**Processes of local alcohol policy-making in England: Does policy transfer provide a more useful framework than evidence-based policy?**

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**Target Journal:** Addiction

**Key message:** Policy transfer is a more useful framework for analyzing public health policy-making processes than evidence-based practice.

**Key words:** policy transfer; alcohol policy; local government; evidence-based policy

**Word Count:** 4,325

**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 which underpin adoption of these policies within local authorities and, particularly, to assess whether the concept of policy transfer provides a better model for understanding local alcohol policy-making than the more commonly used model of evidence-based policy-making. Policy transfer is a process through which knowledge about policies in one place is used in the development of policies in another time or place.

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

**Results:** Examples of policy copying, emulating, hybridization and inspiration were identified in the data. 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 a range of facilitators and constraints to policy transfer, including the historical policy context and structural institutional feasibility that influenced whether or not a policy that was perceived to work in one place might be transferred successfully to another context.

**Conclusions:** Local alcohol policy-making processes in England appear to fit well with the concept of policy transfer, as opposed to the more common conceptions of evidence-based policy-making.

**Introduction**

Measures to reduce alcohol consumption and alcohol-related harm are a component of legal and regulatory systems around the world, for example excise duties, age limits for the sale and purchase of alcohol, and blood alcohol concentration limits for driving.[1] The detail of these policies varies across nations but also varies within countries by city, region or state. In the UK, the national government's alcohol strategy emphasises the role of local authorities (LAs) in identifying and implementing policies that are relevant to the local drinking context. There are 34 upper tier local authorities in England and 57 unitary local authorities and it is on these bodies, and the processes by which they select and develop alcohol policies, which this paper focuses.

Regulatory powers have been devolved to LAs to, for example, restrict opening and closing times, manage the number and positioning of licensed premises and impose additional conditions on individual or multiple alcohol licenses with reference to four licensing objectives: prevention of crime and disorder, public safety (as distinct from public health), prevention of public nuisance and protection of children from harm.[2] Many public health and healthcare services are also commissioned locally, for example IBAs (Identification and Brief Advice) and alcohol treatment. Devolution of powers from national to local policy-makers has been accompanied by the establishment of structures intended to support LAs in developing public health policy, including Health and Wellbeing Boards and directly-elected Police and Crime Commissioners. Therefore, it is perhaps unsurprising that recent years have seen an increase in the extent and variety of policies to reduce alcohol-related harm implemented by LAs, including Cumulative Impact Policies (i.e. a tool for licensing authorities to limit the growth of licensed premises in a problem area), Reducing the Strength campaigns (i.e. voluntary removal of cheap high strength alcohol from shops), and Alcohol Clinical Nurse specialists (i.e. nurses who work with people with problematic alcohol or other substance misuse to offer support, advice and referral to treatment if appropriate).[e.g.3 4]

The process by which LAs select and develop alcohol policies is, however, not well understood. Evidence-based policy (EBP) making, commonly understood as the integration and prioritisation of scientific evidence within the decision making process, is both promoted in national and international guidelines and policy discourse[5] and is increasingly being used in UK policy making.[6] While its efficacy is well-established in medicalised settings, acknowledging concerns around areas such as analysis of intervention context,[7] the applicability of the concept of EBP is unclear for more politicised settings, or settings that lack the evidence-based structures of healthcare policy development such as the UK's National Institute for Health and Care Excellence. "Evidence-based" implies that policies are developed through careful consideration of scientifically verified evidence,[8] privileging research evidence.[9]

However, there are competing considerations in 'real world' policy development, such as uncertainty around policy competence (i.e. the legal power to act in a policy arena), public and media opinion, funding and pressure group activities.[10] There are also considerations as to what constitutes suitable evidence as public health practitioners use a wide range of evidence sources, including local data and practice guidelines, often identified through government websites and personal or expert contacts.[11 12 13] Evidence syntheses (e.g. health impact assessment and systematic reviews) have been promoted as a means of sharing evidence with policy audiences, but there is wide variation in how these tools are received and used to support decision making.[14] Further, evidence may not exist at a local level that is sufficiently context-specific to support policy development.[8 15] Given these concerns, the concept of EBP, while useful in many ways, is an inconsistent fit with processes of local alcohol policy development and an improved model for understanding these processes is required.

In response to challenges of applying the concept of EBP to analyse politicised contexts, political scientists have developed the alternative concept of policy transfer which captures a similar idea of policy spread to EBP[6], but reflects broader processes of policy diffusion which may not include consideration of effectiveness evidence as commonly conceived by public health scientists. Policy transfer is "…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".[16, p.344] Thus, evidence of effectiveness may still play a role in policy transfer but, in contrast to EBP, it need not be a motivation and is not a prerequisite condition. Instead, the concept of policy transfer focuses on understanding a wider set of processes by which policy-makers share learning about what does and does not work.[17]

Policy transfer can occur in multiple forms and is subject to many influences as summarised in Table 1. Transfers have been examined widely at the international level and include both coercive transfer [e.g.18 19] and voluntary transfer [e.g.20 21]. They may also involve the direct copying of policy from one place to another, or lesser degrees of transfer such as emulation, hybridization and inspiration.[16] That a policy has been seen to be successful in one place can often give legitimacy to the attempt to implement it elsewhere; however, unlike EBP, this can be the case whether the policy is being transferred wholly or only in part.[22] Further, Dolowitz and Marsh[19] identify four interrelated facilitators and constraints of policy transfer: past policies (i.e. the historical policy landscape), policy complexity, 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 (both in the national sense and with reference to the technical accessibility of documentation).

INSERT TABLE 1 ABOUT HERE

To date, understanding of the process of policy transfer in the UK has been dominated by the study of cross-national and 'national to local' transfer. However, some 'local to national' and 'local to local' transfer also occurs[23] and there is a gap in our understanding of how these processes are operationalised and the factors that support and hinder them. The aim of this paper is to explore, in the context of local alcohol policy in England, how policies implemented in one LA are adopted by policymakers elsewhere. 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. In an environment where many public health stakeholders emphasise the importance of evidence-based policy-making, policy transfer may offer an alternative perspective, rooted in political science theory, on how local decision makers identify and assess the potential use and appropriateness of public health policy options. Such understanding of the ways in which public health evidence is shared between decision makers may help inform the research and policy communities in refining their 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 testing and generating 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 when compared with EBP. Data from four case study sites (see Table 2) with a reputation for prioritizing alcohol harm prevention were interrogated to examine the objectives of this research. Additionally, given the apparent importance of policy transfer within the data, further data was pursued in more recent interviews by FdV for a fifth case study site. The research was conducted from a critical realist perspective,[24] in which claims about policy transfer arising from the data were discussed with co-authors alongside alternative explanations, to test the robustness of interpretations.

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 approaches. Stakeholders interviewed included representatives from the police, trading standards, public health, licensing and clinical commissioning. Participant names and case study locations have been changed to maintain anonymity. Interviews were conducted by JM, ME, FdV and EH across the different sites between March 2014 and August 2015. Interviews ranged from 35-105 minutes with most lasting approximately 1 hour. Most interviews were conducted face-to-face in the participants' place of work, although some 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.[25] 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 sites was collated by LG and developed into the themes presented in this paper.

**Results**

Instances of policy transfer observed in the data were exclusively voluntary policy transfer. Findings are presented in three sub-themes;

1) Examples of policy transfer between LAs;
2) How knowledge of policies is shared – exploring the ways in which participants describe sharing learning about policies that are successful in other places; and
3) Why do LAs transfer policies, or not – exploring facilitators and constraints on policy transfer.

*Examples of policy transfer.*

Learning from other local authorities was a common feature of public health practice:

> "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) 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 and that transfer of effectiveness evidence, as described by the EBP model, is not necessarily part of this.

Policies could also be transferred between policy areas. 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 sliding scale. 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 information sharing was also outside the 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[19] 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 could also be a disincentive to implement locally:

> "…as I say in Leeds 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 Blackpool 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:

> "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)

> "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)

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.

A relatively recent structural change that was perceived to have reduced the ability of public health to produce timely evaluation of certain policies, and thus reduced capacity to enact an EBP approach to policy-making, is the move of public health from the National Health Service (NHS) to local authorities. This has impacted on data sharing capacities:

> "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)

The economic context, and in particular the pressure to establish and maintain a vibrant nighttime economy was perceived to compete with 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:

> "It's not that we don't see the value of it… 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**

*Key Findings*

Local authorities develop their alcohol policies, at least in part, in line with the principles of policy transfer. A range of factors (e.g. competing LA priorities, regional and national government policy, and past policies) can hinder or support policy transfer between LAs. The transfer of policy knowledge appears to be a dynamic process, driven by a range of different factors dependent upon the context, which occurs in a range of settings. The evidence used to inform policy transfer 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 concerns relating to local contexts and the complexities and political nature of public health decision making.[26]

That alcohol policy transfer between local authorities is a dynamic 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'.[11] 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. Thus, academics and researchers do not feature in the main information sources used by public health policymakers.[11] [12]As Phillips and Green have recently argued:[27] the

transition of public health from the NHS to the more overtly politicalised local government space means policy outcomes have pluralised, with different outcomes prioritised by different people, and context-specific. This is incongruous with normative discourses of EBP, which focuses on homogenous outcomes and context-neutral generalisability.[7]

This is not to say that EBP does not happen in the development of local authority alcohol policy, but rather that policy transfer may provide a more nuanced explanation and thus a better analytical model for what happens in practice. A final example of this can be seen in the disconnect between slow publication of formal evaluations and rapid diffusion of policies across areas. Newcastle was the first city to introduce a Late Night Levy in November 2013. The Levy was subsequently introduced in cities across the UK (e.g. Nottingham in November 2014 and Southampton in April 2015) before the Newcastle Late Night Levy was fully evaluated. An analysis of policy-making informed by EBP would view this narrowly as a problem to be addressed; however, when analysed as an example of policy transfer, it can be understood that 'real time' evaluation has a limited influence on policy because such evidence is not a priority for local policy makers and the policy cycle moves faster than the research cycle.[28]

*Limitations and strengths*

The main limitation of this study is that the interviews were not 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) is relatively limited. 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.

*Implications for research and practice*

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 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. Whilst 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 of 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 EBP approach. Systematic reviews of existing evidence, viewed as gold standard by EBP proponents, are often perceived as too generic or high level by local policymakers and of limited use for innovative policy options.[15] That greater attention should also be paid to concerns regarding the context-specificity of evidence has been argued in other areas of public health.[29 30] In response to the limitations of traditional reviews, Pawson[31] introduced the concept of 'realist evaluation', which seeks information on 'what works for whom in what circumstances'[31 p.342] to develop a transferrable theory that can be applied to improve the chances of policy success. Realist evaluation, which appears more aligned to processes of policy transfer than EBP, may be one way to support the local authority policy process with research evidence.

**Conclusions**

Policy transfer is a process through which knowledge about policies in one place is used in the development of policies in another time or place. Through interviews with a range of stakeholders involved in the alcohol policymaking process in local authorities in England, this study has established that policy transfer provides a better analytical model than EBP for understanding local alcohol policy-making processes.

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**Tables**

Table 1: types and degrees of policy transfer[16], along with facilitators and constraints on transfer[19]

| **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. |

Table 2: Details of interview participants and case study sites

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