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National objectives, local policymaking: public health efforts to translate national legislation into local policy in Scottish alcohol licensing

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Abstract:

Background

Policymaking environments are multi-centric by necessity and design. Alcohol premises licensing is governed by Scottish legislation, which also allows for local autonomy.

Aims and objectives

To describe the obstacles faced by local public health actors seeking to influence the alcohol premises licensing system in Scotland as an example of local advocacy efforts in multi-centric policymaking.

Methods

Snowball sampling identified and recruited twelve public health actors who were actively seeking to influence alcohol premises licensing, along with a national key informant. In-depth interviews (n=13) discussed challenges experienced and

perceptions of best strategies for success. Interviews (69m average) were audio-recorded, transcribed, and analysed using an inductive framework approach.

Findings

Most interviewees operated in local premises licensing arenas, influencing national legislation only through intermediaries. Challenges to engagement included: unfamiliar conventions, stakeholders and decision-making cultures, resources, data gaps, and licensing boards' prioritisation of economic growth. Their preferred solution was a strengthening of national legislation to constrain local autonomy, but they adapted their strategies to the challenges faced.

Discussion and conclusion

The adoption of a particular objective in national government (a public health objective for alcohol licensing) may not remove the need for effective local advocacy in a multi-centric system. Local policymakers have their own conventions, processes and views on evidence, and successful advocacy may involve diverse strategies and relationship building over time. Practitioners advocating policy change may benefit from a better understanding of prior research on how to bring about such change; scholars of such processes could better engage with this audience.

Keywords

Multi-centric policymaking; Multi-level governance; Alcohol premises licensing; Scottish policy

Word Count: 7,972

National objectives, local policymaking: public health efforts to translate national legislation into local policy in Scottish alcohol licensing.

Key Messages:

- A commitment to a policy outcome in national legislation does not guarantee success at local level.
- In multi-centric policymaking, advocacy is needed at different policy levels.
- The case of alcohol premises licensing illustrates how different policy centres have their own conventions and priorities.
- Public health actors described challenges in and bespoke strategies for engaging in their local licensing systems.

Background

There is no single centre of government to which advocates of evidence-informed policy change can appeal. Instead, policymaking systems are 'multicentric': containing multiple 'centres' or venues for authoritative choice, each with separate or shared responsibilities (Cairney, Heikkila and Wood, 2019). Policymaking environments are multi-centric: (1) by *necessity*, as systems are too complex to be controlled by a single central government, and policy outcomes emerge locally, despite attempts by policymakers at the centre to assert control; and (2) by *choice*, when central governments seek the benefits of power sharing across many levels and types of government (Cairney, Heikkila and Wood, 2019).

Some centres can be described as operating at different 'levels' of government, such as when supranational, national, devolved, and local governments produce or influence the policy instruments that contribute to an overall policy (Hooghe and Marks, 2003; Bache and Flinders, 2004). For example, before Brexit in the UK: energy policy responsibilities were spread across the EU (e.g. market and trade regulation), UK (e.g. mineral rights, taxation), Scotland (e.g. renewable energy promotion), and local governments (e.g. land use planning) (Cairney *et al.*,

2019); the UK's 'comprehensive' tobacco control policy contained instruments produced, influenced, or implemented by all four levels (Asare, Cairney and Studlar, 2009; Cairney, Studlar and Mamudu, 2012); and, gender mainstreaming policy was the responsibility of multiple organisations spread across each level (Cairney, St Denny and Kippin, 2020). Our case is one of alcohol policymaking: policy instruments to reduce population alcohol consumption were constrained by EU law (minimum unit pricing was deemed a permitted barrier to trade; whilst taxation by product strength is not allowed), UK (rates of tax or duty on products of different types), Scottish Government (e.g. premises licensing legislation), and local governments (e.g. local licensing policy and decisions).

Studies of multi-centric policymaking highlight a tendency for each centre to process policy instruments in relation to their own rules, networks, and policy frames (Matthews, 2013; Cairney, Heikkila and Wood, 2019). One centre may have the power to direct another but be reluctant to use it, another centre may supplement limited formal powers with high informal influence, and mutual co-operation is by no means guaranteed. A national central government may produce a policy for local governments to deliver, but its instructions may range from a legal obligation to comply, to an encouragement to make sense of policy in collaboration with local stakeholders. If so, terms such as 'implementation' or policy 'translation' do not sum up this process well, and *it makes sense to study the processes of each 'centre' or 'level' in their own right*.

Given this context, many actors (individuals and organisations) seek to influence different policy instruments in one or more centres, and face uncertainty: actors with privileged access in one may be peripheral in another, strategies may be effective in one and fail in others, and the same 'evidence base' may prove decisive in some and dismissed in others (Boswell, 2009; Mazey and Richardson, 2015; Cairney, Heikkila and Wood, 2019). This recognition of multi-centric policymaking prompts actors to consider whether and how to tailor evidence and advocacy strategies to different policymaking audiences or venues and policymakers at different levels of government may respond in different ways (Baumgartner and Jones, 2009).

Winning a policy argument at one level does not automatically mean winning overall, nor does it mean that the same evidence or strategy will necessarily work (or fail) at a different level (Weible *et al.*, 2012).

While all systems can be thought of as multi-centric by necessity, their design varies. Some central governments reassert central control, while others embrace power diffusion (Scheele, Little and Diderichsen, 2017; Hagen *et al.*, 2018; Ståhl, 2018). The self-styled 'Scottish Approach to Policymaking' describes a strong commitment to widespread consultation with stakeholders and to the autonomy of local public bodies to make sense of national policies and adapt them to local contexts (Elvidge, 2011; Housden, 2014; Cairney, Russell and St Denny, 2015). National governments may gather scientific evidence to inform policy but also encourage localism and wide stakeholder ownership. Consequently, some forms of public health evidence may win the day within the Scottish Government without an obligation for local public bodies to act accordingly.

In this paper, we describe the case of alcohol premises licensing in Scotland, as an example of the challenges of translating national policy progress into impact on local outcomes when policymaking is multi-centric (in this case, two levels of government decide how to grant licences to sell alcohol). 'Protecting and improving public health' was set as a statutory objective for alcohol premises licensing in 2005 (Scottish Parliament, 2005), as part of major reforms which followed the Nicholson review (Nicholson, 2003). The Nicholson committee was appointed in 2001 by the then Scottish Justice Minister to review all aspects of liquor licensing and practice in Scotland with 'particular reference to the implications for health and public order' and to recommend changes in the public interest. Nicholson's justification for the public health objective refers to earlier English licensing legislation that includes four other objectives (Parliament of the United Kingdom, 2003) (see below), and simply states "in our view [public health] is an objective which is just as important as any of the others, and we consider that it should feature in any Scottish legislation". Whilst established under the previous Labour-led government in Scotland, these legislative changes preceded a series of

high profile policy changes as part of a national alcohol strategy devised by the subsequent Scottish National Party administrations, which took a 'whole population', public health-focused approach to reducing alcohol-related harm (Scottish Government, 2010). The legislative framework for alcohol licensing is therefore set nationally, but decisions on which premises may sell alcohol are made locally by independent 'Licensing Boards' made up of locally elected politicians, who struggled to grasp the intended meaning and operation of the new objective (MacGregor *et al.*, 2013). These Licensing Boards are required by law to consult on and produce regular statements of local licensing policy outlining how they will exercise of their functions under Licensing (Scotland) 2005 Act and ensure that the policy stated in the statement seeks to promote the licensing objectives. The national policy arena, in which the legislation was reformed and passed, includes overarching objectives to constrain local decisions, but also acknowledges local autonomy in requiring each area to develop its own local policy on licensing matters. Alcohol premises licensing is therefore one key aspect of a wider process of multi-centric policymaking, and forms an ideal case for this paper to illustrate some of the challenges outlined above of achieving effective policy progress.

In Scotland, as in many jurisdictions worldwide, premises may only sell alcohol if they have a permit or licence issued by the local Licensing Board. The Licensing (Scotland) Act (2005) introduced reforms to ensure that licence applications could only be refused if a) a representation is made against the application by a 'statutory consultee' or other party and b) that successfully shows the application is likely to undermine one or more of five statutory 'licensing objectives'. These objectives are focused on preventing crime, disorder and public nuisance, securing public safety, protecting children and young people from harm and protecting and improving public health (Scottish Parliament, 2005). Under the system established, 'statutory consultees' (including the local health board) are informed of licence applications and can formally object to the granting of a licence. including an assessment of whether or not there are geographic areas within the Board's jurisdiction which are deemed to be 'overprovided' with premises.

The explicit inclusion of public health improvement as a decision criterion in premises 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 (Davoren and O'Brien, 2014; Fitzgerald, Winterbottom and Nicholls, 2018). Other systems, such as state monopolies for off-licence sale of alcohol, also have a health remit (Stockwell *et al.*, 2018). Following the change in national legislation, and drawing on international evidence of a link between the availability of alcohol and a variety of public health harms (Campbell *et al.*, 2009; Popova *et al.*, 2009), local public health representatives turned their attention to the licensing system. Based in diverse parts of the NHS or related bodies but acting on behalf of the Director of Public Health as the statutory consultee, these 'public health actors' saw the new objective as synonymous with a goal of 'reducing population-level alcohol consumption' and sought to influence decisions locally to reduce, or at least avoid any increase in, the availability of alcohol (Mahon and Nicholls, 2014; Fitzgerald *et al.*, 2017).

Experience of local policymaking tend to be relatively under-discussed in evidence/policy papers. In this paper we present new data from interviews with public health actors about their mixed experiences of engagement with local Licensing Boards as they sought to translate the national public health objective into local progress on reducing alcohol-related harms, as intended by Nicholson (Nicholson, 2003). We describe and discuss the obstacles they faced and the solutions they developed in seeking to make progress towards public health goals.

Methods

As part of a study seeking to generate learning for public health actors on how to engage with alcohol licensing, we conducted in-depth semi-structured interviews with public health stakeholders with relevant experience.

Sample

We sought to interview 'public health actors' who had recent and in-depth experience of trying to influence local licensing policy and decisions to fulfil the public health objective set in law, acting on behalf of the local health board's Director of Public Health, who is the formal 'statutory consultee' within the licensing system. There is typically one such actor in each of the fourteen Scottish health board areas, based either in the National Health Service or in local strategic and commissioning partnerships known as 'Alcohol and Drug Partnerships' which include NHS and broad public sector representation. In some areas, responsibility for this role is devolved further e.g. to cover a specific local licensing board area where that was a smaller jurisdiction than the health board. These actors typically saw the new public health objective as "synonymous with reducing alcohol consumption" "across all groups" by addressing the availability of alcohol more generally rather than considering the impact of individual premises (Fitzgerald *et al.*, 2017). Potential interviewees were identified by reviewing publicly available information describing prior local efforts to protect public health through licensing in Scotland; and via snowball sampling, starting with one key informant at Alcohol Focus Scotland (AFS), a national charity which had provided extensive support to local health representatives on this issue. We sought to identify all potential interviewees who might meet the criteria above, and developed a list of thirteen individuals. This included one person with a local authority licensing role (not based in the NHS) recognised for long-standing and innovative relevant work. Of the thirteen, one individual declined to participate, indicating that she was not actually actively involved in licensing. All others who were approached agreed to be interviewed; no further participants were sought. We conducted a thirteenth interview with the key informant at AFS who had a role in supporting local public health and licensing actors to act to reduce alcohol-related harms, as well as a national advocacy remit. Table 1 provides the profile of interviewees in aggregate to protect the identity and reduce risk of deductive disclosure.

<Insert Table 1 here>

Recruitment

Interviewees were sent a study information sheet, interview topics (Table 2), and consent form in advance by email and followed up by telephone. Full informed consent was audio recorded with permission.

<Insert Table 2 here>

Data collection

Semi-structured interviews (averaging 69 minutes in duration) were conducted by NF between February and May 2014. This was after Licensing Boards were expected to have published their latest statements of licensing policy in November 2013, when public health actors are typically more active in this arena. Interviews were conducted mainly by telephone which can facilitate participation by professionals in busy roles and is not known to be inferior to face to face (Novick, 2008). Interviewees were also given the option of being interviewed face to face: one chose to do so. During interviews, participants were encouraged to speak freely about their experiences: questions were not asked verbatim of each participant; the topic guide was used as a prompt. All interviews were audio-recorded: six were transcribed from the recordings after the interview; the other seven were simultaneously transcribed during the interviews. In both cases, the recordings were used afterwards to correct the transcripts. As a further check, all transcripts were subsequently sent to interviewees to check for accuracy at which point they also had the opportunity to elaborate or clarify any points as they saw fit.

Analysis

Notes and recordings were reviewed throughout the data collection period and full analysis was conducted afterwards using a framework approach as described by Gale et al. (Gale *et al.*, 2013). NF and a colleague independently coded two interviews manually, then met to discuss codes and broader themes arising and 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. NF and PC discussed the dataset together several times to understand and develop the themes and data under the broad headings of challenges and learning points in line with the focus of this paper.

Ethics

Ethical approval was granted by the Ethics Committee of the School of Management at the University of Stirling. When reviewing the interview transcripts for accuracy, interviewees were also 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.

Findings

Interviewees spoke freely and in detail, identifying several challenges in engaging with the licensing system with a motive of improving public health, which we describe first, followed by their advice to others seeking to do the same. Before this, we outline the role of the key informant who described the intersection between national and local advocacy on this topic. The Scottish national charity for which this key informant worked produced a report in 2012 called "Rethinking Alcohol Licensing" (MacNaughton and Gillan, 2011) which was disseminated widely, and followed this with a series of regional events. The purpose of these events, which were funded by a UK alcohol charity was:

> *"to test out the recommendations that were made [in the 2012 report] with local licensing stakeholders [including] public health representatives… what came out of the regional events was a kind of recognition that there was further guidance and support needed for both public health and licensing regulators to put what was being recommended in the report into practice".* [Key Informant, 35-53]

Our key informant goes on to describe how eight recommendations on national licensing policy from the 2012 report were included in a Scottish Government consultation (Scottish Government, 2012), and were focused on amending licensing legislation and guidance to provide "more clarity". The charity subsequently produced guidance for local areas on how they might respond to this national consultation(Alcohol Focus Scotland, 2013). At the time of interviews, new legislation was planned to reform alcohol licensing, but it was not yet known to our informant what the government were planning to include in the legislation following the consultation.

Challenges for Public Health Actors in Engaging with Alcohol Premises Licensing

Firstly, many public health actors described a learning curve as they sought to understand the local licensing system and devise ways to influence it. Some had had no previous involvement.

> *"This [licensing issue] was suddenly presented and discussed at a Directors of Public Health meeting in Scotland, and [my boss] suddenly became aware 'oh gosh, we're going to be expected to pick up some work about licensing'. We didn't currently have anything happening on that so he asked me if I would get involved…I was really unfamiliar with this. I hadn't done any particular work around alcohol in any shape or form, and certainly nothing around licensing, knew very little about it."* [Interview 12, 55-65]

Second, as public health actors engaged with this work, they became familiar with the conventions and culture of the licensing system, which were very different to what they were used to in terms of formality and the status afforded to them as public health professionals.

> *"Your voice is very small in the [Licensing] Board meeting. You are absolutely, they are on the big seats at the front and you're on a little pokey stool in the corner and you can be invited to speak but if you're not, you don't, it's not equal at all. That's the*

words. There's no equity within a Board meeting. The board members are all referred to as 'Your Honour' and then in some of them, for example within [one area], the Board members and the councillors all sit in an anteroom until the meeting is due to start and then the Clerk [lawyer to the Licensing Board] will walk in the door and she'll say 'all rise' and we all have to stand up and then the Board members all sat down, all puffy with their arrogance and then once they've sat down we are all allowed to sit down. There is nothing in the law that says that's how you're supposed to conduct a Board meeting." [Interview 10, 981-991]

Third, the local stakes seemed higher and reduced the sense of initial optimism associated with national legislation amongst these public health actors. The legal nature of the process was intimidating, and Licensing Board decisions were made under the threat of costly litigation from large businesses if their licence application was refused. Public health actors felt that the national legislation was insufficiently clear or robust to give Boards confidence that such challenges would fail, and that the local authority would not be faced with a large bill for legal costs.

"Fear of litigation is certainly an issue for Licensing Boards – we've said it many times that some support from Scottish Government would be useful, they say it is a local issue that needs to be solved locally." [Interview 4, 149-152]

"The Government could come out with a much stronger position on what do they mean by overprovision. It's left up to interpretation far too much." [Interview 10, 113]

Fourth, effective local participation proved resource intensive. Public health actors focused on collating evidence and making representations on individual applications, both were time-consuming activities that put pressure on local public health capacity.

"*I mean we're only a small [health] board. For me alcohol probably amounted to 10-20% of my workload for part of that intensive time…I've got a whole lot of other things*

that are needing to be taken forward, nothing to do with alcohol." [Interview 12, 865-887]

Fifth, extensive data were available to generate a detailed national picture, but local data were patchy and challenging to turn into an effective local narrative. The data typically included statistics on deaths, hospital admissions, crimes, domestic abuse, arrests and in some cases on children in care, noise, fires and other issues. It was often difficult to pinpoint the data to smaller geographic areas to make the case that specific areas were overprovided or to successfully object to the granting of an individual premises licence. As one participant put it "*all the datasets are slightly not quite what we needed";* there was a lack of data on alcohol sales, or shelf space within off-licences and it was very difficult to map where people buy their alcohol from. Nothing within the legislation obliged licensees to report the volume of alcohol they were selling, a situation seen as '*ludicrous'* by one interviewee.

"*You can't really measure overprovision by number of premises. You can have Tesco and a small corner shop and they're both one premises. So that doesn't actually tell you that much, it depends on how much alcohol they can hold and how quickly they can replenish stocks on shelves etc. We don't have that information and shops don't have to give that. The Scottish Government can help with that, to force shops to give us this information on capacity and supply."* [Interview 4, 164-168]

Some described how different parts of that evidence were more influential:

"[the Licensing Board] *were happy to use alcohol-related crime data if it came from the police, but completely disregarded any of the health statistics"* [Interview 9, 101-132].

Sixth, academic actors saw their influence diminish in local licensing arenas; the evidence almost taken for granted in their professional circles were often not respected. Participants noted that some Boards were not influenced by academic evidence, and were sceptical about the transferability of international evidence:

"I've discovered that that kind of response, appealing to authority or academic authority, is not particularly useful…I mean to give you an illustration, [one team] found themselves having to explain how academic research works in terms of…although the research was done in a particular area, so it's done properly, the findings should be relevant and applicable to a different area." [Interview 11, 310-318]

"*I think some of the reactions I've had have been very stark in that they just point-blankly don't believe that there's any connection between the amount of alcohol outlets leading to over-consumption and health harm. And they just don't believe that, they just don't believe it!...*[One board] *said that they didn't see any value in comparing Scotland to another European country because they felt there were other factors, cultural factors that contribute to a society that drinks."* [Interview 10, L 342-345; 363-365]

Seventh, public health evidence often struggled to compete with other influences and sources upon which Licensing Board members drew, including trade press, personal opinion and economic evidence. Licensing Board members were influenced by licence applicants who argued that their premises would bring jobs to an area. Many public health actors pointed out that economic regeneration or job creation was not an objective of alcohol licensing, but economic arguments continued to influence decisions notwithstanding the legislation.

"[The Chair of the Licensing Board's] *view was that he felt the trade were getting a really rough time and kept quoting articles from the trade magazine and bringing…what he thought was evidence that wasn't really evidence."* [Interview number withheld; 198-203]

"The guidance document makes it very clear that they're not entitled to incorporate those [economic] *considerations and that there isn't a sixth* [licensing] *objective of economic viability."* [Interview 11, 516]

Finally, participants reported that many 'Local Licensing Forums' - bodies established by the national legislation to facilitate stakeholder involvement in the licensing process, including the licensed trade, police, health, young people and local communities – were often dysfunctional. Forums were often described as having '*very heavy trade representation…dominated to a large degree by trade'* which made agreement challenging.

> *"Licensees have a totally different agenda from us…The forum was not sure if what was being proposed was a good thing or not in the end. We couldn't get a letter of response on behalf of the licensing forum to the board because they couldn't agree to speak with one voice."* [Interview 4, 270-272].

> *"What you find with licensing forums is that that combination of having all of those partners around the table at the same time leads to really difficult kind of meetings and sometimes not a lot of action because there are such competing priorities that it's very difficult to find any middle ground."* [Interview 2, 243-245].

Participants expressed a desire for more national guidance in this area.

> *"I don't think there's a huge amount of guidance actually as to what forums are there to do. Also how much the Board actually respect the Forum…its not clear around actually what the role of the Forum is and the interface between the Board and the Forum…"* [Interview 13, 900-910]

Overall, we get a sense from participants that the local arena had its own rules of policymaking regarding the use and interpretation of evidence and engagement with public health and industry actors. While the Scottish Government may have sought to address alcohol-related harms by prioritising public health evidence and at times challenging industry interests, local Licensing Boards drew on their own sources of knowledge and sometimes focused on local economic outcomes and evidence even though this wasn't referenced in the national legislation.

Learning from challenges: advice for other public health actors

In addressing these challenges, the preferred solution of these public health actors was to reduce the ability of local policymakers or the courts to interpret the intentions and limits of national policy, through more or 'better' national guidance or by clarification of key concepts such as 'overprovision'. With the exception of the Key Informant, none of our participants had a national remit however, and so did not seek to influence the national legislation directly. Instead, they adapted their strategies in response to the challenges faced, and some felt that they were building the groundwork and relationships for future success. They spoke freely about what they would advise other public health actors who shared their goal of reducing alcohol harms through local alcohol premises licensing.

Firstly, they recommended forming coalitions with important allies with shared beliefs from whom they could learn. Participants relied on guidance from national organisations, in particular Alcohol Focus Scotland, and drew on the work of others seen as '*pioneers*' in the field in Scotland. Multi-agency working groups, usually including representation from the police and health and/or through local strategic partnerships (Alcohol & Drug Partnerships, 'ADPs') and various combinations of other stakeholders (fire/ambulance/emergency/ environmental/social services and third sector agencies). Some also involved licensees, members of the Licensing Board or forum, or other local authority licensing staff. Having a broad range of stakeholders on the working group was felt to be the *'ideal picture'* by one participant [Interview 2, 165], and participants generally agreed that there was a need to work together to make progress.

> "*I think getting together that multiagency group was felt to be really useful by most of us and I certainly felt that's a really positive way the agencies are all coming together and we're sort of sharing information, talking about things and that can only help."* [Interview 12, 1004-1005].

In one area, a public health actor described how she worked closely with a colleague in the police:

> "'*John' and I really clicked and he's been doing licensing work for a long time and he is really geeky about it. So he really knows his stuff, he knows his law, he knows how to, he's got a very good grasp of how the board meetings work. So when I started attending board meetings and trying to get an understanding of them he was really helpful, to the point where you could ask him, I could have asked him anything. Nothing was a stupid question to him…He was really keen for me to learn as much as I could because he'd felt isolated going to the Board meetings on his own and [an] NHS [representative] had never been there so he would go with his objections…and he'd just be on his own."* [Interview 10, 634-647]

Second, they advised that public health actors work with key insiders to understand how local policymakers think and act. They developed relationships with experienced colleagues within the licensing system including local authority licensing lawyers (known as 'clerks') and licensing standards officers (who were responsible for supporting licenses and monitoring compliance with the legislation by premises).

> *"We got the [a licensing clerk] at the council involved at the start to support us in identifying what information would be useful for the Board and identifying data zones. Because she has a lot of influence over the Licensing Board and they lo her for advice and guidance so we wanted to bring her along with us from the start."* [Interview 3, 37-41]

Participants had positive and negative experiences of working with licensing clerks, depending on the individual and the view taken by the Licensing Board supported by that clerk. One participant noted that "*the health world and the licensing solicitor world are very different. It was a matter of understanding each other's world*." [Interview 8, 38-39]

Third, participants described the need to seek informal venues to engage with policymakers. All participants described various efforts to work with the Licensing Board members (local elected politicians known as 'councillors') but there were few opportunities to do so other than through formal mechanisms and reports at meetings. Some spoke about the value of informal mechanisms of influence such as '*quiet conversations that happen in the corridor*' [Interview 1, 148] or the influence that councillors sitting on the ADP might have on other councillor colleagues in the Licensing Board.

Fourth, participants emphasised a focus on long term relationships and generally avoiding short-term confrontation. Most participants were clear that their efforts needed to be focused on building relationships with the Licensing Board over time, by continually engaging and being present at meetings.

> *"You need to show a willingness to engage with the Licensing Board before they will start taking you seriously. I would say try and listen to what their concerns are and what areas they would be interested in doing something about. Because it at least provides a bridge to facilitate the beginning and it will be the beginning. It will allow you to start work and don't expect that if you've done a lot of work drawing up evidence for overprovision that the Licensing Board will accept it from you if they don't even know who you are, because they won't."* [Interview 9, 769-775]

Most also felt (sometimes after trial and error) that they should not take a combative approach to working with Licensing Boards, and that a supportive approach might be more likely to be effective, though some remained unsure of where the 'balance' should lie.

> *"The Licensing Board members at the end of the day are local politicians. So you need to apply the same approach to any other issue if you were wanting something change in your area and you wanted your local politician to do something about it, I guess there is a bit of lobbying involved in that."* [Interview 2, 325-328]

"Sometimes we've got the balance wrong and we've got some backlash that people felt that "the health lobby had taken over" and we'd occasionally have to backtrack a wee bit to try and get the balance a wee bit better" [Interview 11, 49-51]. "*There's one aspect of me that says I just need to be much more patient, see this as the long game, a drip drip effect, sort of chug along over time and hopefully over time we'll change views…But then there's another argument in my mind that says absolutely not, you made huge strides in progress over the last two years or so on this agenda and you just need to be resolute and continue to be as determined as you have been. Don't give in. so there's a balance to be struck and I'm not too sure if I've got that balance right."* [Interview 11, 774-786]

Fifth, participants emphasised that public health actors should build their reputation by establishing how their evidence could be a crucial resource for policymakers and could build their awareness. Whilst data alone would not convince a Licensing Board to turn down a licence application, it was seen as a prerequisite to overcoming litigation or the fear of litigation.

"Its not enough from a licensing perspective that something is a good idea, something that seems a no-brainer with regards to health improvements. You have to be able to demonstrate to a Sheriff [local judge] why you've refused [a licence application] *and that the reason for refusal falls clearly within the [Licensing] Act."* [Interview 8, 124-128]

Licensing Board members did not necessarily 'buy into' their role in relation to the licensing objective of 'protecting and improving public health' and participants described a need to build their recognition of alcohol problems.

"It's important to win the hearts and minds of the Licensing Board and forum- many older members of Licensing Boards are used to the pre-2009 approach that licensing is about dealing with applications. Some might feel it's about protecting the licensed

trade particularly pubs. They are not totally au fait with health impact across Scotland of the sale of alcohol. They're not au fait with the sheer volumes being drunk compared with the old days. [There are] *Licensing Board members who get data – they think it's a significant problem we have to do something; or they take the view there's nothing we can do which will greatly make a difference; or they take the view that we don't have a problem in our area. In* [the area] *where I am now, the Licensing Board is a mix of all those types of members."* [Interview 8, 155-164]

Sixth, public health actors learned that they needed to develop simple and effective ways to present complex data. Participants focused on presenting data in a way that was clear and digestible: not '*a big alcohol needs assessment because nobody wants to read that*', but short, reader-friendly, reports with clear implications or recommendations for action. It was not always predictable what data or arguments would be most influential. In one area where they felt they had had 'wins', the public health actor concluded that "*it hasn't necessarily been because they've grasped the concept of health harm and the 'whole population approach' but it's been because they can see that cirrhosis of the liver is higher than everywhere else and it's been just that little, just that one nugget that they've hooked onto, and that's changed their mind or influenced their thinking."* [Interview 10, 347-350]

Seventh, participants recommended recognising that the evidence to win the day may not be the evidence most favoured by public health and that actors should draw on multiple forms of evidence to frame debates and win arguments. Whilst international academic evidence appeared to hold little sway, many participants emphasised the importance of local evidence, including the views and experiences of the local community.

"I think [evidence from consultation with local people] added strength to the [statistical] evidence that we had provided. It was not just the hard evidence that was saying it, it was the people living in the communities that were actually concerned about the adverse effects that alcohol was having within their own individual communities and

the difference they thought reducing the number of alcohol outlets would make to their areas. Again it just reiterated and gave a stronger argument in terms of those councillors that are sitting on the Licensing Board, it brought a degree of realism in terms of them being able to equate the views of their electorate in terms of what they felt licensing and overprovision meant to them." [Interview 6, 215-223].

In particular, participants discussed a range of responses to arguments about economic benefits. Some made a strong case that *"[alcohol] must be having a huge impact on the area as a whole, on the chances of economic development, keeping people in jobs, training them up, making the place an attractive area to come to"* and reported that once *"the Board had the data, it was one of those 'we have to do something' moments".*

Some public health actors had success in getting the Licensing Board to declare that an area was overprovided for off-licence premises (those selling alcohol for consumption off the premises), or in one case, off-sales premises above a certain size. These were seen as ways to protect economic activity in some sectors, whilst discouraging larger supermarkets which were seen as driving a lot of alcohol-related harm. Sometimes they chose not to object to licence applications for restaurants too, and occasionally their arguments were supported by existing businesses who saw the measures as protective of their own businesses.

"We took the heat off small businesses and on-sales and we were targeting off-sales... it was clear that if you look at where people are buying alcohol the most it is supermarkets. It is staggering the monopoly that supermarkets have on the market while … small village pubs aren't able to survive." [Interview 7, 274-281]

"These are all on-sales people and they've bought into this argument bigtime, absolutely no question whatsoever. They're active supports both from a hotels, pubs, clubs and social clubs and all the rest of it. They identify with the arguments I've been making and that's been really good." [*Interview* 11, 428-431]

Eighth, participants noted that these processes are lengthy. There is not one moment of authoritative choice in which evidence may win the day. Rather, there is a series of meetings or discussions in which evidence and argumentation are part of a continuous process of debate. Whilst there were some sustained successes, others described progress that had been rolled back following a change in Licensing Board membership or chair. Most participants emphasised the need to take a long-term approach to engaging with the licensing system, to build effective working relationships and influence with Licensing Board members and officials slowly over time. It is about more than statistics or 'rationality'.

> *"After the local elections, about four out of the 8/9 board members stayed the same. The new convenor sits on the planning forum and the economic development forum and has a particular perspective on the role of alcohol in the city which has links to the economic development of the city rather than public health issues. The climate changed completely with the new convenor." [Interview 1, 90-94]*

> *"One of the big learning curve issues for me was that however smart you think you are with these sorts of things, … the nature of this agenda is it's just not sufficient and appropriate just to expect that because you rattle off a heap of statistics and all the rest of it….My original ideas were that folk are reasonable, they're logical, they're rational, let's take a rational approach. But it's not. I mean obviously that's important but there's a hearts and minds element of it and part of that is about the passage of time."* [Interview 11, 57-70]

Discussion and conclusion

Policy theories help us to identify general aspects of the politics of policymaking, shedding light on the (often limited) role of evidence in policy decisions, and how values, processes and conventions underpinning the policy process differ across different levels or centres of policymaking. Case studies add depth to such discussions, showing us exactly the kinds of problems that evidence advocates face in multi-centric systems, and the strategies that seem to work most effectively. In our case study, public health actors new to alcohol premises licensing described a steep learning curve to understand local policymaking, identifying an unfamiliar (often legalistic) policymaking culture, high uncertainty about how to succeed, the need to devote considerable resources to stand any chance of being influential, the difficulties in translating a wide range of (often patchy) data into an effective local narrative, and the struggle to compete with economic actors (often committed to the framing of alcohol in terms of the 'night time economy' (Nicholls, 2015)).

Our findings reflect and reinforce the key tenets described by studies of multi-centric policymaking (Cairney, 2016; Cairney, Heikkila and Wood, 2019). First, the spread of responsibilities for a given issue emerges from necessity, in that no single central government can process and act on all the relevant issues and information. National governments delegate attention and responsibility to local bodies, and each of these in turn develops its own rules, networks, and ways to understand policy problems. Secondly, multi-centre policymaking arises by design. For example, many central governments accept a degree of autonomy among local governments, setting national direction but encouraging (or tolerating) local variation, recognising: more than one electoral mandate; the importance of partnerships between local public bodies and stakeholders; and the benefits of tailoring policy to local communities.

Over the last century, there have been several nationally-led reforms to the system permitting premises to sell alcohol, including various controls on opening hours and days of sale, but

decision-making on individual licence applications has remained almost entirely at local level (Nicholls, 2012). Licensing Boards often process hundreds of applications annually, and local knowledge is seen (by law and by practice) as central to effective policy and decision-making, giving rise to diversity in local approaches (Scottish Parliament, 2015; Fitzgerald, Winterbottom and Nicholls, 2018; Alcohol Focus Scotland, 2020). This diversity has been perceived by some public health actors as 'inconsistency' in application of national licensing laws(Fitzgerald, Winterbottom and Nicholls, 2018), giving rise to calls for greater constraint on local bodies through greater accountability (Wright, 2019). During COVID-19, national policymakers took greater control over licensing decisions in England, for example, permitting licensed premises forced to close during the lockdown to sell takeaway alcohol, without consultation and experienced as '*pulling the rug out from under*", i.e. undermining, local licensing stakeholders (Fitzgerald *et al.*, 2021). In our findings, local policy was not always felt to have been driven by policymaker judgement on what's best for an area, but by constraints (real or perceived) in the power awarded to them under national legislation and potential litigation by economic actors. Whilst the national legislation applies a public health objective, public health impact in the system remains limited, it is not possible to actually reduce alcohol availability, even in 'overprovided' areas, but only to prevent expansions in availability through further licences being granted. This echoes Martineau's discussion of '*responsibility without legal authority'* (Martineau *et al.*, 2014), highlighting tension that can exist in multi-centric policymaking. National legislation ascribes autonomy, but in practice may establish legal constraints to exercising it.

In a multi-centric system, success on a given policy issue requires successful advocacy in each policy centre. Actors need to adapt to their policymaking context, employing effective strategies such as: learning which are the key venues for policy choice; forming coalitions; and engaging for the long term to identify the 'rules of the game' in each venue (Harris *et al.*, 2018; Townsend *et al.*, 2020). Policy choice is continuous, so successful influence of national central government does not preclude the need to be influential in subnational

government. Sometimes advocates may need to use strategies tailored to each centre, or separate groups of advocates may need to win their argument in each centre. In this case, local public health actors were not involved in licensing law changes at national level, and found themselves having to convince a whole new group of policymakers of evidence on links between alcohol availability and harms, and the relevance of such evidence to local licensing policy and decisions. Some viewed local policymaking venues as dysfunctional and lacking the evidence-based culture to which they were accustomed. Their calls for greater accountability were, however, communicated through national bodies which operated to support local actors as well as advocating on the national stage (MacNaughton and Gillan, 2011; Alcohol Focus Scotland, 2014; Mahon and Nicholls, 2014). Thus whilst public health actors were not directly active nationally, they were involved in discussions and consultations supported by others who were, as described by our key informant. Importantly, these national bodies involved local actors in responding to national processes (Alcohol Focus Scotland, 2013), including a government consultation(Scottish Government, 2012). This combination of local intelligence, and national advocacy subsequently led to more central control through new requirements including a statutory duty on Licensing Boards to publish an Annual Functions report within three months of the end of each financial year (Scottish Parliament, 2015). This report must contain a statement explaining how the Licensing Board has had regard to the licensing objectives, their licensing policy, a summary of the decisions made, and information about the number of licences held under the Act in the Licensing Board's area. Other changes were thought to increase local control rather than decrease it, such as amendments to the factors which a Licensing Board may take into account in assessing whether an area is 'overprovided' with premises. This assessment may now take into account not just the number and capacity of licensed premises in a locality, but also their licensed hours and "such other matters as the licensing board thinks fit" (Scottish Parliament, 2015). This increase in local control was perceived as helpful to public health, by increasing the legal authority of licensing boards to set local policy against additional premises in certain areas (Cummins, 2016).

Strengths and limitations

We report on in-depth data from on the perspective of public health practitioners in the licensing system, to illustrate some of the tenets and tensions of that system as an example of multi-centric policymaking in which many centres act independently to produce policy instruments that contribute to a wider aim. Our data highlight some of the challenges and learning that emerged as national licensing policy was interpreted and adapted locally. Interviews were detailed, involving experienced representatives from almost all areas in Scotland where public health actors had been actively engaging with the licensing process. It is possible that there were other public health actors eligible to take part but who were not identified through our snowball sampling and key informant. While there is no reason to doubt the veracity of interviewee reports, the involvement of our key informant may mean sampling was partially biased towards participants who supported a whole population approach to alcohol policy, as advocated by AFS. Further, our descriptions of national action rely on data from just one key informant, but are supported by citation of the relevant documentary evidence in their reports. Our findings necessarily reflect the Scottish licensing context, but highlight features and challenges in local premises licensing and multi-centric policymaking which are likely to apply elsewhere. Further work is needed to understand whether the more recent reforms to licensing legislation have affected public health practices or success.

In the absence of further reforms, public health actors described the strategies that they felt were most likely to be effective for them locally: forming coalitions with important allies in areas such as policing; working with key bureaucrats to further understand local rules; seeking informal ways to influence policymakers outside of formalistic and legalistic processes; building relationships by gaining reputations for reliability and non-confrontation; developing simple and effective ways to frame complex data; using data, such as local opinion, that might be low on an evidence-based medicine hierarchy of evidence; and, engaging for the long term

rather than expecting a direct and immediate relationship between evidence and impact. These strategies are not new, and could be predicted given prior knowledge from studies and theories of policymaking (Weible *et al.*, 2012; Cairney, 2016). Public health actors in this study were generally unaware of such insights and developed strategies more by trial and error. A sense of naiveté that comes across in their descriptions: they were surprised that the evidence they took for granted was not valued or influential in the licensing meetings; that they were not treated with the same respect/status; and that licensing board's priorities were not an exact match with the objectives set for the licensing system in the legislation. They did adapt to this over time, deploying their influencing skills, but there is often a sense that a lot of time was lost in some cases, not only in taking strategies that were ineffective, but also in repairing their reputation within the system as credible actors. There is an irony here: those advocating to local policy-makers for evidence-informed approaches, did not use evidence on how best to do so, suggesting that scholars of evidence and policy processes are not reaching an audience who could benefit from their scholarship.

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