Northern Ireland Assembly

Committee for Communities

OFFICIAL REPORT (Hansard)

Licensing and Registration of Clubs (Amendment) Bill: Public Health Agency

28 January 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Paula Bradley (Chairperson)
Ms Kellie Armstrong (Deputy Chairperson)
Mr Andy Allen
Mr Mark Durkan
Mr Alex Easton
Ms Sinéad Ennis
Mr Robin Newton

Witnesses:

Mr Maurice Meehan	Public Health Agency
Mr Michael Owen	Public Health Agency

The Chairperson (Ms P Bradley): I welcome Michael Owen, senior drugs and alcohol coordinator, and Maurice Meehan, head of health improvement, in the Public Health Agency (PHA). You are both welcome. Michael, I think that you will provide the briefing, if you want to begin. You have up to 10 minutes.

Do we have Michael? We definitely have Maurice. I can see Maurice.

Mr Maurice Meehan (Public Health Agency): Hello, how are you doing?

The Chairperson (Ms P Bradley): Hi, Maurice.

Mr Meehan: We have had some technical issues with getting the audio.

The Chairperson (Ms P Bradley): OK. It would not be the Committee for Communities if we did not have some technical issues. We are well used to that *[Laughter.]* We do not have Michael; he does not appear to have joined the meeting. Maurice, are you happy to do the briefing?

Mr Meehan: No problem. I can do that.

The Chairperson (Ms P Bradley): Brilliant. If you want to go ahead and if Michael can join us, that would be great. We will let him in when we see him on the screen. If you want to go ahead, Maurice.

Mr Meehan: OK. Thanks a million. Excuse me for a wee second. We had to run down and get the battery for the phone just in case, as we were not on audio. Can you give me 30 seconds, if you do not mind?

The Chairperson (Ms P Bradley): That is OK. Go ahead and do that, Maurice. We can wait. It is not a problem. That is the joy of technology.

Mr Meehan: Absolutely.

The Chairperson (Ms P Bradley): I usually just blame everybody else in the room, but I do not think that you have anybody there to blame, Maurice.

Mr Meehan: Thanks for being so forgiving.

The Chairperson (Ms P Bradley): We have Michael with us, too. Michael, you are welcome as well.

Mr Meehan: Great. Good morning, ladies and gentleman. I am Maurice Meehan, the head of public health improvement at the Public Health Agency's northern office. I am also the agency's strategic lead for alcohol and drugs. I am joined by my colleague Michael Owen, who is the thematic lead for alcohol and drugs in the agency. On behalf of the PHA, I thank the Committee for Communities for the invitation to provide evidence on the Licensing and Registration of Clubs (Amendment) Bill. You will be aware that the agency, via our chief executive, Olive Macleod, submitted a written response to the Committee's invitation to make a written submission on the Bill on 14 December 2020.

Our overall view is that any increase in the accessibility of alcohol would put increased strain on health and social services resources on the basis that it would consolidate and further encourage alcohol consumption as a social norm and lead to increased overall population consumption. In turn, that would be expected to lead to increased negative effects on the health and well-being of individuals, families and communities. Although increased alcohol availability may support aspects of our economy, such as tourism, we agree that it is responsible to adopt a whole-systems approach when considering changes to legislation. In financial terms alone, it has been estimated that the social cost of alcohol-related harm in Northern Ireland is at least approximately £900 million each year. That figure would be expected to increase if policies on the wider availability of alcohol were implemented. We strongly contend that it is vital that public health messaging on the negative health and well-being effects of alcohol misuse are regularly communicated in any general liquor licensing system.

One of several objectives in the 'New strategic direction for alcohol and drugs phase 2 (2011-16): A framework for reducing alcohol and drug related harm in Northern Ireland' is to challenge the social norms associated with alcohol misuse that drive the drinking culture. We do not support any change to legislation that would lead to an increase in alcohol accessibility, as our view is that that would reinforce social norms and increase the risk of alcohol misuse and its harms. In addition, we support the addition of any explicit statements that the protection of public health and the promotion of well-being is a key objective of the Northern Ireland licensing legislation.

The Chairperson (Ms P Bradley): Are you still there, Maurice?

Mr Meehan: Yes. Can you hear me?

The Chairperson (Ms P Bradley): Yes, I can hear you. Sorry. We have lost Michael, by the way, but I can hear you.

Mr Meehan: OK. When we consider —.

The Chairperson (Ms P Bradley): Sorry, Maurice. Can I stop you there? A withheld number has come through. Could that be Michael? We are not waiting for anybody else. We will double-check that. I am sorry for interrupting you, Maurice. Go ahead.

Mr Meehan: That is no problem.

The Chairperson (Ms P Bradley): We have brought a withheld number into the spotlight. If you can hear us and you know that you have now been brought into the spotlight, can you tell us who you are?

Mr Michael Owen (Public Health Agency): Yes, I can hear you. My name is Michael Owen. Unfortunately, I was unable to get through on StarLeaf.

The Chairperson (Ms P Bradley): That is dead on, Michael. We are glad to have you here. We keep interrupting Maurice when he is in full flow. I will come back. Thank you, Michael, for joining us. Maurice, do you want to carry on? Sorry.

Mr Meehan: No problem. There was no pun intended in the "full" reference, let me assure you.

Let us consider some of the alcohol statistics that relate to Northern Ireland. Thirty-one per cent of adults binge drink at least once a week. The source data is the adult drinking patterns survey of 2013. Eighteen percent of adults consume alcohol above weekly limits according to the Northern Ireland health survey 2017-18. Alcohol-related hospital admissions, for primary care and any diagnosis, have also steadily increased for males and females. The same pattern was observed for admissions for the diagnosis of alcoholic liver disease. Alcohol-related deaths have increased over the past 17 years for males and females. Finally, 40% of children and young people who are on the child protection register and 70% of looked-after children have that status due to parental substance misuse. The source data for that is our Hidden Harm strategy.

Let us also consider other important evidence that was adapted from the Faculty of Public Health. On advertising and marketing, exposure to advertising has led to both earlier initiation into drinking and heavier drinking by children and young people who are so exposed. Children are more likely to drink beverages that are heavily advertised, unlike adults, who consume a more diverse range of products. The level of intoxication and the odds of drink-driving and being involved in physical altercations on leaving an on-trade venue are doubled by the presence of price promotions. On sales and licensing, there is strong evidence that the price of alcohol is an important determinant in its consumption. A 10% increase in the price of alcohol would lead to a 5% decrease in its consumption. Minimum unit pricing would affect high-risk drinkers and the off-trade most. Moderate drinkers and the on-trade would be minimally affected at the proposed rates. Early reports suggest positive effects in reducing the consumption of alcohol by heavy drinkers in Scotland as a consequence of the introduction of minimum unit pricing. The PHA is very supportive of the potential adoption of minimum unit pricing in Northern Ireland and is keen to follow up with any of you who have an interest in exploring that option.

I am coming to the end of my briefing. On the protection of children and other vulnerable groups, risks are increased when licensed premises have no restrictions on where families can sit, such as at the bar, and the time that families can be present where the focus is on drinking and where alcohol is advertised. UK population-level studies clearly demonstrate an elevated health burden that is attributable to alcohol in areas of higher disadvantage, even though the consumption levels are less.

Thank you for your invitation to provide evidence to the Committee. Michael and I are happy to take any questions that you might have.

The Chairperson (Ms P Bradley): Thank you very much for that, Maurice. It is well recognised that, in Northern Ireland, our relationship with alcohol certainly does not cover us in glory. I worked in Antrim Area Hospital and Whiteabbey Hospital for a number of years. I worked with a lot of people who needed major medical intervention as a result of alcohol dependency. I have seen not only that side of it — the need and reliance on the health service — but the impact that it has on families and society as a whole.

You mentioned £900 million per year as the cost of alcohol-related harm. Do you have any estimate of what the cost would be of additional hours or drinking-up time or of any of the other proposals in the Bill? Have you any estimate of any increase that there would be from that?

Mr Owen: Perhaps I could come in on that, Maurice.

Mr Meehan: OK, Michael, please.

Mr Owen: It is difficult to put an estimate on any one of those or on all of them together, but we have seen that all the legislation in the last 50 years that has increased the availability of alcohol has led to an increase in overall population consumption. It is absolutely impossible for us to say whether that is by 1%, 2% or 3%, but the pattern in every case is that, where availability is increased, consumption increases.

The Chairperson (Ms P Bradley): I know from evidence that we have taken that, for the vast majority of people, alcohol consumption happens in their home; it does not happen in our bars and restaurants. We see that increasing more and more. I think that you will see it increasing during COVID because

people have got into the habit of drinking at home rather than going out, plus it has an economic benefit for them.

Your submission states that you do not agree with the relaxation of the rules on children in licensed premises. I assume that that is because you feel that it encourages children to see drinking as normal. Do you have any of the evidence behind that?

Mr Owen: There is certainly a raft of evidence on children and their attitudes. We in the agency often say to parents — I am a parent of two kids — that they should not underestimate the power of how their behaviours affect their children's attitudes and values. The evidence is clear that children are most greatly influenced by their parents. Even in terms of COVID, we put out a press release last week, and one of our key messages was about not drinking in front of your children. Again, it goes back to the reinforcement of social norms, where children grow up without seeing drinking alcohol as a normal behaviour. Our reservations and concerns about relaxing the rules on children in licensed premises are that it would absolutely reinforce the norm.

The Chairperson (Ms P Bradley): Your submission highlights that you feel that, if current voluntary codes of practice were approved by the Department, they would not go far enough to regulate the industry. What would you like to see in those codes of practice?

Mr Owen: We would like it to be a statutory code of practice rather than an industry-led code. We have seen over the last 30 years industry-led codes of practice on drinks promotions etc. Whilst those codes may be followed by a majority of retailers, there is always and constantly a minority of venues where they are ignored. From our experience to date and certainly from working with the PSNI, we argue that rigorously enforced statutory regulation is likely to be much more effective than a simple industry code of practice. Our concern is also that, if the codes of practice were given some type of approval by the Department for Communities or the Government, they would be seen as stronger than they actually are.

The Chairperson (Ms P Bradley): I understand that.

Members, does anybody want to ask any questions of Michael or Maurice?

Mr Easton: Thank you very much for your presentation. Most of the presentations that we have had so far have been supportive of changing the Bill, but yours is quite stark in contrast, as it is about the problems of increasing opening hours and stuff like that. The amount of money — £900 million — that is being spent on health-related issues to do with alcohol is worrying. I saw some of the statistics, which show that 31% of adults binge drink. I would not have thought that, but, obviously, you know. Do you really believe that increasing opening hours by an extra hour or so will make such a big difference?

Mr Owen: That is what we call the "drip, drip effect". We are clear in our evidence that, on every occasion across the last 30, 40 or 50 years when availability or licensing hours have increased, we have seen an increase in overall population consumption. An increase of an hour or a half an hour may seem modest, but it has had a drip, drip effect over the years until now, as, if one looks at the economics, one sees that alcohol is now more widely available and cheaper than it was 30 years ago.

I am sure that we can come across in a way that makes you think, "What is the PHA talking about? It is only an hour. What big difference will that make?". However, I would say to anyone that they should go into one of our EDs on a Friday or Saturday night to see what difference it makes. People will inevitably drink more if they have more time. Not everyone will, but, if you take it across the entire population, you will find that, without doubt, we will see some form of increase in alcohol consumption.

Mr Easton: OK. If I am correct, you also mentioned that, if there was a 10% increase in the cost of alcohol, there would be a 5% decrease in health issues. Would there be a 5% decrease in the £900 million spent on health?

Mr Owen: No. I think that that is linked to Maurice's introduction, when he talked about what we call "minimum unit pricing". Minimum unit pricing is supported by the industry in Northern Ireland. People see it as some form of additional tax. Basically, you are adding to units, and, therefore, the strongest drinks become the most expensive. The strongest drinks, such as very high-strength lagers and ciders, which are currently sold very cheaply, cause most damage mentally and physically. You see

often, particularly where there is alcohol dependency, how people try to get the highest-strength alcohol for the lowest possible price.

Minimum unit pricing has been shown to be very effective in reducing the harm for the most vulnerable group who are dependent on alcohol. It would add perhaps 10p to a bottle of normal-strength wine, whereas it would have a more significant cost impact on high-strength lagers. The statistic that Maurice was referring to is that a 10% increase in the price of alcohol would lead to a 5% decrease in its consumption. If you look at tobacco sales, you see that they are quite regulated by various forms of tax. As we have seen tobacco increase in cost over the years, we have seen a subsequent reduction in people using tobacco and an increase in people stopping using it. The same argument and evidence apply.

Mr Meehan: Just to add to that, the early results in Scotland are promising. The adoption in Scotland of minimum unit pricing appears to be having positive effects in reducing the consumption of high-strength alcohol among those who previously sought to purchase it at the lowest cost.

Mr Easton: Thank you. You have given me some food for thought.

Mr Newton: I thank Maurice and Michael for their evidence. You referred to minimum unit pricing in Scotland. Historically, the levels of alcohol abuse in Glasgow are very serious, as I understand it, and there is a connection between alcohol abuse and drug abuse in Glasgow. Can you comment on that?

I am intrigued by the last line of part of your written presentation, which states:

> *"In addition, we would support the inclusion of an explicit statement that the 'protection of public health and promotion of well-being' is a 'key objective' of the Northern Ireland licensing legislation."*

Perhaps you could expand on that.

You did not respond to the questions on the small producers of beer, cider and spirits looking to be a tourism asset. Maybe you could comment on that as well.

Mr Meehan: Thank you, Robin. Michael, could you deal with the correlation between drugs and alcohol misuse with reference to not only Scotland but the local profile?

Mr Owen: Yes. Scotland has a long history of a relationship with alcohol, as do Ireland and Northern Ireland. The mortality and consumption rates are higher in parts of Scotland, but, in the North here, we have extremely high rates of alcohol misuse as well.

Drugs and alcohol have an interconnected relationship. People often talk about "gateway drugs" such as cannabis and whatever. We, as an agency, will tell you strongly that the gateway drug to all illicit drug use is alcohol. Literally every child's first experience of drugs is alcohol. We forget that alcohol is a drug. It is a very potent drug. It can be a fatal drug. We forget that, because it is called alcohol, we have nice labels and we have lovely advertising telling us how enjoyable it is. If we look at drug-related deaths, we see that 80% of them involve drugs and alcohol. Alcohol is a depressant. If you add other depressants, that presents serious risk of overdose, respiratory failure and cardiac failure. For us, the relationship is clear. I will not speak on behalf of the Department of Health, but I think that that is why we have an alcohol and drugs strategy and not for one or the other. As I say, frankly, alcohol is a drug. It is a legalised drug, but that does not make it an absolutely safe drug.

The reason that we did not respond about the smaller brewers was that the question was this:

> *"What impact do you envisage this could have on tourism?"*

We did not really think that that was a question for us to answer. Really, I do not know. It may increase tourism; it may not increase tourism. However, our overall view throughout our submission is that any increase in availability will lead to increased consumption across the population.

Maurice, do you want to deal with the point about integrating public health objectives into licensing laws?

Mr Meehan: Making Life Better is our public health strategy. Essentially, we encourage and invite the consideration of public health and well-being across all Departments and all policies. If health and well-being are referenced in the legislation, that strengthens the compulsion for consideration of proactive and protective measures associated with health. As Michael has clearly and starkly indicated, alcohol, while pleasurable in moderation, is a very harmful drug when taken in excess. The £900 million social costs — courts, prisons, hospitals, social care, early deaths and the impact on the economy — are stark. In that sense, we are increasing with you the sense of prioritisation of the health consequences of legislation.

Mr Owen: Maybe I could add a practical example of where the protection of public health and the promotion of well-being are included in alcohol legislation that we have seen in England. That is where the courts can take into account potential public health implications. We know, for example, that there may be higher rates of off-sales and public houses in areas of disadvantage. Courts can then take it into account that issuing a further licence may have a further negative impact on public health locally. That is an example of how some of that can work in the overall licensing system.

Mr Newton: Thank you, Maurice and Michael.

Mr Durkan: Thanks to Michael and Maurice. Guys, I fully appreciate your concerns and understand where you are coming from. I would not for one second doubt the dangers or cost of alcohol abuse and would, therefore, be extremely surprised if you were vocal advocates for any relaxation of the rules. However, is there any evidence that jurisdictions with opening hours similar to those proposed in the Bill have experienced worse effects on the health and well-being of individuals, families and communities? Are we, in Northern Ireland, necessarily in a better position than England as a direct result of our current arrangements?

Mr Owen: Maurice, if you are happy, I will pick up that one.

Mr Meehan: Yes, I would appreciate that, Michael. I do not personally know how I could reference any evidence around the comparative data.

Mr Owen: I do not have the figures to hand, but I can send them through to the Committee if needs be. It is quite straightforward: Northern Ireland has a higher consumption of alcohol by those who drink than by those who do so in England. To put a balance on that, I say that we also have the highest rate of abstainers who do not drink alcohol at all, right across Ireland, compared with England, Scotland and Wales. However, those who decide to drink drink more than our English and Welsh counterparts. We drink slightly less than our Scottish counterparts.

I do not have examples of specific instances in other jurisdictions to tie down to the exact provisions in the Bill. For us, however, it comes back to the overall point, namely that every study that we have looked at from over the past 30 or 40 years has shown that, with any increase in availability, we subsequently see an increase in population consumption. I described it earlier as the "drip-drip effect". We are now at a stage in Northern Ireland where we have allowed so much to be introduced over the years, and some of that has been referred to here. It is certainly not all about pubs or restaurants. A large proportion of our problem now is the home-drinking culture, off-sales, promotions and discounts. We welcome a number of proposals in the Bill around that area, for example not getting loyalty points on a supermarket card for alcohol.

I apologise: I have lost my train of thought. Can I ask what the question was again?

Mr Durkan: It happens.

Mr Meehan: Mark, our overall health profile suggests that 5,500 people in Northern Ireland die prematurely annually. There are a lot of factors associated with that statistic and the fairly extensive loss of years of life expectancy. Alcohol plays a part in that, albeit that it is not, by any means, the only reason. There are significant effects on the wider Department of Health that highlight our poverty prevalence and many other social and economic factors. There is definitely a direct correlation between excessive alcohol intake and hundreds of early deaths in Northern Ireland annually. As you said, an obligation of the Public Health Agency is to think about how it can protect and improve health outcomes and reduce health inequalities. We are obliged to follow the evidence that indicates that increased hours would lead to increased consumption. From our perspective, such a development would be a negative.

Mr Durkan: Again, I reiterate that I am not denying or in any way dismissing the dangers of alcohol abuse. Over the years, there has been a drip-drip effect and relaxations and a trend towards an increase in consumption, but is that increase in overall public consumption directly related to opening hours? Let us look at the lockdown: bars have been closed for a long time, and off-licences have been closing earlier. Has that led to a big reduction in consumption?

Mr Owen: No, through COVID, we have seen that those who have continued to drink have stockpiled alcohol to deal with the restrictions of off-sales closing earlier and the lack of bars and restaurants. It is still early days for us in trying to work through alcohol behaviours during COVID. We have also picked up that a significant number of people have made positive lifestyle changes, including reducing or stopping drinking and increasing exercise.

Mr Durkan: That is not directly linked to opening hours, is it?

Mr Owen: Yes, if you increase opening hours, you increase accessibility to alcohol.

Mr Durkan: It is more of a societal change. I am not sure that it is specifically related to opening hours, given your previous answer on the experience in England. We have more restrictive opening hours, but the people here who drink drink more than those who drink in England, even though they have less restrictive opening hours. I do not know if you know what I am getting at, but some of the Committee members might. In my view, the points that you make on what is proposed in the Bill around opening hours do not stack up.

Mr Owen: You have to look at the complexities on the whole. We are making the case that, if you increase the availability of alcohol, we will see an increase in consumption. We have presented evidence for that. England has different licensing laws that include public health measures. There are also differing societal attitudes towards alcohol and how we use it.

Mr Durkan: It is more about those societal attitudes than it is about the opening hours. There is a correlation, perhaps, between them. I know that you have a lot of work to do on the evidence from the lockdown, but it probably demonstrates that it is not directly related to opening hours.

I have another question, albeit a similar one. I understand and accept your points that you do not agree with the relaxation of the rules on children in licensed premises and that children start to see alcohol as normal behaviour. There is a difference between seeing alcohol as normal behaviour and seeing alcohol abuse as normal behaviour. With regard to experiences elsewhere — not necessarily England; on the continent, for example — it is very much the norm for children to be in licensed premises as their parents or whoever have a responsible drink. Do those children then go on to have issues with alcohol? You are the guys with the knowledge and expertise, but I understand that places that are more liberal suffer less with alcohol addiction and abuse.

Mr Owen: You have made a salient point: it is about what children observe with alcohol. What children observe in Northern Ireland is due to the level of binge drinking. In the Mediterranean countries, for example, binge drinking is much less than here. Alcohol is used in a different way and a less harmful way, frankly. We have a problem where alcohol is used in a more harmful way because we have a culture of binge drinking. When I talk about "binge drinking", by the way, it is defined as having five or more drinks in one session. Some people say, "That is not a binge. A binge means going on for the whole week", but that is how we define binge drinking. The culture in Northern Ireland, pre COVID, is that, come the weekend, we go partying. That is the type of alcohol use behaviour that we are concerned about children being further exposed to. The point is that children in other countries, such as in the Mediterranean, observe a different type of alcohol behaviour from what children potentially observe here, because of the nature and pattern of our alcohol use.

Mr Durkan: Could it be a chicken-and-egg sort of thing here? Are the different societal attitudes down to the fact that children are able to see people drinking responsibly? When they are out, it is generally a celebration or an event with people drinking responsibly, rather than children at home being exposed to people drinking irresponsibly.

Mr Owen: Our key message is that, no matter where the child sees the irresponsible behaviour, it will make some form of impact. Again, it is not just seeing something; it is also about how a child is most influenced by their parents or carers in developing their attitudes and values around alcohol. It is about how we use alcohol in Northern Ireland. We use it differently from countries like France, Greece and

Spain. That is reflected in our level of alcohol death and liver disease, which is higher than all those countries. That is where I am trying to come from. Yes, if children were exposed on every occasion to responsible drinking, that would be different, but the evidence tells us that they are often exposed to irresponsible drinking.

Mr Durkan: Yes, but your conservative respective approach is not working per se.

Mr Meehan: Mark, you raise a number of complex areas about the nature of our society, culture, behaviours and so on. So much of that is likely to be changed by multiple factors. From a public health perspective, we are giving you a firm position based on our analysis. It is up to the Committee to think of the balance of perspectives that it receives. We will be firm in our position relative to the other perspectives that you will receive.

Mr Durkan: I fully concur with your view on minimum unit pricing, for example. That is bang on, and we definitely have to do that. The Bill is not necessarily the vehicle to do it, but it certainly needs to be done. We have seen its positive impact in Scotland.

I will wrap up with one final question. Should the Bill — there will be further amendments — be passed, whilst bearing in mind your opposition, are there any measures that could help to allay your concerns around public health?

Mr Owen: Maurice, do you want me to pick up on that?

Mr Meehan: Our formal duty is to give you an analysis based on the evidence, the health profile, the concerns about alcohol consumption and the potential risks of increased consumption based on the current proposal to expand opening hours. That is our conclusion. We are indicating that the evidence is that this could make what is already a problem in Northern Ireland society slightly worse. Excessive alcohol consumption is a public health challenge as it is, and we are indicating that this could, to some extent, increase the risk on the basis of the profile of need that we see as a consequence of alcohol damage.

Mr Owen: You asked whether there were ways to mitigate the effect, and our basic position is to not go ahead with it. What we have said is that we would support the inclusion of an explicit statement or statements in the legislation about the protection of public health and the promotion of well-being as an overall key objective in any changes going forward.

Mr Durkan: Again, I do not underestimate the size of the challenge. It is a massive challenge that we all have to face and take on.

I have just thought of one more thing. Sorry about this, folks. I know that you did not comment on the proposals from local brewers and the amendment in that regard; you felt that that was outside your bailiwick. Given that we have heard from local brewers and are talking about a generally higher-value and more expensive product — I know that you said that opening taprooms per se would increase availability — does that impact on your view?

Mr Owen: I am not sure that I totally understand the question, Mark, but I will try to address it.

Mr Durkan: I did not ask it properly. I understand it, but I probably just did not articulate it. Given that our local beers and craft beers — we had a lady on earlier who produces cider — are generally more expensive than what is more widely available, would the introduction of those into the market and their promotion not have a positive impact as well?

Mr Owen: OK, yes. I think that I am with your question now. The 10% most harmful drinkers in Northern Ireland will not be customers of those types of establishment, because they seek high-strength, cheap alcohol. It is therefore unlikely that the 10% most harmful drinkers in Northern Ireland will be part of that custom. I think that what you allude to is that, because it is a higher-cost product, it could have an effect similar to that of minimum unit pricing. I would say to you that it is a different customer. The customer who is going for that probably has a greater income and is less disadvantaged than those whom we would target in relation to minimum unit pricing. The point that I make is that your income does not necessarily protect you from the level of alcohol that you take. If you are going over the weekly units, it really does not matter whether you are buying a high-cost

product, a medium-range product or a cheap product. The fact is that, going by those guidelines, you are increasing your risks of alcohol-related harm.

Again, for us, it is just the basic principle that, if you make alcohol more widely available over the population — it is important to realise that we come at this from a population viewpoint and not with specific groups in mind — there is a clear correlation between increased availability and increased population consumption overall.

Mr Durkan: OK, thanks for that.

The Chairperson (Ms P Bradley): I just want to make a point about something that Mark said. There is a great misconception that other countries' issues around alcoholism and alcohol-related harm are not highlighted to the same extent, especially in countries where alcohol is accepted as part of normal daily life. I remember reading a paper about Spain a couple of years ago. Spain's PHA equivalent ran a really big campaign not for holidaymakers but for its own citizens because of the cost of alcohol-related harm in Spain. Sometimes, we look at other countries where we see families out for dinner around the table enjoying a glass of wine and all those other things, but we also see others who are having their breakfast in the morning along with a glass of wine or a pint. The Spanish Government realised that they had major alcohol-related issues amongst their citizens and were trying their best to reduce alcohol consumption in Spain. We do not often see that side of things in other countries; we sometimes see a better picture than that, but it is happening.

Mr Durkan: I am not looking at it through rose-tinted glasses — or even rosé-tinted glasses, Chair. I do not know how much of that problem the Spanish PHA laid at the door of the fact that kids could go into areas that served alcohol. It is a complex area, and I do not expect us to answer it today.

The Chairperson (Ms P Bradley): No, I wanted to say that it is about societal issues rather than just the contributing factors. I am far from teetotal. I like a drink, and I am not against it in any way. However, there are lots of other issues that lead to those problems that, as you were saying, Mark, cannot necessarily be pinned down to one thing as a contributing factor.

I am sorry to butt in there. I will go to Kellie and then Andy. Can you hear us, Kellie?

Ms Armstrong: Thank you very much, Chair, and thank you very much, Maurice and Michael. To be honest, I have been waiting patiently for this type of evidence to come through, because it is a vital part of our considerations. We know that there is alcohol abuse in our society, but we have alcohol in our society. This licensing law will not remove alcohol from it.

I want to ask you a few clarification questions. You are absolutely right: we use alcohol differently from Mediterranean countries. I remember back in the dark ages, when I was at university, I read a study about Northern Ireland — I do not believe that things have changed so much in all those years — that said that the way that we drink alcohol was different from other places. While we may drink less than Scotland, instead of going to the pub at lunchtime for a half-pint while we read the newspaper, we tend to save it all up for a Friday or a Saturday night. When people go out drinking, they mean it, and it normally ends up with quite drunken behaviour. Nevertheless, there are people who can drink safely and can respect alcohol.

The document that you sent us is really helpful. You have said that you are not interested in any changes to children being in bars or the extension of drinking time or extended licensing hours. In your analysis, have you looked at how we could do things differently by accepting that alcohol is in society and that, to manage that alcohol better, we should consider promoting children seeing responsible drinking?

It would have been useful to see, as part of the licensing regime, some sort of enforcement clause. PHA is suggesting ways of bringing in enforcement issues. Enforcement could be brought in so that a bar or a licensed premises that continually had issues at closing time or throughout the evening could have its licence revoked or have limits put on its licence. Is there anything from your analysis that looks at it from the point of view not just of saying, "No, these things are not a good idea" but of laying out how we need to work with alcohol in society?

Mr Owen: Maurice, do you want me to respond? Sorry, Maurice and I are both on the phone, so we cannot see each other.

Mr Meehan: I will respond to Kellie first, and then you can go ahead. We are pleased to know that the robust evidence and the robust position that we are representing is at least a firm consideration for you. I am happy to clarify any of the evidence and research, as well as the prevalence or consequence issues, as they are severe. If we, as a society, are trying to reduce the incidence of early death and to increase life expectancy, particularly for those at greater risk from increased alcohol consumption, much more needs to be done. Our position is solidly pointing the Committee to the consequences of alcohol legislation and the risks associated with some of the measures in the Bill.

Mr Owen: Kellie, thanks for your comment. There are two key strategic drivers for us. One is minimum unit pricing, which we have already discussed. We believe that the evidence is clear that it reduces the harm caused to vulnerable drinkers. We are encouraged by the results and evaluations from Scotland on the effect of its minimum unit pricing.

I am not sure that we have explained ourselves well enough on the other strategic area for us, which is the promotion of public health and well-being as part of an overall legislative framework. To that end, we have looked at other areas, such as England, where public health is incorporated. I know that their licensing laws are different from ours. However, that has allowed enforcement against — I do not like to use this term — a "problem bar" or a repeat offender that regularly has issues at closing time, with antisocial behaviour, with underage drinking and with a raft of issues. There, the local police and the local courts *[Inaudible]* in terms of responding to those and looking at the issuing of licences. Public health is having a direct input into localities and into managing issues with poorly managed establishments. According to our legislation, someone who is intoxicated should not be served. However, we have all been in bars where we have seen people who are clearly intoxicated continue to be served alcohol.

For the agency, the two key issues are minimum unit pricing, which, we believe, will have a positive impact on a population approach, and the greater involvement or input of public health in licensing legislation and decisions.

Ms Armstrong: That is interesting. I noted in your response that you recommend that voluntary codes of practice should be statutory. That is what I want to tease out with you. If there were a statutory code of practice, who would have an input into it: the PHA, the trusts, the Department? I do not want to put words into your mouth, but I assume that you would like to see a code of practice being reflected on at licence renewal time or if there was an enforcement issue.

Mr Owen: Absolutely, that should be part of the consideration of relicensing. We talk about having statutory approval. Obviously, enforcement would be an issue for criminal justice colleagues, but the PHA would be more than willing to be involved and to assist in the development of guidelines. The point is that it needs to have a statutory basis. Our experience as the Public Health Agency since 2009 and previously as health boards is that voluntary codes of practice are rarely as effective as a statutory code of practice with rigorous enforcement.

Ms Armstrong: There could be bars — it does not matter where they are — outside which, at drinking-up time, when people leave, there is an ambulance, there is violence on the street and there are people who are very intoxicated. We know about attacks, whether sexual or physical, that, sadly, happen. As far as the PHA is concerned, is there an easy way for that type of external behaviour to the bar or licensed premises to be collated, or would that need to come from the police rather than you? I am thinking about the pressures that are put on the Ambulance Service and on A&E departments. If there were a statutory code, would that information be easily available without creating too much cost or pressure for the PHA to be a statutory adviser or have a statutory role?

Mr Meehan: Were statutory measures adopted, we would certainly seek clarification of our role relative to the Department of Health. We would invite involvement. There would be an opportunity to bring together accident and emergency data and ambulance data alongside policing and justice colleagues and the Department for Communities, for example. That joined-up thinking about cause and effect and about whether there is a localised problem and localised solutions would lead to better joined-up dialogue between public health, industry, criminal justice and policing.

Ms Armstrong: Would it help the licence holder to consider the impact? To be honest, if I turned up at a bar and had a pint of cider, I would be intoxicated; I am not a big drinker. It is not about breathalysing people; you could breathalyse me, and I could be completely out of it having not had an awful lot, whereas somebody else can cope with an awful lot more alcohol than I could. If there were that impact on their licence, do you think that licence holders would take *[Inaudible]?* A lot of them are

responsible. I am not going to say that they are all terrible; they are not. I am thinking of the areas outside bars *[Inaudible.]*

Mr Meehan: It is helpful to consider the actions that would be incumbent on the licence holder, although some actions may be beyond them. For example, there is a shift to what young people call "preloading": people are consuming a significant amount of alcohol at home before going to bars. Not all the responsibility may fall on the bar owner, but the consequences of someone being drunk or significant numbers of people continuing to receive alcohol on a site and the related behaviours that might be seen outside licensed premises would, possibly, shift the dynamic around cause and effect.

Ms Armstrong: Can I ask about off-licences? I live in a rural area where off-licences sell a range a products, but there is always an issue with young people getting access to alcohol bought for them by an adult in an off-licence. What about the licensing of off-licences? We have been asked about extending licences to other premises, for instance, those of some of the people we heard from earlier today. Should there be a statutory code of practice for off-licences, so that, if an off-licence fails to deliver or fails to manage who buys alcohol, they could lose their licence, and PHA could have a role in that?

Mr Owen: We have tremendous concerns about off-sales because we know that it drives a lot of home drinking. Maurice talked about preloading. That is certainly the culture of young people now. I hate to show my age over the phone, but, in my day, you went to the pub at 7.00 pm or 7.30 pm. Now, however, they tell me that they do not go to the pub until 10.30 pm or 11.00 pm already well stacked. I come back to minimum unit pricing. Many of the drinks that young people stack up with are cheap and high in alcohol. Minimum unit pricing would have an impact there as well.

I have sympathy for the level of policing that we perhaps expect off-licences to carry out. If someone is clearly buying alcohol for a young person, we would expect staff to have adequate training to deal with that and to refuse sale. Unfortunately, we are aware of cases of parents buying alcohol for their children or others' children and of illegal alcohol sales to young people via various routes such as rogue taxis, for example.

For us, a lot of it is how off-sales staff are trained to recognise potential problems and how to implement a code of "Think 25" or "Think 21" when seeking IDs and recognising when someone may be buying alcohol for someone underage. I agree, Kellie, that an off-licence repeatedly ignoring those issues is an enforcement matter. If someone was stubbornly ignoring a statutory code of practice, effective action could be taken to moderate, adapt or remove the licence from that business.

Ms Armstrong: If the legislation proceeds as is — extended times for bars and drinking-up time in Belfast city centre, for example — that will mean people leaving bars later than 1.30 am or 2.00 am. I will not ask you about the money, as it would merely be putting a finger in the air. However, I am thinking about the pressures on A&E departments. We will still have people not able to cope with the alcohol that they have consumed and who need to leave a bar at 11.00 pm or midnight or 1.00 am. If we extend to 2.00 am and there are people knocking around at 3.00 am, I just wonder how that will affect A&E. Anybody who has been to A&E on a Friday or Saturday night knows that they are in for a long wait. There are normally lots of police there, there are people who are intoxicated, and there can be violence. What would be the human impact on A&E departments if closing times were extended? Is it just a little more, or are we expecting another 10% of additional pressures?

Mr Owen: *[Inaudible.]*

Mr Meehan: Kellie, you are right that there will be an inevitable correlation between later closing times and presentations at accident and emergency. I cannot say whether those will be worse or more intense as a consequence of increased consumption, although we have indicated our concern about them. Such an increase would certainly have an effect on accident and emergency departments, ambulances and policing. However, I cannot fully quantify it.

There would be an increased risk due to alcohol consumption; there could also be more of the disorder and violence associated with weekend drinking in city and town centres. Those are managed within current processes. Later closing hours will shift the times that you see increased presentations to accident and emergency. There is no doubt about that.

Ms Armstrong: Excuse my ignorance on shift patterns in A&E and hospitals, but I take it that staff come on at, say, 11 pm and work through until whatever time. Does it cause an issue with shift patterns, or is it OK as it stands?

Mr Meehan: Michael, do you have any thoughts on that?

Mr Owen: Yes. Kellie, it is difficult for the PHA because, as we do not commission services for EDs, we would not necessarily have that level of information; that would be with the Health and Social Care Board (HSCB). Being a registered nurse and knowing colleagues in ED, I know that shift patterns are different. The traditional night-duty shift pattern is 12 hours from 8 pm to 8 am. I imagine that local EDs would adapt their shifts around pressured times to cope with staffing pressures.

I think that the hospital trusts and/or the Health and Social Care Board would be better placed to comment. I am not sure whether you will hear from them. Colleagues tell me that the worst of the night tends to be over by 3 am or 4 am. When the bars and nightclubs start to empty, EDs know that they are looking at three or four hours of dealing not just with seriously ill people with cardiac arrests or heart issues or with victims of car accidents but with alcohol-related casualties. Unfortunately, some of those casualties will be verbally and physically abusive. It is, as you say, a pressured area in which to work.

I have been in the health service for 35 years and started off in casualty. I have watched levels of abuse and threats and physical violence increase year on year. The vast majority of it is linked to patients who have consumed alcohol and, in most cases, are intoxicated.

Ms Armstrong: I will not take up any more of your time in case anybody else needs to come in. Thank you very much to both of you. It was something that I have been patiently waiting to hear evidence on because it is the side of licensing and alcohol that we need to be cognisant of and to balance when making our considerations. Thank you very much.

The Chairperson (Ms P Bradley): Thank you, Kellie.

Mr Meehan: You are welcome.

The Chairperson (Ms P Bradley): There certainly are people waiting to come in. We have Andy and then Sinéad. Kellie mentioned getting evidence from the trust. Just to let you know, the Chief Medical Officer (CMO) was asked to brief the Committee, but, due to COVID-19 pressures, he was unable to do that. However, he will send a written briefing.

Andy and then Sinéad.

Mr Allen: Thank you, Chair. It will come as no surprise that Mark and Kellie covered most of the points that I was going to make.

Can I ask a quick question about the adult drinking pattern survey of 2013 that you referenced in your consultation response? Is there any more up-to-date data? Our research briefings indicated that there was not. Some of the data in it is useful, but it would be helpful to see the current trends. I appreciate that COVID-19 has thrown a spanner into the works

Mr Owen: We are in discussions about that. Most of our surveys involving children and young people are undertaken by the Departments of Health and Education. I am looking at that aspect. I am sorry: I was the person who filled in this paper, and I want to check whether we have any more relevant data. I am pretty sure that we do, so I have to hold my hands up and say that that may be an error on my part. If your people are happy, I will take a fresh look at the statistics and undertake to come back, via the Clerk or the Chair.

Mr Meehan: Andy, as you say, everything is affected by COVID-19 at the moment, but the 10-year census is planned for March of this year. That is a critical platform for data and will include questions about behaviour and alcohol. We will review the paper in light of the response to alcohol-related questions in the census of March 2021. We are due to get important and comprehensive data from the 10-year census.

Mr Allen: I do not underestimate the impact of alcohol-related harm in wider society. The survey data and your consultation response highlight binge drinking and drinking in the pub environment. Looking at the survey responses, perhaps the most significant impact that we face is alcohol consumption in the household. I do not want to pit consumption in pubs and restaurants against that in the household, but do you agree that our most significant problem is drinking in the household?

Mr Owen: You describe such drinking as "in the household" and, from that perspective, we agree with you. However, the source of home drinking is off-sales. Sometimes we lose focus when we talk about "home drinking" because what we are actually talking about is off-sales, and there is no doubt that the advent of increased off-sales, such as in supermarkets, makes an enormous difference. Alcohol is now cheaper than it was 30 years ago, and that has certainly fuelled an increase in the consumption of alcohol over the past 10 years.

Neither should we underestimate the power of alcohol advertising. Women are now either equalling or out-drinking their male counterparts. We can correlate that directly to the industry targeting its advertising at women over a number of years. We can also see that, whilst young people overall drink less than in the past, those who drink do so in a more harmful way. It is easy to see how the industry has targeted young people over the years, particularly with the introduction of what is traditionally known as the "alcopops culture".

Whilst home drinking is a major concern for us, we come back to the question of accessibility. We have seen the wider accessibility of alcohol through off-sales expansion and the overall reduction in price. Therefore, we have seen an overall increase in consumption in the population.

Mr Allen: That is a fair point. You were asked this by Kellie and Mark, but, in dealing with that, one aspect is the introduction of minimum unit pricing, and you have highlighted advertising. Are there other considerations that we should look at?

Mr Meehan: We referenced promotions. The promotion of reductions in alcohol pricing in bars is problematic owing to its link to the risk of significant increased consumption.

Mr Allen: I have one final point. Mark, you will be glad to know that I got your line of questioning about availability and increased opening hours. I am keen to see the data from other jurisdictions, because I would like to be able to compare it. That was teased out in the dialogue on societal patterns in Northern Ireland. COVID has shown where we are. I will leave it there, Chair.

Ms Ennis: Thanks very much for your time. The meeting has been very useful. Mark and Kellie have covered an awful lot of the issues. Like Andy, I got Mark's line of questioning and probably concur with much of what he said. I have a quick point to make that has not been mentioned yet. The Bill proposes to increase the number of licences for major events: does the PHA have a specific view on that? Do you see any risks or harm associated with such events specifically?

Mr Owen: Maurice, you may want to come in on this as well. For us, it is about the general principle of increased availability. It depends on what we mean by "major events", because there can be different aspects to them. I think particularly of young people and the culture at festivals, where, we know, there will be issues with alcohol and drugs among their audience. Compare that with an event such as the Open in Portrush. The point that I am trying to make is that, when we talk about major events, those events may differ. Overall, *[Inaudible]* legislation did not get through on time for whatever reason, and the Open was looking to sell alcohol? No matter what the source is — whether it is a major event, a small event, off-sales or a pub — our basic principle is that, if we increase availability, we will inevitably see some increase in overall population consumption.

Mr Meehan: I do not think that I have anything to add. We work to that key principle that, where you have increased opening hours, there is a risk of increased consumption. The point has been made that we are certainly happy to work with you on whether there is any comparative data from other jurisdictions to show that increased hours lead to a statistical increase in consumption, but that is our bottom-line concern.

The Chairperson (Ms P Bradley): Before you go, may I ask one final question? It relates to the various campaigns that the Public Health Agency is involved in, whether those be radio, television or advertising campaigns. Is there any ongoing campaign that relates to alcohol consumption?

Mr Owen: We have no specific campaign at the moment. You will appreciate that pretty much everything that our communications team has done in the past year has been on COVID messaging. As part of that campaigning, we have used blogs, social media and press releases. Most recently, only last week, on the further lockdown, we focused on not stockpiling alcohol at home. We continue to use our social media channels regularly, by which I mean weekly. There, we can target messages on alcohol and drugs to specific portions of the community. Maurice may want to pick up on this, but, as part of our COVID response, we have published regular blogs on our website. A number of them have included advice and guidance on alcohol. As ever, we have a range of published communications, all of which can be downloaded from our website, including 'You, your child and alcohol' and 'Alcohol — its impact on you'.

There are also links there to our drug and alcohol website, on which there is a wide range of resources, including all the services that can offer help to someone in your area who is having issues with alcohol or drugs. I strongly suggest that you, as MLAs, be aware of that and signpost constituents with whom you may come into contact. We are often told that there is no help for drugs and alcohol, but there is. There is help available in every trust area across Northern Ireland, commissioned by us and the Health and Social Care Board.

Mr Meehan: A component of the messaging that we focus on is family support. We take a holistic approach to prevention and support. Increased risks exist during COVID, but many of those risks for families predate COVID. We have been focusing our family support on ensuring that we pick up families who have concerns about increased alcohol consumption. We definitely have strong data on increased domestic violence during lockdowns. We know that excessive alcohol consumption is a factor associated with that increase in domestic violence.

The short answer is that we have no formal TV or poster campaigns going on. As Michael indicated, however, we are using blogs, social media and press releases. We are certainly maintaining key messages and guidance on alcohol and drugs.

The Chairperson (Ms P Bradley): Thank you for that update. I understand that COVID has taken precedence, but one of the results of COVID is the amount of alcohol that is being drunk at home. As you say, that has led to other problems with domestic abuse, safeguarding children and other issues. Any of the campaigns that the PHA has been part of have been very good, really hard-hitting and effective in getting the message home. I was not criticising you for not having any currently, because I know that the PHA does them so well.

Mr Newton: Chair, you mentioned the figure of £900 million a year as being the social cost of alcohol-related harm. Maurice and Michael, you commented on domestic abuse and child abuse: does that £900 million include domestic abuse, or are additional costs for that?

Mr Meehan: The £900 million is partly made up of the cost of imprisoning people as a consequence of alcohol-related offences. It also takes account of the loss of employment as a consequence of years of life lost and the direct cost of interventions associated with Health and Social Care (HSC) and accident and emergency. Michael, are there any other components of the £900 million?

Mr Owen: I am sorry, but I do not have them in front of me. The figure is from Northern Ireland's drug and alcohol strategy, which is being reviewed and is due for publication this year. I imagine that the CMO's briefing will make reference to that plus any updated figures. I will pull out the full list from the strategy and send it to the Committee Chair and/or the Committee Clerk. Maurice referenced a wide range of components, but I cannot be 100% sure that we have covered everything. I will double-check and resubmit the information to the Committee.

Mr Meehan: Robin, on your question, Michael made the point that the Department of Health has gone out for consultation on its substance use strategy, including alcohol and drugs, which is designed to be an interdepartmental strategy that will carry us forward for the next decade. Today's conversation provides a key opportunity to discuss issues relating to the introduction of health and well-being into the statutory legislation and to joined-up thinking between the Department for Communities and the Department of Health, via the substance use strategy, on how we can achieve some of those measures in legislation. A window is open. Perhaps there will be an opportunity to consider some of those measures, including minimum unit pricing. The issues that have been raised could be productively routed through the Department of Health in the context of the strategy.

Mr Newton: It is certainly my intention to ask the Chair about the protection of public health and the promotion of well-being as key objectives. I will certainly follow up on that.

The Chairperson (Ms P Bradley): Thank you. That is everyone. We went on for much longer than anticipated. Thank you, Maurice and Michael. As I have said at other evidence-gathering sessions, members need to take a balanced approach to looking at the Bill. That includes hearing evidence from everyone who is involved in anything to do with the Bill. Thank you, guys, for coming and answering all the questions in such depth.

Mr Meehan: You are welcome. We are happy to follow up with you. We wish you the very best.

Mr Owen: Thank you all.