NATIONAL COMMUNITY ACTION ON ALCOHOL PILOT PROJECT 2015

EXTERNAL EVALUATION REPORT

An Roinn Sláinte
DEPARTMENT OF HEALTH

alcohol forum
Informing Nationally, Delivering Locally

HSE
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Community Action on Alcohol Pilot Project (CAAP©)

FOREWORD BY THE STEERING GROUP CHAIR

A key recommendation of the National Substance Misuse Strategy is to promote the development of a coordinated approach to prevention and education interventions in relation to alcohol and drugs. Community mobilisation is identified in the Strategy as an approach which has been successful in bringing stakeholders together to develop alcohol and drug policies aimed at tackling substance misuse.

Following endorsement by Government of the measures contained in the National Substance Misuse Strategy, the remit of Drugs Task Forces was expanded to include alcohol in 2014. As coordinating structures, the Task Forces have an important role to play in supporting the implementation of the National Substance Misuse Strategy, across a range of measures.

Against this background, work began on the development of a National Community Action on Alcohol Pilot Project in 2014, in order to provide training and capacity building to enable Drug and Alcohol Task Forces to undertake community mobilisation in line with best practice. A Steering Group was set up to oversee the project, which included members from the Department of Health, the HSE, Ballymun Local Drug and Alcohol Task Force and the Alcohol Forum.

Following a call for expressions of interest, the following Drug and Alcohol Task Forces were selected to participate in the pilot project which commenced in 2015:

- North West Regional Drug & Alcohol Task Force
- Southern Regional Drug & Alcohol Task Force
- Cork Local Drug & Alcohol Task Force
- North Inner City Local Drug & Alcohol Task Force
- Dún Laoghaire/Rathdown Local Drug & Alcohol Task Force.
- Tallaght Local Drug & Alcohol Task Force

It was decided to commission an evaluation of the project in order to identify learning which could be mainstreamed in the context of rolling out the project nationally. This evaluation has concluded that the pilot project has been successful in increasing knowledge of alcohol-related harm and of the policy context, raising awareness of evidence-based approaches and promoting community engagement.

I wish to express my gratitude to the Chairs, Coordinators and members of the six Task Forces and their alcohol sub-committees who gave of their time to participate in the pilot project. Without their involvement, this project would not have been possible.

I would like to thank Kieran Doherty, CEO of the Alcohol Forum for his commitment to the project and most especially, Anne Timony Meehan also of the Alcohol Forum, who played a pivotal role in the overall management of the project and in the delivery of the training to the Task Forces. I would also like to acknowledge the excellent work of Claire Galligan in producing the evaluation report.

I would like to thank the members of the Steering Group for providing their input and expertise over the past 18 months to enable the successful delivery of the project. Finally, the Drugs Policy Unit team in the Department of Health, in particular, Mary Ryan, deserve our thanks for the professional standard of the administrative support given to the Steering Group for the duration of the project.

Susan Scally
Chair of the Steering Group

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Report produced by

Claire Galligan, Social Research and Development Consultancy

Acknowledgements

I wish to express my thanks to the Alcohol Forum, the Project Lead, the five Local and Regional Drug and Alcohol Task Forces, the Alcohol Sub Committee Members and all of the people who participated in the research process. Thanks also to the information officers in the National Documentation Centre (Health Research Board) who helped to source documents.

The National Community Action on Alcohol Project CAAP© was designed, developed and delivered by Anne Timony Meehan National CAAP Project Lead, Alcohol Forum.

List of Acronyms

CAPP	Community Action on Alcohol Pilot Programme
HSE	Health Service Executive
(L/RDATF)	Local and Regional Drug and Alcohol Task Forces (referred to as Task Forces)
DoH	Department of Health (Ireland)
WHO	World Health Organisation

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Executive Summary

1. Introduction

The National Community Action on Alcohol Pilot Project began in January 2015. The project was delivered by the Alcohol Forum in partnership with the Drug Programmes and Policy Unit, Department of Health and the Health and Wellbeing Division of the HSE. The project sought to reduce alcohol related harm, by supporting Drug and Alcohol Task Forces to adopt a 'community mobilization' approach.

The project fits into a national and international policy context, that promotes community mobilization approaches to address alcohol related harms; namely the National Substance Misuse Strategy (DoH, 2012), The Healthy Ireland Framework (2013 to 2025) and the World Health Organisation Strategy on Alcohol (2010).

Evaluation goals

The Community Action on Alcohol Pilot Project sought to work with six Local and Regional Drug and Alcohol Task Forces in five locations. Each project took part in training and a facilitative process to develop an action plan on alcohol. The training and facilitative process was led by the Alcohol Forum.

A process evaluation was undertaken to consider the factors affecting programme implementation (Shreirer, 1994). It aimed to uncover the quality of the programme and provide insight into the links between process and outcome. The key questions posed by the steering committee for the evaluation were:

- To assess the quality of training and the methods used
- To assess if there was an increase in knowledge of alcohol related harms
- To identify whether each Task Force developed an alcohol action plan and identify if monitoring and review measures were included
- To consider the projects contribution to current research

The evaluator adopted a mixed methods approach to collect data. This included structured observation, focus group discussions, semi structured interviews and evaluative questionnaires. The survey and observation instruments utilised Likert scales and open ended questions to collect data. All of the data was transcribed and coded. To add rigour to the study, data from different sources was compared (i.e. triangulation). All participants contributed willingly to the evaluation.

2. Literature Review

Community action (or community mobilisation) is a public health approach to the reduction of alcohol related harm, by changing the context in which alcohol consumption occurs. The chart below outlines common stages in a community mobilisation process (Holder 2004; Gloppen et al 2012; Shakeshaft et al 2014; Wagenaar et al, 2000):

This broad approach has been adopted in many countries including the United Kindgom (Mistral et al, 2007), United States (Waganaar 2000) and Australia (Shakeshaft et al, 2014).

Studies with positive outcomes showed the importance of face to face interaction with the wider community, mass community engagement, a strong community leadership coalition, the use of evidence based methods and ongoing technical support. In many cases community coalitions worked to effect change in public drinking policies, such as the availability of alcohol or alcohol advertising (Drabble and Herd 2014). One study did not identify a significant impact from community mobilisation (Shakeshaft et al, 2014). However, other studies identify the adoption of science based approaches and the functioning of the community coalition as a significant indicator of positive change (Brown et al, 2011; Feinberg et al, 2004). Community grievance (communities being fed up with the status quo) was noted as a pre-cursor to community action (Herd and Berman 2015), however there is other evidence that shows that community action has been successful in communities where there was resistance to defining drinking as a problem (Waganaar, 1999).

Critical strategies for changing policies and carrying out prevention work were identified. Grassroots organising and developing community capacity was seen as central to all other strategies. This highlights the importance of the *process* of engagement. Other strategies included building leadership capacity, working to enforce existing laws and working with the police (Drabble and Herd, 2014). Holder (2004) identified other critical components, including a full time organiser and a concurrent media strategy to support policy initiatives. Five years was identified as a 'reasonable amount of time' for project action (Holmila et al 2007).

A range of data sources have been used to measure the effectiveness of community mobilisation on alcohol. These have included the use of already existing indicators (e.g. hospital admissions and road traffic crash data), the use of 'proxy' buyers and tracking 'alcohol' stories in the media. Many studies utilise 'control communities' to compare outcomes. While some studies look at the reduction of harms, others have examined a reduction in consumption. Community mobilisation is more effective in reducing harm than reducing consumption (Holder, 2004). Little research exists on the *process* employed to mobilise communities in relation to alcohol specifically, this study may contribute in this regard.

Training community leaders has been shown to be effective in contributing to positive community coalition functioning, and readiness to implement science based approaches (Greenberg et al, 2005). The adoption of adult learning principles in substance use education is advocated by the Drugs Education Workers Forum (Butler et al, 2007). This approach should be learner centred, interactive, value personal experience and promote individual and group development.

3. Project Overview

Five projects were selected to take part in the pilot process. Following initial meetings with project leaders, groups were asked to establish sub committees in each area to lead the process. Initial training was held with two of these committees. Each subcommittee then sent representatives to attend five training days in Dublin. Following training, each subcommittee was facilitated (onsite) to support the development of their action plans on alcohol. Ongoing support was also available to sub committees in the form of phone calls and emails with the project trainer, 1-1 meetings, further training onsite for groups and support with completing action plans.

4. Training

As mentioned above, five training sessions were held along with follow up facilitated sessions with project participants. The training was very well received by project participants. The content was organised and the training materials were perceived as useful and easy to understand. The materials drew well from local and international examples and

research in relation to alcohol related harms. The materials encouraged participants to consider the social, political, economic and cultural challenges of addressing alcohol related harm at a community level.

Observation at training sessions showed that there was a high level of participation and that the trainer applied adult education principles and practices in her work, in line with the DEWF standards (2007). The trainer adapted content and her approach in line with the needs of the group. A wide range of teaching methods were utilised including small group work, DVD's, full group discussion, learning games, presentations and peer learning.

The data collected indicated that participants greatly increased their knowledge in relation to alcohol related harms. Questionnaires also indicated that some participants already had knowledge of some aspects of the training. Despite this finding, the majority of people in focus groups said that the training had been extremely useful and relevant for them.

The structure of the training programme did not suit all learners. For those participating from outside Dublin, the travel necessary to take part in the course was very burdensome. In two out of four focus groups, the facilitative sessions were noted as being more worthwhile as it allowed them to apply their learning in practice. Despite this finding, all groups noted the benefit of networking with other Task Forces from around the country.

The facilitative sessions received a very positive review and all noted that it gave 'focus' to their strategic planning in relation to addressing alcohol related harms. During facilitative sessions the trainer went over again, aspects from the training programme, as not all of the people on the subgroup were familiar with the content. It was shown that the training did have an impact on work practices, influencing the formation of the local alcohol action plans. For one group, the adoption of a public health approach to alcohol was a new departure.

5. Local Alcohol Action Plans

Four community action plans were completed by Task Forces involved in the CAAP. A fifth Task Force produced an outline plan, however this was not completed to the standard expected by the programme. This Task Force intends to use this outline plan to progress work in 2016. All of the four action plans that were completed included monitoring, review and self-evaluation measures.

6. Conclusion

The Community Action on Alcohol Pilot Project was successful in introducing a model of community mobilisation to Local and Regional Drug and Alcohol Task Forces. Enabling factors included the high quality of training offered, the knowledge and expertise of the

trainer, the high standard of facilitation and the ongoing support given to Task Forces throughout the process to support their development.

Critical barriers were the challenges faced by some Task Forces to engage stakeholders at a local level to lead a collective approach. The project allowed participants to explore their own attitudes to alcohol and this aspect was named as vital, in three focus groups. The structure of the programme made it time consuming for those outside of Dublin, however the vast majority of participants felt they gained from the networking experience. Having a limited number of sub-committee members at training was seen as a drawback, however this 'disconnect' was later addressed well in facilitated sessions. Other barriers were noted as the high level of resources needed to deliver the project. Through the project, participants learned more about the wider policy context related to alcohol, and commented upon the need for the implementation of national policies to support a reduction in alcohol related harms.

There is little research, in peer reviewed studies, relating to Community Action on Alcohol in Ireland. There is limited research overall in relation to the *process* undertaken by communities to reduce alcohol related harm. This study may make some contribution in this regard. Documenting different approaches used in an Irish context could help strengthen the case for communities and other stakeholders (such as an Garda Síochána) to engage on this issue. This study did not seek to evaluate the quality of plans or their implementation, future studies could also explore this aspect.

7. Recommendations

The Community Action on Alcohol Pilot Project has been successful in increasing knowledge in alcohol related harm, increasing knowledge on the policy context, raising awareness of evidence based approaches and promoting community engagement. Community action on alcohol is a long term process and this project marks the beginning of that process.

Factors that could contribute to the strategic development of the CAAP programme are identified as: The Public Health (Alcohol) Bill 2015. This could offer a supportive policy environment for community mobilisation projects. Engaging a specialist agency to audit plans for fidelity to evidence based approaches and identifying a university partner/s to work along with projects to measure outcomes should be considered for future programmes. Ongoing technical support for projects may also enhance sustainability.

The training was delivered to a very high standard. Factors to consider for future development are identified as: the inclusion of evidence based sources about community mobilisation efforts in the training materials; increasing the level of training with sub-committees onsite and maintaining a networking element to the project (albeit fewer days).

Community mobilisation requires significant investment at a local level. A longer lead in time and an early facilitated session/s with sub committees may help support local 'buy in'. The identification of project leaders within each Task Force and their involvement in all aspects of the project would help build more sustainable outcomes. Identification of a new funding source to support work and, if this is not available, clear expectations about the level of resources required, on the part of managers, is needed to plan for community mobilisation.

1. Introduction

The National Community Action on Alcohol Pilot Project began in January 2015. The project was delivered by the Alcohol Forum in partnership with the Drug Policy Unit, Department of Health and the Health and Wellbeing Division of the HSE.

The aim of the project was to build the capacity of communities, through Local and Regional Drug and Alcohol Task Forces (L/RDATF) to identify alcohol issues and develop Local Alcohol Action Plans.

The objectives of the project were...

1. To introduce a model of Community Mobilization on Alcohol to Local and Regional Drug and Alcohol Task Forces to be implemented in their communities
2. To build awareness of alcohol related harm to both the drinker and to others
3. To raise awareness of the evidence of effective community mobilization measures on alcohol and sustainable actions under each of the pillars of the National Substance Misuse Strategy
4. To promote community engagement and the involvement of all key stakeholders in identifying local needs and in the development of Local Alcohol Action Plans
5. To ensure adequate monitoring, review and evaluation measures are built in to the development of local plans

In February 2015 the Alcohol Forum commissioned an external researcher to conduct an evaluation of the project to assess its effectiveness in meeting the stated goals. This report presents the findings of that evaluation.

1.1 What is Community Action or Community Mobilization?

Community Action (or community mobilization) is a process whereby communities come together and take action to enable change. Communities work with a range of stakeholders (this can include the public, statutory and private sectors) to collectively identify the changes they want to make, using the best available evidence, and plan how they are going to achieve this. The community then implement this plan and monitor its progress. The goal of community action in this project is to reduce alcohol related harm (Alcohol Forum, 2015).

1.2 What is alcohol related harm?

According to the HSE (2008), alcohol-related harm is not confined to the negative consequences experienced by the drinker but extends to harm experienced by people other than the drinker (harm to others). The harm from alcohol is linked to a range of health and social problems such as "accidents, injuries, chronic ill-health, premature death, public safety, violence, child neglect, marital problems and lost productivity" (p. 1).

The National Substance Misuse Strategy (2013) identifies the complex role that alcohol plays in Irish society. While alcohol is used for relaxation and enjoyment, and contributes to the Irish economy, it also has "…major public health implications and it is responsible for a considerable burden of health and social harm at individual, family and societal levels" (p. 4).

1.3 Overview of the project

The Community Action on Alcohol Pilot Project began work in January 2015. The Alcohol Forum invited expressions of interest from Local and Regional Drug and Alcohol Task Forces (hereafter called Task Forces) to take part in the project. 14 projects applied and 5 Task Force groups were selected. These were

- North West Regional Drug & Alcohol Task Force
- Joint Initiative - Southern Regional Drug & Alcohol Task Force and Cork Local Drug & Alcohol Task Force
- North Inner City Local Drug & Alcohol Task Force
- Tallaght Local Drug & Alcohol Task Force
- Dun Laoghaire Rathdown Local Drug & Alcohol Task Force

Following selection, the trainer from the Alcohol Forum visited all five projects to outline the project goals and the work involved in participating in the project. Each Task Force established an 'Alcohol Sub Committee'. Each project committed to sending a number of representatives from the sub-committee to five one-day training courses held between March and July.

The key goals of the training were to help build awareness and knowledge of alcohol related harms as well as increasing knowledge and skills in 'community action'. A key aspect of the project was that 'trainees' would then communicate learning back to their respective alcohol sub committees.

During or following the training process, Task Forces worked on developing a 'local alcohol action plan'. This involved carrying out local research. This information was then used to

help develop a plan. The trainer from the alcohol forum facilitated each group to identify priorities and agree goals for their 'action plan on alcohol'.

1.4 Policy Context

The Community Action on Alcohol Pilot Project sits within the following policy context:

The National Substance Misuse Strategy (DoH, 2012) identifies 4 Pillars for addressing alcohol misuse. These are: *Supply*; *Prevention*; *Treatment and Rehabilitation; Research and Information*. The strategy identifies the need for a "…community-wide, inclusive and coordinated approach to promote greater social responsibility and prevention and awareness-raising" (p. 23). The Strategy also states that: "Communities should be supported to develop the evidence-based skills and methodologies to implement community mobilization programmes with a view to increasing public awareness and discussion of alcohol problems, and to build community capacity to respond to alcohol problems at local level" (p. 23).

A public health and community based approach to reduce the harm caused from excessive consumption of alcohol in communities is also named as a key action in the **HSE National Service Plan 2015** (p. 25).

A goal of **The Healthy Ireland Framework 2013-2025** (DoH, 2013) is "to raise awareness and promote healthy lifestyle choices among the public by understanding and acknowledging the broad causes of ill-health and by devising targeted, inter-sectoral public information strategies and actions to address them" (p.14). It recommends 'community activation measures' under the theme: Empowering People and Communities. These include the recommendations to strengthen participation in decision making for health and wellbeing at community level (3.9) and supporting and improving existing partnerships (3.4). Under the Research theme: the framework aims to support actions to "standardise, expand and mainstream existing work programmes designed to deliver health and social community profiling data at the local level" (5.3).

The Interim National Drugs Strategy (2009 to 2016) identifies alcohol "as a drug and intoxicant which has significant pharmacological and toxic effects both on the mind and on almost every organ and system in the human body" and identifies a range of consequences of alcohol misuse (p.14) at an individual and societal level. The report outlines strategies to address alcohol related harm as part of the wider national drugs strategy, including 'building the capacity' of communities, to avoid, respond and cope with drug and alcohol related problems (3.65, p38).

The World Health Organisation (WHO) Global Strategy on Alcohol (2010) identifies 'community action' as one of 10 interventions that should be adopted by governments. The

strategy states: "Communities can be supported and empowered by governments and other stakeholders to use their local knowledge and expertise in adopting effective approaches to prevent and reduce the harmful use of alcohol by changing collective rather than individual behaviour while being sensitive to cultural norms, beliefs and value systems"(p12). Part of this strategy involves the enactment of supportive local policies and the development of partnership arrangements between community and government sectors. This WHO definition of community action echoes other approaches that will be outlined in the literature review.

1.5 Evaluation Approach and questions

In January 2015 the project steering committee defined the goals for the evaluation and invited tenders. Following selection, the evaluator outlined her methodology to the team and began engaging with the project implementer (Alcohol Forum) and project participants (five Task Force groups and their stakeholders) to gather data to inform the evaluation.

A multi-strategy process evaluation was undertaken. Process evaluation is concerned with *how* a programme is actually delivered. This approach focuses on the activities of a project and considers the factors affecting the programme implementation (Shreirer, 1994).

When examining the process of project implementation, the researcher focussed on two main areas:

1. The implementation process - this is the direct observation of interaction between the project implementer and the project participants. How the participants engage with the project and how the implementers respond to feedback, and
2. The implementation context – this gives attention to the context in which the project is delivered, including the attainment of goals, knowledge and preparation of programme implementers and approaches used (Law and Shek, 2011).

The time allocated to a project and the number and range of project stakeholders can also affect delivery and implementation (Bowes et al, 2009).

A Process evaluation approach aims to uncover the quality of programme implementation and provide insight into the links between process and outcome; it helps to understand the strengths and weaknesses of the programmes and can provide lessons for future implementation (Law and Shek, 2011).

The following questions were determined for the evaluation by the project steering committee, in relation to four aspects of the Pilot:

(1) The Quality of Training

(2) Knowledge/awareness of alcohol related harms

(3) Local alcohol action plan

(4) Contribution to current research

1.5.1 The quality of training

- Is the content underpinned by the best available evidence?
- Is the content linked with participant's previous experiences and current work role? (Situational Relevancy)
- Are course materials / resources of a high quality? (Consider, format, readability and clarity)
- Are training methods based on adult learning principles? (Applying DEWF 2007 Standards)
- Does the trainer use the most effective methods for maintaining interest and teaching the desired attitudes, knowledge, and skills? (Consider the different types of learning strategies used)
- Are participants encouraged to take responsibility for their own learning, and the transfer of new knowledge and skills into work practices?
- How do participants perceive training content and implementation and the extent of learning that occurred? (Changes in participants' knowledge, skills and abilities)
- Is there a change in participants' behaviour (Post-training change in work practice)
- What factors enhanced or inhibited the impact of training on participants' work practices?
- What are the short- and long-term effects of the pilot training programme, and ways in which it can be improved?

1.5.2 Knowledge and Awareness of Alcohol related harms

- Is there a [perceived] increase in knowledge on alcohol related harms pre and post training?
- Is there a [perceived] increase in knowledge of effective public health evidence based measures to reduce alcohol consumption levels and alcohol harms with specific emphasis on community measures?

1.5.2 Local Alcohol Action Plan

- Did each Task Force develop a 'local alcohol action plan'?
- Were monitoring, review and self-evaluation measures built into the plans?
- Did participating Task Forces engage with local stakeholder groups as part of their planning process?

1.5.3 Contribution to current research

- How will this project contribute to the current research effort in the alcohol field and help build capacity for future Community Action on Alcohol initiatives and community-based alcohol intervention research?

1.5.4 Concluding analysis

Consideration of the former questions is intended to inform the following conclusions for the evaluation:

- The enabling factors critical to successful project implementation
- The critical barriers to the Pilot Project implementation, and strategies adopted to deal with barriers
- The determinants of sustainability and transferability in this Pilot Project
- Recommendations for the future or further investigation / evaluation.

1.5.3 Methods used to collect data

For the final evaluation, the evaluator adopted a mixed methods approach to collecting data. Primarily, qualitative approaches were used, this included the use of focus groups, interviews and structured observation. Structured observation is a technique in which the researcher employs 'explicitly formulated rules for the observation and recording of behaviour' and data is recorded using an observation instrument or schedule (Bryman, 2004. P.167). Some quantitative methods were employed in terms of gathering data in relation to the numbers participating, and other monitoring data. All of the project participants involved in the pilot project were invited to inform the evaluation through the following methods:

Evaluation Method employed[1]	Participants/Duration
Primary Sources	
Baseline questionnaire	37 responses
Focus group with training participants	17 participants
Post training session questionnaires	74 questionnaires collected from 5 training sessions
Observation at two training sessions	5 hours observation, 34 participants
Observation at four facilitated sessions	8 hours observation, 34 participants
Focus group discussion with four alcohol subcommittees	34 participants (each lasting approx. 30 minutes)
Project Monitoring forms (June 2015)	4 projects returned forms
In depth interview with the project trainer	2 hour interview
Interview with Task Force leader	30 minute interview
Post facilitation session questionnaire	32 participants (4 groups)
Post session reflection documents	4 submitted
Secondary Sources	
Review of project reports and training materials compiled by the alcohol forum	

Figure 1: Evaluation methods employed and participant numbers

1.5.4 Analysis approach adopted

Survey and observation instruments utilised Likert scales and open ended questions to collect data. All data from face to face sessions, and qualitative data from questionnaires was recorded and transcribed and organised thematically (coded) according to the evaluation objectives. Data was further coded to reveal patterns within these themes, Microsoft excel was used to assist in the coding process.

The process evaluation took a formative approach (Patton 1997), in that the findings from questionnaires and focus group data were shared and discussed with project leaders throughout the process. In this way they were able to adapt the content and the approach taken as the project progressed. The approach also encouraged project leaders to engage in self-evaluation, through written post-session reflection logs. These were shared with the external evaluator to assess progress and adaptation to change. This allows attention to be paid to processes as well as outcomes and can build a sense to trust between the evaluator and those being evaluated (Gardner, 2003).

[1] A sample copy of the training questionnaire, the observation instrument, focus group questions, project coordinator questions and the post facilitation questionnaire are available in the appendix.

1.5.5 Strengths and limitations of the methodology

Multi-strategy (quantitative and qualitative) research approaches have been used by a wide number of researchers for evaluation purposes. Qualitative research can facilitate the interpretation of relationships between variables (Bryman, 2004) which can support the goals of a process evaluation.

Many theorists favour qualitative approaches, because of its 'inductive view of the relationship between theory and research' and its capacity to allow us to see 'reality' through the eyes of people being studied and to probe beneath 'the surface' (Bryman, 2004. P280). Critics of qualitative research say that it is too subjective (the researcher is an active member in the process), it is difficult to replicate and there may be problems of generalisation or transparency (Bryman, 2004, p 285).

This aspect has been addressed here by the breadth and depth of data gathered; therefore the findings are not over-reliant on any one data source. In this way, data from different sources can be compared (i.e. triangulation), this can add depth and rigour to a study, which results in greater confidence in findings (Deacon et al, 1998). For example, data from questionnaires and other monitoring tools were queried in focus groups, interviews and observation sessions. In addition, data collected at focus groups sessions was queried within other focus groups and in the interview with the project trainer. The literature also serves as a measure to query the data collected, however a deficiency of Irish literature on this subject is a limitation, in terms of comparing data from within a common cultural context.

The preliminary findings were shared with the steering committee and the five Task Force coordinators involved in the project. This allowed the evaluator to gauge how the early results fitted with the understanding of participants and organisers. It also allowed the participants and the steering committee to question findings or ask for clarification. This exercise can increase the validity of findings and increase evaluator credibility (Lapan, 2003).

A key strength of the evaluation was the willing participation in the study by all of those involved in the project and the project leaders. The researcher was allowed to observe facilitation and training sessions. All trainees completed questionnaires and took part in evaluative discussions.

1.5.6 Ethical Considerations

Ethical principles in relation to social research were observed for this evaluation (Diener and Crandall 1978). In all aspects, the evaluator explained to participants the purpose of the evaluation and the type of data being recorded, thereby seeking *informed consent*. In observed sessions, participants were assured that discussions between participants would be treated as confidential, with the focus being upon the methods used and dynamics created between participants; and the participants with the trainer, thereby managing an *invasion of privacy*. Survey responses were also made in confidence. The names of projects are not used in connection to the data collected, as their activity is not the primary focus of this evaluation.

1.6 Structure of the Report

Chapter 2 Establishes an 'evidence base' for the project, and queries 'community action' as a strategy to address issues of alcohol related harm. It also seeks to establish 'best practice' in the delivery of training to adults, within a substance misuse and community education context.

Chapter 3 Provides a narrative of the project, outlining key events and inputs.

Chapter 4 Presents and analyses data in relation to the quality of training in the pilot project, and its impact in relation to knowledge and awareness of alcohol related harm.

Chapter 5 Presents and analyses data in relation to the development of 'local alcohol action plans'

Chapter 6 Draws conclusions about the key goals of the evaluation: enabling factors, critical barriers, determinants of sustainability and further research.

Chapter 7 Outlines recommendations for future programmes.

2. The Case for Community Action (or Community Mobilization)

Community Mobilization[2] or Community Action specifies a particular approach to address alcohol related harms. This section outlines the literature in relation to the model and draws conclusions about the process undertaken and its potential for effectively reducing alcohol related harms.

2.1 Introduction

According to Holder (2002), the logic for targeting communities, to address substance misuse is compelling, as substance use occurs within a community setting and the costs associated with alcohol misuse are borne by the community. This can include alcohol related crime, violence and accidents.

Community mobilization is guided by a structural approach (or public health approach) to the reduction of alcohol problems. This means that the 'problem drinker' is not the target of an intervention. Rather, the focus is on "changing the context in which alcohol consumption occurs" (Holder, 2004, p 287). A review of the literature shows that community mobilization has been used as a strategy for the prevention of alcohol and substance related harms in many different contexts (Gloppen, 2012; Wallin, 2005; Shakeshaft, 2014; Holder, 2004). While there are variations in its implementation, a key component of community mobilization is a coalition of local stakeholders, who lead and implement the goals of the coalition. This group has also been called the 'community prevention coalition' (Gloppen et al, 2012).

Some common features of a community mobilization approach (identified in Foundation for Alcohol Research and Education (2012); Holder 2004; Gloppen et al 2012; Shakeshaft et al 2014; Wagenaar et al (2000) are graphically outlined below:

[2] In the literature 'Community Mobilization is the most often used term to describe the approach. In this project community 'action' was adopted as this term was more easily understood by project participants.

Figure 2: Graphic of common stages in a community mobilization process

This evaluation concerns itself primarily with the first four phases of the model, but is also mindful of the context in which the project takes place. Many studies have emphasised the need for approaches to be 'evidence based' and informed by prior scientific evidence (Shakeshaft, 2014; Holder 2004; Gloppen et al 2002; Wallin et al 2005) and the need for a supportive macro policy environment to affect change in alcohol related harms. Affecting the local policy environment is also identified as a key driver for sustainable change (Holder, 2004).

A literature review of community mobilization projects has been undertaken to explore the process and assess the approach' effectiveness in reducing alcohol related harms. The parameters for the research have been informed by Holder's (2002) criteria for inclusion:

- The adoption of a population wide approach (not targeted at high risk groups)
- The project seeks structural (or systems) change[3] – i.e. to change the local policy environment
- The project uses the media strategically to support change
- The project seeks to mobilise the entire community in support of change (they are involved in the design and implementation)

Particular emphasis is given here to the *process* adopted by the projects to create change, as the process is the focus for this evaluation.

[3] System change (structural change) or transformation has been defined as "efforts that strive to shift the underlying infrastructure within a community or targeted context to support a desired outcome, including shifting existing policies and practices, resource allocations, relational structures, community norms and values, and skills and attitudes" (Foster-Fishman & Behrens, 2007, p. 192)

There have been instances of community mobilization around alcohol taking place in Ireland. The 'Time IV a Change Border Region Alcohol Project' took place between 2009 and 2014. This project included a range of interventions including; responsible server training, family conversation toolkit to help talk about alcohol, festival care toolkit events, foetal alcohol spectrum awareness raising events, training programmes to communities and schools and awareness raising events (CAWT, 2014). A second example is the 'Ballymun Alcohol Strategy' (2010 to 2016). The strategy works to address alcohol related harm through a range of interventions, these include a policing strategy in relation to alcohol, responsible server training, advocacy for changes in legislation and using the media to gain support for community policing initiatives (Ballymun Local Drug Task Force, 2015). To date, evaluative research in relation to these projects is not available.

2.2 Exploring a Community Mobilization Approach in four cases

To explore the community mobilization approach, four different cases are considered; The UK Community Alcohol Prevention Programme (UKCAPP); The Communities Mobilizing for Change on Alcohol (USA); The Alcohol Action in Rural Communities Project (Australia) and Communities that Care (USA):

2.2.1 The UK Community Alcohol Prevention Programme (UKCAPP)

took place in three UK Cities: Glasgow, Cardiff and Birmingham and began in 2004. Key partners in all cities included the local authority, public services and licensed vendors. Acting in line with government policy, the interventions were not designed to reduce per capita alcohol consumption, but reduce alcohol related anti-social behaviour (Mistral et al, 2006). An evaluation of the project for the Alcohol Education and Research Council (2007) show a reduction in road accidents, decrease in violent crime, serious assaults and robbery, reduction in A & E alcohol related incidents and positive public feedback. Key barriers were named as engaging stakeholders to back interventions and provide resources (Mistral et al, 2007).

2.2.2 Communities Mobilizing for Change on Alcohol

(CMCA) took place in the United States over a six year period (initiated in 1991). The project focussed on the availability of alcohol to young people and reducing community tolerance of underage drinking (Wagenaar, 2000, p.86). The study engaged seven randomly chosen communities to receive the intervention and eight other randomly chosen communities to serve as a control group. Time was spent training organisers and building relations in communities, from where a core leadership group was established. A key aspect of the project was the engagement of a mass base of support involving a large number of residents. Each community responded to local needs, this included a change in drinking policies at major community events, establishing regular police compliance checks, security at high school dances and accompanying media strategies. Behaviour changed as a result of the intervention, age checking increased and older teens were less likely to buy alcohol for younger teens.

Episodic heavy drinking was not affected, however the 18-20 age group were less likely to be served drink, or to drink in the past 30 days. The project demonstrated that community mobilization efforts could be effective in randomly selected communities, with no previous history of working in this area (Wagenaar et al, 2000).

2.2.3 The Alcohol Action in Rural Communities (AARC) Project was implemented in ten experimental and ten control communities in New South Wales, Australia in 2005. Its aim was to reduce risky alcohol consumption and related harms and conduct a cost-benefit analysis of the community action approach. Once again, community led coalitions were established. The projects used a range of interventions including training for GP's in screening and brief intervention, letters to GP's containing statistics and evidence in relation to alcohol dependent drinkers; letters to employers with follow up training; self-assessment questionnaires distributed through pharmacies and letters to licensees from mayors on 'problem weekends' (among others) (FARE, 2012).

Pre and post intervention surveys were distributed among a large number of community members and data was collected from hospitals, police etc. The study showed that 'routinely collected data' could be used to measure alcohol related harms in different communities (Shakeshaft et al, 2014). The researchers concluded that community action did not provide sufficient evidence that the approach was effective in reducing risky alcohol consumption and alcohol related harms. Self-reported evidence did indicate, however, that average weekly consumption patterns had been reduced. Compared to other prevention measures, this community action approach did not demonstrate cost effectiveness (Shakeshaft et al, 2014).

2.2.4 Communities that Care (CTC) is a holistic training programme for young people that adopts a model similar to community mobilization. Its aim is to address adolescent health and behaviour problems, including alcohol and drug misuse. It adopts a systems approach and relies upon 'evidence based' strategies to inform work in communities. Like the other examples, it is led by a community coalition, directed locally and works for wider engagement in the community (Brown, Hawkins et al, 2011). The process is reinforced through CTC training sessions, technical assistance and ongoing system monitoring (Hawkins and Catalano, 2002). Overall the programme seeks to enhance community' members willingness to support prevention measures and strengthen protective factors which lead to positive health outcomes for young people.

In a study carried by Hawkins et al, (2009), the CTC approach was identified as being effective in reducing alcohol related harms. In a randomised controlled trial of CTC in 24 communities, 12 intervention communities received training and technical assistance. A longitudinal sample of 4,407 students (between 5th and 8th grade) in the control and experimental communities was undertaken. The outcomes were positive, with students in

CTC communities being less likely to engage in 'delinquent behaviours', use alcohol, cigarettes or engage in binge drinking (Hawkins et al 2009).

Science based approaches to prevention were identified by Gloppen, Hawkins et al (2011) as the primary mechanism through which CTC is expected to produce positive change. A randomised control trial, showed that coalitions that had received training and CTC technical assistance were able to maintain a more scientific approach to prevention. While funding was important to coalition sustainability, it is not the only factor. Sustainability is also predicted by 'board functioning, independent of funding' (Gloppen, Hawkins et al, 2012).

2.2.5 Discussion of four cases

The four models presented here, have adopted approaches that are similar, however some differences do occur. Three out of the four cases presented showed that community action was effective in reducing alcohol related harm, later studies will also demonstrate how community action has been effective. While the AARC project did not record a change in behaviour, the study raises questions about the most effective *process* of engaging stakeholders. It is worth keeping in mind that six out of the ten interventions adopted by AARC were paper/letter or online based interventions compared to the face-to-face interventions adopted by other projects.

Studies with positive outcomes showed the importance of face to face interaction with the wider community, mass community engagement, a strong community leadership coalition, the use of evidence based methods and ongoing technical support. The AARC research also raises questions about the effectiveness of community action when compared to strong public policies to reduce consumption. Holder (2004; 2002) maintains that local prevention strategies are more likely to be effective when 'complimentary system strategies' are also employed. Therefore evidence suggests that 'community action' needs to be seen as part of a wider 'macro' effort to reduce alcohol related harms, this may have implications for this evaluation in relation to aspects of sustainability and transferability. While barriers in the UK study were named as the difficulty of engaging stakeholders, it also showed that these barriers can be overcome and interagency working can be effective in reducing alcohol related harm in cities.

2.3 Collaboration, dynamics and motivation

The previous studies raise questions about the level of community engagement for community mobilization approaches to be effective. Brown et al (2011) define community collaboration as the degree to which community members, "representing different sectors

of the community, engage in information exchange, coordination of activities, and sharing of resources to strengthen the prevention of adolescent health and behaviour problems that are of concern to the community" (p185). In a study examining 'Communities that care', the authors identify that collaboration among communities is necessary, but not sufficient on its own to produce "significant effects on drug use outcomes" (p197). The adoption of science based approaches, by the community, is also a significant indicator of positive change.

How does the functioning of the community coalition (or leadership group) impact on the outcomes? Feinberg (2004) found a strong correlation between 'community readiness' and the perceived functioning of the internal workings of the community coalition. This indicates that a strong and cohesive coalition is important to delivering outcomes. "One of the biggest challenges of a coalition, as well as its greatest potential strength, is the integration of diverse perspectives in order to more comprehensively research, plan, and execute goal-oriented action" (Feinberg et al, p172, 2004).

Herd and Berman (2015) explored the factors that motivated people to mobilize to address alcohol related harms in their communities. This qualitative study collected data from interviews with 184 social activists, in seven different US cities. A snowball sampling technique was used. The authors categorised responses into three key areas – grievances, resources and bridging factors.

A prominent role was given to grievances as a pre-cursor for social action. This referred to people who wanted to take action as a result of problems associated with alcohol in their own communities. Secondly, the emergence of coalitions, organisations and leadership (in paid and voluntary capacities), within their own communities with identified resources was also a motivating factor for becoming involved. While funding was seen as secondary to this, it was also seen as helpful in increasing mobilization. Pervasive feelings of frustration were named as the bridging factors, with many people being mobilised because they were 'fed up' with things the way they were (p344).

However there is some evidence that community based responses can overcome issues and be effective, despite an absence of original 'grievances'. In the CMCA, which was developed in randomly selected communities, the project experienced complexities such as turnover of staff. They also had to overcome community resistance to defining underage drinking as a problem. A substantial amount of time was also spent introducing the project into communities and developing local leadership (Wagenaar, 1999, p 93). Another Italian based study, noted (limited) change in public attitudes to alcohol (greater knowledge of alcohol limits) as a result of a community led public education project (Allamani et al), however other commentators have noted that public education strategies, without being complimented by other strategies, will not be effective (Holder, 2013).

The studies noted here, emphasise the need for a high level of collaboration and adoption of science based approaches to bring about change. They also bring our attention to the importance of 'functioning' community coalitions. Studies suggest that a high level of board functioning predicts better capacity to access funding therefore leading to more sustainable outcomes (Gloppen et al, 2012). The prominence given to 'grievances' as an impetus to affect change is also of interest to this study. However, other research has shown (Wagenaar 1999) that communities with no previous work in this area or desire for change, were able to successfully adopt community mobilization approaches. Time is also a factor and it has been shown that a substantial period of time is needed to introduce the project into the communities, develop local leadership, and move local teams to action on specific strategies, this aspect is given further consideration later.

2.4 Strategies for changing the alcohol policy context

The previous sections have outlined some strategies that contribute to positive results for reducing alcohol related harms – these included using the media to support interventions; well-functioning coalitions; wider community buy in; the use of science based evidence approaches and the need for adequate time for project initiation and implementation. Broad systems based approaches are also considered more efficacious that single intervention strategies.

In a qualitative American study, Drabble and Herd (2014) re-iterate the effectiveness of community mobilization approaches to address alcohol misuse, and attempt to address a gap in research, by considering the strategies employed by community activists in seven US cities, through interviews with 184 neighbourhood leaders (between 1996 and 1999). Collectively all of the projects attained some of their goals, these included a change or creation of 6 state laws, 270 alcohol outlets surrendered their licenses and did not reopen and hundreds of billboards (advertising alcohol) were taken down (p. 364).

The authors name a number of strategies' that leaders identified as critical, for changing policies and prevention work in relation to alcohol misuse, the chart below summarises some of their findings:

Critical Strategy	How it was employed
Grassroots organising and developing community capacity	This was seen as central to all other strategies. This was about getting people on board – in the community, with wider community and institutions. It also involved getting wider community buy-in for the actions. This was achieved through conversations, face to face contact, meetings and the use of media. Power was perceived in terms of the number of people they had involved.
Building leadership capacity in people and groups	Taking strategic action to support leaders and leadership capacity – this included educating the community about the issue, through face to face contacts.
Working for the enforcement of existing laws	This included putting limits or controls on the place of advertising billboards, addressing the sale of alcohol to minors, checking licensed vendors (engaging in research projects with local universities).
Meeting local officials	Ensuring communities had a clear understanding of the power structure, attending planning commission re the awarding of licenses, attending public hearings and establishing ongoing productive relationships with policy makers.
Media Advocacy	Leveraging media support to change policies, developing a relationship with the media, holding press conferences, writing editorials etc. [in the days before social media].
Working with the Police	Establishing working relationships with the police to enforce laws and ordinances, addressing shared concerns, engaging with them in 'decoy' operations (young people buying alcohol), assessing and documenting compliance with the law.
Education and Training	Strong value put on conversations to educate community about the issue, to inform the community (door to door), training included advocacy skills, training community members to conduct research and presenting results.
Direct Action	This included the organisation of protests, taking down billboards (within the law), boycotts of problem stores
Changing community norms	This included creating alcohol free events, linking alcohol related issues to underlying issues of poverty and unemployment, working to change norms in families and communities.
Negotiating with Store owners	Working with owners of 'problem outlets' about the concerns and working with them to address problems.

Figure 3: Critical strategies for prevention work in relation to alcohol misuse (Drabble and Herd, 2014)

This study explored the dynamics of community engagement and perceived factors for success. While the elimination of risk factors and enhancement of protective factors is central to 'prevention approaches', (p 951, Hawkins, Catalano et al, 2002) the engagement of people and the ways in which processes are implemented, has significance.

2.5 Context for reducing alcohol related harms

Problems associated with drinking occur, not just to those who are dependent upon it, but also to those who use alcohol in an unsafe way. According to Holder, the logic for targeting communities is compelling, as it is within the community context that costs associated with alcohol misuse are borne, for example alcohol related violence, car crashes etc. Therefore the purpose of community mobilization is to 'change the context in which alcohol consumption occurs' (2004, p.287).

Holder (2004 and 2002) examined research from a range of community mobilization projects (addressing alcohol misuse) to draw conclusions about project effectiveness and factors for success[4]. He concedes that community mobilization has been less effective in reducing alcohol sales or consumption, however concludes that it has been effective in reducing alcohol related problems.

From an analysis of these and other studies, Holder (2004) identified the following critical components for community mobilization:

- A full time community organiser
- Organiser and members working with a range of stakeholders including businesses, police etc.
- Community leadership to be involved in the design, implementation and support approaches
- Needs to involve leaders and citizens, i.e. wider community and citizen involvement
- To be informed by scientific evidence
- A concurrent media advocacy strategy to support policy initiatives

Holder (2004) maintains that changes in attitudes and beliefs are easier to attain (through community mobilization) than changes in behaviour (p295). However, he maintains that the collective risk is reduced through interventions that influence alcohol use.

Some projects carried out over a three year period failed to generate any significant change in alcohol use or harms than control sites (e.g. COMPARI Project; Midford et al, 1998) and LAHTI Project (Homila 1995). However, other projects contradict these findings such as 'Saving Lives' measured a 25% reduction in traffic crashes and project sites and the 'Communities Mobilising for Action on Alcohol' (Wagenaar et al, see 2.2.2)

[4] Holder (2002) draws on research from the following sources: Community Action Project (CAP), New Zealand (1982-1985) (Caswell et al, 1989); Community Alcohol Abuse/Injury Prevention Project (CAAIPP)-USA (1984-1989) ((Buka & Birdthistie, 1999); The Lahti Project-Finland (1992-l995) (Holmila. 1997).; The Saving Lives Project-USA (Hingson, et al., 1996); The COMPARI Project--Australia (1992-1995) (Midford, et al., 1998); The Surfers Paradise Safety Action Project and Its Replications-Australia (1993-1994) Homel, et al., 1997); The CMCA Project-USA-The Communities Mobilizing for Change on Alcohol (CMCA) (Wagenaar, et al., 2000); Community Trials Project-USA (1992-1996), Holder et al, 1997.

The evidence that prior scientific evidence contributes to positive outcomes in community mobilization approaches is strong (Holder, 2004; Gloppen 2012). However, prevention strategies cannot happen within a vacuum. Complimentary system strategies that seek to restructure the total alcohol environment are more likely to be effective than single intervention strategies" (Holder, 2004, p295). Involving community leadership in the design and implementation of approaches and achieving wide citizen engagement, are critical success factors.

2.6 Evaluating Community Mobilization Approaches

The studies listed present a 'snap shot' of the literature that exists in relation to community mobilization approaches. In most cases, project development teams worked closely with university based researchers, to measure the impact of the project in addressing alcohol related harms. Researchers used a number of methods to make these assessments – it included the use of already existing statistical indicators (such as hospital admissions and road traffic crash data). It also included the use of 'proxy' buyers, where a young person's ability to be served, would be measured. The level of media coverage of 'alcohol' related stories was also measured– this related to newspaper stories. This may not be as clear an indicator of public knowledge now, in an age of social media. In addition, 'self-reported outcomes' and 'attitudinal change' were also measured through survey, interviews and focus groups with participants, Shakeshaft et al (2014) queries the reliability of these measures, however many other studies use these measures as an indicator of change.

Time has also been a factor in measuring changes in alcohol related harm. Many studies of three years or less, noted that there had not been enough time to draw full conclusions, or that the timescale of the project had been too short to make any real impact on the results. Usually attitudinal change or an impact of 'social norms' in regards to alcohol can be recorded within this timescale. The studies indicate, logically, that change occurs when projects take place over a longer timescale – Holmila et al (2007), identify that 5 years for the project action and 6 years for research as a 'reasonably good length of time' (p. 537).

In many cases researchers established 'control communities' to see if the changes in the experimental communities could be measured as 'statistically significant'. Some theorists have queried the efficacy of this approach for measuring outcomes. Holmila et al (2007) identify the 'spill over effect', where elements of the intervention may 'spill over' to control areas.

The literature recommends that a 'mixed strategy intervention' take place in community mobilization approaches. Holmila et al (2007) also note the difficulty of measuring the impact of one strategy over another on the final outcome. The authors suggest that combining various types of observations and data, including qualitative and descriptive

accounts, can help provide the kind of information that will allow researchers to assess the utility of the work and the logical path from intervention to outcome. They also suggest measuring immediate outcomes, closer to the specific interventions, to identify links in the causal change (Homila et al, 2007, p536).

Less research exists, in this field, in relation to an examination of the *process* employed to mobilise communities on alcohol related issues. One assumes that factors such as the cultural significance of alcohol and values attached to alcohol usage, could impact on the 'take up' and efficacy of community based approaches. According to Holmila et al (2007), "research on local context, tradition and governing structures should be used in assessing how the given circumstances influenced the impact achieved" (p539). Specifically, the content and approach of training to inform and effect community mobilization approaches *on alcohol*, could not be easily found in the literature. Therefore, this study may be able to make some contribution in this regard, specifically within the Irish context.

2.7 Training, a forerunner to community action

The literature outlined here has noted the importance of increasing the capacity of the community to undertake change and increase their knowledge of 'science based approaches' to reduce alcohol related harms (Wagenaar, 1999; Drabble and Herd 2014; Holder 2004). There is limited information in the literature in regards to training delivery (specifically) for community mobilization to reduce alcohol related harm. However, research about the efficacy of training on the 'communities that care' project (Greenberg et al, 2005), which adopts a similar approach, found that training of leaders in CTC was associated with higher levels of perceived community readiness to implement science based approaches, positive community coalition functioning, increased understanding among CTC participants, fidelity to a risk-focussed approach and board structure and stability (Greenberg et al, 2005).

CTC adopted a similar approach to the one being intended by this Community Mobilization Pilot Project. In a five stage process it assessed community readiness; engaged leaders in training and established leadership boards; carried out a community assessment; developed action plans; implemented and evaluated plans (Quinby et al, 2008). Key differences to *this* project were that training was delivered on-site in community locations, plans were reviewed by external agencies (this review was acted upon by board members) and boards carried out 'community plan implementation training' after plans were completed[5].

The training element of the CTC programme included workshops covering 'the CTC approach' with leaders (ensuring they could explain it to all stakeholders); principles of

[5] These aspects are not features of the Community Mobilization Pilot Project

prevention science, reviewed risk and protective factors; board membership exploration and community board orientation – working arrangements, goals, board maintenance, public relations, youth involvement and funding. Training was carried out with each board independently. Factors that led to beneficial outcomes were named as high quality training delivered by CTC certified trainers, user friendly guides and materials, recruitment of coordinators who were locally selected and community based, use of the youth survey as a data source, good monitoring procedures for achieving milestones and technical assistance from university staff (Quinby et al, 2008).

2.8 Adult learning principles in substance use education

A goal of this study is to consider the implementation of adult learning principles during the process of programme delivery. In a review of existing adult education theory, which informs the integration of adult education principles into public health training, Bryan et al (2009) identify 5 key principles[6]:

1. Adults need to know why they are learning
2. Adults are motivated to learn by the need to solve problems
3. Adults previous experience must be respected and built upon
4. Learning approaches should match adults background and diversity
5. Adults need to be actively involved in the learning process

These principles are echoed in *The Quality Standards in Substance Use Education*, developed by the Drugs Education Workers Forum (Butler et al, 2007). Among other interventions, the *Standards* aim to highlight current guidelines and best practice in relation to 'substance use education programmes in a community setting'[7] in Ireland. These guidelines emphasise the importance of employing active and participatory methods in education, as well as providing opportunities to explore issues and engage in critical reflection in a safe and supportive learning environment. The *Standards* also stress the need for programmes to be informed by 'evidence based practice'.

The *Standards* identify a number of principles for delivery of training in 'substance use' education programmes, which include the need for the programme to be learner centred, interactive, to value personal experience and promote individual and group development[8]. Other standards relate to the need to contextualise programmes within current drug

[6] The principles draw on theories and are major components of two leading models, andragogy (Knowles, 1980, 1984; Knowles et al., 1998) and self-directed learning (Knowles, 1975; Tough, 1967).

[8] The DEWF standards are noted in research objectives for this study. A full list of the principles identified by the DEWF Standards is available in the appendix.

strategies, while also maintaining a local component; setting clear objectives and engaging in ongoing evaluation.

2.9 Conclusion

The goal of community mobilization is to create changes in the local social, economic or physical environment related to alcohol related harms. The view is that the problem is created by the system rather than by problem individuals. Collective risk is thus reduced through interventions affecting community processes and structures that influence alcohol use (Casswell & Gillmore, 1989; Holmila, 1997; Wagenaar et al., 2000).

Community mobilization is not a 'one size fits all' approach. Approaches are tailored by communities to suit their own needs, within the local context, to reduce problems associated with alcohol use. In this way, it is difficult to name a definitive approach to how community mobilization should be conducted, although common patterns of implementation have been identified (see figure 2). By drawing from a number of studies, there are some critical factors that have led to change:

- The application of science based approaches to inform actions
- Strong and cohesive community coalition leading the project drawn from a range of sectors and agencies
- High level of community engagement
- Multi strategy approaches
- Changing the policy context
- Community motivation for change
- Engaging a large number of people and stakeholders through face to face encounters
- Mobilising mass support
- Working with communities over an extended time period (in excess of 3 years)
- A concurrent media strategy

In the literature, there are strong examples of community mobilization projects that have achieved behavioural change, affecting those who use and sell alcohol. In other studies, attitudinal change only is recorded among participants. From an analysis of the studies presented here, the process of how community mobilization was undertaken differs, and it must be considered that the process employed can affect the outcome.

Studies that use a range of strategies (single strategies have not been found to be effective): mobilise people through face to face interactions, work to raise leadership capacity and have developed strong leadership have been shown to work. The use of 'evidence based' approaches to contribute to positive results is emphasised in all studies. However, people

need to understand this evidence base. For example, in the AARC study, communities ranked high-school interventions as their most preferred strategy, "despite the relative lack of evidence for its effectiveness in reducing alcohol related harm among young people" (FARE, 2012, p101).

While not all studies look at the aspect of funding, the majority of projects named here, employed a full time coordinator to carry out the work. In one study funding was named as important, however this was seen as secondary to having good leadership. Issues around the motivation of people to take action were raised in the literature, and whether this impacted on results. One study noted that people with a higher level of grievance are more likely to take action, however another study observed that community mobilization was also successful in communities that were pre-selected by organisers, with no prior history of work in this area.

The policy environment was named as critical by a large number of studies. An Australian study felt that its community mobilization project was hampered by an uncomplimentary policy environment. In the UKCAPP initiative, government policy influenced coalitions to reduce harms rather than focus on lowering consumption. Many studies showed that engaging stakeholders from the public and private sectors was crucial for changing the local policy environment or enforcing already existing laws.

The training processes employed by projects is not overly highlighted in the literature, bar the 'communities that care' programme. The CTC programme delivers on-site training with leadership boards in areas of 'science based approaches', board functioning, planning and implementation. From examining its content, this programme draws on adult education approaches and principles. The Irish based 'Quality standards' also emphasise the need to deliver substance use programmes from an adult education perspective.

Evaluating this work and comparing the processes between communities is tricky. Each community context is different and a wide range of variables can contribute towards a project being successful or not. Many studies employ 'control communities' to compare results. Many studies were able to use already collected data, for example from police and hospitals. Overall, the majority of studies encountered, dealing with community mobilization specifically, focussed on outcomes of projects rather than concentrating on the processes employed. Therefore this study may have something to contribute in helping our understanding of the dynamics at work, at the beginning of a community mobilization process and also provide some findings from an Irish context to this field.

3. Project Narrative Dec 2015 to September 2015

Implementation of Project by the Alcohol Forum

Late in 2014, the Alcohol forum invited applications from interested Task Forces to participate in the pilot project. Fourteen projects applied and five projects were successful. During January and February the Alcohol Forum Project trainer held introductory meetings with each of these five Task Forces to inform their chairperson and coordinator about the project and the level of commitment it would require. The project evaluator was recruited in March 2015.

Over the same time period 'briefing sessions' were held with the selected full Task Force boards and staff. At this session, the Alcohol Forum project trainer spoke to participants about the commitments needed to undertake the project including the governance structure required (formation of an alcohol subcommittee), the project aims and objectives and the project deliverables.

During these initial months some projects established 'Alcohol Sub Committees'[9]. Half day training sessions were planned to take place with each subcommittee, prior to the formal training programme, however three did not go ahead due to pressures of time (In lieu of this, further training was offered to projects post formal training). The Project trainer engaged in phone and email correspondence with all projects to support progress and help them to develop a terms of reference for their Alcohol Sub Committees. Task Forces engaged with the alcohol forum at different levels, in some cases there was a high level of engagement and in other cases this was much less.

In March 2015 the first of five one-day formal training sessions was held in a venue in Tallaght, these continued until June 2015. The training sessions covered the following areas:

[9] One Task Force had formed an Alcohol Sub Committee prior to this start of this project.

Date	Learning Objectives
Session 1, 25th March	Community Action on Alcohol approach; Sources of relevant data; Purpose of gathering baseline information; Data collection and research methods
Session 2, 15th April	Outcomes based evaluation; Logic Models; Project Evaluation
Session 3, 13th May	Alcohol harm in Ireland, including alcohol related brain injury; foetal alcohol spectrum disorder; alcohol related hidden harm, brief advice and brief intervention.
Session 4, 3rd June	Popular media as a marketing tool for alcohol; gaining skills and confidence to use the media
Session 5, 24th June	Effective policy measures to address alcohol harms; planning for action.

At least one representative from each Task Force participated in the all of training sessions, see table of participation below:

Participation in Training	Session 1	Session 2	Session 3	Session 4	Session 5
Numbers in attendance	19	17	15	11	13
Were stakeholders from each Task Force represented	yes	yes	yes	no[10]	yes

Figure 4: Participation in Training

During this time the Project trainer also provided additional phone support and attended meetings with some projects, at their request, to help them develop their project plans. During the summer there was a call for submissions for funding for projects addressing 'alcohol related harm', in addition to the inputs outlined in the chart below, all but one project requested further support from the project to help with the application (all four were subsequently successful in winning funding).

Between July and September 2015 the project trainer facilitated planning sessions with each of the Task Force subcommittees to help them develop their 'alcohol action plans'. The length of time spent planning with the facilitator by each group varied (some groups taking 1 day and others taking 3 days). Four out of five groups managed to complete a local alcohol action plan, to the standard expected by the CAAP. As can be seen from the chart below, the number and range of stakeholders involved in each project varied, as did the depth of baseline research undertaken and the number of meetings held.

[10] One project could not attend this session due to a project launch; this training was delivered at a later date to this committee on site.

	Project A	Project B	Project C	Project D	Project E
Established a sub group in early 2015	Yes	Yes	Yes	Yes	Yes
No. Alcohol subcommittee (Mar 2015*)	18	13	16	10	10
Initial training with subcommittee prior to training	No	Yes	Yes	No	No
Average no. recorded at facilitated sessions	7	11	11	4	4
No. of external stakeholders	6	8	10	2	3
Time dedicated to facilitated session	2.5	3.5 days	3 days	2.5 days	1 day
Additional Training requested and undertaken	Attitudes to alcohol	Alcohol and the Media	Alcohol related harms and attitudes to alcohol	Support with feedback to board	None
Telephone support	yes	yes	yes	yes	no
Additional Supports requested	Desk support to review plan	Supported feedback to subcommittee	1-1 session with project coordinator; desk support to review plan	Planning with coordinator; desk support to review plan	none

Figure 5: Engagement of projects with the CAAP. * Source Alcohol Forum quarterly report.

The table above provides further statistical information on the work of each of the five projects. It outlines the number who were originally registered as sub-committee members and the number who took part in facilitated sessions to lead the action plan. The external stakeholders are those who took part in the process from agencies other than staff or volunteers from the Drug and Alcohol Task Forces. It shows how in all cases the number of stakeholders decreased from those recorded at the start of the project. Two sub groups were in a position to undertake a training session early in the process, as they had engaged a range of stakeholders. There is a correlation between the retention of a higher number of stakeholders with those groups who undertook early subcommittee training, however a causal link cannot be inferred.

In the case of Project E, leadership from the Task Force were not in a position to attend the training programme or progress the project in-house. This was attributed by the project to

a staff member being off sick. While an effort was made by another project leader and external stakeholders to develop an action plan, by taking part in one facilitated session, the action plan was not completed to the standard expected by the CAAP project. In all other cases, the projects were successful in completing their alcohol action plans, however the level of collaboration between internal and external stakeholders was higher in some project than others

4. Training

This section presents the primary research findings in relation to the training aspect of the Community Action on Alcohol Pilot Project. It responds to the following evaluation questions in relation to the quality of training (1.5.1) and knowledge and awareness of alcohol related harms (1.5.2).

4.1 Introduction

During the project, stakeholders from each project attended five structured training days (see figure 4). This section considers the quality of training and the process employed. The findings have been informed through the following methods:

- Observation of 2 training sessions (held in Dublin)
- Questionnaires completed by participants after each session
- Facilitated discussion with trainees
- Focus groups with 4 alcohol sub committees
- Observation at 4 facilitated sessions with sub committees
- Phone interview with one Task Force Chairperson
- Semi structured interview with the alcohol forum project leader
- Review of training objectives and training materials
- Trainers' post session reflection document

4.2 Materials

Representatives from each Task Force were invited to attend a 5 day training programme, which focussed on the objectives outlined below:

	Course Objectives
Session 1	Community Action on Alcohol approach; Sources of relevant data; Purpose of gathering baseline information; Data collection and research methods
Session 2	Outcomes based evaluation; Logic Models; Project Evaluation
Session 3	Alcohol harm in Ireland, including alcohol related brain injury; foetal alcohol spectrum disorder; alcohol related hidden harm, brief advice and brief intervention.
Session 4	Popular media as a marketing tool for alcohol; gaining skills and confidence to use the media
Session 5	Effective policy measures to address alcohol harms; planning for action.

Figure 6: Outline of course objectives for each day of training

Each participant received a training folder, this included a c.d. of policy resources, copies of power-points used at each session, handouts with exemplars, information handouts, definitions of key terms, suggested reading, worksheets, case studies, and 'how to' guides. Trainees were asked to refer to their training materials throughout the training and they were invited to use them as a resource for further reading.

The training materials were well very received by all participants, according to data from post training questionnaires:

The content was organised and easy to follow	100% agree or strongly agree
The materials are useful and easy to understand	96% agree or strongly agree
The objectives of the training were clearly defined	94% agree or strongly agree

Figure 7: Perception of training materials by trainees

Observation at training sessions showed that participants used the training materials while working and intended to use them as a resource for making their alcohol action plans. However, it should be noted that the training materials prepared by the trainer were not the only resources used at sessions. In line with adult education methodologies, participants were also invited to share their own experiences to inform the group, as did the trainer.

A review of the training folder shows that learning goals are clearly stated, learning material is well organised and responds well to the objectives of the session. Power-points are clear, with a good use of visuals and accessible to the audience. Handouts are well organised, clear and easy to read. This was also commented upon positively by participants in post training questionnaires.

The content is underpinned by evidence based sources, and draws from many Irish studies. Session three deals with alcohol related harm. It draws on evidence from a HSE Report 'Alcohol's Harm to others in Ireland (Hope, 2014). In addition it draws on research conducted by Doctor Helen Mc Monagle on Acquired Alcohol Related Brain Injury (Alcohol Forum 2015). This aspect of the training was delivered by Dr. Mc Monagle. It also draws on information about Foetal Alcohol Spectrum Disorder, drawn from research collated by the National Organisation for Foetal Alcohol Syndrome (UK). In questionnaire data and in all focus groups, participants referred specifically to the knowledge that they gained in relation to alcohol related harms, hidden harms, alcohol related brain injury and foetal acquired syndrome disorder (FASD) as being particularly beneficial.

Available evidence is also incorporated in session 5, to allow participants to explore effective policy measures to prevent or reduce alcohol harms. It uses evidence to build a case for policy interventions that work and interventions that do not work, and relates these in a simple way to participants. The material queries how community action could support a change in policy. It draws on WHO data (source unclear) to state 'what has worked' in community action. The material does not outline specific factors that contribute to positive

outcomes in community action (see 2.4). However some of these aspects would have been related by the trainer and are implied in session one, when steps in a community action process are outlined. In line with community mobilization theory, the data relates to the problem environment rather than the problem drinker.

Features of a community mobilization model are identified in session one and an example from Ireland is explored (drawn from a presentation made about the Ballymun Community Alcohol Strategy; Greaves, 2014). The key stages of a community mobilization process compare well with the stages identified by this report[11]. The policy context comes through strongly in the materials, and it is often referred to. The value of a results-based management approach is advocated in session one, other planning models are not considered. Rather than refer to specific information about how community mobilization is measured, the participants were challenged to identify possible indicators from a sample scenario. This is a creative way to get people thinking about how change can be measured. Indicators used by other community action projects to measure progress, as named in the literature (2.6) are not included in project materials, however some information in relation to this may have been related by the trainer. In focus groups, one group noted that they had been able to identify new 'indicators' through the training. Another group felt that the inclusion of the local case study (Ballymun) allowed them to consider the depth of the work needed to carry out local research. It helped them decide to steer away from primary research (as they recognised that they would not have the capacity to carry it out) and instead to look at the work that has already been done to see 'how we can benefit from that experience'. This demonstrates the relevance of the learning and an application of learning to peoples own work context.

Overall, the material takes a holistic view on the issues and examines the local social, political, economic and cultural challenges to addressing alcohol related harms. It encourages trainees to make the link between theory and practice and provides working examples. As well as examining the context, the material encourages participants to explore their own feelings, beliefs and socialisation in relation to alcohol. An analysis of content and discussions with the trainer revealed that getting people to acknowledge that 'alcohol is a major problem', from the evidence presented, is a key component of the course. The trainer conceded that not everyone will change their opinion by the end of a course. A course participant commented; "*we are all ambivalent about drink, there are lots of us who enjoy going for a pint, so there is ambivalence that feeds into this whole thing, if I enjoy a drink can I speak out against it*". Therefore the skill of the trainer about dealing with this 'ambivalence' is a key factor, and cannot be addressed by training materials alone.

[11] Foundation for Alcohol Research and Education (2012); Holder 2004; Gloppen et al 2012; Shakeshaft et al 2014; Wagenaar et al (2000)

The materials are of an excellent standard and draw well from many sources of the best available evidence. The material links with the policy context and provide practical support and guidance to participants in relation to developing a plan.

4.3 Teaching methods

Trainers used learner centred and interactive training methods, using a range of teaching approaches, including the use of power-point, group discussion, small group work, guest speakers, DVD's, use of exemplars, use of visuals and learning 'games'. The approaches used compare well with teaching methodologies and adult education principles advocated in the DEWF standards. This approach was witnessed at observation sessions and substantiated by feedback in questionnaires. The expertise of the trainer and the value of her knowledge to the learning process was specifically commented upon by participants in all of the focus groups and interviews. In addition, the knowledge she carried with her in relation to the experiences of other Task Forces and organisations in addressing alcohol related harm, was noted as being of particular benefit to participants.

Observation at training sessions showed that participants felt comfortable in the learning environment as they were able to disclose experiences and views in relation to alcohol. There was safety within the group to disagree and a wide range of positions were taken. At all times participants were encouraged to be part of the learning conversation, to link learning to their own experiences and apply learning to their own situations.

In line with the principles put forward by Bryan et al (2009, p.559) in training for public health practice, the participants here understood *why they needed to know what they were learning* and actively solved problems around specific issues. For example, the trainer drew on participants' knowledge of how alcohol is used in society and the implementation of the law in regards to alcohol in different contexts. *The learners' previous experiences were respected and built upon*. For example, participants were encouraged to gain a critical awareness of their own attitudes to alcohol and each person's contribution was valued. Throughout, the participants *were actively involved in the learning process* – asking questions, peer teaching (e.g. activity around explaining definitions), small group work and wider group discussions. It was a dynamic and positive learning environment.

The observations made on the training process were substantiated by feedback received from participants in training questionnaires:

Feedback from questionnaires, over 5 sessions	
The trainers were knowledgeable on the training topics	**98% agree or strongly agree**
There was good participation and interaction during the training	**91% agree or strongly agree**

Figure 8: Participants' perception of training delivery

The DEWF standards recommend that adults are involved in the 'planning and evaluation' of the programme and the methodology is 'predicated on a needs assessment' (DEWF, 2007). The trainer took measures to involve trainees from the outset. She carried out briefing sessions with coordinators and chairperson's of each Task Force before training began. She also talked with all groups prior to the training to explain its parameters. During the training the trainer consulted with trainees and gave them options in terms of how work would progress during the training, however due to the nature of the training in a centralised location, a formal training needs assessment was not carried out prior to the training process. An inclusive process was mirrored in the facilitative sessions, where even greater ownership of the learning process was given to trainees. The evaluator consulted with the trainees early in the process about the evaluation and how they would participate. The length of the training questionnaire was amended as a result.

There was evidence that the trainer adapted approaches to meet the needs of the group. Following session one, some feedback indicated that more 'discussion' would be preferred and less 'information based content'. This occurred in future sessions, where a higher level of participative methodologies were employed. There were also some requests at early sessions for the use of other learning tools, such as DVD's - these methods were utilised from session 3. There was a very positive response to the DVD's used in both the questionnaire and focus group data. Despite this, a minority of participants felt that session 3 had 'a lot of presentations' and the trainer also said that this view was communicated to her. She felt that in future courses, training in relation to alcohol related harm should be dispersed throughout the course, which would maintain a clear focus on the issue, for each day of the course. Having said this, data from observation sessions and project material shows that the training each day was very much grounded in work of tackling alcohol related harm.

The trainer engaged in differentiation[12] by providing slides with words and visuals, engaging in mixed methods, moving around the room to support individual learners, changing the pace, engaging learners in group work and peer education. Overall, from observation sessions during training and later in facilitated sessions, the trainer was particularly successful in changing the content and pace to be responsive to the needs of learners and their learning styles.

[12] Differentiation: The term 'differentiation' refers to the method whereby the teacher varies the content, activities, methodology and resources when taking into account the range of interests, needs and experience of the students. It is a process that allows for variation in, for example, pace, amount, content, level and method of curriculum presentation to ensure that learning experiences are appropriate for all students (Tomlinson 1999)

4.3 Learning Outcomes

Through the course participants learned about aspects of planning, evidence based methods, alcohol related harm and using the media[13]. All participants felt that the training would be helpful in building their alcohol action plans (questionnaire data).

Training questionnaires asked respondents to rate their level of knowledge for 'before and after' the training session, in relation to the session objectives. The chart below illustrates the perceived learning achieved in relation to 16 learning objectives across the five training sessions. Over all sessions, 65% noted an increase in learning[14]. 35% noted that their learning in relation to some objectives did not change. Highest learning outcomes were achieved at session 3 (alcohol related harms), where 96% indicated an increase in learning. In session one, the lowest number of participants (58%) report that they have acquired new knowledge.

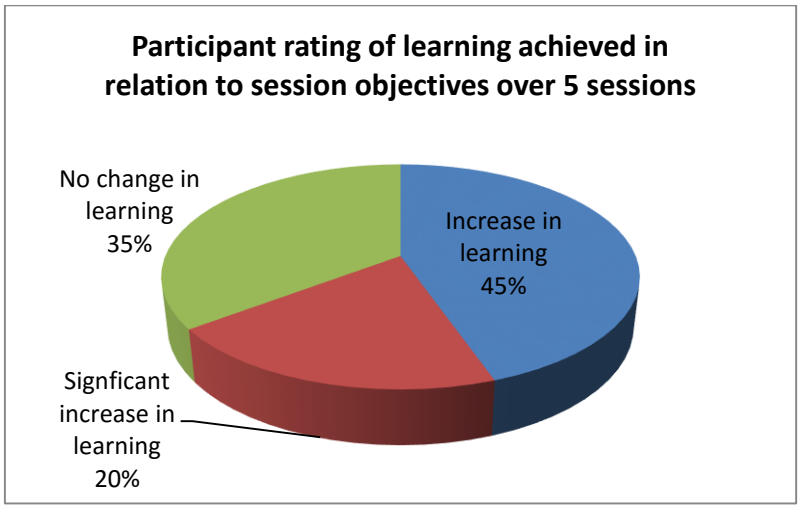

Figure 9: Participants rating of learning achieved in training sessions

In the cases where no increase in knowledge was reported, 98% of respondents stated that their knowledge on the topic was already at a 'moderate' or 'high' level and so further learning was not achieved. In 2% of cases, it was stated that learning on the objective was at a low level and did not improve as a result of the training. It should also be noted however that 99% of respondents found the training overall to be useful or very useful, therefore while some did not experience a change in knowledge of specific objectives, other useful outcomes were perceived. The findings may also indicate that some participants were undertaking training on issues where they already had knowledge. This view was corroborated by another response in the questionnaire by a minority of respondents who

[13] A summarised list of objectives is outlined in figure 6.

[14] Participants were given a 5 point Likert Scale to rate their learning (from very low to very high), an 'increase in learning' equates to a move of one point on this scale, a 'substantial increase in learning' equate to a move of two or more points on this scale. A copy of the questionnaire is available in the appendix.

said that some aspects of the training were repetitive, despite the fact that it 'reinforced' what they already knew.

This interpretation was substantiated by two out of three focus groups. Two groups conceded that while the training had been of an excellent standard, it covered some subject areas that they were already familiar with and used in their professional contexts (e.g. research and planning). They already had a level of knowledge in relation to alcohol related harms, however, specific information in relation to 'hidden harms' were seen as particularly useful : *"ARBI and the specific sessions on hidden harms were very very good. It is important that when we go out to the communities, we are able to say the reason why we believe alcohol is so dangerous and these are facts not our opinion***".** Overall, while some of the learning was not new, it validated their previous learning and increased the quality of their planning. However two groups said that they found the facilitated session more beneficial for moving the whole group forward. A third group felt that the structure of the training worked well for them and that in depth training on the subject is necessary before beginning the planning phase. A spokesperson for the remaining groups said that the training for them had not been as beneficial as expected, however this was due to the fact that stakeholders were unable to attend.

Despite these issues, the feedback from questionnaires indicates clearly that there was an increase in knowledge of 'alcohol related harms' as a result of the training, by 96% of participants. This view was further validated through the focus group sessions, where all three groups who participated named the learning on this subject as a highlight of the course.

4.5 Structure of the training programme

There was a very high level of satisfaction among trainees with the course, with 99% saying that they found the course to 'very useful' and 'extremely useful' after each session. However, some questionnaire data and data collected during the 'action planning phase' reveals some issues with how the training programme was structured.

Participants in three out of four focus groups commented upon the high level of time required to attend training. For those coming from outside of Dublin, up to an additional work day was spent travelling. Others did not attend because of the time commitment (interview and focus group data). Those who did attend said that the time involved impacted on their work and meant that other Task Force work suffered. Other stakeholders commented upon the pressures it put on their own organisations both public and voluntary, and the high costs involved in travelling to Dublin for training. For one Task Force, doing the training in Dublin was so time consuming it took away from their overall time available to develop the action plan, as it meant that they were not able to keep up to date with work on their other projects.

Despite these factors, many did attend the training (see figure 4) and felt that it was valuable to their work.

People in three out of four focus groups shared the view that it would be more beneficial for some aspects of the course to be delivered on-site, applying learning with the development of the action plan. In two groups the trainees felt that the structure worked for them, however they did not need to travel too far outside of their areas to participate. One member of a focus group commented: "In order to get connection, those things have to be contextualised locally … there is no shortage of modules for doing training on public health to alcohol …what there is a shortage of is opportunity, motivation… and all sorts of different resistances". Here the participant was noting that the biggest challenge was getting people to work together on these issues at a local level.

While the training did link concepts to developing the action plan, and did this well, some groups were unable to move forward with their action plans until after the training, as not all members of their alcohol sub committees were participating. One group also noted that the application for dormant accounts in the middle of the training, had diverted attention away from the planning process. Despite these issues, the majority of people in all of the focus groups agreed that the training had been relevant, had put the focus on alcohol and made their planning process more strategic: "*My point of view is that there has been [a gain] very much a focus, streamlining in line with government plans, make it more strategic and make it more objective and measurable at the end of it*".

Part of the training process was for participants to 'feedback' information to those not present. Despite questionnaire data indicating that people were confident to feedback information to their sub committees (88%), discussions with training participants revealed concern on this subject. Early on in the course, there was agreement around the view that "*bringing information back is not straightforward, you have to bring it down, summarise it*". This view was echoed by the trainer, "*imparting training is a huge ask, that being successful depends on the commitment and will of the individual, the capacity of the individual to impart information they received, their recall, they not being a day sick*".

Participants did not all feed back to the same level. For those that did engage in bringing information back, it was time consuming, generated additional work and still they were not able to relate the great detail that was covered in the training. Later on, one group member said that feedback 'had to be on a need to know basis' and invited the trainer to give additional inputs to her alcohol sub-committee to make up what she perceived as gaps in information. This was also undertaken by the trainer with another committee. This meant that some members got certain information twice. For another group, while planning to feedback, the opportunity did not arise to do so: "I am not confident that we explained what we did on the training". Overall, it is unclear what level of information other sub-committee

members received about the training. Further implications of this also became apparent in the facilitated sessions (see section 4.7).

During the observation of training, the evaluator observed a structured dialogue on 'attitudes to alcohol', where people had to stand in different parts of the room according to their views on a topic. It was a very useful approach to enable participants to explore their own views and create discussion and debate. It was interesting to see that participants held widely differing opinions on alcohol in society. It raised a question for the researcher about the absence of other alcohol committee members for this process, in terms of enabling groups to consider each other views and come to a consensus on their approach to alcohol related harms.

This observation was corroborated by two groups that requested the trainer to carry out this exercise again with their alcohol sub-committee to help establish a common approach: "we brought that back to the overall Task Force, we wouldn't have known how to get in there and tackle attitudes in a safe way … if we didn't have that training we wouldn't have touched it". This group felt that it helped them to identify the differences between alcohol related harm and reducing consumption and it helped them to define an aim that everyone in the group could support.

4.6 Networking

The positive emphasis put on the value of networking by participants of the course is at odds with the notion of delivering training on site for groups. The course brought together Task Force workers and other stakeholders from four different counties. Therefore, while the opportunity was not there for Task Forces to progress their work-plans as part of the training, they did gain valuable knowledge and perspectives from other areas. This was rated by 96% of participants as being 'extremely helpful' or 'very helpful' in post training questionnaire data, the benefits were also given great emphasis in comments made on the questionnaires. Participants also found this aspect of the training very enjoyable. This view was corroborated by participants at the focus group sessions and through observation data.

In one session, groups were engaged in looking at how problems could be addressed through limited resources (observation data). While some groups were despondent about this, others were able to give examples of what had been achieved in other places, through the creative use of resources. This is an example of how a shared learning environment can assist groups with problem solving. This aspect of the learning process was also noted by the course trainer, saying that groups shared their 'insights' and 'approaches' to address issues. One participant commented "*looking at what they are considering around alcohol misuse in their own regions was very helpful"*. The value of having people from different sectors (as well as

different geographic locations) also affected the quality of learning, with people being able to address topics from differing perspectives. For example, a participant from An Garda Síochana was able to provide a perspective on the law and its implementation that may not have been known by others.

The impact of having a consistent approach was also commented upon by groups. They felt that their work was strengthened as it was part of a national initiative. One stressed the importance of the public's perception. They felt that if people saw that a wide range of Task Forces are working on the alcohol problem and that is wasn't just an 'isolated activity', it gave the project greater credibility. One group felt that the training and networking experience was particularly effectively for those Task Forces who had not addressed the alcohol issue previously, and less so for those who were already working in this area. All other groups said that it was beneficial, regardless of work already undertaken.

Participants from different Task Forces worked creatively together during the training. The trainer invited groups to sit away from their own colleagues so that the networking experience could be enhanced. The trainer commented that during 'down times' in the session (tea and lunch) colleagues continued to network and share information, this was also witnessed during observation of sessions.

On the fifth training day, participants were asked to engage in an activity to explore how Task Forces can work together in the future to address alcohol related harms collectively. They chose to look at alcohol companies' sponsorship of community and sporting events. According to the trainer, this activity allowed groups to see the value of each other's networks and the strength that they may have in coming together to work on policy issues.

A spokesperson for one group felt that the alcohol forum would be well placed to have an auditing role in relations to plan, to ensure a level of consistency across the country. This echoes the practice of the *Communities That Care* project (Quinby et al, 2008), where a central agency had an auditing role to ensure compliance with evidence based practices. In some regards this did occur, as plans follow a similar format, and the project trainer reviewed plans to support the identification of key performance indicators and monitoring/evaluation methods, however it was not part of this project for the trainer to ensure compliance with evidence based practices.

4.7 Facilitated sessions

Following the formal training programme, the trainer supported Task Forces, through facilitated sessions, to develop their alcohol action plans. All five groups met at least once, with four going on to meet several days to develop their action plans. Parts of four facilitated sessions were observed to inform the final evaluation.

While the aim of facilitated sessions were to guide groups through the process of making a plan, a significant amount of training 'inputs' were included. This included guidance on making a vision and mission statement. The trainer provided examples from a range of agencies. She also presented six slides on 'evidence based approaches', key legislation and the alcohol strategy 'pillars' (among other inputs) to recap on learning from the training and provide information for those who had not been at the training.

For the trainer, gaps in knowledge within the 'alcohol sub committees' became apparent during the facilitated sessions. She felt that this was because all relevant information was not fed back to the wider membership of the alcohol sub-committee, '*while documents may have been sent, these are not always read or understood*'. One focus group member who had not attended training felt that there was a 'disconnect' because she had missed out on the training element. Other people who had not participated felt that it did not leave them at a disadvantage, as they were managing to collaborate in the formation of a plan. However, this does need to be seen in the context that the trainer was providing additional training as part of the facilitated session. The trainer felt that there was duplication for some participants.

For one group, the facilitated sessions were tailored to link in with a previous funding application made to address alcohol related harm: "she helped us to make sense of this process and give us ownership of it". They felt that the facilitated sessions had helped them to identify a common vision and embed the plan among the different members of the alcohol subcommittee. While the original intention was to develop plans before making applications, for this group the timing did not fit. This approach showed flexibility on the part of the trainer, to support the development of a plan which responded to a specific local context and gain wider stakeholder involvement.

Feedback to date from participants on four subcommittees shows that all participants felt the facilitated sessions were very helpful (questionnaire and focus group data). However in one group, not all members felt that the group was ready for this process. In the focus group, group members referred to other commitments, which may explain this response. However it is interesting to note that one group member was 'not sure' if community action is a good approach to address alcohol related harms.

Alcohol Sub Committee	Number Of responses	View of community action approach	Value of facilitative process	Readiness of the group	Participation during the session	View of the facilitator
Project A	5	100% say it a good approach	100% say it is helpful or very helpful	100% say their group was ready	100% say there was good participation	100% agree or strongly agree the facilitator was skilled in her approach

Project B	12	100% say it is a good approach	100% say it is helpful 2/3 say extremely helpful.	100% say their group was ready	100% say there was participation	100% agree or strongly agree the facilitator is skilled in her approach
Project C	10	100% say it is a good approach	100% very helpful or extremely helpful	100% say group was ready	100% say there was participation	100% agree or strongly agree facilitator is skilled in her approach
Project D	5	80% say it is a good approach	100% say it is helpful or very helpful	40% say they were not ready ; 60% say the group was ready	80% say there was participation; 20% are neutral	80% agree or strongly agree; 20% are neutral

Figure 10: Participant responses following facilitated sessions

While participants were encouraged to take responsibility for their own learning, and the transfer of new knowledge and skills into work practices as part of the training sessions (at all stages people were asked to consider new information in light of their own work contexts), this aspect of the training comes into its own in the facilitated sessions. Here, the trainer was able to guide the group while allowing them to come to a consensus on the approach they wanted to take. The approach adopted follows a change management model, in that it engages all of the stakeholders in the change 'vision', seeks to form a powerful guiding coalition and encourages the group to work as a team (Kotter, 1995). The expertise that the trainer brings to the facilitated session, in terms of her knowledge in relation to interventions to address alcohol related harms, provided good focus and clarity for the participants. It is possible that it will also contribute to a higher level of coherence among Task Forces in their strategies to address alcohol related harm.

4.8 Impact of Training on Work Practices

In the post training questionnaires, the vast majority of participants 'agreed' that the training would help them in developing an alcohol action plan (see table below). This view was corroborated in focus groups and interview sessions with Task Forces during the project planning phase. Four out of five projects have managed to complete an action plan to the standard expected by the project. Leadership from the fifth group was not in a position to attend training. While other stakeholders from this community did attend the training, they were not in a position to apply this in a coordinated approach. This example demonstrates the importance of leadership at a local level.

The other four groups felt that training had impacted on work practices. One group member said: *"Every Task Force needs training before you take on the brief, it is a huge brief and a big commitment and you need guidance on where you are going, this [training] focuses you more clearly*".

	Neutral	Agree	Strongly Agree
Training will help us to develop our alcohol action plan N=68	3%	72%	25%

Figure 11: Participants' view of training relevance to work practices

Day	*Comments made by participants, linking learning to work practices*
Day 1	• *Bring information back to the subgroup* • *Link with our local DAFT* • *We definitely are more confident and knowledgeable to lead this* • *Start drawing up plans for research and look at secondary sources of research* • *Feedback to our subgroup*
Day 2	• *Go back to subgroup, work on plan and targets* • *Will feed back to alcohol sub group re training and get them to think about issues in context of logic model.* • *Organise ASAP a meeting with other representatives* • *Meeting others who are working on the same project, liaise more closely with the representatives from my area* • *Feedback to Task Force coordinator initially and subsequently the alcohol sub committee*
Day 3	• *Briefing to the alcohol sub group and use the information for the development of the strategic plan* • *Develop a plan* • *Reconsider priorities to include awareness of FASD (Foetal Alcohol Syndrome Disorder)* • *Look at FASD slightly more* • *Consider both topics for consideration* • *Hopefully our action plan will reflect all today's learning* • *Incorporate learning and specific issues into the discussion about form of our action plan*
Day 4	• *Feedback to alcohol subcommittee, explore setting up media plan over the year, even if only 2 events to start*

	• *Assist in developing alcohol brief locally* • *Communicate knowledge to sub committee* • *Think more about how we can use the media effectively* • *Hopefully some action in local area*
Day 5	• *Start putting plan together and apply for dormant accounts* • *Connect with other trainees* • *I will be in a position to make a contribution to the development of an alcohol policy* • *Focus on the stages with data collection important for baseline* • *Use some of the methods in other aspects of my work* • *Bring back to subgroup*

Comments made on questionnaires, from all five training days, clearly indicate that the majority of participants were planning to use information from training sessions to inform work practices (see table below). In addition, the responses indicate that participants were encouraged to take responsibility for their own learning. Responses suggest that a clear link has been made from theory to practice; and this view was further corroborated with evidence from observation sessions and focus groups. It also indicates that there has been a transfer of new knowledge and skills into work practices.

Figure 12: Excerpt of responses, 'what will you do as a result of this training'.

Participants felt that the training had put a 'focus' on alcohol as opposed to other drugs: "*If you hear about drugs in a community everyone is shouting for resources, but alcohol gets pushed under the carpet all the time'*. In this way the training has pushed 'alcohol' up the list of priorities for Task Forces. This view was shared by the four Task Forces, who contributed to the evaluation, saying that it had made their work on alcohol more strategic and focussed. One group felt that they already gave priority to alcohol, and for that reason, the training did not have as big an impact for them.

The training challenged projects to adopt a 'public health model' approach to address alcohol related harms rather than a rehabilitative model. One person said: "*It is different to our current practice – we are talking about people who may never present to our projects*". This echoes Holders' assertion that community mobilization is about changing the context rather than focussing on the problem user (2004). One group discussed how this was a change in the way they worked. While they had brought together stakeholders in the past to address drug issues, this was the first time they had done it with a specific focus on alcohol.

Projects gained particular insights through the training. One group was able to identify key stakeholders who were missing from their alcohol sub group, and as a result approached them with specific reasons for their inclusion. Another group who were already working in this area, said that the training gave them confidence and validated them in their approach.

They also felt that the training allowed them to focus more on the policy arena, and '*it allowed us to gather data that we hadn't even considered up to that point*'.

All projects said that the particular commitment to the project by the trainer from the alcohol forum had been of benefit to them in the development of their action plan. One person commented: "*You can see the vested interest they have and the commitment they have, they want it to do well*". Other groups also referred to the excellent support they had received, which had helped them to adopt the measures put forward through the training.

In two cases, project leaders did not take part in the training process. In one case this did not stand in the way of this project completing an action plan. This plan submitted for funding, was later used as a framework for building a more detailed plan with community partners. In this way, those who underwent the training did have an opportunity to apply what they had learned. They also felt that their learning would focus their actions into the future.

In the second case, the project did not manage to get their action plan completed to meet the criteria of the CAAP project. While the project chairperson indicated that it had given greater priority to addressing alcohol issues in their Task Force, there was limited engagement with the project. This Task Force intends to continue its community action work in 2016.

According to the project trainer, those who developed community plans with wider community ownership were strategic about who they sent to training. The training advocated that a community coalition be established at the outset to lead the community action project. Early reports indicated that each Task Force had engaged a wide number of stakeholders[15]. Yet, observation at facilitated sessions shows that just 3 projects have adopted this approach. In the other cases, there was a smaller number of external stakeholders (2 people). Groups with a wider number of stakeholders demonstrated a higher level of group ownership of the project. In the project with fewer stakeholders, an external stakeholder said they were unsure of their role in the project, despite attending the 5 days training. It was her view that the project would be carried out by the Task Force staff.

The reasons for lower stakeholder involvement were attributed to the difficulty of engaging people as they are so busy, limited resources and time, an established alcohol agenda and a previous commitment made to a different programme aimed at tackling alcohol misuse. Conversely, in another Task Force, they felt community mobilization contributed to their role in other projects: "*it gives us an avenue into healthy cities...it ties in well with it, rather than reinvent the wheel; it is a way of working together on another partnership".*

All projects said that limited resources would impact on their ability to make their projects work. Even at the planning stage, one project said that a full time person needed to be

[1515] Source: First quarterly report, March 2015, compiled by Alcohol Forum project leader/trainer, see figure 5

dedicated to the project. This relates to the literature where a dedicated resource worker is named as a key aspect of the community mobilization model (Holder 2004). One person said: "*One thing for some young people is parental drinking, there is stuff that needs to happen with parents, that is a gap in our experience, I don't have anyone to work with those parents, and I won't have at the end of this process, we need feet on the ground*". This view was substantiated by all of the projects, they said that the 'alcohol project' had taken resources away from other projects. One person said: *"It is not about new resources but a reconfiguration of what people already do, and that means that other elements of their service lose out*". All groups consulted were deeply disappointed that the 'community commitment' to the project was not being echoed by a 'policy commitment' in terms of available resources (funding) and the implementation of national policies that seek to address alcohol related harm. One person described this as '*putting out a forest fire with a fire extinguisher*'. Despite this view, some projects had come a long way in the development of plans and in the engagement of diverse sectors and interest groups – demonstrating the importance of leadership in adopting the approach.

The discussion above demonstrates that the high quality of training and support offered by the alcohol forum has impacted upon a change in work practices, in terms of the adoption of a public health approach, evidence based measures and a community mobilization model. However, external forces connected with leadership and resources, will also impact on the nature and level of changes in work practices.

5. Local Alcohol Action Plan

In relation to the Local Alcohol Action Plans, the evaluation sought to respond to two questions:

- Did each Task Force develop a 'local alcohol action plan'?
- Were monitoring, review and self-evaluation measures built into the plan?

This chapter will outline the responses to these questions. To inform this, all action plans were reviewed in December 2015. In addition to the other data gathering measures, a short phone interview was held with three coordinators and one chairperson at this time, to enquire about any new developments since previous meetings with the Task Forces (one coordinator could not be reached).

5.1 Did each Task Force develop a Local Alcohol Action Plan?

Four Task Forces completed Local Alcohol Action Plans to the standard anticipated by this project. These plans identified actions under each of the Pillars outlined in the National Substance Misuse Strategy: Supply, Prevention, Treatment/Rehab and

Research/Information. The action plans were broken down into various subject headings: aims, objectives, lead agency, timeframe, performance indicators, resources required and monitoring methods. A fifth taskforce did provide an 'outline action plan', which identifies aims, however no further detail is supplied, therefore it is considered by the evaluator to be incomplete. Despite this, a leader from this Task Force indicated that they would use the 'outline plan' to begin further progress on this work in 2016.

The process that led to the development of Local Alcohol Action Plans has relevance for this question. All plans were developed onsite to respond to perceived local needs. It has already been outlined that different Task Forces had varying levels of stakeholder engagement, this went from a minimum of 2 external stakeholders to a maximum of 10. Where the plan was not completed, there was minimal participation of stakeholders from the Task Force (at the training and facilitation stages), this was attributed to the absence of the lead worker.

All Task Forces that completed an action plan took part in two or more facilitated sessions with the Alcohol Forum trainer. Three of the action plans were reviewed by the project trainer to offer support with the identification of 'key performance indicators' and monitoring methods.

5.2 Were monitoring, review and self-evaluation measures built into the plan

Four projects identified monitoring, review and self-evaluation measures in their action plans:

Project	Monitoring	Review	Self-Evaluation Measures
A	Monitoring methods linked to each project action	Review is named, timeframe for review not indicated	Self-evaluation measures are identified
B	Monitoring methods are linked to each project action	Proposes regular reviews by the steering committee (annually)	Identifies a process evaluation with UCC and self-evaluation measures
C	Monitoring methods are linked to each project action	Proposes a bi-annual progress review	Proposes an annual evaluation informed by self-evaluation measures
D	Monitoring methods liked to each project action	Bi-annual review	Proposes range of self-evaluation measures to inform a midterm evaluation

E	No monitoring measures identified	No review measures or date identified	No self-evaluation measures identified

5.3 Further research on the quality of plans

The terms of reference for this study did not seek to assess the quality of the plans produced. The literature indicates, that for community action to be effective, it should utilise multiple intervention strategies and be informed by evidence based practices. The literature also indicates that a range of measures can be applied for measuring project impacts, such as already available statistics (e.g. hospital admissions), the use of control sites as well as self-reported outcomes. Paying attention to the level of community ownership and community participation in such processes is also worth monitoring in action plans. While it was not the goal of this report to evaluate these areas, it may be worth keeping these in mind for future reviews.

6. Conclusion

The Community Action on Alcohol Pilot Project sought to achieve the following objectives:

- To introduce a model of Community Mobilization on Alcohol to Local and Regional Drug and Alcohol Task Forces to be implemented in their communities
- To build awareness of alcohol related harm to both the drinker and to others
- To raise awareness of the evidence of effective community mobilization measures on alcohol and sustainable actions under each of the pillars of the National Substance Misuse Strategy
- To promote community engagement and the involvement of all key stakeholders in identifying local needs and in the development of Local Alcohol Action Plans
- To ensure adequate monitoring, review and evaluation measures are built in to the development of local plans

This section will summarise the finding from the primary and secondary research and compares them with the literature review findings.

6.1 Enabling Factors

Several authors maintain that training for community action on alcohol is associated with higher levels of perceived community readiness (Wagenaar 1999, Drabble and Herd 2014, Holder 2004). The Community Action on Alcohol Pilot Project delivered high quality training, which drew from science based approaches. The inclusion of science based approaches, is seen as a central feature of community action on alcohol (Wagenaar 1999, Holder 2004). The training was perceived as extremely positive by the participants, it was accessible to them and increased their knowledge on alcohol related harms. The training adhered to most of the DEWF standards (2007), provided 'user friendly guides and materials (Quinby et al, 2008) and was delivered using best practice methods in adult education (Bryan et al, 2009).

All groups consulted said that the training fixed 'alcohol issues' on the agenda for them and they learned new information. Some said that they learned about a public health approach to addressing alcohol issues, which differed from their current modes of intervention. The particular approach and knowledge of the trainer, her dedication to the project and the high level of support she offered, was raised and acknowledged by all focus groups.

Following training, the trainer engaged in facilitated sessions with five groups to support the development of their community action plans on alcohol. Coalitions that receive training and ongoing support are more likely to maintain science based approaches (Gloppen and Hawkins 2012). Facilitated sessions allowed groups to collectively agree upon their vision and approach. Holder also maintains that broad community leadership needs to be involved in the design and implementation of actions. The facilitated sessions 'focussed' participants to develop plans, in line with wider policy instruments and effective (evidence based) policy interventions.

Delivering training at a central location had benefits for the participants, in terms of sharing information, learning about the experiences in different counties, raising ideas for collective working and collective problem solving around alcohol related issues. It also gave participants a sense of this being a national initiative and gave them confidence to tackle alcohol related harms, in that they were not alone. There was consistent attendance by trainees and they participated fully in all of the activities of the training.

6.2 Critical barriers and strategies to address them

This project was particularly successful in addressing barriers they confronted. In addition to the five training days, many more supports were given to projects to help them in their planning and applications for funding. Additional training supports were also given to projects, when requested. The trainer was skilled in building training elements into the facilitated sessions, here the information 'inputs' were welcomed by participants as it gave them greater focus in their planning process. It also addressed skill gaps for those who were unable to attend training. The data shows that the trainer responded to training needs, different learning styles and catered for a range of abilities.

While the training was successful, participants raised issues about the structure of the programme, in terms of the difficulties associated with attending training at a central location, and the amount of time that this required. This project differed from examples named in the literature, where training occurred on site with boards (Quinby et al, 2008). While this approach had benefits for the participants in terms of networking, it also presents itself as a barrier in a number of respects.

All groups outside of Dublin found the training to be time consuming and costly. This view was also held by those who chose not to take part. In two groups some were concerned about the training being divorced from the planning, which they felt lengthened the process for them. For some people, the training covered areas that they were already familiar with in their professional work, however this view was not held by the majority of trainees (e.g. planning and research).

It was hoped at the outset that trainees would be able to bring back information to other members of their subcommittees. While this happened in some locations, it did not occur across the board and participants said that they found this aspect of the project difficult. The project leader addressed this issue well by providing specific additional training sessions for groups on key issues and including training inputs as part of the facilitated sessions. This meant a duplication of training delivered in order to get everyone 'on the same page'. This was an important strategy, as board structure and stability, fidelity to risk focussed approach and a strong community coalition are seen as crucial to positive outcomes (Greenberg et al, 2005).

Time also impacted in other ways. Due to pressures of time at the beginning of the project, three of the specific training days planned with *sub committees* did not take place. This was the first meeting that the project leader was to have with sub committees in each of the areas. The issue was addressed by including the training as part of the '5 days'. However it meant that the trainer did not meet with sub committees until after the training programme was completed. This omission may have lessened the pressure on some Task Forces to establish working sub committees early in the process.

Aside from the training process, external factors impacted on projects abilities to apply learning. In two cases, project leaders did not attend the training and external stakeholders were not in a position to 'push forward' the agenda in their respective Task Forces. It also became apparent, after the completion of training that many of the stakeholders who were initially named by Task Forces (in March 2015) were not participating. A study from the UK also noted the challenge of getting stakeholders involved and dedicating resources (Mistral et al, 2007).

The trainer took measures to address limited stakeholder involvement throughout, by keeping in touch with projects and advising them on strategies to engage members. Despite this, in two cases there was limited external stakeholder involvement. A broad based community coalition to lead the process is recommended (Wagenaar 1999, Holder 2004, Hawkins et al 2002, Drabble and Herd 2014). One of these projects went on to develop an action plan to completion, the other managed to develop an outline action plan.

The literature shows that community action takes time (around 5 years), and this project accounts for a short amount of time in a community mobilization process. Four groups managed to complete their action plans. Two groups were involved in carrying out local research to inform actions and two groups did not carry out local research, all had ongoing research as an 'action' in their plan. This sequence does not follow the approach outlined in the literature (Holder 2004, Shakeshaft et al 2012; Gloppen et al 2012; Wagenaar et al 2000) where local research precedes action planning. It may indicate that support for community mobilization will need to take place over a longer process, or at a pace in line with project development and the engagement of stakeholders. Most projects saw the 'community action on alcohol' as the beginning of a process of addressing alcohol related harm in their communities, and felt that the training was successful in preparing them for the road ahead.

6.3 Determinants of sustainability and transferability

The goals of this project were to train stakeholders in relation to alcohol related harms, raise awareness of policy measures, support community engagement and the development of local alcohol action plans. The evidence has shown that the pilot project was successful in this regard. This process was enabled through the ongoing support of the alcohol forum support worker and the dedication of project participants. It has already been outlined how training and support can be a determinant for effectiveness in the longer term (Gloppen and Hawkins, 2012). During the pilot project the trainer dedicated more time than was anticipated in supporting groups and this additional support has enabled groups to progress further in their planning process. Therefore, a determinant of sustainability is the ongoing support for groups following a formal training process.

The facilitation part of the project was seen as particularly effective for getting everyone on 'the same page' and applying the learning from the training process to their own local context.

External forces were also seen to have a bearing on the sustainability of the process. Participants in three focus groups expressed dismay about the level of government commitment to some policies that have been shown to lower alcohol related harm, e.g. Advertising alcohol through sports and the product placement of alcohol in shops. They were also disappointed that additional resources had not been allocated to communities to work on alcohol. Subsequently, four Task Forces were successful in attracting funding for parts of their alcohol action plans. This view echoes the literature where 'complimentary system strategies' (Holder 2004; Shakeshaft 2014) and 'a full time community organiser' (Holder 2004) are identified as necessary to achieve the best outcomes.

The inadequacy of resources was seen as an impediment to making a plan and enacting it into the future. All projects said that the project had taken time away from other work. One project commented that the work on alcohol could fill a full time job already. Three projects consulted thought initially that applications for funding would occur at the end of this year, to compliment the progress of this project. Instead, a call for applications came in the middle of the year. The changing timeframe for applications was seen as disruptive and unhelpful by all project groups as it meant that plans had to be submitted before their own planning processes were completed. Consequently, however, funding came through when plans were nearing completion, this was described as 'perfect timing' by one Task Force coordinator.

The attention that groups put on the wider policy context and resources, demonstrates that groups are familiar with the alcohol policy environment (a goal of the pilot project) and that they now have greater clarity about what will be needed (in terms of resources) to take measures to address alcohol related harm. It also shows their motivation to effect change in this area.

Board functioning, independent of funding was identified in the literature as a predictor of sustainability (Gloppen, Hawkins et al 2012; Brown et al 2011). Observation of groups has demonstrated that three Task Forces had a strong cohesive coalition with a range of stakeholders (Feinberg et al 2004). Therefore, this may be a predictor of sustainability in this instance. Nonetheless, it is very early in a community mobilization process and groups have related that they intend to progress on this issue.

One project participant talked about 'our ambivalence to alcohol' in Irish culture. It is about holding the conflicting positions of being conscious of the harm caused by alcohol and wanting to do something about it, while also 'enjoying a pint' on a Saturday night. In the literature, 'grievances', were named as a pre-cursor for social action (Herd and Berman, 2015). The 'attitudes to alcohol' session led by the trainer did a lot to explore this issue.

Two groups felt it was so valuable, they asked the trainer to do it again with their respective sub committees. This approach, along with information in relation to alcohol related harms, may be useful as part of a strategy to overcome community resistance to defining alcohol misuse as a problem.

Two projects in this study engaged with local colleges and universities to help them progress their plans. Research has shown that collaboration with university based researchers can support the development of an evidence base for work in the future (Quinby et al, 2008).

6.4 Further research

One in four Irish people (28%) reported experiencing one or more negative consequences as a result of someone else's drinking, such as family problems, being a passenger with a drunk driver, physical assaults, vandalised property and money problems (Hope 2014).

This study explored the process of a training programme to initiate action to reduce alcohol related harm. It noted how the training was effective in increasing knowledge in alcohol related harm, increasing knowledge on the policy environment, raising awareness of evidence based approaches and promoting community engagement. However, the factors that lead to effective change are much wider, including aspects of community motivation and leadership capacity (Drabble and Herd 2014,). This study has also exposed the limited amount of research in relation to the *process* of community action and a dearth of research in relation to community action to address alcohol related harm in an Irish context.

The studies explored in the literature review showed that community action was effective in addressing alcohol related harm. Just one study noted that policy based interventions may be more effective than community action (Shakeshaft 2014). Holder maintains that wider policy intervention and community action can work hand in hand to reduce harm. This was substantiated during the observation of facilitated sessions. In two different communities they were identifying how they could work with the police to better monitor and manage the consumption and purchase of alcohol, so that the laws could be made more effective. Documenting these approaches and analysing if these interventions lead to a reduction in harm in Ireland, could help strengthen the case for communities and the police to engage on this issue, as documented by the UK CAPP (Mistral et al, 2007).

This evaluation does not explore the quality of plans or the impact of the planning process within communities and upon alcohol related harm. Further research, exploring the effect of different community interventions aimed at lowering risk and increasing protection against alcohol related harm, in an Irish context are worth exploring.

7. Recommendations

The Community Action on Alcohol Pilot Project has been successful in increasing knowledge in alcohol related harm, increasing knowledge on the policy context, raising awareness of evidence based approaches and promoting community engagement. This report has also demonstrated the high quality of training delivered and the effective training methodologies employed. Over 95% of participants agreed that the content was organised and easy to follow, the materials were useful and easy to understand and the objectives of the training were clearly defined. Participants were able to apply the learning to their own work contexts, although the level of stakeholder engagement varied. Four out of five Task Forces completed a community action plan on alcohol to the standard expected by the project.

Community action on alcohol is a long term process and this project marks the beginning of this process for many of the groups involved. While some Task Forces were able to begin research processes to inform their 'action plan on alcohol', others have identified 'research' as part of their project actions. Therefore, Task Forces involved in the pilot project progressed their plans at different paces, and noted the high level of resources needed to affect change.

7.1 Process for developing recommendations

The researcher engaged in a discussion with the steering committee and project worker to finalise recommendations for the study (Thornton and Armitage 2010). In the preliminary report, the evaluator drew on all of the findings of the research to inform broad recommendations for future activity. These were then presented to the steering committee for discussion. The steering committee accepted all of the recommendations at this stage, however some suggestions for clarification were made. Also at this stage, the key worker involved in the project suggested a range of pragmatic measures that could be included in future programmes, drawing on the findings of the study. All of this feedback was considered by the evaluator, in light of all the evidence collected. The following recommendations outline the results of this process.

7.2 Factors for Strategic Development

7.2.1 **Community Action on Alcohol is most effective in a supportive macro policy environment** (Holder 2004). The General Scheme of the Public Health (Alcohol) Bill 2015, indicates that some of the concerns raised by Task Forces as part of this study; in relation to the labelling and marketing of alcohol products and minimum unit

pricing will be addressed. These policy measures, if implemented, will compliment and greatly enhance the efficacy of community based efforts to reduce alcohol related harm in our society. Simultaneously, the literature supports the notion that community engagement on addressing the harm caused by alcohol will support the implementation of such policies locally.

7.2.2 In the literature, **fidelity to evidence based approaches** in community action, was seen as imperative to its success. In one case, a specialist agency, checked (or audited) plans for adherence to these methods. Building this aspect into future programmes, could enhance its efficacy and build the expertise of community coalitions. This aspect could also allow for a national overview of community based activities, thereby informing policy initiatives and the identification of shared learning needs.

7.2.3 The current evidence that exists on community mobilisation/action on alcohol has been gathered through **cooperation between projects and university partners** over an extended timeframe. No research of this kind has yet taken place in Ireland. During this project, two participant groups engaged with third level institutions to support the measurement of outcomes and inform actions. This should continue to be encouraged in future programmes. Finding a university partner (at a national level) to work with a range of projects and measure outcomes could also be explored.

7.3 Delivery of Training

7.3.1 The data collected during the training programme indicated clearly that the training materials were of a good standard, organised and accessible to participants. The materials outlined the community mobilisation approach, demonstrated a community mobilisation project in Ireland, research methods, results based management, alcohol related harm, marketing of alcohol, media and lobbying skills and effective policy measures to address alcohol related harm. While the course materials covered the more extreme conditions related to alcohol misuse – Alcohol Related Brain Injury and Foetal Alcohol Spectrum Disorder, it also gives ample coverage to the wider harms caused by alcohol misuse, such as hospital admissions, other medical conditions, public disorder and relationship breakdowns. While a case study from Ireland was included, the training materials could be further reinforced by **including evidence based sources** on effective interventions aimed at lowering risk factors and enhancing protective factors, made by *community mobilization* on alcohol projects to reduce consumption and alcohol related harm.

7.3.2 In this project, representatives from alcohol sub committees attended five days training in Dublin. The project trainer then facilitated the sub-committees over 2-3 days, in the five locations, to support the development of an action plan. While attendance in the training was high, it proved difficult for participants to report back on training as originally intended. In addition, training inputs had to be included in facilitated sessions to bring other members 'up to speed'. Given the 'active' nature of the training process, and the application of learning on-site, it was unfortunate that other sub-committee members were not included. However, the time needed to attend training (especially by those outside of Dublin) was also seen as a barrier. Simultaneously, the networking experience and learning from others was named as highlight of the programme by the majority of participants.

In future programmes, the bulk of the training should be delivered on-site with alcohol sub committees, placing more emphasis on leadership and management of the process. This could combine the facilitative and training aspects of the project and thereby reduce the time invested. By dispersing these training days over a longer timeframe, it allows time for groups to consolidate and carry out local research to inform planning. It also takes pressure off volunteers and staff to attend training within a short timeframe. The use of 'blended learning' for groups, through the use of DVD's, YouTube or other methods, could also be considered to manage the time invested by project providers. Extension of the process to an 18 month timeframe, could allow this to occur, with a longer lead in time for project initiation.

7.3.3 Networking days were seen as a beneficial part of the pilot process, where people learned off each other and the project gained a national identity. Therefore, fewer networking days should be included for alcohol subcommittee members to meet other projects and learn from them. Engaging projects on a regional basis, would cut down on time and travel costs of staff/volunteers for network days.

7.3.4 The literature showed that ongoing technical support contributed to more sustainable outcomes for group. Once groups have completed their local alcohol action plans, maintaining a relationship between the project trainer and the subcommittee, could support them to overcoming some of the issues that will arise.

7.4 Investing in Community Action at a Local Level

7.4.1 The literature is clear that community action is effective when it is **led by a community coalition** and gains wider community 'buy in'. Grass roots organising and developing community capacity was seen as central to all other strategies to

creating change, as well as adequate time for project initiation (Drabble and Herd, 2014). During this project, not all Task Forces established a community coalition that had a wide range of stakeholders. Where external stakeholders were engaged, a more comprehensive discussion on alcohol related harm in the local area and the inputs required to address these occurred in facilitated sessions. Given the large investment made by the Alcohol Forum in working with groups, it is recommended that in future programmes, the alcohol subcommittee is established before the commencement of training. In addition, a facilitated session/s with the alcohol subcommittee should occur at the beginning of the process, in order to build community ownership, explore attitudes to alcohol and become familiar with the community mobilisation approach. A longer lead in time may be necessary to enable this to occur.

7.4.2 This Pilot Project demonstrated the importance of **leadership at a local level**. The projects that progressed the most had strong local leadership and a commitment to the process. The literature echoes this analysis, identifying leadership as the critical factor for changing policies and prevention work in relation to alcohol misuse (Drabble and Herd, 2014). Observation at training sessions clearly demonstrated that the training was an active process. Participants were involved in applying learning to their own situations and problem solving. Where project leaders were not present for this process, it was at a loss to the alcohol subcommittee. In future programmes, leaders need to be a central part of the learning process in partnership with the other stakeholders.

7.4.3 The **management of resources** was a challenge for all Task Forces in executing this project and it is clear that proper engagement with the process requires staff energy, time and commitment. All projects viewed the dormant accounts fund as a great benefit in progressing their action plans. Given the emphasis put on resources (along with leadership) in the literature, efforts should be made to seek future funding and if available, coordination between departments in its delivery could support community mobilisation responses. In the absence of additional funding for future programmes, Task Force managers need to be aware of the scope and the commitment needed and prepare and plan for 'alcohol work' within the available resources.

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Appendix 1: DEWF Standards

Learner centred
Interactive
Empowering
Enjoyable
Promote individual and group development
Supportive
Inclusive
Promote and maintain of respect and confidentia
Relevant
Values personal experience
Agreed ground rules established at the beginning of all groups
Methodology predicated on needs assessment
Relevant to social and economic needs.

Appendix 2: Training Evaluation Questionnaire **(sample)**

Please answer all questions. Indicate your preference by ticking one box in each row. Tell us more about your answers, by writing in the places provided. Please answer all questions.

1. Overall I found the training to be ...

Not useful	Somewhat useful	Useful	Very useful	Extremely useful
☐	☐	☐	☐	☐

2. Tell us about your experience of the training....

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The content was organised and easy to follow	☐	☐	☐	☐	☐
The materials are useful and easy to understand	☐	☐	☐	☐	☐
The objectives of the training were clearly defined	☐	☐	☐	☐	☐
The trainers were knowledgeable on the training topics	☐	☐	☐	☐	☐
There was good participation and interaction during the training	☐	☐	☐	☐	☐
The time allotted was sufficient	☐	☐	☐	☐	☐
The training room was adequate and comfortable	☐	☐	☐	☐	☐

3. What was a highlight of the training for you?

4. What aspect of the training could be improved?

Were the training objectives met?

5. How would you rate your understanding of <u>how the media influences our behaviour?</u>

	Very Low	**Low**	**Moderate**	**High**	**Very High**
Before the workshop	☐	☐	☐	☐	☐
After the workshop	☐	☐	☐	☐	☐

6. **How would you rate your <u>skills</u> to use various media?**

	Very Low	Low	Moderate	High	Very High
Before the workshop	☐	☐	☐	☐	☐
After the workshop	☐	☐	☐	☐	☐

7. **How would you rate your own level of <u>confidence</u> to engage with the media? (As part of a Local Alcohol Action Plan?**

	Very Low	Low	Moderate	High	Very High
Before the workshop	☐	☐	☐	☐	☐
After the workshop	☐	☐	☐	☐	☐

8. **In your view, should a media strategy form part of a local alcohol action plan?**

It is very important	Important	Neutral	Somewhat important	Not important at all
☐	☐	☐	☐	☐

9. **Will you be able to apply what you have learned?**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The training will help in the development of our alcohol action plan	☐	☐	☐	☐	☐
I feel confident that I can communicate this learning to our alcohol sub committee	☐	☐	☐	☐	☐

10. **What will you do as a result of this training?**

11. **Was it helpful to meet with colleagues working in this field?**

Extremely helpful	Very helpful	Neutral	Not that helpful	Not helpful at all
☐	☐	☐	☐	☐

Please explain your answer:

12. **Any other comments you wish to make about the training or the evaluation?**

Appendix 3: Post Training Reflection Document

Community Action on Alcohol Project 2015 Reflection **Post Training**

Trainer's Name: _____ Date: _____

1. Do you feel the learning outcomes were achieved Yes ☐ No☐

2. What aspects of the training worked well?	
3. What would I change if I was to deliver this training again?	
4. Notes on participants' reaction to the training content or methods	
5. Describe any issues arising that may a) contribute to implementation	

b) present as a possible barrier to implementation	

Appendix 4: Training Observation Instrument

Date: 13th May

Topic: To develop a greater understanding and increased knowledge base of the scope and intensity of Alcohol harm in Ireland**.**

Trainer:

Main Goal of the session:

- To build a greater knowledge base of the varied nature and intensity of the impact of Alcohol harm in Ireland:
    - To examine our own attitudes to alcohol
    - Harm to the Drinker
    - Harm to Others
- To introduce and develop the participants knowledge of specific areas of Alcohol Harm
    - Alcohol Related Brain Injury
    - Foetal Alcohol Spectrum Disorder
    - To introduce Alcohol related Hidden Harm
- To introduce innovative use of Brief Advice & Brief Interventions
- To gain from peer experience and perspective

In your observations consider

- Use of Best available evidence
- Situational relevancy – linked to previous and current work role?
- Quality of materials – format, readability and clarity?
- Adopting principles of adult learning:
- Adults involved in the planning and evaluation?
- Inclusion of learning activities
- Problem centred rather than content oriented?
- Are the Most effective methods for maintaining interest being used?
- Are they taking responsibility for their own learning
- Learning strategies used.

Data-based Observations	Interpretations/Questions/Comments

Part II: SUMMARY ANALYSIS

1	2	3	4	5
Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**

_____ 1. The exercise **learning objectives** were met.

_____ 2. The answers the facilitator gave to participants' questions were **clear**.

_____ 3. The facilitator provided illustrative **examples**.

_____ 4. The exercise was **well facilitated**.

_____ 5. The exercise allowed participants to practice **practical skills** related to important concepts

_____ 6. The exercise was an effective way for individuals to learn important **information**

_____ 7. Participants were **actively engaged** in the exercise

_____ 8. The exercise **overall** was effective.

9. How did the facilitator(s) **contribute** to participant learning during this exercise?

10. Note any areas for improvement:

11. What were the Positive indicators for implementation of project?

12. What were the indicators for potential barriers to project implementation?

Appendix 5: Interview questions for Project Trainer

1. **Looking back on the training content, what worked well? What would you change?**
2. **What enhanced the impact of the training?**
3. **What inhibited the impact of the training? how would you deal with these in the future?**
4. **Did the training contribute to better plans?**
5. **Did bringing the Task Forces together contribute to learning? How?**
6. **What worked well when facilitating groups, what would you change?**
7. **Did all Task Forces engage with local stakeholder groups? Did this change the process/end plan?**
8. **Do all Task Forces have a meaningful community action plan, why**
9. **Have Task Forces built in evaluation measures?**
10. **Any other comments you want to make**

Appendix 6: Evaluation of the Facilitative Process *(delivered by the Alcohol Forum) to support the development of a Local Community Action Plan on Alcohol. Please answer all questions.*

1. **Name of your Task Force: _____**

2. **In your view, is a community action plan a good way to address alcohol related harms in your community?**

Yes	No	Not sure
☐	☐	☐

Please explain your response:

3. **Did the facilitative process help your group to develop a Local Community Action Plan on Alcohol?**

Not helpful	Somewhat helpful	Helpful	Very helpful	Extremely helpful
☐	☐	☐	☐	☐

4. **Since beginning this process....**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have increased my knowledge of 'alcohol related harms'	☐	☐	☐	☐	☐
I understand more about community approaches to address alcohol related harms	☐	☐	☐	☐	☐

5. **During the facilitative process**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Our group was ready to take part in this process	☐	☐	☐	☐	☐
There was good participation during the sessions	☐	☐	☐	☐	☐

The facilitator was skilled in her approach	☐	☐	☐	☐	☐

6. **Is there anything you would have changed about the facilitative process?**

7. **Overall, what has been the benefit to your group (if any)?**

Appendix 7: Sample Focus Group questions

1. What have been the good features of this project for your group?

2. What have been the challenging features?

3. Did the training programme have an impact on your work? How?

4. Were you successful in engaging stakeholders?

5. Did your planning process, follow a community mobilisation model? (see diagram overleaf)

6. Has your involvement changed your group or the work you do in any way?

7. Do you have any more work to do on your plan?

8. Do you feel that your plan will be implemented, are there any barriers to implementation

9. Any other comments

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