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Democracy and power in alcohol premises licensing: a qualitative interview study of the Scottish public health objective.

Short running title: Democracy and power in alcohol premises licensing

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Conflict of Interests

The authors declare that they have no conflicts of interest.

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ABSTRACT

Introduction & Aim: There is international interest in how the availability of alcohol can be controlled to reduce harms. An objective of ‘protecting and improving public health’ was introduced to alcohol premises licensing in Scotland in 2005, resulting in public health actors engaging with licensing in new ways. We aimed to explore their experiences, including perceptions of the distribution of power, and constraints on their influence and that of the general public within the licensing system.

Design and Methods: In-depth, semi-structured interviews were conducted with 13 public health actors who had recent and extensive experience of involvement in local licensing in 20 Scottish licensing jurisdictions. Interviews were audio-recorded and analysed using an inductive framework approach.

Results: Public health actors reported experiencing the licensing process as inherently unfair, with structures and traditions that were largely unhelpful to their efforts to support the public health objective. These included influence exerted by local officials, the formal and quasi-judicial conduct of licensing meetings, and the disparity in resources available to public health actors versus licence applicants – with many larger applicants engaging specialist lawyers to represent their interests. The influence of public opinion – through, for instance, elected representatives’ perceptions of public attitudes, consultation exercises, and local ‘licensing forums’ – was seen as having a limited effect on decision-making.

Discussion and Conclusions:

Changes to Scottish alcohol licensing ostensibly designed to enhance democratic engagement and promote public health, were as yet insufficient to change the system, or empower stakeholders, to achieve that goal.

Introduction

Systematic reviews suggest measures addressing the physical and temporal availability of alcohol are effective in reducing alcohol-related harms, although the mechanisms and scale of this effect remain unclear (1–12). There is evidence of a strong association between outlet density, alcohol-related harms, and deprivation (13–15) including in Scotland (16–18). In order to reduce harms, there is a long-standing history of regulation of the availability of alcohol in many countries, with restrictions varying from total bans on sales, to restricted distribution via state monopolies, to relatively permissive regimes such as that in the United Kingdom (UK).

In the UK, alcohol availability is regulated through a system of local authority premises licensing which differs slightly across the four nations of the UK. In Scotland, under the 2005 Licensing Act ('the Act'), licensing boards are the decision-making body on licensing matters. The licensing system regulates who can sell alcohol, where it can be sold, the conditions of sale and the hours and days of sale. There are several actors and structures within the system established under the Act (Box 1) which for the first time, created a role in the licensing system for local public health departments based within the National Health Service. Along with the police and others, these health authorities became 'statutory consultees' who are informed of all applications for new or changed premises licences. Such applications can only be refused if a) a 'representation' is made against the application by a statutory consultee or other party and b) that 'representation' successfully shows the application is likely to undermine one or more of the statutory 'licensing objectives'.

The statutory licensing objectives in Scotland are:

- preventing crime and disorder
- securing public safety
- preventing public nuisance
- protecting children and young people from harm
- protecting and improving public health

The explicit inclusion of public health improvement as a decision criterion in licensing is relatively unique globally – only the first four objectives apply in England whereas some licensing jurisdictions (including some Australian states and territories) have a requirement to consider 'harm minimisation', which may include public health (19).

Local licensing boards must produce a regular 'Statement of Licensing Policy' (SLP) (every 4-5 years), and are required to consult publicly on their proposed policy. SLP's must include a statement on 'overprovision'; that is, whether there are areas in the boards jurisdiction where the number, or density, of outlets is deemed excessive. In such areas, applications may be refused solely on grounds of overprovision, and the burden of proof regarding the licensing objectives is reversed: applications are expected to be refused unless they demonstrate that to grant the licence would not undermine the objectives. This statutory requirement to assess overprovision is stronger than a non-statutory right to create 'cumulative impact zones' in England

and Wales. A recent study of that provision found that the presence of effective cumulative impact zones was associated with a small (8 per 100,000 of the population) reduction in alcohol-related hospital admissions (20) and a reduction in alcohol-related crime (21).

Earlier studies of the implementation of Licensing (Scotland) Act (2005) concluded that licensing stakeholders found the public health objective problematic, and needed more guidance on the establishment and operation of local licensing forums and the 'overprovision' assessment (22–24). Against this backdrop, and supported by a national charity, Alcohol Focus Scotland (AFS), local public health teams in Scotland have been keen to use their enhanced role in licensing more actively, and have focused particularly on the overprovision assessment as a means of preventing increases in outlet density. No previous study have captured the experiences of practitioners with a public health remit working in the new licensing environment in Scotland. Since their remit and background are substantially different from that of licensing actors, we expect them to have experienced the new legislation differently, and to have constructed knowledge about how to approach the licensing system from a different perspective. This study was originally initiated by public health stakeholders in one local area who had not yet engaged in the licensing system, and who hoped to learn from the experiences of others.

In this analysis, we draw on our data to:

- explore public health stakeholders perceptions of the distribution of power within the licensing process and how such power is manifested and maintained by different parties;
- critically analyse current and potential mechanisms of influence for the general public and public health professionals in the licensing process as experienced by public health actors.

Methods

Sample

'Public health actors' (individuals with a professional remit to protect and promote public health generally or to reduce alcohol-related harm) who had *recent and in-depth experience of engagement with local licensing* were purposively sampled by reviewing publicly available information and snowballing, principally via one key informant at AFS. We also interviewed this key informant, and an individual with a local authority licensing role recognised for long-standing and innovative work on public health. Potential respondents were contacted by email or telephone to invite them to participate. After 13 interviews, one additional individual declined to participate, citing a lack of action on this issue in her area, and on the advice of the key informant, it was felt that no further interviewees were available with relevant experience, regardless of whether data saturation had been achieved. The 13 interviewees covered almost all of the licensing board areas in which public health actors had been actively involved, including 20 of the 22 boards that had declared any form of overprovision at the time (23) (Table 1).

Data collection

Interviewees were sent a study information sheet by email and followed up by telephone. Full informed consent was recorded prior to in-depth interviews which were not time-limited, averaged 69 minutes in duration, and sought saturation within each interview (25). All interviews were conducted by NF between

February and May 2014. Participants were informed of the original purpose of the study as above. At the time of the interviews, NF, was working as a Lecturer in Alcohol Studies at the University of Stirling. She had 14+ years' experience of qualitative interview studies, including with similar participants, but had not previously conducted research on alcohol premises licensing. Several of the participants were previously known to NF (see Table 1) through her involvement in previous unrelated research or training delivery. Twelve of the interviews were conducted by telephone, there being no strong evidence that face-to-face interviews are superior (26). Interviewees were provided with a topic guide (Table 2) in advance.

Interview participants were encouraged to speak freely about their experiences, and questions were not asked verbatim. Particular attention was paid to participants' reflections on the research questions and their advice to others. All interviews were audio-recorded and transcribed. Transcripts were checked for accuracy by interviewees, who were given the opportunity to elaborate or clarify any points.

Analysis

Thematic data analysis was conducted using a framework approach (27). NF and JW independently coded two interviews, then met to agree a draft coding framework. This was refined by both following analysis of three further interviews and then re-applied manually to all interviews by NF. A framework matrix was used to chart the data using Microsoft Excel, enabling a holistic, descriptive overview of the entire data set to be taken. Findings were discussed in detail with JN and JW to inform this paper, but not with interviewees.

Ethics

Ethical approval was granted by the Ethics Committee of the School of Management at the University of Stirling. The West of Scotland Research Ethics Service confirmed that NHS ethical approval was not required for this interview study. Interviewees were invited to highlight any segments of interview which they felt might identify them, and agreement was reached as to how these would be used. For example, in some cases it was agreed that the interview identification number or the interviewee's organisation type would not be used in conjunction with a specific quotation.

Results

Interviewees provided rich, free-flowing descriptions of their experiences, outlining what they did and why, how others reacted, how they perceived the outcome of their efforts and what they had been surprised by or felt they had learned in the process. Themes emerging from the data fell into six overarching categories (28), two of which – 'power, autonomy and bias' and 'public and stakeholder involvement' – are drawn on here (Table 3).

Licensing board independence and accountability

Licensing Boards were experienced by many study participants to be highly autonomous bodies who hold power independently of the authority of the local council. As one participant said: '*nobody in the council could squeeze their thumbs*' – meaning that nobody could exert influence over the Licensing Board members [Line number (L) 25, Interview 1, ADP]. This was considered to be true of councillors more generally.

"[Local councillors] are a very sensitive group...they're very independent. If they don't want to listen to you then they just won't. They don't have to answer to anybody." [L256, Interview 10, Public Health]

Some interviewees felt that there was a need for better mechanisms to ensure that Licensing Boards were accountable and consistent, and to deal with lack of transparency and poor public consultation.

"[Licensing Boards] don't need to report [whether they have functioning Licensing Forums] and nobody holds them to account whether they have or they haven't so they just get away...[a local licensing clerk] was trying to get us as health to take the lead on the forums but this is clearly a local authority responsibility." [L829, Interview number withheld, Public Health]

While Licensing Boards were seen as collectively autonomous, many respondents felt that key individuals wielded disproportionate power. Licensing clerks and licensing convenors (see Box 1) were seen to be especially influential in shaping board attitudes towards the public health objective. These two roles represent two distinct sources of power: the political power of the convenor, as both an elected member and chair of the board; and the clerk, whose authority rests on their knowledge of the law, professional expertise and practical experience in the field.

"A key factor in the Licensing Board in this area comes down to the beliefs, behaviour and nature of [a licensing clerk who] is quite an influential individual, with a particular line of thought" [L115, Interview number and type withheld].

"The convenor of the Licensing Board was very, very, sympathetic to the public health agenda. He really wanted to use the Licensing Board as a mechanism to reduce the amount of alcohol that was within [the area]." [L207, Interview 10, Public Health]

One described how the degree of respect in which a convenor was held by the local community meant other board members were unwilling to challenge his authority: *'I think there is a reluctance [to disagree]...people feel like they're getting on the wrong side of that man. Which is quite palpable actually'* [L219, Interview number and type withheld].

This influence had two reported consequences. Firstly, if a convenor was staunchly opposed to public health arguments, interviewees felt that little could be done to progress their agenda: *'things are not going to change with the current convenor and board'* [L319, Interview number and type withheld]. Secondly, it resulted in inconsistency across neighbouring Licensing Boards and over time. In particular, local government elections (every 4-5 years) could result in a change in membership of the Licensing Board, which could completely change the 'climate' for public health.

"The chair [convenor] of the licensing board [at that time] gave the impression that if he could do away with licensing completely and just allow free licensing, he would do it [L116]....The new chair

was, I would say, easier to work with and probably understood the issues better.” [L477, Interview 13, Public Health]

Changes in Licensing Board membership also meant that public health actors had to ‘*explain everything again*’ [L108, Interview 3, ADP], to build new relationships and raise awareness, and that was no guarantee of continuity in any progress made.

“It’s a rollercoaster ride working with the Licensing Board. One minute you’re getting somewhere and the next minute you’re back nowhere. It’s one of those committees that just does what it wants. With every new administration you have to start again.” [L447, Interview 1, ADP]

Power in the process

Power was also structured, and re-enforced, through highly protocol-driven and hierarchical Licensing Board meetings, which mostly (though not universally) operated like formal court proceedings. Many participants experienced these meetings as unnecessarily and ‘*absolutely intimidating*’ [e.g. L981, Interview 10, Public Health], and ‘*inaccessible to communities*’ [e.g. L370, Interview 2, Key Informant]. In this context, both legal expertise and professional status conferred significant authority. Interviewees reported that the presence of specialist lawyers at Licensing Board meetings contributed considerably to the intimidating atmosphere.

“When [colleagues] saw the applicants attending with their lawyers...that terrified them even more...the set up in [some areas] is much more formal than it needs to be.” [L414, Interview 9, Public Health]

“What we have found is that we are presenting evidence to advocates [Scottish term for trial attorneys (USA) or barristers (UK)] who are very, very qualified in being able to operate in what is a semi-judicial setting and we don’t necessarily have those kind of skills... When you look at it critically, no matter how senior a representative goes along from health – we do not have the level of experience that an advocate has.” [L435, Interview 6, ADP]

The expert status enjoyed by public health actors in their more familiar professional contexts counted for little in a quasi-judicial environment. This not only created trepidation but led public health actors to perceive the whole process as unfair and unequal, as unlike many licence applicants, they did not have the resources to engage specialist lawyers who could ‘*pick their way around the law*’. Thus the legalistic nature of Licensing Board meetings – which, from an applicant’s perspective serves to guarantee equality under, and the proper application of, the law – was seen by public health actors as a mechanism that disempowered community members and undermined their capacity to engage in the process. Most interviewees also felt that the legalistic nature of the process also disempowered the Licensing Board, because elected members were very anxious to avoid potentially expensive legal challenges to application refusals.

“The elected members are scared of the lawyers, scared that they will be taken to court and that they will get into trouble because the lawyers are so efficient and experienced.” [L81, Interview 4, ADP]

It was generally felt that, ultimately, power within the current system lay not mainly with Licensing Boards, but skewed towards those with the greatest resources to pay for legal expertise. Legal challenges were not generally viewed a means to ensure the law was properly applied, but as a threat and disincentive to refusing applications on the grounds that defending decisions in court was expensive and time-consuming.

Public involvement

In a few areas, local Licensing Forums (see Box 1) were reported to be active, with a good range of membership across trade, public sector and community representatives in line with the legislation, having ‘*a very robust agenda*’ [L51, Interview 5, ADP] and ‘*asking the difficult questions of the [Licensing] Board*’ [L52, Interview 11, ADP]. In those areas, public health actors exerted most of their efforts through the forum, citing that the legislation requires Licensing Boards to provide ‘*a statement of reasons to Licensing Forums if they don’t go with their recommendations*’ [L346, Interview 2, Key Informant].

However, many participants reported ongoing problems with Licensing Forums. Some noted that it was difficult to attract community representation: one commented that ‘*I think they’d bite the arm off anybody who wanted to step forward as a member*’ [L536, Interview 11, ADP]. Forums were described as ‘*top heavy with trade*’ or ‘*a Forum of licensees basically*’ or ‘*full of trade who try to protect the trade*’ or ‘*very heavy trade representation...dominated to a large degree by trade*’ [from 4 different interviews, interview numbers and types withheld]. Some Forums had not met for a long time, or did not function well.

“All the Licensing Forums in our area have been more or less dysfunctional...in practice we have not seen even one of them working closely with their licensing board.” [L806, Interview 12, Public Health]

“The Licensing Forum is a collection of very disparate people who aren’t used to working together and they are not very comfortable with the public health objective at all” [L244, Interview 7, Public Health]

The conflict within Forums sometimes meant that they were unable to have a meaningful impact on the actions of their Licensing Board because ‘*they couldn’t agree to speak with one voice*’ [L270, Interview 4, ADP].

Community consultation

The depth of public consultation by Licensing Boards on policy varied very widely. It was felt that some such consultations were tokenistic, for example ‘*just a couple of lines on the council’s website to say that the policy is up for renewal if anybody wants to respond on it*’ [L427, Interview 13, type withheld]. In other cases public health actors or Licensing Forums, sometimes at the request of the Licensing Board, led consultations which were reported to have been broader and/or more in-depth. There was a widespread perception that

despite the statutory requirement to consult, in reality there were ‘no standards on these things’ [L308, Interview 1, ADP].

Some interviewees were involved in, or aware of, work which aimed to support community groups leading action on licensing by helping them to become official consultees to the process (in which case they would routinely be informed of licence applications arising) or to raise objections to applications. Public health actors took the view that the opinions expressed by the general public through public health-led consultations were highly supportive of overprovision policies. This underpinned a consensus across interviews that ongoing and greater consultation with, and involvement of, the general public was important and could be a ‘game-changer’.

“Because Licensing Boards are [made up of] elected members, local residents have enormous power and that was a real turning point in our engagement with the Licensing Board– as soon as they realised we had the voices of local communities that had far greater impact.” [L68; Interview 4, ADP]

Discussion

Public health actors reported considerable challenges in engaging with the alcohol licensing system in Scotland. These included the disproportionate influence of key individuals (often antagonistic to public health involvement), inaccessible, intimidating practices and culture, little accountability or meaningful public involvement.

These findings reaffirm the conclusions of other analyses of public health action in local regulatory environments (29,30). In particular, they demonstrate the complex ways in which power operates in the licensing context. For example, while the primary legislation contains mechanisms for empowering local communities through consultations, the impact of such consultations is limited by their accessibility and visibility. This can both reduce the capacity of the general public to comment on licensing policy, but also exaggerate the level of support for, or opposition to, specific policies since respondent samples are highly skewed towards those motivated to seek out and engage with otherwise obscure consultation processes. The complexity and inaccessibility of the licensing process served to increase the power of both licensing officials and those who are professionally familiar with licensing law (24,28–33).

While a number of public health actors identified greater community engagement as key to re-orienting licensing towards public health goals, this is far from certain. Firstly, while participants in this study reported that community actors generally supported more restrictive policies, it cannot be assumed that this can be generalised, or that consultations conducted by other stakeholders (such as licensees/applicants) would not find the opposite. It seems likely that opposition to overprovision policies expressed by some elected Licensing Board members reflect at least an expectation of opposition in the wider community. The permissive underpinnings of British licensing – especially the requirement that, in the absence of formal challenges all applications will be approved – are based on the assumption that market viability is, by itself, evidence of sufficient community support – and, therefore, benefit (34–36). Such assumptions may be challenged by the better presentation of locally specific public health evidence (31); however, communities

may still decide that the costs of more restrictive policies outweigh the public health advantages. However, while the consequences of more widespread community engagement cannot be presumed, there remains a clear argument for it to be better facilitated, and for a move away from the use of *'standard, formulaic phrases... to affirm that consultation views have been taken into account'* where *'only in a minority of statements is it evident that stakeholder engagement has been meaningful'* (23)(p17).

While the licensing system is designed to allow for local variation and discretion in decision-making, the existence of objectives is intended to establish some degree of consistency. In practice, such consistency has been lacking both within and between licensing boards (23), and this study suggests that licensing board membership and leadership are key factors in shaping how the public health objective is used. All licensing board members are already required to complete one day of training and pass an exam within three months of being elected to a licensing board but that is apparently insufficient to ensure consistency of approach. The discretionary nature of licensing means that boards and officials have significant capacity to shape the delivery of national policy directives: sometimes extending their scope, but at other times causing them to remain unimplemented, or inconsistently applied (37), a recognised feature of local governance more generally (38). Licensing displays many features of 'street-level bureaucracy' (39), in which power rests with those responsible for the 'coalface' implementation of high-level policy directives.

Greater accountability may increase consistency to some degree: the Air Weapons and Licensing Act (Scotland) 2015 requires Boards to issue annual reports *"explaining how the Board has had regard to the licensing objectives, their licensing policy statement(s) including their duty to assess overprovision, decisions made and licences held in the Board's area"* (40). This provision will first have effect in the 2017/18 financial year. Participants in this study were mostly (though not universally) focused on preventing increases in outlet density and made little use of powers to set trading hours, an approach that has been found to be effective in reducing alcohol-related violent crime in several Australian cities (41–44). The Air Weapons and Licensing Act (Scotland) 2015 specifically allows licensing boards to consider licensed hours in making their assessments of overprovision, which should give licensing boards greater flexibility to manage hours of trade in areas with high levels of assaults or other alcohol-related harms. That may be an easier argument to make than that a licence should be declined.

Perhaps the critical constraint on the implementation of potentially restrictive policies is fear of litigation from applicants and associated costs to local authorities. Licensing decisions are made in the shadow, as it were, of the appeal court; in this context, power is vested not only in legal specialists, but those who can afford to employ them. These fears are exacerbated by lack of clarity on what constitutes overprovision of licensed premises and profound methodological difficulties in attributing population-level harms to individual premises (10,12). Greater accountability alone, without improving confidence in how the legislation may be interpreted by the courts, may put Licensing Boards in a difficult position (31). One approach could be for public health actors and local authorities to pool resources and expertise on strong cases that could establish a helpful legal precedent.

In entering the licensing process, public health is seeking to establish its voice in a quasi-judicial regulatory environment dominated by legal specialism, political authority, and the experiential, local knowledge of licensing officials. Finding a place in established networks of power that are resistant to change requires flexible thinking on all sides, and will take time (45). Where public health actors feel frustration at institutional blocks to their engagement, licensing officials express scepticism as to why population-oriented perspectives should be prioritised within a regulatory environment that, by tradition, deals with local, specific and proximate issues (22).

Strengths and limitations

This is the first study to focus on the perspective of public health actors seeking to implement the Scottish public health objective in alcohol licensing. Interviews were in-depth and the sample included representatives from almost all areas in Scotland where public health actors have been active on this issue. We did not place a time limit on interviews, seeking to ensure that narratives were complete for each individual interviewee, but did not assess the saturation of the whole dataset as no further interviewees experienced in this area of work were available. Respondent views, whilst grounded in extensive experience, clearly reflect the Scottish licensing context and may be more likely to converge towards support for population level interventions in alcohol policy: the ‘whole population approach’ adopted by the Scottish Government (46) and supported by Alcohol Focus Scotland. It is not possible to determine the veracity of participant reports or the extent to which they would differ from accounts of other public health actors in different countries, or those with less experience in the licensing system in Scotland. Nonetheless, the reports from participants in this study highlight issues relating to power, accountability and public involvement which can inform debates elsewhere and resonate with recent findings from elsewhere in the UK (47) and Australia (48).

Conclusions

Public health has faced significant challenges in the Scottish licensing context; however, some progress has been made in establishing public health as part of licensing policy and practice in some areas (24). One of the difficulties lies in the asymmetric power of regulatory officials, legal specialists, the local community and the various responsible authorities including public health. Recent legislative changes may go some way towards rebalancing that power (49), but may not go far enough, and could be limited by the capacity of local implementation to distort central directives (32,38). Understanding how and why local regulatory systems such as alcohol licensing establish and enforce distinctive relationships of power is important since it is, ultimately, through those systems that broad policy goals such as those expressed in Scotland’s national policy ‘Changing Scotland’s Relationship with Alcohol’ (46), make a difference on the ground. At the same time, however, public health actors need to carefully consider what their most productive, and cost-effective, role in local licensing is likely to be. As one contributor to a complex regulatory environment in which multiple stakeholders have an interest, public health will need to continue to develop an understanding of the licensing system and the priorities and values of licensing officials, politicians and the public. This ought to enable them to develop and make more effective use of evidence that can, over time, speak to and influence those priorities and values in this highly contested area of activity.

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Box 1: Structures & Actors in Alcohol Premises Licensing in Scotland. See also (50)

The Licensing Board: Membership of the licensing board consists of between 5 and 10 local 'councillors' (elected members of the local government – known as the 'local authority' or 'council') who are appointed to the board by the local authority for a term of 4-5 years.

The Convenor: The licensing board elects its own chairperson known as the 'convenor' who has the casting vote in decisions

The Licensing Clerk: A local council-employed lawyer who provides legal support to the licensing board.

Licensing standards officers (LSOs): practitioners employed by the local council to provide guidance to licensees (those holding a licence to sell alcohol), ensure compliance and mediate in disputes.

The Local Licensing Forum: Local licensing forums were established under the 2005 Act with the purpose of ensuring community stakeholders had an active voice in scrutinising the operation of licensing in their area. Each licensing board area should have a forum to give advice and make recommendations to the licensing board. Forums are made up of 5-21 members including at least one LSO, a representative from the health board, and commonly also licence holders; police; education, social work representatives; young people; local residents and members of the licensing board.

Table 1: Profile of Interviewees (n=13) in line with COREQ Guidelines (51)

Descriptor	Breakdown. NB: These are not indicated specifically for each interviewee as it could easily compromise anonymity.
Organisation/Type (all of these are collectively referred to as ‘Public Health Actors’ in this paper)	Alcohol and Drug Partnership ^a (6) National Health Service/Public Health (5) Key Informants (2): Alcohol Focus Scotland (AFS) (1); Recognised licensing expert (1)
Health Board areas in which interviewees had experience:	8 of 14 health board areas were covered.
Licensing Board areas in which interviewees had experience:	20 of 40 licensing boards were covered.
Licensing Board area policy status.	The extent to which the sample included licensing boards which had declared overprovision (OP) was analysed using AFS data on policies published by April 30 th 2014(23): <ul style="list-style-type: none"> • Widespread OP declared (4) • Limited OP declared (4) • No OP declared (5) • Policy not published (7) <p>The 20 licensing board areas <u>not</u> covered by the sample included 1 which declared limited OP and 1 which declared widespread OP.</p>
Relationship Established:	Prior to interview, 4 participants were well known, 2 less well-known and the others not known at all to the interviewer.
<p>^a ADPs are local strategic multi-agency partnerships responsible for taking forward action to address alcohol and drug misuse.</p>	

Table 2: Summary of Topic Guide

Top-level Questions from Topic Guide	
1.	How did you get involved with the issue of overprovision of licensed premises (in your area/organisation)?
2.	Who else was involved in the initiative? How were they involved?
3.	How did you build support/win 'hearts and minds' with different stakeholders?
4.	When and how were community members/the general public involved in the initiative?
5.	What data did you collect and why?
6.	How successful do you think your efforts have been? <ol style="list-style-type: none">What else can/should be done locally on this agenda?What would you do differently if starting this process?
7.	What else can be done nationally on this agenda?
8.	From all that you've mentioned, what would you pick out as the key lessons for others trying to take action on identifying and addressing overprovision in their area?

Table 3: Categories underpinning this paper, extracted from analysis framework.

Theme 3. Power, Autonomy, Bias	
3a Licensing board autonomy & accountability	<i>Independence and control of LBs. Mechanisms to hold LBs accountable for upholding the L Scotland Act or implementation of L objectives.</i>
3b Legalistic licensing system	<i>Formal and legal processes and requirements; Disempowerment of LB outsiders; Disempowerment of LB - fear of litigation.</i>
3c Conflicts of interest	<i>Ability of individuals and organisations to act independently & without bias - for PH actors & others. Types of bias - host organisation; personal interests...Issues about representation on forums are not included here, but in 6a, 6a, though COIs of individuals on forums would be included.</i>
3d Power and influence of individuals	<i>The influence of individuals on action & progress. Lack of continuity when personnel/LB membership changes.</i>
Theme 6. Public and Stakeholder Involvement	
6a Forum as Public Involvement mechanism	<i>Representativeness of members; Appointment of members.</i>
6b Functioning of forums	<i>Effective operation; Representation of stakeholder views to the LB: Conflicts within forums</i>
6c LB statutory consultation	<i>Breadth of formal consultation; Scope; Standards; Impact</i>
6d PH-led consultation/ research into public views	<i>Methods used; questions asked; groups and numbers involved; Impact</i>
6e PH-led public engagement/ empowerment	<i>Engagement; awareness raising; support; empowerment; Campaigning. Public power.</i>