CITY OF PLYMOUTH

Joint Select Committee

National Alcohol Harm Reduction Strategy

DECEMBER 2004

Preface

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Chair of Joint Select Committee,
National Alcohol Harm Reduction Strategy

Alcohol is a legal drug that is widely accepted and enjoyed by many for a variety of reasons. For many users there are few short or long term adverse effects. However, for a significant number of people, alcohol causes a variety of problems that can ultimately be life- threatening. The alarming statistic of 1 in 13 of the United Kingdom adult population is alcohol-dependent.

Alcohol makes a significant contribution to the United Kingdom economy. The total value of the alcoholic drinks market is in excess of £30 billion. Putting this in context, however, a recent worldwide rebranding exercise for one type of vodka cost two and a half times as much as the £95 million spent annually on alcohol treatment in England and Wales.

The National Alcohol Harm Reduction Strategy aims to tackle the harms and costs of alcohol misuse in England. It has four main strands – better education and communication; improving health and treatment services; combating alcohol-related crime and disorder and working with the alcohol industry. The Strategy, the Licensing Act, the forthcoming Public Health White Paper and other promised Government legislation will all seek to regulate and mitigate the social effects of alcohol use on both individuals and communities.

The Committee was particularly concerned about the impact of alcohol misuse on young people in Plymouth, both in regard to their being at risk of significant harm from alcohol-fuelled parental domestic violence and their own drinking. Mrs French from Hamoaze House informed the Committee that in the course of working with young people, the following information had been gathered: out of a total of 32 young people, five in the under eleven-age range were living in households where alcohol misuse was a problem, with 14 similarly affected in the over eleven-age range.

The Committee was impressed by the testimony of a representative from the local branch of Alcoholics Anonymous, who is a recovering alcoholic herself. The Committee felt that this review should include the foreword from Alcoholics Anonymous' booklet, "Who Me?"

Alcoholism is a fatal illness for which there is no known medical cure, and many of its victims are forced to wage a losing battle, not only against the ravages of the illness, but also against the ignorance of a society which largely refuses to regard the alcoholic as a sick person. To many people, the word 'alcoholic' means someone who is perverse and weak willed. 'Why on earth doesn't he control his drinking?', they ask. Those of us who are alcoholics, and who have tried to control our drinking know just how impossible a task that is. This is because alcoholism is an illness. While we stay away from drink, we function much like other people. But if we take any alcohol whatsoever into our systems, something happens both physically and mentally which makes it difficult or impossible for us to stop.

I would like to thank the members of the Joint Select Committee, the officers who supported the scrutiny process and the witnesses who were able to take part and who provided us with valuable information. I would also like to thank Linda Gilroy, MP, for attending a meeting of the Committee to talk to her report, “National Alcohol Harm Reduction Strategy – Views from Plymouth”, and to answer questions from Committee Members.

1.0 Summary

The Joint Select Committee has completed its inquiry into the National Alcohol Harm Reduction Strategy. The Committee's aim was to investigate the harms and costs of alcohol misuse as identified in the Strategy via research and witness evidence. The Committee wanted to make recommendations that would help develop and implement an alcohol harm reduction strategy in Plymouth, working in partnership with local agencies and stakeholders. Where possible, this work has been linked with Plymouth City Council's Statement of Licensing Policy.

2.0 Recommendations

2.1 The "Alcohol Harm Reduction Strategy for England" makes a recommendation about who should deliver the Strategy at a local level at page 88 in the document and point 41 in the action plan. This recommendation should be considered in conjunction with Plymouth City Council's Statement of Licensing Policy for the purposes of implementation.

We recommend that as the agreed crime reduction body, Plymouth Community Safety Partnership – incorporating Plymouth Drug and Alcohol Action Team – work to the timescale of 12 months for the delivery of a local alcohol harm reduction strategy that will be reviewed on a regular basis.

For the attention of: Cabinet

2.2 **We recommend** that representatives from local health services, voluntary organizations and the alcohol and hospitality industries be invited to join the membership of Plymouth Community Safety Partnership.

For the attention of: Plymouth Community Safety Partnership

2.3 **We recommend** that the local authority continue to take the lead in managing Plymouth's night-time economy in partnership with other agencies and stakeholders.

For the attention of: Cabinet

2.4 **We recommend** that as part of a local alcohol harm reduction strategy, a review of night transport provision be undertaken in areas of Plymouth where there is a concentration of pubs and clubs, focussing on -

- more late night buses;
- current siting of taxi ranks;
- (the Licensing Committee) investigating ways of licensing more taxis specifically for the night time trade;
- any other transport issues affecting dispersal from pubs and clubs.

For the attention of: Cabinet

2.5 **We recommend** that the Licensing Committee consider staggered closing times for pubs and clubs in order to assist dispersal.

For the attention of: Licensing Committee

2.6 **We recommend** that as part of a local alcohol harm reduction strategy, a Plymouth alcohol harm reduction guide be produced, focussing on -

- personal safety;
- minimizing the risks of alcohol-related crime and disorder;
- minimizing environmental and noise pollution.

For the attention of: Plymouth Community Safety Partnership

2.7 **We recommend** that as part of a local alcohol harm reduction strategy, the "City Safe" programme be fully endorsed and actively promoted as a Plymouth initiative and model of good practice, and run in conjunction with Plymouth City Council's Statement of Licensing Policy.

The Committee welcomed any City-wide initiatives that restricted the sale of alcohol to those under 18 years of age.

For the attention of: Cabinet

2.8 **We recommend** that the "Best Bar None" award be welcomed as a model of good practice, and developed as part of a Plymouth initiative in formulating a local alcohol harm reduction strategy.

For the attention of: Cabinet

2.9 **We recommend** that as part of the element of combating crime and disorder in a local alcohol harm reduction strategy, consideration be given to –

- creating more Alcohol Free Zones;
- creating more Glass Free Zones
- greater use of Anti-Social Behaviour Orders (ASBOs).

For the attention of: Cabinet

2.10 **We recommend** that as part of a Plymouth initiative in developing a local alcohol harm reduction strategy, consideration be given to strengthening the current Club Watch Radio System (that co-ordinates door staff in pubs and clubs).

For the attention of: Cabinet

2.11 **We recommend** that as part of a local alcohol harm reduction strategy, initiatives be explored in relation to conveying messages about the harms and costs of alcohol misuse in the settings of schools, local communities and the workplace.

For the attention of: Cabinet

2.12 **We recommend** that an Evening and Night Time Economy Manager post be created, with strategic and operational responsibility for -

- the development and implementation of a City-wide evening and night time economy;
- licensing, planning and enforcement issues related to Plymouth's evening and night time economy.

For the attention of: Cabinet

2.13 **We recommend** that supermarkets and off-licenses request proof of age if individuals attempting to purchase alcohol appear to be under 25 years of age.

For the attention of: Cabinet

2.14 The Committee was concerned that there was no provision in Plymouth for an alcohol treatment centre. The Committee also took the view that the low level of services available to young people in Plymouth who had alcohol-related problems should be addressed as a matter of urgency.

We recommend that consideration be given to supporting expansion, within available resources, of existing alcohol treatment and assessment services, working towards development of closer integrated working across all sectors.

For the attention of: Primary Care Trust and partners

2.15 **We recommend** that Primary Care ensures provision of advice and access to a range of appropriate interventions in respect of alcohol-related illness, across all available settings.

For the attention of: Primary Care Trust

2.16 **We recommend** that the Government give consideration to additional funding for Drug and Alcohol Action Teams, whilst welcoming the funding announced in the Public Health White Paper.

For the attention of: Central Government

2.17 **We recommend** that Plymouth City Council review its policies on substance misuse in the workplace, once a local alcohol harm reduction strategy is in place.

For the attention of: Cabinet

2.18 **We recommend** that under Section 17 of the Crime and Disorder Act, planning applications that may incur a security risk assessment due to being associated with the sale of alcohol be forwarded to the City Centre Community Safety Manager and the Licensing Officer for comment and to highlight crime prevention measures needing consideration or implementation.

For the attention of: Cabinet

2.19 **We recommend** that integrated impact assessments be undertaken as part of planned City development, and linked to a local alcohol harm reduction strategy.

For the attention of: Cabinet

2.20 **We recommend** that the Overview and Scrutiny Commission receives an update on the development and implementation of a local alcohol harm reduction strategy in six months time, and that a full review be undertaken in twelve months time, linking in with the review of Plymouth City Council's Statement of Licensing Policy.

For the attention of: Cabinet

3.0 INTRODUCTION

3.1 Joint Select Committee

3.1.1 The Overview and Scrutiny Commission agreed on 8 April 2004 that a scrutiny review of the National Alcohol Harm Reduction Strategy should be conduced by a Joint Select Committee, with two Members drawn from each of the six Overview and Scrutiny Panels.

3.1.2 It was originally intended that the outcome of this scrutiny review would inform the review being undertaken by the Community Cohesion and Equalities Overview and Scrutiny Panel on licensing. There was a delay in progressing the review on the National Alcohol Harm Reduction Strategy due to the difficulty in identifying a lead officer, and in the event the licensing review was completed first.

3.1.3 The Members of the Committee comprised –

- Councillor Mrs Aspinall (Chair)
- Councillor Savery (Vice Chair)
- Councillor Ken Foster
- Councillor James
- Councillor Kerswell
- Councillor Nicky Wildy
- Councillor Tom Wildy
- Councillor Williams
- Mr Willis (Co-opted Representative)

3.1.4 The Committee was supported by a small team of Officers – Keith Halsey (Community Safety Co-ordinator), Mike Jarman (Strategic and Operational Development Manager [Alcohol], Plymouth Drug and Alcohol Action Team) and Andrew Pearson (Democratic Support Officer).

3.1.5 The Committee met on seven occasions between 20 September and 30 November 2004. Four evidence-taking sessions were held (on 14 October 2004, 25 October 2004, 1 November 2004 and 12 November 2004). A list of witnesses and other contributors to the report can be found at Appendix 2.

3.2 Terms of Reference

3.2.1 The purpose of the review, as identified in the Committee's Scrutiny Plan, was to –

(i) Examine the implications of the National Strategy and consider the development of an effective alcohol harm reduction strategy based on integrated local partnerships, joint protocols and better communication between agencies.

(ii) To consider how the strategy can be applied to the new licensing policy.

3.3 Key Objectives

3.3.1 The key objectives of this scrutiny were determined at the scoping meeting on 14 October 2004, as follows –

(i) To explore a range of issues around alcohol misuse.

(ii) To investigate measures to reduce the harms and costs of alcohol misuse.

(iii) To investigate the implications for health of alcohol misuse.

(iv) To investigate community safety issues and anti-social behaviour relating to alcohol misuse.

3.4 Scope of the Review

3.4.1 The scope of the review was also determined at the meeting held on 14 October 2004, as follows -

(i) To investigate the management of alcohol consumption.

(ii) To investigate support and treatment services for people who misuse alcohol.

(iii) To investigate combating alcohol-related crime and disorder.

(iv) To link this work with the new licensing policy.

(v) To make recommendations for future action around developing an alcohol harm reduction strategy for Plymouth.

4.0 BACKGROUND INFORMATION

4.1 The National Context

4.1.1 The "Alcohol Harm Reduction Strategy for England" was published in 2004. Its aim was to set out a strategy for tackling the harms and costs associated with alcohol misuse, and to prevent any further increase in the identified harms and costs.

4.1.2 The Strategy also linked with a range of Government priorities and initiatives, including –

- encouraging regeneration and active and cohesive communities;
- raising productivity;
- tackling health inequalities and promoting public health;
- tackling crime and anti-social behaviour;
- promoting leisure and tourism.

4.1.3 Nationally, harms that were alcohol-related included –

- 150,000 people entering hospital annually;
- an estimated 1.2 million violent incidents annually;
- up to 1.3 million children affected by family drinking;
- up to 17 million days lost from absence and up to 20 million days lost as a result of reduced employment activity.

4.1.4 Nationally, the costs of alcohol-related harm included –

- up to £7.3 billion for crime (plus human/emotional costs of £4.7 billion);
- between £1.4 billion and £1.7 billion to the National Health Service;
- approximately £6.4 billion in lost productivity.

4.2 The Local Context – Experience in Plymouth

4.2.1 The following views were expressed by witnesses in relation to alcohol misuse issues that particularly affected Plymouth –

(i) There was a concentration of licensed premises in localised areas such as Union Street, the Barbican and Mutley.

(ii) Areas such as Union Street had a reputation beyond the confines of Plymouth, which adversely affected perception of the City and ultimately levels of investment.

(iii) The number of students in Plymouth with disposable incomes was increasing.

(iv) Historically, Plymouth had been affected by the strong drinking culture of Services' personnel, who also had disposable incomes and who tended to go out to pubs and clubs en masse.

(v) Plymouth experienced similar problems in relation to social deprivation and substance misuse as other comparable cities.

4.2.2 A survey of local residents' views about alcohol misuse was undertaken by Linda Gilroy, MP, in 2002/03, and included in the document, "National Alcohol Harm Reduction Strategy – Views from Plymouth". A total of 1550 questionnaires were distributed in the Barbican, Union Street and the City Centre over a three-day period in December 2002, with a response date of 8 January 2003. 31 questionnaires (2% of the total distributed) were returned. Although this survey was undertaken prior to the publication of the "Alcohol Harm Reduction Strategy for England", the findings dovetailed with the content and spirit of the original discussion document.

4.2.3 The responses provided a snapshot of the feelings of residents living in areas of Plymouth where local public space was used extensively by people who were inebriated. The following is a brief summary of the responses –

- all but one of the respondents perceived a clear link between alcohol and anti-social behaviour;
- residents' perceptions of the groups causing most problems was primarily that of young people, with students and Services' personnel highlighted;
- all but two respondents thought that the banning of alcohol in public places was a good idea;
- pressure from friends was identified as the greatest influence on the behaviour of those misusing alcohol.

4.2.4 Plymouth Community Safety Partnership was the body that had been charged with developing and implementing a local alcohol harm reduction strategy as a priority in the Crime Reduction Strategy. (It was noted that Plymouth Community Safety

Partnership was the local version of the Crime and Disorder Reduction Partnership.) The local alcohol harm reduction strategy was being championed by Ms James, Chief Executive of the Primary Care Trust.

4.3 Licensing Act 2003

4.3.1 Section 5 of the Licensing Act 2003 put a duty on local authorities to prepare, consult on and publish a Statement of Licensing Policy. Plymouth City Council's Statement of Licensing Policy Draft Consultation Paper was aimed at residents, businesses and interested parties affected by the Council's new role as the licensing authority for licensing premises for the supply of alcohol, the provision of entertainment and the provision of late night refreshment.

4.3.2 The aim of the policy was to secure the safety and amenity of residential communities while facilitating a sustainable entertainment and cultural industry. The Council, in adopting the licensing policy, recognised both the needs of residents for a safe and healthy environment to live and work, and the importance of safe and well run entertainment premises to the local economy and vibrancy of the City.

4.3.3 In the preparation and publication of this policy, Plymouth City Council as the licensing authority had regard to the guidance issued by the Secretary of State for Culture, Media and Sport under Section 182 of the Licensing Act 2003. The guidance was intended to aid local authorities in carrying out their functions under the Act, and to ensure the spread of best practice and greater consistency of approach. The legislation was fundamentally based on local decision-making informed by local knowledge and local people. The intention was to encourage and improve good operating practice, promote partnership and to drive out unjustified inconsistencies and poor practice.

4.4 Licensing Scrutiny Review

4.4.1 The Overview and Scrutiny Commission agreed on 12 February 2004 that a scrutiny review on licensing should be undertaken by the Community Cohesion and Equalities Overview and Scrutiny Panel, on receipt of Government guidance. The Community Cohesion and Equalities Overview and Scrutiny Panel resolved on 8 September that a Select Committee would conduct the review.

4.4.2 The terms of reference of the review were to examine the development of a policy on licensing arising from the introduction of legislation to transfer responsibility from local Magistrates Courts to local authorities. The review focussed on what interested parties thought of the Council's Statement of Licensing Policy Draft Consultation Paper, and what amendments needed to be made.

5.0 EVIDENCE

5.1 Written Evidence – Management of Alcohol Consumption

5.1.1 The alcoholic drinks market was a substantial part of the United Kingdom economy, with –

- the total value of the United Kingdom alcoholic drinks market exceeding £30 billion;
- United Kingdom consumers spending more of their disposable income on alcohol than on personal goods and services, fuel and power, or tobacco.

5.1.2 It was estimated that the alcoholic drinks industry generated approximately one million jobs in the United Kingdom across the whole of the value chain.

5.1.3 Excise duties on alcohol raised approximately £7 billion annually in Exchequer revenues.

5.1.4 In terms of education and information about alcohol use and misuse, consumers received information from a number of sources –

- the government (where the focus was on public health and drink driving);
- the alcohol industry (where the focus was on advertising and product information);
- family and friends, and also the media.

5.1.5 Young people in particular often received conflicting messages about drinking. Advertising and product information tended to focus more on the positive impact of alcohol than on the harms and costs associated with alcohol. Young people were more susceptible to advertising because –

- social identity and peer group pressures were significant influences;
- they were more likely to be aware of and to follow trends in fashion;
- they were less likely to have established brand and drink preferences.

5.1.6 Alcohol education in schools was successful in imparting information, but was less successful in changing behaviour. There was evidence to suggest that peer-led prevention programmes (in tandem with teacher-led prevention programmes) and interactive programmes to develop interpersonal skills were effective in reducing young people's alcohol use.

5.1.7 The Office of Communications (Ofcom) had overseen a fundamental review on the code rules on alcohol advertising and their enforcement, focussing on the following issues -

- advertisements for alcoholic drinks on television must not be likely to appeal strongly to people under 18, in particular by reflecting or being associated with youth culture;
- advertisements must not link alcohol with sexual activity or success, or imply that alcohol can enhance attractiveness;
- television advertising for alcoholic drinks must not show, imply or refer to daring, toughness, aggression or unruly, irresponsible or anti-social behaviour;
- alcoholic drinks must be handled and served responsibly in television advertising.

The new rules were due to come into effect from 1 January 2005. Work was ongoing to translate these rules into guidance.

5.2 Written Evidence - Combating Alcohol-Related Crime and Disorder

5.2.1 The costs of alcohol-related crime and disorder fell into three main categories –

(i) Anticipation of crime (including insurance and security measures).

(ii) Consequence of crime (including stolen or damaged property, victim support and loss of productive output of the victim).

(iii) Response to crime (including the police, the Crown Prosecution Service, Magistrates and Crown Courts, legal costs and costs to the prison and probation services).

5.2.2 Nationally, alcohol-related crimes included –

- an estimated 1.2 million incidents of violence;
- 80,000 arrests for drunk and disorderly behaviour
- 19,000 sexual assaults;
- 360,000 incidents of domestic violence;
- 85,000 cases of drunk driving.

5.2.3 In Plymouth, the Crime and Disorder Audit 2004 reported that –

- there was a 29% increase in alcohol-related offences in Plymouth in the period 2001/02-2003/04. (This included a 37% increase in those who were drunk);
- the age profile (2003/04) of alcohol-related offences was from 14-82 years, with the average being 21 years;
- alcohol misuse continued to fuel City Centre violence, with 80-90% of arrests on Thursday, Friday and Saturday nights alcohol-related;
- alcohol misuse continued to be a factor in reported incidents of domestic violence.

Alcohol-related offences in Plymouth 2001-2004

Total Number	**2001/02**	**2002/03**	**2003/04**	**% Change 01/02-03/04**
Disqualified from Driving	130	180	200	+ 15%
Drink Driving	580	570	670	+ 15%
Drunk	510	550	700	+ 37%
TOTAL	**1220**	**1300**	**1570**	**+ 29%**
Rate per 1,000 Population	4.3	4.2	6.5	
Rate per 1,000 Households	9.8	9.7	15.0	

5.3 Written Evidence – Treatment of Alcohol Abusers

5.3.1 The Government's recommended guidelines for alcohol consumption per week were 21 units for men and 14 units for women. A unit was defined as 8g of alcohol. This was equivalent to –

- a half pint of ordinary strength beer;
- 125ml (a small glass) of wine at 9% strength;
- one measure of spirits.

5.3.2 Almost one in three adult men and nearly one in five women exceeded the recommended weekly guidelines for alcohol consumption.

5.3.3 The number of women drinking above recommended guidelines had risen by over half in the last fifteen years. There was also evidence that women were now drinking more frequently. As a result, women were more at risk as regards sexual health and personal safety.

5.3.4 Those in the age range 16-24 consumed the most alcohol. Whilst the volume of alcohol consumed lessened with age, the regularity of consumption increased. (Those in the age range 45 and over were more likely to drink on a daily basis, for example.)

5.3.5 Two extreme, harmful drinking patterns were apparent –

- chronic heavy drinking (high frequency/high volume), and
- "binge" drinking (low frequency/high volume).

5.3.6 Two-thirds of chronic drinkers were men, and likely to be aged over 30. This group was at increased risk of a variety of health harms such as cirrhosis, cancer and suicide. They were also more likely to drink drive and initiate incidents of domestic violence.

5.3.7 "Binge" drinking was defined as drinking over twice the daily guidelines in one day. Those in the age range 16-24 were more likely to "binge" drink, but "binge" drinking accounted for 40% of all drinking occasions by men and 22% by women. This group was at increased risk of accidents and alcohol poisoning, and men in particular were more likely to be both victims of violence and to commit violent offences.

5.3.8 Young people in the United Kingdom were among the heaviest teenage drinkers in Europe. More than a third of 15 year olds had reported having been drunk at age 13 or earlier. Although there had been no sustained increase or decrease in the number of school-age children drinking alcohol over the last fifteen years, there was a clear increase in the amount that was being consumed.

5.3.9 Most alcohol use amongst school-age children occurred amongst the oldest age groups. Nationally, in any given week, alcohol will have been consumed by –

- 20% of 13 year old boys and 21% of 13 year old girls;
- 49% of 15 year old boys and 45% of 15 year old girls.

5.3.10 Alcohol misuse led to increased risk of harm depending on the following factors –

- individual reactions and circumstances;
- the nature of the harm;
- the interaction of alcohol with other factors.

5.3.11 Alcohol was frequently one amongst other factors that caused harm such as drug use and mental health problems. About one third of those with serious mental health illness had substance misuse problems, and around a quarter of those who used drugs also had problems with heavy drinking.

5.3.12 The Public Health White Paper was not available at the time this scrutiny review was concluded, so it was not known how this might affect alcohol treatment services nationally and at a local level. The Department of Health had commissioned St George's Medical School and Kable (a consultancy company) to conduct an audit

required by the National Alcohol Harm Reduction Strategy. This was an ongoing piece of work. A substantial amount of information was being sought from both providers and commissioners, with the audit being regarded as vital to the future of alcohol treatment in England.

5.4 Oral Evidence

5.4.1 The Committee held sessions to hear from a variety of witnesses. Please see Appendix 2 for a list of witnesses and other contributors. The findings of these sessions are at Section 6.0, FINDINGS, of this report.

6.0 FINDINGS

6.1 Management of Alcohol Consumption

6.1.1 Councillor Wheeler informed the Committee that "City Safe" was a voluntary, best practice scheme in Plymouth that was operated with the participation of pub and club owners. It sought to introduce agreements on drinks promotions, "happy hours", etc, and to ensure that there were stricter controls on proof of age, with driving licences or passports, for example, being required for entry to clubs. (It was noted that there was widespread counterfeiting of age-related IDs at present.) "City Safe" would also look at introducing amnesty bins for drugs and promotional information on sensible drinking.

6.1.2 "City Safe" was intended as a model of good practice and would operate in conjunction with Plymouth City Council's Statement of Licensing Policy. Please see Appendix 3 for more information about the "City Safe" scheme.

6.1.3 A specialist post had been created in the Council in line with the Safer, Cleaner Streets Agenda to concentrate on underage sales of alcohol, tobacco, solvents, fireworks, etc. Although parent companies usually had excellent procedures in place, it was sometimes the case that service counter staff did not follow them and so became legally liable themselves when selling to underage customers.

6.1.4 As part of the underage sales initiative, Plymouth City Council employed a badging system at displays or promotional events, with members of staff wearing high profile visibility jackets.

6.1.5 Plymouth City Council had been working jointly with the police to target hotspots where groups of young people congregated to drink, with the potential for disturbance and vandalism. This initiative had had some success in reducing access to alcohol, although there remained the significant problems of parents supplying their children with alcohol and older youths purchasing alcohol on behalf of younger children.

6.1.6 The Environmental Regulation Service enforced health and safety legislation in over 6000 premises and investigated accidents. One of the issues considered was whether there were any policies or controls over alcohol use, and people's fitness to work; for example, operating machinery and driving forklift trucks. There was a strong link between alcohol consumption and increased risk of accidents at work.

6.1.7 Councillor Weekes in a written submission to the Committee noted that there was clear evidence that young people were in contact earlier than ever before with alcohol, and becoming more reliant. The Youth Service had undertaken a great deal

of work with young people around this issue, with detached and outreach workers having ongoing contact.

6.1.8 Negotiations were currently underway with officers from the local authority and Harbour Drug and Alcohol Service and the Youth Enquiry Service to establish a Youth Service post attached to the former organization. This post would help strengthen interventions, and undertake awareness raising and sign posting advice and guidance. There would also be a training role that would allow detached work across the City to be strengthened. Harbour Drug and Alcohol Service currently had some workers who worked in the clubs, and in the past there had been close links with the staff of the Frederick Street Centre and some of the Union Street clubs which allowed targeted interventions.

6.1.9 Councillor Pattison pointed out that alcohol was the biggest drug problem in the City. The Local Strategic Partnership would have a role in framing how to tackle the harms and costs of alcohol misuse, although this had yet to be progressed. In terms of education for young people, Councillor Pattison was keen that the pre-adolescent age range in particular was targeted to ensure that the message about alcohol misuse was made as early as possible.

6.1.10 Councillor Pattison informed the Committee that the licensing trade was the only business that did not have to pay its own policing costs, which came out of the public purse. This was in marked contrast to businesses such as Plymouth Argyle Football Club and even Plymouth City Council, who had to pay policing costs for events it arranged.

6.1.11 Mr Jones, representing Pub and Club Watch, stressed the need for greater enforcement. Alcohol retail outlets such as supermarkets, 24 hour convenience stores and petrol stations were not part of the “City Safe” scheme, and so could offer cheap discounts and special offers. Mr Jones suggested that Members of the Licensing Panel should sit on the “City Safe” Forum.

6.1.12 The Committee learned that Plymouth City Council had an Alcohol and Drugs at Work Policy that was implemented in June 2000. This linked to other policies and procedures, in particular the Employee Staff handbook that also dealt with alcohol and drug use in the work place.

6.1.13 Mr Williams, Personnel Manager, stated that managers were encouraged to deal with employees who had alcohol-related problems on an informal basis initially, usually with the involvement of a Trade Union representative. Referrals could be made to Occupational Health and also the Harbour Centre for counselling and other interventions, but it was noted that this was a stepped process that could lead to disciplinary action and ultimately dismissal for the employee concerned. Overall, Mr Williams did not believe that alcohol misuse amongst employees was a major problem for Plymouth City Council.

6.1.14 Mr Harrison, Operations Manager with Plymouth Gin, informed the Committee that work was ongoing with the Portman Group to ensure that alcohol products were labelled appropriately, whilst the parent company that owned Plymouth Gin was linked to the Swedish Government, which helped to ensure compliance with regulatory codes of conduct. Plymouth Gin took the view that its products should be marketed on appeal to taste and enjoyment rather than as a lifestyle enhancer or accessory. This was helped by the fact that gin was not really part of the “binge” drinking culture, as it appealed for the most part to older, more discerning customers.

6.1.15 Plymouth Gin had recently opened a bar in their own premises in the Barbican. The site was over six hundred years old and, as part of a deliberate marketing strategy, it operated as a members-only cocktail lounge that closed at 11.00pm. It did not offer discounts or promotional offers on alcohol. There was no loud music and a non-smoking policy was in operation.

6.1.16 Mr Harrison emphasised to the Committee the need for staff in pubs and clubs to be fully trained. The British Institute of Innkeepers ran a training course for bar staff that cost £100-£150 for a day.

6.1.17 Mr Harrison felt that it was unclear whether a voluntary approach by agencies and the alcohol business would prove successful in achieving such objectives as curbing under age drinking and making Plymouth safer and more welcoming at night. The emphasis needed to be on education both in schools and the wider community, so that the mystique of alcohol was lost.

6.1.18 The University of Plymouth Students' Union (UPSU) had eight bars across four sites, with an annual turnover of around one million pounds. Mr Clayton, Commercial Services Manager, informed the Committee that the culture in the University's bars was welcoming for students that were mainly in the 18-21-age range. Although not the cheapest option, the University's bars offered good value for money. In the last year the police had only had to be called on one occasion when a student signed in someone who later started causing problems. UPSU had its own Advice Centre staffed by three workers that offered advice for students with alcohol, gambling and other problems.

6.1.19 The University's bars did not have multiple or time limited offers on alcohol, and there were no special offers for new students. They did offer 20p off a standard pint, but this was not widely advertised. There was a link with other pubs and clubs in Plymouth on Mondays, Tuesdays and Wednesdays, with the proviso that these establishments met the standards adopted by the University's bars. It was not possible for UPSU to address directly the pricing policies of individual clubs and bars, but influence could be exerted by the example of best practice and better education. Both Mr Clayton and Mr Cooke, General Manager, were of the view that a voluntary code had its limitations, given that the element of enforcement was absent.

6.1.20 The originator of the "Best Bar None" Award was the Greater Manchester Police, and was open to Students' Unions in membership with NUS Services Ltd. In judging the entries, the following categories were considered -

- door policy;
- glasses and bottles;
- drink and drugs;
- CCTV;
- crime prevention;
- lighting;
- fire;
- security and first aid;
- the environment;
- general safety;
- additional information.

6.1.21 The Committee was informed that Plymouth Argyle Football Club had expanded alcohol licences in the new stadium, with five licensed areas open to the general public. There had been no specific problems arising from this.

6.1.22 Mr Tall, Associate Director (Youth Development) with the Club, told the Committee that he was not aware of any alcohol-related problems in the last four years with either playing or administrative staff. Education about substance misuse was very important for the young people at the Club, most obviously if they wanted to go on to play sport at a professional level. There was zero tolerance for instances of drug use, but a second chance was usually afforded someone who had misused alcohol depending on the level of offence or consequences of misuse.

6.1.23 The Club also had an outreach programme that reached between 5000 to 6000 children. The emphasis was on healthy lifestyles, with information provided about the harmful effects of cigarette, alcohol and other drug use.

6.1.24 Mr Tall stated that as a stakeholder in the City, the Club welcomed instances of alcohol-related misconduct being brought to its notice, as measures such as banning individuals from the ground could then be enforced.

6.1.25 The Committee was informed by Mr Jones, Principal Parks Services Manager, that in total there were 950 hectares of open spaces and parks in Plymouth. The main concerns around alcohol misuse in such areas were –

- peripatetic groups of young people drinking alcohol, and in the process causing noise and nuisance value to local residents;
- homeless people using alcohol (more of a problem in summer);
- large events, where strict guidelines for the sale of alcohol were enforced.

There was a good working relationship with the police in regard to enforcement issues in the City's parks and open spaces..

6.1.26 Broken glass from bottles and glasses in parks and open spaces – in particular, playgrounds - was identified as a major problem. Area working teams were on hand to deal with this, and other, maintenance issues.

6.1.27 A Community Ranger had a defined education role linking in with youth workers, and workshops were held about alcohol and drug misuse. The Community Ranger also gave talks to schools and community groups.

6.1.28 Other initiatives in Plymouth's parks and open spaces included having more alcohol free zones, and creating more youth facilities such as basketball courts and lit five-a-side football pitches.

6.2 Combating Alcohol-Related Crime and Disorder

6.2.1 The Committee learned that measures in place in Plymouth to address alcohol-related crime and disorder included –

(i) Wardens funded as a back to work scheme for the long-term unemployed, with those involved tending to be more mature people. The scheme operated Mondays-Fridays only at present. Wardens had a janitorial and community safety role, and carried radios connecting them to the police. A permanent scheme with accredited (by the police)

wardens was due to be operational by April 2005. This was under the management of the Plymouth City Centre Company

(ii) Alcohol bans were enforced mainly by wardens, who spent a lot of their time moving on drunks. This was allied to a zero tolerance approach to begging and busking, with people being asked to donate to charities rather than giving direct to those begging. (It was noted that this was linked to Plymouth's daytime economy and not the evening economy.)

(iii) The Club Watch Radio System that helped co-ordinate door staff.

(iv) Around 9 Help Points in the City Centre that were connected to CCTV headquarters.

(v) Plymouth Against Retail Crime. To date, 57 people had been banned from City Centre shops, although it was noted that a physical ban from a designated area required an Anti-Social Behaviour Order (ASBO).

(vi) CCTV was a locally funded resource and was seen as a model of good practice. 240 cameras with high quality definition were installed in the City, and images were transmitted direct to Crownhill Police Station. Mr Artherton, City Centre Community Safety Manager, informed the Committee that as many as 100 incidents a month of anti-social (including violent) behaviour and criminal damage were recorded by CCTV and used in criminal prosecutions.

Response times to incidents tended to be lengthier at weekends than during the week, and were dealt with on a priority basis. Difficulties occurred when a number of incidents happened at the same time.

6.2.2 Under the Safer, Cleaner Streets Agenda, the actions taken by Street Services in cleaning up the City Centre and other areas early each morning had the effect of bringing these areas back into a presentable state as quickly as possible. Action to remove graffiti and other damage, and to generally keep the environment pleasant and clean, had a major impact on crime, fear of crime and people's perceptions of alcohol issues.

6.2.3 Devon and Cornwall Local Criminal Justice Board (LCJB) had its inception in 2001. One of its primary aims was to prevent partnership working becoming fragmentary and to have shared targets that were met. Examples of these targets were narrowing the justice gap and ensuring that there were fewer ineffective trials, and promoting public awareness in the justice system via education and the raising of awareness.

6.2.4 There was no health representative on the LCJB at present, but the organization was linking closely with the four Drug and Alcohol Action Teams in the Peninsula. The LCJB took the view that they needed to engage with the alcohol business at a strategic level, and Plymouth was regarded as an example of good practice in this area.

6.2.5 Mr Miller, retired magistrate, told the Committee that he supported Exclusion Orders, but that there were difficulties in enforcement. It was easier to ban people from pubs and clubs than it was to – for example – exclude them from a designated area in the City. Mr Miller was unclear how Fixed Penalty Fines would work given that they were difficult to enforce with individuals. Also, the courts were discouraged from sending

people to jail for non-payment of fines. Mr Miller regarded the licensing of door supervisors as a great step forward.

6.2.6 Alcohol-related incidents of domestic violence were on the increase, and both courts and the police were now encouraged to take a more serious view than had perhaps been the case in the past. Mr Miller was of the view that drink-driving penalties were not strong enough at present. Convicted offenders had the opportunity to attend a course on the dangers of alcohol misuse that earned them 25% off their driving ban.

6.2.7 Mr Miller was not aware of any alcohol treatment service in Plymouth that offenders could be directed to attend as part of their sentence. Anything that was set up would need to meet nationally recognized standards. An element of mandatory learning about alcohol use could be included in a Community Punishment Order. Mr Miller felt that education about the harms and costs of alcohol misuse in schools and the wider community was a priority. He also supported bar staff gaining the British Institute of Innkeeping Certificate.

6.2.8 Superintendent Strawbridge endorsed a voluntary approach to regulation, but was of the view that for this to be effective it needed to be high profile, and that establishments should regard accreditation as both positive and desirable. The three criteria for premises that presented problems were identified as –

- capacity
- location, and
- lateness in closing.

6.2.9 A voluntary approach needed to be firmly rooted in such social legislation as the new Licensing Act, which lay a great responsibility on the local authority whilst at the same time offering a huge opportunity to be legally audacious. Saturation issues in areas such as the Barbican, Union Street and Mutley could be addressed by having staggered closing times, for example. The opportunity also existed to link in with the wider Mackay vision for the City.

6.2.10 In terms of enforcement, Superintendent Strawbridge suggested to the Committee that a multi-agency team was needed to manage Plymouth's day and night economy on a whole needs basis. Superintendent Strawbridge supported the granting of late night taxi licences, adding that taxi marshals could be employed to ensure that taxis did not leave their engines running and so cause a nuisance to residents. Other issues that might usefully be considered were the provision of night security on buses, the arrangement of street furniture and an increase in Alcohol Exclusion Zones.

6.3 Treatment of Alcohol Abusers

6.3.1 Witnesses were unanimous in their view that there was a gap between the demand for and provision of alcohol treatment services, not only in Plymouth but also nation-wide. Historically, alcohol treatment had not been regarded as a stand-alone service, coming under the umbrella of substance misuse. Two main factors had resulted in alcohol treatment being regarded as a "Cinderella" service –

(i) lack of dedicated funding from central Government , and

(ii) lack of national or local performance targets, with the result that there was little incentive to divert scarce resources to this work .

6.3.2 The current situation with alcohol treatment services was analogous to that of drug treatment services a decade ago. Money for drug treatment services had started to become available from 1997, and services were now more securely funded and resourced. It was nevertheless clear that the scale of alcohol misuse was much greater than drug misuse. The Committee was informed by several witnesses that current demand for alcohol treatment services in Plymouth (and elsewhere) was only a fraction of the real demand. Referrals for alcohol formed between a quarter and a third of all referrals received by Harbour Drug and Alcohol Service. However, one in five patients admitted to Derriford Hospital had alcohol-related problems, for which there was no follow-up treatment available.

6.3.3 The Committee learned from Dr Campbell, general practitioner, that alcohol treatment was regarded as an enhanced service provision within the new general practitioner contracts in Plymouth, with the result that general practitioners did not have to take on such treatment as statutory work, which was relegated to a discretionary, optional extra. Dr Campbell was of the view that general practitioners should offer advice about alcohol problems, which could be a life-threatening issue, as a form of brief intervention.

6.3.4 Dr Campbell was the designated general practitioner responsible for alcohol enhanced service provision in Plymouth. He was indirectly accountable to the Drug and Alcohol Action Team, but more directly accountable to the Medical Director of the Plymouth Hospital NHS Trust and the Mental Health Directorate.

6.3.5 Mr Faragher, Chief Executive of Harbour Drug and Alcohol Service, identified the following reasons for gaps in the provision of alcohol treatment services in Plymouth -

- the lack of an agreed overall framework;
- a lack of information about how issues to do with alcohol misuse were being tackled;
- the lack of a co-ordinating mechanism for people to be aware of what services were available, and how these could be accessed;
- a lack of skills and knowledge in non-specialist agencies who became involved with alcohol misuse;
- the lack of a core treatment facility for those dependent on alcohol.

6.3.6 Plymouth Drug and Alcohol Action Team acted as an integrated, joint planning and commissioning service, funding all drug and alcohol treatment services in the City (including resources in the private and voluntary sectors such as Broadreach House and Hamoaze House.)

6.3.7 The Integrated Drug Service provided the majority of treatment for people suffering from drug and alcohol problems in Plymouth. It combined the previous Community Drug Service from the Primary Care Trust, the Harbour Centre Alcohol Drug and Advisory Service from the voluntary sector, and the Substance Misuse Assessment Team (SMAT) from Social Services.

6.3.8 Whilst in reality there was a degree of crossover in drug and alcohol treatment, it was not always possible for agencies to be flexible in regard to funding. Dr Battersby, Consultant Psychiatrist in Substance Abuse, provided the Committee with an example where, if a drug treatment bed was unoccupied, it could not then be used as an alcohol treatment resource because the funding was ring-fenced.

6.3.9 At present, in addition to Dr Battersby, Harbour Drug and Alcohol Service employed one addiction counsellor (1.4 wte combined). Historically, there had been an additional two posts, but these had been vacant of late due to illness and staffing problems. They were currently being reinstated by the Primary Care Trust to bring the staffing complement back up to the previous 3.4 wte. This provision was for the whole of Plymouth.

6.3.10 Mr Faragher expressed the view that a core alcohol treatment team was required in Plymouth. A team of ten professionals and another ten in liaison roles located with key agencies, plus administrative backup, would allow 300 to 400 people with alcohol-related problems to be supported at any one time. Mr Faragher suggested that a pooled budget from all agencies involved in alcohol misuse would pay for this core alcohol treatment team.

6.3.11 The Integrated Drug Service in Plymouth required 40 residential detox placements annually, and Broadreach House supplied part of this demand, being a 36-bed unit offering a six-week detox programme (although this was not available solely to Plymouth residents).

6.3.12 The mentally ill were one of the most vulnerable groups in society. They often experienced multiple problems and required clear pathways for treatment. The Committee was informed that one third of people with mental health problems also had significant alcohol problems, and historically this group had tended to fall between two treatment stools. Mental health workers in general would not take on cases where drink or drugs were involved.

6.3.13 The homeless were another vulnerable group identified in the Strategy. A relationship existed between alcohol and homelessness, although its precise nature was less obvious. Dependence could lead to homelessness, but could also exacerbate problems that already existed. In other cases, problems with alcohol might develop as a result of being homeless. In Plymouth, this group had no direct link into drug and alcohol treatment, and the provision of services was dependent on clinical need.

6.3.14 Several witnesses identified a need for greater provision of alcohol treatment services for young people. In the private and voluntary sector, Hamoaze House had day programmes for young people, the majority of whom had been referred as a result of having been excluded from school or for substance misuse (including alcohol). Because of its Care Standards registration, Broadreach House primarily dealt with clients aged over 18 years of age. One exception to this was Longreach, a long-term unit for women aged 16+.

6.3.15 Alcoholics Anonymous (AA) was a self-referring organization and a free resource that offered a 12-step programme of recovery. In Plymouth, the age range in AA was between 17 and 70, and both the homeless and those with mental health problems had sought help in the past. Statistically, the highest number of people recovering successfully from alcohol had done so via AA.

6.3.16 Alcoholics Anonymous ran thirty-three meetings a week in Plymouth and maintained a 24-hour helpline. One particular group in Plymouth comprised 80 people and had a sobriety level of over 300 years; this group was regarded as an example of good practice nationally.

6.3.17 Ms Hughes, Alcohol Nurse Specialist with the Ministry of Defence, informed the Committee that her role included screening referrals for alcohol problems, assessment and the provision of intervention on an open-ended basis. A weekly

support group and a monthly course on alcohol misuse were in place, and from 2005 a weekly course on alcohol misuse would be run. Ms Hughes' remit included the Royal Navy, the Army and the Royal Air Force, and covered a Services' population of approximately 14,000.

6.3.18 The interventions and treatments provided by the Services differed from that offered to non-Services' personnel in that there was the additional element of discipline and compliance with orders. Services' personnel were referred via medical officers, self-referral or as a result of disciplinary action, which occurred when someone presented a risk to themselves or to others.

6.3.19 Ms Hughes was able to detox Services' personnel on base, and there was provision for patients to be admitted to the Priory (a private provider) for further treatment. So far, two people had been admitted to the Priory, one for alcohol misuse and one for drug misuse.

7.0 CONCLUSIONS AND RECOMMENDATIONS

7.1 Overall Conclusions

7.1.1 Alcohol played a key role in society, being associated with pleasure, relaxation and socialising. Over 90% of adults in the UK – nearly 40 million people – used alcohol, the majority doing so without causing harm to themselves or to others. Drinking in moderation had been proven to confer some health benefits; for example, consumed in low amounts at regular intervals, alcohol could lower the risk from coronary heart disease and ischaemic stroke.

7.1.2 Alcohol also played a key role in the economy, particularly the tourist and leisure industries. UK consumers spent more of their disposable income on alcohol than they did on personal goods and services, for example. The total value of the UK alcoholic drinks market was in excess of £30 billion.

7.1.3 It was clear that for many people, however, there were harms associated with the misuse of alcohol. Almost one in three adult men and nearly one in five women exceeded the recommended weekly guidelines for alcohol consumption. Two harmful drinking patterns were evident – chronic and "binge" drinking. Groups such as young people, under age drinkers and, increasingly, women, were at particular risk. The costs of alcohol misuse manifested themselves in crime, health interventions and lost productivity.

7.1.4 There was a clear recognition by the Committee that the drinking culture within Plymouth had to change, and that the Mackay vision should be embraced whereby a future for the City was proposed that "delivere[d] the highest possible quality buildings and public spaces to attract and sustain the highest quality business, education, living, and recreation opportunities for citizens, investors, and visitors alike – matching Plymouth 2020's Vision and Goals Statement."

7.1.5 Alcohol education was vital if consumers were to make informed choices about their drinking. There was evidence that alcohol education was more successful in imparting information than it was in changing behaviour. The Strategy was clear that for consumers' attitudes to alcohol misuse to change, education in isolation would not be effective unless it was harnessed to other measures such as tougher enforcement.

7.1.6 The Committee welcomed the initiative taken by one supermarket chain that required evidence of proof of age if the purchaser looked under 25 years of age.

7.1.7 It was clear from the evidence given by witnesses that education about alcohol use in Plymouth required a high profile. Some of the initiatives that had been mentioned in witness testimony included that of a Community Ranger going into schools and community groups to talk about health and safety issues in parks and open spaces, and the outreach work undertaken by Plymouth Argyle Football Club with young people in respect of healthy lifestyles.

7.1.8 It was clear from both research and the evidence of witnesses that alcohol misuse problems in Plymouth were under-reported and under-recorded. There were many more people at risk from alcohol misuse than from other forms of substance misuse, but when compared there were far fewer advice, assessment and treatment resources in place. One in five of patients admitted to Derriford Hospital had alcohol-related problems, for which there was effectively no follow-up treatment available.

7.1.9 There was no real alcohol treatment service infrastructure in place in Plymouth, and as a result improvements would have to start from a low base. There were a number of historic reasons why this was so, with alcohol coming under the overall umbrella of substance misuse. The situation was further exacerbated by the lack of dedicated funding from central Government. In Plymouth, alcohol-related illness was treated as an enhanced service provision within primary care, with the result that general practitioners as part of their contractual arrangements did not have to offer advice or treatment in relation to alcohol.

7.1.10 Research had shown that heavy drinkers who were given a 10-15 minute session in a healthcare setting on the risk and harms caused by heavy drinking were twice as likely to cut down six to 12 months later, compared with those receiving no attention. It appeared that brief interventions were an effective, low-cost preventative measure for heavy drinkers, and should therefore be encouraged.

7.1.11 Current options for patients with alcohol-related problems included referral to Harbour Drug and Alcohol Service (which had a waiting list of over 300), to one of the providers in the private and voluntary sector or self-referral to Alcoholics Anonymous. The fact that two dedicated alcohol treatment posts had remained vacant at Harbour Drug and Alcohol Service for some time as a result of illness and staffing problems had been a factor in the long waiting list for assessment and referral. One possible option that had been put to the Committee was the creation of a core alcohol treatment team and a core treatment centre, although funding for this and any other initiative in this area would need to be resolved.

7.1.12 A number of initiatives were already in place or coming on line in Plymouth to manage the consumption of alcohol and to combat alcohol-related crime and disorder. “City Safe” was a joint initiative by Plymouth licensees, Plymouth City Council, Devon Fire and Rescue and the police to raise standards in pubs and clubs. (See also Appendix 3.) This was a voluntary code, and a number of witnesses had pointed out that without powers of enforcement its recommendations could easily be flouted. It was hoped, however, that signing up for “City Safe” would be regarded as desirable and conferring considerable benefit to licensees in Plymouth.

7.1.13 Alcohol-related crime and disorder in Plymouth remained a major concern, with a 29% increase in alcohol-related offences in the period 2001/02-2003/04, and 80%-90% of arrests in the City Centre on Thursday, Friday and Saturday nights being

alcohol-related. The Committee was particularly concerned about the link between alcohol and domestic violence, and that children at risk as a result of these two factors might not be being identified at an early enough stage for effective intervention to take place.

7.1.14 Partnership working was highlighted in the Strategy as the way forward, and this had also been echoed by the witnesses who had appeared before the Committee. Representatives of organizations such as Alcoholics Anonymous, Plymouth University Student Union, the Local Criminal Justice Board and the local alcohol nurse specialist working with the Services, had requested closer links and greater involvement in helping to implement an alcohol harm reduction strategy in Plymouth. The Plymouth Community Safety Partnership (the local version of the Crime and Disorder Reduction Partnership) was the body currently responsible for delivering a local alcohol harm reduction strategy, and its membership needed to be more inclusive to reflect a more cross-cutting approach.

7.1.15 The various witnesses had identified a number of issues that would help reduce the harms and costs of alcohol misuse, and aid the implementation of an alcohol harm reduction strategy in Plymouth. These included –

- ensuring that premises granted a license for one purpose did not change functions; for example, starting out as a restaurant and then moving to a night club;
- circulating pictures of known troublemakers to pubs and clubs in Plymouth. (It was noted that this was open to challenge under the Human Rights Act);
- reviewing current siting of taxi ranks and having more licensed taxis available between the hours of midnight and 3.00am;
- discouraging cheap drink offers and other such promotions;
- encouraging the use of existing enforcement measures;
- consideration being given to creating an Evening and Night Time Economy Manager post;
- strengthening the Club Watch Radio System that co-ordinated door staff;
- reviewing Plymouth City Council's Alcohol and Drugs Policy at Work in line with a local alcohol harm reduction strategy;
- consideration being given to supporting the expansion of a core alcohol treatment team that did not come under the umbrella of substance misuse, and also a core treatment facility.

7.1.16 The Committee noted that this report had originally been intended to be completed before the scrutiny review on licensing, so that its recommendations would inform implementation of the latter. Due to timetabling and staffing difficulties, this had not proved possible.

7.1.17 The Licensing Authority had a duty under the Licensing Act 2003 to carry out its licensing function with a view to promoting the four licensing objectives –

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

Applicants for licences would be expected to demonstrate in their applications how they intended to meet these objectives, and a licence would only be granted where the Licensing Authority was satisfied that all the objectives could be met.

7.1.18 The four licensing objectives and the measures identified by the Licensing Authority for meeting these in licence applications – such as the use of toughened glasses and proof of age, for example – were to a large extent aligned to the key aims of the Strategy. This was an area that the Committee felt required further work and one that should be revisited by the Overview and Scrutiny Commission at a later date.

7.2 Recommendations of the Strategy at a Local Level

7.2.1 The Strategy stated that "local authorities will wish to produce an alcohol strategy. This is likely to be in the context of existing strategies and will be left to the discretion of local authorities."

7.2.2 The Strategy noted that if interventions at both a national and local level were to be successful in reducing the harms and costs of alcohol misuse, they needed to be –

- coherent;
- sustained;
- strategic;
- measured;
- publicly supported.

The Strategy also stated that without clear responsibilities at local and national levels, and clear indicators of progress, effective change was unlikely.

7.2.3 Three mechanisms were identified in the Strategy for delivery and to monitor progress -

- better co-ordination and a more strategic approach in central Government;
- a clear framework of directional indicators to enable measurement of progress towards the overarching objective of reducing harm, and arrangements for monitoring progress;
- <u>arrangements for delivery at local level allowing flexibility to meet local priorities within the strategic objective of reducing harm.</u>

7.2.4 The guiding principles of delivering the Strategy in a local context were –

- maximum local flexibility;
- a minimum of new bureaucracy;
- raising the profile of alcohol misuse in existing services and structures.

7.2.5 The Crime and Disorder Act 1998 set out a statutory requirement for responsible authorities (the police, local authorities and other local agencies and organizations) to develop and tackle crime and disorder in their area. Crime and Disorder Reduction Partnerships (CDRPs) were a multi-agency approach to encourage partners to promote consideration of crime and disorder issues in their own core activities.

7.2.6 The Strategy identified that Crime and Disorder Reduction Partnerships formed the obvious bodies for formulating and delivering local strategies within the wider framework set by Local Strategic Partnerships (which brought together at local levels

the public, private, community and voluntary sectors). The Strategy also recommended that membership of local Crime and Disorder Reduction Partnerships should include representatives from local health services, voluntary organizations and the alcohol industry. It was noted that the Community Safety Partnership was the local body in place in Plymouth.

7.2.7 It was recommended in the Strategy that Crime and Disorder Reduction Partnerships could help individual members achieve their objectives by –

- providing a forum for agreeing a strategic framework on alcohol misuse which reflected local priorities, ensured complementary objectives and sat within existing strategies where appropriate;
- ensuring that organizations shared information and good practice;
- providing a forum for agreeing how organizations would work together.

7.2.8 The Strategy specifically identified in the key area of education and communication that partners would work with local schools and institutions to find innovative ways of conveying messages about alcohol and achieving behavioural change.

7.2.9 The Strategy specifically identified in the key area of treatment that all Drug and Alcohol Action Teams in the country would be encouraged to take on responsibility for alcohol services. Primary Care Trusts would remain responsible for treating alcohol-related conditions, whilst all partners would share a responsibility for the identification and referral of individuals with alcohol-related problems, and for wider prevention activity.

7.2.10 The Strategy specifically identified in the key area of community safety that the police would take the lead in demonstrating a reduction in alcohol-related crime and disorder. Better management of the night time economy was likely to be at the heart of this for many partnerships, and the local authority would need to take a lead.

7.2.11 The Strategy specifically identified in the key area of working with the alcohol industry that local authorities would take the lead in setting up local social responsibility schemes to feed into the management of the night time economy, and in bringing together all the statutory partners needed to manage it effectively.

7.3 Overall Recommendations

7.3.1 Please see Section 2 of the report. All recommendations have indicated the organizations or individuals for which they are of specific interest.

7.4 Progress on Implementation

7.4.1 Please see recommendation 2.20 in Section 2 of the report.

Appendix 1 – Reference Materials

1. Alcohol Harm Reduction Strategy for England, Cabinet Office, 2004

2. Executive Summary – Alcohol Harm Reduction Strategy for England, Cabinet Office, 2004

3. Interim Analytical Report, Strategy Unit Alcohol Harm Reduction Project, 2004

4. National Alcohol Harm Reduction Strategy, Views from Plymouth, compiled by Linda Gilroy, MP, 2003

5. Plymouth City Council Statement of Licensing Policy (Draft Consultation Paper), 2004

6. Plymouth City Council Liquor Licensing Scrutiny Review, 2004

7. Plymouth City Safe Joint Initiative

8. Plymouth Crime and Disorder Audit, 2004

9. Who Me? Alcoholics Anonymous

10. Response to National Alcohol Harm Reduction Strategy, Alcohol Concern, 2004

11. Alcohol –Related Crime Facts and Figures, report by Sandy Teske

12. Best Bar None Initiative

13. Health Development Today, Issue 24, December 2004/January 2005

14. Draft Interim Planning Statement, A Vision for Plymouth, 2003

Appendix 2 – Contributors

The Committee would like to express its sincere thanks to all those who provided information and advice:

- Mr Mike Artherton, City Centre Community Safety Manager, Plymouth City Council
- Dr Alison Battersby, Consultant Psychiatrist in Substance Abuse
- Dr Hugh Campbell, General Practitioner
- Mr Robin Carton, Assistant Head of Environmental Regulation Services, Plymouth City Council
- Mr Joff Cooke, General Manager Student Union, and Mr Paul Clayton, Commercial Services Manager, Plymouth University
- Mr David Draffan, City Centre Manager, Plymouth City Council
- Ms Hannah Duncan, Local Criminal Justice Board Performance Officer
- Mr Tony Faragher, Chief Executive, Harbour Drug and Alcohol Service
- Mrs Roma French, Chief Executive Hamoaze House
- Ms Linda Gilroy, Member of Parliament
- Mr Keith Halsey, Community Safety Co-ordinator, Plymouth City Council
- Mr Sean Harrison, Operations Manager, Plymouth Gin
- Ms Pam Hughes, Alcohol Nurse Specialist, Ministry of Defence
- Mr Mike Jarman, Strategic and Operational Development Manager (Alcohol), Plymouth Drug and Alcohol Action Team
- Mr Nick Jones, Principal Parks Services Manager, Plymouth City Council
- Mr Peter Jones, representing Pub and Club Watch
- Lieutenant Ian Kennedy, Department of Community Psychiatry, Royal Navy
- Mr Tom Miller, former Chair of Plymouth Magistrates Bench
- Councillor Christopher Pattison, Cabinet Member for Social Services and Health
- Superintendent Peter Strawbridge, Devon and Cornwall Constabulary
- Mr David Tall, Associate Director (Youth Development), Plymouth Argyle Football Club
- Ms Sandy Teske, Corporate Consultation Officer, Plymouth City Council
- Mr Garry Wallace, Plymouth Drug and Alcohol Action Team Co-ordinator
- Councillor Alan Weekes, Cabinet Member for Youth and Community Development
- Mr Rick Weeks, Business Development Manager, Broadreach House
- Councillor George Wheeler, Cabinet Member for Environment and Street Services
- Mr John Williams, Personnel Manager, Plymouth City Council
- Representative from Plymouth Alcoholics Anonymous

Appendix 3 – "City Safe"

CITY SAFE

CITY SAFE IS A JOINT INITIATIVE BY PLYMOUTH LICENSEES, THE CITY COUNCIL, DEVON FIRE AND RESCUE AND THE POLICE TO RAISE STANDARDS IN PUBS AND CLUBS BY.....

1) THE RESPONSIBLE SALE OF ALCOHOL.

2) CUSTOMER SAFETY.

3) EXCLUDING TROUBLEMAKERS.

4) NOT TOLERATING UNDER AGE DRINKING.

5) GOOD NEIGHBOURLINESS.

6) DRUG AWARENESS.

7) STAFF TRAINING.

NAME OF PREMISES

SUPPORTS THE CITY SAFE INITIATIVE FOR A SAFER NIGHT OUT IN PLYMOUTH.

1) **THE RESPONSIBLE SALE OF ALCOHOL**
NO "ALL IN FEE" NIGHTS.
FAIR, RESPONSIBLE SUSTAINABLE DRINKS PRICES.
NO PROMOTION OF BINGE DRINKING.
NOT TOLERATING DRUNKENESS OR SERVING INTOXICATED CUSTOMERS.

2) **CUSTOMER SAFETY**
USING CCTV IN PREMISES.
USING THE RADIO SYSTEM TO WARN AND INFORM OTHER PREMISES.
PROVIDING NON ALCOHOLIC DRINKS FOR DRIVERS.
DISABLED ACCESS FRIENDLY.
PROMOTING THE USE OF TOUGHENED GLASSWARE AND/OR PLASTIC BOTTLES AND GLASSES.
REMOVING EMPTY GLASSES AND BOTTLES.
NO OVERCROWDING POLICY.
ADVISING CUSTOMERS TO "STAY WITH FRIENDS" AND USE TAXIS TO GO HOME.
LOOKING OUT FOR POTENTIAL CONFRONTATIONS BETWEEN CUSTOMERS.
WATCHING OUT FOR VULNERABLE CUSTOMERS.
HEALTH & SAFETY POLICY.

3) **EXCLUDING TROUBLEMAKERS.**
USING EXCLUSION ORDERS TO BAN UNRULY CUSTOMERS – "BANNED FROM ONE BANNED FROM ALL".
USING EFFECTIVE DOOR CONTROL.
NOT TOLERATING ABUSE OR VIOLENCE TO CUSTOMERS AND STAFF.
USING CCTV IN PREMISES AND THE PUB/CLUBWATCH RADIOS TO WARN AND INFORM OTHER PREMISES OF TROUBLEMAKERS.

4) **NOT TOLERATING UNDER AGE DRINKING.**
BY ONLY ACCEPTING PHOTO ID SUCH AS PASSPORTS OR DRIVING LICENCES.
MAKING STAFF AWARE OF THEIR LEGAL RESPONSIBILITIES.
USING APPROPRIATE SIGNAGE "IF YOU LOOK UNDER 21 YOU MAY BE ASKED FOR ID".

5) **GOOD NEIGHBOURLINESS.**
CONTROL OF CUSTOMERS LEAVING PREMISES.
STOPPING NOISE EMANATING FROM PREMISES.
KEEPING THE NEIGHBOURHOOD TIDY.

6) **DRUG AWARENESS.**
NOT TOLERATING THE SALE OR TAKING OF DRUGS IN THE PREMISES.
WHERE APPROPRIATE RANDOM SEARCHES OF CUSTOMERSAND OR USING "DRUG AMNESTY BOXES".

7) **STAFF TRAINING**
MANAGERS AND STAFF AWARE OF THEIR "DUTY OF CARE" TO CUSTOMERS.
STAFF AWARE OF THEIR LEGAL RIGHTS AND RESPONSIBILITIES.
ENCOURAGING STAFF TO UNDERTAKE APPROPRIATE TRAINING COURSES.
REGULAR ATTENDANCE OF PUB/CLUBWATCH MEETINGS FOR THE OWNERS AND MANAGERS OF PREMISES.
ANTI RACISM POLICY.

NAME OF PREMISES

SUPPORTS THE CITY SAFE INITIATIVE FOR A SAFER NIGHT OUT IN PLYMOUTH.