Processes of local alcohol policy-making in England: Does the theory of policy transfer provide useful insights into public health decision-making?

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Key message: Policy transfer provides useful insights into the drivers of public health decision-making in local government.

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Abstract

Background and aims: Recent years have seen a rise in new and innovative policies to reduce alcohol consumption and related harm in England, which can be implemented by local, as opposed to national, policy-makers. The aim of this paper is to explore the processes that underpin the adoption of these alcohol policies within local authorities. In particular, it aims to assess whether the concept of policy transfer (i.e. a process through which knowledge about policies in one place is used in the development of policies in another time or place) provides a useful model for understanding local alcohol policy-making.

Methods: Qualitative data generated through in-depth interviews and focus groups from five case study sites across England were used to explore stakeholder experiences of alcohol policy transfer between local authorities. The purposive sample of policy actors included representatives from the police, trading standards, public health, licensing, and commissioning. Thematic analysis was used inductively to identify key features in the data.

Results: Themes from the policy transfer literature identified in the data were: *policy copying*, *emulating*, *hybridization*, and *inspiration*. Participants described a multitude of ways in which learning was shared between places, ranging from formal academic evaluation to opportunistic conversations in informal settings. Participants also described facilitators and constraints to policy transfer, such as the historical policy context and the local cultural, economic, and bureaucratic context, which influenced whether or not a policy that was perceived to work in one place might be transferred successfully to another context.

Conclusions: Theories of policy transfer provide a promising framework for characterising processes of local alcohol policy-making in England, extending beyond debates regarding evidence-informed policy to account for a much wider range of considerations. Applying a policy transfer lens enables us to move beyond simple (but still important) questions of what is supported by 'robust' research evidence by paying greater attention to how policy making is carried out in practice and the multiple methods by which policies diffuse across jurisdictions.

Introduction

Measures to reduce alcohol consumption and alcohol-related harms are a component of legal and regulatory systems around the world. Examples of policies include excise duties, age limits for the sale and purchase of alcohol, and blood alcohol concentration limits for driving (1, 2). The detail of these policies varies across nations as well as within countries by city, region, or state. In the UK, whilst some alcohol policies are established at a national level, the most recent Government Alcohol Strategy (3) published in 2012 placed renewed emphasis on the role of local authorities (LAs) in identifying and implementing policies that are relevant to the local drinking context. There are 353 LAs in England (27 county councils covering 201 district councils, and 125 single-tier authorities) (4), and it is at this local administrative level that this paper focuses to understand the processes by which sub-national policy makers select and develop alcohol policies.

There are important differences between the national and local policy context in the UK, particularly regarding the actors involved. However, many actors work across multiple levels of government and thus it is not just local actors who are influential at the local level. For example, central government shapes the policy context for local alcohol policies (5), while other national organisations including Public Health England and the Local Government Association are active in enhancing the uptake of policy innovations that work in specific areas. National advocacy, professional and trade organisations, such as the Institute for Alcohol Studies, the Institute of Licensing, the Wine and Spirits Trade Association and the Association of Licensed Multiple Retailers, also target local areas to support or contest policy innovation (6). Further, there are a range of national level alcohol industry initiatives, such as Best Bar None and Purple Flag, which are adopted to differing degrees in different local areas. Regional organisations and partnerships such as Balance North East and Safe, Sociable London Partnership can also drive policy development by, for example, promoting public health approaches to licensing. Finally, a wide range of local actors influence policy both within and outside of local authorities, often working together in partnership (7). These includes public health teams, clinical commissioning groups, trading standards, the police, safer communities teams, social care services, healthcare provider organisations, local business groups, elected members and the general public. This list of actors across multiple levels of government is not exhaustive, but it provides an insight into the complexity of the alcohol policy network that shapes local policy action.

Members of this policy network have different histories, designated roles, motivations and views on the forms of evidence which are and should be used to inform policy decisions (6, 8). In this paper, we focus on the latter point regarding evidence use. Whilst scientific studies are seen as the 'gold standard' by many actors (8), its value to local decision-making may be limited as it is rarely specific to the local context and there are often problematic and unexplained inconsistencies between findings

(6). As such, local evaluation data and expert opinion or individual testimony are often seen to be of greater value to decision-makers (6, 8-10). Therefore, across the policy network, there is no one form of evidence or evidence base used to inform policy which supersedes all others (6).

The actions that emerge from the local alcohol policy network are constrained, enabled and shaped by the wider regulatory and legislative framework. Some alcohol policies are statutory obligations and others are just encouraged to a greater or lesser degree by central government. The renewed emphasis on local alcohol policy implementation following the 2012 Government Alcohol Strategy coincided with other policies which established structures intended to support LAs in developing public health policy more broadly, such as Health and Wellbeing Boards and directly elected Police and Crime Commissioners. Additionally, it was only in 2011 that licensing legislation was amended to give health authorities a role in alcohol licensing (11), a role which transferred to local Directors of Public Health when public health transitioned to local authorities (6). Further, some alcohol policies are not in the public health policy domain, but have the potential to bring public health benefit. For example, whilst the 2003 Licensing Act (12) devolved regulatory powers to LAs to, for example, manage the number and positioning of licensed premises and impose additional conditions on individual or multiple alcohol licenses with reference to the four national licensing objectives (13), evidence presented must be framed in non-health terms because protecting the health of the population is not a licensing objective (5).

The resulting range of alcohol policies adopted across local areas is broad and just a few examples are presented here to illustrate that diversity. Cumulative Impact Policies (14), which are a tool for licensing authorities to limit the growth of licensed premises in a problem area of high alcohol density, are a formal policy that is embedded in statutory guidance that supports the 2003 Licensing Act. “Reducing the Strength” (15), a voluntary removal of cheap, high strength beer and cider from shops, is a non-statutory initiative. Hospital Alcohol Liaison Teams (16), with specialists who work with people with problematic alcohol or other substance misuse in hospital to offer support, advice, and referral to treatment if appropriate, and Identification and Brief Advice, a simple intervention aimed at individuals at risk through drinking above the guidelines, are both non-statutory initiatives but their adoption is encouraged in the 2012 Alcohol Strategy. Hospital Alcohol Liaison Teams and IBAs may be commissioned by Clinical Commissioning Groups or Local Authorities depending on the split of public health responsibilities between these bodies in different local areas.

Given the wide range of actors and the varying regulatory and legislative framework which relates to different types of alcohol policy, it is perhaps unsurprising the process by which LAs select, adopt, and develop local alcohol policies is complex, geographically varied and not well understood. In the late

1990s, as part of the New Public Management under New Labour, there was a drive for such policy making to be evidence-based at all levels of government, an aspiration shared by researchers and many other stakeholders. This placed an emphasis on policy development through a systematic consideration of scientific evidence (8, 17-21). The underlying assumption was that robust evidence leads to better decisions being made. Over time however, thinking has shifted towards a drive for evidence-informed policies, which acknowledge a range of competing considerations in 'real world' policy development, such as uncertainty around policy competence (i.e. the legal power to act in a policy arena), political ideology, public, patient, and media opinion (which may be supportive or resistant to a change in policy), funding, and interest group activities (8, 22-24), that can impact on the extent to which the policies that are implemented are evidence-based. As such, whilst policies may be evidence-informed, scientific evidence may not be a primary driver of public health decision-making; for example, decision-makers use a range of sources, including personal experience and local data identified through government websites, local organisations, and personal or expert contacts (2, 9, 25, 26). In local alcohol policy development, a lack of scientific evidence of effectiveness has not halted, for example, the widespread introduction of voluntary schemes such as Best Bar None (27).

To understand how policy-making decisions are made in practice, the concept of policy transfer has been developed, which reflects broader processes of policy diffusion that may not prioritize consideration of effectiveness evidence as commonly conceived by public health scientists. Policy transfer has been defined as "…a process in which knowledge about policies, administrative arrangement, institutions etc. in one time or place is used in the development of policies, administrative arrangements and institutions in another time or place" (28, p.344). Evidence of effectiveness may still play a role in policy transfer, but need not be a motivation and is not a prerequisite condition. Policy transfer focuses on understanding the wide set of processes by which policy-makers share learning about what does and does not work (29). To date, study of policy transfer in the UK has been dominated by cross-national and 'national to local' transfer (30) (31); but 'local to national' and 'local to local' transfer does occur (31, 32) and there is a gap in our understanding of how these processes are operationalised and the factors that support and hinder them.

Policy transfer can occur in multiple forms and is subject to many influences as summarised in Table 1. These forms include both *coercive transfer* (30, 33) and *voluntary transfer* (34, 35). They also include the direct copying of policy from one place to another, or lesser degrees of transfer such as emulation, hybridization, and inspiration (28), (36). For example, a policy seen to be successful or labelled 'best practice' (36) in one place is often seen as a legitimate option for transfer to elsewhere; however, this does not mean the policy will be replicated in full. Instead, it may only be the underlying theories, a small number of elements or even the eye-catching branding that is transferred. (37). In studying

processes of policy transfer, Dolowitz and Marsh (30) identify four interrelated facilitators and constraints: *past policies* (i.e. the historical policy landscape), *policy complexity* (i.e. the number of facets of a policy), *structural institutional feasibility* (i.e. the likelihood a policy could be implemented given the local ideology, cultural proximity, and economic, technological and bureaucratic context) and *language* (i.e. both in the national sense and with reference to the technical accessibility of documentation).

INSERT TABLE 1 ABOUT HERE

The aim of this paper is to explore, in the context of local alcohol policy in England, the processes of how policies implemented in one LA are adopted by policymakers elsewhere. We did not focus on any particular policy but rather allowed interview participants to focus on what they felt to be relevant. Specifically, we consider whether policy transfer provides a good model for thinking about local public health policy-making processes by examining: 1) examples of alcohol policies that are transferred, 2) how knowledge of policies is shared, and 3) the factors that influence why policymakers do or do not implement policies used in other LAs. Policy transfer may offer a perspective, rooted in political science theory, on how local public sector decision-makers identify and assess the potential use and appropriateness of policy options to improve public health. Such understanding of the ways in which public health evidence is shared between decision makers may help inform research and policy communities to refine evidence dissemination strategies.

Methods

Qualitative interview data were used to explore stakeholder experiences of alcohol policy transfer between LAs. These data were drawn from a larger project designed to test and generate evidence for local practitioners and policymakers on preventing alcohol related harm. In the course of wider data analysis we saw repeated examples of policy transfer and sought to investigate this emerging theme to begin to understand how local alcohol policy transfer operates and its relative utility as an analytical model for understanding of practice in this area.

Data were collected from five case study sites selected for their prioritization of alcohol harm prevention (see Table 2). Data from the first four sites were not always collected with policy transfer in mind; however, as this theme emerged during analysis, further data were sought in later interviews by FdV in the fifth case study site. The types of alcohol harm prevention policies implemented across the case study sites included: policies to reduce the availability of alcohol, policies that influence the night-time drinking environment, and policies to influence the price of alcohol.

INSERT TABLE 2 ABOUT HERE

Ethical approval was obtained from the relevant partner institutions prior to commencing fieldwork (see Table 2). A purposive sample of stakeholders working in LA alcohol policy was recruited for interview across all sites through a combination of direct approach to key actors defined by their central roles in different aspects of LA alcohol policy-making and snowballing from these key actors. Stakeholders interviewed included representatives from the police, trading standards, public health, licensing and commissioning. Participant names have been removed and case study locations have been described by broader geographic region only to maintain anonymity. Interviews were conducted by JM, DG, FdV, MC, and VH across the different sites between March 2014 and August 2015. Interviews ranged from 35-105 minutes with most lasting approximately one hour. Most interviews were conducted face-to-face in the participants' place of work, although a small number took place in cafes near to a place of work or by telephone. Interviews covered: (i) the participant and their role in LA alcohol harm reduction, (ii) LA alcohol policies and links with other organizations, and (iii) monitoring and evaluation of alcohol-related activities and policies. Interviews were digitally recorded and transcribed verbatim.

Thematic analysis was used inductively to identify key themes in the transcribed data (38). LG used data from two case study sites to develop and refine codes emerging from the data within and between transcripts. A subsample of the transcripts were independently coded by PB and crosschecked with LG, before the final policy transfer coding structure was shared with ME, FdV, and EH for application to interview data from other case study sites. Coded data from all five case study sites was collated by LG and developed into the themes presented in this paper. The research was conducted from a critical realist perspective in which co-authors discussed claims about policy transfer arising from the data alongside alternative explanations, to assess the robustness of interpretations (39, 40).

Results

Instances of policy transfer observed in the data were exclusively voluntary (see Table 1 for definition). Findings are presented in three sub-themes;

1) Examples of policy transfer between LAs;
2) How knowledge of policies was shared – exploring the ways in which participants described sharing and learning about policies that were successful in other places; and
3) Why do LAs transfer policies – exploring facilitators and constraints on policy transfer.

Examples of policy transfer.

Learning from other local authorities was a common feature of public health practice. Participants described examining and trying to implement a range of policies that were already in place in one or more locations around the country, illustrating that alcohol policy transfer occurs for a range of different policy objectives and across relatively wide geographical areas. Examples include:

> We looked at a study they did in Westminster [LA] for six months where they [designated] 'stress areas' [*identifying and applying special CIP measures to areas with a large number of licensed premises in close proximity to each other*]. (Public Safety, North East)

> We've just got something in place now… well we're trying to bring it in, you know, the 'Ipswich model' [*voluntary removal of cheap super strength alcohol from a shop*]. (Police, Yorkshire & Humber)

> We provide lots of material and literature; the 'Challenge 25' thing is a big thing; it's always been in [town] as long as I've been here because a lot of authorities only have Challenge 21 but Challenge 25 seems to be the thing [*a retailing strategy that encourages anyone who is over 18 but looks under 25 to carry acceptable ID*]. (Trading Standards, North West)

> We use the 'Cardiff model' as a way to do some of that, so all those different, multiple views on the same problem [*a data sharing process that combines information from EDs with police data to produce a regularly updated list of violence hotspots, violence times and weapons used*]. (Information Analyst, North East)

The degree of policy transfer (e.g. copying vs emulation (see Table 1)) was not always evident in the data, as the process of policy development was not a focus of the interviews. However, these examples do support our hypothesis that elements of the concept of policy transfer are embedded in the everyday working of policy actors.

Policies were also transferred between policy domains. In the East of England, a twin-pronged strategy that had been used to address major crime was the inspiration to develop a strategy to reduce street drinking. Elsewhere, participants described the possibility of sharing ideas between policy areas, for example alcohol policy emulating tobacco policy:

> Wakefield have a very advanced tobacco control function in their local authority so if they were to take the principles that they've applied to tobacco control and apply those to alcohol control licensing I would imagine that would work well. (Trading Standards, Yorkshire & Humber)

How is knowledge of policies shared?

Policies perceived to have been successful in one LA were shared with other LAs using a variety of types of information of differing levels of rigour and across a range of exchange settings. The types of information shared could be placed on a continuum. At one end was scientific evaluation commissioned from academic institutions, for example:

> It's a formal evaluation, and that should be ready for about October of this year… That's been undertaken by the University of [anonymised]. (Commissioning, Yorkshire & Humber)

At the other end may be opportunistic, informal conversations with contacts that might be able to provide information on a particular policy operating in their local area, for example:

> I then took the opportunity to speak to a police colleague, a superintendent at the time, about it and obviously they then considered whether they thought it was appropriate to use the pilot in some of our more challenging areas. (Community safety, North East)

> The people to talk about regarding the alcohol services is [name] in Liverpool and [name] in Liverpool. They've been around for a long, long time. (NHS, Yorkshire & Humber)

The context for this information sharing which underpinned policy transfers was also outside formal evidence dissemination structures and often involved events that participants attended as part of their job-role, during which they might encounter useful informal and incremental learning about policies implemented in other places:

> I sit on the Yorkshire and Humber underage sales, the meeting that we have across this region; so I'm reasonably in tune with how other departments do it. (Trading Standards, Yorkshire & Humber)

> I mean me and [Jane] have our own meetings together as well about three or four times a year where all the West Yorkshire Licensing Officers come together, and then we try and display best practice there, which works well. (Police, Yorkshire & Humber)

Participants also detailed a number of dedicated events for sharing information on alcohol policies. This included describing dedicated conference style events for disseminating learning; for example:

> We did a conference on Reducing the Strength, and this was something that I think some of the other authorities looked into... (Licensing, East of England)

Two similar events on minimum pricing and general approaches to local alcohol problems took place in the North East and South West respectively. Additionally, a number of smaller exchange events were arranged between local authority actors to share learning around the development, implementation, and impact of local policies, for example:

> We did an exchange with Blackpool constabulary one night. They wouldn't let us do it now, but we just went to play with them for two days in Blackpool. (Police, Yorkshire)

> …discussion with Nottingham who came up to see us actually about it was about the night-time levy and as part of just the discussions mentioned the super strength free pilot and shared some information with us. (Community safety, North East)

Why do local authorities transfer policies, or not?

Evidence relating to two of the facilitators and constraints on policy transfer identified by Dolowitz and Marsh (30) was present in our data: past policies and structural institutional feasibility. Historical policy context was perceived to influence the likelihood of certain policies being implemented now, for example, in relation to the proximity of licensed premises to schools:

> We've never ever got involved with that level of representation regarding location or I'm not aware of any trading standards up and down the country that make representations to that effect... certainly in the last 20 years we've never... (Trading Standards, Yorkshire & Humber)

Observing difficulties associated with policies previously implemented (or attempted) elsewhere was also a disincentive to implement locally:

> …as I say in [city] they've had, I know of definitely one, possibly two, where their legal team have objected to it because it's in a cumulative impact but they have appealed on it and they have won, they have ended up winning the licensed premises…. so really when you've got a stated case like that you think, well, does it work, and is it worth it? (Police, Yorkshire & Humber)

> Yeah the councillors voted it down [the proposed introduction of an Early Morning Restriction Order]. I think it suddenly became a matter of is this [city] or is it not? (Community safety, North East)

Structural institutional feasibility, including ideological, cultural, economic, technological, and bureaucratic context, dominated in participant descriptions of the factors that influence policy transfer. Participants identified that the range of local policies available was framed in the policy context created by the UK national government and that national and regional policy structures could mandate a change in local level policy. For example, in the North East there was a perception that Government encouragement to develop a particular drinking culture conflicted with local perceptions about how the local drinking culture could feasibly develop over time:

> I think in the early days the government was very clear about a Mediterranean culture, whether that works within this city, I'm not sure. (Trading Standards, North East)

Further, in the East of England the view was expressed that a policy that would not necessarily benefit the local area because of differences in drinking environments compared with the larger administrative centre could nonetheless be imposed by a higher tier of government:

> So they'd [the upper tier in a two tiered local authority] say, oh right we're going, we're going to have [a policy] and we're going to roll it out in [the administrative centre] first and then it'll come out to all the districts. Well that's great but we don't need it thanks... (Community safety, East of England)

Thus, some local areas felt constrained in their policy options by bureaucratic context and local drinking culture and ideology that could conflict with national and regional policy directives.

Participants also described the importance of local context in understanding whether a policy could (or should) be transferred between places, for example, in relation to a policy which aims to reduce alcohol-related harm by promoting responsible management and operation of licensed premises:

> For instance Best Bar None was introduced in [the city] some 3 or 4 years ago. It was very, very successful and has since been picked up by many towns based on the best fit model because each town has different challenges, different types of premises. Best Bar None in a village setting with one pub would be totally irrelevant. (Licensing, East of England)

As such, policies were not always transferred wholesale but instead there was an accumulation of lessons drawn from elsewhere that was relevant to the local context, resulting in hybridization of policy to best-fit local conditions.

There was also a perception that structural changes, in the move of public health from the National Health Service (NHS) to local authorities, have made more difficult the timely evaluation of certain policies because of issues around data sharing:

> When we moved across to the local authority the changes in the Health and Social Care Act meant that data couldn't be shared. So we are now intelligence based but not allowed to see the intelligence. Now we see it a year later whereas before we could see it within five weeks. (Public Health, North West)

That is not to say that systems were unproblematic when public health was based in the NHS, but that sharing certain types of information has become more difficult and this can present an additional barrier to making timely evidence-informed decisions. In the absence of evaluation evidence, policy transfer may be more dependent on other forms of evidence, such as past experience and conversations with public health practitioners in other areas.

Participants identified challenges related to the current economic climate, which brought to the fore familiar tensions (41) between fostering a vibrant nighttime economy and some policies to reduce alcohol related harm (e.g. Cumulative Impact Policies):

> The night-life is important to the city centre and the businesses. So it's about achieving that balance between the concerns of the residents and members, and the concerns of business. (Trading Standards, North East)

Finally, limited funding impacted LAs abilities to explore policy options and implement new policies. Many local areas identified that, at present, the introduction of new policies with a cost implication is likely to be considered unfeasible:

> It's not that we don't see the value of [setting up multiple access points for alcohol brief interventions]… we don't have funding to fund that at the moment, but it's definitely an intervention that we see as worthwhile. (Commissioning, Yorkshire & Humber)

> I would say that would probably be something we could have a look at… if there was some funding there. You know, look at other areas, what's working in other areas. (Specialist Support Team Manager, North West).

Discussion

From our interviews with stakeholders from different English local authorities, we found evidence of approaches to local policy development that fit with theories of policy transfer. These approaches include emulation, hybridization, and inspiration from policies implemented in other areas. Likewise, a range of factors observed in previous studies of policy transfer (e.g. competing priorities and the influence of regional and national government policy or past policies) were seen to hinder or support policy transfer between LAs. We often identified no single model or moment of policy transfer; instead it appears to be a dynamic process, driven by a range of different factors dependent upon the local context and occurring across a range of knowledge exchange settings over time. The evidence used to inform policy transfer also appears to be drawn from a modified hierarchy of evidence that is based less on a narrow view of methodological quality and intervention effectiveness and instead pays greater consideration to personal contacts in other jurisdictions, the transferability of scientific evidence to local areas, and the complexities and political nature of public health decision making (10, 42). That is not to say that well-evidenced schemes are not transferred, but that focusing on such examples misses many other important processes by which poorly evidenced, but potentially successful, interventions in one area still influence policy processes in other areas.

That alcohol policy transfer between local authorities is a dynamic and idiosyncratic process aligns with previous research which identified the types of evidence used by public health policymakers as diverse, such that the most valuable evidence is local data, the most influential evidence is personal and political information, but the most frequently cited evidence is 'other people' (9). Of note for the research community is that academic evidence often does not align to the needs of policymakers and, as such, is rarely seen as relevant, with academic institutions poorly represented in the networks of stakeholders through which policy transfer occurs (9, 26). Further, as Phillips and Green have recently argued (43): the transition of public health from the NHS to the more overtly politicalised local government space means the policy outcomes of concern in policy processes have expanded beyond those captured by public health research evidence, with different outcomes prioritised by different stakeholders. Thus, policy transfer can provide a more nuanced explanation and so a useful analytic

model for what happens in practice, with scientific evidence just one of the many considerations used to support the development of local alcohol policy.

The main limitation of this study is that the interviews were not all conducted to explore alcohol policy transfer between local authorities in England. As such, understanding of factors such as the drivers and constraints of policy transfer, as well as what is being shared through the policy transfer process (i.e. high-level ideas or in-depth policy knowledge) presents important questions for future research. However, the data showed consistent findings across both multiple case study sites and interviewees working in different areas. Thus a high level of confidence can be placed in the results as documenting typical policy-making processes within English local authorities in the area of alcohol and, potentially, public health in general.

This research provides initial insights into how policy transfer operates as a model for local alcohol policy-making in England. Further research is required to develop an understanding of how this model differs across the country, in other areas of public health, and in local policy-making in other countries. Important questions include: *In what ways do processes of policy transfer in local policy-making differ from those already documented in national policy-making? In what ways do national and local processes of policy transfer interact such that national policies become local and vice versa? What are the spatio-temporal dimensions of local policy transfer - are local policies transferred across nations and from only proximal or also distal time periods?* A purpose built study designed to examine these questions in a range of local authorities (e.g. large and small metropolitan, rural, high alcohol-related hospital admission, high alcohol-related crime, leaders and laggards in alcohol policy implementation) is the next logical step, as this would enable a more thorough interrogation of the role of policy transfer and the types of evidence that alcohol policymakers in local authority use.

Respondents identified that heterogeneous sources of information are used to inform local policy transfer. While the traditional hierarchy of evidence may be too narrow in focus to fully inform policy development, it is nevertheless important to develop a mechanism through which there can be a systematic gathering of local knowledge relating to a policy to ensure that decision makers are able to appraise the strengths and limitations of policy options within the many process which play a role in policy transfer. However, learning is also required by those advocating an evidence-informed practice approach. Systematic reviews of existing evidence, viewed as gold standard by in healthcare research, are often perceived as too generic or high level by local policymakers and of limited use for innovative policy options (44). Further, they do not speak to the wider range of outcomes, beyond those considered by public health research, which are now in play in local decision-making that affects the health of the population. That greater attention should also be paid to concerns regarding the context-

specificity of evidence has been argued in other areas of public health (45, 46). In response to the limitations of traditional reviews, Pawson (47) introduced the concept of 'realist evaluation', which seeks information on 'what works for whom in what circumstances' (47 p.342) to develop a transferrable theory that can be applied to improve the chances of policy success. Realist evaluation may be one way to support the local authority policy process with research evidence. Additionally, local case studies could be used to develop potential common ground between policy transfer and evidence-informed practice, (25) developing more robust ways to evaluate local case studies and being more sensitive to the kinds of data that decision-makers find useful could provide a means for policy transfer to become more evidence informed. Such work could also examine the influential role of national, regional and local actors in decision-making, to understand the role of such agencies in influencing the shape of local alcohol policy.

Conclusion

Theories of policy transfer provide a promising framework for characterizing processes of local alcohol policy-making in England. These extend the debate about evidence-informed policy to account for the activities of a broader range of policy actors, their prioritization of different forms of evidence, and the role of different, oftentimes competing, priorities, which jointly contribute to a more nuanced picture of local alcohol policy development. Applying a policy transfer lens enables us to move beyond simple (but still important) questions of what is supported by 'robust' research evidence by paying greater attention to how policy making is carried out in practice and the multiple methods by which policies diffuse across jurisdictions.

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Tables

Table 1: types and degrees of policy transfer and facilitators and constraints on transfer

Types of Transfer	**Description**
Coercive	A policy to which a territory has a compulsion to conform, for example IMF and World Bank 'no reform, no money' position or decisions of the European Court of Justice for EU member states.
Voluntary	Lesson drawing between places, where learning may or may not lead to policy transfer, for example the UK introduction of car seat-belt legislation or the smoking ban in public places.
Degree of Transfer	
Copying	Direct and complete transfer from one place or time to another.
Emulation	The transfer of the ideas behind a policy or programme.
Hybridization/Combinations	Mixtures of several different policies.
Inspiration	A policy in one jurisdiction inspires a policy change, but where the final outcome does not draw upon the original policy.
Facilitators/Constraints on Transfer	
Past Policies	The historical policy landscape, i.e. previous policies implemented in an area.
Policy Complexity	A policy with more parts and connections (e.g. who is involved in the process and the number of elements to the policy) is potentially more challenging to transfer.
Structural Institutional Feasibility	The likelihood a policy could be implemented given the local ideology, cultural proximity, and economic, technological and bureaucratic context in the destination place compared with the place of policy origin.
Language	The language used within policy documentation can both constrain and facilitate transfer.

Sources: *Dolowitz D, Marsh D. Who learns what from whom: a review of the policy transfer literature. Political studies. 1996;44(2):343-57.*
Dolowitz DP, Marsh D. Learning from abroad: The role of policy transfer in contemporary policy-making. Governance. 2000;13(1):5-23.

Table 2: Details of interview participants and case study sites

Location	Number of participants	Method	Stakeholder roles	Data collection period	Ethical approval
East of England	16	Individual and group interviews	Licensing, Public health, Police, Community safety	August 2014 – October 2014	Granted by LSHTM.
North East	7	Individual interviews	Public health, Alcohol services, Licensing, Community safety, Police, LA information analyst, Trading standards	March 2014 – November 2014	Granted by the University of Sheffield
North West	15	Individual and group interviews	Licensing, Public Health, Trading standards, Police, Ambulance, Education, Housing	March 2014 – June 2015	Granted by the University of Lancaster
South West	2	Individual interviews	Licensing, Alcohol strategy	July 2015	Not required – service evaluation
Yorkshire & Humber	7	Individual interviews	Public health, Acute health, Trading standards, Police, Commissioning	June 2014 – March 2015	Granted by the University of Sheffield