LICENSING COMMITTEE (Licensing Act 2003 Functions)	Agenda Item 23 Brighton & Hove City Council

Subject:		Health Impact Assessment of Licensing		
Date of Meeting:		27 November 2008		
Report of:		Director of Environment		
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Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Annual Report of the Director of Public Health 2007 highlights the area of alcohol misuse.

1.2 The government's strategy: "Saving Lives, our healthier nation" committed itself to reducing binge drinking and promoting responsible alcohol retailing.

1.3 The national alcohol harm reduction strategy seeks to improve health and treatment, increase education and communication, tackle crime and disorder and work with the alcohol industry to develop responsible marketing.

1.4 The most recent national alcohol strategy was published last year by the Department of Health and called "Safe, Sensible, Social". It identified a need to ensure licensing laws protect young people from alcohol fuelled crime and disorder, to sharpen the focus on 18-24 year old binge drinkers and harmful drinkers and to promote sensible drinking.

1.5 The purpose of this report is to apprise licensing members of work funded by the PCT and commissioned by the city council to appoint consultants to undertake a health impact assessment into flexible licensing hours in Brighton and Hove.

2. RECOMMENDATIONS:

2.1 That this report is noted.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Brighton & Hove City Council has been granted funding by Brighton & Hove Primary Care Trust and City Council Directorate of Public Health. Consultants chosen by competitive tender are Ben Cave Associates Ltd.

who are experienced, specialist health impact assessors, recognised nationally and internationally.

3.2 The Licensing Act 2003 establishes a single integrated scheme for licensing premises, which are used for the supply of alcohol, to provide regulated entertainment or to provide late night refreshment. The Act contains measures to provide more flexible opening hours for premises, with the potential for up to 24 hour opening, seven days a week, subject to representations from local residents, businesses and responsible authorities.

3.3 The stated objectives of the Act are: Prevention of Crime and Disorder, Public Safety, Prevention of Public Nuisance and Protection of Children from Harm.

3.4 The Government's Alcohol Harm Reduction Strategy includes measures to change attitudes to irresponsible drinking and behaviour, including:

- making the sensible drinking message easier to understand and apply;
- targeting messages at groups such as binge drinkers and chronic drinkers;
- providing better information for consumers, on products and at the point of sale;
- providing more support and advice for employers.
- Safe. Sensible. Social – the next step in the National Alcohol Strategy (DH, 2007) identifies the need to:
- Ensure that the licensing laws protect young people from alcohol-fuelled crime and disorder;
- Sharpen the focus on under 18s, 18-24 binge drinkers and harmful drinkers;
- Promote sensible drinking through investing in better information and communication.

3.5 The Public Health White Paper, Choosing Health, includes measures to work with the alcohol industry to promote sensible drinking.

3.6 At the 31/3/2007, there were 1089 licensed premises and there were 1025 at transition in November 2005. The main effects or the new Act appear to be longer opening hours (but not 24/7) and more convenience stores becoming "off-licences". One of the key protections for local residents for premises not supporting licensing objectives (crime prevention, public safety, public nuisance and protecting children) is the review process where a licence can be reviewed. Since transition, there have been over 20 reviews including five police closures for disorder. The results were that two licences have been revoked (a violent pub and an off licence persistently selling to young people – u 18s) three off licences received licence suspensions for persistent sales to children, many licences had conditions modified to either prevent noise nuisance or restore order, others were given advice or no further action.

3.7 The Director of Public Health reported last year that our city was in the worst quintile in England for alcohol related months of life lost, alcohol specific hospital admission, alcohol related violent and sexual offences and an estimate of binge drinking (adults consuming double daily recommended level in one sitting). Recent trends of violent crime show decline. As at end of June 2008 violent crime in a public place is down 32% compared to same time last year (source – Paul Knight, Crime Reduction Officer, John Street Police Station, Brighton).

3.8 Indicators to be used in this study are:

1. Reduce impact on acute hospital
2. Reduce public place violent crime
3. Reduce domestic violence
4. Reduce alcohol related offending

3.9 Impacts that can also be measured, indirectly impacting on health, include enforcement outputs like reviews, fixed penalty notices, legal action etc. plus alcohol linked suicide and noise complaint and enforcement statistics.

3.10 The interim report is appended and a final report is due at the end of this financial year.

3.11 The health impact assessment may be used to inform statement of licensing policy, local alcohol harm reduction strategy, community safety, transport, tourism, economic development, community development and violent crime reduction strategies.

4. CONSULTATION

4.1 The steering group for the Health Impact assessment comprises:
Cllr Carol Theobald, Cllr Jeane Lepper, Adam Bates, Linda Beanlands, Terry Blair-Stevens, Jean Cranford, Barbara Hardcastle (PCT), Steve Hodson (ESFRS), Peter Mills (Sussex Police), Tim Nichols, Chris Owen, Chris Parfitt, Liz Rugg, Becky Woodiwiss (PCT), Mike Taggart, Graham Stevens, Chris Wilson, Nigel Liddell (Brighton Business Forum), Sussex Ambulance Service, Paul Iggulden and Erica Ison (Ben Cave Associates)

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The full cost of delivering the report will be covered by the PCT funding of £34,000 already received by B.H.C.C.
Finance Officer Consulted: Karen Brookshaw Date:22/10/2008

Legal Implications:

5.2 There are no direct legal implications.

Lawyer Consulted: Rebecca Sidell Date: 24.10.08

Equalities Implications:

5.3 Alcohol related crime, violent offences and sexual offences are areas of concern nationally and for the city.

Sustainability Implications:

5.4 Business tourism is the fastest growing domestic market (reference Brighton & Hove Strategy for Visitor Economy 2008 – 2018)

Crime & Disorder Implications:

5.5 40% of recorded violent crime is alcohol related and Brighton & Hove is second highest to Hastings in the South East Coast strategic health authority (reference Annual report DPH 2007). The Community Safety Strategy aims to reduce alcohol related anti-social behaviour.

Risk and Opportunity Management Implications:

5.6 No assessment has been made locally of the impact of the new licensing laws on health.

Corporate / Citywide Implications:

5.7 Alcohol related harm indicators for the city include alcohol related months of life lost, alcohol specific hospital admissions, and alcohol related crime.

SUPPORTING DOCUMENTATION

Appendices:

1. Flexible alcohol licensing hours in Brighton and Hove Rapid assessment of health impacts

Documents In Members' Rooms

1. None

Background Documents

1. The Annual Report of the Director of Public Health 2007

Report of second stage:
Flexible alcohol licensing hours in Brighton and Hove
Rapid assessment of health impacts

September 2008

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Contents Amendment Record

This report has been issued and amended as follows:

Issue	Revision	Description	Date	Signed
First	V1	For internal QA	26th September2008	Paul Iggulden
Second	V4	Issue for SG	30th September2008	Paul Iggulden Ben Cave Erica Ison

Prepared by Ben Cave Associates Ltd
Commissioned by Brighton and Hove City Council

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Abbreviations and acronyms

BME .... Black and Minority Ethnic
DES........ Direct Enhanced Services
GP .... General Practitioner
HIA........ Health Impact Assessment
LAPE .... Local Alcohol Profiles for England
PCT........ Primary Care Trust

SBI .... Screening and Brief Interventions
SOA .... Super Output Area
WHO..World Health Organization

1. Introduction

1.1 In May 2008 Ben Cave Associates (BCA) were commissioned by Brighton and Hove City Council to undertake the Health Impact Assessment (HIA) of the Introduction of Flexible Alcohol Hours in Brighton & Hove.

1.2 The outline proposal for the assessment identified four key stages as:

- First stage: project start up;
- Second stage: Literature review - scoping and review of key documents and evidence;
- Third stage: Stakeholder consultation; and
- Fourth stage: Appraisal and analysis and preparation and presentation of final report.

1.3 An inception meeting was held on 14th July 2008 and the project scope as set out in the outline proposal agreed.

1.4 This briefing report provides a combination of report on progress made todate, initial findings from the project and methodology for consultation approach.

1.5 The report is provided to the full Steering Group for the first meeting on 7th October 2008. There are a number of questions raised in the report for Steering Group members to consider. Discussion of these at the Steering Group meeting will help us in progressing the project.

Key questions: these are included in the report in italics and summarised below:
Key question 1: are there suitable events at which the HIA consultant team could discuss issues relating to alcohol with children and young people?
Key question 2: Do Steering Group members wish to amend the list of issues to be investigated?
Key question 3: what period does the Steering Group suggest is chosen as the monitoring baseline period?
Key question 4: Would Portsmouth or Southampton represent an appropriate comparator?
Key question 5: Are there specific communities that the Steering Group wishes to monitor impacts on?
Key question 6: we welcome feedback from Steering Group members on these schema and in particular on the completeness of Figure 6 (benefits) and Figure 7 (harms)
Key question 7: Do Steering Group members have a view on the number of indicators they would wish to see used to monitor impacts and the relative importance of comparing Brighton and Hove with other areas versus comparing parts of the City with the whole?

Update on first stage progress

1.6 The outline proposal for this assessment identifies the following outputs for the first stage:

- Steering group convened;
- Agreed list of risks to this contract;
- Agreed scope;
- Agreed methodology;
- Agreed timeline;
- Agreed consultation strategy.

1.7 In the following points we discuss progress made against these outputs.

1.8 An inception meeting was held on 14th July with BCA consultants and Brighton and Hove City Council commissioners (Tim Nichols, Head of Environmental Health & Licensing and Jean Cranford, Licensing Manager).

1.9 The project scope, methodology and timeline as per the outline proposal were discussed and agreed. It was noted that the indicative timeline detailed in the proposal was subject to a one month delay as a result of the project starting one month later than forecast.

1.10 The project is anticipated to report by end of January 2009.

1.11 The four key stages to the project are detailed at 1.2 of this report; the outline project proposal is available on request.

Risk management

1.12 Project risks were discussed by BCA consultants and it was agreed that these should be reported as part of this interim report.

1.13 BCA have identifed the following risks to completion of the assessment:

- The HIA in itself will not change perceptions though it will be a valuable source of information to support such change;
- A multi-agency Steering Group representative of the wide range of key stakeholders is vital to this assessment;
- Lack of agreement on project scope / emphasis of approach will make meeting expectations difficult;
- Failure of consultation approach to engage with the wide range of stakeholders;
- Consultants unable to access the full spectrum of available data for the monitoring review; and
- The HIA gives rise to adverse publicity regarding the impacts of flexible licensing hours.

1.14 In discussion at the inception meeting it was agreed that the first and last mentioned risks above would be best minimised by the adoption of a proactive communications strategy for the assessment and subsequent findings.

HIA Steering Group

1.15 The inception meeting agreed the need for a multiagency Steering Group.

1.16 BCA were requested to provide a list of potential Steering Group members, terms of reference for the group and text for an invitation letter.

1.17 The invitation letter and terms of reference were e-mailed by JC to potential Steering Group members.

1.18 The full Steering Group will meet twice, following the second and fourth stages of the HIA.

Structure of report

1.19 A consultation strategy for the HIA has been agreed by the HIA Management Team. This methodology is detailed in Section 2 of this report.

1.20 A review of policy has been undertaken. This gives the context for flexible licensing hours and is reported in section 3.

1.21 Understanding the health and well being of the local population is a key part of a health impact assessment. An initial profile is provided in section 4.

1.22 Section 5 of the report details the approach being used to establish indicators for monitoring impacts arising from the introduction of flexible licensing hours.

1.23 The policy context, population profile and methodology sections will form the basis of sections for the final report.

2. Methodology for consultation

2.1 This section provides an overview of the consultation strategy agreed by the HIA Management Team. The consultation strategy addresses the following:

- key stakeholder groups to consult;
- methods of consultation;
- agreed approach to consultation;
- issues to be explored during consultation;
- outputs from the consultation events;

- miscellaneous.

Stakeholder groups for consultation

2.2 The following stakeholder groups were agreed as key groups to consult:
- Councillors;
- Drug and Alcohol Action Team & their extended networks, e.g. Community Safety Partnership, Crime & Disorder Reduction Partnership, Magistrates Court, and Services for Children and Young People;
- Licensees and other business interests and associations;
- Public sector staff on "frontline" – ambulance, A&E, police & fire & rescue, including dedicated team for West Street; and
- General public, including residents associations/networks.

Methods of consultation

2.3 The following methods of consultation were identified as appropriate for the timeframe and resources available for this HIA:
- stakeholder workshop, 3.5 hours;
- focus groups, 1-1.5 hours;
- one-to-one interviews; and
- group interview.

Agreed approach to consultation

2.4 The agreed approach was informed by the recent consultation as part of the HIA of the Open Market in Brighton.

2.5 This suggested that (consultant) time is used most effectively if there are a number of consultation events clustered together over a short period.

2.6 Focus groups (1-1.5 hours) for particular stakeholder groups are more attractive than longer workshop events; providing a choice of focus groups at appropriately selected times of the day will increase the likelihood of stakeholder participation.

2.7 The agreed general approach, to maximise impact of the available consultants' time, is detailed below (Table 1: Consultation approach).

Table 1: Consultation approach

	Tuesday	*Wednesday*	*Thursday*
Morning		Stakeholder workshop: public & voluntary sector & transport providers	Interviews – one-to-one or group: frontline staff
Afternoon -	Focus group: Public/residents	Focus group: Licensees/business	Focus group: councillors
Early evening	Focus group: Licensees/business	Focus group: Public/residents	

Engagement with children and young people

2.8 The timeframe and budget allocated to this HIA are not sufficient for the HIA team to develop and deliver consultation with children and young people using peer-consultation techniques (usually the most appropriate and effective with respect to sensitive issues such as alcohol use).
2.9 However, it would be possible to conduct focussed consultation with children and young people at events which are already scheduled and where the staff involved enjoy a rapport, and have established trust, with the children/young people.

2.10 The consultant team would develop the materials for the consultation and agree the most appropriate course of action with the responsible adults. This might mean leading the consultation with support, observing the consultation and answering questions or simply receiving the results. We would work at all times with the responsible staff and we would work to BCA Child Protection Policy and the Child Protection Policy of the host organisation.

Key question 1: are there suitable events at which the HIA consultant team could discuss issues relating to alcohol with children and young people?

Issues to be explored during consultation events with particular stakeholder groups

2.11 This section outlines the key issues to be investigated through consultation events.

Key question 2: Do Steering Group members wish to amend the list of issues to be investigated?

General

2.12 We will use the following questions to frame the consultation with all groups:

- What are your concerns about the proposal?
- What are your positive expectations about the proposal?
- What do you think will be the harmful or negative effects on health and well-being?
- What do think will be the beneficial or positive effects on health and well-being?
- How could we reduce, minimise or avoid the harmful or negative effects?
- How could we enhance the positive effects?

2.13 The use of these questions will be supported by an appraisal tool developed from the Brighton & Hove Health Considerations Checklist and the Barton and Grant health map, and informed by previous HIA work by Ben Cave Associates on the Alcohol Harm Reduction Strategy for the Department of Health and Home Office (1).

2.14 All participants will be asked to consider effects on the population as a whole, and relevant vulnerable groups within the population, e.g. children and young people, and people who have problems with alcohol use. In addition, the results of previous surveys on this issue will be taken into account when developing the framework for any of the consultation events.

Specific issues to be addressed with different stakeholder groups

2.15 Public & voluntary sector staff

- Barriers to or conflicts around the implementation of the proposal
- Suggestions for consideration during the forthcoming Review of Licensing Criteria
- How the HIA results can be used to enhance:
  a. the local Alcohol Harm Reduction Strategy;
  b. the statement of licensing policy;
  c. implementation of the Tourism Strategy;
  d. implementation of the Crime Reduction Strategy;
  e. the provision of children's and youth services.

2.16 Licensees/business interests

- Suggestions for consideration during the forthcoming Review of Licensing Criteria
- How the HIA results can be used to enhance implementation of:
  a. the local Alcohol Harm Reduction Strategy;
  b. the statement of licensing policy;
  c. the Tourism Strategy;
  d. the Crime Reduction Strategy.

Outputs from the consultation events

2.17 The consultant team will produce a thematic summary of the collected responses from all consultation events for distribution to participants for their information. The responses from the consultation events will also be used in the Final HIA Report and Public Health Management Plan.

2.18 The consultant team will not be producing transcripts for any of the consultation events. If transcripts are required under Brighton & Hove City Council's and/or Brighton and Hove City Teaching Primary Care Trust's public consultation policies or strategies, it will be necessary for either City Council or PCT staff to undertake this task or for additional resources to be made available.

3. Population health profile for Brighton and Hove

Key demographic data

3.1 The population of Brighton and Hove City differs from the national population by having a higher proportion of young adults and fewer children. This is particularly the case among the more deprived parts of the city (2;3).

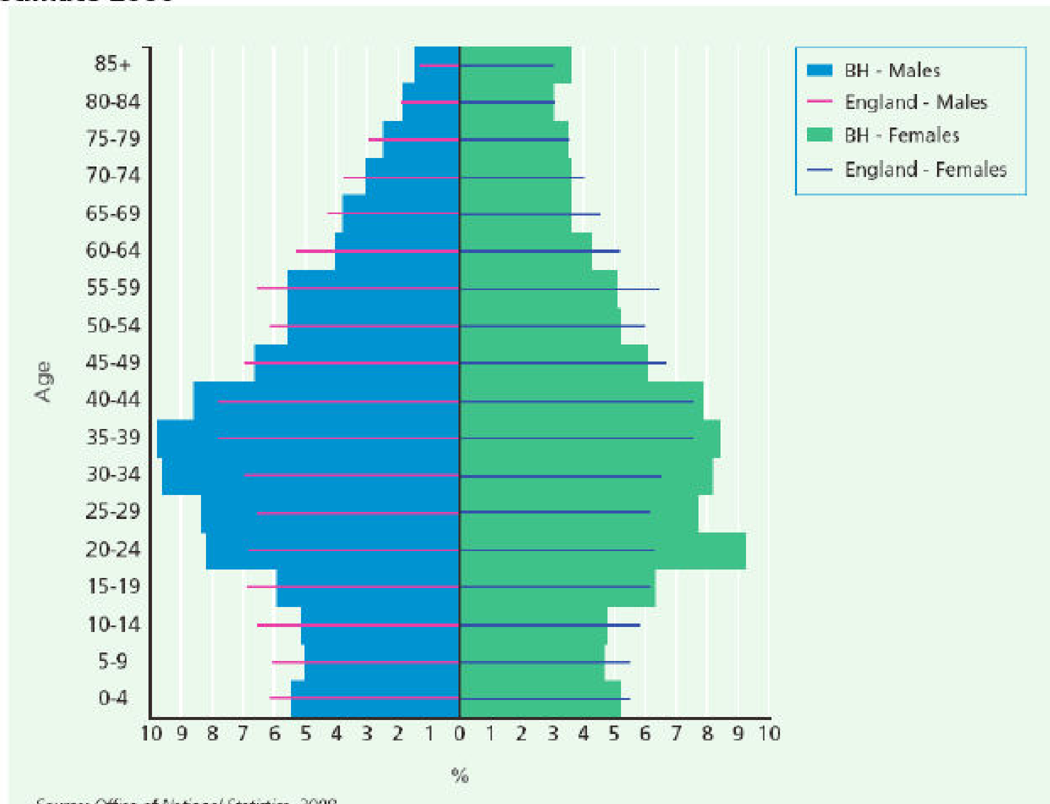
3.2 The resident population for Brighton and Hove City in 2001 was recorded as 247,817. Compared with the national picture there is a higher proportion of young adults (aged 16 to 44 years) and elderly (over 75 years) compared with England and Wales and relatively fewer children (under 16 years) and older working age adults (aged 45 to 64 years).
Between the 1991 and 2001 Censuses, the growth rate of Brighton and Hove was similar to the national growth rate (2%), but lower than the average growth in the South East (4%) (4;5).
Estimates for mid-2005 indicated that there were 255,022 people living in Brighton and Hove (6).

3.3 Figure 1 shows the population age and sex structure for Brighton and Hove in comparison with England as a whole. Brighton and Hove have a relatively young population compared with England, though this is not because of an above average proportion of children. The proportion of children less than 16 years of age (16.65%) is substantially less than the rest of the South East (19.93%), and England and Wales (20.16%). However, the city has a relatively high proportion of 16-44 year olds. This may be partly attributed to the high proportion of university students who live in Brighton and Hove (6).

3.4 The proportion of children aged 15-19 years is projected to decrease over the next ten years whereas the population aged 10–14 years, 5–9 years and particularly 0–4 years is set to increase. This has obvious implications for services such as maternity services, health visiting services, primary school services, and in later years, services for teenagers and adolescents including secondary school services (6).

3.5 There are more females (51.6%) than males (48.4%) in Brighton and Hove (4). Women generally have greater morbidity, but longer life expectancy than males.

Figure 1: Population of Brighton and Hove compared with England mid-year estimate 2006



3.6 Eighteen percent of the population of the city (or 44,893 people) were migrants in 2001 (4), placing Brighton and Hove as the area with the highest percentage of migrants in the South East and the 15th highest percentage nationally. A migrant is defined as a person whose address one year before the census was different from their address on census day.
Migrants are people who either moved into the area, out of the area or within the area in the year before the census was undertaken. The city had a net in-migration of 5,139 people over this period (5).

3.7 Among Black and Minority Ethnic (BME) groups, nearly a third (29.8%) were migrants, compared with 18% for the city on average (4). This is higher than the percentage of all people in BME groups who are migrants in the South East and considerably higher than the percentage for England and Wales. This means that BME groups are far more likely to move, either within the city or in or out of the city, than people of white ethnic background. There was a net in-migration of 885 people belonging to a BME community (5).

3.8 Approximately 10% of the total population in Brighton and Hove belong to a BME group. However, among 16-24 year olds this figure is much higher (17.5%). This may be influenced by the high student population, although even in the younger 0-15 year age range there are more children and young people from BME groups than there are among adults. The BME population in Brighton and Hove is very diverse and there are no outstanding groups (6). BME populations often experience poorer health and have unequal access to health services compared with the general population.

3.9 The white non-British population is larger overall than the non-white population in the city. Over one quarter of white non-British residents were born in Ireland and the remainder in other EU countries, with an estimated 1000 white residents originating from Eastern Europe (6). Eastern European migrant workers have unique health needs, compared with the White British population.

Key health indicators

3.10 On the average, residents of Brighton and Hove do not enjoy the same level of health as the population of England. Although all-cause mortality and stroke and heart disease deaths have decreased for both men and women over the last 10 years, life expectancy in men, infant deaths and early deaths from cancer are worse than the England average (7).

3.11 The percentage of people with a limiting long-term illness in the city was estimated to be 18.3% at the 2001 Census. Limiting long-term illness includes any long-term illness, health problems or disability, which limits daily activities or work. At that time, the percentage was similar to the national average for England and Wales, though greater than the 15.5% in the South East. Among those of working age, 13% of Brighton and Hove residents had a limiting long-term illness compared with 10.6% in the South East generally (4;5).

3.12 When asked about their health, the majority of residents responded that they were in good health (68%), which is similar to the average of England and Wales. The proportion of those who were not of good health (9%) was also similar to the national average (4;5).

3.13 People in Brighton and Hove engage in several adverse health-related behaviours. More than 1 in 4 adults are estimated to smoke which is higher than the England average. The rate of hospital stays related to alcohol is high with 1,200 admissions a year. Drug misuse is more common than in England, though binge drinking is similar. The level of people recorded with diabetes, however, is better than the England average. Also lower than average, an estimated 1 in 5 adults are obese. The percentage of children in Reception classified as obese is again lower than the England average (7).

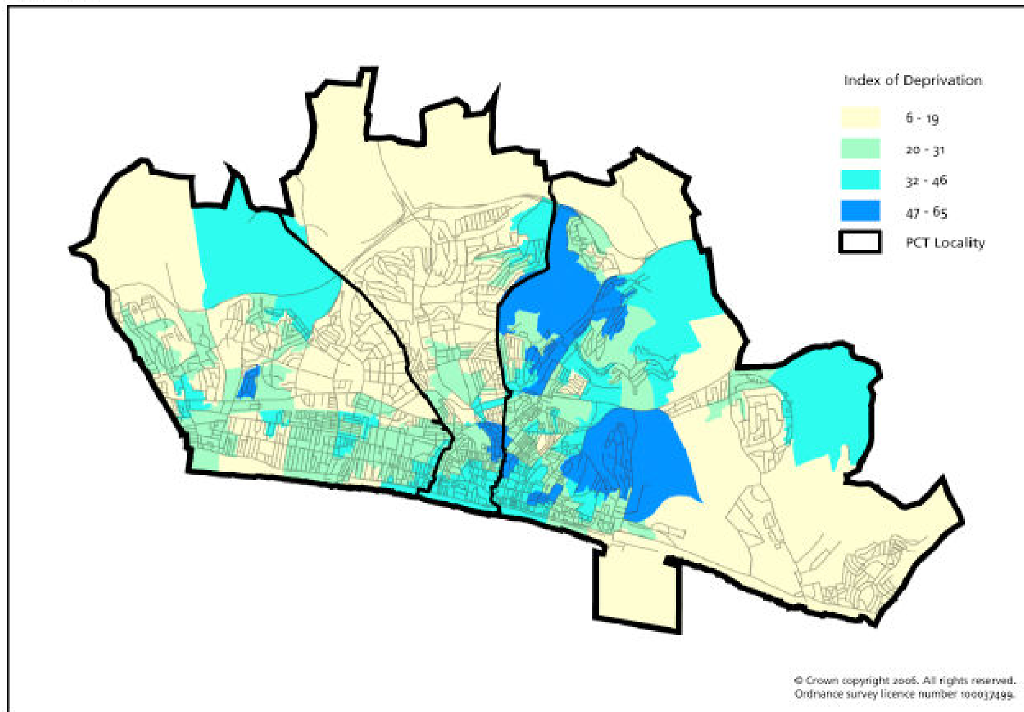
3.14 Brighton and Hove has relatively high levels of deprivation compared with regional and national averages. Fifteen of the 164 lower layer super output areas (LSOAs) in the city are in the 10% most deprived across England and 35 (21%) LSOAs are among the 20% most deprived in England (see Figure 2). Children with multiple needs, children with disability and children of lone

parents are heavily concentrated in the most deprived areas of the city. More than half of lone parents and carers in the city are out of work and 30% of all Brighton and Hove's children and young people live in a lone parent household where the parent is out of work (6).

3.15 Location, gender and deprivation contribute to health inequalities in Brighton and Hove. Life expectancy for men is reduced by seven years for those living in deprived areas and by four years for women. Child poverty is on the average significantly worse than in the England population (6).

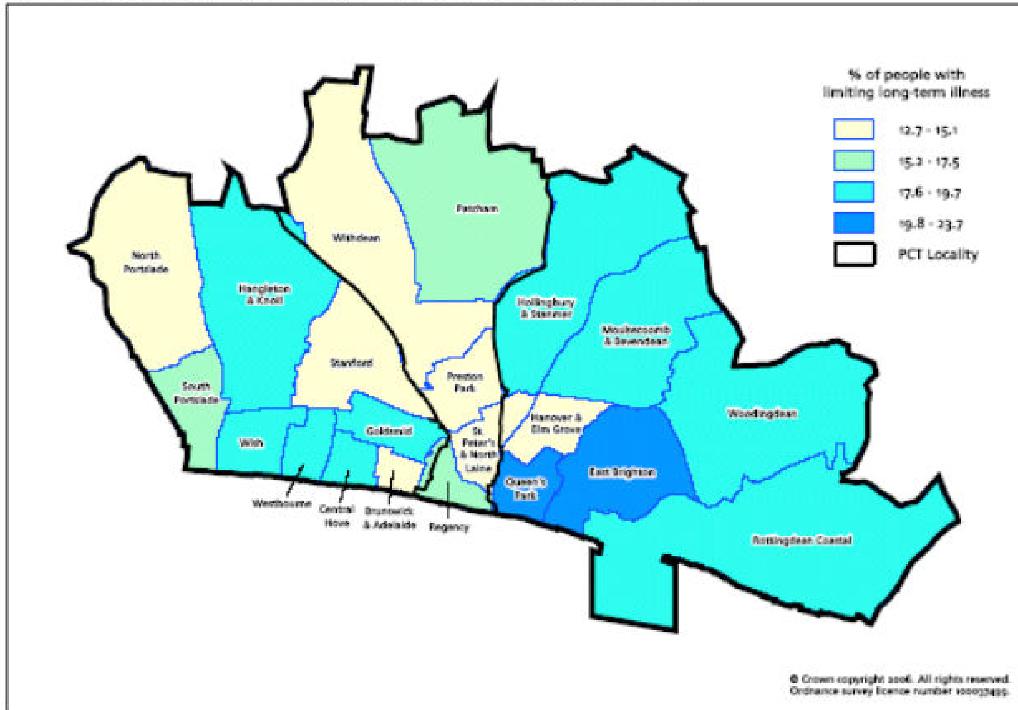
3.16 The pattern of self-reported limiting long-term illness in Brighton and Hove is shown in Figure 3.

Figure 2: Index of multiple deprivation (2004) by super output area in Brighton and Hove



Source: Public Health Directorate, Brighton and Hove City PCT

Figure 3: Limiting long-term illness in Brighton and Hove



Source: Citystats, Census 2001.

Alcohol-related Harm in Brighton and Hove

"Pubs and clubs play an important role in our city's culture and economy but alcohol is a factor in at least 40% of violent crime… Through Operation Athlete almost 200 parents of children who have had alcohol confiscated have been sent information about alcohol, young people and risks … Brighton & Hove is known as a good place to enjoy pubs and clubs but people want to be confident drunken behaviour won't spoil their enjoyment." (8).

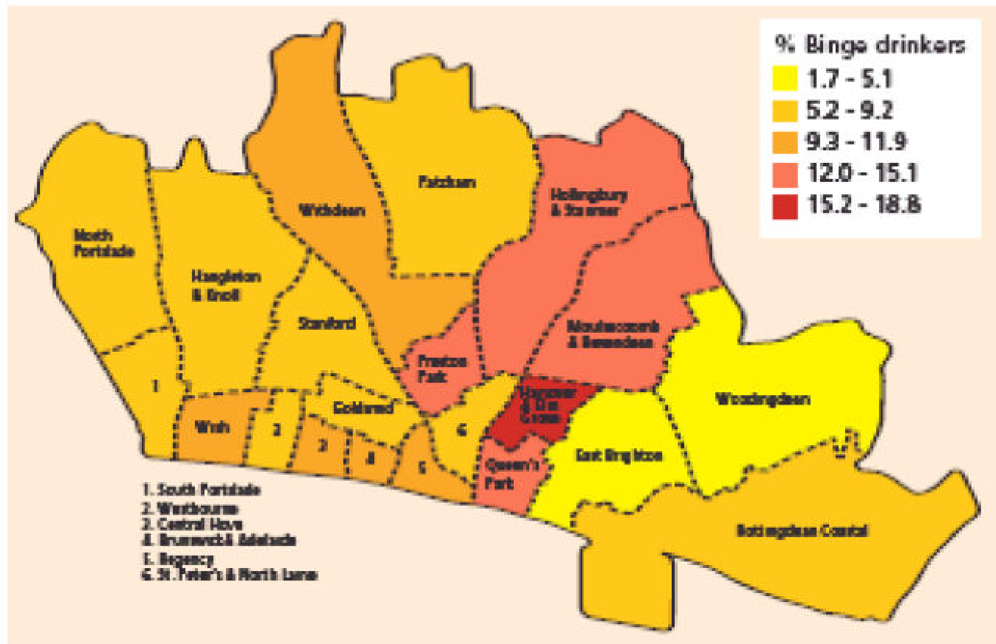
3.17 The alcohol-related harm profile is significantly worse in Brighton and Hove compared with the national average. Among men, there are significantly greater alcohol-specific mortality and hospital admission rates. Among women, hospital admission rates are higher compared with the England population (9).

3.18 Compared with regional averages, residents of Brighton and Hove have:

- lost more months of life due to alcohol
- greater alcohol-specific mortality, alcohol attributable mortality and mortality from chronic liver disease
- been admitted to hospital more frequently due to alcohol-related harm or other alcohol-specific or alcohol-attributable reasons
- committed more alcohol related crimes, including violent crimes and sexual offences
- more frequently made alcohol related claims for incapacity benefits among working-age people
- been more likely to engage in hazardous, harmful and binge drinking
- more employees that work in bars
- fewer alcohol attributed land-transport accidents
- fewer alcohol-specific hospital admissions for under 18s (9)

3.19 The Sustainable Community Strategy for Brighton and Hove plans to address the city's alcohol problems by educating residents, especially children and young people, about sensible drinking; developing an Alcohol Harm Reduction Strategy; and by increasing the availability of drug and alcohol treatment (10).

Figure 4: Percentage of residents reporting binge drinking in previous 7 days



From Brighton and Hove PCT (3)

Note: The definition of binge drinking is drinking over twice the daily guidelines in one day (8+ units for men and 6+ for women) (11).

4. Alcohol Policy Context

National Context

Health

4.1 In 2004, the Government published the Alcohol Harm Reduction Strategy for England (12). It was the first cross-government statement on the harm caused by alcohol, which included a shared analysis of the problem and the programme of action to respond. In June 2007, the Department of Health and the Home Office jointly launched an updated government alcohol strategy, Safe Sensible Social: The next steps in the National Alcohol Strategy (13), setting out clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause. The strategy outlines a coordinated response across a wide range of areas including local communities, the police, local authorities, the NHS, voluntary organisations, the alcohol industry, the wider business community and the media.

4.2 The Choosing Health White Paper (14) stresses the role of the individual in improving and maintaining health:
'Interventions and policies designed to improve health and reduce health disadvantage should provide the opportunity, support and information for individuals to want to improve their health and well-being and adopt healthier lifestyles. Policy cannot – and should not – pretend it can 'make' the population healthy. But it can – and should – support people in making better choices for their health and the health of their families. It is for people to make the healthy choice if they wish to'.

4.3 The Wanless review (15) outlines the rights and responsibilities between the individual and government:
"… people need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make … These failures can be tackled not only by individuals but by wide ranging action by health and care services, government – national and local, media, businesses,

society at large, families and the voluntary and community sector. The main levers for Government Action include taxes, subsidies, service provision, regulation and information".

4.4 The Commissioning Framework for Health and Well-being (16) builds on the White Paper Our health, our care, our say (17), which promised to help people stay healthy and independent, to give people choice in their care services, to deliver services closer to home and to tackle inequalities. The Framework identified alcohol-related disease to be a major contributor to health inequalities. It also emphasized the need for the education of children and young people about alcohol. The Framework will include an interactive web-based commissioning tool; a web-based local alcohol profile; data on the contribution of alcohol to different types of health and crime harm; guidance on developing local indicators; and guidance on the Commissioning Framework for Health and Wellbeing and alcohol.

4.5 The Department of Health has stated in Alcohol Misuse Interventions: Guidance on developing a local programme of improvement (18) that it will provide guidance on developing local programmes for screening and brief interventions of hazardous and harmful drinkers, together with guidance on treatment for dependent drinkers. The Department of Health will also work with the regulatory bodies to support local health and social care organisations in responding to the findings of any reports produced by the regulatory bodies.

4.6 Alcohol Needs Assessment Research Project (19) was commissioned by the Department of Health. It presents information at a national and regional level to highlight the range of alcohol use disorders in the population and the range of services currently available to offer treatment for alcohol problems. The report identifies gaps in services and the regional variations in access to current treatment.

4.7 The report, Indications of Public Health in the English Regions 8: Alcohol (20), produced alongside the national strategy, contains 84 separate measures (comprising 36 different indicators) relating to individual, community and population implications of alcohol use, with various measures of the effects this has on health and wellbeing, focusing on the nine English regions. Where possible, the situation in England has been put into a wider European context with comparators across the rest of the UK and other EU countries.
4.8 The Local Government and Public Involvement in Health Act 2007 (21) requires PCTs and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of their local community. As of April 2008, PCTs will also be required to include alcohol in their JSNAs (22).

4.9 The Department of Health launched a National Alcohol Harm Reduction Campaign on May 19, 2008 to raise awareness of alcohol units and the health risks of regularly exceeding Government 'lower-risk' drinking levels (23).

4.10 A new NHS guidance document has been released, Clinical directed enhanced services (DES) guidance for GMS contract 2008/09 (24), to support the delivery of clinical directed enhanced services, alcohol being one of the five key health and service priorities. The DES allows specific funding for GPs to deliver Screening and Brief Interventions (SBIs) to newly registered patients. The DESs began in April 2008 and are scheduled to run for 2 years (22).

4.11 The launch of the Prison Service Alcohol Strategy (25) for prisoners was in response to the wider Government policy, Alcohol Harm Reduction Strategy for England (12). The Strategy provides a framework for addressing prisoners' alcohol problems balancing treatment and support with supply reduction measures. The focus of the Strategy is to improve consistency and build on good practice for the delivery of services within existing resources.

Community Safety

4.12 The Police and Justice Act 2006 (26) has helped to build safer communities by making sure key elements of the government's police reform programme and the Respect Action Plan are implemented. The Act is also helping to sustain further improvements in police performance at neighbourhood, force, national and international levels. Notably, the Act has already helped to amend the Crime and Disorder Act 1998 to make Crime and Disorder Reduction Partnerships

(CDRPs) and Community Safety Partnerships (CSPs) more effective at tackling crime, anti-social behaviour and substance misuse in their communities.

4.13 In addition, the Home Office 'Guide to Effective Partnership Working' (27) provides new statutory requirements and recommended best practice for CDRPs in the form of 'Hallmarks for Effective Partnership Working', including the role of PCTs and Local Health Boards in tackling drug and alcohol misuse. From April 2008, Home Office declared a statutory duty for CDRP to have a local alcohol strategy (22).

4.14 The Tackling Violent Crime Programme (TVCP) (28) focuses on alcohol-related and domestic violence because together these make up the majority of violent crime incidents. Research shows that domestic violence accounts for 16-25% of all violent crime, and that approximately half of violent crime incidents are alcohol-related. Geographically the programme focuses on a relatively small number of areas, in which research has shown a significant percentage of violent crime to occur. The aim is that targeting activity in these areas should produce a reduction in the national level of violent crime. Partnership working is a key focus of the TVCP.

4.15 The National Probation Service has an important part to play in tackling alcohol misuse within its wider role of protecting the public and preventing further offending by rehabilitating offenders. A great deal of good work is already being done. Working with Alcohol Misusing Offenders – A Strategy for Delivery (29) aims to develop more consistent and co-ordinated delivery.

4.16 Under the Criminal Justice Act 2003 (30), a caution with specific conditions attached to it may be given where there is sufficient evidence to charge a suspect with an offence which he or she admits, and the suspect agrees to the caution. The Act also stipulates that the courts can make an alcohol treatment requirement (ATR) one of the possible requirements. The court may not impose an alcohol treatment requirement unless the offender expresses willingness to comply with its requirements.

4.17 Arrest Referral (13) is one of a growing number of initiatives intended to disrupt the link between substance misuse and offending. It aims to do so by improving the uptake of substance misuse treatment and care services among arrestees whose offending may be related to drug use or drug and alcohol use.
4.18 The National Probation Service (NPS) has two substance misuse group work programmes, which address alcohol-related offending behaviour: 1) the Drink Impaired Drivers (DID) scheme, which is aimed at drink drivers with no other criminogenic need; and 2) the Lower Intensity Alcohol Module (LIAM) for those offenders whose alcohol misuse and offending needs might require referral to another programme (e.g. tackling violent behaviour), but where there is still a need for alcohol-related offending to be addressed (13).

Licensing

4.19 The Rogers Review (31) identified alcohol licensing as one of the five main national enforcement priorities. Alcohol licensing seeks to prevent risks, such as anti-social behaviour and violence, that could affect all parts of society particularly the young and vulnerable.
4.20 The Department for Culture, Media and Sport are responsible for alcohol and entertainment licensing policy. The 2003 Licensing Act (32) was created to provide a new system of licensing for the sale and supply of alcohol, the provision of regulated entertainment and the provision of late night refreshment. The Act does not prescribe days or opening hours when alcohol can be sold, rather it aims to promote four fundamental objectives:

- the prevention of crime and disorder;
- public safety;
- the prevention of public nuisance; and
- the protection of children from harm.

4.21 The measures in the Licensing Act will be complemented by provisions in the Violent Crime Reduction Act 2006, sections 21–22 of which will allow licensing authorities to fast-track licence conditions, on the application of a senior police officer, in cases of serious crime and disorder (13).

Industry Voluntary Codes and Campaigns

4.22 The Portman Group's Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks (33) was introduced in 1996 following a public consultation. The Code, which is supported throughout the industry, seeks to ensure that drinks are marketed in a socially responsible way and to an adult audience only. The Code has an open and accessible complaints system. Complaints under the Code are ruled on by an Independent Complaints Panel (33). If a product is found in breach of the Code, a Retailer Alert Bulletin is issued, asking retailers not to stock the offending product unless and until it has been amended to comply with the Code.

4.23 Social Responsibility Standards for the Production and Sale of Alcoholic Drinks in the UK (34) were launched in November 2005. The Standards were drawn up by the Wine and Spirit Trade Association, the British Beer and Pub Association and the Scotch Whisky Association and have had full support and input from thirteen other trade bodies and several Government departments. The Standards set out best practice for the promotion of sensible drinking, responsible marketing and promotions and responsible retailing of alcoholic drinks. They are based on a set of social responsibility principles around the promotion of responsible drinking and the avoidance of promoting or condoning illegal, irresponsible or immoderate drinking.

4.24 In April 2007, the alcohol industry agreed with the Department of Health additions to labelling to support sensible drinking. During 2008, the Government will continue to consult on the extent to which these additions – along with a pregnancy message – have been implemented. It will also consider consultation on possible legislative options should insufficient progress have been made by then (13).

4.25 On November 16, 2007 Ofcom and Advertising Standards Authority (ASA) jointly published a research report on the impact of alcohol advertising on young people following the tightening of the Advertising Codes in October 2005. The new rules were designed to make alcohol advertisements less appealing to the under 18s and, in particular, to prevent alcohol advertisements from being associated with or reflecting youth culture (13).

4.26 For over two years, the British Beer & Pub Association's Challenge 21 campaign (35) has been raising awareness of the underage sales issue among publicans, their staff and pub goers alike. The BBPA and its members have now issued over 350,000 Challenge 21 posters to British pubs. The Challenge 21 message - that if you look 21 or under you should expect to be asked for ID if you try to buy alcohol - now has a strong and visible presence right across the country.

Children and Young People

4.27 Every Child Matters: Change for Children (36) is a new approach to the well-being of children and young people from birth to age 19. The Government's aim is for every child, whatever their background or their circumstances, to have the support they need to: Be healthy; Stay safe; Enjoy and achieve; Make a positive contribution and; Achieve economic well-being.

4.28 With respect to alcohol, young people were first introduced as a priority in the updated Alcohol Strategy: Safe. Sensible. Social (13). Following this, a Youth Alcohol Action Plan (37) was developed to take further actions on reducing young people's drinking and related anti-social behaviour and health harms. This Action Plan sets out how the Government will address youth problems with alcohol through a strong partnership with parents, industry, criminal justice and law enforcement agencies and communities.

4.29 In July 2005 the government launched its green paper Youth Matters setting out proposals designed to improve outcomes for 13-19-year-olds. A consultation on Youth Matters was run from July to November 2005. With over 19,000 responses from young people, this is one of the largest responses to a government consultation from any one group. The government's response to the consultation, Youth Matters: Next Steps (38), set out the vision for empowering young people, giving them "somewhere to go, something to do and someone to talk to". Acknowledging the hardships and risks that can limit the opportunities available to youth, the government has dedicated several programmes of work to help limit the problems associated with substance misuse, offending, teenage pregnancy and homelessness.

4.30 The NICE guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people (39) calls for anyone who works with young people to identify those who are vulnerable to drug problems and intervene at the earliest

opportunity. It gives advice on stepping in and helping young people access the right support and services and outlines effective individual, family and group-based support which can improve motivation, family interaction and parenting skills.

4.31 The NICE guidance on school based interventions to prevent and reduce alcohol use (40) is aimed at anyone who works with children and young people in schools and other education settings. It gives advice on incorporating alcohol education into the national science and personal, social and health education (PSHE) curricula, and helping children and young people access the right support. It also looks at how to link these interventions with community initiatives, including those run by children's services. There are no national guidelines on what constitutes safe and sensible alcohol consumption for children and young people, so the recommendations focus on: encouraging children not to drink, delaying the age at which young people start drinking and reducing the harm it can cause among those who do drink.

4.32 Since 2006 the Department of Health and Home Office have jointly worked on the advertising campaign, Know Your Limits (41), which urges young drinkers to know their limits and to stay within them. It is aimed at 18 to 24 year olds, although it also reaches out to younger, illegal drinkers.

South East Regional Context

4.33 At the regional level, the South East of England is following the strategies outlined at the national level, namely The Alcohol Harm Reduction Strategy for England and Safe, Sensible, Social. The next steps in the National Alcohol Strategy (42).

4.34 The National Alcohol Strategy Implementation Toolkit is a resource provided by the national authority to help regional and local teams develop strategies to address alcohol-related crime, ill health and other harm in line with the National Alcohol Strategy. It has been written specifically to help alcohol leads and others within local authorities, primary care trust (PCTs), children's services and delivery partnerships such as Crime and Disorder Reduction Partnerships (CDRPs) and Drug and Alcohol Action Teams (DAATs) (42).

4.35 The Vision for the South East is to reduce the excessive drinking of the minority who drink in a way that is a nuisance or a danger to others and themselves to a level that is safe, sensible and social. Specifically they are targeting: under age drinking, binge drinking, and harmful drinkers. They are currently working on supporting South East partnerships with the implementation of their Alcohol Strategies, sharing good practice and co-ordinating the delivery of the updated National Alcohol Strategy across the South East through a new strategic regional programme board (42).

4.36 Work is currently underway to address alcohol misuse by (42):

- Producing a GOSE statement of priorities on Alcohol
- Organising a regional Alcohol event
- Ensuring that a cross-cutting alcohol strategy and plan that is fit for purpose is produced in each upper tier/unitary authority
- To maintain the networking forum of alcohol practitioners in the region
- To set up an internal committee to scrutinise current and future Local Authority alcohol strategies/action plans ensuring they are fit for purpose
- To ensure cross-cutting targets are embedded in the Local Area Agreements as appropriate

4.37 The Regional Public Health Group in GOSE is also developing a Regional Alcohol Manager function which will be used to (42):

- Support LAA NI39 target setting and delivery by local partnerships
- Support SHA performance management of LAA NI39 NHS Indicator targets
- Influence the development and support delivery of local PCT targets related to NI39
- Enable regional co-ordination and joint working with CSIP for targeted and enabling support commissioned by DH to reduce alcohol-related admissions
- Co-ordinate and target action to support local social marketing initiatives

Brighton and Hove Local Context

4.38 Local Area Agreements set out the priorities for the local area. LAAs are agreements between central government, local authorities and their partners, through the Local Strategic Partnership, to improve services and the quality of life in a particular place. The 35 targets for the period 2008-11 in the Brighton & Hove Local Area Agreement include targets around alcohol harm, drugs misuse, perceptions of anti-social behaviour, first time entrants to the youth justice system, domestic violence and prolific offenders (43).

4.39 Brighton & Hove's Sustainable Community Strategy (10) sets out the vision and plans of the agencies, organisations and communities who work together through the 2020 Community Partnership to improve the quality of life of local residents. The Strategy has eight priority themes, three of which have specific goals related to alcohol: 'Reducing Crime and Improving Safety', 'Children and Young People', and 'Improving health and well-being'. The Strategy plans to:

- Educate residents, especially children and young people, about sensible drinking
- Develop an Alcohol Harm Reduction Strategy
- Increase the availability of drug and alcohol treatment, partly through establishing a treatment centre targeting parents and carers and recognising many people have joint alcohol and drug misuse issues
- Increase enforcement against alcohol sales to under-18s and improve alcohol advice and treatment options;
- Reduce harmful levels of drinking and continue high visibility policing at recognised hotspots;
- Use planning policy to prevent over-concentration of super-pubs; and
- Involve the Licensees' Association and the Business Crime Reduction Partnership to promote good practice in pubs and clubs and help prolific offenders with drug and alcohol problems into treatment.
- Reduce the number of alcohol-related criminal offenses

4.40 In April of this year the Crime and Disorder Reduction Partnership (CDRP) of Brighton and Hove published its Brighton & Hove Community Safety, Crime Reduction and Drugs Strategy 2008-11 (43). This strategy aims to make the city safer by

- reducing crime, disorder and anti-social behaviour;
- reducing fear of crime;
- reducing harm from drugs and alcohol; and
- improving community safety

4.41 Brighton and Hove Drug & Alcohol Action Team (DAAT) has a membership consisting of senior managers from the City Council, the Police, the PCT, Probation and from Treatment service providers. The DAAT has a remit to oversee the delivery at a local level of the Government's National Alcohol Harm Reduction Strategy (2004). The local delivery is taken forward by a number of groups responsible for specific areas of the strategy (44).

4.42 One of DAAT's initiatives, Sussed about Drink, is a website designed to engage a younger audience by highlighting immediate, rather than long term, impacts of drinking to excess. There is also an over-18s section where people can learn about sensible drinking, take online drink tests and find out where to get help in Brighton & Hove (44).

4.43 The Alcohol and Entertainment Licensing Authority in Brighton and Hove is the City Council. It follows laws sent out in the national 2003 Licensing Act; however, on 13 March 2008 Council included in the Licensing Policy for 2007-2010 a Special Policy regarding cumulative impact which provides, along with the Act and government guidance & regulations, the basis of licensing decisions. There are four main principles behind this system (45):

- to prevent crime and disorder
- to prevent public nuisance
- to protect children from harm
- public safety

4.44 The new system began on 24 November 2005. The aim is to help build a fair and prosperous society, properly balancing the rights of people and their communities by following the above principles. It also intends to encourage tourism, reduce alcohol misuse, improve the self-sufficiency of local communities and reduce the burden of unnecessary regulations on businesses (45).

5. Review of Brighton and Hove data relating to alcohol and health

5.1 This section presents findings from the early stages of the data review work. It contains some unresolved issues on which we would welcome feedback from the Steering Group at it's meeting on 7th October 2008.

5.2 Establishing a set of indicators to monitor the effects of flexible alcohol hours is an important aspect of this HIA work.

5.3 The review of data has highlighted a range of issues; we welcome Steering Group feedback on these.

Dimensions of comparison

5.4 In this review work we consider two key 'dimensions of comparison'.

5.5 The first dimension of comparison is that of time.

5.6 The intervals between data points in the time trend will vary depending on the indicator under consideration and in particular the ease of collecting data.

5.7 We will need to establish a baseline from which to monitor effects. We note that the Licensing Act 2003 came into force in November 2005.
Key question 3: what period does the Steering Group suggest is chosen as the monitoring baseline period?

5.8 The second dimension of comparison we consider is that of geography or place.

5.9 Comparison can be made between Brighton and Hove and external comparators such as values for:

- England;
- Regional level; and
- Comparable large towns / cities.

5.10 Crime & Disorder Reduction Partnership (CDRP) Families have been established by the Home Office to facilitate comparisons. Each CDRP is joined by its 14 most similar CDRPs (based on criteria defined by the Home Office) to form a family group consisting of 15 CDRPs. Brighton and Hove CDRP family includes neighbouring South Coast cities of Portsmouth and Southampton. The Office for National Statistics (ONS) clusters are another means of identifying comparator towns / cities.

Key question 4: Would Portsmouth or Southampton represent an appropriate comparator?

5.11 We might also consider making comparisons between part of Brighton and Hove and the city as a whole.
Key question 5: Are there specific communities that the Steering Group wishes to monitor impacts on?

5.12 Clearly an approach that combines time and place will provide greatest insight into impacts. The dimensions introduced above provide useful prompts for the review of data.

Approach to review

5.13 We have considered the impacts of flexible alcohol hours and have begun to establish a conceptual framework to guide the data review.

5.14 The following diagrams are not formal causal pathway models. They represent prototype schema to support the data review work. We welcome comments on the diagrams that follow.

5.15 A high level view of the introduction of flexible alcohol hours is shown in Figure 5. The benefits of alcohol are considered as in Figure 6. We have identified a number of potential alcohol

related harms. Figure 7 presents a wide range of potentially adverse impacts of alcohol. The diagram currently contains a mix of harm related elements and data representing alcohol related harm.
Key question 6: we welcome feedback from Steering Group members on these schema and in particular on the completeness of Figure 6 (benefits) and Figure 7 (harms).

Figure 5: High level alcohol schema

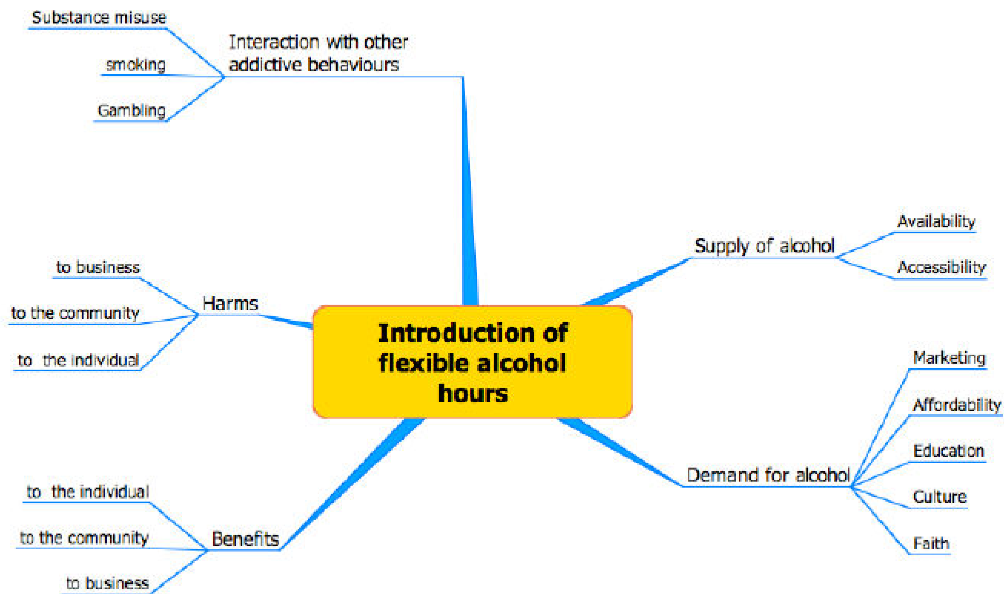


Figure 6: Alcohol related benefits

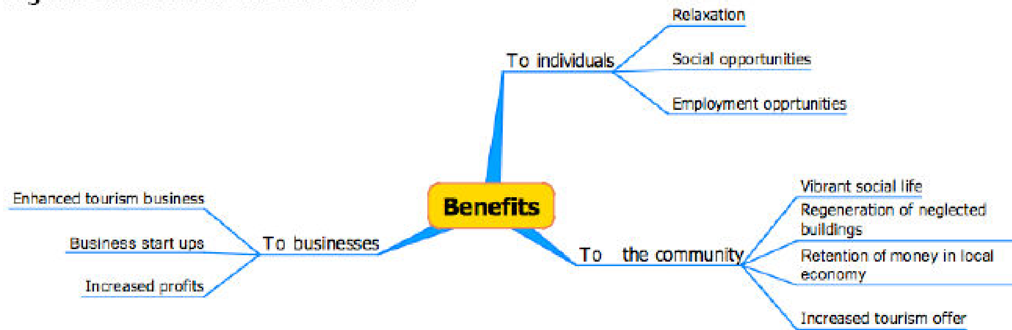


Figure 7: Alcohol related harms

5.16 We have reviewed a range of sources to establish the impacts identified above. These include Alcohol Indications, LAPE profile, Alcohol Concern Night time economy factsheet, www.localalcoholstrategies.org.uk, Home Office guidance for local partnerships on alcohol related crime and disorder data. We have begun to identify data for these impacts.

5.17 We continue to work closely with the PCT Alcohol Health Needs Assessment project to share intelligence on local data; thanks are due to Barbara Hardcastle for her support and collaboration.

5.18 Based on Figure 7: Alcohol related harms we have established the following long list of indicator topics (Table 2).

Table 2: Long list of indicator topics

Impact theme	Subtopic
1 Cultural	1.1 Mono-culture (other entetainments cann't afford rates / rents)
2 Crime and disorder	2.1 Drink driving offences
2 Crime and disorder	2.2 Licensing offences
2 Crime and disorder	2.3 Alcohol related public disorder offences
2 Crime and disorder	2.4 Alcohol related violence
2 Crime and disorder	2.5 Fear of crime
2 Crime and disorder	2.6 Confiscation of alcohol from young adults
2 Crime and disorder	2.7 Alcohol related anti-social behaviour
2 Crime and disorder	2.8 Alcohol related vandalism
3 education	3.1 Fixed exclusions
3 education	3.2 Attainment
3 education	3.3 Childhood development
4 employment	4.1 Alcohol related sickness / absence
4 employment	4.2 Alcohol related loss of employment
4 employment	4.3 Loss of income due to alcohol related vandalism
5 environment	5.1 Noise nuisance complaints
5 environment	5.2 Fires where alcohol a factor
5 environment	5.3 Street cleaning related to alcohol
5 environment	5.4 Waste from licensed premises / in vicinity of
6 Families	6.1 Children in problem drinking households
6 Families	6.2 Domestic violence
6 Families	6.3 Drinking during pregnancy
6 Families	6.4 children accessing child specfic support - alcohol related
6 Families	6.5 Parents / carers referred to treatment / support services
7 Health services	7.1 Primary care
7 Health services	7.2 Hospital admissions
7 Health services	7.3 A&E attendances
7 Health services	7.4 Ambulance callouts
8 housing	8.1 Homeless / rough sleepers with alcohol problems
8 housing	8.2 Housed tenants with alcohol problems
8 housing	8.3 Tenancies lost where alcohol a factor
9 Individual health and well being	9.1 Lifestyle - alcohol consumption
9 Individual health and well being	9.2 Stress and mental well being (as result of environmental problems)
9 Individual health and well being	9.3 Alcohol related mortality
9 Individual health and well being	9.4 Risk taking sexual activity
9 Individual health and well being	9.5 Risk of accidents
9 Individual health and well being	9.6 Road traffic accidents
9 Individual health and well being	9.7 Alcohol related morbidity

1

5.19 This will need to be expanded to take into consideration alcohol related benefits (Figure 6).

5.20 We have begun and will continue to investigate the availability of local data against each of these topics.
5.21 Against the 38 harm subtopics identified above we are currently evaluating 61 potential indicators.

5.22 This involves identifying key contacts and contacting them to establish meta data. Key questions we ask about local data include:

- Source of data;
- Level of geography – is it Available down to PCT / ward / SOA / Postcode;
- Is a Male / Female split available;
- Age breakdown; and
- How regularly produced / what period is data available for?

5.23 We will then report back to the Steering Group findings along with an assessment of the value of each indicator for monitoring the impacts of flexible alcohol hours.

Key question 7: Do Steering Group members have a view on the number of indicators they would wish to see used to monitor impacts and the relative importance of comparing Brighton and Hove with other areas versus comparing parts of the City with the whole?

6. List of references

1. Cave, B., Ison, E., Stuckler, D., and Coutts, A. Review of the National Alcohol Harm Reduction Strategy for England. 2007. Ben Cave Associates Ltd for the Department of Health. Available at www.dh.gov.uk/

2. Brighton and Hove City Teaching Primary Care Trust and Brighton and Hove City Council. The Annual Report of the Director of Public Health. 2004.

3. Brighton and Hove City Teaching Primary Care Trust and Brighton and Hove City Council. The Annual Report of the Director of Public Health. 2005. Available at www.brightonhovecitypct.nhs.uk

4. Office for National Statistics. National Census. 2001.

5. Brighton and Hove City Council. 2001 Census Briefing Series. 2001. Available at http://www.brightonhove.gov.uk/index.cfm?request=b1000175

6. Director of Public Health, Brighton and Hove Primary Care Trust, and Brighton and Hove City Council. Annual Report of the Director of Public Health: Brighten Up! Growing Up in Brighton and Hove. 2008.

7. Association of Public Health Observatories. Health Profile 2008: Brighton and Hove.2008.

8. 2020 Community Partnership. Reducing Crime & Improving Safety: Alcohol. 2007. Available at http://www.brightonhove.gov.uk/index.cfm?request=c1165405

9. NorthWest Public Health Obervatory. Local Alcohol Profiles for England: Profile of alcohol related harm - Brighton and Hove. 2008. Available at www.nwph.net/alcohol/lape

10. Brighton and Hove City Council. Creating the City of Opportunities: A sustainable community strategy for the City of Brighton and Hove, 2006-09. 2006.

11. Strategy Unit. Interim analytical report for the National Alcohol Harm Reduction Strategy. Strategy Unit Alcohol Harm Reduction project 2003.

12. Strategy Unit. Alcohol Harm Reduction Strategy for England. 2004 Cabinet Office.

13. HM Government of Great Britain. Safe. Sensible. Social. The next steps in the National Alcohol Strategy 2007. Availableat www.dh.gov.uk

14. Department of Health. Choosing health: making healthier choices easier. CM 6374 2004. Available at www.dh.gov.uk

15. Wanless, D. Securing good health for the whole population. Final report 2004 HM Treasury, HMSO. Available at http://www.hmtreasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm

16. Department of Health. Commissioning framework for health and well-being. Consultation draft 2007. London. Available at www.dh.gov.uk

17. Department of Health. Our health, our care, our say: a new direction for community services. Cm 6737 2006. London.

18. Department of Health. Alcohol misuse interventions: guidance on developing a local programme of improvement.

25. HM Prison Service. Addressing Alcohol Misuse: The Prison Service Alcohol Strategy. 2008. Available at http://www.hmprisonservice.gov.uk/resourcecentre/publicationsdocuments/index.asp?cat=88

26. Home Office Police. Police Reform: The Police and Justice Act 2006. 2006. Available at http://police.homeoffice.gov.uk/policereform/PoliceandJusticeBill1/

27. Police and Crime Standards Directorate Home Office. Delivering Safer Communities: A guide to effective partnership working. 2007.

28. Home Office Crime Reduction. Tackling Violent Crime Programme. 2004. Available at http://www.crimereduction.homeoffice.gov.uk/tvcp/tvcp01.htm

29. Ministry of Justice. Working with Alcohol Misusing Offenders: a strategy for delivery. 2006. Available at http://noms.justice.gov.uk/newspublicationsevents/publications/guidance/NPS_alcohol_misuse_strategy?version=1

30. Home Office. Explanatory Notes to Criminal Justice Act 2003. 2003. Available at http://www.opsi.gov.uk/acts/acts2003/en/ukpgaen_20030044_en_1

31. Rogers Review. Rogers Review of Local Authority Regulatory Priorities. 2007. Available at http://archive.cabinetoffice.gov.uk/rogersreview/

32. Home Office. Explanatory Notes to Licensing Act 2003. 2003. Available at http://www.opsi.gov.uk/acts/acts2003/en/ukpgaen_20030017_en_1

33. Portman Group. Code of Practice. 2008. Available at http://www.portmangroup.org.uk/textonly.asp#Code%20of%20Practice

34. The Wine and Spirit Trade Association, the British Beer and Pub Association, and the Scotch Whisky Association. Social Responsibility Standards. 2005. Available at http://www.wsta.co.uk/index.php?option+com%1Fcontent&task=59&Itemid=104

35. the British Beer and Pub Association. Challenge 21. 2008. Available at http://www.beerandpub.com/industryArticle.aspx?articleId=85

36. HM Government. Every Child Matters: Change for Children. 2004. Available at http://www.everychildmatters.gov.uk/

37. Department for Children, Schools and Families, Home Office, and Department of Health. Youth Alcohol Action Plan. 2008.

38. Department for Education and Skills. Youth Matters: Next Steps. Something to do, somewhere to go, someone to talk to. 2006.

39. National Institute for Health and Clinical Excellence. Interventions to reduce substance misuse among vulnerable young people. 2007. Available at http://www.nice.org.uk/

40. National Institute for Health and Clinical Excellence. School-based interventions on alcohol. 2007. Available at http://www.nice.org.uk/

41. Department of Health. Current Campaigns. 2008. Available at http://www.dh.gov.uk/en/News/Currentca mpaigns/index.htm

42. Government Office for the South East. Alcohol - The Local Profile. 2008. Available at http://www.gose.gov.uk/gose/communitySafety

2005 National Treatment Agency for Substance Misuse.	
19. Department of Health, University of London.St George's.Division of Mental Health.Section of Addictive Behaviour, Kable Limited, and MORI Social Research Institute. Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England. 2005.	43. Partnership Community Safety Team. Brighton and Hove Community Safety, Crime Reduction and Drugs Strategy 2008-2011. 2008.
20. North West Publich Health Observatory, Centre for Public Health, Liverpool John Moores University, and South West Public Health Observatory. Indications of Public Health in the English Regions 8: Alcohol. 2007.	44. Brighton and Hove Primary Care NHS Trust. Sussed Professional. 2006. Available at http://www.sussedprofessionals.net/
21. HM Government of Great Britain. Local Government and Public Involvement in Health Act. 2007. Available at www.opsi.gov.uk	45. Brighton and Hove City Council. Brighton and Hove Council Services. 2008. Available at http://www.brighton-hove.gov.uk/
22. Ranzetta, L and Morris, J. Alcohol Policy UK: News and analysis for the alcohol harm reduction field. 2008. Available at http://www.alcoholpolicy.net/	
23. Department of Health. National Alcohol Harm Reduction Campaign. 2008. Available at http://www.info.doh.gov.uk/doh/embroadcast.nsf/vwDiscussionAll/960C163382EBB8CE80257442004CE541	
24. NHS Employers. Directed enhanced services. 2008. Available at http://www.nhsemployers.org/payconditions/primary-893.cfm	