major offences = Public order offences + Sexual offences + Violent offences.
[7] These are not counts of whole admissions or actual persons admitted. They are the total number of admissions to hospital considered to have been caused by alcohol consumption, by LSOA of residence and by the year in which the episode ended, based on summing the proportion of each admission considered to have been caused by alcohol consumption (also known as the alcohol attributed fraction).
[8] Clarification over which 12-month period these data were applicable to was not provided.

Table 3
Barriers and facilitators affecting operationalising and sustaining community involvement from a licensing perspective.

Theme	**Theme definition**	**Subthemes**
Extent of alignment with statutory requirements and political support	*The extent of backing from licensing authorities and the formal national, community or system regulations (rules, policies, laws) impacting the intervention*	(i) Fit with statutory requirements (barrier) (ii) Extent of political support (barrier)
Ability to operationalise and support local assets	*The availability of funding as related to the intervention; and the physical, technical, service and training structures or resources existing in the community or larger system in which the intervention is embedded*	(i) Funding and capacity to provide ongoing support to AHCs (barrier) (ii) Identifying and harnessing useful assets (barrier and facilitator) (iii) Meaningful training provision (facilitator)
Opportunity for and ability to raise licensing issues	*Beliefs, values, customs and practices of the community and licensing processes within which the intervention is embedded in relation to licensing*	(i) Traditional low levels of community engagement (barrier) (ii) Ability to identify AHC involvement in licensing activity (barrier) (iii) Working with responsible authorities (barrier) (iv) Place-based factors affecting licensing engagement (barrier) (v) Building community capability as health assets (facilitator)

are mechanisms that if a premises is not doing what they are supposed to do and promoting the licensing objectives, then those people can be called to task. So, the pathway side of it and the health side of it really for me isn't our avenue" (P8).

Indeed, the impact of alcohol harm at a local level was reported by one licensing lead as something they were largely uninformed about:

"I am not involved with the, for instance, the public health people, I don't see the data on alcohol abuse in certain areas, or anything like that, I wouldn't be able to comment on the impact locally, but I am sure there is an impact" (P6)

While LA public health teams operate as RAs and have the opportunity to comment on licensing applications, Participant 8 indicated that comments were '*very few and far between*':

"Although licensing legislation in Scotland does have public health licensing objective, in England and Wales, it doesn't. Albeit the public health is what we call a responsible authority and can make comments on licence applications, they are very few and far between" (P8).

One licensing lead described how support had been sought by the public health team to understand how they could make effective licensing representations using health data. Advice was provided about relating the objection to the *'public safety'* licensing objective:

"So the sort of thing I discuss with the colleagues from public health is, where you have an area where you've got a, sort of, there is public health evidence of high deprivation or wholesale alcohol abuse or something of that nature, if they have that data and those statistics, a relevant representation may be that they will say well, look, … the admissions data for this particular area of [name of LA]*- the hospital - these are the number who were treated for alcohol issues or here is this piece of data or that piece of data. And essentially their argument - the last thing that this area needs now is another place selling alcohol or an existing off-licence that is deciding it's going to open until two o clock in the morning, for example. And their argument would be, well, on the basis of public health and public safety, this shouldn't be allowed" (P6).*

(ii) **Extent of 'political' support**

None of the licensing leads made any reference to CICA having wider backing from public officials or locally elected council members in their LAs, suggesting alcohol harm was not a political priority at the time. Only one licensing lead highlighted being supported by their line manager regarding their involvement in delivering training to the AHCs:

"My Head of Service has been supportive of doing it and allowed me to have the time to go and do the presentations and so on" (P8).

One licensing lead noted that by attending the training of AHCs and gaining greater insight into the ambitions of CICA their own support for the programme grew:

"after I'd been to it my view did change about…because I knew a little bit more about what the aim of it was. So, my view did change, and I thought it was a good idea what was going on" (P3).

However, while understanding the ambitions of CICA and the value of developing a community place-based approach, Participant 10 did not view implementing CICA as something for which they had responsibility or ownership. Although not explored or reported explicitly, this may have been a barrier to proactively engaging with AHCs in their area:

"I guess I came on board to offer the licensing experience and support, as opposed to… I don't know, I guess have like ownership or sort of I'm not sure if sort of responsibility, it's the right word but ..You know, if it was my project as it were I wouldn't have considered it that" (P10).

Theme 2: Operational concerns and approaches

(i) **Funding and capacity to provide ongoing support to AHCs**

Despite the national recommendation to encourage greater community involvement in licensing, licensing leads identified how limited funding impacted on their ability, and the ability of wider licensing teams, to engage with the community, including through rolling out CICA:

"this is a very commendable project, it's something that I think that most, if not all of them [licensing managers]*, want to be involved in, want to try and support, but in practical terms, the levels of support they could give it would be limited, because of the pressures on their licensing teams across the region" (P6).*

With licensing leads having to absorb their involvement in CICA into their existing workload, two participants identified issues around how '*capacity*' would impact ongoing '*commitment and motivation'* and the sustainability of CICA:

"I guess it's getting like a lot of things, it relies on sort of the capacity and I guess commitment and motivation and sort of… I suppose one of the challenges is keeping that up" (P10).

Despite legislative guidelines recommending community involvement, Participant 3 indicated that a re-negotiation of time related to CICA would be required suggesting an ongoing challenge of committing capacity to establish, foster and develop community-based relationships:

"time is of the essence unfortunately, especially now we're cut to the quick because I was going to say that to you. If you're running any more [cascade training courses] *I would then have to…we've got a new different management structure, I'd have to run it past our management to make sure it was okay that I attended and stuff like that" (P3).*

(ii) **Identifying and harnessing useful assets**

Given the role AHCs were anticipated to play in licensing activity and the opportunities for licensing leads to co-facilitate AHC training, it was notable across all interviews that discussion about licensing leads engaging with the AHCs themselves over the 12-month intervention period was limited. Interestingly, of the six licensing leads interviewed, two (Areas 6 and 10) reported not being involved in cascade training in their area, despite second generation training taking place, suggesting that community-based engagement in alcohol licensing activity was not a priority at this time. One licensing lead did reflect on their likelihood to engage further with AHCs. Their perception was that this was more probable if AHCs were proactively bringing issues to the attention of the licensing leads/unit/department; that the lever for engagement was a level of activity and insight at local levels which actively sought out licensing engagement rather than a licensing lead proactively engaging with AHCs around intelligence gathering:

"I suppose the key to it is the proactivity and I suppose the areas that there is more engagement, there is maybe a higher degree of proactivity from the person, from the residents, is to 'look, we have these issues, how can you help us?' I suppose there is the tendency to think, oh if you don't hear anything everything's fine you know and take that approach" (P10).

Only one of the licensing leads identified the cohort of trained AHCs as an asset with whom they were working on an ongoing basis to have wider conversations in the community around alcohol harm:

"getting feedback from the community in what's called the [name of LA] *'Let's Talk About Alcohol' campaign and some of the CICA volunteers are involved in coming to those sessions" (P4).*

This licensing lead identified a need for the LA to harness AHCs' interest; engage them in relevant alcohol harm reduction activities; and consider ways to retain engagement over the longer term, although it

is notable that the activities discussed do not directly relate to licensing decision-making:

> *“perhaps involving them in those projects* [the ‘Reducing the Strength’ and ‘Challenge 25’ campaigns] *and (…) like keeping them involved, like I said we wouldn’t want them to just attend that training session, hear that information and then be completely detached from, from it. And in terms of scoping that role, like I say it’s just when we do go and, or if public health or whoever it may be, have events on or whatever, they’re involved and brought to them really just so, so they can be part of it and keep their interest, engaged, keep them engaged […]. Because they’re engaged initially at the training session and you wanna keep that engagement ongoing rather than just for that one time, then that’s the key isn’t it?” (P4).*

It was mooted that to gain more impact from AHCs as formal assets, the communities within which they were situated needed to become more aware of the AHCs presence and role:

> *“Making the wider public at large aware of it, so that they know how they could get involved in it and just promoting the fact that there are these volunteers who are in the community, who’ve been trained who have an awareness of how they can get involved and just the promotion of it really” (P4).*

Involvement in CICA had made some licensing leads reflect on the wider presence of volunteer-led community assets. In one area, where CICA had been less successful at becoming established, the licensing lead reflected on environmental volunteer groups working at a community level but was less aware of sustainable volunteer-based projects focused on ‘*social*’ outcomes, such as alcohol harm:

> *“we have ‘Friends of Parks’ groups for instance in* [name of LA]…*I think the approach for the environmental stuff, that’s quite a common thing. Social stuff, I don’t know” (P6).*

Another licensing lead reflected on the challenges of accessing communities on an ongoing basis due to limited resources. They suggested professionals already working at community level, such as community police officers, could become useful AHCs. This suggests that at 12 months some licensing leads were still reflecting on how to continue capacity building and develop assets at a local level.

(iii) **Meaningful training provision**

Four licensing leads suggested the licensing element of the training course could be amended to make it more meaningful and appropriate for AHCs as it was *“a little bit too in-depth”* (Participant 4). Suggestions were made regarding the key licensing elements that needed to be delivered in the training:

> *“Effectively somebody who’s getting involved in a licensing application needs to be aware of the licensing objectives and they need to be aware of the timescale and they need to be aware of the point of contact of where they can make the applications and those are the key elements of it really” (P4).*

Another licensing lead stated AHCs only needed to know *‘the basics’:*

> *“I think laymen only need to know basics. So, it doesn’t have to be any in depth about this is how licensing works and, you know, maybe about all the law and everything else. They need to know the basics and, you know, people put in application, they put a blue notice up, it’s in the paper. You can then do this at this point” (P3).*

Licensing leads found that by changing the licensing input at the cascade stage they felt they gained more ‘*buy-in*’ from AHCs*:*

> “[the training input] *being at a higher level wasn’t really suitable or relevant and when it was pitched at the right level, that, that helped with their buy-in” (P4).*

One licensing lead felt the licensing aspect of the CICA intervention would benefit if AHCs were involved in additional activities to help extend their involvement in licensing beyond the training session:

> *“rather than maybe just having a training session, it’s like right, go away and you know do stuff, or you know …as a variation… you may be, you know, I guess, an ongoing programme” (P10).*

While licensing leads suggested the licensing content of the course was overly complicated and could be amended to be more appropriate, two officers suggested that getting engaged in licensing issues at a community level was straightforward. One lead stressed that AHCs were *“told of how simple it can be to get involved”* (P4). A second lead expanded by outlining the approach AHCs and community members should take:

> *“I mean what we do is, every council has to, list the applications - current applications in consultation, on the website. And I guess what we do is we have a link if somebody wants to comment and some guidance notes around submitting the comments and trying to do so effectively. And we include in our policy separate advice on that. So, there’s a section on doing that. And if people are reluctant, how they… I suppose alternative measures for having those concerns raised. So, we do have information that we publicise and have available on how people can engage and do so effectively, and then also equally raise concerns. It’s things like that you can pretty easily do through the website” (P10).*

Licensing leads therefore felt that processes existed to support community engagement, and this could be achieved *‘pretty easily’*. However, licensing leads’ testimonies raised a range of broader factors that may have impacted on the AHCs’ ability to engage in licensing issues within the 12-month period of the CICA intervention.

Theme 3: Raising licensing issues

Significant differences existed between the LAs in the number of licensed premises situated within the CICA LSOAs (Table 1: Range: 0-59). Logically, this would suggest some communities had greater opportunity to become involved in the licensing process than others. However, despite this, there were no differences in the perceived level of involvement of AHCs in contesting licensing applications by making representations across LA areas. This was despite the fact that the AHCs had appeared very engaged with the licensing aspect of the training:

> *“I feel like my experience of the volunteers had been that they were all very engaged, certainly with the training and with the scheme. It’s actually from a licensing perspective, getting them to get involved was probably the, the right way of saying that. It’s been…I don’t feel like they’ve been involved as much as we could, as they could have been and as I would have liked, from the start, from the start of the scheme and initiative” (P4).*

Licensing leads highlighted a range of structural barriers they perceived as impacting community members’ ability to influence licensing decision-making:

(i) **Traditional low levels of community involvement**

Area 9’s licensing officer stated they received only one community representation during the 12-month intervention period (from a non-CICA area), indicating community engagement in licensing operating from a low base. When discussing community engagement in licensing more generally, a different licensing lead felt public *‘apathy’* was a barrier:

> *“I just feel that there can be a kind of apathy from the public not to get involved in the applications and that it’s just the same in one, from one area to another area. An area where you’ve got particular alcohol problems, density of premises just as much as you would have an area where you’ve not got those issues” (P4).*

Licensing leads suggested multiple barriers impacted on community members' willingness to make representations, although these perceptions did not appear to be informed by direct conversations with AHCs. Perceived barriers included the *'potential for conflict'*; lack of anonymity; potential need to attend a Licensing Committee '*hearing*'; and concerns about whether their involvement would have an '*impact*' on the outcome:

> *"I think they can possibly get deterred from… there's a range of things. There's the potential for conflict. The… I suppose they could go to a hearing. There might be some doubts as to how realistic an effect or impact they can have" (P10).*

Involvement in one particular licensing issue was facilitated by a licensing lead's personal reassurance to a community member, but there was no suggestion that this involvement was related to one of the CICA areas:

> *"sometimes it comes down to the fear of repercussions, sometimes they feel like they don't want to get involved because they might have a viewpoint but they don't want to get involved but I thought it was my job really to reassure them and particularly one of the complainants who changed her mind initially said that she wanted to withhold all her details and obviously so that (pause) only so much weight can be given to that representation if it's anonymous and everything's taken out of it if they don't attend the hearing" (P4).*

This indicates a potential conflict for community members between wishing to retain their anonymity set against a perception that anonymised community representations limit influence with licensing committees.

(ii) **Ability to identify AHC involvement in licensing activity**

One of the challenges identified by a number of licensing leads was whether they would be able to know if AHCs were becoming involved in informal licensing activities e.g. informing others about the Licensing Act 2003 or wider education of local community members about licensing. They acknowledged that AHCs could be using their training to inform wider community members of which they would be unaware:

> *"So personally, I couldn't really say to you, Oh yeah, I know that happened because it was one of the champions. But that doesn't mean that that hasn't happened and it's just word of mouth and it has been one of the champions who said, Well, try that or do this or go to licensing, ask them the question" (P3).*

> *"I have not had the 'phone calls in terms of it's from a CICA project, but if individual X that lives on* [Name of street]*, whatever, has been to the champion and said, all this information is available on the website, I wouldn't necessarily know" (P8).*

It was acknowledged that AHCs could utilise other routes for licensing information or support which licensing leads would be unaware of:

> *"it may well be that they don't necessarily only speak to me on it. They might speak to the licensing advisors (in RAs) which obviously we are dealing with, with numerous conversations every day" (P8).*

Significantly, one licensing lead indicated *'a lot of'* licensing applications over a 12-month period were *'quite minor'* – assumed to mean minor variations - and therefore uncontested (supported by the data in Table 1) which created a challenge regarding *'objective assessment'* of AHC involvement in increasing community engagement:

> *It's difficult to gauge, because often a range of applications we get over a one-year period, a lot of them will be quite minor and perhaps we won't get any objections at all, because they won't be contested by anyone. Others may be more controversial. And it's hard to gauge whether we would have had more objections or more engagement from the community over any of these, than we would if CICA was in place or not. It's very difficult to make an objective assessment of that (P6).*

One of the challenges identified was that AHC activity would only be recognised if AHCs declared their role, or a community member informed licensing that AHCs had played a role, when a representation was made:

> *"I think the only way we could be sure about that, if we have representations made from persons within this groups, and when they made the representation, they actually said well, actually, we are linked with the CICA project and we've done a lot of work and we've had information from that project and we think, in regard to that, we are going to object and these are the grounds we are going to object. Other than that, they don't say who they are when they object, it's difficult to make an objective judgement" (P6).*

(iii) **Working with responsible authorities**

One lead indicated that the ability of AHCs or community members to address premises licensing issues may be limited unless a co-ordinated multi-agency approach was taken to address licensing applications. Notably, the focus here was on licensed premises as settings that create issues relating to crime and disorder:

> *"So perhaps one sort of route could be, with the projects, for those groups that have engaged with the project, when they have one of these issues, perhaps don't just go straight to the licensing authority, if it's a concern about crime issues, go and speak to the neighbourhood police officers, and say well, look, we've got this application come in, we're really unhappy about this, because of this, this and this. Would the police be prepared to support us, in terms of putting our objection in?" (P6).*

Furthermore, licensing leads identified that communities are *'hampered'* if the relevant RA does not object to an application, limiting the power communities have to raise concerns:

> *"One of the issues, when we have a new premises application, a new premises licence application, is sometimes the residents will object and they might say well, we are going to object on the grounds of crime and disorder, that this premises will increase the levels of crime and disorder in the area. And the applicant will say well, hang on a minute, the police haven't made a relevant representation, the police are quite happy with it and it sort of undermines what the residents are saying, (…) and if police don't object it sort of hampers the residents, it makes it harder for residents to make their argument. Similarly, if you were saying, well, this premises is very noisy and it keeps residents awake at night and Environmental Health don't object, then it makes it more difficult to make that argument" (P6).*

(iv) **Place-based factors regarding licensing engagement**

Licensing leads identified that factors to do with the intervention areas themselves may have impacted on the ability of AHCs to get directly involved in influencing licensing issues within the timescale of the intervention period. For instance, Area 9 has 22 licensed premises. During the interview with the licensing lead, the licensing register was checked regarding applications made during the intervention period. Low levels of activity across the LA overall were reported and confirmed by a later data check (Table 1). Limited engagement in licensing by AHCs was suggested as a result of limited opportunities to become involved:

> *"I can't say that I've seen any benefit of it* [CICA] *but I think that is probably because there haven't been any issues or the type of applications we've been having in. I've just been having a quick flick (through the register). We have had a couple of applications in* [area name] *but nothing that would really cause any problems" (P3).*

A lack of licensing issues that needed pursuing during the timeframe of the intervention was also reported by Participant 8:

> *"I am not aware off the top of my head of any real problems within* [area name] *and any potential reviews that the responsible authorities, be it the*

police, licensing authority, trading standards, that are calling for review of licences because we've got such problems" (P8).

This lack of opportunity may in part be due to changes in the overall licensing environment. One licensing lead suggested applications were shifting towards '*online sales*' and '*tried-and-tested*' suppliers, such as supermarkets, and that the overall level of engagement in relation to alcohol licensing activity was low:

"I've not had anything off anybody. We've not been inundated with applications, I must admit. And we seem to be changing the face of [area name]. We get applications now more for … like they want to open a business that's online. So, they want to do the sales online. We get a few of them. We've got quite a lot of new developments, haven't we? So, we've got places like, the little shops are now like, the [Names of three large supermarket chains]*, so they're more tried-and-tested people." (P3).*

Similarly, during the interview, the licensing lead in area 6 (20 licensed premises) didn't *"recall any particular licensing applications"* during the 12-month intervention period.

Opportunities to get involved due to *'problems with specific premises'* were also perceived by licensing leads as *'unpredictable'*. The likelihood therefore of *'problem premises'* suddenly appearing in the specific intervention area was perhaps unlikely during the period of the intervention:

"equally, if you're then looking at problems with specific premises, again that's the only other situation whereby you might need to get involved, and again that's unpredictable as to whether you know there will be problem premises" (P10).

One licensing lead reiterated the focus on intelligence gathering through web-based online forms and digital spaces as a significant 'place' for community licensing engagement:

"as soon as anybody phones it's, 'What's your email address? I'll send you the link to this or send you the link to that" (P3).

(v) **Building community capability**

Licensing leads continued to report positive support for the asset-based community development (ABCD) approach underpinning CICA and the principle of identifying and mobilising individual and community assets:

"I thought it was a really good idea (…). And one of the challenges, I guess for members of the public, in licensing is sort of getting to grips, I guess, with the processes and you know I think it can often be a bit daunting. So, the idea of having training and sort of growing experience for them, you know, was a good one" (P10).

It was notable however, that across all interviews, discussion about the AHCs themselves was limited. Only two discussed issues relating to accessing communities to address alcohol harm in the community and a further licensing lead spoke about the sense of social value gained by AHCs. Given the key role AHCs were anticipated to play in delivering the intervention and the role licensing leads were anticipated to have in co-facilitating first and second generation AHC training, it is interesting to note the limited conversation related to the volunteers as assets. Only one licensing lead described continuing relationships with their AHCs by the *'Council'* (LA):

"and I see some of the volunteers, now I've seen them since at [Provider organisation name] *when I've gone to meetings and stuff, they're aware of, of who I am and I'm involved and that yeah, just a friendly face really that can chat about things and how they're involved because I know that the Council have made use of the CICA volunteers" (P4).*

Two licensing leads identified a need to understand how CICA could impact on licensing activity at scale. Notably, licensing leads in the nine authorities across GM received no 'central' briefing regarding why specific intervention areas had been selected or specific information regarding the intervention theory underpinning the implementation process. A view was shared that a wider network of AHCs operating across a wider footprint may demonstrate an *'effect'* from the training:

"And it's just I think perhaps it's because the .. like the cohort were from one particular area. Maybe it may take several cohorts from different areas to spread that message around the borough for them to get involved more and that may be how we can see the effect that that training can have" (P4).

A different licensing lead questioned whether the way the intervention was set up enabled it to have sufficient *'reach'* to make a '*difference*':

"The thing I probably wondered about was how does this scale up to an area like [name of LA]*. There's 300,000 residents in* [name of LA] *and there's lots of localities probably where we have issues related to deprivation and alcohol with these groups, or there should be. So, I don't know enough about the programmes to comment on that, but I suppose the question is: does it reach out enough to make a real big difference?" (P6).*

In two different areas, despite neither licensing leads being involved in cascade training, both perceived building community asset capability as positive and empowering the lives of residents:

"I think it can only help, in the areas where you have it. Because it's only going to be a positive thing, because it's going to help the lives of the residents, living in those areas, and it's going to empower those people to engage with the licensing authority when the time comes" (P6).

It was acknowledged however that building community capability *'needs time', 'momentum'* and commitment:

"It has potential but it needs time and it needs people who are committed. If you've got both those things, then you've got the chance of success. But I'd say, particularly sometimes in these communities it's a struggle, you've got to keep at it because people soon lose momentum. You've got to not badger people but keep them onboard at regular intervals while something's in its infancy until it beds in and possibly that's what didn't happen here" (P1).

One licensing lead acknowledged the opportunity for a consultative role for AHCs in future policy development:

"it would be great if there was, I suppose, a real network of these kind of representatives and individuals who I suppose you could engage with, not only in respect of an area, but I suppose in respect of wider licensing issues, and licensing consultations and… I mean, we've not done any licensing consultations, but for example you know I would include the CICA rep in any sort of revisions to the policy and things like that" (P10).

Discussion

This study aimed to understand factors affecting the sustainable involvement of volunteers in alcohol licensing decision-making from a licensing authority perspective. We provide novel insight into a community-based intervention with a focus on alcohol licensing. There was no evidence that AHCs had been involved in licensing through official channels. The review of the data on applications revealed that there were not many licences in a small area, and therefore only limited scope to make objections. The interviews revealed insight into other barriers, which included lack of alignment with operational priorities and political support; financial constraints and how to effectively operationalise AHCs; and broader inherent challenges for AHCs to raise licensing issues.

Establishing and facilitating community networks with responsible authorities

CICA trained AHCs to deliver alcohol advice to members of their community and influence alcohol-related licensing issues in their local-

ities. Significantly, AHCs engaged in brief advice conversations more readily than they demonstrated 'engagement' in licensing decision making, although anecdotal evidence shows AHCs using their licensing knowledge informally. The logic model underpinning CICA assumed the community could be involved in decision-making and enforcement activities, which would in turn affect alcohol access and availability (Cook et al., 2018). It was assumed that providing AHCs with knowledge about their 'power' to make representations, offering support and building community capacity would translate into observable involvement in licensing decision-making at LA level. However, the licensing data provided by LAs indicated that there had been no formal involvement in licensing that could be directly attributed to AHC involvement, and this was confirmed by the interviews and anecdotally by other key stakeholders involved in CICA. This indicates that the AHCs may not have perceived that they had equity of 'voice' and the 'power' to effect change and influence decisions, and this is explored as part of the wider study. Indeed, the licensing leads appeared to acknowledge that a community 'voice' in isolation has less opportunity to influence outcomes and suggested instead that communities could work with others with 'voice', for example, the various responsible authorities (RAs) who have a 'statutory voice' to influence decision-making. The challenges for local communities to carve out and exercise this role should not be underestimated. For instance, as RAs, even professional public health teams in England identified a perceived 'lack of status' in the licensing process as a barrier (Reynolds et al., 2019). Public health practitioners reported feeling unable to 'go it alone', perceiving their representations carried weight at a licensing committee hearing only when representations were also made by other RAs (Reynolds et al., 2019).

Influencing change in a licensing context remains challenging. In Australia, voluntary agreements - known as liquor accords - between licensing officials, community stakeholders and police - designed to reduce alcohol related harm have been reported to have limited impact (Curtis et al., 2017; Curtis et al., 2016). In the UK, given public health practitioners' reported experiences of influencing the licensing process, it is perhaps not surprising that AHCs were not observed to participate in statutory procedures. It suggests that AHCs would be better able to represent their community interests if they approached the most appropriate licensing officer from the most relevant RA for support and advice, for instance crime issues to the police or noise issues to the environmental health service of the local authority, rather than making representations independently. Therefore, when establishing the AHC role, supporting AHCs to develop connections and networks with licensing officers across a range of RAs may be more likely to facilitate community action than focusing on creating links with the licensing authority's licensing lead in isolation. It indicates that even though mechanisms may be in place to encourage community engagement, the ability to influence licensing decisions requires a level of mastery and self-efficacy by AHCs and emphasises the need for someone to help facilitate AHC approaches to other RAs until AHCs have developed the presence, skills and resources to navigate the appropriate systems. Furthermore, licensing leads acknowledged that AHC activity may take alternative forms at grassroots level in relation to education and signposting, which would not be necessarily evident to licensing leads.

Identifying the scope /opportunity for community involvement

Community engagement in licensing decision-making was predicated on there being some perceived problems with the alcohol environment within AHCs' local communities. The contextual data showed that in some areas there were few new applications or amendments, and therefore limited opportunity for involvement. The number of licensed premises within the intervention areas (range 0-42) did not appear to be related to the perception of AHC licensing engagement from a licensing authority perspective, suggesting that the characteristics of 'place' did not affect overall levels of engagement in licensing activity. Only area 8 reported representations made on new licensing applications during the 12-month intervention period (n=4). However, these were made by elected public officials not RAs or residents.

Some licensing leads reflected on the issue of scale of the CICA intervention and the potential to achieve a greater impact from a licensing perspective if the intervention was implemented on a broader scale. However, the original programme theory articulated a place-based approach, where local communities would be motivated to improve their immediate neighbourhoods. It also incorporated another major element to the role: that of providing brief alcohol advice to fellow members of the community. There had been a deliberate attempt by the programme designers not to 'dilute' the intervention by increasing the scale. It is possible that the two different mechanisms of action of the intervention might have worked better at different scales.

Acknowledging the systemic challenges of influencing licensing decision making

Making representations relating to any of the four licensing objectives creates significant challenges for community members. Foster (2016) reported residents withdrawing representations against licensing applications amidst concern about intimidation, and concerns about reprisals have previously been mooted by AHCs and local leads (Ure et al., 2021). A licensing lead interviewed for the current study indicated that anonymous representations carry less weight. However, publicly participating in a statutory process requires lay people to take on considerable responsibility and personal risk on behalf of their local area. The continued low level of engagement in licensing decision-making by residents is in line with previous research (Foster, 2016). Furthermore, this appears to continue to reflect the broader experience of England residents, with 73% reporting feeling unable to influence local decision-making in general (Department for Digital, Culture, Media & Sport, 2020).

This absence of engagement may in part be related to a disparity between the perception of licensing leads that getting involved in licensing is *'easy'* and the experiences of residents or AHCs. A Statement of Licensing Policy document review, completed as part of the wider study, indicates challenges regarding the availability of licensing information, accessibility and readability at LA level. It is noteworthy given the focus on *'data'* that the evidence (data) potentially required to support a representation may not be easily accessible to a local community or AHC. The lack of availability of a full public licensing register in six of the nine LAs supports this perspective. Additionally, this fits with the experience of the research team who experienced challenges in gaining access to licensing data (Table 2) at Ward/LSOA level from the LAs participating in this study, primarily due to limited resource capacity at the LA. Furthermore, while all licensing teams have adopted web-based portals to enable *'easy'* engagement, this is predicated on interested parties having access to digital devices and digital literacy; that is the "skills to locate, comprehend and consume digital content" (Spiers, Paul, & Kerkhoff, 2018, p. 2236). Digital marginalisation is a very real issue in the wider setting of this study. In the city region where the study took place, 1.2m of a population of 2.8m (circa 43%) are identified as excluded in some way from the opportunities digital brings: 700,000 people are using the internet in a narrow or limited way and a further 450,000 are non-users (GMCA, 2020). A lack of digital engagement is likely to be a particular issue for the CICA intervention areas, as they were specifically located in areas with multiple challenges including high levels of deprivation. Further work to explore the public's experiences of licensing authorities' web-based portals to support engagement is necessary. Furthermore, anecdotal evidence suggests that the barriers to participating at a community-level in licensing decision-making have increased further during the COVID-19 pandemic as licensing committees moved online.

Table 4
Anticipated outputs **(see logic model - Cook et al., 2018)** and recommendations for licensing to support and sustain community engagement in licensing decision-making.

Anticipated outputs	Delivery in practice	Recommended mechanisms for impact
Grassroots organising and mobilisation	• Licensing leads were not involved in the organising or mobilisation of community volunteers per se but did deliver technical training. • Not all areas experienced alcohol availability and accessibility issues limiting opportunities for grassroots involvement at LSOA level.	• Licensing engagement needs to be harnessed through collaborative community partnerships creating a sense of shared commitment/goals over a sustained period. • Interventions that include a specific alcohol availability and accessibility dimension need to be implemented at a broader (LA) level.
Training on how to engage with the licensing process	• AHCs gained knowledge around: The Licensing Act 2003; the LA's Statement of Licensing Policy; the role of Responsible Authorities; the availability of public licensing registers of applications received and premises licences issued, and; how to make 'representations' or objections and request reviews that address one of the four licensing objectives.	• Training on the licensing process to be simplified to focus on process, timescales and licensing objectives. • Specific training for AHCs in evidencing data that 'speak licensing officer language'/address a relevant licensing objective to leverage licensing requirements. • AHCs to be trained to access and review licensing applications and copies of premises licences on the Public Register. • LAs to offer alternative modes for community members to access the LA Public Register. • Specific training provision on what community members do if concerned about fear of reprisal or intimidation.
Relationship building with decision makers/networks	• Initial licensing leads' involvement with AHCs at first generation training. • Support provided by licensing leads across 5 areas through involvement in cascade training. • No further involvement or direct contact reported between actors post cascade training. • Challenges with accessing licensing data at LSOA level. • Contact with licensing leads was limited to the Licensing Authority only.	• Time/capacity for licensing leads to support AHCs to be made available. • Consistent approaches to recording licensing data at LSOA level are required. • During training, licensing leads to review with AHCs and local co-ordinators, licensing activity at LSOA level – to develop awareness and common understanding of licensing issues and co-develop licensing knowledge of local area. • AHCs to be informed/introduced to Licensing Officers in other RAs in LA area that could support representations or reviews in relation to the four licensing objectives. • Facilitated community network including officers from RAs to be established
AHCs use confidence to put skills into practice	• No evidence of engagement in licensing activity through 'official' channels. • Perception of multiple barriers to community involvement.	• Licensing authorities to support community engagement in licensing decision-making by promoting collaborative working with RAs if there is a fear of intimidation and reprisal.

AHC Alcohol Health Champion.
LA Local Authority.
RA Responsible Authority.

To conclude this discussion, Table 4 provides an overview of the anticipated outputs of CICA in respect of AHC involvement in licensing decision-making; how it worked in practice through a licensing lead lens; and recommendations to adopt/consider when implementing community-based licensing focused interventions.

Limitations

This study has several limitations. Firstly, the sample by its very nature was limited in size given only nine licensing leads across nine LAs were eligible to participate. Secondly, although all licensing leads directly involved in the study were invited for interview, we were unable to recruit all leads identified by our purposeful sampling strategy. The findings detail the perceptions of licensing leads in local authorities in the North West of England and may therefore not be generalisable across settings internationally. With hindsight, it may have been beneficial to have gathered licensing data from licensing leads prior to interviews taking place. This would have provided further depth relating to engagement in licensing decision-making by RAs and residents more broadly, and across a wider LA footprint, against which the AHC engagement could be considered.

Conclusion

As seen in other international studies, CICA demonstrates the complexity inherent in empowering communities to take charge and raise important issues relating to alcohol availability where they live or work. 'Place-based' factors limited the training of AHCs to specific targeted areas, since the intervention areas were at relatively small scale. This was suggested as one explanation for limited engagement in licensing decision-making. Extending a training and support programme such as this to a LA level (average 180,000 population) may provide a greater range of opportunities to mobilise communities in areas where there are higher numbers of licensed premises. Developing AHCs' or residents' capabilities and networks to develop relationships may enhance their capacity to influence statutory process.

This might be achieved by developing collaborative dialogue between communities and licensing officers across RAs. The evidence from this study is that communities continue to struggle to influence statutory processes that affect alcohol availability where they live, and further consideration of how to enable increased community engagement is necessary.

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.drugpo.2021.103412.

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