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Local policies to tackle a national problem: Comparative qualitative case studies of an English local authority alcohol availability intervention

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ABSTRACT

Cumulative impact policies (CIPs) are widely used in UK local government to help regulate alcohol markets in localities characterised by high density of outlets and high rates of alcohol related harms. CIPs have been advocated as a means of protecting health by controlling or limiting alcohol availability. We use a comparative qualitative case study approach (n=5 English local government authorities, 48 participants) to assess how CIPs vary across different localities, what they are intended to achieve, and the implications for local-level alcohol availability. We found that the case study CIPs varied greatly in terms of aims, health focus and scale of implementation. However, they shared some common functions around influencing the types and managerial practices of alcohol outlets in specific neighbourhoods without reducing outlet density. The assumption that this will lead to alcohol harm-reduction needs to be quantitatively tested.

1. Introduction

For many countries, alcohol related harm is a major national health concern (World Health Organisation, 2014) that increases healthcare costs (Scarborough et al., 2011) in addition to costs from crime and disorder and losses of workplace productivity (Anderson et al., 2009).

Although frequently regarded as a national problem, interventions to prevent or treat alcohol related harms are often developed and administered at the level of local government (Alcohol Public Policy Group, 2010; Fitzgerald and Angus, 2015; Hech et al., 2014). For example, restriction of alcohol availability is a key area of interest to policy-makers and practitioners, both in the UK and elsewhere, but restrictions can take different forms and their delivery varies by locality (Foster and Charalambides, 2016; Livingston, 2012; Nicholls, 2012). They may, for example, take the form of modifications to economic availability (e.g. raising the price of alcohol); spatial availability (e.g. reducing spatial density of alcohol outlets) and temporal availability (e.g. restricting times of sale).

Currently, the licensing of alcohol outlets represents arguably the most important lever for modifying the spatial and temporal availability of alcohol in the UK: a process that is administered by local licensing authorities (Martineau et al., 2013a; Nicholls, 2015). In England, the focus of this study, licensing authorities are situated in 326 principal local government authorities (LGAs) and have considerable leeway to develop tailored alcohol strategies, drawing on a mixture of compulsory and discretionary powers. This provides a mechanism for local variation in the type of interventions delivered and the'intensity' of delivery. De Vocht et al. (2015) have found that 'intensity' of local licensing policies, which they defined as willingness to administer cumulative impact policies (explained below) and refuse licence applications, was associated with area-level reductions in alcohol-related hospital

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admissions. This raises the possibility that variations in local licensing policy can influence area based inequalities in alcohol related harms.

1.1. Cumulative impact policies

This study focuses on a discretionary intervention that is available to licensing authorities in LGA's in England and Wales: Cumulative Impact Policies (CIPs). CIPs were first described in guidance relating to the Licensing Act, 2003, and by 2014 there were over 100 LGAs across England and Wales with CIPs (Morris, 2015). They allow licensing authorities to designate a specific area or areas (referred to as Cumulative Impact Zones (CIZs)) within LGA boundaries as requiring a more stringent licensing policy to tackle alcohol related harms that are assumed to be linked to high outlet densities. CIPs are intended to shift the burden of proof during licensing decisions by establishing the legal presumption that contested applications for premises located within CIZs will be refused unless the applicant (i.e. retailer) can demonstrate how they will avoid compromising each of four licensing objectives encoded in English law. These objectives are (i) prevention of crime and disorder; (ii) public safety; (iii) prevention of public nuisance and (iv) protection of children from harm. In contrast, where CIZs are not in force, the legal presumption is that licence applications will be granted unless an opposing party can demonstrate that one (or more) of the objectives would be compromised (Home Office, 2012).

Unlike in Scotland, there is no licensing objective for England and Wales that deals specifically with public health protection (Fitzgerald, 2015). However, licensing authorities can choose to use health justifications to support their case for creating CIPs, and so CIPs have been considered a means by which English Public Health authorities can become involved in alcohol licensing policy, even without a specific public health licensing objective (Martineau et al., 2013a; Andrews et al., 2014).

As CIPs appear to strengthen legal powers to reject alcohol licence applications, and are justified in terms of harms caused by high alcohol retail density, it might be assumed that their primary purpose is to reduce or cap outlet density by facilitating refusals of new applications for licences. However, analysis of Home Office data found that 86% of licence applications in CIZs were granted in 2014 (Morris, 2015). The precision of these early estimates has been questioned by Foster and Charalambides (2016) but their own investigations also confirm that new licences are regularly granted within CIZs.

If CIPs are not being used to cap the number of alcohol licences, this raises important questions about the purpose of the intervention. Hence, research that aims to provide a richer understanding of the intervention and its mechanisms for achieving impact is appropriate. Guidance on evaluating complex interventions have emphasised the importance of conducting (often qualitative) research to help better understand intervention aims, mechanisms and pathways to impact (Craig et al., 2008). Local practitioners have also been found to particularly value evidence from local case studies (McGill et al., 2015).

We therefore conducted qualitative case studies of purposively selected English LGAs. These case studies allowed us to map variations in the purpose, nature and implementation of CIPs. We aimed to improve understandings of what CIPs are, what they are intended to achieve and how they can vary. Specifically we used the findings to address the following questions: (i) what do local stakeholders consider to be the aims or purpose of CIPs in their areas? ; (ii) do stakeholders consider CIPs in their area to be mechanisms for reducing alcohol availability? ; and (iii) are the CIPs considered to have other uses besides or instead of modifying availability? The findings have important implications for policy makers seeking to determine whether this intervention can be tailored to tackle alcohol related harms in different localities, and it has implications for future attempts to understand and evaluate the impacts of local alcohol interventions such as CIPs.

2. Method

Our approach reflected key principles of comparative case study design: using a multi-faceted approach to develop a pluralistic understanding of a phenomenon in a 'real-life' context (Crowe et al., 2011). Our intention was to understand both how CIPs were formally described by different LGAs in key policy statements, but also to gain a richer understanding of how key local policy stakeholders developed, understood and implemented the intervention. Case studies are particularly useful for understanding topics in which the boundaries between the phenomenon of interest and its context – in this case the CIPs and the local policy environments from within which they are enacted – are not easily definable because of different and potentially contested meanings and assumptions (Yin, 2003).

2.1. Recruitment and data collection

Researchers from universities situated in four English regions (North West, North East, South West, and London) used local knowledge and contacts to select five LGAs that had reputations for being active in developing local policies around alcohol licensing, harm prevention and reduction. We felt that LGAs that were active in this policy area would be more willing to participate and would provide richer data about the different ways CIPs could be implemented. However, this meant that LGAs that made alcohol harm reduction a lower priority (perhaps because other issues in their area were considered a greater priority) were not a focus of the study. LGAs that pursued other activities to reduce alcohol harms but did not have CIPs were not included.

The LGAs that did participate included two regional cities, a regional town, an area that included small towns and rural areas, and a small borough in London. All contained a mixture of disadvantaged and more affluent sub-areas as well as sub-areas that were considered night time economy destinations (these were larger in the more urban LGAs). Besides implementing CIPs, the five LGAs also implemented other interventions affecting the local 'alcohol environment' including community safety activities, further regulation of the night time economy and encouragement of voluntary initiatives involving licence-holders.

Researchers conducted semi-structured individual and/or group interviews with local stakeholders involved in the implementation of CIPs and/or delivery of LGA alcohol strategies (see Table 1 for study sample). As a minimum we required each case study to include interviews with public health and licensing leads and documentary analysis of local licensing policies. Additional interviews, focus groups and other fieldwork depended on local availability: the researchers set no *a priori* limit on the amount or type of additional data that could be collected if considered relevant to the research topic. In two areas, ethnographic methods were employed to observe licensing policy in practice, including observations of licensing meetings and ongoing contact with key informants within the context of their work practices in alcohol licencing (see notes to Table 1). Most interviews were at least an hour in length and conducted face-to-face, although telephone interviews were conducted when necessary.

The study was approved through ethics committees at the London School of Hygiene & Tropical Medicine, University of Sheffield, and University of Lancaster. Informed consent, anonymization and data security conformed to institutional ethical standards.