

**Galway City Strategy to Prevent and Reduce Alcohol Related Harm
(2013-2017)**

Evaluation

Kirsty Doyle, Catherine Anne Field and Saoirse Nic Gabhainn
Health Promotion Research Centre
NUI Galway

February 2018

Acknowledgements

We wish to thank all the stakeholders involved in this evaluation who gave generously of their time and insight. We are also grateful for the assistance of the NUI Galway Librarians with the sourcing of literature and the staff of the HSE Health Promotion and Improvement for providing the strategy documentation. Thanks also to Dr. Vivienne Batt, Administrative Director of the Health Promotion Research Centre at NUI Galway.

DRAFT

Table of Contents

1. Introduction	p. 4
2. Methodology	p. 6
3. Summary of literature	p. 9
4. Stakeholder perspectives	p. 20
5. Consultation on findings	p. 35
6. References	p. 36
7. Appendices	p. 39

DRAFT

1. Introduction

Galway City is the first city in Ireland to develop a five-year strategy to prevent and reduce alcohol-related harm. This strategy was developed by Galway Healthy Cities Alcohol Forum, which is a sub group of Galway Health Cities Forum, in collaboration with a wide range of organisations and community groups including HSE West, An Garda Síochána, Western Region Drugs and Alcohol Task Force, Galway and Roscommon Education and Training Board, Galway City Council, NUI Galway, Galway Mayo Institute of Technology and Galway City Community Network. The strategy, which takes a community action approach, is informed by research on effective approaches to tackling alcohol-related harm. It has four key areas including: prevention; supply, access and availability; screening, treatment and support services; and research, monitoring and evaluation. Under these four key areas, 16 goals and 40 strategic actions were identified.

The Galway City Alcohol Strategy was developed as part of the leading out of the World Health Organization (WHO) Healthy Cities Project in Galway City. The WHO Healthy Cities Project was established to help put health high on the social, economic and political agenda of cities (Galway Healthy Cities Project, 2017). Central to the Healthy Cities approach is strong political commitment and leadership from mayors and city governments. In addition to political leadership and commitment, the Healthy Cities approach requires a steering committee or council with representation from all relevant organisations which may include: health, transport, urban planning, housing, environment and sanitation (WHO and United Nations Development Programme, 2016). There are now thousands of cities worldwide who are part of the WHO Healthy Cities Project. The purpose of the Galway City Alcohol Strategy, which was launched in February 2013, was to prevent and reduce alcohol-related harm within the city.

Preparations for the Galway City Alcohol Strategy began in Autumn 2011, and involved a year-long consultation process with key agencies and the general public. The consultation process involved roundtable discussions to discuss the nature and extent of alcohol-related harm in Galway City and how best to address it, public submissions which were given via group consultations, online survey, email and phone, as well as feedback on draft strategies.

In addition to the five-year Alcohol Strategy, yearly action plans were also developed. The Galway Healthy Cities Alcohol Forum met three times each year to oversee the implementation of the yearly action plans. At the end of each year of the strategy a review and planning event was held. At this event a progress report was compiled and presented to stakeholders, and strategic actions were set for the following year.

One of the goals outlined in the Galway City Alcohol Strategy is to monitor and evaluate the progress and impact of the strategy. In meeting one objective under this goal, the current evaluation was commissioned by Health Promotion & Improvement, Health Service Executive West following an open tender process. The agreed aims and objectives were:

To evaluate the implementation of the Galway City Strategy to prevent and reduce alcohol related harm in order to:

- Examine the role of stakeholders in the implementation of the alcohol strategy
- Examine and appraise the structures, practices and procedures adopted and compare these with best practice examples
- Determine what goals and strategic actions have been achieved
- Identify the barriers and enablers to the implementation of the alcohol strategy
- Make recommendations that will strengthen achievements and support the development of the strategy going forward.

This report is structured around the aims and objectives of the evaluation and aligned research questions. First the approach to data collection and analysis is presented. This is followed by a summary of findings from the desk study on existing literature and the documentation provided on the development and implementation of the Strategy. The main body of the findings, which is based on the interview and questionnaire data collected from stakeholders, is presented by research question. The presentation of data is followed by the key recommendations from this evaluation.

2. Methodology

Study Design

The evaluation consisted of a mixed methods study including an initial desk study followed by a qualitative stakeholder study, and was divided into three phases.

Phase One

Phase one involved a desk study to examine existing literature for evidence on topics relevant to the evaluation and a documentary analysis of all relevant Galway City Alcohol Strategy documents. The literature was searched using different amalgamations of the following search terms: city alcohol strategy, evidence-based, best practice, Healthy Cities, and evidence-based evaluation. The results of these searches were then reviewed to determine if they were evidence-based and therefore, suitable for inclusion in the study. One purpose of the review was to identify and analyse the literature on evidence-based evaluations of alcohol control policies and city alcohol strategies. However there was a relative dearth of relevant literature in this area identified. Another purpose was to identify evidence-based alcohol control policies to determine the extent to which the Galway City Alcohol Strategy was informed by research on effective approaches to tackling alcohol-related harm, as it states in its strategy.

The documentary analysis involved the analysis of all relevant documents that were produced as part of the Galway City Alcohol Strategy including minutes, progress reports and publications. From this analysis, the level of involvement of all stakeholders was established. This information was used to determine if stakeholders should be invited for a one-to-one interview or asked to conduct a survey in phase two of the evaluation. Similarly, information gathered from both the literature review and documentary analysis was used to inform the development of the interview guide and questionnaire for the stakeholder study in phase two.

Phase Two

The objectives of phase two were to determine the stakeholders' perspectives and experiences of developing and implementing the Galway City Alcohol Strategy. This phase

included one-to-one interviews and surveys with stakeholders who had been identified during phase one.

Interviews

The first part of the stakeholder study consisted of one-to-one semi-structured interviews. Semi-structured interviewing includes open-ended questioning in which the interviewer seeks in-depth information on the experiences and perceptions of the interviewees. Purposeful sampling was used to guide recruitment for these interviews. This type of sampling involves selecting participants who are particularly knowledgeable about or experienced with the research topic, and is used widely in qualitative research (Palinkas *et al.*, 2015). For this study, stakeholders were invited for interview if they were involved in the development and implementation of the Galway City Alcohol Strategy, or became involved after the strategy was developed but had regularly attended the Galway Healthy Cities Alcohol Forum meetings and the annual Review and Planning Events. The level of involvement of all stakeholders was established from the desk study during phase one of the evaluation and was used to decide which stakeholders would be invited for interview. A list of potential participants suitable for interview was then drawn up and letters of invitation were sent. The letters outlined the purpose of the research and included information on the voluntary and confidential nature of participation, as well as the right to refuse or withdraw from the study at any time. Potential participants were given three weeks to respond to the initial invitation letter before a follow up email was sent. Where participants did not respond to either the letter or email, contact was attempted via telephone.

Upon initial agreement to participate, a date, time and location for the interview were agreed. Potential participants were sent an electronic copy of the information sheet and consent form a couple of days before the interview was due to take place. Before the interview began, potential participants were provided with further details of the study including assurances that all of their data would be anonymised and their responses confidential. After the information sheet was discussed and the consent form signed, the interview was conducted. Due to the fact that some of the stakeholders were spatially dispersed across Ireland and that resources for the project such as time were limited,

telephone interviews were conducted where it was not possible to meet stakeholders in person. All of the interviews were recorded with the permission of the stakeholders, and then transcribed verbatim. The data were subsequently analysed thematically in *NVivo*, a qualitative data analysis software package developed by QSR International.

Survey

The second part of the stakeholder study consisted of developing and disseminating a survey to gather the experiences and opinions of stakeholders who had chosen not to take part in an interview, or who had a more limited involvement with the Galway City Alcohol Strategy and therefore had not been selected for interview. The questions for the survey were informed by the desk study in phase one and were similar to those asked in the interview guide. Purposeful sampling was also used to guide recruitment for this stage of the stakeholder study. The survey was developed in Survey Monkey and an invitation to participate, along with the link to the survey, was sent out to the selected stakeholders by email. The stakeholders were given two weeks to complete the survey and during this period were emailed reminders to encourage participation. All survey responses were anonymous. Once the survey was closed the data were extracted from Survey Monkey and transferred into SPSS, a quantitative data analysis software package developed by IBM.

Phase Three

The third and final phase of the evaluation involved triangulation of all data collected as part of the study. The first part of this phase included an appraisal process that compared the findings from the desk study with those from the stakeholder study. The second part of this phase included a stakeholder consultation. As part of the consultation process, a brief summary of the findings from the evaluation were integrated into an electronic survey and emailed to all stakeholders. Stakeholders were invited to agree or disagree with specific findings and to add further comments, as they felt appropriate. The purpose of this consultation was to clarify and validate the findings, as well as to help in the process of developing realistic, evidence-based recommendations on how the Galway City Alcohol Strategy should proceed.

3. Summary of Literature

Healthy Cities

The Galway City Alcohol Strategy was developed as part of the leading out of the World Health Organization (WHO) Healthy Cities Project in Galway City. As outlined above, the WHO Healthy Cities Project was established to help put health high on the social, economic and political agenda of cities (Galway Healthy Cities Project, 2017). As part of the WHO Healthy Cities Project, cities and towns are linked through various national and regional networks. One such network is the WHO European Healthy Cities Network which consists of almost 100 cities and towns from across 30 countries in the WHO European Region (WHO Regional Office for Europe, 2017). The WHO European Healthy Cities Network was launched in 1987-88 (Tsouros, 2015) and adopts specific themes for a period of five years, known as a phase. To date it has had six phases. During the fifth phase of the WHO European Healthy Cities Network there was a strategic shift which formally recognised political governance as critical for both health equity and for health development at all levels of society (Tsouros, 2015).

The importance of political leadership and governance for transforming health within Healthy Cities has also been outlined in a policy brief which was distributed at the 9th Global Conference on Health Promotion in Shanghai (World Health Organization and United Nations Development Programme, 2016). Within the policy brief, examples were presented of how city governments and mayors played a critical role in leading and implementing the Healthy Cities initiatives. For example, the case of New York was highlighted where the Mayor successfully enacted and implemented the Smoke-Free Air Act. However, while political leadership and commitment were noted as critical, it was also outlined that this political commitment is only one part of the 'whole system' (World Health Organization and United Nations Development Programme, 2016, p. 5) approach that Healthy Cities should adopt. Central to this approach is an interdisciplinary committee or council that includes representation from various sectors including health, urban planning, environment, local businesses and local community groups.

The effectiveness of an interdisciplinary approach to Healthy Cities was outlined by Lee (2014) in the WHO publication *Cities for Health*. This article describes how the substantial growth of cities worldwide and the epidemiological shift from infectious to non-communicable diseases (NCDs) is presenting new challenges for creating Healthy Cities. In order to address these new health challenges, it is recommended that we utilise the lessons learned in tackling the epidemics of infectious diseases in the 19th and early 20th century. Lee (2014) explains that changes in environmental conditions by sectors such as sanitation, urban planners, building regulators and architects in the 19th and early 20th century were essential to controlling the outbreaks of these infectious diseases. She argues that environmental changes, which are designed and constructed collaboratively across sectors, are also essential to preventing and treating NCDs in all age groups. She outlines New York City (NYC) as one example where there has been a collaborative cross-sector approach to improving health. For example, in 2006 the NYC Health Department reached out to other city agencies to develop partnerships. In order to bring together the various sectors concerned with the planning and construction of the built environment, a Fit City Conference was organised. Following the second Fit City Conference evidence-based guidelines for health and physical activity, the Active Design Guidelines (ADG), were developed by various agencies including public city agencies, private sector firms and non-profit and community groups (Lee, 2014). The ADG were published in 2010 and following the passing of a mayoral executive order, have been incorporated into all new major renovation, building and street construction projects.

Evidence has shown that political leadership and commitment are critical to successful Healthy Cities Projects. In addition, the scientific evidence has also shown that changes in the physical and social environments can play a key role in producing Healthy Cities. For example, as shown by the controlling of infectious diseases in the 19th and early 20th century, cities can play a major role in changing environments by bringing together various sectors to work collaboratively. However, in order to be successful, interdisciplinary approaches to Healthy Cities must identify and work on priority issues that can benefit all sectors involved. These benefits may include not only health outcomes, but also economic or environmental objectives.

Evaluating Community and City Alcohol Strategies

Away from the WHO Healthy Cities Project, many communities have tried to reduce alcohol-related harm directly through community-based interventions. One such study by Holder *et al.* (2000) focused on evaluating the effect of a community-based environmental intervention to reduce high-risk drinking and alcohol injuries. The five-year intervention was conducted from 1992 to 1996 in three intervention communities, with three matched comparison communities serving as controls. There were five components of the intervention which included (1) mobilising the communities for support; (2) assisting with responsible on-site beverage service training and increasing the enforcement of these practices; (3) assisting with training for off-site alcohol retailers in order to reduce underage access to alcohol and increase enforcement of these laws; (4) enhancing enforcement of drinking after driving through increased roadside checkpoints and use of alcohol sensors; and (5) helping communities develop local restrictions on access to alcohol through zoning. While the effectiveness of each component had been determined by previous studies, the components had never been used together as part of a comprehensive community-based intervention to reduce alcohol-related injuries.

The authors of the study hypothesised that the community-based intervention would reduce binge drinking and driving after drinking, which would lead to reductions in alcohol-related crashes and assaults (Holder *et al.*, 2000). As such, outcome measures for the evaluation were chosen to reflect drinking and alcohol-related injuries. Outcomes for drinking and driving after drinking were assessed by approximately 120 general population telephone surveys per month. Those individuals surveyed were randomly selected from households in all intervention and comparison sites. Outcomes for alcohol-related injuries were assessed by traffic data on motor vehicle crashes and emergency department surveys, although data for the latter could only be obtained for one intervention and comparison pair and one additional intervention site. Results from the population surveys showed that self-reported alcohol consumption had declined six per cent per drinking occasion and that self-reported driving while 'over the legal limit' was 51 per cent lower per 6-month period in the intervention sites compared to the comparison sites. Results from the traffic data revealed that, compared to the comparison communities, night-time injury crashes in the intervention communities had declined by ten per cent and that motor vehicle crashes,

where the driver had been drinking, had declined by six per cent. In addition, data from emergency departments showed that assault injuries had decreased by 43 per cent. Based on these results, Holder *et al.* (2000) conclude that a coordinated, community-based intervention can reduce high-risk drinking and alcohol-related injuries due to assaults and motor-vehicle crashes.

Similar to the above study, Kypri *et al.* (2010) evaluated an intervention to reduce alcohol-related harm through restricted pub closing times in the central business district (CBD) of Newcastle, Australia. The decision to restrict the opening hours of 14 pubs from 5 a.m. to 3 a.m., with a 1 a.m. lockout, was made by the Liquor Administration Board in 2008. After a legal challenge by the pubs, an out-of-court agreement was made to relax the restriction to a 1.30 a.m. lockout and 3.30 a.m. closing. The authors of the study sought to test whether the restricted closing hours reduced assault within the CBD and also, whether the incidence of assault was displaced from the Newcastle CBD to the control site. In order to conduct the evaluation a 'non-equivalent control group design' was adopted (Kypri *et al.*, 2010, p. 304). Newcastle CBD, where the restricted closing hours were in effect was the intervention area, while Hamilton, another entertainment zone where closing times were not restricted, served as the control site. Although Hamilton had many similarities to the CBD, there were a number of differences including the age of those involved in assaults, and the considerably smaller size of the nightlife area in Hamilton compared to the CBD. However, in the absence of a more suitable nightlife district in the Newcastle area, Hamilton was chosen as a 'non-equivalent' control site (Kypri *et al.*, 2010).

As well as restricted closing times, the intervention in the 14 pubs also included: adopting a management plan; taking part in compliance audits; having a responsible service of alcohol officer; not serving alcohol 30 minutes before closing; not serving shots after 10pm; not permitting the stockpiling of drinks; shared radios; and the training and notification of intervention conditions to all staff (Kypri *et al.*, 2010, p. 106). The intervention came into effect on 21 March 2008. The period from April 2001 to March 2008, before the introduction of the intervention, was compared to the post-intervention period, April 2008 to September 2009. Cases included in the study were non-domestic violence incidents including 'common assault, actual or grievous bodily harm, assault of police or shooting with

intent other than to murder, as defined under the NSW Crimes Act 1900' (Kypri *et al.*, 2010, p. 106). Of the assault cases which met these criteria, only those that occurred between 10pm and 6am and were located in the intervention or control site were included for analysis in the study.

Negative binomial regression was used to model and analyse the number of assaults per month both before and after the intervention. Overall, the findings from the analysis indicate that the incidence of assault post intervention was significantly below the number that was expected without implementing the intervention. This suggests that restricted closing hours in the CBD reduces the incidence of assault. In addition, the analysis indicates that the reduction of assault in the intervention area was not displaced to the control site.

The incidence of assault was also used as a measurement in the Wolverhampton Keep It Safe campaign. This campaign was launched as part of the city alcohol strategy, the objectives of which were to encourage 'sensible drinking, safe sex and getting home safely' (Jervis, 2009, p. 2). It took place between December 2008 and March 2009 and targeted the city centre and other prominent areas in Wolverhampton. As part of the campaign there was an increased police presence, safety messages delivered via an extensive marketing campaign, safe areas to wait for taxis and have non-alcoholic drinks, more visible street pastors with linked radios offering help, increased provision of public bathrooms, distribution of kits which included condoms, flip-flops and plasters, and temporary and mobile medical centres throughout the city to take pressure off the Accident and Emergency (A&E) Department and the Ambulance Service.

In order to evaluate the campaign, three key indicators were measured which included the incidence of alcohol-related violent assaults, alcohol-related ambulance call-outs and alcohol-related A&E attendances. The evaluation included an analysis of both quantitative and qualitative data. The quantitative data was collected from the Police, A&E and the Ambulance Service, while the qualitative data was collected via questionnaires with partner agencies and the general public. The results of the evaluation indicate that the Keep It Safe campaign was a success. For example, compared with the same period in 2007/08, there was a 29 per cent reduction in violent crime, a seven per cent reduction in alcohol-related

ambulance call-outs and an eight per cent reduction in alcohol-related A&E attendances. In addition to these outcomes, the Keep It Safe campaign also highlighted how agencies can work together successfully to achieve mutual objectives.

Moving to the Irish context, the Ballymun Community Alcohol Strategy 2010-2016 focused on bringing multiple agencies together to work towards reducing alcohol-related harm in the community. By mobilising local and community services the strategy aimed to reduce the overall level of alcohol consumption in the community, modify local drinking patterns, and change attitudes towards alcohol and alcohol-related harm (Ballymun Local Drugs Task Force and Safer Ballymun Community Safety Forum, 2010). In order to enable the monitoring of the strategy over time, the Ballymun Community Alcohol Strategy steering group commissioned research to obtain baseline information on awareness, behaviours and attitudes regarding alcohol in the Ballymun community. This baseline information was gathered by conducting 355 interviews with residents in the Ballymun area in 2011. To ensure a representative sample, a two stage approach was adopted: stage 1 included a stratified random selection of geographical points (Ipsos MORI, 2012), while stage 2 centred on the selection of participants within the specified geographical areas. This process was repeated in 2015 in order to determine the progress of the strategy over the four year period.

The comparison of the 2011 and 2015 data demonstrates that there has been a significant reduction in the proportion of residents in Ballymun who have ever consumed alcohol (92 per cent compared to 84 per cent) and those who have consumed alcohol in the past year (83 per cent compared to 77 per cent). Other notable findings include the proportion of Ballymun residents who would consume six or more drinks on a single occasion on a weekly basis which has fallen from 34 per cent in 2011 to 19 per cent in 2015 (Ipsos MORI, 2016). While comparisons of the 2015 and 2011 surveys indicate positive outcomes for the Ballymun Community Alcohol Strategy 2010-2016, a full evaluation of the strategy has yet to be conducted.

In 2014, following recommendations from the National Substance Misuse Strategy (Department of Health, 2012), the remit of the Drugs Task Forces was expanded to include

alcohol. In order to build capacity among the Task Forces to undertake community mobilisation on alcohol, the National Community Action on Alcohol Pilot Project (CAPP) was developed. CAPP was delivered by the Alcohol Forum in collaboration with the Drug Programmes and Policy Unit, Department of Health, and the Health and Wellbeing Division of the HSE (Galligan, 2015). Five projects took part in the pilot during which training and ongoing supports were provided. The subsequent process evaluation documented factors enabling the development of community action plans included high quality of training, facilitation and support. Barriers to implementation included challenges in engaging local stakeholders, limited number of sub-committee members in attendance at training and the burden of travelling to Dublin for training. Further recommendations included implementation of the Public Health (Alcohol) Bill 2015; partnering with a specialist bodies to ensure adherence to evidence-based policies and to measure outcomes. Local leadership, training and support for localised committee structures and dedicated funding were all identified as key for such community mobilisation (Galligan, 2015).

Evaluating Alcohol Policy

In addition to evaluations of specific community and city alcohol strategies, evaluations of contemporary alcohol policies using measurement tools such as indexes are increasingly being conducted in order to compare the effectiveness and enforcement of policies across jurisdictions. While the use of indexes has a number of drawbacks, including the possibility of misleading policy conclusions being drawn from poorly designed indexes, there are also a number of benefits. These include the ability of indexes to capture and enable a “big picture” view (Moxham-Hall & Ritter, 2017) of complex issues and to compare policies between jurisdictions. In addition, indexes can also be used to measure the ‘implementation, effectiveness, or enforcement’ (Moxham-Hall & Ritter, 2017) of policies and therefore, are useful for policymakers in terms of refining policy or deciding where to target resources.

In their systematic review of all published alcohol and illicit drug indexes to date, Moxham-Hall and Ritter (2017) identified three types of indexes: Harm Indexes, Policy Indexes, and Treatment Need Indexes. Whereas the Harm Indexes mainly focused on the measurement of harms resulting from illicit drug use, the majority of the Policy Indexes focused on

measuring the implementation and effectiveness of alcohol control policies. The goal of the Treatment Needs Indexes was to establish the level of treatment needed in different areas. However, these rarely distinguished between alcohol and illicit drugs. As the Policy Indexes focused almost exclusively on alcohol control policies, it is these indexes that are of interest here.

The indexes classified as Policy Indexes in the Moxham-Hall and Ritter (2017) review had four main areas: 'the existence of a policy, the implementation level of a policy, an effectiveness weighting (where more effective policies have higher weights), and an enforcement level' (p. 114). The domains and associated indicators varied across the different alcohol policy indexes for various reasons. For example, the publication of a systematic analysis of the effectiveness of alcohol control policies (Babor *et al.*, 2010) provided for the development of new alcohol Policy Indexes. Many of these used the seven control policy areas identified in the Babor *et al.* (2010) study as their key index domains. However, more recently, alcohol Policy Indexes have moved away from selecting these seven control policy areas as their key index domains. Instead, domains and indicators are selected using modified Delphi techniques. In each study where the Policy Indexes were developed as an evaluation tool to measure alcohol control policies, higher scores on the alcohol Policy Index (which indicated effective alcohol control policies) correlated with lower rates of alcohol consumption.

Another quantitative tool to assess alcohol control policies was developed by Carragher *et al.* (2014). The tool, which is called the Toolkit for Evaluating Alcohol policy Stringency and Enforcement (TEASE-16), was used by the team to evaluate 16 alcohol control policies in nine areas of the Western Pacific. The toolkit has five main components. The first component is five regulatory domains which include physical availability (of alcohol), drinking context, alcohol prices, alcohol advertising, and drivers of motor vehicles. The second component includes 16 alcohol control policies that are evidence-based and which fit into one of the five regulatory domains. The third component is an effectiveness star rating, which rates the effectiveness of the policy in reducing alcohol-related harm. The fourth component includes the level of stringency, which refers to the relative strictness of each alcohol policy. Last, the fifth component includes the level of enforcement. This refers

to the strength at which the 16 alcohol policies are implemented and includes three categories: poor, moderate and strong.

Like previous research (e.g., Brand *et al.*, 2007), this study found that areas with 'more stringent' and 'strongly enforced' alcohol policies had significantly lower levels of alcohol consumption (Carragher *et al.*, 2014, p. 730). Therefore, as levels of alcohol consumption are related to the strength of alcohol policies, alcohol policy frameworks should be evaluated regularly in order to refine policies and to measure their impact on consumption. TEASE-16 is a tool which can be utilised for such an evaluation. TEASE-16 can identify both strong and weak alcohol policies and therefore, can show policy makers where to target their efforts in order to strengthen weak policies. One limitation of this study was that the choice of analytic methods was restricted due to the small number of study areas, which reduced statistical power (Carragher *et al.*, 2015). In order to overcome this limitation the authors recommend that future studies using TEASE-16 include a larger number of study areas so that multiple regression analysis can be conducted and therefore, the study can account for the causal relationship between consumption, policy and alcohol-related harms.

In addition to the indexes outlined above, other methods have also been used to evaluate alcohol control policies. One of these methods is the International Alcohol Control (IAC) study which was developed to evaluate the impact of alcohol policies. The IAC study is an international collaborative project and is modelled on the successful International Tobacco Control (ITC) study (Fong *et al.*, 2006). The aims of the study are to evaluate the impact of alcohol control policies on policy-related behaviours and alcohol consumption within and between participating countries (Casswell *et al.*, 2012). In order to fulfil these aims, a survey instrument and a policy analysis protocol were developed. The survey instrument measures policy relevant behaviours such as amounts of alcohol purchased and price paid among a general population sample of drinkers. The survey is longitudinal and includes replenishment samples to compensate for attrition among respondents (Casswell *et al.*, 2012). The policy analysis protocol evaluates the policy contexts, including regulation and implementation, in each participating country. The initial participating countries include England, Scotland, New Zealand, Thailand and South Korea. The IAC study shows the impact of alcohol control policies in different cultural contexts and enables 'more confident

inferences to be made about the casual effects of policies and/or combinations of policies' (Casswell *et al.*, 2012, p. 1466). Furthermore, it also provides a greater understanding of the transferability of effective alcohol control policies.

Stakeholder-based evaluations

In addition to the quantitative methods outlined above, effective evaluations have also been conducted using qualitative methods such as stakeholder interviews. The advantages of using these interviews for evaluation are that they can provide richer information than what can be achieved with other methods of data collection (Boyce & Neale, 2006). In addition, interview-based evaluations can be particularly useful when evaluating the implementation of a strategy or programme as it enables the various stakeholders involved in the process to discuss at length factors which affected implementation. One example of this evaluation approach includes the evaluation of the National Institute for Health and Care Excellence (NICE) alcohol misuse standard (Knight *et al.*, 2017). This evaluation aimed to assess the implementation of the quality standard on alcohol misuse (QS11) which was published by NICE in 2011, and consists of a list of statements from evidence-based research aimed at improving quality within the health and care sectors. In order to evaluate the implementation of the QS11, structured qualitative interviews were conducted with individual stakeholders who had experience of either commissioning or delivering alcohol healthcare services in South East London. The structured interview guide consisted of 52 questions which included four questions for each of the 13 statements in the QS11 guidance. Data from the structured interviews were analysed using directed and conventional content analysis. One of the strengths of this evaluation is that it included a wide range of professional perspectives including healthcare professionals and commissioners (Knight *et al.*, 2017).

Stakeholder interviews have also been used alongside other methods in evaluations. For example, in order to evaluate the fifth phase of the Australian National Drug Strategy (NDS) an evaluation framework was developed which focused on collecting data from multiple sources and triangulating these in order to determine the effectiveness, efficiency and future needs of the NDS (Siggins Miller, 2009). Methods of data collection included an analysis of a wide range of documentation which was supplied to the evaluators, a review of

relevant literature, repeated stakeholder interviews which were conducted either face-to-face or via telephone, and case studies which provided closer analysis of selected components of the evaluation. After analysis and triangulation of the data, the initial findings were presented and discussed with stakeholders and those who had commissioned the research in order to assess the validity of the findings.

Similar to the above study, semi-structured stakeholder interviews were conducted alongside other methods in a study which assessed policy implementation in educational institutions. This research was conducted in two Further Education Colleges in England and focused on managers and staff mediating change within the colleges as a result of the implementation of the 1992 Further and Higher Education Act (Alexiadou, 2001). The data collected for this study included analysis of relevant documentation and 36 semi-structured interviews with managers and staff at the colleges. A further example of stakeholder-based evaluations includes the process evaluation of the National Drugs Awareness Campaign (Sixsmith & Nic Gabhainn, 2007). This research aimed to outline specifically the process involved in the development of the National Drugs Awareness Campaign. Two sources of data were collected for the evaluation including relevant documentary evidence and semi-structured interviews. Across the three phases of the evaluation, 94 interviews were conducted with stakeholders who had been actively involved in the development of the campaign. After the data were collected, they were then analysed and integrated for reporting.

Other studies have used a larger number of sources to collect data. One instance of this is the evaluation of alcohol and drug abuse prevention in Stockholm. This study had two aims. The first was to assess the barriers and facilitators for alcohol prevention in each of the districts, while the second was to analyse the association between the strength of youth prevention programmes and the overall change in alcohol use and alcohol-related problems in the study areas (Romelsjö *et al.*, 2003). Methods of data collection for the evaluation included repeated semi-structured interviews with a wide range of stakeholders, a questionnaire, and analysis of numerous data sets concerning young people and alcohol. The advantage of using multiple data sources, as shown in the above studies, is to provide greater validity for the evaluation findings (Boyatzis, 1998).

4. Summary of stakeholder perspectives

This section draws on data from the documentation supplied, the interviews with stakeholders (n=20) and the questionnaires returned from stakeholders (n=22).

4.1. Who were the stakeholders in the Galway City Alcohol Strategy?

Types of stakeholders

Both organisations and individuals were identified as stakeholders, as were sectors of the community and statutory bodies. Some were identified early in the process and were core to the development and implementation of the strategy, while others were identified later on. This is in line with the developmental nature of a partnership process and is entirely appropriate.

Core stakeholders

The core stakeholders were those engaged in setting the agenda and the Galway Healthy Cities Alcohol Forum (GHCAF) which was largely driven by HSE Health Promotion and Improvement, the Western Region Drug and Alcohol Task Force and Galway Roscommon Education and Training Board

Stakeholders in the Galway Healthy Cities Alcohol Forum

A diverse group of stakeholders were engaged in the GHCAF, the body that met regularly to agree actions, review progress and share information on relevant national or local initiatives, developments or obstacles. The membership of this group was more flexible over time, and demonstrated a range of levels of commitment, knowledge, ambivalence, practical input and responsibility to the action plans and overall strategy implementation. This group included An Garda Síochána, Galway City Council, Addiction Services (HSE), Health Promotion and Improvement (HSE), Western Region Drug and Alcohol Task Force, NUI Galway, Public Health (HSE), Environmental Health (HSE), Galway City Chamber of

Commerce, VEC/Galway Roscommon Education & Training Board, Galway City Community Forum, Galway Mayo Institute of Technology, .

Broader stakeholder groups

Others identified as stakeholders in the documentation provided include sectors such as Sports, Businesses, Tourism, Education, Voluntary and Community, Media and Vintners. A wider group were part of a support and liason network, including Active Retirement groups, St Vincent de Paul, the Homeless Forum, the Hotel Federation, the Probation Service, Social Work and Tusla.

Alcohol Industry involvement

The GHCAF had agreed that the Alcohol Industry would not be invited to participate in the their meetings, but that engagement with the industry would be critical to success.

4.2. What was the level of engagement and collaboration in the process of developing and implementing the strategy?

Induction of stakeholders

The range of level of involvement was broad, and while many had been involved since 2012, some had only become involved in 2016 and 2017. A small number of stakeholders interviewed were responsible for developing and driving the strategy, however most were engaged on foot of a direct invitation or were requested to do so by their managers. Furthermore, a few had become involved through their voluntary attendance at a consultation. Stakeholders were identified through their organisations such as the community and voluntary sector, the City Council and the University, while others were included due to their specific expertise or experience in alcohol-related areas. Another area of recruitment was through work on the Galway Healthy City Initiative and WHO Health Cities. A number of stakeholders conveyed motivation to be involved in the strategy due to the many associated harms of alcohol use. All reported feeling very 'included' in the process

and many reported that the welcoming nature of the group was a positive factor in people continuing their involvement.

Consultation process

When asked about their experience of being involved, most reported that their ideas were listened to and that they felt free to make contributions. They described how the GHCAF provided space for views from all areas. However, some felt that although they were listened to, they were unsure that their ideas and contributions were implemented. A number of respondents reported that they were directly involved in the implementation of strategic actions, while others reported that they had only recently become involved or that their work role was not related to implementation. Some stakeholders reported a lack of clarity around their role on the GHCAF which they would like to resolve. The collaborative nature of the strategy was highlighted many times with members identifying partnership development and engagement as a key part of the process, in particular the opportunity to share information.

The documentary analysis found clear identification of the various roles of stakeholders agreed (Nov 2011 Minutes). The consultation process was clearly laid out and agreed well in advance. An on-line questionnaire to agencies (n=124) confirmed the need for a strategy and identified priority issues to be addressed. Two consultation roundtables were held (June 19th, 2012 (n=42) and September 18th, 2012 (n=42) and were formally written-up. An on-line questionnaire for the public (n=78, plus 10 emails/telephone calls) was followed by consultation meetings with the Community Forum (September 2012, n=28) and with Comhairle na nÓg (October 2012, n=63).

On-going engagement of stakeholders

Most stakeholders had been involved in consultations or events, while some reported specialist input related to their professions or membership of the 'steering committee'. Some reported membership of the GHCAF, with attendance at up to eight meetings. Of those who had attended Yearly Review and Planning Events, most had only attended one.

Varying levels of involvement was evident with some highly involved and others taking a more passive role; a number arrived late to the process and therefore had a less active role. While stakeholders identified challenges within the strategy almost all intend to continue engaging in the process going forward.

Progress on actions was detailed at GHCAF meetings, and it was clear who was responsible for specific components. While the meetings of the GHCAF were clearly focused on the previously agreed actions and priorities, the supplied documentation demonstrates that meetings also included information sharing and updates on other alcohol-related matters.

4.3. What governance structures, practice and procedures were in place during the strategy process?

Documentary analysis found there was clear consideration of processes and procedures from the outset in 2011, with a core group identified and a looser set of stakeholders to liaise with and keep informed. Within the core group there were identified sub-groups with clear sets of responsibilities and tasks. Follow-up on issues and actions were clear and well documented, and the consultation, review and planning days were carefully planned in line with good practice.

Structure and management of meetings

All stakeholders commented on the highly organised nature of the strategy meetings. Meetings were described as extremely well structured and efficient with a clear agenda and task assignment. The time management of meetings was also noted with stakeholders describing that they were 'punctual' but also made 'efficient' use of time.

Attendance and accountability

Overall attendance was considered strong. However while many noted that members were 'regular and consistent' attendees, others had more 'sporadic' attendance. Some stakeholders felt there was a good level of accountability particularly given the task oriented

nature of the work. However it would seem it was mainly core members who were accountable with a number of stakeholders noting that some take a more passive role within the strategy. It was generally agreed that consistent attendance by key organisations and members was crucial to the success of the strategy.

Review, planning and communication

Structures and processes were reviewed by the GHCAF regularly, which meant there were opportunities to change as well as reiterate commitments and responsibilities. The terms of reference for the GHCAF were dated April 2013 though it is unclear whether this is simply an updated version of what was already in place since the group started working together in 2011.

Review and planning processes were a strength that was also identified by stakeholders. Clear minutes of all meetings were maintained, and actions were regularly reviewed, monitored and disseminated. Good communication with stakeholders was another strength identified in the structure and operation of the strategy. Stakeholders received regular updates at and between meetings; they were also kept abreast of national developments such as the Public Health (Alcohol) Bill. Reviews were also conducted to identify knowledge gaps, topical issues and new stakeholders.

Considerable attention was also paid throughout to communications and media strategy, including public advocacy work, maintaining and monitoring traffic on the dedicated website, and producing press releases on topical alcohol-related issues. Multiple submissions to public consultations were also made, including those on the provisions of the Public Health (Alcohol) bill, to the Galway City Development Plan and in opposition to proposed amendments to the City Council bye-laws on the consumption of intoxicating liquor in public places.

Leadership

Leadership was a strong feature of the strategy; while many organisations were represented it was largely driven by individuals within HSE Health and Improvement, the Western Region

Drugs Task Force and Galway Roscommon Education and Training Board. Many stakeholders identified the importance of a coordinated team that was well led. This strong team is considered crucial to 'pulling together', 'prioritising' issues and 'driving' them. Particular attention was paid to the need for a dedicated person whose main professional responsibility would be to drive the strategy otherwise it risks slipping down the agenda. Meaningful collaboration with all stakeholders was considered crucial and seen as one of the main strengths and successes of the Ballymun strategy.

Ownership of strategy

There was consensus that the strategy 'needs a home' with some stakeholders feeling it fits better at a local level and others feeling it would be better to link it into national strategies. The strategy currently sits with Galway Healthy Cities structures, which is led by HSE Health Promotion and Improvement. A number of advantages to this were highlighted such as the location within Health Promotion and Improvement, its access to staff and resources and its ability to avoid conflict of interests from the drinks industry. However it was also noted that the HSE is limited in its ability to criticise current service provision. A number of stakeholders raised the possibility of the next round of the strategy being led by the Western Region Drug and Alcohol Task Force, while others explicitly recommended this change.

4.4. Were these structures in line with good practice evidence?

Stakeholders rarely commented on the extent to which good practice was in evidence. Nevertheless there were many examples of good practice as well as some areas of practice that could be reviewed.

Evidence of good practice

Clearly the chosen actions and priorities were evidence-based, and this was widely celebrated across stakeholders. Considerable effort went in during the early stages of the

strategy to identify and collate multiple sources of data held by organisations, sectors and individuals. Such local, contextual data collection is in line with best practice, helping to ensure that actions are relevant and appropriate.

The process of consultation at the outset of the strategy development also echoes many elements of best practice. Potential contributors had a range of possible opportunities to engage with the process, these were widely publicised and clearly successful given the extent of the input recorded. Participants felt 'heard' and this extended to the annual review and planning meetings.

In relation to the structural issues, good practice was evident in the clarity around roles and actions at all stages, along with excellent record keeping and communications. Such clarity was sustained with the annual reporting and planning procedures, and in general the transparency of implementation also demonstrates good practice.

In addition, conceptions of best practice from various disciplines and professions were included in the decision-making processes adopted. This reinforced stakeholders' sense of ownership and commitment to the strategy, and also maximised the potential impact of processes and actions undertaken. Such a multi-disciplinary and cross-sectoral approach is clearly in line with best practice.

Issues of good practice to be addressed

Four areas may deserve further attention in relation to good practice; conceptual model, broader links and embeddedness, monitoring and evaluation, and membership of the GHCAF.

The strategy does not appear to be guided by an overarching conceptual or logic model of the strategy process. Such a model would link actions with potential outcomes, help explain priorities over time and how positive outcomes could be achieved. This would primarily assist others in replicating or extending the work of the GHCAF.

The strategy draws on and is linked to both national and international policy and strategy in the area. In order not to relinquish potential synergies GHCAF needs to continue it's

commitment to the Irish Community Action on Alcohol Network (ICAAN) and to collaborating with similar groups and networks as they emerge.

The lack of baseline data means that it is impossible to determine the extent to which key goals, and the actions designed to meet them, have been met. The local alcohol survey undertaken in 2015 will be very helpful to future reviews, but unfortunately the data were collected some three years into the strategy implementation.

There is an intractable problem in many partnerships with the managerial level of staff representing participating bodies at decision-making fora. A number of stakeholders attending the GHCAF meetings reported that they are not in a position to make decisions or commit to actions on behalf of their organisation. This is a difficult problem to address and resolve, but must be considered a limiting factor.

The issue of leadership was raised by some stakeholders. The early leadership of Health Promotion and Improvement was widely acknowledged as crucial to the development and implementation of the strategy. The current commitment of both Health and Improvement and the WRDATF to leading the implementation was also widely praised. However some staff changes and other strategic developments impacting on the responsibilities of individuals means there remains a question over future leadership of the strategy. Best practice dictates that this is a key issue that needs to be resolved positively.

Clarity is required on the future structures of the Alcohol Forum, not just how it is led or the relative decision-making responsibilities of those who attend. Success and sustainability are driven by multiple interacting influences, including many reported by members of the Alcohol Forum. Consideration should be given to widening the opportunities for participation both to diverse, heterogeneous organisations and by enabling meaningful contribution at multiple levels. Clear organisational structures with formal buy-in and memorandums of understanding with key partner organisations could facilitate more efficient progress towards policy goals.

4.5. What enabling factors were crucial to the implementation of the strategy?

Evidence base

The Galway City Alcohol Strategy used an evidence based approach and this was identified as a key strength of the strategy by most of the stakeholders. Many welcomed and commended the involvement of Dr. Ann Hope as a regular advisor to the strategy.

Stakeholders described the value of gaining knowledge and awareness of salient evidence in order to develop and implement the strategy. However some stakeholders reported frustrations when there was reluctance to accept the evidence base or ambivalence towards the evidence itself, for example despite the lack of supportive evidence some stakeholders continue to advocate for increased alcohol education in schools.

Collaborative process

Collaboration and relationship building was a key feature of the strategy. Stakeholders regularly recalled the benefits of working with others with a shared goal and also commented that the inclusive nature of the strategy partnership, development and engagement was a key part of the process. Specific benefits identified as part of the collaborative process were the opportunities to network and liaise with other organisations and share information.

Communication strategy

The communication approach of the strategy was praised. It was clear that notice of meetings were communicated well in advance and attendance was encouraged. Stakeholders received regular updates at and in between meetings; they also reported being updated on National developments. There was evidence of a good communications and media strategy, including public advocacy work, awareness raising and management of the dedicated website as well as regular production of press releases on alcohol-related issues.

Structure and organisation

The structured approach adopted was seen as an enabling factor in the successful development and management of the strategy. During the development phase of the strategy, the stakeholder group was relatively consistent. There was a strong emphasis on the adoption of annual goals, information gathering and clarity around responsibilities. Clear progress was made between meetings that was reflected in minutes and other documentation. Similarly the clear annual progress was well documented and consistent across years, gathering momentum and instilling trust in stakeholders over time. The adoption of a community orientation was also cited by respondents as being important to the success of the strategy.

Review Process

The adopted mechanisms to review progress over the previous year and to plan implementation for the following year were clearly enablers of the overall strategy implementation. This facilitated a broader range of stakeholders to come together annually and for those who were not directly involved in implementation or in the GHCAF it facilitated their engagement with alcohol as a priority issue and with the specifics of the strategy in Galway.

4.6. What barriers impeded or obstructed the strategy implementation?

Stakeholders identified a number of barriers to the effective implementation of the strategy many of which were structural in nature and included support for the strategy, service provision, policy and governance, resource deployment and more general ambivalence towards alcohol as a priority issue.

Buy in and support for the strategy

The issue of whether support is needed from the top-down or the bottom-up was highlighted regularly. It was acknowledged by many stakeholders that there is real 'passion'

at the grassroots level particularly from those at the 'coalface'; however most agreed bottom-up support alone will not achieve change and almost all highlighted the need for top-down support from a senior level to drive the successful development and implementation. The need for leadership within stakeholder organisations was also raised with many noting that membership of the GHCAF was often delegated to someone more junior or someone with a specific interest or expertise in alcohol rather than the decision-maker. Other related barriers included turnover of those attending GHCAF meetings, with some in attendance not necessarily well informed or their not having any role in relation to implementation. Some stakeholders identified statutory and commercial bodies as distinct groups who could have engaged more with the strategy and provided more help to support and drive it. The need for political and government support was also raised by stakeholders and the importance of the Public Health (Alcohol) Bill was mentioned by many.

Current provision of services

The current management of alcohol use services was regularly identified as a substantial barrier to the successful achievement of the goals of the alcohol strategy. Most stakeholders identified the basic lack of services for alcohol and the poor funding of services in this area. Other issues raised were the fragmentation of current service delivery in particular the treatment parameters which often result in the exclusion of service users with an alcohol problem alone.

The need to prioritise funding for the development of new alcohol treatment services was highlighted as an immediate requirement. Stakeholders also suggested that the SAOR model (O'Shea *et al.*, 2017) of training be expanded, and to progress the training of existing healthcare professionals. It was also noted that there is an historical problem of which agency or organisation takes 'ownership' of alcohol.

Perceptions and prioritisation of alcohol

Stakeholders discussed the priority that gets placed on addressing alcohol in general as a barrier to the development and implementation of the strategy, and noted the presence of

an ambivalence towards alcohol among stakeholders and the wider community. Some cited the social acceptance of alcohol as a barrier to it being prioritised but also noted conflicting interests such as the drinks industry and, more specific to the Galway strategy, the 'Purple Flag' and the 'Stop out of control drinking' initiatives. Some stakeholders felt that there is growing recognition that alcohol is a priority area and that this is a crucial time for achieving change. There was universal agreement that the issue of alcohol needs to be kept on the agenda at both a local and national level.

Limited baseline data

Baseline data collection plans, for example the door to door survey mirroring the Ballymun baseline data collection, were not executed. This would have been very useful for monitoring and evaluation purposes. In June 2012 it was noted that there was sufficient information indicating that Alcohol was a problem and it was agreed not to progress a survey until at least after the consultations for the Strategy. The Galway City Alcohol Survey, undertaken by Ipsos MRBI in late 2015, reported on the alcohol-related attitudes, awareness and behaviour of 500 adults as well as the views of citizens on alcohol policy and strategy implementation (Hope, 2016).

National policy and governance

From 2014 on, the annual action plans highlighted 'critical success factors' that required implementation. In 2014, 2015, 2016 and 2017 the centrality of the proposed Public Health (Alcohol) Bill and its specific measures were featured on the front page of the action plans. It is clear that the lack of progress on this bill has obstructed the potential of the Strategy to meet its goals. There is ample evidence in the documentation provided of sustained advocacy towards the passing and implementation of this bill. This includes submissions from the GHCAF supporting the measures in the bill, stressing that they are evidence based and in line with best practice and providing explicit examples of their potential use to combat alcohol-related harm. In addition, guidance on the provisions of the bill were circulated to the public and stakeholder groups.

4.7. What progress has been made under the strategy to date?

The reported achievements of the strategy were related to both the process and the outcomes. In relation to process, the linking of agencies with one another, the periodic prioritisation of goals, and the linking of actions with evidence were all seen as successful. Raising awareness and agenda setting were frequently reported as the most successful outcomes, but there was also reference to possible falling hospital attendances, the work towards the introduction of minimum pricing, alcohol-free activities, and developing a sense of shared responsibility among services.

Each Annual Action Plan contained a summary of progress on the action plan of the previous year. In almost all cases these followed a similar pattern and documented considerable progress which can be seen in Appendix 1.

Some actions appeared to show less clear progress than others, for example the implementation of the Festival Care Guidelines was raised at most meetings, but implementation of the guidelines appears out of reach without the support of festival sponsors.

4.8. What recommendations can be made going forward?

A future strategy

There is a clear expectation that there will be a second strategy. While there was much support for the current strategy, particularly the explicit nature of the actions and links to the evidence base, some suggestions were made for a potential second strategy. These included having fewer actions and being more 'creative' in developing the actions. There was also a suggestion that drugs could be included in the strategy, to mirror the national strategy, though there was a recognition that this could result in lower levels of public engagement and interest.

Future processes and procedures

It was suggested that further embedding the strategy into the Healthy Ireland agenda should be a priority as was linking in explicitly with other groups across the country who are engaged in similar activities. Continued commitment to working in partnership with the community action projects of regional Drug and Alcohol Task Forces and as part of the National Community Action on Alcohol projects (Galligan, 2015) was also prioritised.

In terms of local process, it was proposed that submissions to the annual reviews and planning meeting could be facilitated in a broader way, which would not require physical attendance, such as written submissions or electronic input.

Future stakeholders

The current stakeholders suggested that implementation could benefit from linking in with existing community structures, being more community-based throughout the whole life cycle of the strategy, not just at the consultation phase. Other recommendations for future stakeholders included engaging with the Road Safety Authority to promote safe driving, and engaging with the business sector in general and particularly those involved in selling alcohol.

Future ownership

The issue of where the 'home' for the strategy should be was raised by stakeholders. There was much praise and appreciation of the contribution of the core stakeholders, and the current structures, but some suggested that a natural home for the strategy should be with a multi-agency type structure. For such a move to be successful, there is recognition that the current level of commitment and engagement from the HSE would have to be sustained, and indeed the need for strong and continued leadership was considered more vital than which organisation or structure provided it with a 'home'.

Others suggested that greater involvement of agencies on the implementation group in implementing actions, to include for example the City Council, would be very welcome.

Future actions

Stakeholders argued that any new strategy needs to maintain the focus on awareness raising, information sharing and ensuring that alcohol remains on the agenda. This refers to the agenda of organisations for whom alcohol is a service provision issue such as the HSE and Tusla, but also that it is retained on the political agenda. Numerous stakeholders raised the need for a renewed focus on service provision and the potential positive impact of the Public Health (Alcohol) bill. These were both considered essential for future advocacy and implementation.

A number of stakeholders suggested there would be benefit to having local alcohol prevention 'champions' with widespread appeal across sectors who would advance actions in the strategy.

Although some stakeholders recommended reducing the overall number of actions, others recommended actions to improve the strategy for the future. Many of these concerned sustaining current actions or continued emphasis on matters such as enforcement of legislation, lobbying for resources, raising awareness and understanding and the promotion of alcohol free activities. Others suggested actions included limiting where alcohol can be purchased, more intense community engagement, greater involvement with local and national politicians and the inclusion of the voice of young people.

5. Consultation on evaluation findings

Phase three of the study comprised a consultation on the key findings of this evaluation. All stakeholders were invited to evaluate and provide feedback on the study findings, as outlined in section 2 above. The level of agreement with the study findings was very high, as outlined below in table 1.

Table 1: Summary of consultation on evaluation findings

Findings	Agreement	Comment
Stakeholders	94%	More engagement with local communities and responsiveness to change in context required.
Engagement and collaboration	94%	Stakeholders felt 'included' and agreed that the collaborative process adopted was crucial.
Governance, practice and procedures	100%	The need for a dedicated person and agency to provide leadership was stressed.
In line with good practice	94%	These points were least clear to stakeholders, monitoring progress and leadership were highlighted.
Enablers to implementation	100%	The annual review process was emphasised as a learning and networking opportunity.
Barriers to implementation	94%	Lack of progress on alcohol services and the public health alcohol bill are central. Greater commitment from some stakeholders needed.
Progress made	83%	Raising awareness should impact on the agenda of all stakeholders.
Recommendations	94%	Recommendations should be discussed at the GHCAF.

The level of consensus from stakeholders was high, with clear support for the key findings from those who responded.

DRAFT

6. References

Alexiadou, N. (2001). Researching Policy Implementation: Interview data analysis in institutional contexts. *International Journal of Social Research Methodology*, 4(1), 51-69.

Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K. Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Österberg, E., Rehm, J., Room, R. and Rossow, I. (2010). *Alcohol: No Ordinary Commodity - Research and Public Policy* (2nd ed.). Oxford: Oxford University Press.

Ballymun Local Drugs Task Force and Safer Ballymun Community Safety Forum (2010). *A Road to Change: Ballymun Community Alcohol Strategy 2010-2016*. Dublin: Ballymun Local Drugs Task Force and Safer Ballymun Community Safety Forum.

Boyatzis, R.E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, CA: Sage.

Boyce, C. and Neale, P. (2006). Conducting In-depth interviews: a guide for designing and conducting in-depth interviews for evaluation input. *Pathfinder International Tool Series: Monitoring and Evaluation*. Watertown, MA: Pathfinder International.

Brand, D.A., Saisana, M., Rynn, L.A., Pennoni, F. and Lowenfels. A.B. (2007). Comparative analysis of alcohol control policies in 30 countries. *PLoS Med*, 4(4), 752-59.

Carragher, N., Byrnes, J., Doran, C.M. and Shakeshaft, A. (2014). Developing an alcohol policy assessment toolkit: application in the Western Pacific. *Bulletin of the World Health Organisation*, 9, 726-733.

Carragher, N., Byrnes, J., Doran, C.M. and Shakeshaft, A. (2015). Methodological and statistical considerations in alcohol policy evaluation. *Bulletin of the World Health Organisation*, 93, 740C-740D.

Casswell, S., Meier, P., MacKintosh, A.M., Brown, A., Hastings, G., Thamarangsi, T., Chaiyasong, S., Chun, S., Huckle, T., Wall, M. and You, R.Q. (2012). The International Alcohol Control (IAC) study - evaluating the impact of alcohol policies. *Alcoholism: Clinical and Experimental Research*, 36(8), 1462-1467.

Department of Health (2012). *Steering Group Report on a National Substance Misuse Strategy*. Dublin: Department of Health.

Fong, G.T., Cummings. K.M., Borland, R., Hastings, G., Hyland, A., Giovino, G.A., Hammond, D. and Thompson, M.E. (2006). The conceptual framework of the International Tobacco Control (ITC) policy evaluation project. *Tobacco Control*, 15(suppl iii), iii3-iii11.

Galligan, C. (2015). *National Community Action on Alcohol Pilot Project 2015: external evaluation report*. Letterkenny: Alcohol Forum.

Galway Healthy Cities Project (2017). *What is Galway Healthy Cities?* [online], available: <http://www.galwayhealthycities.ie/> [accessed February 2018].

Holder, H.D., Gruenewald, P.J., Ponicki, W.R., Treno, A.J., Grube, J.W., Saltz, R.F., Voas, R.B., Reynolds, R., Davis, J., Sanchez, L., Gaumont, G. and Roeper, P. (2000). Effect of community-based interventions on high-risk drinking and alcohol-related Injuries. *Journal of the American Medical Association*, 284(18), 2341-2347.

Ipsos MORI (2012). *Ballymun Alcohol Survey*. Dublin: Ballymun Local Drugs Task Force and Safer Ballymun Community Safety Forum.

Ipsos MORI (2016). *Ballymun Study of Attitudes and Behaviours towards Alcohol*. Dublin: Ballymun Local Drugs Task Force and Safer Ballymun Community Safety Forum.

Jervis, R. (2009). *Wolverhampton Keep It Safe: an Evaluation Report*. Wolverhampton, UK: Wolverhampton City Primary Care Trust.

Knight, A., Littlejohns, P., Poole, T.L., Leng, G. and Drummond, C. (2017). The NICE alcohol misuse standard - evaluating its impact. *International Journal of Health Care Quality Assurance*, 30(3), 260-273.

Kypri, K., Jones, C., McElduff, P. and Barker, D. (2010). Effects of restricting pub closing times on night-time assaults in an Australian city. *Addiction*, 106, 303-310.

Lee, K.K. (2014). Working across sectors for health equity: the case of New York city, in World Health Organization and Metropolis (eds.), *Cities for Health*. Kobe, Japan: WHO Centre for Health Development.

Moxham-Hall, V.L. and Ritter, A. (2017). Indexes as a metric for drug and alcohol policy evaluation and assessment. *World Medical and Health Policy*, 9(1), 103-126.

Palinkas, L.A., Horwitz, S.M., Green, C.A., Wisdom, J.P., Duan, N. and Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533-544.

Romelsjö, A., Hæggman, U., Braun, C., & Danielsson, A. K. (2003). The evaluation of alcohol and drug abuse prevention in the 18 districts of Stockholm. *Nordic Studies on Alcohol and Drugs*, 20(s1), 101-104.

Siggins Miller (2009). Evaluation and monitoring of the National Drug Strategy 2004-2009: final report, Volume 1: findings and recommendations [online], available: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/FD973BE3A786C9B0CA257682000E70DC/\\$File/eval1.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/FD973BE3A786C9B0CA257682000E70DC/$File/eval1.pdf) [accessed February 2018].

Sixsmith, J. and Nic Gabhainn, S. (2007). *A Process Evaluation of the National Drugs Awareness Campaign 2003-2005*. Dublin: National Advisory Committee on Drugs.

Tsouros, A.D. (2015). Twenty-seven years of the WHO European Healthy Cities movement: a sustainable movement for change and innovation at the local Level. *Health Promotion International*, 30(s1), i3-i7.

World Health Organization and United Nations Development Programme (2016). Policy brief 1: Healthy Cities. *9th Global Conference on Health Promotion Shanghai*, [online], available: <http://www.who.int/healthpromotion/conferences/9gchp/policy-brief1-healthy-cities.pdf> [accessed February 2018].

World Health Organization Regional Office for Europe (2017). WHO European Healthy Cities Network [online], available: <http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network> [accessed February 2018].

Evaluation of Galway Healthy City Alcohol Strategy: Themes and quotes

Research Questions	Theme	Quotes
Level of engagement and collaboration in the strategy process	Inclusive Nature of Process	"They really involved every member of the group and everybody had their say". (SH03)
	Consultative Approach	"they brought us into a room, big circle you know, asked people for their opinions and their views and so it was good. It was good. I felt that they were listening to all the service providers that were involved." (SH08)
	Diversity of Stakeholders	"It's a real mix of agencies and authorities and voluntary bodies and it's a real mix but yet everyone would have a vested interest in reducing alcohol related harm." (SH07)
Governance structures, practice and procedures of strategy process	Meetings well-structured and efficient	"I think they were very well run, always on time, there was nothing rushed, there was always time to discuss particular issues and there was always discussions... I thought they were very good productive meetings and I was always keen to make sure I attend them." (SH17)
	Strong Communication	"The people involved in the HSE and health promotion were very good at communication. They had a good website and they learnt a lot, they had small little cards that could be left in GP surgeries. I think the communication that was done was very good that's a key thing for getting this out there ... making contact with GP and service providers and getting your message out on local radio and newspapers." (SH17)
	Strong Leadership	"I mean the evidence is really really strong around the world ... I know that from Health promotion, you need somebody leading it you need someone that there is on their job spec that they're responsible for it...when you don't have it as the top of somebody's job it doesn't get done, it gets weakened." (SH6) "Well it was very helpful that the HSE were there and put in a lot of the work. I mean if you go to a meeting and there are six or seven different groups and they all go away from the meeting, you need someone to co-ordinate well and bring it forward and steer it and move it, pushing it along and that is what [Name] did. She was very much the leader and without that, you were going nowhere." (SH19)
Evidence of good practice	Evidence based	"The one thing about the strategy I think as well was when it was developed is very much coming at looking at evidence based actions ... to change things we need to look at marketing, supply and availability, and they are the things that will make an impact with regards to alcohol and alcohol harms." (SH05)
	Transparent process	"...it (<i>the alcohol strategy</i>) has demonstrated its successes and its blocks on an annual basis and I think that's important. We can be so busy doing work that we don't put the time into demonstrating it. You know putting it together to show actually this was a solid piece of work. It took a lot of work and this is what the outcomes were ... constantly looking at the actions and the goals with regard

		to how are we going to do that and how can we possibly do that?". (SH05)
	Lack of baseline data	"...one of the things was the whole notion of the baseline at the beginning, doing a baseline study or research at the beginning so that you have something then to compare to at the end. I think that's one of the things, one of the learnings possibly in it. We did do research the year before ... but it's not from the beginning so that's just one of the, I suppose the kind of the key learnings". (SH5)
	Buy-in / support	"It comes down to if you don't have the head of the organisation backing what you do then it doesn't happen". (SH6) "I think part of the problem for some of the initiatives is that they need a higher level of cooperation from senior management and in all the organisations in order to sort of facilitate change. Particularly around service developments...you know they need to go right to the top and make sure that there is some commitment for to develop it you know. You need to be careful not to constantly just get the people who agree with you but sell the message to the people who don't". (SH8)
Enablers to the process	Evidence Base	"So definitely having Ann [Hope] on board gave it credibility throughout and it also gives a lot of confidence ... because lots of different strategies will say that they're evidence-based but actually I question whether they are, whereas Ann is very very clear. ... we know that this is going to work or this has the potential so we're not doing the things, we're not going to waste our time and energy and limited resources doing stuff that looks good, gets PR but actually doesn't do any good at all". (SH4)
	Collaborative work with diverse groups	"And there are all these different voices coming from so many different perspectives ... they are hearing what the issues are for people trying to operate the strategy in different places". (SH09)
	A well-structured and organised team	"Having a dedicated sort of team ... they've pulled it all together, they've prioritised the actions, they've monitored the actions, you know they've done what they can to keep the issue on the sort of public agenda and on the political agenda and the health agenda. So that's successful". (SH08)
Barriers to the process	Buy-in and support from a senior level	"I think it needs to be at a higher level of engagement because ... you have to get the buy in from on top otherwise it's very hard to make change from the bottom up I think in this instance because some of it requires change in organisations and some of it requires political change and some of it requires money. So it's difficult really". (SH8)
	Fragmentation of services	"there was an alcohol service in Galway but it has been under funded for years, had very little support and now has been told they can only see people with co-morbid conditions so that's really frustrating cause what it means on the ground is that for the public there's no primary care alcohol service provision in Galway". (SH8)
	Ambivalence	"I don't think people see it as a big enough problem ironically and

	over prioritisation of alcohol	it's very frustrating". (SH08)
Progress to date	Awareness raising	"I think one of the things that the strategy's done really well is the business of you know prevention, education, raising the issue ... it's like they put out a consistent message and they kept repeating it ... I think it's important to keep doing that". (SH08)
	Shared responsibility among services	"It was good that the different organisations in the area sat down together and voiced their opinions, their problems. When you work in the Guards, or you work in a hospital or wherever you work, you can see your problems in relation to an issue, but you don't necessarily understand other people's problems. So, it was good that we could work together and see if we could help each other". (SH19)
	Training and education	"Raising awareness, prevention and education, brief intervention, you know teaching people how to sort of look for alcohol issues ... I do think they've been good at that. They've done training like the Saor training, the you know brief intervention training, motivational interviewing ... how to sort of spot the issues, getting the other professionals and service providers to look at how to identify the problems early". (SH08)
Challenges	Service availability	"...but then you know there's a cliff edge then cause there's no treatment which is painful ... but it is ... it's terrible. You know cause it's very frustrating if you go out and raise awareness for the public and then the public come looking for help and there's no... That's a real road block I think for the strategy". (SH08)
	The need for implementation of Public Health Alcohol Bill	"I think the key thing is to concentrate on trying to get the legislation changed ... we did great work, we got out the evidence about what works and what doesn't work and they just have to keep at it and it's tough work ... it is still far too accessible to get drink and one reason is because it's too cheap you have supermarkets completely almost being loss leaders". (SH17)
Recommendations	Building and strengthening community structures	"The community element of it is probably I think the area we need We have a lot of the strong players from organisations and structures and I do think it is an area that could have an added benefit to the structure of strategy going forward". (SH05)
	Ownership	"At some levels there is really good engagement but at other levels there is a reliance on, an over reliance on us on some stuff, I would like to see more shared ownership". (SH20)
	Local champion	"I was suggesting that we needed a leader you know in Galway, somebody who is in the business community but is not a publican, someone who is respected and well known in Galway, that becomes a sort of, a, what would you call it, who speaks in support of the." (SH6)