Northern Ireland Assembly

Committee for Communities

OFFICIAL REPORT (Hansard)

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

4 March 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
Ms Karen Mullan
Mr Robin Newton

Witnesses:
Dr Helen McAvoy Institute of Public Health
Dr Joanna Purdy Institute of Public Health

The Chairperson (Ms P Bradley): Helen McAvoy and Joanna Purdy, you are both very welcome. Will you make some opening remarks? You have a maximum of five to 10 minutes, after which members will ask you some questions. Please go ahead.

Dr Helen McAvoy (Institute of Public Health): Great. Thank you very much. I am here with my colleague Joanna Purdy. We work together in the policy team in the Institute of Public Health. Thank you very much to the Chair and members of the Committee for the invitation to present today. The institute is an all-island body that informs public policy to support healthier populations in Ireland and Northern Ireland. We have offices in Dublin and Belfast and are jointly funded by the Departments of Health in both jurisdictions.

Alcohol is not an ordinary commodity. That is why a higher level of regulation around its sale is needed, particularly with regard to the protection of children. From a public health perspective, licensing regulations offer an opportunity to address patterns of consumption through regulation of patterns of sale. The last 12 months have been incredibly challenging for many people as a result of the pandemic, including those employed in the pub, club and restaurant sector. It is understandable that measures are put in place to support the recovery of that sector. However, we feel that care is needed in the selection of measures that not only support recovery but support and protect public health.

In today's presentation, I intend to focus on seven points: four are general points about the Bill, and the others are specific to the clauses. Will I go ahead with that, Chair, or do you want to pause at this point?

The Chairperson (Ms P Bradley): No; please go ahead.

Dr McAvoy: The first point relates to the relationship between alcohol licensing and public health. It is our view that measures that make alcohol easier to buy facilitate more drinking. More drinking can drive more harms. That is a relationship that has been recognised by the World Health Organization. Alcohol licensing also has some longer-term influence on norms around drinking. For example, making alcohol available in cafes, cinemas and sporting venues can fundamentally change the experience of those activities and create additional opportunities for drinking occasions.

When we in public health look at alcohol-related harm, we think about the population as a whole. Nearly two thirds of people in Northern Ireland report that alcohol-related antisocial behaviour was either a "very big" or "fairly big" problem in nightlife settings. The one in four people in Northern Ireland who are non-drinkers, as well as the three in four who drink, will be impacted by the alcohol licensing environment. At present, one in three male drinkers and one in 10 female drinkers drink above the low-risk guidelines, and one in 10 drinkers are in a bit of bother with problematic drinking. In summary, the drinking patterns and extent of alcohol-related harms in Northern Ireland mean that caution is needed in the adoption of measures that may increase the accessibility of alcohol.

My next point relates to the stated policy objective of the Bill. Without a clear reference to public health and safety in the stated objective of the Bill, it is possible that, in fact, alcohol-related harms could increase as a consequence of the Bill and the policy objective still be met. With that in mind, we invite the Committee to consider including some reference to the protection of public safety at least, and public health ideally, in the wording of the overall policy objective of the Bill.

My third point relates to public health as a licensing objective. I know that there are not specified licensing objectives in the Bill. The rest of the UK has licensing objectives, and Scotland has public health as a stated licensing objective. If there is no scope to do that within the Northern Ireland governance structures, the Bill could make alternative provisions to provide a meaningful role for local health authorities when licensing deliberations are made on, for example, the granting of new licences, licence renewal and granting of additional late-night opening or special events licences.

My next point relates to health impact assessment. The Making Life Better public health framework promotes a "health in all policies" approach. One of the tools that may be useful to the Committee in that regard is health impact assessment. That is a process by which a policy can be judged as to its potential effects on the health of a population and the distribution of those effects. That is a useful tool to balance the protection of public heath with economic and social considerations, and it can create proposals around how public health harms can be mitigated.

I will move on to specific clauses. Home delivery of alcohol has become even more of a concern in the context of the pandemic. We really welcome action being taken in that regard. It is a really important part of the Bill, and we strongly welcome it. Regarding self-service and vending machines, we welcome the commitment to close off what are novel avenues of alcohol supply but question the scale of the impact. We have no data on the significance of this type of supply. However, we do have evidence that 11% of 11- to 16-year-olds in Northern Ireland reported having bought alcohol from a pub or club. A focus on self-service and vending may have limited impact on reducing access, whereas greater regulation of serving practices to young people might be a better target for change and enforcement. Could the Bill make provisions for an enhanced programme of test purchasing as well, or make provisions for enhanced penalties for licensed premises that are proven to serve alcohol to minors? On that, how confident is the Committee that the issues will be addressed in a voluntary code that was drafted by those with a commercial interest in the sale of alcohol rather than specified as components of the Bill itself?

As regards alcohol promotions, we welcome the proposed restriction on off-sales drink promotion in supermarkets. However, similar to the other measures, that is a limited response to the broader challenge of alcohol promotion and advertising activities. We also support the practical alignment of entertainment and alcohol licences. In summary, we invite the Committee to progress the measures in the Bill as they relate to self-service and vending, promotions and home delivery, but also invite the Committee to enhance the scope of the regulatory measures in line with the evidence and with a firm commitment to statutory-led monitoring and enforcement.

With regard to extended trading hours and special events, the net effect of additional licensing hours may well be increased accessibility of alcohol and increased alcohol consumption. We could not see in the Bill any limits to the number of additional special event licences that could be granted or the number of additional trading hours per premises or geographic area. It is our understanding that there is no publicly available record of the number of authorisations or additional hours granted. We invite

the Committee to include in the Bill a commitment to shared data on the application and granting of those extended drinking hours.

Longer allowable trading hours have been tried in many countries, including England and Wales, Australia and Iceland. Many studies have tried to capture the effect of those changes. Not all of them reached the same conclusions. From our perspective, systematic reviews provide the best way of guiding decision-making. Those select the best-designed research studies, pool their findings and provide the best possible assessment on the body of good evidence available. From that, there is some evidence that extensions of trading hours are associated with increased assaults and injuries, increased demand for policing and increased demand for front-line services, including health services. That evidence needs to be taken into account.

We have additional concerns about the public health impact of proposals for alcohol licensing in sporting clubs. From a public health perspective, sports clubs are a real asset. They are a community asset. They support active and healthy lives and social inclusion. We urge the Committee to protect against creating the conditions where both national sporting events and local club events can be transformed into drinking occasions through things like branding, marketing, promotions and licensing arrangements.

I am coming to the end; do not worry. On the proposal on drinking time, we do not really find any evidence to say that extending drinking time leads to the outcomes of reduced instances of drinking too quickly or supporting a more gradual departure of customers. We invite the Committee to defer the provisions for increased drinking until such time as there is better evidence on the health and social outcomes and impacts for policing.

In summary, licensing reform that increases overall trading hours and creates additional opportunities for drinking occasions is likely to increase consumption. In the absence of a clear timeline for the introduction of minimum unit pricing and broader regulation of alcohol marketing and supply, the licensing reforms, as specified, have the potential to have some negative public health impacts. That concludes my presentation.

The Chairperson (Ms P Bradley): OK, Helen. Thank you very much. Joanna, do you have anything to say at this stage, or are you happy enough that we go to questions?

Dr Joanna Purdy (Institute of Public Health): I am happy for you to go to questions, Chair.

The Chairperson (Ms P Bradley): As part of our evidence gathering, we want to strike a balance and hear from everyone involved. We certainly have heard, in some of our witness sessions, about the impact on health and the harm related to alcohol. Does the Bill, in your opinion, strike that balance in looking at public health?

You maybe heard on our call earlier that, when we asked the Department about an evaluation plan, officials said that it was far too early even to look at any evaluation plan, yet that was brought up by the University of Stirling last week during a briefing. We also want to ask you about the reviews of these measures that the Department wants to take. Do you think that it needs to be included in the Bill that reviews must take place?

Dr McAvoy: On the question relating to evaluation, in general, the earlier we can plan for evaluation, the better. There are obviously deficits in the data, but there is probably also data that may not be fully interrogated as yet in its relevance to the Bill. The earlier that you can start to plan evaluation, the better, because, if there is data that is not being collected, plans need to be put in place to collect it and get the baseline. That takes time. For example, Scotland has a monitoring programme, linked to its legislation on minimum unit price, which reports in directly. Therefore, Scotland has set up a number of studies to examine the impacts of minimum unit pricing. That was supported by Public Health Scotland and other bodies, so there is a precedent to that approach being taken when new legislation on alcohol is put in place to monitor the impacts in an objective and neutral way.

With regard to the balance, the short answer, from a public health perspective, is that it depends what two agendas you are trying to balance. There is the potential for increases in alcohol consumption, but that would depend very much on the degree to which the licensed premises take up the full scope of what is available in any, essentially liberalised, licensing regime. When the Licensing Act in England and Wales went to 24-hour licences, not all the licensed sector rushed out and said, "We all want 24-

hour licences". In fact, some of them look for quite modest extensions. I do not know whether that is the case.

The concern is that, in the absence of knowing how the business sector might respond to being given the opportunity for additional licences, and without any limits on the number or nature of those licences, and without public health having a voice in the decision-making, there would not be a balance from the public health perspective with those things in place.

The other piece is in relation to the fact that alcohol policy spans many Departments. We are very keen to see minimum unit pricing come in on an all-island basis, based on very strong evidence of its success in Scotland to date. The balance of measures around alcohol licensing versus pricing versus the other things all need to be taken account of so that there is a wider balance across the broader alcohol policy agenda.

The Chairperson (Ms P Bradley): Just to follow on, you mentioned that you want to encourage us to consider the inclusion of public health as a defined objective in the Bill. Could we have a bit more detail on that? Is that found anywhere else? For example, is it in the Scottish Bill?

Dr Purdy: I will just pick up on the questions about the public health licensing objective. That was incorporated in the Licensing (Scotland) Act, which came into effect in 2005, although it was some years down the line before the licensing objective was fully implemented.

Obviously, the Scottish system is quite different. It has licensing boards and licensing is administered through local authorities, which is different to the administration of licences here through the courts system. It is important to remember that the public health licensing objective offers a number of potential benefits. It allows public health, health agencies and the health sector to be involved in licensing decisions. Those groups know their communities and the alcohol-related harms that are experienced in those communities. They have data and evidence at a local level and can articulate that very well to licensing authorities in order to set out the harms that communities are experiencing. They also, potentially, have the power to object to any licensing decisions. As well as that, they can help to inform any new licensing decisions or any amendments to existing licences, such as for extended opening hours. The focus on public health data and local data is immensely important in those decisions when it comes to looking at the impact on existing services and even any further pressure on services. It is an opportunity to bring health to the table when making licensing decisions.

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

Mr Newton: Thank you, Helen and Joanna, for being with us today and for your submission, which is excellent and well put together. There is a great deal of clarity in it. My question is about the protection and promotion of public health, which is the fifth objective in the Scottish legislation. In your submission, you:

"invite the Committee for Communities to carefully consider the wider public health implications"

in line with the protection and promotion of public health. Would you perhaps go a little further than inviting the Committee? Would you go as far as a recommendation? Can you expand on what you said?

Dr McAvoy: In order to have public health as a central consideration in the Bill, we identified the different mechanisms by which that could be actioned. One of those was to have public safety or public health named as a key component of the Bill's policy objectives. The second one was to have public health as a named licensing objective. We were trying to integrate public health concerns at the highest level not only in what the Bill hopes to achieve but in the mechanisms through which the Bill will be delivered and enforced at local level.

The concern is that there are a number of strong voices around the licensed sector, each with their own agenda. We are thinking about the communities that will be living in that licensed environment. We have said that one in four of those adults is a non-drinker and that they will be unlikely to benefit from any increase in licensing hours. Others will argue that they might, but there are children who live in that community and there are people who will experience direct and indirect alcohol-related harm. From that perspective, it is not an ideological approach to say that we need to reduce drinking. We do need to reduce drinking, otherwise we will not reduce alcohol-related harm. We also need to ensure that the community where everyone lives is designed in a way that is right for them.

Mr Newton: Is there any indication that the inclusion of that objective in the Scottish legislation has been successful?

Dr Purdy: Would you like me to respond to that, Helen?

Dr McAvoy: Yes, thanks, Joanna.

Dr Purdy: Implementing a public health licensing objective in Scotland has not been without its challenges. Professor Fitzgerald, who presented to the Committee last week, published a paper on that in 2017. That research paper highlighted the fact that there was success around winning hearts and minds as part of that political process and achieving success in recognising the importance of focusing on public health and the alcohol-related harms that occur in communities. We know, for example, that disadvantaged communities are disproportionately affected by alcohol-related harms. The level of alcohol-specific deaths in the most deprived communities is three times that in the least deprived.

Something like a public health objective is hugely important to look at the availability and accessibility of alcohol in, for example, low income or more deprived communities in order to assess the impact that it has on individuals and families and to consider what conditions and measures around licensing can be put in place to ensure that no further harm is caused as a result of increased alcohol consumption or increased access to alcohol.

Ms Armstrong: Thank you both very much for your presentation. Joanna, I am interested in teasing out further the public health objective. It makes sense that there is a wider issue to licensing consideration. In Scotland, does that translate as consideration, when licences are being given out by a local authority, of the spatial spread of those licences? We received maps from our researchers, which had come from elsewhere, that showed where pubs and hotels are concentrated. As you can imagine, that is in the larger towns and cities. However, Scotland looks at this from a public health point of view. I am thinking about, as it says in your paper:

> *"the prevention of crime and disorder, the protection of public safety, the prevention of public nuisance, the protection of children from harm".*

If we took that, we would perhaps not want to have such a concentration of alcohol available through those premises. Unfortunately, our current licensing system does not appear to take that into consideration. Should that be considered?

Dr Purdy: Thank you for your question, Kellie. Absolutely. In Scotland, the licensing objective applies to the over-provision in any given area, so it absolutely deals with issues around alcohol outlet density.

We know from some early work that we did a few years ago that alcohol outlet density is a particular concern and adds to alcohol-related harms. The public health objective essentially deals with the issue of over-provision. England and Wales have a slightly different system. They do not have a public health objective. They have cumulative impact policies, sometimes referred to as "cumulative impact areas", where they examine, as the name suggests, the cumulative impact of having the total number of off-licences and on-licences in any given area.

A quite significant project, the 'Change in Alcohol Outlet Density and Alcohol-related Harm to Population Health' (CHALICE) study, was conducted in Wales. It was published perhaps five years ago. We are happy to send that to the Committee after today's session for your information.

Dr McAvoy: I will follow up on what Joanna said. One of the concerns in less socially advantaged areas is that you may get a number of off-licence and on-licence premises coming together. What happens, then, is that they start to compete with one another on price. You then start to see co-location of betting shops and other outlets. That can create its own difficulties as well. They can become centres for street drinking and so on, which is probably the opposite of what we would like to see happening in the urban regeneration and social development of disadvantaged communities. That is the sort of broader perspective that needs to be taken into account.

There are two aspects. There is the temporal availability of the sale of alcohol and whether it is sold during the day, night or in the morning, and there is the geographic availability of the number of outlets. When you get a lot of outlets together, it can essentially create no-go areas for the rest of the community where people feel uncomfortable and intimidated, and there is street drinking, crime and so

on. Again, that is not what any strategy would look for in the social development of disadvantaged communities. Temporal availability and outlet density, with geographic availability, are both salient concerns.

Ms Armstrong: My goodness, it takes me back to my student days and the lonely hearts club that used to be Spuds in Shaftesbury Square. It was exactly as you described. Everybody emptied out of the pubs to go there to get something to eat. To be honest, I dread to think how any taxi driver got past that area.

In the Bill, the extension of hours and drinking time just means that there will be that type of congregation, especially in areas where there are a number of bars and pubs. It will just be moved back for a time.

When the police gave their presentation, they talked about the late-night levy that is used elsewhere. From a public health perspective, are you aware of whether that late-night levy is used to fund pressures on the health service resulting from people gathering at the end of the night? I am thinking of your list around public disturbance, crime and public safety. I know that it is not used very often, but, when it is used, is that public levy in part paying for health pressures?

Dr McAvoy: In principle, prevention is better than cure in trying to prevent those problems. I appreciate that they have a substantial cost to health and social services, including the Police Service, public transport and so on. Our front-line workers, who have been so important to us during the pandemic — ambulance drivers, the police and A&E staff — are also the people who will deal with any increase in alcohol-related harms in the acute setting of the late night or the early morning, so prevention is better than cure.

However, late-night levies have been used. I think that they are a good idea. There is a particularly good example in Newcastle upon Tyne. It operates a late-night levy. That has included funding for the police, the fire service, health and social care, the ambulance service and a medical pop-up facility in high-drinking areas. It has facilitated the involvement of NGOs that have an interest in getting involved. For example, when people are intoxicated, you may see an increased risk of sexual assault and an increased risk of mental health crisis. If there has been a relationship break-up or an argument, you may see increased risks of violent assault. NGOs working in that space recognise that they can have a role to play in addressing those issues.

When we think about mental health, sometimes we miss the impact of alcohol on people's mental health. It is strongly associated with the risk of suicide for people who are alcohol-dependent or have a problematic relationship with alcohol, and also, in general, for younger men who are intoxicated and become impulsive and have taken action that they would otherwise not have taken. That is a very difficult situation, and we need to think not only about the role that acute intoxication plays but about people who have a longer-term problematic relationship with alcohol. That will be relevant to the new mental health strategy.

Ms Armstrong: I am thinking in particular of the difficulties that we will have with our budget going forward. As we all know, plenty of NGOs, such as the SOS bus and the Street Angels, provide an amazing service. However, they do so without funding, and it could become problematic to deliver those services. A late-night levy might provide an income. Has there been any kickback from the commercial providers — the people who hold licences in any other area — against the late-night levy? Have they just accepted the levy as part of the way to protect their customers, especially after very late nights?

Dr McAvoy: I do not know the answer to that. Additional trading hours are profitable for the licensed sector, and we should not pretend that they are not. I do not know whether the scale of what they need to provide towards a late-night levy is significant compared with the profits that they make in the additional hours. I do not know the maths or the economics of that. Do you have anything to add on that, Joanna? We could certainly look into it for you.

Dr Purdy: There has been no formal evaluation of late-night levies. As I understand it, there has been good uptake in the London boroughs, for obvious reasons, and in other city centre locations. We know that it is working well in Newcastle upon Tyne. Around 70% of the levy goes towards policing, and the other 30% is managed by local authorities, which distribute it towards social care costs. One of the points that has emerged around late-night levies is to do with the geographic area in which they are applied. Where a licensed premises is permitted to stay open between midnight and 6:00 am, that

permission applies to all the licensed premises in that council district, as I understand it, regardless of the harm that might result from customers exiting a particular premises. Smaller establishments may not experience the same level of harm, violence or assaults or things like that. There have been challenges from some proprietors about that geographic spread. If something like a late-night levy were to be introduced in Northern Ireland, it would be worth having conversations with people in the Newcastle upon Tyne area to find out a little bit more about how it works, its practicalities and how it is rolled out.

Ms Armstrong: Thank you very much. I have asked all my questions. Thank you for providing us with such detailed responses.

The Chairperson (Ms P Bradley): No other members have indicated that they wish to ask a question. Thank you, Helen and Joanna, for joining us today and for your very informative briefing.