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Research Paper

‘The opportunity to have their say’? Identifying mechanisms of community engagement in local alcohol decision-making

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ABSTRACT

Background: Engaging the community in decisions-making is recognised as important for improving public health, and is recommended in global alcohol strategies, and in national policies on controlling alcohol availability. Yet there is little understanding of *how* to engage communities to influence decision-making to help reduce alcohol-related harms. We sought to identify and understand mechanisms of community engagement in decision-making concerning the local alcohol environment in England.

Methods: We conducted case studies in three local government areas in England in 2018, purposively selected for examples of community engagement in decisions affecting the local alcohol environment. We conducted 20 semi-structured interviews with residents, workers, local politicians and local government practitioners, and analysed documents linked to engagement and alcohol decision-making.

Results: Four rationales for engaging the community in decision-making affecting the alcohol environment were identified: i) as part of statutory decision-making processes; ii) to develop new policies; iii) as representation on committees; and iv) occurring through relationship building. Many of the examples related to alcohol licensing processes, but also local economy and community safety decision-making. The impact of community inputs on decisions was often not clear, but there were a few instances of engagement influencing the process and outcome of decision-making relating to the alcohol environment.

Conclusions: While influencing statutory licensing decision-making is challenging, community experiences of alcohol-related harms can be valuable ‘evidence’ to support new licensing policies. Informal relationship-building between communities and local government is also beneficial for sharing information about alcohol-related harms and to facilitate future engagement. However, care must be taken to balance the different interests among diverse community actors relating to the local alcohol environment, and extra support is needed for those with least capacity to engage but who face more burden of alcohol-related harms, to avoid compounding existing inequalities.

Introduction

Community engagement promotes the involvement of citizens in decision-making that affects their lives (Attree, French et al. 2011). Engaging the community in actions targeting the alcohol environment has been recommended in global strategies to reduce alcohol-related harms (World Health Organization 2014) and reflects broader commitments to promote citizen contribution to improving health and inequalities (Public Health England 2015, World Health Organization 2017). While there are rich bodies of knowledge around mechanisms for supporting community engagement to improve health (see for example Pennington, Watkins, Bagnall, South, & Corcoran, 2018), there is a paucity of research into this in the context of alcohol decision-making. Given increasing evidence of effectiveness of local alcohol policies for

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reducing health and social harms (Martineau, Tyner et al. 2013, De Vocht, Heron et al. 2017), it is important to examine what role communities can – and should – play in influencing decision-making processes, to help reduce harms from the local alcohol environment. As a first step towards this aim, we describe the findings from case study research which explored mechanisms of community engagement in alcohol decision-making in local government areas in England.

Community engagement to improve health

Engaging the community in decision-making is often seen as an inherently 'good thing' (Parry, Laburn-Peart et al. 2004), and constitutes various practices for involving citizens in policy and other decisions outside traditional representative democratic structures. Community engagement can be seen as a form of participatory democracy (Carpenter & Brownill, 2008), reflecting broader political shifts towards localism and the dispersal of control over resources to the local level (Buser 2012). Community engagement may also help improve health and reduce inequalities (Popay, Whitehead et al. 2015). Including the community in the design and / or delivery of policies or programmes may help improve their appropriateness and therefore effectiveness to address health and / or social issues (Bridgen 2004). Engagement may empower communities to build individual and collective capacity to shape broader determinants of health (O'Mara-Eaves et al., 2013) and to feel more 'in control', with potential health benefits (Whitehead et al., 2016).

Common critiques of 'community engagement', however, highlight the varying levels of power offered to community members through engagement; from the least empowering practices of information-giving and consultation, to the most empowering where the community is in control over what decisions are made (Popay, Attree et al. 2007).'Tokenistic' engagement, with no real possibility for communities to influence decisions (Taylor 2006), may lead to disillusionment and disempowerment of citizens (Blakeley and Evans 2009). Furthermore, defining 'community' can be problematic (Reynolds 2018), as it cannot be taken to be a fixed, homogeneous entity (Stephens 2007). Therefore, the range of interests, practices and identities of communities in relation to the local alcohol environment must be considered carefully when exploring how communities might be enabled to influence alcohol decision-making.

For the purposes of the research described in this paper, we adopted a broad definition of 'community', to include groups of people connected by location, identity and / or interest, to enable understanding of the different people who might become engaged with local alcohol decision-making. We also recognise the conceptual fluidity of 'community engagement', alongside 'public' or 'citizen' 'involvement' or 'participation'. Subtle distinctions between definitions of these terms typically reflect motivations for, and types of participation, and levels of empowerment (Brunton, Thomas et al. 2017). The framing of 'community engagement' used for this research was broad and open, to include any practices that facilitate the sharing of views of people positioned outside standard local government decision-making structures (McGrath et al., 2019).

Local alcohol decision-making to reduce harms

Local policies and decision-making processes can help reduce health and social harms by shaping the accessibility and availability of alcohol (Burton, Henn et al. 2017). International research highlights the effectiveness of licensing policies and legislation for reducing alcohol-related harms (Foster et al., 2017), and in many countries, including the UK, the function for granting licenses to sell alcohol is managed by local government. Under The Licensing Act 2003 for England and Wales, local authorities (LAs) can shape the hours and conditions of alcohol sales by individual premises through their statutory responsibility for approving licence applications, or by revoking licences where breaches of conditions have occurred, in line with the four licensing objectives (Reynolds, McGrath et al 2018). These are: i) prevention of crime and disorder, ii) protection of public safety, iii) prevention of public nuisance, and iv) protection of children from harm.

The Act designates as 'responsible authorities' a range of agencies working in or in partnership with LAs, including licensing, environmental health, planning, public health, child protection, police and others. These responsible authorities have a right comment on applications for new licences to sell alcohol and for revisions to existing licences, and to call for reviews of existing licences. Members of the public are also permitted to comment on licence applications or existing licences in the same way, and new licence applications must be made publicly available for consultation. For comments – or 'representations' – to be considered valid they must relate directly to one or more of the four licensing objections, and be received within the allotted timeframe, typically 28 days. Any valid representations submitted (by responsible authorities or members of the public) must be considered at a hearing overseen by the local licensing committee (comprising locally elected councillors) before a decision is made by the committee. The committee may decide to grant, refuse or revoke a licence, or impose conditions upon the premises and the sale of alcohol (Reynolds, McGrath et al 2018).

Each local authority area in England must also develop a Statement of Licensing Policy (SLP) which sets out local priorities for licensing practice and decisions, and must be reviewed every five years (Nicholls 2015). As with other policy making at the local government level, each SLP is subject to a local statutory public consultation process.Some LAs may also choose to implement additional (optional) policies relating to managing the alcohol environment, such as the cumulative impact policy (CIP), designed to address issues relating to density of alcohol availability (Pliakas, Egan et al. 2018). Following the statutory public consultation process, a CIP can be used to designate specific local areas as suffering a high density of alcohol harms, and any applications for new licences in these areas will be refused unless applicants can demonstrate that they will not contribute to these levels of harm (Egan, Brennan et al. 2016). In addition to alcohol licensing processes and policy, there may also be potential for other types of place-shaping decision-making, such as planning policy or local economic strategies implemented by LAs, to help reduce harms from the local alcohol environment. However, there is currently only limited understanding of the possibilities for this in England (McGrath et al., 2019).

Efforts to involve the community in reducing alcohol harm typically take the community as the setting and / or target population of interventions (Room 2017), for example initiatives involving voluntary restrictions on liquor licensing in remote areas in Australia (D'Abbs and Togni 2000). Another interpretation of 'community' has been seen in Community Alcohol Partnerships (CAP) established in the UK since 2007 (see https://www.communityalcoholpartnerships.co.uk/), through which alcohol retailers, licence-holders and business owners work with local government and other statutory stakeholders to target under-age drinking and related issues. However, the CAP model has been criticised for its restricted definition of 'community', which focuses on the local alcohol industry rather than residents, and lacks evidence of effect for reducing alcohol-related harms (Petticrew, Douglas et al. 2018).

There are formal recommendations for communities to play a more active role in shaping licensing decisions; for example, in guidance supporting the Licensing Act 2003 for England and Wales, which recommends:

> "encouraging greater community involvement in licensing decisions and giving local residents the opportunity to have their say regarding licensing decisions" (Home Office 2015, paragraph 1.5).

There have been similar recommendations in licensing legislation in New Zealand and Australia (Kypri and Maclennan 2014,

Livingston, Wilkinson et al. 2016), and in Scotland formal structures involve community members in reviewing and advising local licensing processes (Scottish 2007). However, the extent to which these recommendations and structures enable residents and other communities to participate in and influence alcohol decision-making is unclear.

There are few reported examples of successful community engagement in licensing in England (McGrath et al., 2019), although an initiative to empower community members to intervene in local licensing processes is currently being evaluated in Greater Manchester (Cook, Hargreaves et al. 2018). In Scotland, ensuring community representation on local licensing forums remains challenging (Fitzgerald, Winterbottom et al. 2018), and in Australia and New Zealand, recent research suggests very little evidence of the successful involvement and impact of the community on licensing decisions (Kypri and Maclennan 2014, Livingston, Wilkinson et al. 2016). However, literature describing indigenous communities' involvement in policies to control local access to alcohol suggests that community input to decisions about alcohol prohibition and restriction can lead to positive health outcomes (Muhunthan, Angell et al. 2017). This indicates that more understanding is needed of the different ways communities can be enabled to engage in decisions affecting the local alcohol environment, both through licensing and other areas of decision-making.

Aim

This research aimed to identify examples of community engagement in local alcohol decision-making, to explore the 'communities' involved, the kinds of participation facilitated and any outcomes of engagement. As such, we sought to contribute to identifying how best communities can be enabled to influence decisions to reduce harms from the local alcohol environment.

Theoretical framing

We drew on two theoretical framings in this work. First, we adopted a systems perspective toward the local alcohol environment and how policies and decisions might influence it. Systems perspectives incorporate a range of theories to understand how factors are interconnected within a complex and dynamic 'whole' (Hummelbrunner 2011, Gates 2016). This thinking has been increasingly employed in public health and social policy research, to take better account of the interrelatedness of different spheres of action and how they might be engaged to bring about change as a result of a policy or other intervention (Caffrey and Munro 2017). Systems perspectives have also been applied to understanding the complex factors shaping alcohol consumption and harms, for example alcohol advertising (Petticrew, Shemilt et al. 2017) and licensing processes (Fitzgerald, Egan et al. 2018). For our research, this perspective would enable us to think broadly about our conceptualisation of the 'local alcohol environment' and the range of interacting actors, spaces, practices and interests that constitute it, and shape the resultant social and health outcomes. It would influence our open and flexible definition of 'community' in relation to the local alcohol environment, and the multiple different sites of local government decision-making we would examine for examples of community engagement, beyond the most obvious field of licensing.

Second, we were influenced by post-structuralist perspectives on policy-making (see Bacchi 2009), which underpin our engagement with the theorisation of 'decision-making' as a 'distributed' process (Rapley 2008). While the aim of this research was not to conduct formal analysis of local alcohol policy, or how alcohol 'problems' are constructed through policy, our approach reflects Bacchi's framing of policy-making as a set of socially and materially-constructed practices (2009). Through this we could acknowledge the dynamic processes through which decision-making occurs, involving multiple spaces, actors and practices, to examine how and where mechanisms of community engagement are facilitated (or otherwise) within these processes. Taking decision-making as a process 'distributed' across "time, courses of actions, people, situations and technologies"(Rapley 2008, p430), rather than confined to any single occasion or interaction, would allow us to explore possibilities for community engagement in decision-making in both formal contexts (such as the licensing process) and informal.

Together, we felt these two theoretical framings (systems perspective and distributed decision-making) would enable the examination of community engagement in local alcohol decision-making in relation to a wide and dynamic range of actors, practices, spaces and sets of interests. As such, we could explore the possibilities – and constraints – for different community groups to influence the local alcohol environment through *and* beyond the statutory structures for participation.

Methods

We adopted a qualitative case study approach to identify and understand mechanisms of community engagement in alcohol decision-making in local government areas in England, between May and October 2018. Our approach was a 'collective' case study (Stake 1995), incorporating a comparative design to understand community engagement in alcohol decision-making as a multi-faceted phenomenon, from in-depth, situated study (Crowe, Cresswell et al. 2011). Cases were defined as LA areas, a generic term to capture the formal local government organisations across England.

Study development, and case site selection and recruitment

At the beginning of the study we held two one day-long workshops with 21 people including local authority and other local and regional statutory agency employees (we refer to these in the paper as 'practitioners'), community members and voluntary sector representatives. We invited them to explore perceptions of what constitutes the local alcohol environment and the different groups and interests of 'the community' in relation to the local alcohol environment. Participants were recruited via existing public health, licensing and voluntary sector networks. A range of activities were used to facilitate discussion around these key concepts and the different possible pathways of to influence decision-making around alcohol at the local authority level. The insights from these workshops were used in three ways to shape the design of the case study research. First, to help refine our conceptualisation of the local alcohol environment as a 'system', enabling us to identify the kinds of actors, organisations and spaces to explore through the case study data collection. Second, to identify examples of local authorities in which community engagement in local alcohol decision-making was known to be happening, or had happened within the previous two years. Third, to help inform the development of the semi-structured interview topic guides for use in the case study data collection.

Drawing on this information, we purposively selected LAs that reflected a range of geographical locations, and using existing contacts (typically within public health teams) invited each LA to participate. Consequently, the research centred on three LAs from the North West, Yorkshire and the Humber, and South East regions of England, and comprising one city with rural outskirts, and two mixed urban / rural areas.

Data collection methods

We conducted semi-structured interviews with key stakeholders, and documentary analysis of reports, strategies and other documents, to generate an in-depth perspective of how and why community engagement mechanisms had occurred, which actors were involved, and the extent to which they had or were seeking to shape alcohol decision-making within the LA. Our conceptualisation of 'community' was

guided by insights from the stakeholder workshops, including local groups of people negatively affected by the local alcohol environment, but also those who contribute to, enjoy and / or profit from the alcohol environment.

Interview participants were identified through a snowballing and purposive sampling process, typically stemming from initial conversations with contacts at each LA to identify relevant activities and stakeholders. We recruited participants to offer a range of perspectives, including LA employees and employees of other local or regional public bodies (referred to as 'practitioners'), local politicians and, where possible, community members who had participated in engagement processes, including local residents, workers, and representatives of local community or voluntary groups. Relevant documents were identified through the interviews, as participants described community engagement and / or alcohol decision-making processes.

Data collection was conducted by EH in LA-01, MM in LA-02 and JR in LA-03, and we held regular discussions during the data collection and analysis processes to share updates and insights from the case sites. Interviews were conducted according to participants' preferences, most commonly in workplaces, but also in public locations including a quiet café and university building, and for one interview, in the participant's home. One interview was conducted by phone at the participant's request. The semi-structured topic guide was developed to explore specific examples of community engagement in alcohol decision-making (how these examples of engagement were developed, who was involved, for what purpose and with what outcomes), as well as views on the local alcohol environment and the value of community engagement. Questions were tailored to participants' roles and backgrounds. Interviews typically lasted between 40 and 90 minutes, and were audio recorded with participants' consent (two participants declined), and transcribed verbatim, or detailed notes were taken with direct quotations, where possible. Documents were analysed using a semi-structured template developed to capture the nature, author(s), purpose and intended audience of the document; information about community engagement processes; information about alcohol decision-making processes; and how the document contributed to understanding of the case study in this area.

In total, 20 interviews were conducted across the three case sites involving 22 participants (two interviews involved two participants, at their request), and documents reviewed included proposals for new licensing policies, minutes from task group and council committee meetings, strategy documents and a presentation on data gathered through community engagement to support a proposed licensing policy (see Table 1).

Analysis

Interview transcripts were analysed thematically (Braun and Clarke 2006). A blended deductive / inductive approach was employed, using some pre-determined themes (relating to rationale, mechanisms, actors and outcomes of community engagement processes) and identifying new themes through line-by-line coding of the data. Highlighting and comments functions in MS Word software were used to annotate text in the transcripts against the pre-determined themes, and also for new ideas which were then collated into codes and later refined into themes. These emergent themes included conceptualisations of alcohol decision-making, identifying influence on decision-making, how community engagement becomes prioritised, contextual factors shaping engagement, and perceptions of absence within the engagement process. Information was extracted from documents on examples of engagement processes, stakeholders and outcomes, and a thematic approach was taken to identify diverse ways in which community engagement was framed within these documents. Coding was conducted by JR, supported by discussion with MM and EH regarding development of emerging themes and interpretation. Preliminary findings were then discussed and refined with the wider research team. These discussions also facilitated reflection on our respective positions in relation to the data collection and interpretation processes, enabling us to take account of our broader understanding of each case site context beyond the information available in the interviews and documents. They also allowed us to draw on our varied experiences in the fields of community engagement and alcohol policy research to interrogate the data across case sites, for example how to account for inequalities and different levels of capacity to engage with decision-making among populations in each area.

Comparisons were made between the three case sites to identify common and disparate features of the community engagement mechanisms identified. The themes and examples were then brought together to identify broader narratives of the ways in which community engagement in local alcohol decision-making is enacted in local government settings. Although not the focus of this paper, the findings from the case study research were subsequently shared with practitioner and community stakeholders at a participatory workshop, to identify specific recommendations for supporting engagement in local alcohol decision-making. These recommendations are reported in detail elsewhere (Reynolds, McGrath et al. 2019).

Positionality of the research team

The wider research team comprised academic researchers from social science and public health backgrounds, two public members experienced in contributing to public health research on alcohol (among other issues), and one public health practitioner. Our respective research and practice experience cover theory and practice of community engagement and empowerment, social policy, alcohol policy and alcohol harms. This range of perspectives proved valuable for our discussions in planning the research, and enabled us to question each others' assumptions and interpretations of the findings. Our varied backgrounds sometimes gave rise to differences in opinion around key concepts and their application in the research, for example whether local business owners should be included in the definition of 'community', which is not typical in community engagement research, and the implications of this. However, working through these differences through discussion also enabled us to think more critically about how the context of alcohol decision-making relates to broader practices of community engagement, contributing to our interpretation of the implications of our findings.

Ethical considerations

This research was approved by London School of Hygiene & Tropical Medicine. Potential interviewees were given a participant information sheet and the opportunity to ask questions about the research process before giving consent. Written informed consent was taken before each interview, and participants were asked explicitly to give consent for being audio-recorded and for (anonymised) quotations from their interview to be used in the research outputs. All participant names, roles, organisations, documents and areas were anonymised to maintain confidentiality of responses and to allow participants to speak freely about their experiences.

Results

We identified a range of examples of communities being engaged in processes that might influence the local alcohol environment across the three case sites. These examples predominantly fell within alcohol licensing processes and policy, but others cut across different areas of local government. The examples reflected different rationales for community engagement, and involved multiple groups of people and sets of interests. Not all examples of engagement had clearly identifiable outcomes, but there were a few scenarios in which engagement was considered influential on alcohol-related decisions. An overview of

Table 1
Summary of data collection in each case study site.

Local authority	Location and type of LA	Data collected
LA-01	North West. Metropolitan borough; mixed urban and rural.	*5 interviews completed*: • Head of licensing • Local politician • Public health practitioner • Alcohol practitioner from regional public health team • Representatives of local alcohol recovery organisation (double interview). *Documents reviewed*: • Draft guidance for community involvement in licensing • Alcohol inquiry report • Alcohol strategy.
LA-02	South East. Unitary authority; mixed urban and rural.	*7 interviews completed*: •Public health practitioner • Two local politicians • Community safety officer • Manager of local alcohol treatment service • Member of local residents' association • Former president of local students' union. *Documents reviewed*: • Council minutes from licensing committee on revisions to licensing policy •Local alcohol policy proposal • Presentation on data collected through community engagement.
LA-03	Yorkshire & the Humber. Metropolitan borough; city with rural areas.	*8 interviews completed*: • Two public health practitioners • Local politician and chair of licensing committee • Manager of local bar • Alcohol treatment service 'expert by experience' member of alcohol strategy implementation group • Three members of city centre residents' association (one double interview) • Head of city centre local economy team. *Documents reviewed*: • Minutes from meeting of licensing policy task group • Presentation and report summarising evidence gathered around CIP. • Alcohol strategy • City Centre Plan.

the three case sites is presented in Box 1, and below we describe the different rationales for community engagement.

Box 1
Summary of case study areas and community engagement examples

LA01. North West of England; mix of rural and urban. Large inequalities in life expectancy across the borough, in part due to alcohol misuse.Some former industrial areas,and higher rates of unemployment than the national average.Examples of community engagement in alcohol decision-making:
- The development of guidance to support resident input to the alcohol licensing process, which arose in part through an earlier citizen-led 'alcohol inquiry'.
- Local politicians seeking to support residents to influence licensing decision-making.

LA02. South East of England; mix of rural and urban areas. Some affluent populations in historic areas, and pockets of deprivation, with struggling businesses in many village centres.Changing demographics and land uses, including a recent expansion of local universities, and areas becoming commuter suburbs for London.Examples of community engagement in alcohol decision-making:
- Consultation with communities regarding proposal for a cumulative impact policy for licensing.
- Incorporation into licensing policy of students' union recommendations for addressing sexual harassment.

LA03. Yorkshire and the Humber; former industrial city with rural outskirts. Ongoing development and building in the city centre in recent years, increasing the residential population of the city centre, including a large student population. Concerns about increasing trends of alcohol-specific mortality and hospital admissions.Examples of community engagement in alcohol decision-making:
- Consultation of, and evidence gathering by, residents regarding alcohol-related issues in the city centre for the proposal of a cumulative impact policy.
- Representation of different communities across local government committees shaping the local alcohol environment.

Rationales for community engagement in alcohol decision-making

Rationales for community engagement were interpreted through analysis of stakeholder interviews and documents; they were rarely explicitly stated. These rationales reflected different values and expectations, including opportunities for engagement within statutory decision-making processes (specifically licensing); strategic gathering and use of information to support policy solutions to local alcohol problems; broader forms of participatory democracy through representation in decision-making spaces; and more informal and ad hoc forms of engagement arising in other spaces. These are discussed with examples below.

i) As part of statutory decision-making processes

Licensing featured commonly as the decision-making context for community engagement, reflecting the statutory right of residents to submit 'representations' (objections) to licence applications or against existing licensed premises. However, accounts of this process often focused on the challenges faced by residents in successfully influencing licensing decisions.

In LA01, public health practitioners described working with a regional collaborative group to develop guidance to support residents to make representations against alcohol licence applications and existing licences. At the time of fieldwork, the draft guidance was being finalised. Interviewees talked about this project arising in part following an alcohol inquiry conducted several years earlier, through which residents and other stakeholders identified alcohol-related priorities for the local area, including "*making it easier for people to have a say in … applications for licensed premises*" (voluntary organisation representative, LA01). To develop the guidance, local residents with experience of submitting licensing representations were consulted through focus groups to "*get insight into the process from their point of*

view" (public health practitioner, LA01). This was interpreted by interviewees as a form of community engagement in itself, although some acknowledged the approach was more consultative than fully participatory.

Insights from this consultation included recognition of the common barriers faced by residents including the "*impenetrable*" language and "*intimidating*" licensing process. A licensing practitioner echoed this perspective, acknowledging the lack of clarity on the LA website around how residents can submit representations. The draft guidance developed was framed as offering advice for "*anyone who would like to have a say on how alcohol impacts their community*" (draft guidance document, LA01). However, interviewees recognised that the potential success of the resource could be limited by a lack of capacity among some practitioners to promote the guidance, especially if they viewed it as leading to additional workload in managing community inputs.

In other case sites, residents' attempts to influence licensing decision-making were also described. In LA02, a member of a residents' association described how the group was established in part to try to address local alcohol problems relating to an "*excess of alcohol outlets and some really dumb [stupid] opening hours*". The chair of the group described finding the licensing process challenging at first, admitting that they "*made a complete nonsense*" of their early representations (resident, LA02). However, he indicated that liaising with an LA practitioner who shared their concerns about local alcohol issues, and residents continuing to report alcohol-related problems, had led to "*getting things changed*" regarding licensed premises, such as "*soundproofing of a basement in a restaurant*". In contrast, residents in LA03 described their frustrating lack of success in objecting to new applications particularly for off-sales licences, which they perceived to be contributing to a concentration of "*cheap booze*" and "*anti-social behaviour*":

> "*basically the licence will be granted no matter what… even though we bang on, say there's far too many*" (Resident's association member 1, LA03).

This lack of influence within the statutory licensing process prompted the group to try to find other avenues for engaging with alcohol decision-making, to be discussed later.

Elected representatives can present an alternative route of engagement with licensing. A local politician in LA01 described issues including cheaply available alcohol, and related anti-social behaviour and vandalism. However, she also conveyed residents' reluctance to submit complaints, which, she felt, indicated that the issues had become 'normalised'. She described occasions when she had tried to support residents to submit representations against licence applications:

> "*I went to speak to [a resident] and I said… we'll talk to your neighbours and I'll get them to sign a petition if they're upset about [the licence application] and I can take that down to the council and he said, yeah OK*" (Local politician, LA01).

However, the local politician acknowledged the limitations of her efforts to help residents to make changes within the restrictions of the licensing process, and within a context of deeper disengagement among residents in deprived areas, who have been "*battered down*" through wider social and economic decline. Other interviewees, such as the chair of the licensing committee in LA03, recognised inequities of engagement, perceiving residents of more affluent areas and with more experience of engagement being more likely to seek to influence alcohol decision-making.

i) Engagement as part of the development of new policies:

In two case sites, community engagement occurred as part of the development of proposals for CIPs. In LA02, a public health practitioner described her previous unsuccessful attempts to propose a CIP to address issues with the night-time economy. However, with the support of a local politician on the licensing committee, there was a renewed energy to pursue the CIP. The proposal was developed by the public health team, supported by other practitioners and politicians, and incorporated engagement with local community groups to gather information to "*demonstrate that issues are happening and caused by customers of licensed premises*" (Proposal for cumulative impact policy, LA02).

The engagement activities included an online questionnaire for residents and local business owners asking about local alcohol issues, with 'free text' boxes for respondents to record their personal experiences. The public health practitioner described visiting a range of local groups, organisations and individuals to talk to them about issues faced and to encourage them to complete the questionnaire:

> "*[we went to] the PACT [Police and Community Together] meetings, the community meetings, spoke to community leaders, business, and sat down with them and said right, this is what we're looking at, these are the reasons why and we need your story*" (Public health practitioner, LA02).

Engaging community groups to help generate a 'story' to support a CIP was prominent in accounts of the process of developing the policy proposal in LA02, often presented as distinct from the usual 'data' on alcohol-related issues. The personal nature of the 'stories' – residents and business owners conveying "*their experience of alcohol harms in their own words*" (LA02 presentation on CIP development process) – was perceived by practitioners to be particularly compelling. Combining community perspectives with other types of data (for example licensing, police and health data) was viewed as constituting a level of 'evidence' that could not be ignored by decision-makers:

> "*the amount of evidence that was put into that report was just vast… I don't think there was any manoeuvrability not to implement it*" (Community safety practitioner, LA02).

The proposed CIP was approved by the licensing committee, and subsequent changes were made to the SLP to include the CIP, explicitly acknowledging that "*members of the public identified that there are issues with alcohol-related harms*" (Statement of Licensing Policy, LA02). One local politician described the CIP as having "*come from the community*", although practitioners also acknowledged that having political support during the development process was "*key*".

In LA03, work to propose a CIP arose following frustrations with licensing processes for addressing perceived harms, but initially was driven more by an established residents' association. Members of the residents' association described residents and workers in the city centre regularly facing anti-social behaviour seen as linked to "*the amount of off-licences*" (Residents' association member 1, LA03), and compounded by addiction and homelessness in the area. Following a lack of success objecting to new licenses, they were prompted to consider other options:

> "*So that's when we looked around to see what we could do, we looked that other cities and towns had gone for cumulative impact policies… We got in touch with licensing and said can we have a cumulative impact policy? – we'll look into it*" (Residents' association member 2, LA03).

Direct engagement between the residents' association and Director of Public Health for LA03 then led to the establishment of a task group at the LA, including a range of agencies and members of the residents' association, to explore evidence for policy options (including CIP) to address the city centre alcohol issues. The public health practitioner who coordinated the group described the experiences of residents as a starting point for building a more robust and "*balanced*" overview of evidence to support policy recommendations. She described developing a consultation survey to explore the nature of alcohol-related problems in the city centre and assess whether a CIP was appropriate. She used different techniques to encourage responses from residents, workers, business owners, students, service providers and other "*consumers*" of the city centre. Meanwhile the residents' association continued to collect their own insights on alcohol-related issues in their area, inviting

comments via their website and passing diaries to local residents, business owners and employees to record alcohol-related incidents they witnessed.

The findings from the consultation were brought together with data provided by the residents' association and from other agencies such as the police into a report summarising the "*evidential basis*" supporting the introduction of a CIP, to be considered by the licensing committee. At the point of writing the CIP proposal had been considered by the committee and the licensing team authorised to conduct a formal consultation. However, there was some reservation expressed by the public health practitioner and residents, regarding whether the CIP would be approved: "*no not hopeful at all, but we will keep pressing*" (Residents' association member 1).

i) Engagement through representation

Though less prominent than the previous two rationales, there were examples of engagement through processes of 'representation' in alcohol decision-making spaces. This occurred in all case sites, but in LA03 in particular, multiple committees were identified which facilitated engagement through representation. These included (among others) an alcohol strategy implementation group guiding the delivery of the LA's five-year alcohol strategy (described below), a service user reference group for alcohol treatment and recovery services, and a city centre task group including local residents and business owners advising on the day and night-time economies.

The alcohol strategy implementation group comprised different LA stakeholders and public and voluntary sector agencies, plus an 'expert-by-experience' (EBE). The EBE described his role in the group as valuable for bringing a "*lived experience*" perspective of alcohol addiction and recovery:

> "*everybody else was from a corporate type of area, whether it's [alcohol recovery charity], department of public health, fire, police, whatever, but they'd not actually got a person that had been through the system and walked in the shoes of people with alcohol problems*" (Expert-by-experience, LA03)

He described giving his views in discussions on issues such as safe drinking campaigns in the local night-time economy, the proposed CIP and the national policy issue of minimum unit pricing for alcohol. However, while the EBE's role was conceptualised (if implicitly) by the practitioners leading the group as representing the interests of alcohol recovery service users, the EBE did not see his participation as a form of 'community engagement'. Instead, he described his involvement in the group, alongside a range of other voluntary activities, as part of his personal process of recovery from alcohol addiction and related issues.

The capacity of these representative forms of engagement to have real influence on decision-making was not always evident. The EBE described being "*listened to*" and having his points noted in meeting minutes, which he valued, but from these accounts the implementation group appeared to operate more as a discussion space rather than one in which policy or strategy decisions were made. Similarly, a member of the city centre residents' association described attending a city centre task group as an opportunity to communicate "*views directly to the council*", but stated that their influence as residents on decisions about the city centre was "*a work in progress*".

The communicative function of these representative spaces was recognised from the LA perspective as a mechanism to report back and respond to issues highlighted by community groups. A local economy practitioner in LA03 described the city centre task group, with representation from local businesses and residents, as being a valuable network for feeding back on changes more efficiently than responding to individual complaints:

> "*It's quite a good closed circle there where we can feed back and how things have changed and what influence they have had*" (Local economy practitioner, LA03).

As such, this community engagement through representation appear to operate less as opportunities for direct influence on decision-making, and more as opportunities for communication between the community and LA about the local alcohol environment.

i) Ad hoc engagement and relationship building

A final rationale, identified particularly in LA02 and LA03, reflects more informal processes through which communities became engaged, with clear influence on decision-making in one example. In LA02, the activities of the students' union of a regional university to address sexual harassment in the night-time economy led to engagement with LA practitioners and subsequent changes to licensing policy. The union developed training for local licensed premises to support a 'zero tolerance' approach to sexual harassment. A former student described building up relationships through this process with a range of stakeholders from several LAs across which the university was located (including LA02). This facilitated a more formal proposal by the union to include recommendations around sexual harassment in the SLP in LA02, which was subsequently approved as part of a revised SLP: "*they passed it, no debate*" (Student union member, LA02).

Relationship-building as a form of engagement was also identified in LA03, though without direct influence on decision-making. A public health practitioner described the value of the Best Bar None (BBN) initiative in LA03 for enabling communication with the local business community and understanding better the problems in the local alcohol environment. While BBN was designed as an accreditation scheme to promote responsible management in licensed premises (see http://bbnuk.com/), it seemed to provide an additional engagement function in LA03. The public health practitioner described "*build[ing] up a relationship with premises*" (Public health practitioner 2, LA03) through working with businesses to support their BBN accreditation. She gave the example of responding to concerns raised by premises managers about the safety of women in relation to 'predatory' male customers by organising adult safeguarding training for staff. A bar manager, who had participated in the BBN scheme, described the value of being able to share information with practitioners and get help with issues in the night-time economy.

These more informal mechanisms of communication and relationship-building between different groups in the community and LAs may not always lead directly to decision-making such as licensing policy changes, but can facilitate small-scale actions following better understanding of the local alcohol environment.

Discussion

In this paper we described research to explore opportunities for community engagement in local alcohol decision-making in England. This reflected the lack of current understanding of the possibilities (and challenges) of involving communities in decisions that shape their local alcohol environments, despite an international push towards community engagement in strategies to reduce alcohol harms. Through interviews and documentary analysis in three local authority areas, we identified four rationales for community engagement: as part of statutory consultation processes (particularly licensing); as part of the development of new policies (such as CIPs); through representative structures (such as committees for the local economy); and arising in a more ad hoc way through other activities (such as a student union campaign around sexual harassment). The examples of engagement identified occurred most commonly in relation to alcohol licensing, involved multiple local government stakeholders including local politicians, public health, community safety and local economy

practitioners, and different community actors including residents, local businesses, students, and alcohol treatment service users.

Some examples of community engagement had clear impact on policy and other decision-making. Through engagement mechanisms, community members (and their views on the alcohol environment) can become a valuable source of 'data', to be combined with other sources as a comprehensive package of 'evidence' to support new alcohol policies such as a CIP. Critical literature on policy making processes recognises that multiple types of information may be regarded as 'evidence' within 'evidence-based policy making', not only those defined from the scientific perspective as meeting standards for rigour (Dobrow, Goel et al. 2004). This study demonstrates that opinions and experiences of residents and other interest groups can sit alongside more traditional sources of information within the policy process. However, as with scientific evidence, community input will be only one of many factors that are considered within decision-making process. Our findings also support recognition of the value of narrative and storytelling in the policy-making process (Lowndes 2016), whereby the emotive and personal nature of community stories of facing alcohol harm can be powerful drivers for policies to restrict alcohol provision.

Our research also highlights the potential for communities to adopt a more active role than that of 'storytellers' and contributors of evidence in response to practitioners' requests, by helping instigate policy-making processes, such as for the introduction of CIP or the revision of an SLP. In these situations, groups mobilised around particular issues (such as a residents' association, or student union) can become visible actors in the policy making process, thus enacting a more 'bottom-up' form of community engagement to influence alcohol decision-making. The example from LA03 highlighted the potential for communities to initiate a kind of policy transfer process (Gavens, Holmes et al. 2017), by identifying the use of CIPs in other areas to reduce alcohol harms and putting pressure on decision-makers to consider implementing them locally. The findings also highlight possibilities for successful engagement in decision-making via forms of community-led activism (for example around sexual harassment in the night-time economy). This reflects literature on social movements to influence alcohol policy (Herd and Berman 2015), but it is important to note that these movements typically arise around issues of alcohol-related antisocial behaviour and crime, rather than the impacts of alcohol on individual health.

By adopting a framing of decision-making as 'distributed' (Rapley 2008), we were able to identify the more informal, discursive spaces in which relationship-building and information-sharing between community members and practitioners can occur around local alcohol issues, which may still be considered valuable parts of longer-term decision-making processes. A recent review of community engagement in decision-making highlighted the perceived value of engagement processes for maintaining relationships between the community and decision-makers, and for helping to keep particular issues 'on the agenda' in local government (McGrath et al., 2019). This suggests that opportunities for regular dialogue between different community groups and practitioners should be supported outside formal consultation or representative structures, to help share information about the alcohol environment, and facilitate future engagement for decision-making.

However, our case studies also highlighted multiple challenges faced in engaging community members effectively. Many of these challenges are not unique to alcohol decision-making, but reflect knowledge across broader community engagement literatures of the barriers to involving the public. Difficulties navigating local government consultation and decision-making processes, and understanding technical and bureaucratic language are well recognised, for example for community engagement in planning (Carpenter & Brownill, 2008). In Scotland, recent research has highlighted challenges in ensuring community representation in participatory licensing forums, conveying doubts over how much influence community input to licensing really has (Fitzgerald, Winterbottom et al. 2018). This corresponds with frustrations expressed by community members and practitioners in our case sites, indicating the complexity of legal frameworks underpinning the licensing decision-making. Expectations for demonstrating evidence of harm in representations against licence applications are challenging even for practitioners to meet (Reynolds, McGrath et al. 2018), and therefore may limit community members' capacity to engage and shape licensing decisions, and possibly dissuade people from future engagement.

Furthermore, while not the main focus of this study, our findings can speak to the persistent issue of inequalities of engagement processes which may further exclude those people with least capacity to be involved (Barnes, Newman et al. 2003). Our case studies illustrated active involvement in alcohol decision-making of some community groups, but also the difficulties of engaging residents in deprived areas. This echoes recent research from New Zealand describing attempts by Māori communities to influence licensing policy in local government being largely overlooked by decision-makers, likely entrenching existing inequalities faced by this population who suffer higher alcohol-related morbidity (Kypri, Maclennan et al. 2019). Given the disproportionate harms from alcohol faced by people of low socio-economic status (Jones, Bates et al. 2015), it is particularly concerning if they are marginalised from alcohol decision-making processes, as this may further compound the unequal burden of alcohol-related harm faced by them compared with more empowered groups. Adopting a targeted approach to engagement may help to involve those more marginalised and address alcohol harms, as suggested by recent evidence of the impact of indigenous community input to alcohol policies in Australia, Canada and the US (Muhunthan, Angell et al. 2017).

The issue of 'community' as a complex concept, reflecting a dynamic set of actors and interests (Reynolds 2018), is particularly pertinent in the context of engagement in alcohol decision-making. Our case studies highlight that the term 'community' can cover multiple interest groups seeking to be engaged in decision-making processes relating to alcohol. These communities were characterised primarily by locality and interest (such as residents, and people working in areas with high alcohol provision), but also by experience (such as alcohol treatment service users), and identity (such as a local students' union). The systems perspective underpinning this study enabled us to identify the varied interests of a wide range of actors in relation to the local alcohol environment. These interests, of people who are negatively affected by, profit from and / or seek to enjoy the alcohol environment, may be in conflict, and challenging to manage through engagement processes. While local decision-making always requires balancing of different concerns, opening up engagement processes through formal and informal means may privilege the interests of actors with more resources to become involved, for example those with financial interests in the alcohol environment (Petticrew, Douglas et al. 2018). This speaks to wider concerns over the position of the alcohol industry in relation to health – and other – decision-making, with fears about the risks of industry influence leading to ineffectual, and even harmful alcohol policies (Petticrew, McKee et al. 2018).

Limitations

Our findings are drawn from small-scale case studies in three LA areas in England, selected for known alcohol-related community engagement activities. While there is some diversity across the types of LA included in the sample, the cases may not be directly transferable to local government structures in other countries or across England. We faced challenges in recruiting other LAs, and reasons given for declining participation included a lack of capacity be involved, undergoing restructuring and redundancies within the LA, and not seeing the research topic as a priority. Consequently, our findings reflect contexts where this issue has been prioritised and / or better resourced, but also that community engagement in alcohol decision-making may be viewed more as a 'luxury' rather than a core activity of local government in the

current climate of austerity and severe budgetary constraint. Furthermore, we recognise that some practitioners' interviews may have reflected 'public' accounts of their views on community engagement, particularly when interviewed in the workplace. As such, some challenges, frustrations and reluctance to engage with community members felt by practitioners might have been obscured in the data we collected due to the normative expectation that community engagement is a 'good thing'.

Although our research was informed by a systems perspective towards the local alcohol environment, and took an inclusive view on the range of actors that might be involved there were some obvious gaps. We found it difficult to engage with planning practitioners, and to identify mechanisms of community engagement in planning that might have influenced the local alcohol environment. This limitation might reflect the networks we used to gain access to the case sites, primarily through public health contacts. However, it might also reflect the acknowledged divisions between some local government departments, for example between licensing and planning, underpinned by separate legislation governing decision-making in these areas. More research to explore how community engagement in planning might help to shape the local alcohol environment is needed, particularly given the shift towards participatory approaches to planning in the UK and elsewhere in recent decades (Carpenter & Brownill, 2008).

Conclusion

Our research has identified a range of formal and informal mechanisms which should be supported at the local government level to promote engagement of diverse community groups in decision-making on the local alcohol environment. There are clear examples of how some of these mechanisms can lead to policy change, particularly licensing policy, where community experiences constitute an influential part of the body of evidence mobilised to support new policies to reduce harm from the alcohol environment. More informal modes of relationship-building between practitioners and community members should be supported around alcohol-related programmes and through broader place-focused initiatives and discursive spaces. However, care must be taken to consider the range of interests and capacity to engage among different communities, particularly those most vulnerable to alcohol-related harm, and those who seek to profit from the local alcohol environment. Further understanding is needed of how different interests are represented in actual decisions and policies made, in relation to the local alcohol environment, and how these decisions impact on the alcohol-related social and health harms suffered by different groups in the community.

Declaration of Competing Interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome. We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us. We confirm that we have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing we confirm that we have followed the regulations of our institutions concerning intellectual property. We further confirm that any aspect of the work covered in this manuscript that has involved either experimental animals or human patients has been conducted with the ethical approval of all relevant bodies and that such approvals are acknowledged within the manuscript.

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