

Influencing the Implementation of a Public Health Objective in Scottish Alcohol Licensing: A Qualitative Interview Study – Summary Report. December 2015

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ABSTRACT

Aims: This study aimed to explore how public health actors have attempted to influence local alcohol licensing policies and decisions in Scotland to ensure that the licensing objective of 'protecting and improving public health' is met and to identify the factors which have been important in their experiences for helping or hindering their efforts.

Methods: Semi-structured telephone interviews were conducted with 13 individuals, covering 20 of the 40 Scottish licensing boards, who had recent and in-depth experience of trying to influence local licensing policy and decisions. Interviews were audio-recorded and analysed using an inductive framework approach.

Results: The process of influencing licensing policy and decisions was one which required intensive effort and a wide range of strategies including developing expertise, working in alliances across the public sector and with licensing actors, raising awareness of others, building relationships over time and using a variety of sources of evidence including public opinion. Important factors which helped and/or hindered their efforts included aspects and perceived deficits of the licensing system in terms of both law and tradition; the influence exerted by individuals with particular views; perceptions of bias or conflicted interests on all sides; differing levels of expertise and understanding among all involved; attitudes to alcohol, licensing and evidence; capacity and resources, and the complexities of gathering data.

Conclusions: This qualitative study describes a number of ways in which public health actors have sought to influence alcohol licensing, and sets out a wide range of challenges which they encountered. It suggests that the introduction of a public health objective to the licensing process does not guarantee that the objective will be understood, operationalised or achieved by the relevant authorities and that guidance and support is needed at both national and local level, including through further legislation.

Introduction

Alcohol licensing is the system by which the sale of alcohol to the public is regulated. It has historically been used as a mechanism of preserving social order rather than protecting health¹ however the Licensing Scotland Act 2005 introduced a new objective for the licensing system in Scotland, that of protecting and improving public health. The act also established Local Licensing Forums, to be made up of representatives of various organisations including police, health, licensees and the public, with the purpose of keeping under review the operation of the Act by the licensing authority in their area (the 'Licensing Board').

There is good evidence, internationally recognised, including a recent study in Glasgow, Scotland, that suggests that outlet density is associated with increased consumption of alcohol and therefore increased alcohol-related harm²⁻⁹. The legislation appears to take this evidence into account by requiring Licensing Boards to include a policy on the 'overprovision' of licensed premises in triennial statements of their licensing policy. The Alcohol etc. (Scotland) Act 2010 introduced further requirements for Licensing Boards to consult with the relevant local health authority ('Health Board') when preparing their licensing policy statement and to notify Health Boards of all premises licence applications as well as include a nominated representative of the Health Board on the Local Licensing Forum.

Since 2005, there have been a number of studies of the implementation of licensing legislation in Scotland¹⁰⁻¹², however little work has been done to specifically capture the perspective of individuals with a public health remit. This study sought to interview 'public health actors', that is individuals employed by Health Boards, or local Alcohol and Drug Partnerships (multi-agency partnerships responsible for local alcohol and drug strategy) about their work on licensing issues, to add to contemporary discussions.

The aims of this study were therefore:

- to explore how public health actors have attempted to influence local alcohol licensing policies and decisions in Scotland to ensure that the licensing objective of 'protecting and improving public health' is met and

- to identify the factors which have been important in their experiences for helping or hindering their efforts.

Methods

Sample

This study sought to identify and interview ‘public health actors’ who had recent and in-depth experience of trying to influence local licensing policy and decisions. ‘Public health actors’ is used in this study to mean individuals whose job and organisation includes a substantial remit to protect and promote public health generally or the prevention of alcohol-related harm specifically. We identified such individuals in two ways: by reviewing publicly available information describing prior efforts to protect public health through licensing; and via snowball sampling, principally via one key informant at Alcohol Focus Scotland (AFS). AFS is a voluntary sector organisation which has played a key role in supporting local action on this, and the key informant was therefore well-placed to identify individuals active on this issue. We also interviewed this key informant, along with another individual with a local authority licensing role recognised for long-standing and innovative work in this area. After 13 interviews, one additional individual suggested by the AFS key informant declined to participate, citing a lack of action on this issue in her area as the reason. At this point it was agreed with the key informant that most if not all of the licensing board areas which were active on this issue had been included and no further participants were sought.

Data collection

Interviewees were sent a study information sheet by email and followed up by telephone. Full informed consent was recorded prior to semi-structured telephone interviews (averaging 69 minutes in duration) being conducted by NF between February and May 2014. Previous experience interviewing individuals in similar roles found telephone interviews to be preferable to participants as they can be more easily re-arranged with little should urgent commitments arise. Interviewees were provided with a topic guide in advance, developed by NF.

During interviews, participants were encouraged to speak freely about their experiences, and questions were not asked verbatim of each participant. Particular attention was paid to drawing out participants’ reflections on the research questions and their advice to others.

All interviews were audio-recorded: 6 were fully transcribed, and in the other 7 notes were simultaneously typed during the interviews and the recordings used afterwards to expand and correct the notes. All notes or transcripts were subsequently checked for accuracy by interviewees at which point they also had the opportunity to elaborate or clarify any points.

Analysis

Notes and recordings were reviewed throughout the data collection period and full analysis was conducted afterwards using a framework approach¹³. NF and JW 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.

Ethics

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

Top-Level Results – Full results & Quotations will be presented in peer-reviewed papers.

The themes emerging from the data could be organised into six overarching categories:

1. Learning, Expertise, Capacity and Persistence
2. Working with Others
3. Power, Autonomy, Bias
4. Evidence
5. Attitudes to Alcohol and Alcohol Licensing
6. Public and Stakeholder Involvement

Each overarching category is discussed in further detail in the following sections.

1. Learning, Expertise, Capacity and Persistence

1. Learning, Expertise, Capacity and Persistence	
1a Learning about Influencing Licensing	<i>Formal and informal mechanisms of learning for PH actors - peer support, national guidance.</i>
1b Other Expertise	<i>Data analysis, legal and economic expertise - confidence and availability of expertise</i>
1c Long term approach, persistence	<i>Timing, preparation, planning for future, taking a long-term view. Reviewing all L applications;</i>
1d Capacity	<i>Capacity to respond regularly and rapidly; Level of effort/time spent/required.</i>

Many of those interviewed described their experiences when they first started to work on this issue as a '*steep learning curve*', while some others felt that their work built on a history of effort by their organisation prior to them becoming involved. It was clear that there was a degree of discomfort in some of the former group, who felt that they learned as they went along rather than having expertise in the topic.

Most interviewees described drawing on at least one sources of learning, most commonly learning from people in similar roles in other areas (particularly but not limited to prior work by West Dunbartonshire), or learning through various forms of support provided nationally by Alcohol Focus Scotland. Both were highly valued.

Some participants highlighted the need for a structure through which they could access peer support with this issue, through some kind of national forum for shared learning amongst the public health community, preferably led by a national organisation.

It was clear that most participants had committed what they felt was a lot of time to working on alcohol licensing issues, and that continued progress would require a lot of time and a '*long term approach*' [L351, Interview 4, ADP]. On being asked what they would advise others starting this work, many felt that *starting earlier* was important [Interviews 1, 4, 5, 6]. Significant time was required to gather, interpret and present evidence to licensing boards (see Theme 4), to involve and consult with the public (see Theme 6) and to monitor and respond to individual license applications as they arrived. Finding the time to do this

was experienced as very challenging by some, particularly those who felt that their organisation or team was smaller than others.

2. Working with Others

2. Working with Others	
2a Alliances	<i>PH actors from various organisations working in partnership with public sector colleagues from other organisations on licensing issues</i>
2b PH Actors working with Licensing Actors	<i>Perceptions & reports of working with LSOs, L clerks, L boards. Mechanisms for communication with L actors.</i>
2c Helping or Influencing	<i>Efforts to influence LB members & how such efforts are framed/perceived - helping versus lobbying/campaigning. Presentation of 'recommendations' or 'options' to LBs</i>
2d Raising awareness	<i>Efforts to inform LB and other stakeholders about alcohol harm, overprovision etc.</i>
2e Building relationships	<i>Relationship building with LB and others; Time needed to build; More than awareness - 'hearts and minds'</i>

While individual efforts were important for leading and driving the work in some cases (see Theme 1), most participants also described the formation of an alliance with other public sector colleagues. Most commonly individuals from Alcohol and Drug Partnerships worked closely with colleagues from public health departments, however many also formed multi-agency working groups. The remit, lifespan and membership of these working groups varied considerably. Some had an ongoing remit to take forward action on overprovision and public health in licensing; others had a specific remit only for data collection and analysis for a defined period.

Having a broad range of stakeholders on the working group was felt to be the '*ideal picture*' by one key informant [L165, Interview 2, Key Informant], who also noted that '*the ADPs have a pretty important key role to play in this because they already have the key partners sitting around the table*' [L168]. This was generally supported by many interviewees who felt that there was a need to work together to make progress.

All participants described various efforts to work with licensing board members (who were local politicians, elected to the local authority, known as 'elected members' or 'councillors').

Most participants were very clear on the importance of building relationships with the licensing board over time. This was felt to be best achieved by continually engaging with the licensing process, including responding to individual applications as they came in and being regularly present at licensing board meetings – to achieve a kind of ‘*drip, drip effect*’ [L502, Interview 13, Public Health]

Some also liaised or worked directly with solicitors employed by the local authority with a remit to support the licensing board (known as ‘licensing clerks’) and a few mentioned working with a licensing standards officer.

In all efforts to work with licensing actors (and the public), interviewees described the importance of raising awareness about alcohol issues generally, overprovision, the role of the forum and ADP and correcting myths and misperceptions. Similarly to the discussion on building relationships above, this was also seen as involving a continuous effort.

3. Power, Autonomy, Bias

3. Power, Autonomy, Bias	
3a Licensing board autonomy & accountability	<i>Independence and control of LBs. Mechanisms to hold LBs accountable for upholding the L Scotland Act or implementation of L objectives.</i>
3b Legalistic licensing system	<i>Formal and legal processes and requirements; Disempowerment of LB outsiders; Disempowerment of LB - fear of litigation.</i>
3c Conflicts of interest	<i>Ability of individuals and organisations to act independently & without bias - for PH actors & others. Types of bias - host organisation; personal interests...Issues about representation on forums are not included here, but in 6a, 6a, though COIs of individuals on forums would be included.</i>
3d Power and influence of individuals	<i>The influence of individuals on action & progress. Lack of continuity when personnel/LB membership changes.</i>

Throughout the interviews there was discussion of issues relating to power and control, and the extent to which organisations were independent, neutral or influenced by particular agendas, conflicts or fears. Licensing Boards were described as autonomous bodies, in that

'nobody in the council could squeeze thumbs' i.e. to influence the Board members [L25, Interview 1, ADP]. They had *'democratically elected powers to make decisions about licensing...and make a value judgement'* [L330, Interview 2, Key Informant].

The issue of accountability of Licensing Boards was raised by a number of interviewees who felt that there was a need for much greater mechanisms through which they could be held accountable. Greater accountability, it was felt, could address issues such as inconsistent decisions on similar or identical applications, failure to engage in meaningful consultation about licensing policy, and lack of transparency about decision-making. Interviewees suggested annual reporting, reporting to the boards of the local authority and NHS and engagement in the community planning process as ways in which accountability might be improved.

Interviewees' descriptions of the role of local licensing forums in holding licensing boards to account are outlined in relation to the sixth theme below: Stakeholder and Public Involvement.

Another way in which the power of licensing boards was maintained, was through highly protocol-driven and hierarchical meetings which mostly (though not universally) operated very much like court proceedings. Many participants experienced these as *'absolutely intimidating'* [e.g. L981, Interview 10, Public Health] and *'inaccessible to communities'* [e.g. L370, Interview 2, Key Informant].

Some participants called for the government to address this issue by underwriting local authorities against legal action resulting from refusals to grant alcohol licenses. Another way to increase the resources of local authorities to address some of the perceived inequality was to remove the cap on licensing application fees so that Licensing Boards could potentially generate income to fight legal challenges by levying larger fees on applications from big corporations.

4. Evidence

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4a. Defining overprovision of L premises	<i>Challenges and difficulties in defining OP; choices re. geographical unit of analysis; historical practices and understanding of OP</i>
4b. Hard (imperfect) data	<i>Emphasis on quantitative data, challenges of measuring capacity and provision, relating harm to provision.</i>
4c Presentation of evidence	<i>Oral and written presentations; importance of presenter, and clarity and simplicity of data presented.</i>
4d Softer data	<i>Importance and power of qualitative evidence and public opinion - anecdote/personal experience; [Methods used to collect data covered in 6d]</i>
4e Perceptions of data	<i>Ownership of evidence; Acceptance of evidence; Attitudes towards harder and softer evidence including public views.</i>

One of the most challenging aspects for public health actors was being clear on what overprovision actually meant, and what evidence might demonstrate that it did or did not exist. Many made reference to historical understandings of overprovision as relating to areas of high crime or public disorder arising from a high density of on-sales premises in an area, typically a town or city centre. Many felt that the concept of overprovision was not totally clear from the legislation and that more guidance was needed.

The lack of guidance meant that around the different areas, different datasets were used to judge levels of provision, with varying thresholds for designating an area as overprovided. All areas described gathering data on alcohol related harm, most commonly alcohol-related deaths, alcohol-related hospital admissions or discharges, alcohol-related crime or police incidents, which were available at local level. A wide range of other data were used, many of which were only available at an area wide level: social services, environmental health, fires, ambulance call-outs, domestic abuse, consumption data, noise, addiction treatment and other figures.

It was considered challenging by many to gather and analyse robust data, one noted that '*all the datasets are slightly not quite what we need*' [L345, Interview 1, ADP] and another noted clear weaknesses in the data, in particular the ability to link alcohol-related harm to any specific premises or even geographic area. For this reason, some also defined overprovision (particularly for off-sales premises) across a larger area, on grounds that many people travel to buy alcohol to drink at home. Interviewees noted that they did not have reliable

information on the capacity of licensed premises, and some felt that more information was needed on the volume of alcohol sold.

Participants reported some difficulties with choosing geographical areas in which to report data for overprovision assessment. Most used intermediate data zones; some looked at both localities and town-based analysis. One problem with intermediate data zones was that they sometimes had names which bore no resemblance to what local people called the area.

It was also felt that the presentation of data by members of the community was more powerful than by public health actors and in some areas great care was taken to ensure that *'that the board understood that this was [Licensing] forum piece of work and that members of the community were involved.'* [L76, Interview 13, Public Health]

Some participants reported a considerable degree of shock and frustration the evidence they presented *'didn't result in the outcome we were hoping'* [L122, Interview 1, ADP]. One key informant felt that *"if the licensing board had the full data of the extent of alcohol problems in the area they generally would be horrified. They would think 'we have to do something' [L353, Interview 8].* This was the case in a couple of areas, however it did not accord with the experiences of many other participants.

Interviewees reported that councillors did not always have a good understanding of health data, or of what constituted good evidence. One described how a councillor who was on the licensing forum would refer to trade magazines as evidence and another declared that in his view there were a lot of places in a particular area which actually had no pub close to them and which would welcome an another pub. In this latter case, the interviewee noted that *'your expert statistical backed evidence doesn't outweigh that in that sort of scenario'.* [L622, Interview number and type withheld]

A general distrust of data was also reported. It was not only people's attitudes to data that were important, but people's attitudes to alcohol more generally and to the role and purpose and effectiveness of alcohol licensing which had an influence.

5. Attitudes and Beliefs Regarding Alcohol and Alcohol Licensing

5. Attitudes and Beliefs Regarding Alcohol and Alcohol Licensing	
5a Attitudes to alcohol in general	<i>Perceptions of alcohol problems; sense of problems only in other places or groups;</i>
5b Role of licensing in relation to PH & other objectives	<i>Importance of mood of L board; focus on short term issues (e.g. disorder) or long term (e.g. health); Acceptance of availability as driver of consumption and harm;</i>
5c Views on the Effectiveness of the L system to address alcohol-related harm.	<i>Perceived limitations of the L system in improving public health. Return on time invested in taking action on this issue. L as just part of a bigger alcohol policy picture.</i>
5d Economic arguments	<i>How economic issues influence licensing decisions; lack of data/method to compare risks/benefits of new L applications; beliefs in economics being more important than PH</i>

As reported above, the attitudes and views of individuals had influence on the efforts of public health actors, and the interviewees discussed these views in some detail, noting the need to ‘*take the temperature of the licensing board to guide what you do*’ [L416, Interview 1, ADP]. Interviewees recognised that the attitudes and beliefs of all involved regarding alcohol-related harm in general were important. They reported having to address myths and stereotypes raised by members of licensing boards, forums and the general public such as that problems related only to young people’s drinking, or those dependent on alcohol. They felt that action in relation to the public health objective of licensing required an acceptance of ‘a whole population approach’ and the idea that alcohol consumption needed to fall across all groups. Many participants felt that this idea had not been fully accepted yet, that people felt the problems lay in other areas, or with other people.

One participant felt that alcohol was a ‘*key feature common to every aspect of politics*’ and that ‘*alcohol lubricates political discussion, facilitators fundraisers*’ [L372, Interview number and type withheld]. He felt that because of this ‘*Councillors are often torn between the academic perspective and their own experience.*’ [L381].

Apart from believing that there was a sufficiently high level of alcohol-related harm for action to be taken, progress required that licensing actors believed that addressing public health was a legitimate role of licensing and that the system could make a difference. Not all did believe so, according to interviewees. One strategy widely reported was to

communicate to licensing board members that their role was part of a wider strategy of addressing alcohol-related harm, along with initiatives such as minimum unit pricing, treatment and so on.

Concerns about the effectiveness of alcohol licensing to tackle alcohol-related harm were by no means restricted to licensing actors. Some interviewees noted that licensing was relatively powerless to address online sales of alcohol which they felt was worrying. The issue of economic arguments being used to favour the granting of licences was raised by most participants. Licensing board members were felt to be highly 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 and felt that the legislative guidance should clearly state whether economic arguments can or cannot be used to justify applications. Others felt that it was already clear that such arguments should not be used, but that they continued to influence decisions notwithstanding the legislation.

Some interviewees tried to counter economic arguments by presenting data on the harms of alcohol such as the cost of fires, or loss of productivity due to over-consumption, however they felt that “*a piece of work needs to be done in relation to whether more jobs equals better health*” [L49, Interview 6, ADP].

6. Public and Stakeholder Involvement

6. Public and Stakeholder Involvement	
6a Forum as public involvement mechanism	<i>Representativeness of members; Appointment of members.</i>
6b Functioning of forums	<i>Effective operation; Representation of stakeholder views to the LB: Conflicts within forums</i>
6c LB statutory consultation	<i>Breadth of formal consultation; Scope; Standards; Impact</i>
6d PH-led consultation/ research into public views	<i>Methods used; questions asked; groups and numbers involved; Impact</i>
6e PH-led public engagement/ empowerment	<i>Engagement; awareness raising; support; empowerment; Campaigning. Public power.</i>

As noted in relation to the evidence above, the involvement of the general public was considered crucial to the efforts of most of the public health actors interviewed. As the legislation provides that each licensing board must establish a local licensing forum with representation from the licensed trade, the police, health, young people and the community, this was in theory a key mechanism through which licensing boards were accountable locally.

In some areas, through the efforts of public health actors, the local licensing forum was clearly active, had a good range of membership across trade, public sector and community representatives and worked well with the local licensing board. Those interviewees described much or all their work on licensing being executed through the forum, citing that the legislation provides that licensing boards have to provide *'a statement of reasons to licensing forums if they don't go with their recommendations'* [L346, Interview 2, Key Informant]. Some also described how they supported the members of the forum by supporting their attendance at national licensing conferences and keeping them informed through presentations. One felt their forum was well placed to hold the licensing board to some account and another was unsure.

Many participants reported ongoing problems with forums. These included that forums had not met for a long time, were not representative, or were not able to function well when they did meet. Some were described as *'top heavy with trade'* or *'a forum of licensees basically'* or *'full of trade who try to protect the trade'* or *'very heavy trade representation...dominated to a large degree by trade'* [Quotes from 4 different interviews, interview numbers and types withheld]. They noted that it was often difficult to get community representation onto forums: one commenting that *'I think they'd bite the arm off anybody who wanted to step forward as a member'* [L536, Interview 11, ADP].

Apart from the provisions to include community members on licensing forums, communities were also involved via various forms of consultation. This included consultations conducted by licensing boards to fulfil statutory requirements to consult on licensing policy, and consultations conducted by public health actors or licensing forums to supplement quantitative evidence presented regarding overprovision. The depth of consultation varied very widely. It was felt that some licensing boards conducted tokenistic consultation for example *'just a couple of lines on the council's website to say that the policy is up for renewal*

if anybody wants to respond on it' [L427, Interview 13, type withheld] whereas others asked public health actors or licensing forums to run the consultation on their behalf. In general (though not universally), the consultations run by public health or forums were broader and more in-depth and this was the case whether they were conducted independently of or on behalf of the Licensing Boards. There were '*no standards on these things*' [L308, Interview 1, ADP].

Most participants felt that this process took time and needed to be started early.

Conclusions

Progress towards protecting and improving public health is being made within the current Scottish licensing system, but requires extensive effort with no guarantee of success. Action by government could shore up the system by introducing greater clarity particularly in relation to determinations of overprovision. This ought to give proactive Licensing Boards the confidence to act decisively, support greater consistency in practice, and justify the introduction of greater accountability, for example through detailed annual reporting which ought to nudge other Boards along the same path. As criminal courts seek to become less formal and intimidating, there is no reason why Licensing Boards should not do the same, and recognise that not to do so is to maintain inequality in the system. Boards should also be held accountable for the functioning of their Licensing Forums and the extent to which their public consultations are meaningful. If more resources are needed, consideration should be given to how they can be generated within the system through licence application fees.

Implementing the intention and letter of the law is important, but the authorities also need to keep their eye on the 'curve' as availability is increasingly dictated beyond the scope of outlet density, via online sales and home deliveries, particularly from supermarkets. The government would be well advised to consider how that situation is compatible with the public health objective, and consider acting over and above, and if necessary before, introducing minimum unit pricing.

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Conflict of Interests

The authors declare that they have no conflicts of interest.

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