
Licensing Law and the Impact of the Public Health

Objective - A Review Paper

Final Report by MP Consultancy

Commissioned by:

Alcohol Focus Scotland

August 2008

Documentation Information

Project Title: Licensing Law and the impact of the public health objective - a review paper			
Document Type: Final Report			
Filename: Licensing and Public Health Review Final Paper v3 1 150808			
Author: Matthew Plunkett			
Version	Date	Distribution	Comments
V1 0	19/06/08	MP	FINAL
V3 1	15/08/08	MP	FINAL
Issued for Submission			
Author:			

Acknowledgements

This research was commissioned by the Alcohol Focus Scotland and conducted by MP Consultancy.

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1. Introduction

The Licensing (Scotland) Act 2005 represents the most fundamental overhaul of Scotland's licensing laws for 30 years, and has followed on from recommendations contained within two major reports prior to this concentrating on drinking in the community (Scottish Executive [Nicholson] 2003, and Scottish Executive [Daniels] 2004).

Within the new Licensing Act there is a clear aim not only to address crime and disorder and wider community safety issues, but also to have a positive impact on the wider health of communities. However, there is concern that little is known about what that impact may be, and whether or not this impact, if any, can be defined.

To assist Licensing Boards in addressing this key objective of the new Licensing Act, Alcohol Focus Scotland commissioned a brief review the current literature within the alcohol field to see if there is any evidence that shows the impact of Licensing Law on the wider health of a population. Two further elements of work complemented this review. As a requirement of the 2005 Act Licensing Boards have had to recently put together at the end of 2007 Policy Statements indicating how they will address each of the objectives as set out in the Licensing Act 2005. A brief review of the policy statements was conducted (see section 5) to gauge how Licensing Boards were indicating how they were going to tackle the public health objective. There was then an opportunity to take this knowledge and discuss the issues with a group of key stakeholders within a workshop setting (see section 6) to attempt to set some practical goals in achieving the public health objective across communities in Scotland.

2. Background to Licensing of Alcohol

2.1 The Context of licensing being used to impact public health

The first aspect of this work was a brief literature review (see section 6 for details on methodology) and it is important to note the subtle but important differences with regards to how the literature and the debate regarding licensing and public health are positioned. There is a clear juxtaposition with regards to licensing law and public health. On the one hand licensing law is focused on the control and sale of alcohol involving an industry that focuses on increasing those sales within a regime that has increased availability and access to alcohol, and on the other hand there is a public health agenda that focuses on reducing the harm of alcohol on the population.

No literature has been found within this brief review that looks specifically at licensing being utilised to address public health and in some way that is unsurprising. There is undoubtedly a range of literature that has focused on changes to licensing law and how that affects overall public health (mainly focusing on links between opening hours and levels of consumption). However in more recent times especially in the UK the broadening of availability and access through changes to licensing has focused on the policy context of public safety, and a crime and disorder agenda.

2.2 A Brief Scottish Policy Context

Licensing legislation has a long history in Scotland and its content has always differed significantly from that of England. Licensing in Scotland has been in general over a long historical period more restrictive than the rest of the UK, although not necessarily so in recent years.

The first licensing legislation, making it a requirement to register to sell alcohol, was introduced in 1756. In 1887, the Hours of Closing Act fixed closing time at 10 p.m. in all but the largest cities. There was a gradual evolution of licensing laws during the 19th century, culminating in the Licensing Act (Scotland) in 1903. The regulations imposed at that time persisted with some minor changes, until the 1962 Acts that provided for standard permitted hours for the whole of Scotland and for Sunday opening (largely restricted to hotels). (Ritson 2004)

From the early 1970's the Clayson committee developed a number of conclusions that were eventually incorporated into the Licensing (Scotland) Act 1976, which formed the basis of licensing law to the present (Clayson Report, 1973, Plant 2003).

A key aim of the Clayson recommendations, and the 1976 legislation, was to reduce the pressure to drink in a concentrated way and remove some of the myths of Scottish drinking places especially the male dominated pub culture. It recommended longer opening hours and the option of requesting special dispensation to open for extended hours. Contrary to a number of expectations these extensions became the norm in many parts of Scotland (Ritson 2004).

With the 1976 changes Scotland has been cited as an example of deregulation that did not result in a dramatic increase in crime, although as Foster (2003) has noted, this initial change in 1976 coincided with severe economic recession in the country and cannot be taken as an indication of successful policy (Foster, 2003; IAS, 2005).

Certainly in Scotland, available data shows higher rates of heavy drinking than in England, a rise in alcohol-related injuries and offences associated with alcohol misuse and a substantial rise in the rate of alcohol dependence and related liver disease (Elmers, 2003; Plant, 2004; IAS, 2005).

Within this context the Nicholson Committee published a review of Licensing Law in Scotland (Nicholson Committee, 2003). This was produced in light of evidence of increasing alcohol-related harm, and concerns about public order, especially with a focus on evidence relating to drunkenness amongst Scottish teenagers (Hibell *et al.*, 2000).

Also within the UK there has over the last 10 years been a considerable debate with regards to the role of the alcohol industry, licensing and control of alcohol and public health, as well as the relationship between alcohol price and the level of consumption and associated harm. So within that context the first major licensing legislation change since 1976 came about with the Licensing Act 2005 (which comes into operation from 2009). This has also been produced close to similar legislation change in England and Wales with a 2003 act.

There are some subtle, but significant differences, between the English and Scottish approaches. In Scotland, a public health principle has been enshrined in the new licensing legislation which

places a duty on local licensing boards to consider the **protection and improvement** of public health when granting or reviewing licences. The new legislation also prohibits irresponsible drinks promotions in pubs, clubs and restaurants (the on-trade sector), meaning that 'happy hours', 'all you can drink' offers in return for a club entry fee, and other similar promotions, will be outlawed.

More recently, the Scottish Government has also published regulations potentially that will require retailers to have separate display areas for alcohol (Mandatory regulations cited in SHAAP 2007) Other measures currently being considered by the Scottish Government include extending the provisions of the licensing legislation banning irresponsible drinks promotions to cover supermarkets and off-licences, and invoking a 'polluter pays' principle in licensing (SHAAP 2007, Scottish Government 2008)). As recently as June 2008 consultation on the increasing the age to 21 years for those who can buy alcohol from an off sales has been produced (Scottish Government 2008).

It is also apparent that the character of the night time economy has changed within the city centres of the UK which has also not only added to the policing and safety problems, of especially weekend drinking, but also added to the wider remit of what is meant by 'protecting public health'.

2.3 Key Point Summary

- Licensing has to be seen in the context of dealing with an industry that wants to encourage the sales of alcohol compared to a public health argument for the reduction of overall alcohol consumption
- The literature currently available often focuses on how changes to Licensing Law have a negative impact on public health focusing on changes to opening hours.
- Historically Scottish Licensing Law has differed from those in England and Wales.
- The Scottish principle to consider the protection and improvement of public health when granting and renewing licenses is not in current England and Wales legislation

3. Evidence of the Impact of Licensing

3.1 International Evidence

There is very little literature that focuses on the positive use of licensing as having an impact on public health. From the literature that does exist it again focuses on impacts that have an effect on public health from the point of view of the liberalisation of opening hours and the effect on consumption and public order. The evidence from countries that have moved from strict opening hours to a more relaxed regime, through changes to licensing such as Australia, New Zealand, Ireland and Iceland, is that more liberalised licensing regimes have tended to result in higher levels of consumption and more alcohol-related problems of crime and disorder.

A considerable amount of academic comment has focused on international studies that have confirmed that longer opening hours increased drunkenness, excessive drinking and related disorders (Hadfield, 2007; Hayward and Hobbs, 2007; Plant and Plant, 2005; IAS, 2005).

For example, in Australia, a relaxation of controls led to a rise in alcohol consumption and a significant increase in assaults in or near pubs with extended trading hours (Chikritzhs *et al.*, 2000; Chikritzhs and Stockwell, 2002). In addition, peak times for road traffic accidents changed in line with the altered licensing times (Smith, 1988). Overall, it was argued that late-night opening of licensed premises delayed alcohol-related violence, road crashes and other accidents until after midnight when police and emergency services were less able to cope with the demand (Chikritzhs and Stockwell, 2002). In 2007 demands were made for an end to 24-hour licensing.

In New Zealand, since 1989 the law has permitted 24-hour opening. An evaluation of the impact of the *Liquor Act* found that late-closing premises were most likely to require police intervention, to attract 'migrating drinkers' and to be associated with increased street disorder. A rise in excessive drinking among teenagers in New Zealand was partly attributed to licensing liberalisation and the police reported more arrests of drink-drivers in the early hours of the morning following extended licensing times (IAS, 2005).

In Iceland, permitted hours for selling alcohol were abolished between 1999 and 2000. During that time the total number of admissions to A&E increased, with a 34 per cent rise in alcohol-related violence. Drink-driving was estimated to have risen by 80 per cent. On the positive side, the experiment reduced the numbers of people on the streets in the early hours of the morning. However, in 2001 fixed closing times were re-introduced (Ragnarsdottir et al., 2003).

Closer to home, the experience within the Republic of Ireland are noted as deterrents against liberalising the licensing law. In Ireland, an increase in late night disorder and violence was attributed to the extension of licensing hours, introduced in 2000. The Irish Government has recently reduced trading hours in response to these concerns (Plant and Plant, 2005; IAS, 2005).

However Room (2003 and 2004) in an extensive 40 year review of the impact of the control and licensing of alcohol in Scandinavian countries found that when controlling the sale and access to alcohol within the countries of **Sweden, Norway and Finland** there has been a reduction in alcohol related problems.

3.2 Impact of the England and Wales Licensing Act 2003

From 2007 onwards there has been an emerging literature that has focused on the impact of the England and Wales 2003 Licensing Act that was brought in from 2005. An important point to consider with the 2003 Act (as previously mentioned in section 3) is that it does not focus on specifically public health impacts per se. Indeed public health is not alluded to at all as a main objective of the England and Wales Act. The main objectives are:

- The prevention of crime and disorder
- The protection of children from harm
- The prevention of public nuisance
- and public safety.

This is the main difference with the Scottish Act that public health is absent from the objectives of the Act. Again however it is interesting to note that although it is not a main objective of the act public health keeps getting dragged into the picture.

The Licensing Act 2003, which came into force at the end of November 2005, abolished set licensing hours in England and Wales. Opening hours of premises are now set locally through the

conditions of individual licences. The aim was to liberalise a rigid system whilst reducing the problems of drinking and disorder associated with a standard closing time. The Act gave licensing authorities new powers over licensed premises, whilst giving local people more of a say in individual licensing decisions. It was hoped that in the longer term its provisions – coupled with other government initiatives – would help to bring about a more benign ‘euro style’ drinking culture.

The emerging evidence to date, provided within the evaluation of the impact of the recent England and Wales licensing reform, suggests that the liberalisation of opening hours has not been accompanied by necessarily an increase in alcohol consumption (Home Office 2007).

The General Household Survey (GHS), which includes self-report data on alcohol consumption, indicates a fall of 6% in the average number of units of alcohol consumed per week between 2005 and 2006. It also suggests that the proportions of men and women drinking (respectively) more than 21 and 14 units a week on average have continued to fall. The evaluation report does note that recent extensive publicity about the dangers of drinking, and in particular binge drinking, may have led some people to moderate their behaviour, but might equally have made others less inclined to admit to how much they have drunk.

The home office impact studies also promote data from Her Majesty’s Revenue and Customs (HMRC), based on actual excise duty returns, that suggests that, while the GHS may be overestimating the fall in consumption, there is nevertheless evidence of a decrease. Indications from HMRC data are of a 2% fall in 2005 and 3.3% fall in 2006.

Though this has to be carefully assessed as it would be wrong to suggest that such falls were simply due to the removal of fixed opening hours - or to yet draw conclusions about the long term trend, regardless of changes in licensing laws. The factors driving consumption are complex and will vary for different groups within a population.

In relation to admissions to accident and emergency departments, the Violence and Society Research Group at the University of Cardiff collected data on violence-related attendances at 33 Accident and Emergency departments in 2006. This used the time of the incident as a proxy indicator of alcohol related crime. The Group has used the same approach over time which allows an analysis of trends since 2000. It found that in 2006, 6,000 fewer people sought treatment in A&E departments for violence related injury – a fall of 2% since 2005. This continues a downward trend observed over previous years but at a slower rate since 2000. The researchers concluded

that *'these findings are not consistent with the hypothesis that implementation of the 2003 Licensing Act in November 2005 would increase violence in England and Wales'*. (Sivarajasingam et al 2007))

The Cardiff work covered 33 A&E Departments, but smaller studies from individual areas show that issues do vary at a regional and local level. The variation may be due to a number of factors, including the design of the research, seasonality, recording policies and practices and different local night time economy policies and practices.

For example a study by the United Bristol Healthcare Trust for the Alcohol Education and Research Council looked at the experience of the Emergency Departments covering the city centre and waterfront areas of Bristol from Sept 2005 for an initial period of four months (spanning the change in licensing laws). This found that over this period the concentration of incidents had not increased but that longer health effects were not yet apparent.

A one-off study relating to St Thomas' hospital in central London found an increase in overnight alcohol-related attendances at their A&E department. In March 2005, just under 3% (79) of overnight A&E visits were alcohol-related – this had risen to 8% in March 2006. The number of alcohol-related assaults increased from 27 to 62, and alcohol-related hospital admission via A&E increased from 24 to 61. The London Ambulance Service reported a 2% increase in alcohol-related call-outs in the first ten months following licensing reform, but with a larger increase of 10% in the subsequent ten months.

Studies undertaken by John Moore's University Liverpool found that A&E attendances in relation to assault cases presenting at Arrow Park A&E on the Wirral had fallen by 15% and attributed this fall to a combination of licensing changes and better policing and enforcement.

Alcohol-related illness or injury accounts for 221,325 hospital admissions per year (2006/7 data). While this figure has risen consistently over recent years, the increases predate the change in licensing laws (November 2005) by several years. It is too early to detect any changes in longer term health trends and alcohol related deaths. Alcohol-related demands on Accident & Emergency (A&E) departments appear to have been stable in aggregate, though some hospital services have seen increased demand, others a fall.

In the run-up to implementation of the 2003 Act, there was widespread concern that the legislation would lead to '24-hour drinking' and an increase in associated problems. These fears were not met in the year after implementation. Nor are there any clear signs yet that the abolition of a standard closing time has significantly reduced problems of crime and disorder (Hough et al 2008).

Data released by some police forces have shown a rise in murder/attempted murder and manslaughter in pubs and night-clubs since the passing of the new Act (Slack 2007). However, a survey of 30 police forces which compared the twelve month periods before and after the change, reported a 1% fall in recorded incidents involving violence, disorder and vandalism, and a fall of 5% in serious violent crimes (Babb 2007). Equally, although some A&E departments have recorded a rise in alcohol related attendances, the survey of 33 departments in England and Wales, concluded that there was little evidence that the 2003 Act had any significant effect on violence-related injuries. (Sivarajasingam *et al.*2007). The data, therefore, indicate a variable pattern with no substantial change overall.

The scale of change in licensing hours in England and Wales has been both variable and modest: while the majority of pubs have extended their hours, most of these extensions have been short. The limited evidence suggests that alcohol consumption has fallen slightly, although some people are drinking until later into the night. The overall volume of incidents of crime and disorder remains unchanged, though there are signs that crimes involving serious violence may have reduced. However, there is evidence of temporal displacement, in that the small proportion of violent crime occurring in the small hours of the morning has grown.

The main conclusion to be drawn from the evaluation is that licensing regimes may be one factor in effecting change to the country's drinking culture – and its impact on crime – but they do not appear to be the critical factor. The key issue is how they interact with other factors. Indeed several studies concluded that the impact of licensing cannot be considered independently of other factors. A report for the Alcohol Education and Research Council (AERC) published in January 2008 found that:

“Assessing the impact of the Licensing Act 2003 will require time. Furthermore, in the light of other interventions – such as the development of local alcohol policies and strategies and encouragement to mount partnership, multi-agency responses to prevention and harm reduction – it is unlikely that change can be attributed to any one kind of intervention.”

3.3 Key Point Summary

- The international research has focused on the impact on public health with the liberalisation of opening hours. There is a considerable amount of research evidence that confirms an increase in alcohol related problems with the introduction of longer licensing hours.
- In **Australia** with changes to licensing hours in the late 1980's and 1990's there was a significant increase in assaults, increase in road accidents.
- There seemed to be a delay of incidents, but the use of more resources by services (Chikritzhs and Stockwell, 2002)
- When opening hours were liberalised in **New Zealand** there were problems with migrating drinkers and increased street disorder, more drink drivers were seen in the early hours of the morning (IAS 2005)
- In **Iceland** research showed that there was an increase in admissions to A&E and increase in alcohol related violence with the liberalisation of opening in 1999 and 2000. In 2001 fixed closing times were brought back in.
- Plant and Plant (2005) showed that in **Ireland** with changes to licensing hours were associated with an increase in late night disorder (Plant & Plant 2005)
- Across Scandinavian countries such as **Sweden Norway and Finland** there has been greater control over opening hours and accessibility to alcohol and in managing licensing laws such as Saturday closing has seen less consumption and less alcohol related problems (Room 2003, 2004)

- With the **England and Wales** Licensing Act 2003 there were 4 objectives – crime disorder, children & harm, public nuisance, public safety
- Political objective of euro style drinking culture with a liberalisation of trading hours
- The Act brought in more localised decision making, and possible 24 hour drinking provision however the clear focus of the Act has been on addressing alcohol related crime and disorder.

- Recent research has seen a debate over the evidence and level of impact of the new legislation.
- There is some evidence to show that there has been a drop in the overall level of alcohol consumption since the introduction of the legislation; however it has been argued, that merely reflects change in consumption patterns and ignores variation amongst a number of sub groups.
- Studies of A& E records in Cardiff, Bristol, Liverpool and London have all led to different conclusions with either results showing an increase in alcohol related attendances since the introduction of the new laws or slight drop off's. The best position is to suggest that the picture is mixed and probably has not changed to a great extent.
- The fixation on results has been on levels of alcohol related violence and disorder but the evidence has often come from scant health data.
- The longer term effects of the new legislation in England and Wales is unknown and it is too early to say.

4. Research Evidence of Ways Forward

4.1 Public Health versus Liberalisation of Availability

Historically, the cross-departmental nature of alcohol policy has proved a source of tension and conflict both between government sectors and within wider policy networks and external interest groups (Baggott 1990; Thom 1999; Greenaway 2003).

Recent policy initiatives are no exception. Alcohol policy statements surrounding Licensing law especially in Scotland have aroused a storm of controversy in the media. In relevant academic and professional journals particular emphasis has been given to the conflict of interest between the alcohol industry and groups representing health and crime and safety priorities with the England and Wales Act (e.g. Room 2004; Babor 2004; Drummond 2004; Jayatilaka 2004; Stockwell 2004; Foster 2003; Thom 2005).

Much of the debate surrounding licensing law and public health does not revolve around the use of the legislation being utilised to impact health in a positive manner, but around the rationale and evidence for permitting 24 hour licensing and the affect on public health in a negative way.

There is also the sense when dealing with the impact of licensing laws that many people want legislation to do too much and also to do it with one hand tied behind its back. An example of this with the England and Wales 2003 act is that overall health related data – from A&E departments, ambulance crews and health professionals was lacking in certain aspects of its evaluation. This is in accord with the findings from a survey of 46 (13%) licensing teams in England and Wales in 2006 (Alcohol Concern 2007). The Alcohol Concern survey found that mainly crime related data were being collected. There was very little information from health or social services.

In terms of impact the initial conclusions of the 2003 Act in England and Wales has been that things have stayed relatively the same. Overall, there had been little change in alcohol-related harms following the extension of licensing hours. Noise levels, alcohol-related violence/fights, drink driving, alcohol related crime and under-age drinking were all reported as 'much the same'. Key informants have considered the costs of implementation to have been moderate to high and most felt that costs would remain the same in the near future (Foster et al 2008) .

Clearly, the increase in discounted alcohol sales by supermarkets and the introduction of the smoking ban are also strong influences on patterns of consumption, as is a growing trend towards drinking at home. These trends need to be considered alongside consumption in on and off licensed premises when looking at health effects.

It is important to note that Foster et al (2008) see economic considerations – in particular the degree of ‘affluence’ or ‘deprivation’ of a community – as being expected to influence the development and implementation of licensing policy. A national survey by Foster et al found that in ‘disadvantaged’ areas stakeholders were less likely to be consulted than in ‘affluent’ areas.

Concerns regarding changes in licensing have also tended to focus on the expected increase in problems in urban areas, in particular in city centres. Again Foster (et al 2008) found that rural areas had a lower level of consultation with stakeholders; fewer licensing officers and police activity; lower costs and lower levels of involvement and influence of stakeholders. In sum, judging by key informants’ perceptions, concerns over the possible impact of the Licensing Act emerge as an urban phenomenon within England and Wales.

A lot of the evaluation of the England and Wales 2003 act found an inconsistent picture regarding the effects of licensing change on alcohol-related harms; but reports indicate that, overall, there has been little change for the better or for the worse.

These developments draw attention to the continuing tension between health concerns and criminal justice concerns which has been a feature of debates on the Licensing Act from its inception. There are no easily available answers. Assessing the impact of the England and Wales Licensing Act of 2003 will require time as will the 2005 Scottish Act. Furthermore, in the light of other interventions – such as the development of local alcohol policies and strategies and the encouragement to mount partnership, multi-agency responses to prevention and harm reduction – it is unlikely that change can be attributed to any one kind of intervention.

A “true picture” of the changes introduced may not emerge for a number of years and in terms of health consequences, many years. Since the Licensing Act is just one of a number of changes aimed at reducing alcohol-related harm and promoting “sensible drinking”, evaluation of the impact of Licensing Acts, in isolation from other interventions, is likely to prove difficult.

4.2 Reducing the harm of alcohol: protecting and improving public health

The range of problems associated with alcohol comes not simply from the effects of alcohol consumption or trading hours, but also from the broader historical, socio-economic, cultural, and situational contexts to consumption (Gofton, 1990; Marsh & Kibby, 1992; Sumner & Parker, 1995; Tuck, 1989). Socialisation into alcohol-based leisure within British culture must include an understanding of both the effects of alcohol intoxication and the close association for many people between drinking and intensive weekend consumption patterns, aggression, unsafe sexual encounters, public disorder, and other potentially risk-taking or harmful behaviours.

There is no doubt, as Measham (2006) states, that there is a distinct cultural context to British licensed leisure since the mid-1990s. It appears that determined excess rather than restraint has come to dominate young adult life when they go out and buy drink.

This provides a conflict to the traditional focus of alcohol education and prevention that has been the reduction in demand for and use of alcohol through public health programmes targeted at either the general population or specific “at-risk” groups. Despite mixed evidence of the effectiveness of these strategies (e.g., Foxcroft, Lister-Sharp, & Lowe, 1997), they remain a key priority. For example, in the UK, individual alcohol manufacturers introduced alcohol unit-based information labels on alcohol products in 2004. Research on information and warning labels across the world suggests varying degrees of success with these approaches (e.g., Stockley, 2001).

As Duff (2004) suggests there is a policy gap between prevention and treatment, because most strategies address drug use “at the two extreme ends of the drug use spectrum”: primary prevention initiatives, which are directed at young people who have not yet started their drug using careers, and treatment efforts for clients whose use has already become problematic. Duff asks, “What exists for the vast majority of existing... users once prevention has failed and before treatment is considered?” (2004, p. 388).

A key aspect of demand reduction in the UK within alcohol public health programmes is the use of unit-based notions of sensible and risky consumption levels. Indeed this is heavily mentioned within the current statements of licensing policy from local Scottish licensing boards.

Understanding of alcohol units and sensible drinking levels continues to grow in the general population, with the most recent national surveys suggesting that 83% of adults have heard of units as a measure of alcohol consumption and 61% have heard of daily benchmarks, with higher

awareness amongst younger drinkers (Lader & Goddard, 2004). However in a recent study in Scotland there were very low estimates in terms of the correct number of units in a range of alcohol products (Scottish Government 2008b)

So although most young adults know about units of alcohol and many can recall recommended sensible drinking levels, this does not necessarily mean that they then apply them to regulate their own consumption levels on a night out or link that to the products they are drinking. It appears then that consumption levels do not reflect a lack of knowledge of health risks, rather that young people are aware of recommendations on sensible consumption, but do not consistently apply them to their own behaviour.

Thus, whilst the premise of alcohol demand reduction strategies is that a shift in knowledge, attitudes, and/or values will result in a shift in behaviour, it does not allow for contradictory, risk-taking, and sensation-seeking conduct (Duff, 2004). Just because people know something is risky or potentially harmful does not necessarily mean that they will stop the behaviour. Moreover, the reasons for this conduct may relate specifically to the risk-taking aspects of consumption and the broader celebration of quality of life over longevity, in defiance of health education advice and even as a challenge (Cronin, 2004). This complex relationship between knowledge, motivation for change, and actual behavioural change needs further consideration in relation to harm minimisation.

As Engineer et al (2003) notes in relation to their Home Office qualitative study exploring the social context to “binge” drinking amongst 18-to 24-year-olds in the UK, if alcohol education and demand reduction initiatives are not grounded within their appropriate cultural context, a serious credibility gap develops between actual and desirable behaviour.

Research by Measham and Brain (2005) with over 350 young adult weekend drinkers in Manchester found evidence of the pursuit of determined drunkenness as a specific aim of weekend drinking. However it also explored the relationship between practices of self-regulation and social regulation and found that when drinkers discussed their desired and actual levels of intoxication in detail, they were bounded by concerns about health, personal safety, image, identity, and so forth, and that these in turn interacted with gender, age, ethnicity, and socioeconomic class to produce a complex amalgam of influences on drinking practices to result in a “controlled loss of control” (Measham & Brain, 2005; see also, Brain, 2000; Hayward, 2004; Measham, 2002). The Manchester study provided support for the argument that a new culture of intoxication has emerged that features a determined drunkenness by young adults as part of a

broader cultural context of risk-taking and hedonistic consumption-oriented lifestyles bounded by occasion and location. It is to this cultural context that effective harm reduction and demand reduction policies must be addressed, and could open a door to addressing public health via the licensing arena.

The 2005 Scottish Licensing Act affords that opportunity and follows a more radical policy of supply-side controls, restricting alcohol marketing and certain sales strategies that are seen as encouraging irresponsible or excessive consumption (for example, “happy hours,” bottomless glass drink-all-you-can promotions, and so forth) (Office of Public Sector Information, 2005). So whilst English and Welsh legislation regulates consumers, Scottish legislation regulates both retailers and consumers.

Protection and improvement of public health within a Licensing regime has to make real this objective, which can build upon existing work as well as integrating and enhancing other aspects of Licensing Law, together with applying a systems approach to the overall arching goal of improving public health.

There must be better opportunities to assist and support local Licensing Boards in making sense of the public health objective so for example:

- How exactly are the ‘relevant bodies’ going to assist licensees at a local level address local alcohol harm?
- How do you make real the local context of policy statements?
- What exactly is a multi agency approach?

This has to move beyond promotion of sensible drinking in a generic sense, there has to be a match of health messages with actual change within off and on sales establishments. As is demanded in a number of the existing policy statements so that suitable and sufficient measures have been implemented to protect health.

One route forward would be to think beyond generic public health messages and engage in proper consistent harm reduction initiatives. While the term ‘harm reduction’ has emerged from the illicit drugs field in the past 20 years and is frequently applied to alcohol policy, the yardstick of ‘not necessarily requiring reduced alcohol use’ does not apply in most instances. However, there are still some potentially important examples of harm reduction to be recommended in modern alcohol policy, although there has been inconsistent progress with their implementation (Stockwell 2006).

It is acknowledged that many people prefer to use the term 'harm reduction' in a way that incorporates aspects of 'use reduction'. But this often blurs meanings and can ultimately lead to a lack of clarity both in thinking and in practice.

So for example how can local licensing forums, community safety partnerships, violence reduction units, trading standard officers and community health partnerships encourage and enhance purer forms of harm reduction that may already be in place but not consistently delivered:

- Consistent and cheap late night transport schemes (Stockwell 2006)
- Extensive and wide use of plastic shatterproof glassware (Graham et al., 2004).
- Limiting of crowds and crowding policy
- Consistent and extensive staff training on drunkenness and diffusing arguments with agreed follow up (Graham & Homel, 1997)
- Consistent and extensive staff training on selling to under age individuals (Saltz 1997)
- Potential of wider use of designated places schemes
- Consistent and effective degrees of enforcement of licensing law regarding service to intoxication and drinking in public (McKnight and Streff, 1994; Stockwell, 2001b)
- Media campaigns that link clearly to that enforcement
- No free re entry schemes (Homel, McIlwain, & Carvolth, 2004).
- Consistent provision of food and snacks along with tap water and soft drinks
- Staff alcohol workplace policies within off and on sales
- Use of guidelines and labelling connected to brief interventions (National Health and Medical Research Council [NHMRC], 2001),
- Use of information and health messages that are specific topic led e.g. care for those who have lost consciousness (Youth Research Centre 1995)
- Community mobilisation in local areas with clear distinct engagement (Loxley et al., 2004).

Indeed within the recent *Changing Scotland's Relationship with Alcohol discussion paper* there is considerable focus on multi component partnership work (e.g. Fife Alcohol Partnership group p27 Scottish Government June 2008) which stresses purer forms of harm reduction methods including bottle marking schemes, diversionary activities and soft drink pricing. This is encouraging in the sense that the systems approach to addressing alcohol issues as developed by Holder (2000) is becoming more and more recognised.

In the UK, some of the most fully developed harm reduction initiatives in relation to recreational substance use focused on illicit drug consumption, particularly in dance clubs. These efforts were initially implemented at the local level, and gradually become part of a national policy: for example, the groundbreaking local *safer dancing* initiative in Manchester in 1993, which combined local government, voluntary sector drugs agency, and academic input (Newcombe, 1994); and, more recently, the national *safer clubbing* guidelines on good practice (Webster, Goodman, & Whalley, 2002).

Despite the far greater numbers involved and the far greater health, social, economic, and public order harms from alcohol, the tailoring of these illicit drug-based harm reduction measures to *safer drinking* initiatives has yet to be fully developed in relation to national policy in the UK – safe zones and focus on wider night time economy has developed in a range of urban centres but again that has not necessarily been consistent across the whole of Scotland (certainly beyond the urban centres).

At the international level, alcohol harm reduction programmes include the following: unit and warning labels on beverage containers, safer bars programs, designated driver and responsible drinking companion schemes, subsidised late night public transport, free water and non-salty bar snacks, and consumption advice, such as interspersing alcoholic beverages with soft drinks and not mixing different types of alcoholic beverages (Graham et al., 2004; Homel, McIlwain, & Carvolth, 2004; Plant et al., 1997). Nevertheless, such schemes often remain patchy, underfunded, and uncoordinated, lacking inter-agency collaboration and state support. It appears that, “. . . throughout the world, governments are struggling with the concept of harm minimisation in relation to legal drugs” (MacAvoy & Mackenzie, 2005, p. 87).

An ethics of moderation and current public health programmes that focus on individual recommended daily sensible consumption levels collide with an emergent culture of intoxication, with evidence of determined drunkenness by individuals, an economic climate of deregulation of the alcohol market, and a political context of licensing reform. This results in a credibility gap between recommended and actual practices for drinkers, alcohol manufacturers, and alcohol retailers.

The question then is how we might manage moderation in relation to alcohol consumption within a prevailing public health paradigm of demand reduction, against a socio-economic backdrop of

market deregulation and consumer choice, when individuals are operating within a culture of excess? Certainly as Valentine et al (2007) points out the fixation with binge drinking within the young adult population in urban centres is at best missing the complexity of people's drinking experience and at worst misleading and dangerous. This has led to many people being unwarrantedly insulated from concern about their own drinking.

Measham (2006) stresses the importance of evidence-based realism in public health demand reduction programmes, alongside the development of strategies to reduce harm focusing not only on the individual, but also the wider environment of consumption through safer drinking initiatives, along with multi-agency and multi-site efforts. Above all, alcohol policies must attempt to bridge the "credibility gulf" between the scientific evidence on risks to health and safety and the need to be culturally appropriate, context-specific, and credible to be effective.

4.3 Key Point Summary

- Much of current debate revolves around negatives of increased consumption following liberalisation of licensing hours and a fixation with alcohol related crime and disorder. Often the impact is being measured utilising crime related data with very little health or social data.
- The UK picture re alcohol control and its impact on public health is historically unclear.
- Foster et al 2008 in a national survey of key stakeholders found that although the costs of the implementation of the England and Wales Licensing Act 2003 was considerable, often there had been a fixation on the impact on urban centres as well as a disregard of the rural picture and a lack of consultation with those in disadvantaged economic areas.
- Protecting and improving public health not just promoting this message
- Interventions have to sit within context of drinking for the populations that are being targeted.
- Measham (2006) demands a better understanding of the cultural context of drinking especially young people's 'determined excess'.
- There is a conflict between traditional alcohol education and prevention reduction in demand generic messages on sensible drinking and the reality of how most people drink.
- Duff (2004) considers there to be a policy gap that finds a system that focuses on prevention of drinking in the young and then provides services who get into problems with alcohol - what exists for vast majority?

- There is the wish to move beyond general promotion of 'sensible drinking' and the understanding of units. In recent studies (Scottish Government 2008b) there is evidence to show that people have a limited understanding of units and strength of drinks.
- Licensing Boards and Forums along with Community Safety Partnerships, Violence Reduction Units, Licensing Standards Officers, and Community Health Partnerships must engage better with the licensed premises in protecting the public health from a harm reduction perspective.
- How can the 'relevant bodies' at a local level be assisted in delivering local consistent approaches?
- Harm reduction does have a role within local action plans that Licensing Forums and Licensing Boards can fit into which would protect the public health of Licensees patrons but not necessarily focus on reduction in use.
- For example consistent and extensive use of consistent and cheap late night transport schemes (Stockwell 2006), plastic shatterproof glassware (Graham et al., 2004), limiting of crowds and crowding policy, consistent and extensive staff training (Graham & Homel, 1997), consistent and effective degrees of enforcement, consistent provision of food and snacks along with tap water and soft drinks, staff alcohol workplace policies within off and on sales, use of guidelines and labelling connected to brief interventions (National Health and Medical Research Council [NHMRC], 2001), use of specific info and health messages e.g. care for those who have lost consciousness (Youth Research Centre 1995).
- It must be stressed the importance of evidence based realism in the development of strategies to reduce harm not only focusing on the individual but also on the wider drinking environment.
- This also has to be placed in a context that enhances inter agency working that provides an overall systems approach, practical questions regarding how exactly relevant bodies are going to assist Boards and Forums at a local level, with Licensing Boards understanding what other organisations and agencies are doing and how this fits into the decisions that they make.

5. Licensing Board Policy Statements

To enable a better indication of how the main objective of addressing public health through the Licensing Act 2005 has been tackled by local Licensing Boards MP consultancy also reviewed the recent Statements of Licensing Policy across Scotland.

The Statements of Licensing Policy have been prepared by each Licensing Board across Scotland's 32 local authority councils in terms of Section 6 of the Licensing (Scotland) Act 2005 to assist in the implementation and administration of the licensing of the sale and supply of alcohol within their areas and to outline the way they intend exercising their functions under the Act.

Section 6 brings into law a recommendation of the Nicholson Committee Report (para 6.39). Nicholson (2004) noted that many Boards had prepared policy statements. However in 2004 this practice was not universal, with some Board members expressing concern that a policy might be perceived as restricting Board discretion and for that reason open to challenge.

Nicholson did not see a policy statement as being challengeable especially if it was framed in the context of local circumstances and was not inconsistent with general licensing law. A policy statement reflecting a local context indicating in general terms the manner in which the Board is likely to approach certain issues Nicholson saw as helpful to licensees, potential licensees and licensing practitioners. Nicholson also suggested that a licensing policy could, as appropriate, reflect any views or suggestions made to Boards by local Licensing Forums. This recommendation has also been introduced into the 2005 Act.

Within the Policy statements there is clear direction to each of the 5 objectives as set out in the 2005 Act. Each licensing board had November 2007 as a deadline for the provision of a 3 year policy statement and therefore MP Consultancy reviewed all 32 statements (MP Consultancy is aware that there are more than 32 boards however some combined their divisions for statements).

5.1 Structure of Policy Statements

There is considerable variation and discretion in the structure of the statements of licensing policy across the councils. All the councils (n=32) have put together detailed statements that cover their responsibilities under the new Act, however there is a great variation in how each has addressed the question of impacting on public health with a variety of focus on that topic.

MP Consultancy looked at all the policy statements to consider whether or not one of the key objectives of the new Act would be mentioned specifically in terms of a response from the local boards. 14 local boards (44%) produced detailed sections on how as a board they will address issues concerning public health. Twelve of the boards (37.5%) considered the topic with a brief specific standard mention, whilst 6 local boards provide no specific mention at all with regards to a key objective of public health. It was recognised that a number of control measures can affect public health in general terms across other responsibilities i.e. when dealing with children, sale of alcohol to young people etc but for these statements there was otherwise no specific section with a focus on public health.

5.2 Specific Issues

Of those who do specifically address public health within their statements (n=26, 81%) the majority mention virtually in a standard format a number of key aspects:

- Boards wish to see premises thriving in the city but this cannot be at the expense of public health and wellbeing.
- The board will have particular regard to the views of the relevant bodies responsible for, and interested in, the protection and improvement of public health.

Only a small number of boards specifically mention interaction with other forums for example continued representation on the local Drugs and Alcohol Action Team, other Licensing Forums, or close liaison as part of the wider alcohol agenda, particularly in relation to the public health and child protection licensing objectives. Indeed Dumfries and Galloway are the only licensing board that specifically mention within their policy statement the need for a 'multi agency approach'.

- Applicants expected to demonstrate in their operating plan that suitable and sufficient measures have been identified and will be implemented and maintained to protect patrons' health.

The vast majority of these measures focus on making available information i.e. posters, beer mats, leaflets with regard to

- Anti drink driving and promoting awareness of campaigns such as designated driver schemes;
- Sensible drinking,
- The effects of excessive alcohol consumption
- Overt display of unit information and information signage within different areas

A smaller proportion of licensing boards specifically mention issues concerning public health messages regarding contact points where assistance is available to address problem drinking.

Around 12 to 14 boards specifically mention within their policy statements issues concerning:

- the risk of harm to children's health and an applicants expectation that they will be expected to demonstrate that they have given particular care to introduce measures designed to protect children's health while in or around their premises.
- Licence applicants, door supervisors and premises managers, as well as other staff employed in the premises, being vigilant at all times to the risks of excessive consumption;
- For staff to have a clear understanding of the offences committed in connection with the service of alcohol to children or persons who are drunk.

A small number of local boards request that there should be an established practice within the premises to ensure that a standard approach is taken where patrons' demeanour demonstrates an excessive consumption of alcohol.

- The provision of a wide selection of reasonably priced non alcoholic beverages and provision of free tap water.

Only a small number of boards link within their public health section an encouragement to provide food on the premises, and the requirement for adequate ventilation and sanitary provision.

Again only a small proportion of local boards mention appropriate training of staff members and only three boards specifically comment on having an alcohol policy in the workplace for staff.

It is important to stress that within the principles of the Act there is a focus on the duty of local Licensing Boards to consider the *protection and improvement* of public health when granting and renewing licenses. From the guidance issued by the Scottish government the License statements have focused on the *promotion* of the objectives. The actual protection and improvement of public health is not clear for the vast majority of policy statements- indeed for a lot of the local boards this has mutated into the promotion of generic public health information messages.

5.3 Key Point Summary

- Policy statements address each of the objectives within the new 2005 Licensing Act and how each licensing board is approaching them.
- 32 statements were reviewed for details on a specific section on public health and 14 (44%) had specific detailed section, 12 (37.5%) had brief standard section and 6 (%) had no specific section
- Often approach objective in a standard format for example *'Boards wish to see premises thriving in the city but this cannot be at the expense of public health and wellbeing'* or *'will have particular regard to the views of the relevant bodies responsible for, and interested in, the protection and improvement of public health'*.
- Small number of boards specifically mention interaction with other forums
- For example continued representation on the local DAT, other Licensing Forums, or close liaison as part of the wider alcohol agenda, particularly in relation to the public health and child protection licensing objectives.
- Indeed Dumfries and Galloway only licensing board that specifically mention within their policy statement the need for a 'multi agency approach'.
- Applicants are expected to demonstrate in their operating plan that suitable and sufficient measures identified, implemented and maintained to protect patrons' health. The vast

majority of these measures focus on making available information i.e. posters, beer mats, leaflets.

- A smaller proportion of licensing boards specifically mention issues concerning public health messages regarding contact points to address problem drinking.
- Around 12 to 14 boards specifically mention within their policy statements issues concerning: the risk of harm to children's health, the risks of excessive consumption; or with serving of alcohol to children or persons who are drunk.
- A small number of local boards request that: A standard approach is taken where patrons' demeanour demonstrates an excessive consumption of alcohol, and/or the provision of a wide selection of reasonably priced non alcoholic beverages and provision of free tap water.
- Only a small number of boards link within their public health section: an encouragement to provide food on the premises, plus adequate ventilation and sanitary provision. Or appropriate training of staff members and only three boards specifically comment on having an alcohol policy in the workplace for staff.
- It is important to stress that within the principles of the Act there is a focus on the duty of local Licensing Boards to consider the *protection and improvement* of public health when granting and renewing licenses.
- The License statements have focused on the *promotion* of the objectives.
- The actual protection and improvement of public health is not clear for the vast majority of policy statements- indeed for a lot of the local boards this has mutated into the promotion of generic public health information messages.

6. A Licensing Law and Public Health Objective Seminar

To complement the review of the literature and the brief review of the licensing Board Policy statements a seminar was held that brought together an extensive range of professionals across the Scottish Alcohol arena. Representatives included those from Scottish Government, Academia, both the statutory and non statutory voluntary sector, the on sales trade and alcohol industry as well as Alcohol Focus Scotland as hosts (see section 7 appendices for organisations represented). All had interest in seeing the public health objective being developed from licensing Boards and forums.

Following a presentation on the both the research and literature evidence regarding Licensing Law its impact on public health, there then followed a detailed discussion on the issues surrounding the implementation of the public health objective within the new Licensing legislation of 2005.

It was generally agreed that the inclusion of the public health objective within the legislation is a good step forward. However there was also agreement that there was a considerable amount of work to do to assist Licensing Boards and Licensing Forums in fulfilling the objective.

6.1 Summary Discussion Points

- Members of the group stated that in a number of local areas across Scotland there was a considerable amount of good work already happening on localised plans in addressing public health within the arena of licensing, however it was not consistent.
- This highlighted the need for consistent approaches being adopted, but also the wish to see better joined up thinking overall with respect to the decision making process that Licensing Boards undertook.
- It was stressed that work has to be done in guiding Licensing Boards and Licensing Forums in understanding that the decisions that are made within those forums both at a planning and commercial level have a direct impact on the public health of the community.
- It was felt that there was an opportunity to provide Licensing Boards and Forums with a much better understanding of what public health issues and concerns were. It was suggested that those sitting on Licensing Boards would not necessarily make the link

between what they had responsibility over, and addressing public health both at a micro and macro level.

- The concept of public health has to be defined for those audiences in the local context of where those individuals engage with the system.
- This concept must also take into account the local context of the drinking culture of the local areas. Licensing it was felt can inform public health improvement and drinking culture change - it can influence the nature and selling of alcohol within the local environment.
- The group felt that there should be the aim to better support and guide Licensing Boards and their Forums in this understanding process both with a national perspective, but more vitally putting it into a local context that reflects the decisions that have to be made on a day to day basis.
- Licensing Boards have to fit this into the practical day to day pressures and decision making processes that they undertake within the wider community planning agenda.
- Therefore better informed decisions can be made when applications arise - how might a Licensing Board object on the grounds of public health - they need to be guided through this process.
- It was agreed that Licensing Boards need to be informed by Licensing Forums and provided with both a balanced national and local perspective with regards to public health concerns.
- There was concern at the level of inconsistency of Licensing Boards and their approaches to the public health objective with 32 differing plans and policy statements.
- However it was also recognised that there is a massive amount of change occurring in this area, inconsistency is going to occur. Local context need to be taken into account and uniformity may not be the answer.
- There is a clear debate over whether or not there needs to be further direction and control coming from central government. However it was pointed out that the political landscape at present is focusing on local decision making and a commitment to de-centralisation.
- There was an overall wish to see more accountability. It was recognised by the group that the legal framework was already set, however there was a real wish to see more accountability in place to make sure that Licensing Boards have the correct procedures to make sure that the public health objective is addressed.
- This could come in the shape of corporate governance or good practise guidelines/ advise that Licensing Forums and Boards would have to take on board.
- The group felt that it was no good setting up a process that demanded a public health objective to be met, however then leaving it to fail. The Licensing Boards need as part of a

package of support a range of options that they can pick from. These can be developed to meet specific local need; however it would allow more sophisticated methods of addressing the public health objective.

- It was recognised that for Licensing Boards this adoption of addressing public health could be risky. There are often competing elements both inside and outside of the Licensing Boards. Yet the group felt that it was important that Boards in some way be accountable to for the proper introduction of this objective.
- One method of pushing this process forward it was suggested was the requirement for Licensing Boards to include a health impact assessment within their local plans.
- It was noted that to get the full benefit from an exercise like a health impact assessment they needed to have the authority and the statutory requirement and necessity for one to be done.
- However it was felt that in the climate of considerable change there was an opportunity to cajole, aide, and guide Licensing bodies into better consideration of the context of a local community's public health in light of the other demands of developing the local economic environment.
- For example how does the issue of public health link in with the decisions made within urban and rural planning and the consequences of the development of a night time economy?
- A number of the group felt that there was a very deep set incongruity regarding health messages, on the one hand urging individual restraint so that the young are urged to be careful and drink less, yet encouragement of excess is all around them - how do the young make sense of this - they have all this access and are encouraged in excess, but then the message is don't drink much drink sensibly.
- It was felt that it would take a considerable amount of work to get Licensing Boards and Forums to think carefully re the consequences of the decisions that they make within a wider public health sense - there is often an encouragement to increase vibrancy within urban city centre areas, but also that is matched against the public health resource of dealing with the amount of people who are drinking.
- There are a wide range of interests to consider from political, to commerce, to the wider health of the population.
- It was made clear that the group felt that it was vital that the Licensing Forums informed the Boards properly and gave a balanced representation of the issues.

- The role of public servants was also stressed with the role of the clerks important within the process of how a Board works - how do they understand public health issues – how do they inform the board in making good decisions.
- Critically the group felt that there needed to be better access to the whole process for the community and the public in general. Of those who raise objections they are often not aware of what a Board can and cannot do, but also the Board may not have the awareness of the public health information that individuals who raise objections have.
- There was a request for a National Licensing Forum to be re-instated with representation coming from interests such as public health, the alcohol industry, trade and associations, criminal justice and local authority.
- It could provide strong support and guidance to Licensing Boards and Forums as well as a voice to central government.
- Potentially a route for the creation of such a forum would come from COSLA, with close links to Local Authorities.
- There was also a wish from the group to see better joint approaches involving Community Health Partnerships and Community Safety Partnerships.
- Though it was recognised that Licensing Boards and Forums would again have to be guided and supported in understanding their role and responsibilities in feeding into these different arenas.
- There is a considerable amount of work to be conducted in assisting Forums with attendance, format and role in guiding Licensing Boards.
- Also enabling Licensing boards to take on board a Forums views and perceptions of local context.

6.2 Key aspects that need to be addressed

- The overall aim is to have a smoother transition to the changes in 2009 coming from the Licensing Act 2005.
- At present the picture is not perfect and is very fluid however a number of practical system problems can be overcome with support; for example with detailed development of better local action plans, the correct member attendance, mix, and balance of forums, getting Licensing Standards Officers in place in all areas of Scotland
- Further support from Local Authorities and District Councils, and an enhancing of their understanding of how public health is impacted by the Licensing decision making process.
- There needs to be a better definition of public health objectives for those in Licensing, they need to be better informed both within a local and national context.
- As part of this work needs to be done with Boards and Forums have to be aware of their processes having consequences and impact in the overall context of having an aim to reduce overall alcohol consumption of the population.
- There needs to be a proactive movement towards the aim of bringing more accountability and local measurement of the public health objective within the Licensing arena.
- The re-instatement of a National Licensing Forum with representation across trade, industry and health to give a national voice of support and a link into central decision making bodies.
- Development of enhanced inter and multi agency working with Licensing Boards and Forums establishing better practical links with other related bodies such as Community Health Partnerships, Community Safety Partnerships and Violence Reduction Units.
- With a better understanding of public health issues through enhanced knowledge of what is meant by public health in a wider sense, then there is the potential for better decisions re public health impact at Licensing Boards and Forums.

7. Appendices

7.1 Attendees and Non attendees at Licensing and Public Health Seminar June 24th 2008

Host: Alcohol Focus Scotland

Jack Law - Chief Executive

Barbara O'Donnell – Director of Operations

Mary Elmers – Head of Training

Two other members of AFS?

Facilitating - Matthew Plunkett – MP Consultancy

Ian Innes - Perth and Kinross Licensing Board

Peter Brunt -

Gary Cox - Scottish Government

Tony Rednall - Scottish Government

Paul Waterson – Licensed Trade Association

Peter Morrison - Grampian Police

Jill Miller – Glasgow City Council

Evelyn Gillan - SHAAP

Dr Pete Seaman - Glasgow Centre for Population Health Glasgow University

Joanne Winterbottom Glasgow City Council

Organisations unable to attend:

COSLA

Strathclyde Police

Licensing Services Ltd

7.2 The Literature Review Methodology

7.2.1 The Focus of the Review

The brief literature review covered English language literature which relates in the first instance to Licensing Law in the Alcohol field relating to health impact.

7.2.2 Questions Considered

The main question focused upon within this review paper was:

- Is there evidence of any intent to impact health through the use of Licensing Law?

Supplementary questions:

- If so how is this defined and what is meant by 'health impact'?
- What measures have been taken and what the implications of legislation if any have been on health?
- Have any changes been practical?
- In what forms do they exist and are they known by anything else?
- Is there any practical evidence of Licensing Law effecting health
- What level of effectiveness and impact, against what criteria?
- Have any evaluations been carried out and what did these evaluations find?

Right from the first stages of the review it was clear that there was a dearth in the literature available specifically focusing on *licensing and health impact*. Therefore the search criteria for the review were widened to include any relevant data on licensing *per se to investigate for health impact*.

English language articles were analysed and collected through the Bath Information and Data Services (BIDS) and Athens academic services as well as the databases listed in the appendix (see Appendix A). In general material from the periods 2000 to late 2007/early 2008 was collected, both from the UK and internationally (on necessary occasions literature is quoted from pre 2000 sources).

The data resources have been searched to gather the following:

- Published papers in peer reviewed academic journals

- Published Government papers
- Previous literature reviews and meta- analyses
- News articles
- Any available reports, reviews and outcome studies from services
- Also, material in more unconventional forms ('grey literature')

7.2.3 Search criteria

The terms in table 1 outline the main words used in various combinations when searching the databases. Single word and Boolean searches (words separated by the operators 'OR', 'AND' and 'NOT,' e.g. Albany University Library, 2004) were used when the exact phrase searches yielded too many, too few or irrelevant results.

Different databases operate using different taxonomies, so to ensure that this was due to the lack of research rather than the combination of words used, searches were modified to extract information from the databases.

When the terms below produced a high amount of information, other words were gradually introduced to the search criteria until the titles or abstracts or articles became more relevant to the review. These words were used to ensure additional information was not missed, but were not included in all searches as some searches gave a sufficiently small number of results to be examined in full without being further limited by these additional terms.

Table 1: Words used in searches

Licensing	Law	Health	Alcohol	Act	Impact	Public
Assessment	Consumption	Harm	Reduction			

7.3 Appendix 1 – Database Searches

Cochrane Library

NHS Research and Dissemination Database

NHS Centre for Reviews and Dissemination

NHS Health Scotland

MP Consultancy

MIMAS Web of Science

ASSI

BIDS

Alcohol Concern

Alcohol Focus Scotland

Scottish Drugs Forum

Scottish Association of Alcohol Action Teams

Science Direct

NHSSurveys.com

National Treatment Agency

Ingenta

Blackwell- Synergy

Alcohol Concern (Website and Library)	http://www.alcoholconcern.org.uk
Alcohol Information Scotland	http://www.alcoholinformation.isdscotland.org/
Applied Social Sciences Index and Abstracts (ASSIA, through Cambridge Scientific Abstracts)	http://www.csa.com
BIDS	http://bids.ac.uk
Biological Sciences (through CSA)	http://www.csa.com
Biology Digest (through CSA)	http://www.csa.com
Google	http://www.google.com
Home Office	
Ingenta	http://www.ingenta.com
ISI Web of Science	
Medline (Through CSA)	http://www.csa.com
MIMAS Web of Science	http://www.wos.mimas.ac.uk
National Institute on Alcohol Abuse & Alcoholism	http://www.etoh.niaaa.nih.gov/
Ovid	http://gateway.uk.ovid.com
PubMed	http://www.ncbi.nlm.nih.gov/entrez/query.fcgi
Scottish Government	

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