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Public Health and Alcohol Licensing in the UK Challenges, Opportunities, and Implications for Policy and Practice

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Abstract

This article discusses the role of public health in alcohol licensing in the UK, with a particular focus on the implementation of national legislation and guidance in local regulatory environments. It identifies a number of practical and theoretical challenges through an analysis of historical trends in licensing practice, recent policy developments, and key licensing decisions and appeals. There are strong historical precedents for a focus on strategic harm reduction in UK licensing; however, because licensing primarily addresses the proximate effects of retail, the incorporation of health considerations presents novel difficulties. These center on the identification and deployment of data, the attribution of population-level harms to individual outlets, alcohol industry resistance, local authority risk aversion, and epistemological tensions between public health and licensing. The conclusion proposes that for public health perspectives to gain traction in the licensing environment, clear and realistic goals need to be established, research needs to emphasize local data, and there needs to be a better understanding of the approaches to evidence, knowledge and decision-making that characterize licensing and other local regulatory services.

Introduction

In the mid-2000s, the alcohol licensing system in the UK underwent a major overhaul. In England and Wales, the 2003 Licensing Act (implemented in 2005) moved responsibility for decision making from local magistrates to local councils, removed statutory restrictions on opening hours, and introduced “licensing objectives” and “responsible authorities” as key elements of the licensing system. Under the 2003 Act, licensing committees are directed to accept applications automatically unless a representation is submitted by a “responsible authority” such as local police, trading standards, fire and rescue or children’s services. Representations have to show that the proposed license threatens to undermine one of the following four licensing objectives: the prevention of crime and disorder, the protection of children from harm, the protection of public safety, and the prevention of public nuisance. If a representation is made, then “the licensing authority’s discretion will be engaged” in deciding whether to grant or impose conditions on the license, meaning, importantly, that the discretion of licensing authorities is explicitly conferred by legislation and sits at the heart of licensing practice (Home Office, 2013). The Licensing (Scotland) Act 2005 (implemented in 2009) established a similar system, however, it included “protecting and improving public health” as a fifth licensing objective and made public health boards responsible authorities. In 2011, in England and Wales, local public health teams were added to the list of responsible authorities and so were empowered to make representations on license applications. However, this was without the concomitant introduction of a public health objective.

This article considers the challenges faced by public health bodies in operationalizing their new role within alcohol licensing. Key national policy documents were accessed via Home Office, Department of Health, and Scottish Government websites; local council proceedings and licensing policy documents were accessed via local authority websites; and further unpublished documents were accessed via the author’s role as co-chair of a national network on licensing and public health coordinated by Public Health England. The challenges identified are both practical and conceptual. They reflect the state of current evidence regarding alcohol availability and harm at local levels, the quasi-judicial nature of the licensing system, the dynamics of “multilevel governance,” and, finally, an epistemological tension between the perspectives adopted by licensing practitioners and those adopted by public health professionals. These tensions have concrete implications for both the development and the implementation of alcohol licensing policies, and while the examples provided are specific to the

UK, the challenges identified have relevance for other jurisdictions in which comparable licensing systems exist.

Public Health and Alcohol Licensing in Historical Perspective

In their 1903 history of British licensing, Sidney and Beatrice Webb argued that licensing developed “not in any abstract theory, but in a practical necessity of the state” (Webb & Webb, 1903, p. 2). That “practical necessity” involved the following three core realities: that alcohol caused known harms (primarily associated with public order), that prohibition was neither desirable nor practical, and, critically, that alcohol was an important source of tax revenues. Licensing was designed to regulate alcohol retail through three key instruments: selection, withdrawal, and conditionality. That is, local authorities can select who is awarded a license, they can withdraw a license if necessary, and they can impose a range of conditions on a license that restrict how the given trade is carried on. However, the powers of selection and withdrawal have reduced through time, with the consequence that British licensing today functions primarily through its powers of condition setting (see, e.g., Light, 1999 on the demise of the “principle of need”).

Health considerations have historically played a limited role in UK licensing. Licensing was initially designed as means of limiting public disorder and regulating behavior, however, health considerations have long played a part in motivating, if not framing, legislative change, especially where it has responded to public concerns over high levels of consumption. During the Georgian Gin Craze, for instance, health effects ranging from premature mortality to fetal damage were regularly cited as reasons for strengthened licensing legislation, although health was never a formal licensing consideration (see, e.g., Hales, 1751; Wilson, 1736). As both overall consumption and temperance activism peaked in the late 19th century, health effects again became a key part of public debates. Temperance groups such as the Band of Hope produced regular calculations of the costs of alcohol-related health harms to the nation, the medical temperance movement was prominent in calling for restrictions on availability, and doctors such as Francis Anstie developed widely adopted versions of recommended drinking guidelines (Berridge, 2005; Kneale, 2014; McAllister, 2014). However, the most extensive investigation into licensing of the late-Victorian period—the 1899 Royal Commission on Licensing, otherwise known as the “Peel Commission”—made scant reference to public health

impacts in its prolonged analysis of the effect of availability and density on alcohol harms, focusing instead on drunkenness, disorder, and moral decline (House of Commons, 1899).

In 1917, the Central Control Board (CCB), established under the Defence of the Realm Act to regulate the alcohol trade during World War I, published a report entitled *Alcohol: Its Action on the Human Organism* (see Duncan, 2014, for a recent history of the CCB). The CCB report presented a detailed analysis of the acute and chronic effects of alcohol as understood at the time but was explicit in separating the question of health from issues of licensing and other forms of regulation (CCB, 1917). A 1931 Royal Commission on licensing discussed “with some reluctance” what it called the “highly controversial subject” of alcohol’s physiological effects (House of Commons, 1931, p. 13). Like the 1899 Royal Commission, the 1931 Commission called for population-wide controls on the availability of alcohol, however, like the CCB it refrained from doing so in relation to the known health effects of alcohol.

Licensing, by and large, was understood to be an instrument designed to regulate behavior and to tackle consequences that were temporally and geographically proximate to consumption. Licensing, in its original conception, could deal with alcohol retail as a proxy for alcohol harms because alcohol was usually bought and consumed in the same place. However, while the individual outlet was the primary unit of licensing practice broader, strategic issues regarding availability and density grew in importance throughout the 19th and early 20th centuries. In other words, it became clear early in licensing history that it was not simply a responsive instrument which regulated specific outlets in an environment otherwise driven by market forces; rather, that it could be used to shape the wider retail context through area-wide, policy-driven approaches to the general availability of alcohol. As early as 1795, the London magistrate Patrick Colquhoun published a report calling for licenses to be limited to 1 per 50 families, and an 1817 Metropolitan Police report concluded that in some boroughs “licenses are granted with great facility, and far beyond what appears to be necessary for the public accommodation” (Colquhoun, 1795; House of Commons, 1817, p. 9). By the 1870s, there was intense political debate on whether and how local authorities could plan to reduce outlet density and to what end. Indeed, local plebiscites on prohibition (known as “local option” or “local veto”) became the subject of heated political debate between 1870 and 1900 in the UK. Key to these disputes was the question of whether alcohol policy should strategically plan to reduce alcohol harms in general, rather than reactively respond to problems at specific premises (Nicholls, 2009). An increase in outlet density associated with both urbanization and the vertical integration of an increasingly conglomerate brewing industry,

therefore, forced the question of whether licensing should be precautionary and strategic, rather than reactive, and whether it should concern itself with the protecting of the wider public good beyond simply preventing disorder at the level of individual outlets.

In the late 19th and early 20th centuries, many countries saw public debates on the strategic and area-based functions of licensing leading to political action (Livingston et al., 2007). Most notably for the UK, a 1904 Licensing Act based on the majority report of the Peel Commission allowed for the forced reduction in pub numbers by local magistrates—albeit with the critical (and intensely disputed) caveat that licensees should be compensated for their loss of livelihood. Subsequently, in 1915 the CCB closed large numbers of pubs in areas where the trade was nationalized, such as Carlisle. Throughout the first half of the 20th century, licensing practice and theory accepted that national legislation should—to a greater or lesser degree—set a strategic framework through which alcohol consumption and associated harms could be reduced. That is, national alcohol policy was construed as an instrument for proactively reducing both consumption and harm. So, for instance, despite noting that in England and Wales “excessive drinking . . . has been greatly, even spectacularly diminished,” the 1931 Royal Commission asserted nonetheless that “it is the clear duty of the State to take all reasonable action which will assist to reduce excessive drinking to the lowest dimensions possible” (House of Commons, 1931, pp. 13, 19).

However, this presupposition was not incontrovertible. A significant reduction in general consumption, combined with the decline in organized temperance, and, importantly, the rise of the disease model as a frame for understanding alcohol harms, contributed to a shift in political thinking in regard to licensing from around the 1940s. Kneale and French (2008) have argued that the geographical concern with density and availability tends to be associated with a framing of alcohol problems as distributed across populations, rather than isolated among harmful subgroups. Hence the disease model militated against licensing acting as a population-level instrument and encouraged the view that licensing was primarily a matter of administration and outlet-level interventions.

In England, this shift in emphasis was reflected in Licensing Acts of 1961 and 1964, both of which moved away from increasing restrictions on availability and toward the liberalization of operating hours, especially for off-licenses. In 1972, an interdepartmental committee on licensing, known as the “Erroll Committee,” provided an extended justification of this conceptual trend by framing licensing as primarily responsible for ensuring market functionality and limiting its restrictive concerns to harms

that occurred at the margins. According to the Erroll Committee report, too much licensing theory had previously been motivated by three erroneous principles of alcohol policy: that drinking is always socially damaging, that drinking patterns and trends were homogenous, and that the law is decisive in changing culture. Instead, so the report argued, licensing should proceed from the principle that most drinkers are moderate; that policy should not demonstrably increase drinking; and that licensing law should apply only to public order, amenity, and public safety (House of Commons, 1972). In other words, strategic and precautionary approaches to general harm should not be a function of licensing; rather, it should be reactive and narrowly concerned with proximate effects.

The 2003 and 2005 Licensing Acts

The Erroll Committee recommendations did not lead to legislation, partly due to opposition from public health advocates (e.g., “Editorial: Liquor Licensing and Public Health,” 1976). In Scotland, by contrast, the recommendations of the parallel “Clayson Committee” did lead to some liberalization of the licensing regime under a Licensing Act of 1976 (Clayson, 1973; Nicholls, 2012). Nevertheless, the broad trend toward liberalization continued across the UK, with changes to the law on Sunday opening and daytime operating hours throughout the 1980s and 1990s and, ultimately, the introduction of the 2003 and 2005 Licensing Acts. The discretion of local authorities to select or reject license applications according to local “need” had been weakened throughout the 20th century (Light & Heenan, 1999), but the 2003 Licensing Act and the 2005 Licensing (Scotland) Act marked a fundamental shift toward the deregulatory principles outlined in both the Erroll and Clayson reports. This legislation not only introduced the principle of automatic application acceptance but also included no requirement for the renewal of premises licenses (a power that had been used in previous eras to manage the quality and quantity of supply). Under the 2003 Licensing Act, personal licenses only required renewal after 10 years, with the consequence that the power to remove both personal and premise licenses is restricted to cases where very significant noncompliance is proven—which is very rare. In 2013–14, of 9,638 applications for alcohol retail premises licenses in England and Wales, 8,736 were granted; in the same period, of a total of 204,300 premises licenses in force, 4,038 (just under 2%) were suspended and 42 closed down (Home Office, 2014). In 2013, there were 581,000 personal licenses in England and Wales; in the same year, just 22 were revoked, forfeited, or suspended (Home Office, 2014). Government legislation due to be introduced in 2015 will weaken these powers further by removing the need for personal license renewals altogether.

It is clear, therefore, that licensing's powers of selection and withdrawal are currently rarely applied. The majority of activity that occurs within the British licensing system is, rather, concentrated in the area of conditionality. Furthermore, current licensing law specifies the harms that can be taken into consideration on application and only allows such harms to be considered where a representation is made. This contrasts with licensing in other jurisdictions, most notably in many Australian states and territories, where a requirement to consider the extent to which any proposed license may contribute to existing harms is built into the decision-making process (Davoren & O'Brien, 2014; Manton & Zajdow, 2014). This potentially wide-ranging, precautionary principle (however inconsistently applied in reality) is largely removed from British licensing. It is also important to note, as Hadfield and Measham (2015) have argued, that many of the responsibilities historically held within licensing enforcement (such as tackling sales to drunk customers) have recently been "outsourced" to alcohol providers themselves through "partnership" schemes such as Best Bar None and the Purple Flag awards, which create "significant obstacles to the pursuit of statutory intentions and ultimately the public good" (p. 529). In other words, the historical function of licensing as the primary instrument for regulating proximate effects has also, to a degree, been privatized and reassigned to the alcohol retail industry itself.

While both the 2003 Licensing Act and the 2005 Licensing (Scotland) Act established a permissive framework for licensing, two instruments were introduced that allow for a degree of strategic planning. Firstly, local licensing boards (in both England and Scotland) are required, following local consultation, to produce Statements of Licensing Policy (SLPs)—every 5 years in England and every 3 years in Scotland. These set out the "general approach to making licensing decisions" that the local authorities will adopt in applying the provisions of the Licensing Act (Home Office, 2013). SLPs establish basic operational principles such as whether age-verification schemes will be promoted, what levels of staff training will be expected, what strategies for partnership working between local agencies will be supported, and so forth. They set out the overarching framework within which licensing decisions will be made, although they are, of course, constrained by the provisions of the primary legislation. In the case of appeal, courts need only "have regard" to SLPs and are "entitled to depart from . . . the statement of licensing policy . . . if it is considered justified to do so because of the individual circumstances of the case" (Home Office, 2013, p. 82).

Despite these constraints, the introduction of SLPs has been described as representing “a sea-change in the way British licensing boards operate, shifting licensing from being an application-driven process to a policy-driven one” (MacNaughton & Gillan, 2011 p. 23). In reality, however, SLPs have tended to lack strategic vision: rather than setting out how policies might contribute to wider harm reduction (or economic development) goals across local areas, many focus instead on outlining the operational parameters and procedural frameworks within which broadly reactive, application-driven licensing decisions will be made (Alcohol Focus Scotland, 2014). Nevertheless, the requirement for SLPs does provide an opportunity for greater strategic planning, including a stronger focus on health considerations (see Hecht et al., 2014, for a recent review). In England a provision was added under the 2003 Licensing Act (although not formally enshrined within it), allowing local authorities to establish limited areas of “cumulative impact” where applications can be refused unless applicants demonstrate how their license will avoid undermining the existing licensing objectives. Scotland goes further and requires all licensing boards to include a statement on the potential “overprovision” of any area with particular types of outlets within their SLP. Cumulative impact and overprovision policies create a “rebuttable presumption” against the grant of a license: whereas the usual practice is to approve a license unless objections are raised by a responsible authority, in this case, the assumption is to refuse unless the applicant can explicitly demonstrate what measures they will take to avoid adding to the cumulative impact of other outlets in the designated area (Home Office, 2013, p. 88). Cumulative impact and overprovision policies, and to a lesser degree SLPs, have emerged as the most fertile ground for public health engagement with licensing in the UK, but significant challenges remain.

Health and Licensing in Practice: The Scottish Experience

Following the introduction of a public health licensing objective, considerable work was needed to build relationships between local public health officials—usually based in 1 of the 14 regional National Health Service (NHS) health boards that operate in Scotland—and licensing authorities. In addition to the predictable, bureaucratic challenge of establishing a voice within a relatively fixed set of relationships, public health also faced resistance from many within the alcohol industry, who perceived health advocacy as being motivated by an overarching desire to simply reduce alcohol availability, regardless of the specific conditions in local areas. As one leading industry solicitor argued, “There is no other reason for seeking to make ‘protecting and improving public health’ . . . a licensing objective, unless a reduction in alcohol consumption generally by the population is intended” (Popleston Allen,

2014). Public health officials working on behalf of regional health boards were also accused of engaging in “indiscriminate, badly considered carpet-bombing” of licensing committees with representations based on evidence that had no prospect of impacting on decisions (Cummins, 2014).

The national charity, Alcohol Focus Scotland, took the lead in both supporting capacity building among relevant agencies and advocating for the primary role of health considerations in licensing practice. In a report entitled *Re-thinking Alcohol Licensing*, Alcohol Focus Scotland argued that licensing practice needed to reintroduce a focus on public welfare that had been lost over the course of the 20th century (MacNaughton and Gillan, 2011; Nicholls 2012). Additionally, they carried out a review of the practical consequences of the adoption of a public health objective between 2010 and 2013. That review found that adoption was generally slow and marked by a lack of mutual understanding but also by resistance among licensing board members, trade representatives, and licensing lawyers to approaches such as the adoption of overprovision policies covering wide areas, which were perceived as threats to established licensing principles and practices. Nevertheless, it found that inroads had been made in regard to both overprovision and SLPs. According to the review, in 2013, 10 licensing boards had declared overprovision in some areas, compared to 7 in 2010, and a third of the SLPs made some use of health evidence (either local data or reference to international research on alcohol and health) to “assist the reader to understand the reasoning for the licensing policy” in 2013 compared to a tenth in 2010 (Mahon & Nicholls, 2014).

Health and Licensing in Practice: England and Wales

In England and Wales, regional Directors of Public Health (DPH) were added to the list of responsible authorities for licensing in 2012. However, public health was not included as a licensing objective, therefore, regional health boards have had to engage with a complex and bureaucratic process without having the legislative capacity to make concrete demands (Martineau, Graff, Mitchell, & Lock, 2013). This, unsurprisingly, has led to very inconsistent levels of engagement by area, often depending on the personal leadership of DPH’s or the work of local alcohol agencies to drive engagement forward.

The UK Government’s 2012 Alcohol Strategy stated that it was “vital that licensing authorities are able to take health-related harms into consideration in decisions on cumulative impact policies,” and it contained a proposal to introduce public health as a licensing objective in areas of cumulative impact

(HM Government, 2012, p. 14). However, implementation of this proposal was subsequently put on hold on the grounds that “[while] there is good international evidence that controls on premises density reduce a range of harms from alcohol, including crime and health harms . . . more work is needed at a local level to put in place processes to underpin it” (Home Office, 2013b, p. 15). In 2011, a national licensing and public health network was established by Alcohol Research UK and Alcohol Focus Scotland and in 2014 brought under the auspices of the Public Health England—an executive agency of the Department of Health established to “protect and improve the public’s health and wellbeing and to reduce health inequalities” (Public Health England, 2014, p. 4). As had been previously noted by researchers (e.g., Newton, Hirschfield, Sharratt, & Rogerson, 2010), data identification and collection were identified as a critical issue: What data were relevant? How should that data be both collected and presented? And to which aspects of licensing practice and policy should it be applied?

In some areas, for instance, Brighton and Hove, systems linking outlet data, crime mapping, and hospital records were established through a multiagency “Alcohol Programme Board,” consisting of local health teams, police, licensing, and trade representatives (Public Health England and Local Government Association, 2014). Nevertheless, while public health teams sometimes play a key role in supporting data linkage, such information is usually tied to accident and emergency admissions (the so-called “Cardiff Model” of emergency department data linkage provides the blueprint for many schemes) and so falls under existing licensing concerns with public order and public safety (Shepherd, 2007). This is also reflected in national guidance (Department of Health, 2012; Home Office, 2012). Data linking of this kind is a powerful tool—both in the UK and elsewhere (Livingston et al., 2007)—but is currently operationalized through the crime and disorder licensing objective, and despite the obvious relationship to health outcomes, there is no necessary reason why it should be covered by a public health objective that is designed to primarily address chronic rather than acute harms.

Licensing, Street-Level Bureaucracy, and Multilevel Governance

In political science, the concept of multilevel governance refers to the “dispersion of power from national and central government to other levels of government . . . and non-governmental actors” (Cairney, 2012, p. 154). This can involve dispersion upward to supranational levels (such as European Union directives governing issues, e.g., alcohol pricing) and downward to the regional and local. It captures the reality that policy development and implementation takes place across a range of local,

regional, national, and international settings—with central government functioning as one actor among many rather than the dominant force (Cairney, 2012). While this devolved, multistakeholder, negotiated model of governance is often taken to be characteristic of the modern, decentralized, increasingly privatized state, alcohol policy can be seen as a long-standing instance of multilevel governance in practice. Since the first Licensing Act of 1552, licensing has represented an arm of the state that operates through autonomous local agencies, among whom significant levels of discretion apply (Valverde, 2003a). Furthermore, commercial actors—the brewers and landlords—have always played an essential role in policy enforcement and have exerted significant influence in policy development, a process that has recently been intensified through the partial “outsourcing” of key implementation roles (such as preventing sales to drunks customers) to industry-led partnerships such as “Best Bar None” and “Purple Flag” (Hadfield & Measham, 2015). More recently the creation of responsible authorities extends formal governance roles to regulatory authorities such as the police and trading standards officers, and a range of nongovernmental organizations, such as Alcohol Focus Scotland, have acquired important roles in both the development and implementation of licensing policy nationally and locally.

For their part, licensing committees and officers function, in many respects, as a form of what Michael Lipsky has called a “street-level bureaucracy”: that is, a level of governance in which decisions are made by an enormous number of local authorities and officials, working collectively and individually, who are required to exercise their discretion in applying the law, and whose judgments are based largely on experiential knowledge, albeit within a broad legislative framework (Lipsky, 1980). This has profound implications in regard to policy development and implementation: in licensing, local implementation finally determines what effect national policy will have, and local implementation is shaped by an array of stakeholder interests. Furthermore, as Lipsky argues, “the decisions of street-level bureaucrats, the routines they establish and the devices they invent . . . effectively *become* the public policies they carry out” (1980, p. xii; see also Buvik, 2013).

One consequence of this dynamic is that discretion becomes critical in both policy implementation and the exercise of power. Licensing committees are expected to use their discretion in responding to representations: whether that be refusing a license application or, in the vast majority of cases, applying conditions to it. As a regulatory authority, licensing teams work with police, trading standards, and other agencies to address issues of crime, disorder, underage sales, and so forth and have discretion in terms of their responses: whether to issue warnings, provide support, review licenses, attach new

conditions, or, ultimately, revoke a license entirely (although, as we have seen, this is extremely rare and functions as a threat more often than an applied sanction). Discretion is, therefore, both explicit (committees are required to apply discretion in deciding on applications) and implicit (licensing teams have discretion in how to respond to problems at given premises). Although working within the framework of primary legislation and statutory guidance, and with regard to the stated licensing objectives, the discretionary power of licensing committees, and the legal clerks to those committees, remains significant. While not formally interpreting the law, the discretion afforded to officers means that the application of the laws and guidance can vary widely. Indeed, describing police practice, Valverde memorably refers to broad categories such as “public nuisance” (the prevention of which is one of the licensing objectives), as creating “swamps of discretion” within which local officials can not only interpret national policy but also effectively recreate it (Valverde, 2003b, p. 159).

As Lipsky notes, the application of discretion and the belief that “experience provides the basis for knowledge” is both a practical necessity (not all underage sales case can realistically be prosecuted; judging intent accurately requires learned experience) and also self-validating in that the exercise of discretion confirms the professional expertise of the individual decision maker (1980, p. 115). The discretionary action becomes, in effect, the law. To recognize this is not to condemn local officials but to draw attention to the epistemological world they inhabit: one that applies different mechanisms of self-validation, institutional discipline, interpersonal relationships and knowledge-based power to a world of public health expertise more closely tied to academic measures of factual validity, professional status, and institutional authority (Phillips and Green, 2015).

A second consequence of the localism of alcohol licensing is that it provides an opportunity for what policy scientists call “venue shopping” by agents involved in the development of alcohol policy. On the one hand, local areas provide the opportunity to test and develop new policies but equally, they provide opportunities for opponents to challenge and derail national legislation. In this instance, when national legislation threatens the interests of the alcohol industry, local settings can provide the opportunity for challenges that make national legislation ineffective or impractical.

An example of this is Early Morning Restriction Orders (EMROs) introduced in England and Wales under the 2011 Police Reform and Social Responsibility Act. EMROs allowed local authorities to identify specific areas in their jurisdiction where they could introduce blanket closures of outlets at any time between midnight and 6 a.m., as long as the decision was based on clear evidence that such a

policy would reduce the harms identified. The alcohol industry was united in its opposition to EMROs, and, in 2012, the Association of Licensed Multiple Retailers (ALMR) established a fighting fund to bring appeals against any local authority that attempted to introduce one (Pescod, 2012). Two cases in particular provided the opportunity for high-profile challenges. In Hartlepool, in the North East of England, a proposed EMRO was challenged by an ALMR-funded legal team that included a number of leading licensing solicitors. The challenge rested on evidence that crime in the relevant area had, in fact, fallen significantly since the liberalization of licensing in 2005, that EMROs would affect good and bad businesses alike, and that the measure would have negative economic impacts (Hartlepool Borough Council, 2014). At the full council meeting in May 2013, the EMRO proposal was rejected on the grounds that there had been improvements in crime in the area but more importantly that the licensing committee was “mindful of the concerns raised by local licensees that a reduction in opening hours, in the current economic climate, could have serious consequences for the viability of their businesses” (Hartlepool Borough Council, 2013 p. 9). Reflecting on the decision, one trade solicitor wrote that the decision was “an important precedent—it shows that . . . financial implications for the area are a fundamental factor” even though economic development was not a licensing objective (Poppleston Allen, 2013).

Shortly afterward, the northern seaside resort of Blackpool proposed an EMRO and employed a prominent licensing solicitor, Philip Kolvin, to defend the measure. Commenting on the Hartlepool EMRO rejection some months earlier, Kolvin had described EMROs as “a draconian measure” and a “blunt instrument”—views exploited with some enthusiasm by the team opposing the policy at the Blackpool licensing committee (Degun, 2013). In this instance, industry solicitors produced “voluminous documentation” (Blackpool Borough Council, 2014a, p. 1) in support of their cases: over 800 hundred pages of testimony and evidence including around 250 pages of crime data acquired through Freedom of Information Act requests to the local police, extensive case law analysis, and commissioned academic opinion on the likely impact on the local economy (Blackpool Borough Council, 2014b). In February 2014, the local authority withdrew the proposal. In doing so, it stated that while “the case did not turn on any detailed statistical examination” of crime figures “the Committee did not feel the EMRO would have a positive effect on violent crime.” It further cited the “potential negative impact of the EMRO on Blackpool as a whole,” noting that “some investment had been placed on hold and it was likely there would be some negative impact that reached further than those premises trading in the EMRO area” (Blackpool Borough Council, 2014a, p. 5).

In both cases, a national body defending national interests targeted local areas and poured significant resources into producing high-profile victories that severely undermined the policy at a national level. These are clear illustrations of trade power manifested through its asymmetric ability to harness specialist legal resources; they also point to the way in which the politically charged, and often adversarial, contexts for licensing decisions can benefit specialist legal “insiders” as skilled in winning arguments as in establishing facts (Hadfield, 2006). However, they should also provide some cautionary lessons for public health bodies seeking to engage in licensing. In both Hartlepool and Blackpool, claims regarding increased alcohol-related crime rates post-2005 were found to be flawed. Notwithstanding Stockwell and Chikritzhs’ (2009) and Hadfield’s (2007) critique of early evaluations, the bulk of evaluative research on the 2003 and 2005 Licensing Acts does not show a clear and attributable rise in alcohol-related crime (indeed, both per capita consumption and crime rates have fallen since implementation), although the logistics of policing crime in the early hours have certainly been made more difficult and population trends mask variations among specific areas—especially those with significant nighttime economies (Foster, Herring, Waller, & Thom, 2009; Hadfield & Measham, 2010, 2015; Humphreys & Eisner, 2010, 2014; Humphreys, Eisner, & Wiebe, 2013; Hough, Hunter, Jacobson, & Cossalter, 2008; Newton et al., 2008). Hartlepool and Blackpool were unable to provide local data that countered these findings, and while Blackpool Council denied their decision turned on this issue, it was a line of attack that was central to the trade submissions in both cases.

In both Hartlepool and Blackpool, and a third decision to drop an EMRO proposal in the London Borough of Lambeth, economic consequences—and whether restrictions on licensing would “make the current businesses unviable”—were cited as significant considerations (Lambeth Borough Council, 2014, p. 63). While economic development is not formally a licensing objective, local authorities invariably consider economic impacts for both political and practical reasons—a factor recognized in case law (e.g., *Hope and Glory Public House Limited v. City of Westminster Magistrates Court* [2011] EWCA Civ 31, ¶42). Finally, health-related evidence was submitted which, while persuasive in correlating health outcomes to availability in general terms, was unable to prove area- or outlet-specific causality in this quasi-judicial context. The reluctance of other local authorities to propose EMROs following the Hartlepool, Blackpool, and Lambeth decisions illustrates an important consequence of venue shopping in this context: that councils, by nature risk averse when facing legal challenges, are far less likely to introduce restrictive policies following high-profile defeats elsewhere.

Evidence, Knowledge Translation, and Civic Epistemologies

In Scotland, public health engagement with licensing has been extensive in some areas (such as West Dunbartonshire) but limited in others. The active capacity building and advocacy actions of Alcohol Focus Scotland have been key to maintaining momentum and helping local health boards and licensing forums better understand the public health objective, but progress remains difficult (Mahon & Nicholls, 2014). In England and Wales, areas where the regional Director of Public Health has a commitment to the issue, or where regional advocacy groups have actively promoted public health engagement, have seen promising initiatives—outlined in the Appendix. However, these remain a minority of cases and have led mainly to improved local information sharing between police, health authorities, and licensing rather than widespread changes in decision making. The development of guidance documents (e.g., Local Government Association and Alcohol Research UK, 2013; Public Health England and Local Government Association, 2014), research-generated models for data sharing (e.g., Newton et al., 2010), and support from bodies such as Public Health England can support the work of public health teams, but there is widespread agreement that building effective relationships between public health and licensing is not a straightforward process.

The challenges faced by public health teams in the UK licensing contexts speak directly to wider conceptual problems regarding the notion of “evidence-based policy making.” While health advocates often call for application of “the evidence” in licensing decisions, this singular use of the term fails to capture the more complex reality. As numerous political scientists have recently argued, the notion of evidence-based policy making is an ideal-type model of decision making. It describes an aspiration but has only limited purchase on the reality of political action at all levels of governance (Cairney, 2014; Cairney & Studlar, 2014; Hallsworth, Parker, & Rutter, 2011; Smith & Joyce, 2012). This is because it relies on two problematic assumptions: firstly, that political decision makers have the potential to be fully rational actors whose decisions are based simply on the weighing of scientific evidence, and not by other considerations such as public opinion or political viability; and secondly, that there is only ever a singular evidence base or that single bodies of evidence trump others in all settings. In reality, evidence is usually multiple and often conflicting and operates differently across the many levels and agents of governance involved in alcohol policy. Therefore, a judgment needs to be made not as to what evidence is more compelling but which evidence speaks to the values that motivate action—and in which contexts. Even where scientific consensus is relatively coherent, it is not always decisive. As MacGregor puts it, “the dominant view held by politicians is that evidence alone is insufficient when

decisions are being made” (MacGregor, 2013, p. 227). And, as Cairney (2014) and Hallsworth, Parker, and Rutter (2011) argue, this is not a failing, rather it is a reminder that politics, while undoubtedly shaped by power, access, lobbying, and other distorting effects, is about values, decision making, and negotiating the interests of stakeholders, not simply a narrow positivism in regard to bodies of scientific research.

Local licensing practice has, throughout history, made extensive use of certain types of evidence. Police and crime evidence, both data based and anecdotal, have always been important (Hadfield, 2006; Jennings, 2012). Evidence on local economic impacts has also mattered, often counterbalancing police evidence on harms. In both cases, what matters is local specificity: licensing has only limited use for macro-level data, because it is a level of governance whose purview is the local and the individual. As one British licensing lawyer has put it “licensing boards are very different animals to Government and the legal framework within which they must exist is constructed with unique and interesting apparatus. Government can take high-level policy approaches: licensing boards by their nature and the legal system within which they operate must consider the fine detail and the local issues” (McGowan, 2015). This is not limited to licensing: As a number of recent studies have found, where governance operates at a local level, local evidence and, indeed, individual testimony, will often carry far more weight with decision makers than large bodies of international evidence that have little obvious connection to regionally specific conditions (MacGregor, 2013; Lorenc et al., 2014; Toner et al., 2014). However, the challenge of developing reliable and robust local data requires far more consistent data collection practices among licensing authorities as well as better data sharing between licensing, the police, health, emergency services, other regulatory authorities, and—critically—the retail sector itself (Hadfield & Newton, 2010; Humphreys & Smith, 2013; Newton et al., 2010).

In addition to practical and pragmatic considerations regarding the development and effective presentation of tractable local data, formal public health engagement in licensing presents an epistemological challenge. Lipsky’s concept of “street-level bureaucracy” centers on the claim that the pressures and dynamics of regulatory practice create ways of seeing, evaluating, judging, and understanding at the local level which are distinct from those employed at other levels of governance. Writers such as Mariana Valverde (2003a, 2003b, 2011) and Shelia Jasanoff (2007) have also explored the way in which different epistemologies operate in different policy environments. Valverde argues that licensing “sees” alcohol as an issue of administration, management, negotiation, permission, and discretionary judgment based, critically, on *local* knowledge and experience. She compares this

epistemological condition of “seeing like a city” with the way in which expert knowledge, working with population-level and macro-data, “sees like a state.” Parallels can be drawn between this and Shelia Jasanoff’s concept of “civic epistemologies,” that is, those bodies of knowledge which are less informed by high-level, expert knowledges (Jasanoff’s example is biotechnology) than by day-to-day experience and practical learning.

A striking example of this, albeit in a conflictual context, is illustrated in a letter written to the *Edinburgh News* by a member of the Edinburgh licensing board in November 2014. Relations between licensing and public health had been strained in Edinburgh since changes to the licensing board membership had weakened prior support for public health-oriented approaches to policy (see, e.g., *Alcohol Focus Scotland*, 2014, p. 9). In a number of public exchanges, local health and police officials had strongly criticized the convener of the Edinburgh licensing board for rejecting international evidence on availability and harm and promoting instead the economic benefits of alcohol retail in the city (e.g. Gillan, 2014; Gourtsoyanis, 2014; McCann, 2014). In defending the convenor, a fellow elected member wrote dismissively of public health claims regarding outlet density, stating that:

The concept of overprovision is open to question—particularly with regard to off-sales. You wouldn’t purchase your weekly food shop twice because you live near two supermarkets, so logic follows the same applies to a six-pack of beer or a bottle of wine. And as acknowledged by virtually all in attendance at the last board meeting—including legal and police representatives—anyone can quote from academia to support their own view. (Cook, 2014)

This rejection of “academic” (which is to say, high level and usually international) evidence in favor of what might be called “native wisdom” is characteristic, if usually expressed in less confrontational terms. Describing a different contrast in perspectives on evidence, a public health specialist from a large English town observed that

In terms of the evidence base, we must remember that a solicitor’s definition of evidence and a public health definition are likely to be incomparable. A solicitor may look for documents or material objects to determine whether a belief is true or not. Public Health evidence is likely to consist of guidance, reviews of research and

evaluation documents. While the expression is the same, the characterization of “evidence” is likely to differ. (Carbery, 2014, p. 41).

As Phillips and Green (2015) show, in most cases experiential knowledge is not simply pitted against high-level research evidence for confrontational purposes, but because that kind of knowledge often has more relevance to the decisions at hand. While the *Edinburgh News* letter cited above may, with justification, be seen as the aggressive rejection of all scientific research in favor of subjective opinion, it points in the direction of a more nuanced dynamic operating within licensing boards across the country. In the quasi-judicial environment of the licensing committee, “as a matter of law, academic studies are of lesser evidential value than material fact” (McGowan, 2015) and reviews of ecological studies in distant countries will generally hold less weight than the experience and local knowledge of licensing officials, local police officers and, indeed, individual members of the public.

In reality, licensing boards are often unable to practically deploy aggregate population-level data estimates on the relationship between availability and harm, not because they don’t wish to, nor because they cannot understand it, but because it has no practical purchase on what they do. It may be evidence but evidence without traction—rather as equations on the nature of centripetal force may be of little use to a mother teaching her child to ride a bicycle. Freeman and Sturdy (2014) propose three modes for understanding how knowledge and evidence operate in different policy contexts: mobile, informed but also subjectively inflected knowledge as held by individual actors (what they call embodied knowledge); knowledge as contained in policy documents (inscribed knowledge); and knowledge as translated and deployed in policy making (enacted knowledge). That these modes of knowledge are nonidentical highlights the extent to which appeals to a pure “evidence base” has only limited valence in policy environments where not only different types of knowledge operate, but where these knowledges function differently depending on whether they are being deployed in the development of individual expertise, the creation of durable documents, actual deployment in policy making and implementation or (it could be added) policy advocacy. The kinds of evidence generally developed and deployed by public health professionals clearly have a role to play, however, they have not yet proved decisive in UK settings, which raises the question of how they can gain traction at all, what the realistic parameters of impact are likely to be, and how to balance a need to maintain a concept of “the evidence base” with the reality of knowledge translation, the fragmentation of policy ideas (Smith, 2013), and the multiple nature of knowledge in the licensing environment.

Conclusion

The 2005 Licensing (Scotland) Act and the 2011 Police Reform and Social Responsibility Act have provided the first formal opportunities for structured involvement of public health in British licensing. However, operationalizing those powers has been challenging and impact has been limited so far—partly due to limitations in the primary legislation, partly due to trade actions to undermine restrictive policies, and partly because of practical and conceptual differences between the worlds of licensing and public health.

While it may be argued that health considerations have no historical grounding as a feature of licensing practice, the reality is more complex. In the UK, licensing may have developed in such a way as to foreground reactive and the administrative aspects, but it has always incorporated strategic elements. Until at least the 1960s, there was a commonly held assumption that licensing should seek to actively reduce harms associated with alcohol through strategic planning. However, the role of health in this was always ambiguous—partly because of limited evidence regarding alcohol and health at the time but also because of the awareness that chronic health impacts are not the kind of proximate effect licensing developed to address. In the UK context, therefore, claims regarding the role of licensing in strategically promoting the public good (however that is defined) have strong historical justification: The diminution of that focus was a feature of mid- to late-20th-century approaches. Nevertheless, there are far fewer precedents for the formal incorporation of health considerations so this presents novel challenges.

How might these challenges be addressed? Clearly there is a risk of disillusionment, frustration, or simple lack of capacity, leading to a gradual disengagement. It may, equally, transpire that the purviews of public health and licensing are so distinct as to render attempts to bring the two together impractical. However, since alcohol retail has undeniable public health consequences, and since licensing remains the primary legislative instrument through which retail is regulated, then public health considerations should, presumably, play a formal role. What that role will be, what expectations should be applied to it, and how it can gain the traction necessary to become integral remain open to question. As a contribution to addressing these challenges, two principles can be proposed on the basis of the foregoing analysis:

(1) *Goal setting*: The goal of a reduction in overall availability is not identical with (although not mutually exclusive of) the goal of the routine consideration of public health evidence in the licensing process. However, the latter does not necessarily imply the former. The former requires a high-level reconceptualization of the basic functions of licensing, as proposed in MacNaughton and Gillan (2012). Furthermore, the strategic functions of licensing currently enshrined in the requirement for the development of local SLPs could be strengthened considerably, and in such a way as to take into account the health impacts of alcohol retail. The strategic and precautionary functions of licensing have certainly been weakened over the 20th and early 21st century, but they remain capable of reaffirmation in revised primary legislation. In lieu of changes to primary legislation, however, a modest, pragmatic, and limited engagement with licensing bodies—making health considerations part of the routine practice of licensing officials—is an achievable goal. In order for this to occur, however, public health teams would need to become “useful” to licensing officers and their evidence relevant and tractable. A number of the local actions outlined in the Appendix point toward this approach, and researchers continue to explore models for effective data sharing, although with a primary focus on injury reduction (Moore et al., 2014; Newton et al., 2010).

(2) *Defining the evidence*: Licensing is not only an administrative function but a special governmental epistemology. It tends to “see like a city” and so has only partial use for evidence which “sees like a state.” At an operational level, epidemiological evidence on the aggregate relationship between availability and harm has little relevance, since attribution cannot apply at outlet level and will, in most cases, be challenged on appeal. Data need to be local, robust, and demonstrably applicable to the case under consideration. The role of international evidence on general trends will, in most cases, only be contextual rather than a determining factor. In the licensing context, epidemiological evidence on health harms is only one form of evidence among many and is unlikely to be determining in most cases. In a licensing context, unlike that of public health research, “international” does not connote “compelling”; it connotes “nonlocal”—and, therefore, probably not relevant. High-quality, consistent, and relevant local data development is, therefore, a critical step toward establishing public health considerations in everyday licensing practice.

Venue shopping is inevitable in the context of local licensing reform—not only on the part of the trade but also among local authorities or advocacy coalitions seeking to establish more restrictive principles in case law. However, developments that fail due to inadequate or inappropriate evidence will, because of the risk aversion of local authorities, create a disincentive to further action. The implication of this is

either the more cautious use of international evidence in local contexts or the introduction of clearer guidance on the status of what, in the Australian context, has been called “general evidence,” in relation to local and outlet-specific evidence (Davoren and O’Brien, 2014, p. 44).

Short of changes to primary legislation, any such developments are unlikely to transform licensing practice or general availability. However, given the considerations outlined above, that is not inappropriate: making health considerations a routine aspect of licensing practice, and a strategic frame in the development of local policy statements, may establish the legislative and procedural groundwork for more ambitious goals for the future. If the goal is to bring the health harms associated with alcohol down, then a step along the way may have to be bringing the two worlds of licensing and public health closer to a productive, sustainable relationship.

Appendix

Table A1. Local Actions to Support Public Health Engagement in Licensing (Illustrative Examples).

Organization	Action
Lambeth Borough Council	Between January and May 2014, the Safe Sociable London Partnership ran a pilot supporting the local Director of Public Health to make representations on local license applications using a data tool developed for the purpose. Initial evaluation recorded that of 53 applications received, 14 representations were made (in conjunction with other responsible authorities, 1 application was refused, 1 revoked, and 2 were withdrawn)
Brighton and Hove City Council	In 2010, an Alcohol Programme Board was established including the local DPH, licensing teams, police, local trade, and other stakeholders. A representation from the board led to the refusal of an alcohol license for a Sainsbury's in Brighton (Brighton and Hove Council, 2011 and 2013)
West Dunbartonshire Council	In 2010, West Dunbartonshire Council imposed an overprovision policy across a large area (18 intermediate data zones). This policy was introduced to promote the crime and disorder and public health licensing objectives
Balance North East	Coordinates data sharing across North East Emergency Departments. Supported 2014 Newcastle City Council Statement of Licensing Policy which included a provision to impose a minimum price on premises under extreme circumstances. Supports the introduction of a fifth licensing objective to protect public health
Drinkwise	Runs regular workshops on licensing and public health for stakeholders in North West of England. In 2014, Drinkwise carried out an audit of Statements of Licensing Policy for all North West authorities and established a regional Alcohol Inquiry. Supports the introduction of a fifth licensing objective to protect public health

Public Health England	Has developed guidance for regional Directors of Public Health in engaging with licensing. Provides support for Local Alcohol Action Areas, exploring the hypothetical use of a public health licensing objective. Supports the introduction of a fifth licensing objective to protect public health
Local Government Association	Worked with both Alcohol Research UK and Public Health England to develop licensing guidance for local Directors of Public Health. Supports the introduction of a fifth licensing objective to protect public health
Public Health Liverpool	Developing extensive data linkage documents for use in representations to local licensing authorities
Glasgow and Clyde NHS	Has employed a permanent member of staff to oversee the public health representations to local licensing authorities in the region
Alcohol Focus Scotland	Provides support and toolkits for local health boards and licensing teams in support of the public health objective. In 2014, it produced an audit of Statements of Licensing Policy and a review of public health engagement in licensing across Scotland with Alcohol Research UK

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References

Alcohol Focus Scotland. (2014). *Review of statements of licensing policy*. Edinburgh, Scotland:

Alcohol Focus Scotland.

Berridge, V. (2005) *Temperance: Its history and impact on current and future alcohol policy*. York, England: Joseph Rowntree Foundation.

Blackpool Borough Council. (2014a). *Minutes and decision of the licensing committee meeting 3rd-7th February 2014*. Retrieved November 16, 2014, from

<https://www.blackpool.gov.uk/Business/Licensing-and-permits/Documents/EMRO-decision-100214.pdf>

Blackpool Borough Council. (2014b). *EMRO-ALMR evidence*. Retrieved November 16, 2014, from

<https://www.blackpool.gov.uk/Business/Licensing-and-permits/Documents/EMRO-ALMR-evidence.pdf>

Brighton and Hove Council. (2011). *Agenda item: Sainsbury's Unit 1 134-138 North Street:*

Application for a new premises license. Retrieved November 16, 2014, from <http://present.brighton-hove.gov.uk/mgAi.aspx?ID=18253>

Brighton and Hove Council. (2013). *Health and Wellbeing Overview and Scrutiny Committee Report*

on Alcohol: Agenda Item 56. Retrieved March 17, 2015, from [http://present.brighton-hove.gov.uk/Published/C00000728/M00004127/AI00031418/\\$20130319124655_003175_0014681_ReportTemplateCommittee.doc.pdf](http://present.brighton-hove.gov.uk/Published/C00000728/M00004127/AI00031418/$20130319124655_003175_0014681_ReportTemplateCommittee.doc.pdf)

Buvik, K. (2013). How bartenders relate to intoxicated customers. *International Journal of Alcohol and Drug Research*, 2, 1–6.

Cairney, P. (2012). *Understanding public policy: Theories and issues*. Basingstoke, England: Palgrave Macmillan.

Cairney, P. (2014). *Evidence-based policymaking: If you want to inject more science into policymaking*

you need to know the science of policymaking. Paper presented at

Political Studies Association Annual Conference, Manchester. Retrieved November 16, 2014, from http://www.psa.ac.uk/sites/default/files/conference/papers/2014/Cairney%20PSA%202014%20EBPM%2028.2.14_0.pdf

Cairney, P., & Studlar, D. (2014). Public health policy in the United Kingdom: After the War on Tobacco, is a War on Alcohol brewing? *World Medical and Health Policy*, 6, 308–323.

Carbery, F. (2014). Weighing up the public health impact of a home delivery service in Bury. *Journal of Licensing*, 9.39-42.

Central Control Board. (1917). *Alcohol: Its action on the human organism*. London, England: Her Majesty's Stationery Office.

Clayson, C. (1973). *Report of the departmental committee on Scottish licensing law CMND 5354*. Edinburgh, England: Her Majesty's Stationery Office.

Colquhoun, P. (1795). *Observations and facts relative to public houses*. London, England: J Downes.

Cook, N. (2014). Licensing critics forget our individual liberty. *Edinburgh News*. 3rd November. Retrieved November 16, 2014, from <http://www.edinburghnews.scotsman.com/news/opinion/letters/letters-licensing-critics-forget-our-individual-liberty-1-3591957>

Cummins, J. (2014). A fact-based take on alcohol, please. *Scottish Licensed Trade News*. July 10. Retrieved November 16, 2014, from <http://sltn.co.uk/2014/07/10/a-fact-based-take-on-alcohol-please/>

Davoren, S., & O'Brien, P. (2014). Regulating to reduce alcohol-related harm: Liquor licensing and the harm minimisation test. In E. Manton, R. Room, & M. Thorn (Eds.), *Stemming the tide of alcohol: Liquor licensing and the public interest*. Victoria, England: Foundation for Alcohol Research and Education.

Degun, G. (2013, May 7). Hartlepool Borough Council rejects EMRO. *The Publican's Morning Advertiser*. Retrieved March 17, 2015, from <http://www.morningadvertiser.co.uk/General-News/Hartlepool-Borough-Council-rejects-EMRO>

Department of Health. (2012). *Information sharing to tackle violence: Guidance for Community Safety Partnerships in engaging with the NHS*. Retrieved November 16, 2014, from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212949/CSP-Guidance-September-Final.pdf

Duncan, R. (2014). *Pubs and patriots: The drink crisis in Britain during world war one*. Liverpool, England: Liverpool University Press.

Editorial: Liquor Licensing and Public Health. (1976). *British Medical Journal*, 1, 359.

Foster, J., Herring, R., Waller, S., & Thom, B. (2009). The licensing act 2003: A step in the right direction? *Journal of Substance Use*, 14, 113–123.

Freeman, R., & Sturdy, S. (2014). *Knowledge in policy: Embodied, inscribed, enacted*. Bristol, England: Policy Press.

Gillan, E. (2014, October 9). City must heed alcohol warnings. *Edinburgh News*. Retrieved November 16, 2014, from <http://www.edinburghnews.scotsman.com/news/opinion/evelyn-gillan-city-must-heed-alcohol-warnings-1-3567710>

Gourtsoyanis, P. (2014, October 3). Senior cop clams licensing chief Eric Milligan. *Edinburgh News*. Retrieved November 16, 2014, from <http://www.edinburghnews.scotsman.com/news/crime/senior-cop-slams-licensing-chief-eric-milligan-1-3588500>

Hadfield, P. (2006). *Bar wars: Contesting the night in contemporary British cities*. Oxford, England: Oxford University Press.

Hadfield, P. (2007). A hard act to follow: Assessing the consequences of licensing reform in England and Wales. *Addiction*, 102, 177–180.

- Hadfield, P., & Measham, F. (2010). After the act: Alcohol licensing and the administrative governance of crime. *Criminology and Public Policy*, 9, 69–76.
- Hadfield, P., & Measham, F. (2015). The outsourcing of control: Alcohol law enforcement, private-sector governance and the evening and night-time economy. *Urban Studies*, 52, 517–537.
- Hadfield, P., & Newton, A. (2010). *Alcohol, crime and disorder in the night-time economy*. London, England: Alcohol Concern.
- Hales, S. (1751). *A friendly admonition to the drinkers of gin, brandy and other distilled spirituous liquors*. London, England: SPCK.
- Hallsworth, M., Parker, S., & Rutter, J. (2011). *Policy making in the real world: Evidence and analysis*. London, England: Institute for Government.
- Hartlepool Borough Council. (2013). *Licensing committee: Minutes and decision record*. May 7, 2013. Retrieved November 16, 2014, from http://www.hartlepool.gov.uk/egov_downloads/07.05.13_-_Licensing_Committee_Minutes_and_Decision_Record.pdf
- Hecht, C., Pashmi, Ghazaleh & Andrews, M. (2014). *Called in for Review: London Statement of Licensing Policies – Lessons Learnt and Future Development*. London: Safe Sociable London Partnership.
- Home Office (2013). *Amended guidance issued under Section 182 of the Licensing Act 2003*. London: Home Office.
- Home Office. (2013b). *Next steps following the consultation on delivering the Government's alcohol strategy*. London, England: Author.
- Home Office. (2014). *Alcohol and late-night refreshment licensing in England and Wales March 31, 2014*. London, England: Author.
- Home Office Alcohol Policy Team. (2012). *Additional guidance for health bodies on exercising new*

functions under the Licensing Act 2003. London, England: Home Office.

Hope and Glory Public House Limited v City of Westminster Magistrates Court [2011] EWCA Civ 31 (Case No.: C1/2009/1736). London, England: Royal Courts of Justice.

Hough, M., Hunter, G., Jacobson, J., & Cossalter, S. (2008). *The impact of the Licensing Act 2003 on levels of crime and disorder: An evaluation*. London, England: Home Office.

House of Commons. (1817). *Report of may 1817 relative to public house licenses—report of the committee on the state of the metropolis*. London, England: C. Clement.

House of Commons. (1899). *Final report of her majesty's commissioners appointed to inquire into the operations and administration of the laws relating to the sale of intoxicating liquors*. London, England: Her Majesty's Stationery Office.

House of Commons. (1931). *Report of the royal commission on licensing (England and Wales)*. London, England: Her Majesty's Stationery Office.

House of Commons. (1972). *Report of the departmental committee on liquor licensing*. London, England: Her Majesty's Stationery Office.

HM Government. (2012). *The government's alcohol strategy*. London, England: Her Majesty's Stationery Office.

Humphreys, D., & Eisner, M. (2010). Evaluating a natural experiment in alcohol policy: The Licensing Act 2003 and the requirement for attention to implementation. *Criminology and Public Policy*, 9, 41–67.

Humphreys, D., & Eisner, M. (2014). Do flexible trading hours reduce violence: A theory-based natural experiment in alcohol policy. *Social Science and Medicine*, 102, 1–9.

Humphreys, D., Eisner, M., & Wiebe, D. (2013). Evaluating the impact of flexible alcohol trading hours on violence: An interrupted time-series analysis. *PLOS ONE*, 8, e55581.

Humphreys, D., & Smith, D. (2013). Alcohol Licensing data: Why is it an underused resource in public health? *Health and Place*, 24, 110–114.

Jasanoff, S. (2007). *Designs on nature: Science and democracy in Europe and the United States*. Princeton, NJ: Princeton University Press.

Jennings, P. (2012). Policing drunkenness in England and Wales from the late eighteenth century to the First World War. *Social History of Alcohol and Drugs*, 26, 69–92.

Kneale, J. (2014). Moderate drinking before the unit: Medicine and life assurance in Britain and the US c. 1860-1930. *Drugs: Education, Prevention and Policy*. Early Online doi:10.3109/09687637.2014.964185 , 1-7.

Kneale, J., & French, S. (2008). Mapping alcohol: Health, policy and the geographies of problem drinking in Britain. *Drugs: Education, Prevention and Policy*, 15, 233–249.

Lambeth Borough Council. (2014). *Agenda item: proposal for the introduction of an Early Morning Alcohol Restriction Order*. January 15. Retrieved November 16, 2014, from <http://moderngov.lambeth.gov.uk/mgAi.aspx?ID=24903>

Light, R., & Heenan, S. (1999). *Controlling supply: The concept of 'need' in liquor licensing*. Bristol, England: University of the West of England.

Lipsky, M. (1980). *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

Livingston, M., Chickritzhs, T., & Room, R., (2007). Changing the density of alcohol outlets to reduce alcohol-related problems. *Drug and Alcohol Review*, 26, 557-66.

Local Government Association. (2014). *Public health transformation nine months on: Bedding in and reaching out*. London, England: LGA.

Local Government Association and Alcohol Research UK. (2013). *Public health and alcohol licensing in England*. London, England: Local Government Association.

Local Government Association and Public Health England. (2014). *Public health transformation nine months on: Bedding in and reaching out*. London, England: Local Government Association.

Lorenc, T., Tyner, E., Petticrew, M., Duffy, S., Martineau, F., Phillips, G., & Lock, K. (2014). Cultures of evidence across policy sectors: Systematic review of qualitative evidence. *European Journal of Public Health*, 24, 1041–1047. doi:10.1093/eurpub/cku038

McAllister, A. (2014). Giant alcohol: A worthy opponent for the children of the Band of Hope. *Drugs: Education, Prevention and Policy*. Early Online doi:10.3109/09687637.2014.977227 , 1-8.

MacGregor, S. (2013). Barriers to the influence of evidence on policy: Are politicians the problems? *Drugs: Education, Prevention and Policy*, 20, 225–233.

MacNaughton, P., & Gillan, E. (2011). *Re-thinking alcohol licensing*. Edinburgh, Scotland: Alcohol Focus Scotland.

Mahon, L., & Nicholls, J. (2014). *Using licensing to protect public health: From evidence to practice*. London, England: Alcohol Research UK.

Manton, E., & Zajdow, G. (2014). Public interest objectives and the adoption of harm minimisation. In E. Manton, R. Room, & M. Thorn (Eds.), *Stemming the tide of alcohol: Liquor licensing and the public interest* (pp. 20–28). Victoria, England: Foundation for Alcohol Research and Education.

Martineau, F., Graff, H., Mitchell, C., & Lock, K. (2013). Responsibility without legal authority? Tackling alcohol-related health harms through licensing and planning policy in local government. *Journal of Public Health*, 36, 435–442. doi:10.1093/pubmed/fdt079

McCann, D. (2014). Licensing chief denies disorder linked with alcohol. *Edinburgh News*. May 14. Retrieved November 16, 2014, from <http://www.edinburghnews.scotsman.com/news/licensing-chief-denies-disorder-linked-with-alcohol-1-3410453>

McGowan, S. (2015). Licensing: Public health evidence and causality. *Stephen McGowan's Licensing Blog*. January 8. Retrieved January 9, 2015, from:

<https://licensinglaws.wordpress.com/2015/01/08/licensing-public-health-evidence-and-causality/>

Moore, S., O'Brien, C., Aslam, M. F., Cohen, D., Hood, K., Huang, C., . . . Shepherd, J. (2014). All-Wales licensed premises intervention (AWLPI): A randomised controlled trial to reduce alcohol-related violence. *BMC Public Health*, 14, 21.

Newton, A., Hirschfield, A., Armitage, R., Rogerson, M., Monchuk, L., & Wilcox, A. (2008). *Evaluation of Licensing Act: Measuring crime and disorder in and around licensed premises* (Research Report). Huddersfield, England: University of Huddersfield.

Newton, A., Hirschfield, A., Sharratt, K., & Rogerson, M. (2010). *Building an evidence base on alcohol supply points: A pilot project to generate intelligence for managing areas with licensed premises*. London, England: Alcohol Research UK.

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

Nicholls, J. (2012). Alcohol licensing in Scotland: A historical overview. *Addiction*, 107, 1397–1403.

Pescod, A. (2012, December 14). ALMR sets up fighting fund to cover legal challenges to late-night levy and EMROs. *The Publican's Morning Advertiser*. Retrieved March 17, 2015, from <http://www.morningadvertiser.co.uk/General-News/ALMR-sets-up-fighting-fund-to-cover-legal-challenges-to-late-night-levy-and-EMROs>

Phillips, G., & Green, J. (2015). Working for the public health: politics, localism and epistemologies of practice. *Sociology of Health and Illness*, Early Online doi:10.1111/1467-9566.12214, 1-15..

Poppleston Allen. (2013, May 17). The inside track on Hartlepool council's EMRO decision. *The Publican's Morning Advertiser*. Retrieved March 17, 2015, from <http://www.morningadvertiser.co.uk/Opinion/Poppleston-Allen/The-inside-track-on-Hartlepool->

council-s-EMRO-rejection

Poppleston Allen. (2014, July 8). A drink to your good health. *The Publican's Morning Advertiser*. Retrieved March 17, 2015, from <http://www.morningadvertiser.co.uk/Opinion/Poppleston-Allen/A-drink-to-your-good-health>

Public Health England. (2014). *Who We Are and What We Do: Our Business Plan for 2014/15*. London: Public Health England.

Public Health England and the Local Government Association. (2014). *Public health and the Licensing Act 2003—a guidance note on effective participation by public health teams*. London, England: Public Health England.

Shepherd, J. (2007). *Effective NHS contributions to violence prevention: The Cardiff Model*. Cardiff, England: Cardiff University.

Smith, K. (2013). Institutional filters: The translation and recirculation of ideas about health inequalities within policy. *Policy and Politics*, 41, 81–100.

Smith, K., & Joyce, K. (2012). Capturing complex realities: Understanding efforts to achieve evidence-based policy and practice in public health. *Evidence and Policy*, 8, 57–78.

Stockwell, T., & Chikritzhs, T. (2009). Do relaxed trading hours for bars and clubs mean more relaxed drinking? A review of international research on the impacts of changes to permitted hours of drinking. *Crime Prevention and Community Safety*, 11, 153–171.

Toner, P., Lloyd, C., Thom, B., MacGregor, S., Godfrey, C., Herring, R., & Tchilingirian, J. (2014). Perceptions on the role of evidence: An English alcohol policy case study. *Evidence and Policy*, 10, 93–112.

Valverde, M. (2003a). Police science, British style: Pub licensing and knowledges of urban disorder. *Economy and Society*, 32, 234–252.

Valverde, M. (2003b). *Law's dream of a common knowledge*. Woodstock, NJ: Princeton University Press.

Valverde, M. (2011). 'Seeing like a city': The dialectic of modern and premodern ways of seeing in urban governance'. *Law & Society Review*, 45, 277–312.

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

Wilson, T. (1736). *Distilled spirituous liquors the bane of the nation*. London, England: J Roberts.