



▶ Local and National Alcohol Policy: how do they interact?

Centre for History in Public Health, LSHTM, University of London

Summary report

KEY MESSAGES

History

The importance of long histories. Many problems and policy responses in the present have their roots in the 19th and 20th centuries. Deep social, economic and cultural changes affect the amount of alcohol consumed and how it is consumed - policy is at best one part of this.

The historical role of alcohol policy development at the local level needs to be remembered. The drive for 'local option' (whether an area should be dry or not) was an issue for local democracy to be decided through the ballot box.

Licensing has historically been an area which also catalyzed these tensions at the local level.

Industry moves to develop the 'improved public house' show how economic self-interest and harm reduction could go hand in hand.

National policy development has a history. The role of the Central Control Board during WWI brought together industry and temperance but with an emphasis on science and evidence-based policy. The results were considerable and illustrate what such alliances can achieve at a time of crisis.

Policy

Local policy development is again important in the complex matrix of policy formulation and local variation is an essential part of current policy, for licensing in particular.

Licensing is better designed to deal with proximate social disorder consequences than with non-proximate health harms. It has always had to balance harm reduction with trade regulation and the need to support local industry and investment. Legal challenges in local settings are critical for the success or failure of national policy.

There is still a need for overarching national coordinating strategies.

The recent example of Scottish policy development - especially regarding attempts to implement minimum unit pricing - is instructive. This can be explained by:-Scottish traditions of advocacy; smaller government; and the SNP narrative of innovation and renewal.

Local and National Alcohol Policy: how do they interact?

History and Policy Seminar May 2014

Introduction

Today alcohol is rarely out of the news. Whether it is 'binge drinking' by young people or the health effects of a daily glass of red wine, alcohol poses numerous problems for contemporary policy-makers at the local and national level. Such dilemmas, of course, are anything but new.

The specific aim of this seminar was to explore the interaction between the local and the national in the making of alcohol policy in the past and in the present, focusing on continuities and changes over time.

The core question addressed was the relation between history and the 'here and now'. Underlying this is the issue of how people involved in policy and practice use history. Of course they find it interesting, but it seems also to play a legitimizing role, either for current policy and practice or for arguments for change. Different people interpret history in different ways. These processes emerged in the seminar discussions reported below.

James Nicholls

Director of Research and Policy Development, Alcohol Research UK.

James Nicholls opened the seminar by exploring the historical perspective on the interaction between the local and the national in alcohol policy. Taking late 19th and early 20th century Britain as a case study, Nicholls examined two issues which caused concern at the time, but which also have contemporary resonance. The first revolved around outlet density: the number of drinking establishments within a particular area. The second issue was about the drinking environment itself. Attempts were made to 'improve' pubs, to make them larger and lighter, and to encourage them to serve food and provide alternative activities, which, it was believed, would make the pub's clientele drink less and behave better. A common difficulty for both issues, Nicholls pointed out, was the 'clumpy' or 'patchy' interaction between national policies and those that operated at the local level. History, he suggested, could not solve such problems, but it can help remind us what the shape of such problems is, and point to the different worldviews and epistemologies that are at work.

In 2011, the Coalition Government introduced legislation empowering local authorities to restrict the sale of alcohol at night through two instruments: the Early Morning Restriction Order (EMRO) and late night levies. The EMRO allowed local authorities to identify areas where retail between midnight and 6 o'clock in the morning could be curtailed or banned. The late night levy allows local authorities to specify areas where local retailers contribute to a levy to support the cost of police in the night-time economy.

The Coalition Government's intention was to rebalance licensing in favour of local communities and authorities (Home Office, 2010) - but neither EMROs nor late night levies have been widely implemented. Councils who chose to introduce EMROs found themselves challenged by solicitors working on behalf of the Association of Licensed Multiple Retailers. These lawyers used both legal argument and extensive analysis of evidence, including FOI requests, to successfully block the introduction of EMROs (Blackpool Borough Council, 2014).

This all indicates features of multi-level governance. The role of central government in designing, setting and implementing policy is one facet only of a larger structure of governance. In this case, we see that it is actions at varying layers of governance which shape licensing policy. Along with the various layers of central and local government and local appeal courts, there are the influences of complex structures involving numerous stakeholder groups, - NGOs, the drinks trade, different

government departments - as well as the wider political and legal context. This dynamic of multi-level governance is built into the DNA of alcohol regulation, especially licensing.

Licensing by definition means the devolution of power to local authorities. This has allowed regional innovation. Currently in Scotland, national policy has developed in a distinctive way but is now being challenged at the European level (Nicholls, 2012; Katikireddi et al., 2014). In England, a number of local authorities are considering introducing by-laws for minimum unit pricing. Thus innovations and challenges happen not only at the national level but at other levels of governance.

In the last third of the 19th century, the control of outlet density was a key concern - as it is today. A second issue was the regulation of the drinking environment. This was a period when consumption across the UK was at a peak and alcohol-related crime also rose and was a matter of concern. At the same time, the temperance movement effectively politicized concerns over alcohol and framed the issue as one of population over-consumption. The parallels with today's debates are obvious.

In 1869, legislation was passed bringing beer houses back under the control of local magistrates (repealing the 1830 Beer Act). There was rising concern about an increase in the number of beer houses and this in turn helped to encourage the rise of the temperance movement. Alcohol became a key political issue for the rest of the 19th

Century (Harrison, 1971; Jennings, 2008; Greenaway, 2003; Nicholls, 2009). Beer houses were now required to apply for licences thus allowing local magistrates to control the number of pubs in their area. The renewal of licences also became an important way of regulating the trade. However, given the economic power of local brewers, refusing to renew licences could undermine the security of brewer investment in local pubs, and local brewers and local magistrates often moved in the same circles. The question of whether licences were property was tested in a very famous case known as *Sharpe v Wakefield* in 1891. This case revolved around a refusal to renew an alcohol licence, which was challenged right up to the Court of Appeal. The Court ruling found, importantly, that magistrates should be free to use their discretion when renewing licences, and that a licence renewal should effectively be considered a new licence.

In the late 19th Century some licensing benches worked very hard to reduce outlet density while others did not.

The Peel Commission in the late 1890s looked in close detail at all aspects of licensing, in particular the matter of outlet density (House of Commons, 1899). In consequence in 1904 a new Licensing Act was passed which ostensibly enshrined the right of local magistrates to reduce density. However, after much political controversy, it was decided that anyone whose premises were closed down should receive compensation from a levy placed on local brewers. This made the issue

clearly one of property (Greenaway, 2003; Nicholls, 2009; Jennings, 2009).

An alternative to licensing emerged in arguments for the municipalisation of the alcohol industry itself. This became known as the 'Gothenburg System'. In the 1870s, interest grew in a policy solution first developed in Gothenburg in Sweden. There the local authority had taken wholesale control of the drinks trade. Landlords were put on flat wages thereby removing the profit motive and the incentive to encourage people to drink more. This model accepted the legitimacy of alcohol consumption but rejected licensing as ineffective in minimizing harm. The new approach seemed to offer a new form of direct local control and was championed by amongst others Joseph Chamberlain, Mayor of Birmingham. This potential example of policy transfer was, however, stymied at the centre and never rolled out.

With World War One, the Central Control Board (CCB) was established to oversee the production and sale of alcohol across the UK (Duncan, 2014). The concern was initially with the efficiency of shipyard workers and there was pressure for either prohibition or at least much stronger regulation of alcohol (Greenaway, 2003). The CCB imposed strict national limits on operating hours - which were only finally repealed with the 2003 Licensing Act. It also established direct control over the alcohol industry in Carlisle and areas around Gretna. This modification of the Gothenberg System became known as the 'Carlisle Experiment'.

The Carlisle Experiment continued beyond the end of World War I, but was not rolled out across the rest of the UK. It did have influence elsewhere however, especially in Canada where a number of control boards (such as the Liquor Control Board of Ontario) were established after the repeal of national Prohibition (Malleck, 2012). At the same time in England, the idea of pub improvement grew and between 1920 and 1940 it is estimated that over £90 million was invested by the brewers in improved pubs (Greenaway, 1998; Gutzke, 2006). The motivation was, ostensibly, a progressive desire on the part of the brewers to improve society – though it was also motivated by a need to expand pub attendance among the new middle classes (Greenaway, 1998). It was a kind of corporate social responsibility scheme of its day.

All this demonstrates that all policy development is messy. Local areas can facilitate innovation but sometimes this is quashed at national level. These various examples indicate the interplay between local and national legislation – so that the outcome was characteristically patchy and clumpy rather than uniform. Resistance through legal challenges mediated the impact of national intentions. While national legislation sometimes facilitated local action, it was often local innovations and local inconsistencies which drove national policy debates.

Another contemporary lesson is that where alcohol policy threatens trade interest, it will get tested in the courts. The alcohol industry is powerful locally as a lobbyist and employer and will

almost always use its economic influence to resist legislation that constrains its business operations. The CCB provides a unique example of co-working between sections of the alcohol industry, government and alcohol control advocates to place restrictions on trade freedom; however, while this suggests such actions are possible, it also demonstrates that ‘exogenous shocks’ to policy equilibrium – in this instance, wartime conditions – may be necessary for such innovations to occur.

Professor Betsy Thom

Head of the Drug and Alcohol Research Centre, Middlesex University London

The role of knowledge, and how this is implemented, was a theme taken up by Betsy Thom, Professor of Health Policy at Middlesex University, in her presentation on the social science perspective on local and national alcohol policy. Thom focused on the role of ‘partnerships’ in alcohol policy-making and implementation. Partnerships, or multi-agency working, have been around since at least the 1960s, but came to the fore as part of New Labour’s devolution agenda. Local partnerships, it was hoped, would be a non-ideological and pragmatic way of addressing complex problems such as alcohol. Studying how such partnerships worked on the ground, however, revealed a number of difficulties, such as the fact that alcohol-related issues around crime, trade, price and advertising cut across a number of areas of government and policy making, making coordination difficult.

Understanding partnerships is essential to understanding the link between national and local policy (Thom, Herring et al 2013). The idea is not new: it is contained in earlier discussions of multi-agency collaboration, joint working, joined up thinking, inter-professional collaboration and so on. For example, in the 1960s, in the alcohol field, there were coordinating umbrella organisations, which eventually became Alcohol Concern. There was also in the 1980s and 1990s a growth in alcohol forums, bringing together local people, probation, specialist services and education. In 1990, a network of 14 regional alcohol misuse coordinators was set up by the Health Education Authority to add a strategic level to policy making. The Alcohol Improvement Programme (AIP) under the last New Labour government also involved a system of Regional Alcohol Managers with a similar set of functions (Thom, MacGregor et al 2013).

The shared concept in all this is of an intermediary level of communication between national and local policy. New Labour emphasized the idea of partnerships with Health Action Zones, Health Improvement Programmes, Local Strategic Partnerships, Crime and Disorder Reduction Partnerships and so on. Through legislation, they placed a formal duty of partnership on local authorities, health authorities and others. There was a shift to a regulated, monitored and statutory requirement for partnership working across a number of areas, including crime and health. The

thrust was for a mechanism to inject national policy into the local sphere.

Under the AIP, [described in more detail by Don Lavoie below] partnership was regarded as a facilitating factor to implement the high impact changes which were intended to tackle the rising rate of alcohol-related admissions to hospitals.

The context for this was the devolution and localism agenda. And, regarding 'wicked' issues like alcohol, the view was that these cannot be dealt with by one discipline, profession or agency. A multi-agency, multi-professional and multi-disciplinary approach was thought to be needed. This all formed part of New Labour's Third Way approach to social policy, which also involved adherence to the idea of evidence-based policy.

There have been few attempts to measure the outcomes of partnership working. However qualitative research on partnerships has found that those involved have felt that coordination was very difficult. The partnerships were very large and very complex and this caused problems of accountability, power struggles and tensions. It was difficult to agree priorities and goals and difficult to overcome policy silos and cross cultural boundaries. Poor communication and problems with information-sharing were frequently mentioned.

The conclusion of much research was that partnership is a particular form of governance which needs to take more account of professional experience and knowledge and pay more attention to

user voices. (This has led to a new interest in ‘civic science’ to bring lay voices into governance).

Research in this area has also thrown up new ideas about the links between evidence and policy. When one looks at what people are actually doing at local level, one finds they are trying to *implement knowledge*. Rather than talk about *evidence*, it may be more useful to talk about *knowledges*.

What knowledge are people trying to translate and make suitable for their local areas and put into action? A recent book by Freeman and Sturdy (2014) sees knowledge as forming three types: embodied; inscribed; and enacted. The idea is that policy itself is a body of knowledge. Embodied knowledge is the knowledge held by the people who are actors in the different policy spheres. This is about how to do things, skills and content. This belongs in the person and can move with that person. Inscribed knowledge is written in policy documents, guidance, circulars, minutes of meetings and so on. Enacted knowledge gives meaning and significance to inscribed knowledge. It is transient and can happen in a corridor or in a meeting; it is produced through interactions in meetings and contacts. These forms of knowledge all interact in knowledge communities. The empirical questions then are: what is being done with the knowledge that comes down from the national level in the form of policy documents; how is it translated; how is it changed in interactions and then acted out in different ways in local areas?

Given all this, it is not surprising that national policy usually comes out rather different in the end from what was intended initially.

Don Lavoie

Alcohol Programme Manager, Public Health England

The multi-faceted nature of the problems posed by alcohol also came up in the final presentation, by Don Lavoie. In giving the policy perspective, Lavoie noted that alcohol was an issue where it is very hard to get the policy right, as it cuts across so many areas. He pointed out that a national strategy on alcohol is a relatively new development, and was initially focused on the crime and disorder associated with alcohol use. The health dimension to alcohol problems was later integrated, with many Primary Care Trusts also taking up the issue at the local level. More recently, at the national level, Public Health England has made combatting the health problems caused by alcohol a priority, leading the agency to develop policies that encourage lower risk drinking.

Alcohol is part of our society – 85% of the population use it at least occasionally (ONS/GHS 2009). Alcohol-related hospital admissions are a policy concern (PHOF 2014). It is only in the last ten years that the Government has put together a cross- government strategy. Previously there was no national or England-wide strategy. The first strategy was the *Alcohol Harm Reduction Strategy* in 2004 (HMG 2004)

and was mainly crime orientated because it was the Home Office which had had the strength to push for a national strategy. As well as crime and disorder issues however, there was a lot of health information in this strategy: for example, calls for a national needs assessment and for better information and brief advice, attention to 'what works' and so forth.

The first ever national needs assessment concluded that about 25% of people are drinking more than is healthy for them. Over a million people show signs of dependence. There were huge regional variations however. Only 1 in 18 people who had some sign of dependence were getting involved in treatment (DH 2005).

The Alcohol Improvement Programme was part of the policy response to these findings. Built into this activity at the centre was the production of *Models of Care* and a review of the effectiveness of treatment for alcohol problems (DH 2005). Central Government through the Department of Health also commissioned SIPS (Screening Intervention Programme for Sensible Drinking).

In 2007 the next step took the form of the document *Safe, Sensible and Social* (HMG 2007). Health was much more prominent in this document. It involved a call for action to forge a clear national understanding of what is and what is not acceptable drinking. A focus of attention was on alcohol-related hospital admissions. A large number of local and health authorities agreed to look at this

issue at local level. To assist them, the Department of Health produced local alcohol profiles, developed through the North West Public Health Observatory. A National Alcohol Treatment Monitoring System was also established. All this gave local planners and providers much more information about their needs and treatment services. All this information was brought together in another document *Signs for Improvement* (DH 2009) and high impact changes were outlined, encouraging commissioners to develop relevant activities and services. The forms of intervention from which local planners could select as appropriate included: licensing; minimum unit pricing; control of outlet density; specialist treatment; alcohol care teams; alcohol health workers; and brief advice. NICE also published basic guidance (NICE PH24). In all therefore, the Alcohol Improvement Programme involved a wide range of activities covering evidence, support and implementation.

The Coalition Government in March 2012 produced its own *Government Alcohol Strategy* (HMG 2012). This is very much driven by the Home Office. The stress was on the harms of violence caused by binge drinking. At the same time, research at Sheffield University on minimum unit price showed that almost half of all the alcohol is consumed by 10% of the population and 20% of the population drinks about two-thirds of the alcohol consumed. Across the population today, 15% do not drink at all and 60% drink at relatively low risk

levels. That leaves about 25% of the population who are drinking at risk.

At national level, there are a number of options to tackle these matters such as minimum unit price or banning multi-buys, working with the industry through the Responsibility Deal and, in the NHS, the Health Check now has an alcohol component to it. At local level, there are sobriety schemes.

All this is taking place in a very changed landscape of public agencies with the formation of Public Health England and Police and Crime Commissioners.

Alcohol is now the third leading cause of preventable ill health and death in this country. 9 million adults are drinking above the lower risk guidelines. Government policy is to create an environment that supports lower risk drinking.

DISCUSSION

Putting such policy into practice, and the dilemmas that local and national policy makers face both today and in the past, was a key theme of the discussion which followed the presentations. Local authority representatives, social scientists, practitioners and historians entered into useful dialogue. Among the issues considered were multi-level governance, the contrast between national policy and local implementation and the role of data versus personal testimony in policy-making decisions.

Governance

Participants commented on the complexity of the present-day world of multi-level governance and the variety and roles of policy communities. They noted the growth and shape of local partnerships and described relations between local government and public health.

Governance was seen to operate at a number of levels – national, regional and local - as well as at the European level, through the European Union.

Most of the discussion in the presentations had been about England. In Scotland it was observed that there is a distinctive national policy on alcohol. The *Licensing Act 2005* was implemented in 2009. In 2008 what was in effect a National Alcohol Strategy was produced, which built on an extensive review of evidence. The Scottish policy explicitly has the objective of reducing overall consumption. The aim is not just to target those who are drinking hazardously, harmfully or dependently. The aim is to ‘shift the curve to the left thus bringing the tail along with it’ – a public health approach that assumes (or hopes) that population-wide health improvement can benefit those at highest risk of ill health.

This progressive policy came about because of a fortunate conjuncture of circumstances, especially the election of government who were prepared to consider more radical policies aimed at alcohol harm-reduction. In addition to considering WHO guidance views were sought on introducing alcohol interventions, reducing alcohol waiting

times, increasing funding for specialist services, and introducing minimum unit price. This latter policy is being challenged by the Scottish Whisky Association in the courts. An influential figure had been a graph showing steeply rising liver cirrhosis – ‘this was really powerful in waking up the politicians’.

The policy is being monitored and evaluated and indications are that alcohol-related deaths are coming down dramatically. It is recognized that some of the results on reduced consumption may relate to the recession as much as to the alcohol policy.

Discussion turned to considering the question of when, how and why do particular problems, like health or social disorder, come under the purview of particular instruments of governance?

The role of various government departments in designing and implementing national policy was discussed, along with recent policy documents and changes.

It was observed that the ‘messiness’ of policy development in multi-level governance is useful for the drinks industry, allowing them opportunities to shape policy implementation through action at the local level

It was also noted that while New Labour had emphasized devolution, it had also centralized. Partnership was a mechanism both for centralizing and for devolving.

Partnerships currently are under pressure. They are starting to fracture or disappear. There has been a loss of capacity. Currently with austerity policies, local government is being hollowed out. Restructuring of the NHS has added to the problems.

Among the various policy actors discussed there was some consideration of the role of the media. It was observed that some of the changes and shifts in policy that have been seen at national level have been in part due to media campaigns. The criticism of the 2003 Act was led by the Daily Mail. Local media are also important. Local news reports regularly on the terrible injuries from alcohol-related activity outlined in magistrates courts. One participant mused that perhaps new media may be able to galvanise local communities against this in the same way the Temperance Movement organized local communities in the past.

Implementation issues

The 2003 Act which liberalized drinking was thought by some participants to bear a great responsibility for today’s problems in local areas.

Examples of local action in the field were given. For example, in Suffolk, there is a local initiative called ‘Reducing the Strength’, aiming to tackle the problems of street drinking, particularly of cheap and strong alcohol. This is claimed to have reduced the number of

street drinkers by half in this local area. Shops have signed up to a scheme to remove cheap ‘supersize’ beers and ciders from sale. This involved a partnership between the constabulary, the public health department, local government, country council, treatment agencies, the industry itself, the drinks trade and the local community.

The key to much local policy development lies with funding opportunities. A problem in most local areas has been the relative neglect of alcohol vis-a-vis drugs over recent years. Although public health grants for both these are now combined and ring fenced, allowing potentially greater attention to alcohol, these ring fences will not last forever and reductions in budgets are expected.

Some boroughs have big night-time economies which can include both on and off-license premises, each of which present particular issues in terms of public order and health. For example, Islington has more 24 hour retailers than anywhere else in the country. To address such problems, some local authorities have adopted and enforced Cumulative Impact Policies aimed at providing greater powers to cap new licenses and/or impose terms and conditions on the kinds of premises that operate in specific areas. The late night levy has also been adopted in a few areas. The late night levy has also been adopted in a few areas. But

attempts to tackle related problems are challenged by retailers.

Supermarkets are important retailers today - a difference from the 19th century. In the past, there was a closer relationship between where the purchase was made and where the alcohol was consumed. One of the issues that faces licensing is that it is designed to deal with a kind of geographical problem which has changed significantly. Drinking at home is now a big issue and clubs and pubs are not making the profits they used to. Further taxation is not an option, some thought.

Attention was given to emerging patterns of licensing at the local level. Issues considered included: what were the objectives of licensing – to control behavior or was there concern for health? Historically, one of the roles of licensing was to have concern for the public good more generally – there was a wider public interest represented in licensing. That is to say, licensing is geared to tackle ‘proximate effects’ (i.e. immediate consequences in and around places where alcohol is sold). It is not well-designed to address ‘non-proximate’ consequences, such as health impacts.

The influence of commercial interests on local policy decisions was a key theme in discussion. It was observed that when drunkenness comes to court it is a criminal matter whereas licensing decisions are civil matters with a different approach and a different level of proof. Licensing decisions previously

had to be ‘necessary’ for the promotion of the licensing objective: now they only have to be ‘appropriate’. This is a much easier test for a local authority to demonstrate.

This led discussion to the role of legal challenges. The people who understand the licensing laws best in this country at present are a handful of lawyers who work for a handful of companies: a local authority lawyer pitched against them has an uphill task.

It was noted that ‘even if the decision is initially found in favour of the public health interest, there will almost always be an appeal and a huge team of lawyers will come in and be successful at delaying the decision’. Where licensing decisions risk setting precedents counter to commercial interests, as in the recent case of Early Morning Restriction Orders, well-financed appeals are commonplace. These sometimes aim at getting decisions overturned, but sometimes simply delay decisions long enough for there to be a shift in the balance of power amongst local councilors.

These contemporary examples were linked to earlier cases. The 1904 Licensing Act, designed to reduce the number of public houses, foundered in large part because of a legal judgment two years later where an appeal by two brewery companies vastly inflated the amount of compensation payable. Time and again in the 19th Century, prosecutions foundered in the courts because publicans and their lawyers were able to argue that the evidence was insufficient. The importance of the law

and the courts is very significant – a point that holds true historically and today.

Today where appeal cases are successful, this is often because it is possible to show that there is local feeling about the issue. However some noted that while local residents can have a powerful voice, local businesses have a significantly more powerful voice.

To make progress, it is necessary to get local politicians to understand what the issues are, get them to see what the data are, get them involved with public health, and see the bigger picture. Some felt that public health practitioners and campaigners have to put in a huge amount of effort locally for small results. This led discussion to consider the role of public health locally.

Recent research has shown that there are differences in interpretations of the public health role. Some see this as about influencing opinion, lobbying and building relationships over time. Some feel community activism is important. Others concentrate on accumulating data and analyzing it and producing documents and plans including in order to influence the strategic direction of local licensing boards

Some attention was given to treatment responses. One of the challenges for alcohol treatment has been not just the limited amount of funding or resources but also the limited treatment populations that it reaches. The real challenge is to fill the gap between alcohol brief intervention and standard treatment services - that is the need to

reach those with early or mild dependency. The view was that there is a need to improve equity of access across the alcohol dependency spectrum.

Data versus testimony

The assumption that just providing data will lead to the right decision is flawed. Local councillors making decisions are influenced by their perception of what the views of the public on the ground are. ‘Councillors glaze over when they hear all the statistics and data but as soon as a community member speaks up, it puts more pressure on the politicians’.

The experience in Suffolk, for example, was that evidence on its own was not sufficient to convince a politician. ‘When it comes to persuading a politician, you need to put that evidence in such a way that it creates a story and not expect them to look at lots of facts and figures’.

Regarding evidence, the comment was made that alcohol has always been a difficult area. In the 19th Century, people were always struggling with the meaning of drunkenness statistics and the effects of excess pubs. With alcohol, the evidence has always been a grey area.

A final point here is that it seems that licensing deals with a different set of knowledge than public health, indicating a tension between administrative knowledge and expert knowledge. While public health sees the population, licensing sees the street.

Different worlds use different epistemologies.

The drinking environment

Discussion looked at the history of improvements in pubs and long term changes in the culture of drinking. One commented that ‘many remember fondly what it was like when there was no 24 hour drinking’. It was thought there is a need now to change the drinking culture and/or look more closely at how retail environments shape drinking cultures

Linked to this were questions about the impact on families and children. The effect of drinking on social relationships and particularly on children was a key issue in the 19th century and remains so today. The number of children who come to the attention of social services because one or both parents has a drinking problem is high.

An important element in today’s drinking environment is the night-time economy, which is about alcohol and use of other substances – poly drug use. The separation of policies on alcohol from those on drugs presents problems of coordination. The English drugs strategy does incorporate severe alcohol dependency for whom the main policy response is treatment – in England about 35,000 people come into drug treatment currently who also have a coexisting drug problem.

CONCLUSIONS

A common theme in the discussions was of the unintended consequences of national policy decisions, that is, the tendency of policies either to not work or have contrary or unexpected results (the 1830 Beer Act, the 1904 Licensing Act, the 1990 Beer Orders).

Local variations were notable. It emerged that such variations should be seen not as defects to be remedied by attempts at tighter control but were in themselves forms of policy creation – an essential part of the policy development process.

While currently there is much attention to localism and devolution, it could be concluded that too much localism implies the abandonment of any attempt at a sensible national policy on alcohol.

What came through was the long history of local-national interactions in alcohol policy making, especially around outlet density and improvements to drinking establishments. And the long history of the complexity of relationships between the local and national, and their 'clumpy' nature.

The multi-faceted nature of the problems alcohol poses was a key observation as well as how this cuts across different areas of government, especially health and crime, making the policy making situation particularly complex.

A key observation was that there are different types of knowledge and civic epistemologies. How evidence is

interpreted and operationalised is critical. The problem public health faces in working with licensing is less about evidence than about epistemologies and the way different types of knowledge interact.

It was striking that personal testimony seemed more influential than data in swaying both licensing and political decisions. Details on the actual processes of decision-making in local partnerships, licensing boards and Magistrates Courts were very revealing.

Historians remind us of the power of local government in Victorian Britain. This was significant when compared to today. Related to the decline of local government is the role partnerships now play as an intermediary between the local and the nation – have they emerged to fill a vacuum and what are the implications of this?

One of the big differences when comparing today with 1870-1920 is that this was the heyday of local government – this is inconceivable today with the 'complete eclipse' of local government in many areas, albeit the licensing context in local government has been empowered by the 2003 *Licensing Act*. In place of elected locally representative government are a myriad of partnerships and networks. (Some amendments to the 2003 Act were introduced in the *Police Reform and Social Responsibility Act 2011*).

The weakness of the DH when compared to the Home Office or Cabinet Office in recent years in promoting policies seemed important. The situation in

Scotland appears different where health concerns seem to be more powerful. Quite why this is merits further thought and analysis. Vested interests opposing health policies are important as pressure groups and even within government itself. One of the advantages of devolved powers seems to be its smaller scale so joint working seems more possible. Personalities and leadership also matter of course. In Scotland there was a champion in the form of the Justice Secretary.

Linked to this was the overall nationalist rhetoric – a narrative of national renewal which helped in framing the public health orientation of the policy. It helped to demonstrate that Scotland could be distinctive and lead the way.

Notwithstanding an incessant rhetoric of 'partnership', 'stakeholders', 'networks', etc, central government seems to have had the power to dismantle and reconstruct institutional arrangements set up only a few years previously and to shift the priorities of policy.

Implementation issues emerged as important: national policy design often fails to take into account practical matters of coalface implementation issues - high-level thinking does not match delivery-level concerns.

Historically, the number of pubs reduced in England more because of economic, social and cultural changes from the 1870s onwards – people's behavior changed. What history shows is that policy-makers come and go but it is underlying changes working themselves out that create a society that consumes more or less alcohol.

However there are examples where policy has been part of these social and cultural changes or has catalyzed changes to push them in a certain direction.

HISTORIANS' OVERVIEW

Perhaps finally winding up the event by stressing the importance in the end of the social, cultural and economic forces at work over the efforts of policy makers might have been a bit bleak for a seminar on the lessons of history for policy and practice. However, it is a fair point in spite of the evidence of valiant local public health efforts.

An interesting question is when did health promotion become a licensing consideration? The 1931 Royal Commission was wary of speaking too much about health impacts, describing them as a 'thorny issue'. There is however a wider point about the powers of local government, with a key phase being that of municipalisation of the industry and nationalization. War and control policies generally influenced the development of alcohol policies.

In Victorian times, there was the expectation that local authorities or local boards could (and should) be in a position to control policy in discrete areas of social policy. J.S.Mill's ideas as put forward in *Considerations on Representative Government* neatly squared the circle between the tensions of democracy and efficiency which the later C20 saw re-emerging with a

vengeance. The almost universal expectation by Liberal, Unionist and Labour politicians alike between c.1870 and 1914 was that alcohol issues would one day properly be 'settled' by some form of local control with possibilities of experimentation (local veto; municipal control; licence restriction schemes etc.). Both the technical complexities of liquor licensing (with the judicial element being an important factor) and the high politics profile of the issue meant that a solution was impossible.

The CCB was mentioned in discussion.(Berridge,2014) It is interesting that this centralised body, acting in the perceived interest of national efficiency, with quite draconian powers, nevertheless took very seriously the issue of local bodies. This is seen in its fostering of the Carlisle scheme and the arrangements for a local committee to administer and direct it. (Robert Duncan's recent book is worth reading on this). Carlisle became a sort of alternative model for the drink question with the distinct Southborough Committee of 1927 and the Royal Commission on Licensing of 1929-31 showing that contemporaries still believed this to be the case.

However, economic, cultural and social developments had by this date rendered any distinctiveness between the Carlisle model and normal drink control virtually meaningless as public houses rapidly 'improved' and drunkenness fell away sharply.

Regarding the historical purposes of licensing: The 1817 parliamentary committee on licensing in the capital

gave as the purposes of licensing (in this order) 'the advance and security of the Revenue against the unlicensed vend of excisable liquors' and the 'conservation of the public peace and morals'. In their 1903 history of licensing, Sidney and Beatrice Webb argued that licensing emerged as a system of governance for three primary reasons: 1) alcohol caused social disorder, but 2) prohibition was neither practical nor desirable, and 3) alcohol was an important industry and source of state revenue. It is clear that licensing has always been caught between regulating the legitimate trade, protecting state revenues, and preventing harms to the general public. Allied to this are the myriad difficulties of implementation (reported from history and in the seminar) and enforcement - as well as the wariness of politicians (Bruce, Gladstone, Salisbury and so on to the present) to risk the judgment of popular opinion by restricting public access to alcohol.

Some further afterthoughts included the comment that both the policies of minimum unit price and banning multi-buys have apparently been abandoned for England at national level. It was also noted that with regard to sobriety schemes, the initial Home Office evaluation suggested they were ineffective mostly because people opted not to use them. They are now being piloted again in London.

With regard to the path-breaking policies introduced in Scotland it is worth noting that alcohol-related deaths have been falling in Scotland since 2003

(unlike in England and Wales where they only started to decline from 2008). The latest report from Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) states that 'declining affordability of alcohol due to the economic downturn and associated policy contexts across Great Britain in recent years is responsible for a substantial proportion of these improvements. However, the ban on quantity discounts in the off-trade and the increased delivery of ABIs [alcohol brief interventions] may have made a contribution to the declines in alcohol consumption and harms respectively.' ((Beeston et al., 2014: ii).

In England, the 2003 Licensing Act has been widely blamed for developments (such as the increase in densities of high-volume bars in urban centres) that actually pre-dated its implementation. Here is another example of unintended consequences: presented as a measure to encourage more 'continental' drinking, the liberalisation of licensing hours actually contributed to a trend towards a later start to the night-time economy, combined with increased 'preloading' driven by cheap alcohol available in shops and supermarkets. This has negatively affected police logistics by pushing alcohol-related crime into the early hours of the morning; however, there is no evidence the Act increased overall crime rates and alcohol consumption has - for a range of other reasons - actually fallen by 18 per cent since the Act was introduced. It would be wrong to

suggest that the 2003 Act was a disaster, though equally wrong to say it succeeded on its own terms in regard to culture change.

A key lesson from history is that so long as licensing remains a largely inaccessible area of local government, dominated by expert regulators and specialist lawyers - to the exclusion of the general public - then it will continue to lack democratic accountability. Central policy will continue to be stymied or distorted at implementation level, and the public will have little awareness or understanding of how and why this happens. Overall it seems there is a need to make the licensing system more transparent: for most people it is a complete black box.

Alcohol policy will always involve a tension between central policy and local delivery - and this is not necessarily a bad thing, since patterns of both consumption and harm are geographically varied. However, understanding how the national and local interact is key to supporting effective policy development and delivery. History provides plenty of examples to help develop that understanding today.

References

- Beeston C, Geddes R, Craig N, Gordon R, Graham L, McAuley A, McCartney G, Reid G, Robinson M, Van Heelsum A (on behalf of the MESAS project team) (2014) *Monitoring and Evaluating Scotland's Alcohol Strategy*. Fourth Annual Report. Edinburgh: NHS Health Scotland
- Berridge, V. (2014) Drugs, alcohol and the first world war *Lancet* (2014), 384, 1840-41
- Blackpool Borough Council (2014). Minutes and decision of the licensing committee meeting 3rd-7th February 2014. Retrieved 16th November 2014 from <https://www.blackpool.gov.uk/Business/Licensing-and-permits/Documents/EMRO-decision-100214.pdf>.
- Department of Health 2005 *The Alcohol Needs Assessment Research Project (ANARP)*
- Department of Health 2009 *Signs for improvement—commissioning interventions to reduce alcohol-related harm*
- Department of Health 2006 *Models of care for alcohol misusers (MoCAM)*
- Duncan, R. (2014). *Pubs and patriots: the drink crisis in Britain during World War I*. Liverpool: Liverpool University Press
- Freeman R. and Sturdy S. (eds.) 2014 *Knowledge in Policy. Embodied. Inscribed. Enacted* Bristol: Policy Press
- Greenaway, J. (1998). The “improved” public house, 1870-1950: the key to civilized drinking or the primrose path to drunkenness. *Addiction* 93.2, 173-81.
- Greenaway, J. (2003). *Drink and British politics since 1830: a study in policy-making*. Basingstoke: Palgrave Macmillan.
- Gutzke, D. (2006). *Pubs and progressives: reinventing the public house in England 1896-1960*. Dekalb: Northern Illinois University Press.
- Harrison, B. (1971) *Drink and the Victorians: the temperance question in England, 1815-1872*. London: Faber and Faber.
- HM Government 2004 *Alcohol Harm Reduction Strategy*. London: TSO
- HM Government 2007 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*. London: TSO.
- HM Government 2012 *The Government's Alcohol Strategy*. London: TSO.
- Home Office (2010). *Rebalancing the Licensing Act: a consultation on empowering individuals, families and local communities to shape and determine local licensing*. London: Home Office.
- House of Commons (1899). *Final report of Her Majesty's Commissioners appointed to inquire into the operation and administration of the laws relating to the sale of intoxicating liquors C. 9739*. London: HMSO.
- Jennings, P. (2008) *The local: a history of the English pub*. Stroud: Tempus.
- Jennings, P. (2009). Liquor licensing and the local historian: the 1904 Act and its administration. *The Local Historian* 39, 24-37.
- Katikireddi, V., Hilton, S., Bonnell, C. and Bond, L. (2014). Understanding the development of minimum unit pricing of alcohol in Scotland: a qualitative study of the policy process. *PLOS ONE* 9.3, e91185.
- Local Alcohol Profiles for England (LAPE) <http://www.lape.org.uk/>
- Malleck, D. (2012). *Try to control yourself: the regulation of public drinking in post-prohibition Ontario, 1927-44*. Vancouver: UBC Press.
- NICE PH24 - Alcohol-use disorders: preventing the development of hazardous and harmful drinking <https://www.nice.org.uk/guidance/PH24>
- NICE CG 115 - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence <https://www.nice.org.uk/guidance/CG115>
- NICE CG 100 - Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications <https://www.nice.org.uk/guidance/CG100>

Nicholls, J. (2009). *The politics of alcohol: a history of the drink question in England*. Manchester: Manchester University Press.

Nicholls, J. (2012). Alcohol licensing in Scotland: a historical overview. *Addiction* 107.8, 1397-403.

ONS 2009 *General Household Survey 2009 & mid-2009 population estimates*

Public Health Outcomes Framework (PHOF) 2014 Screening and Intervention Programme for Sensible Drinking (SIPS)

<http://www.sips.iop.kcl.ac.uk/>

Thom B., MacGregor S., Godfrey C., Herring R., Lloyd C. Tchilingirian J., Toner P. 2013 The Alcohol Improvement Programme – evaluation of an initiative to address alcohol-related health harm in England. *Alcohol and Alcoholism* 48 (5): 585–591

Thom B. Herring R., Bayley M., Waller S., Berridge V. 2013 Partnerships: survey respondents' perceptions of inter-professional collaboration to address alcohol-related harms in England, *Critical Public Health*, 23 (1): 62-76

Webb, S and Webb, B. (1903). *The history of liquor licensing in England, principally from 1700 to 1830*. London: Longmans, Green & Co.

Niamh	Fitzgerald
Helen	Garratt
Janice	Gibbons
Evelyn	Gillan
Daniel	Grace
Lesley	Graham
John	Greenaway
Wayne	Hall
Jan	Hart
Rachel	Herring
Dave	Humphreys
Paul	Jennings
Amanda	Jones
Vittal	Kakireddi
James	Kneale
Don	Lavoie
Ian	Leete
Susanne	MacGregor
Jane	McGregor
Alex	Mold
James	Morris
Jo	Neale
James	Nicholls
Marcus	Roberts
Jane	Simmonds
Stephanie	Snow
Colin	Sumpter
Betsy	Thom
Elizabeth	Tyner
Ian	Wardle

LIST OF PARTICIPANTS

Simon	Aalders
Rob	Baggott
David	Beckingham
Virginia	Berridge
Helen	Boaden
Andrew	Brown
Matt	Egan
Viv	Evans

THE SEMINAR SERIES

The workshop was part of a series of events organised jointly by the Centre for History in Public Health, LSHTM and the Centre for the History of Science, Technology and Medicine at the University of Manchester. The seminar series, sponsored by the

Wellcome Trust, aimed to bring together historians, social scientists, policymakers, practitioners and other researchers to explore the role of policy in history and the place of history in policy processes. Previous events have examined the history and policy around cancer, policy pilots and the role of the GP. Each workshop followed a common format, with a historian, social scientist and practitioner or policy maker each giving a brief presentation, followed by an extensive discussion with an invited audience.

This seminar on alcohol policy was arranged by the Centre for History in Public Health. The first session was chaired by Dr Alex Mold. The second session was chaired by Professor Virginia Berridge. The organising committee consisted of Virginia Berridge, Matt Egan, Susanne MacGregor, Alex Mold and James Nicholls. Administrative support was provided by Ingrid James. The briefing paper was prepared by the organizing committee with Professor Susanne MacGregor taking the lead.