**FROM THE MINISTER OF HEALTH**

**Paula Bradley, MLA**
**Committee for Communities**

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Dear Paula,

**THE LICENSING AND REGISTRATION OF CLUBS (AMENDMENT) BILL – WRITTEN EVIDENCE FROM THE DEPARTMENT OF HEALTH**

As set out in my response of 3 December to your committee's letter of 23 November 2020, I attach (**Appendix A**) some written evidence from the Department of Health for the Committee for Communities to consider as part of their deliberations on the Licensing and Registration of Clubs (Amendment Bill).

Yours sincerely

Robin,

**Robin Swann MLA**
**Minister of Health**

**APPENDIX A**

**1. The Policy Objectives of the Bill**

**Overall**

Our current strategy to address the harm related to alcohol and drug misuse is supportive of any steps that seek to further restrict or regulate the accessibility of alcohol, as the evidence shows that this helps to address and reduce alcohol-related harm. In the main, the Bill attempts to build on measures already in place aimed at addressing the concerns surrounding alcohol consumption, and contribute towards a reduction in alcohol-related harm. DoH has been working closely on these issues with DfC over a number of years.

Accordingly, the Department will continue to work with DfC on the potential for further legislative change required in this area, in particular, the potential for public health to become an objective within the licensing regime. This would allow us to consider the harm related to alcohol use, but also issues in relation to wider health protection – such as the current pandemic.

Addressing the harm related to alcohol and other drugs is a key public health priority, and must continue to be so over the coming years. We have provided some background history and context which the Committee may find helpful during their deliberations.

Many of the services provided in Northern Ireland relate to both alcohol and drug related harm and thus much of the policy response is centred on substance use issues as a whole and are not necessarily alcohol specific.

**Licensing**

Alcohol is not an ordinary commodity. It cannot, and should not, be treated like bread or milk. Its sale is highly regulated for a reason. Licensing therefore plays a key role in setting the context within which alcohol is available. It also helps to set our "social norms" around alcohol use – loose regulations and wider availability makes alcohol seem more a part of everyday life; whereas tighter regulation and lower availability makes alcohol seem more like a substance that should be treated with care and consideration.

The term "passive drinking" was coined by Sir Liam Donaldson, former English Chief Medical Officer, to highlight the impact that alcohol misuse has on wider society, including: harm to the unborn foetus; acts of violence, vandalism, assault and child abuse; self-harm and the burden carried by the NHS and friends & family who care for those damaged by alcohol. "Passive Drinking" resonates with many as it highlights that alcohol misuse isn't just about individuals. Much like passive smoking – we also need to act to protect others from the health and social impact of other people's alcohol misuse.

The key to preventing alcohol related harm is to stop people misusing alcohol and to promote low risk drinking. While education and information help, the evidence shows that it is more important to create the right environment through licensing and regulation to signal to people that they should be consuming alcohol at low levels.

Liquor licensing therefore plays a key role in setting the environment, culture and social norms in which alcohol is consumed, and the evidence also shows that tackling the availability and accessibility of alcohol is one of the most effective ways of addressing

excessive alcohol consumption (see *Alcohol: No Ordinary Commodity*, Thomas Babor et al, 2010 and the report by the North/South Alcohol Policy Advisory Group on reducing alcohol harm by tackling availability[1]). The most effective measures include:

- Initiatives which increase prices – potentially including increased taxation, minimum unit pricing, and bans on discounts or promotions;
- Increasing age of sales;
- Restrictions on hours and days of sales;
- Restrictions on outlet density;
- Strict enforcement; and
- Restrictions on advertising/marketing.

I believe consideration should be given to making Public Health a key consideration under our licensing regime. This has been the case in Scotland for quite some time now, and it allows health organisations and community and voluntary groups to make representations on the granting/renewal of licenses in terms of the impact on the public health in an area. For example, this could pick up issues in relation to Alcohol Outlet Density. Higher alcohol outlet density has been shown to be associated with higher overall alcohol consumption and frequency of drinking. Higher AOD has also been associated with various aspects of alcohol-related harm, including alcohol-related accidents, self-reported injuries, suicide, alcohol-related road traffic accidents and fatalities.

**POLICY BACKGROUND**

Since 1986, there have been a number of Government initiatives to develop and implement a strategic response to alcohol and drug use. Initially there were separate strategies for Drug (1999) and Alcohol (2000) use, however in 2001 the Model for the Joint Implementation of the Drug and Alcohol Strategies (JIM) was launched.

In 2004 following a review of the two strategies and of the JIM, there was agreement that a *New Strategic Direction for Alcohol and Drugs*[2] (NSD) needed to be developed to tackle the harm related to these issues in Northern Ireland. Its implementation began in October 2006.

In 2011, following a review of the initial NSD, it was agreed that it would be updated, revised, and extended. This process also allowed the NSD Phase 2[3] to reflect new trends and re-direct effort to where it was most needed or to where new issues/concerns were emerging.

**Review of NSD Phase 2**

During 2018, the Department of Health undertook a full review of NSD Phase 2. The review evaluated the impact of NSD Phase 2 on its aims of preventing and addressing harm related to substance use in Northern Ireland.

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[1] http://www.publichealth.ie/sites/default/files/Reducing%20alcohol%20related%20harm%20by%20addressing%20availability%20maximising%20benefits%20from%20North%20South%20cooperation%20download.pdf

[2] https://www.health-ni.gov.uk/articles/alcohol-and-drugs-misuse#toc-0

[3] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-new-strategic-direction-phase-2-2011-16.pdf

The final review was published in January 2019[4]. In summary, the review reported some encouraging signs in relation to reductions in substance use at the population level – for example, there had been significant reductions in the levels of binge drinking and the percentage of young people who drink and get drunk. Among adults, prevalence of illegal drug use had largely plateaued and significant numbers of individuals and families continue to access treatment and support services for alcohol and drug use. In addition, drug use among young people had fallen significantly.

However, this was offset by increases in a range of indicators related to harm. For example, hospital admissions and deaths as a direct result of harm related to substance use, are high and rising, and there are ongoing concerns about polydrug use, the misuse of prescription drugs and Novel Psychoactive Substances. There appears to be a significant cohort of people engaging in increasingly risky behaviours, causing an acute increase in related harms. This has also impacted justice related issues, including organised crime, exploitation, trafficking, etc.

In terms of progress against the outputs within the NSD Phase 2, 24 (17%) of the outcomes within the strategy had been completed, 98 (70%) of the actions were classed as being on track for achievement as they were long term or ongoing in nature, and in 17 (12%) of the actions progress was being made but with some delay. 2 (1%) of the actions were not on target for achievement, mostly as other areas had been prioritised instead.

Stakeholders felt that NSD Phase 2 acted as a driver for increasingly effective collaboration and partnership working at both strategic and operational level, and successfully raised the profile of alcohol and drug-related harm in Northern Ireland. In particular, the consistency, diversity of representation and commitment of the NSD Steering Group was recognised. The Regional Commissioning Framework for Alcohol & Drugs was credited with bringing about service improvements in terms of better availability, accessibility, equity, co-ordination and consistency. Investment in workforce development was also highlighted, as was the progress made on embedding transition to an evidence-informed harm reduction approach.

However, stakeholders also felt there should have been greater alignment between strategic and operational elements of NSD Phase 2, along with better/more effective integration across the strategic agendas of other Government Departments. Also by placing focus on issues related to acute service provision, more structured opportunities may have been missed for evidence-informed future planning. Stakeholders also felt there could have been a better response to unintended outcomes and change management issues caused by the implementation of the Regional Commissioning Framework, and benefits could also have accrued from more data sharing and critical evaluation on existing programmes and services.

**Pre-Consultation Process**

Following the publication of the final review, the Department took forward a pre-consultation exercise as the first step of potentially developing a new substance use strategy for Northern Ireland.

[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/NSD%20PHASE%202%20Final%20Review%20-%20October%202018_0.pdf

**New Substance Use Strategy – Consultation**
Under New Decade, New Approach, the Executive is committed to publishing a successor to the current alcohol and drug strategy. Northern Ireland's new Substance Use Strategy "Making Life Better – Preventing Harm & Empowering Recovery: A Strategic Framework to Tackle Substance Use" was issued for public consultation on 30 October 2020[5].

Underscored by six population-level outcomes, the proposed vision of the new strategy is that people in Northern Ireland are supported in the prevention and reduction of the harm related to the use and misuse of alcohol and other drugs, and will be empowered to maintain recovery. Supporting people with co-occurring mental health and substance use issues is a key priority within the strategy, with an associated action seeking to remove barriers and improve access by ensuring that our treatment system can better support those with both mental health and substance use needs.

The document has been co-produced by the Department of Health, working in partnership with key stakeholders, both inside and outside government, including service users. The 14-week consultation closes on 05 February 2021, and subject to the necessary approvals, it is expected that a final Strategy will be launched in Spring 2021.

**Minimum Unit Pricing**
The harms caused by the misuse of alcohol are a major public health issue in Northern Ireland and the introduction of legislation for Minimum Unit Pricing (MUP) or Alcohol has the potential to be a key population-level health measure to address this issue. Health Minister Robin Swann has therefore made a commitment to have a full consultation on MUP once the new substance use strategy for Northern Ireland is launched, currently out for public consultation.

There is no predetermined outcome for the MUP consultation, which will examine a range of possible options in respect of alcohol pricing, including consideration of the emerging evidence of the effectiveness of MUP following its implementation in Scotland and elsewhere. Any policy considerations arising from the consultation will be brought to the Executive in due course.

**CONTEXT AND STRATEGIC DRIVERS**

Substance use, and the related harm, is not just an issue of personal responsibility and people's behaviours. It is very much interlinked with wider health outcomes, including health inequalities, and more widely with the economic, social and environmental circumstances in which people are born, grow, live, work and age.

We know there are overlaps and interactions between substance use and poverty/deprivation, mental health and wellbeing, community relations, community safety and justice, employment, economic development, trauma, and the impact of our past. To truly address this issue, we need to work collectively as Government and society to tackle these wider determinants.

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[5] Consultation on the New Substance Use Strategy | Department of Health (health-ni.gov.uk)

**FACTS and FIGURES**

**Alcohol Prevalence**
The use of alcohol is common in Northern Ireland. The most recent survey findings indicate that 79% of respondents drink alcohol; this proportion has remained relatively consistent since 2010/11.

In 2017/18, a fifth (20%) of respondents reported drinking above recommended weekly limits[6], with males (31%) around three times more likely to do so than females (9%).

The proportion drinking above guidelines has fallen from 26% in 2010/11 to 20% in 2017/18. The proportion of males drinking above guidelines has fallen from 37% in 2010/11 to 31% in 2017/18 and the proportion of females has fallen from 15% to 9%.

Considering deprivation, in 2017/18 there was no significant difference in the proportion who drank above the guidelines between those living in the most deprived (21%) and those living in the least deprived (22%) areas. However, those in urban areas (22%) were more likely to drink in excess of the guidelines than those in rural areas (17%).

**Binge Drinking 2005-2013**
Patterns of consumption are also important, with those who drink large volumes of alcohol in one sitting putting themselves at a higher risk. The most recent figures (2013) show that around 31% of adults binge drink[7] but this has fallen from 38% in 2005.

Over a third of males (35%) and more than a quarter of females (27%) had engaged in at least one binge drinking session in the week prior to the survey. Younger adults (18-29 year olds) were more likely to binge drink than older adults (60-75 year olds).

**Prevalence – Children and Young People**
Consumption of alcohol among our young people is also an issue of concern, with this having the potential to impact on a young person's immediate wellbeing, academic achievement, and longer term health and wellbeing as an adult.

Young Persons Behaviour and Attitudes Survey in 2019[8] shows that since 2000, there has been a decline in both the proportion of young people ever having drank alcohol and the proportion of those who drink that report having been drunk. The proportion of young people aged 11-16, reporting to have ever taken an alcoholic drink has fallen from 59% in 2000 to 29% in 2019.

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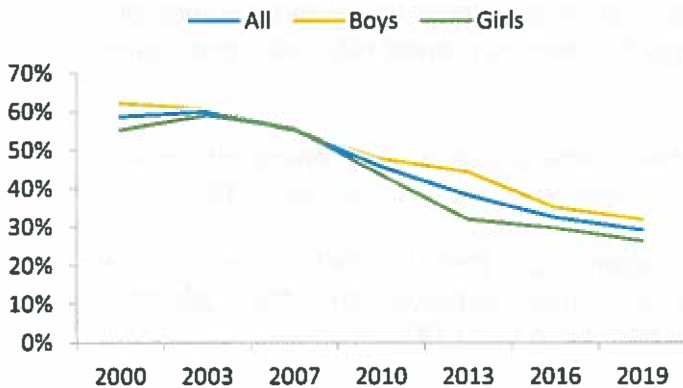
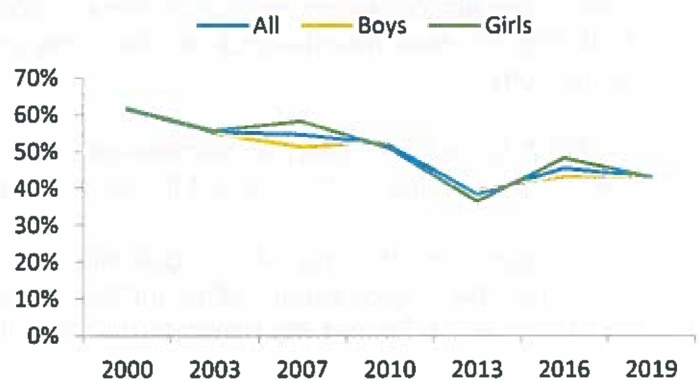
[6] The Chief Medical Officers' guideline for both men and women is that to keep health risks from alcohol to a low level, it is safest not to drink more than 14 units a week on a regular basis.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

[7] https://www.health-ni.gov.uk/publications/adult-drinking-patterns-northern-ireland-survey-2013

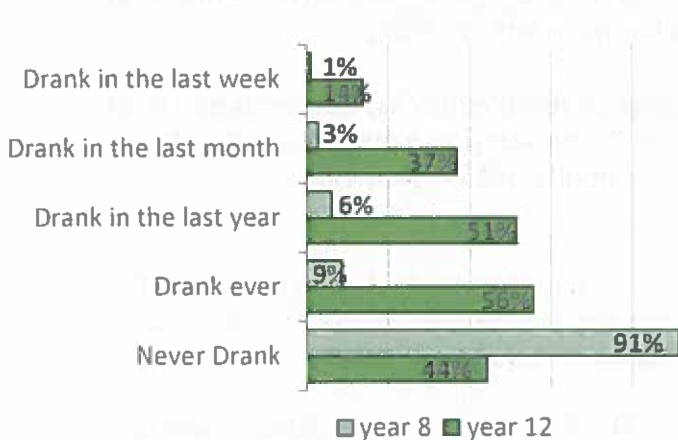
[8] https://www.health-ni.gov.uk/articles/young-persons-behaviour-attitudes-survey

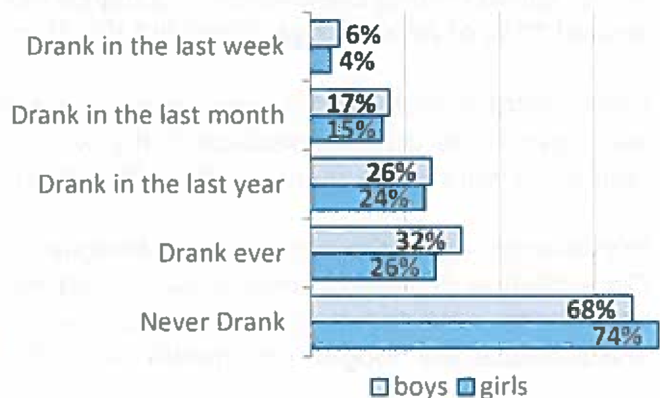



In 2019, boys (32%) were more likely to have taken a drink than girls (26%); and those in Year 12 (56%) were more likely to have done so than those in Year 8 (9%).

**Have you ever taken an alcoholic drink (not just a taste or a sip)?**

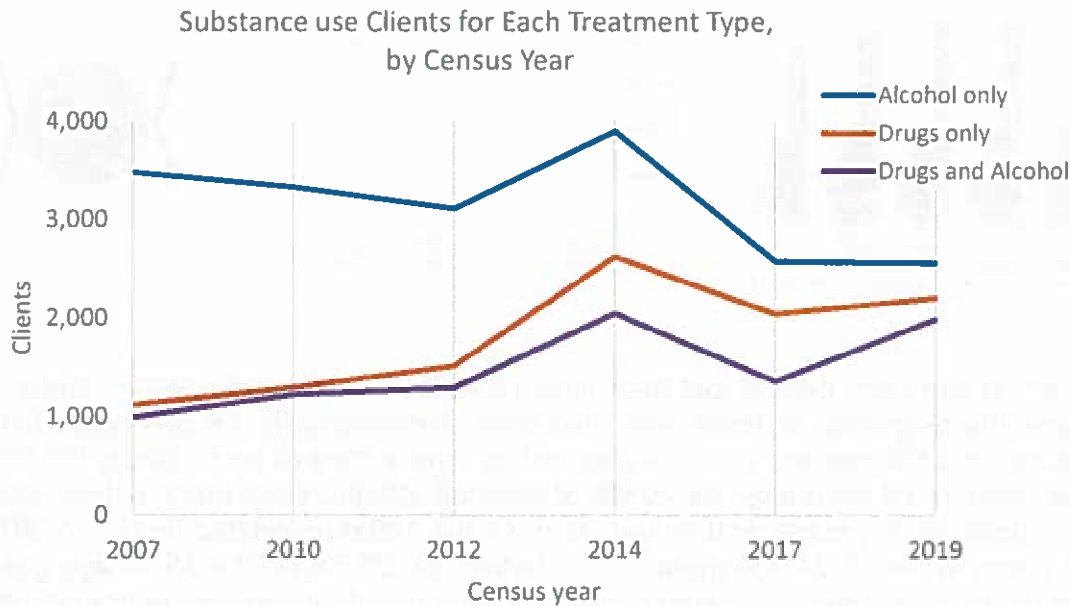



## Treatment

On 30 April 2019, a total of 6,743 persons were reported to be in treatment for use of alcohol and/or drugs[9] in Northern Ireland. The chart below shows the trend over the last 12 years. In 2019 there was an increase in the number of clients in treatment. Previous to 2019, the number in treatment had remained relatively stable with the exception of 2014. It should be noted that additional lottery-funded alcohol projects were running during 2014 which would have contributed to the increased number of clients in that year.

[9] https://www.health-ni.gov.uk/sites/default/files/publications/health/drug-alcohol-census-2019.html




In 2007, 62% of clients presented for alcohol only, by 2019 this had fallen to 38%

Clients presenting for Drugs only increased from 20% in 2007 to 33% in 2019

Drugs and alcohol increased from 18% to 29% for same period

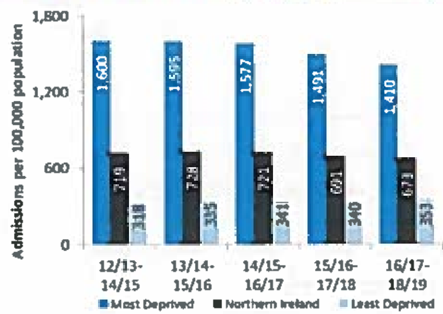
Treatment types have changed over the years with increases in the proportion of clients in treatment for drugs, or drugs and alcohol, and a decrease in those for alcohol only.

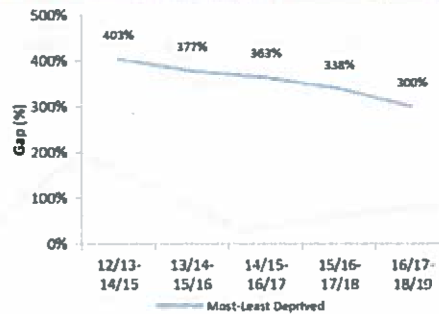
**Admissions to Hospital**

Admissions to hospital for alcohol (only) related diagnosis have remained at around 12,000 per year for the last 5 years, though interestingly admissions for alcohol and drug related diagnosis have fallen from 1,883 a decade ago to 1,263 in 2018/19. Admissions to hospital for drug (only) related diagnosis have also fallen from 3,346 a decade ago to 2,543 in 2018/19. However, it should be noted these figures are only for those who get admitted, not all those who attend Emergency Departments, and that both remain high.

Age standardised admission rates, which allow for direct comparison over time and between different population groups, show a fall in alcohol related admissions in NI (from 719 to 673 admissions per 100,000 population) and its most deprived areas (from 1,600 to 1,410 admissions per 100,000 population) over the last five years. With a slight increase in the least deprived areas (from 318 to 353 admissions per 100,000 population), the inequality gap in admissions between the most and least deprived areas has narrowed slightly however the rate in the most deprived areas is four times the rate in the least deprived areas.

Standardised Admission Rate – Alcohol Related Causes NI



## Deaths

284 people[10] in Northern Ireland lost their lives related to an alcohol-specific cause. In recent years, the proportion of those who died from alcohol-specific causes aged 55-64 has increased; in 2018 this age group accounted for over a third of such deaths (36.6%), while those aged 45-54 accounted for 29.6% of the total. We therefore have to think about how alcohol impacts on people as they get older. Of the 189 drug-related deaths in 2018, 72 (38.1%) were in the 25-34 age group with a further 50 (26.5%) in the 35-44 age group – therefore we seem to have a growing cohort of young people experiencing drug related harm.

The statistics (based on the period 2014 to 2018) also indicate that there are notably higher numbers of alcohol-specific deaths in areas of deprivation across Northern Ireland, with the age standardised death rate in the most deprived areas (31.7 deaths per 100,000 population) being more than four times the rate in in the least deprived areas (7.6 deaths per 100,000 population).

Standardised Death Rate – Alcohol Specific NI

## Costs

A report in 2008 estimated the cost of alcohol misuse alone at up to £900 million[11] made up as follows:

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[10] https://www.nisra.gov.uk/statistics/cause-death/alcohol-deaths#toc-0

[11] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf

| ANNUAL COST ESTIMATE | |
|---|---|
| Cost Element | Upper £m |
| Health Care | 158.0 |
| Social Work | 82.0 |
| Fire and Police | 279.3 |
| Courts and Prisons | 103.6 |
| Wider costs (including workplace) | 258.2 |
| **TOTAL** | **881.1** |

However, these financial costs do not reveal the true impact that substance use related harm has on individual people, their families and on local communities across Northern Ireland.

**2. Easter Opening Hours and Additional Permitted Opening Hours**

The Department of Health believes that Public Health should be a key consideration under our licensing regime and should be a factor for consideration when decisions on extending opening hours are made.

Careful consideration needs to be given to any measure that significantly increases opening hours, which would increase the availability of alcohol. The balance of reliable evidence suggests that extended late night trading hours leads to increased consumption and alcohol-related harms and have been associated with increases in:

- Consumption of higher strength alcoholic drinks
- Assaults and injuries
- Drink driving
- Demand for policing in the early hours of the morning
- Resource demand related to changes in shift patterns of frontline workers
- Public disorder in the early morning
- Late night/ early morning demand for health service response to alcohol-related harms

You may wish to refer to the World Health Organisation report (WHO (2009). Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. Denmark: World Health Organization) that concluded that "while extending the times of sale can redistribute the times when many alcohol-related incidents occur, such extensions generally do not reduce the rates of violent incidents and often lead to an overall increase in consumption with association problems".

**3. "Drinking-up Time" and the Alignment of Alcohol and Entertainment Licences**

The proposal to extend the duration of the "drinking-up time" in licensed premises from 30 minutes to 60 minutes might allow for a crowd to disperse over a longer period of time, thus allowing for the better management of safety issues. However, in practice it may simply lead to individuals purchasing larger quantities of alcohol at "last orders", staying the in the premises for longer, and becoming more intoxicated. In practical terms, it may just move the demand on our Police and health services to later in the evening. Perhaps

the impact of the provision could be monitored before deciding if this is something that works for the longer term.

I welcomes the proposal which should remove the current inconsistency between liquor and entertainment licences, and remove any loopholes or incentives for premises to continue to serve alcohol after hours.

**4. Supporting Tourism, Special Events and Small Producers**

I have no specific comment to make in relation to tourism.

However, the Department believes that the granting of additional hours for special events and making additional allowances for small producers should always take into account the public health implications beforehand.

**5. Children and Young People (under the age of 18)**

(Specific data relating to Children and Young People is set out in the Policy section.)

While the removal of the requirement for Children's Certificates could be seen as a loosening of these regulations, in practice the Department understands this is primarily an administrative change and that all the safeguards under the current Children's Certificate are replicated by the amendment. It is vital that these safeguards are properly enforced and monitored.

In general very careful consideration needs to be given to children remaining in licensed areas of hotels etc. to closing time during family events as we there is the potential to would further expose young people to alcohol, and potentially excessive alcohol consumption. It would also further the normalisation alcohol consumption among this age group.

In addition, careful consideration needs to be given to underage functions being held in licensed premises. Doing so perpetuates the norm that all functions – from christenings, through formals, to wedding and funerals – must be celebrated in licensed premises and that alcohol is at the heart of all these events.

Delivery of Intoxicating Liquor To Young Persons – I agree with this amendment – home delivery of alcohol should be no different to purchasing alcohol in on or off trade premises.

The linking of sporting clubs and alcohol consumption is a concern in terms of linking alcohol with sporting success and the normalisation of alcohol consumption – particularly among young people.

**6. Alcohol Consumption and Alcohol-Related Harm**

Measures to restrict the advertising of alcohol sales promotions are welcomed by the Department to help reduce the normalisation of alcohol consumption – particularly among young people.

Delivery of Intoxicating Liquor To Young Persons – the Department agrees with this amendment – home delivery of alcohol should be no different to purchasing alcohol in on or off trade premises.

The Department supports the prohibition on alcohol sales via vending machine and any supply of alcohol not made under the direct supervision of a licensee. This will ensure these premises can continue to monitor alcohol consumption and take a proactive approach in maintaining health and safety in these settings.

**7. Regulation, Enforcement, Offences and Penalties**

The Department welcomes any proposals that mean that codes of practice have a real impact on licensees and that help to improve the effectiveness of these approaches.

The Department has no other comments to make in this area.

**8. Resource Implications for Certain Organisations/Bodies**

(Specific data relating to hospital admissions and costs are set out in the Policy section.)

The proposal to extend the duration of the "drinking-up time" in licensed premises from 30 minutes to 60 minutes might allow for a crowd to disperse over a longer period of time, thus allowing for the better management of safety issues. However, in practice it may simply lead to individuals purchasing larger quantities of alcohol at "last orders", staying the in the premises for longer, and becoming more intoxicated. In practical terms, it may just move the demand on our Police and health services to later in the evening. Perhaps the impact of the provision could be monitored before deciding if this is something that works for the longer term.

**9. Registered Clubs**

The linking of sporting clubs and alcohol consumption is a concern in terms of linking alcohol with sporting success and the normalisation of alcohol consumption – particularly among young people.

**10. Additional Information**

The Department of Health believes that Public Health should be a key consideration under our licensing regime. This has been the case in Scotland for quite some time now, and it allows health organisations and community and voluntary groups to make representations on the granting/renewal of licenses in terms of the impact on the public health in an area. For example, this could pick up issues in relation to Alcohol Outlet Density. Higher alcohol outlet density has been shown to be associated with higher overall alcohol consumption and frequency of drinking. Higher AOD has been associated with various aspects of alcohol-related harm, including alcohol-related accidents, self-reported injuries, suicide, alcohol-related road traffic accidents and fatalities.