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Evaluation of the Communities In Charge of Alcohol (CICA) Programme in Greater Manchester

Submission date
10/03/2017

Recruitment status
No longer recruiting

Registration date
12/09/2017

Overall study status
Completed

Last Edited
16/09/2024

Condition category
Mental and Behavioural Disorders

[_] Prospectively registered
[X] Protocol
[_] Statistical analysis plan
[X] Results
[_] Individual participant data

Plain English summary of protocol

Background and study aims
Excessive alcohol consumption harms an individual's health and social relationships. It places a burden on hospitals. It also harms society more generally, as urban areas become less pleasant to visit and crime increases. The impact of alcohol abuse is worse for people living in poorer areas. The amount of alcohol consumed in different communities depends on a range of factors, with a variety of studies showing that the widespread availability of cheap alcohol increases both levels of drinking and harm to individuals and society. The aim of this study is to provide vital evidence for local authorities planning community action on alcohol, by testing a programme called 'Communities In Control of Alcohol' (CICA) that is planned to take place in Greater Manchester. Through CICA, local people who have previously received existing 'health champions' training are trained as 'alcohol health champions' (AHCs). These AHCs are in turn able to train others, and all trained individuals achieve a formal Level 2 qualification as an AHC. Training enables AHCs to have informal healthy conversations with family, friends and colleagues, organise healthy events and model healthy behaviour with respect to alcohol. CICA provides training and local support for communities to get involved in alcohol licensing decisions, and aims to put local communities in a position to help reduce the availability of alcohol and the impact of alcohol abuse.

Who can participate?
All residents living in selected areas in the ten boroughs of Greater Manchester

What does the study involve?
Each of the ten boroughs in Greater Manchester choose a small geographic area (consisting of around 4,000-7,000 residents) to apply the CICA programme. The chosen areas have high current levels of alcohol harm and significant economic and social deprivation. The order in which the 10 areas are allocated to the CICA programme is determined by random allocation. During the first year of the study, five individuals in each area are trained and supported in rolling out training to a further 30 individuals in each area (350 in total across Greater Manchester). A range of methods are used to assess whether CICA reduces alcohol harm. These include observations, where researchers shadow AHCs to understand how they work in the community, and surveys of

AHCs to understand how they are applying their new knowledge and skills. The CICA areas are compared with similar areas that have not received CICA in order to find out whether CICA reduces the undesirable consequences of alcohol such as hospital admissions, A&E attendances, ambulance call outs and levels of crime over a one to four year period. If CICA does appear to reduce these harms in the community, in year five the costs of running CICA are compared with the potential money saved to calculate whether CICA could save society money.

What are the possible benefits and risks of participating?
If successful, CICA will be immediately applied throughout Greater Manchester to benefit the population of 3 million people. National policy and decision makers will be briefed on how CICA might work if applied to the whole of the UK, and how much money could be saved by doing so. The findings will be promoted widely in the press, through social media as well as scientific journals and conferences. Possible benefits of being a health champion (which is a volunteering role) include improvement in health, self-esteem and personal development. AHCs receive training and a qualification (level 2 award), which may increase employability. There are no known risks of taking part in CICA as a health champion.

Where is the study run from?
University of Salford (UK)

When is the study starting and how long is it expected to run for?
March 2017 to February 2022

Who is funding the study?
NIHR Public Health Research Programme (UK)

Who is the main contact?
Prof. Penny Cook
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Study website
http://hub.salford.ac.uk/communities-in-charge-of-alcohol/

Contact information

Type(s)
Public

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Additional identifiers

EudraCT/CTIS number

IRAS number

ClinicalTrials.gov number

Secondary identifying numbers
PHR 15/129/03

Study information

Scientific Title
Communities In Charge of Alcohol (CICA) Programme: evaluation of an area-level natural experiment in Greater Manchester

Acronym
CICA

Study objectives
This study will evaluate a complex community-level intervention that was already in the planning phase prior to the funding for the evaluation, and is researcher-influenced but not researcher-controlled, evaluated as a natural experiment with an element of randomisation.

Hypothesis: Alcohol harm (hospital admissions and crime) is lower in areas with the CICA programme.

Ethics approval required
Old ethics approval format

Ethics approval(s)
University of Salford Research Ethics Committee, 30/05/2017, ref: HSR1617-135

Study design
Stepped wedge randomized trial

Primary study design
Interventional

Secondary study design
Stepped wedge randomized design

Study setting(s)
Community

Study type(s)

Prevention

Participant information sheet
Not available in web format, please use contact details to request a participant information sheet

Health condition(s) or problem(s) studied
Alcohol-related health conditions and alcohol-related crime

Interventions
CICA is a bespoke community engagement and alcohol health champions (AHC) training programme. AHCs will be trained to (i) give alcohol-related brief advice to individuals and (ii) help communities tackle the availability of alcohol in the local environment through the licensing process.

The CICA training programme aims to give AHCs the confidence and tools to:
1. Support individuals to reduce drinking and/or to guide individuals towards specialist services /organise community awareness events (how to help and support individuals; alcohol's impact on local communities; collaborative work to reduce alcohol harm; how to use a range of data sources to capture evidence of alcohol impact: day 1)
2. Establish community action against alcohol harm (delivered in collaboration with the local area's alcohol licensing officers: specific local arrangements for licensing decision making; strategies to create interest and mobilise communities in becoming active in the local licensing process: day 2)
3. For first generation ('seed') AHCs only, train subsequent AHCs (enable participants to prepare and set up programme material; select appropriate material relevant for delivery in their area using PTLLS 'Preparing to Teach in the Lifelong Learning Sector' approach: day 3).

Each of the ten boroughs in Greater Manchester will choose a small geographic area (consisting of around 4,000-7,000 residents) to apply the CICA programme. This will be an area that has high current levels of alcohol harm and significant economic and social deprivation. For this area-level analysis, the order in which the 10 areas are allocated to the intervention has been determined by simple randomisation using a computer. During the first year of the project, five individuals in each area will be trained and these will be supported in rolling out training to a further 30 individuals in each area (350 in total across Greater Manchester). In order to take advantage of this 'natural experiment' the trialists will compare before and after CICA, and will select areas in each borough that are similar in terms of geography and social variables to the sites being investigated to act as comparison sites. A range of methods will be used to assess whether CICA does indeed reduce alcohol harm. These include observations, where researchers shadow AHCs to understand how they work in the community, and surveys of AHCs to understand how they are applying their new knowledge and skills. By comparing the CICA areas with the matched comparison areas that have not experienced CICA, the study will measure whether the intervention reduces the undesirable consequences of alcohol such as hospital admissions, A&E attendances, ambulance call outs and levels of crime over a one to four year period. If the intervention does appear to reduce these harms in the community, in year five the trialists will also be able to calculate whether CICA could save society money. This would involve calculating the costs of running CICA versus the potential money saved.

The statistical analysis will be at the level of the small intervention area (the equivalent of 3-4 lower super output areas, LSOA), comparing with areas where CICA has not been introduced yet. Two distinct approaches are used:

1. 'Internal' evaluation: trends are compared in area-time intervention areas before and after the intervention using a stepped-wedge randomised trial design. Randomisation will be concealed from the rest of the investigators and the implementation team until two months before each given area's turn in the sequence of roll out.
2. 'External' evaluation: the impact of the intervention will be assessed using two complementary methods: (a) intervention and control areas inside the GM area will be matched by area-level deprivation, population size, age distribution and baseline alcohol-related burden by calculating propensity scores. Temporal trends in each of the outcomes will be plotted graphically and analysed.

Intervention Type
Behavioural

Primary outcome measure
Measured at baseline, 1 year and 2 years:
1. Alcohol-specific hospital admissions (narrow measure)
2. A&E attendances
3. Alcohol related call outs for ambulance services
4. Numbers of crimes in local area (violence, sexual offences, criminal damage and public order offences, occurring between Friday and Sunday)

Secondary outcome measures
Measured at baseline, 1 year and 2 years:
1. Community activity around alcohol licencing:
1.1. Alcohol licences challenged
1.2. Alcohol licence reviews requested
1.3. Alcohol licence representations submitted
1.4. Issues reported to local licensing authorities
1.5. Alcohol licence investigations initiated
2. Alcohol licensing outcomes - numbers of:
2.1. Licence applications refused
2.2. Existing licences revoked
2.3. Licences amended with reduced hours
2.4. Licences with other amended conditions
2.5. Cumulative impact zones established
2.6. Local electoral turnout (as a proxy measure of community engagement)

Overall study start date
01/03/2017

Completion date
28/02/2022

Eligibility

Key inclusion criteria
This is an area-level intervention. CICA explicitly aims to reduce health inequalities due to alcohol harm by focusing this community-level intervention in a geographical area of priority in terms of having high levels of alcohol related harm and significant economic and social deprivation. Each borough in Greater Manchester will decide which small area within their respective borough will receive the intervention.

Participant type(s)
All

Age group
All

Sex
Both

Target number of participants
The population of one or two Lower Super Output Areas in each of ten boroughs. An LSOA typically has 1,500 residents, therefore 15,000 to 30,000 residents will be part of the intervention.

Key exclusion criteria
N/A - this is an area-level intervention

Date of first enrolment
01/06/2017

Date of final enrolment
01/06/2019

Locations

Countries of recruitment
England

United Kingdom

Study participating centre
University of Salford
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Sponsor information

Organisation
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Sponsor type
University/education

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ROR
https://ror.org/01tmqtf75

Funder(s)

Funder type
Government

Funder Name
Public Health Research Programme

Alternative Name(s)
NIHR Public Health Research Programme, PHR

Funding Body Type
Government organisation

Funding Body Subtype
National government

Location
United Kingdom

Results and Publications

Publication and dissemination plan
Findings will be shared via briefings to key partners nationally and in Greater Manchester (GM). This will begin as soon as intermediate outcomes are demonstrated such as any impacts on the availability of alcohol as a result of community action (year 2), and will make use of Local Government Association networks and the communications departments of the Association of Directors of Public Health. The RSPH will prepare newsletters to Health Champions/wider workforce and publicise findings in its journal Perspectives in Health and to the Membership of RSPH. National conferences (e.g. Public Health England Conference) will be used to directly

disseminate the findings to public health practitioners. Key conferences (Kettil Bruun Society-Social and Epidemiological Research on Alcohol: Annual Conference and the 12th European Public Health Conference 2019) will be used to promote the findings to an international audience. Open access peer-review journal articles will be published in key journals and reports made available via NIHR PHR Journal (and associated websites). It is anticipated that the main findings will be published in early 2022, with preliminary findings (based on one year's data) published in 2021.

Intention to publish date
28/02/2022

Individual participant data (IPD) sharing plan
The data sharing plans for the current study are unknown and will be made available at a later date.

IPD sharing plan summary
Data sharing statement to be made available at a later date

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Protocol article	protocol	19/04/2018		Yes	No
Results article	qualitative study results	01/03/2021	12/02/2021	Yes	No
Results article	Data from pre-implementation phase	29/11/2022	14/12/2022	Yes	No
Results article		01/09/2024	16/09/2024	Yes	No