# An Alcohol Strategy Framework for Dudley

# 2014-2017

## FOREWORD

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Alcohol has been brewed and consumed for thousands of years and various attempts to control its use or make it illegal have mostly failed. In this country it is a licensed substance that is widely available and is part of the social fabric of our society. It is drunk in moderation and enjoyed by a large part of the population with no ill effects.

There is a darker side to alcohol consumption that is reflected in its role in violent crime, domestic violence and anti-social behaviour. It plays a role in increased divorces and there are a large number of children affected by parental alcohol misuse. It is estimated that the costs to the health service of treating people affected by alcohol is £1.2 billion per annum.

Dudley has higher than regional and national rates of premature mortality from alcohol specific conditions and whilst the rate of male mortality has decreased slightly, the rate of premature mortality for females has increased. The rate of alcohol related admissions to hospital has been used as an outcome measure to assess the level of alcohol harm in the population. At one time in Dudley, between 2004 and 2008, this rate was increasing between 20% and 25% per annum. For the last three years the rate of increase has slowed to less than 1% per annum, however Dudley's rate is still above West Midlands and England averages and there is more to be done to reduce rates below the regional and national averages.

This strategic framework builds upon the work done to reduce alcohol related harm and retains a focus on evidence based interventions to raise awareness and change lifestyles. The real change that would make the biggest difference is to tackle the affordability and availability of cheap alcohol and there are some limited actions that can be taken at a local level through voluntary agreements and greater use of existing flexibilities in the licensing laws. Advocating for a 50p minimum unit price would deliver noticeable health gains for those that consume large amounts of cheap alcohol.

The strategic framework sets out the actions to be taken using the Life Course Stages and identifies the priorities based on the wider social determinants of health as well as downstream interventions.

Ultimately the success of this strategy depends on all partners committing to addressing the alcohol problem at their individual and collective level of engagement.

Valerie Little

Director of Public Health

# ALCOHOL STRATEGY

## 2014-2017

The aim of this alcohol framework is to implement priority actions that will improve the health and well-being of people in Dudley by reducing the harm that alcohol can do to individuals, families and the whole community.

It shares the vision of Dudley's Health and Wellbeing Strategy to reduce health inequalities by seeking to reduce premature mortality from alcohol related conditions and to reduce alcohol related admissions to hospital.

It contributes to the Safe and Sound Board's vision of making Dudley a safer place to live by reducing alcohol related crime and disorder.

# ACKNOWLEDGEMENTS

Thanks go to everyone who has given their time to write, read and comment towards the development of the Alcohol Strategy.

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# Intervening in the social determinants of health to improve health harms related to alcohol and reduce health inequalities.

Health and well-being outcomes are linked to wider determinants such as education, work and the environment. The Government's Public Health Outcomes Framework (DH 2012) emphasises the importance of planning and delivering services in the broader context of delivering health such as early years, poverty, education, employment, and the social and physical environment. Major reductions in health inequalities will not occur without action to reduce inequalities in the social determinants of health.

If we want to see a reduction in premature alcohol mortality and alcohol related morbidity (as measured by alcohol related admissions to hospital) then we need to do more than invest in improved services and 'downstream' targeted interventions and awareness. The Marmot Review (DH 2010) proposed intervening in six areas:

- Early years
- Skills and education

- Employment and work
- A minimum income for healthy living
- The physical and social environment
- Ill health prevention

It is beyond the scope of a strategy that is focused on reducing alcohol harm to achieve this, which is why this framework draws on the Dudley Health and Wellbeing Strategy (2013-2016) and Dudley's Health Inequalities Strategy (2010-2015) to show that broader actions to improve the social determinants of health will impact on improving alcohol harm.

Because it is more difficult to address the 'causes of the causes' of health inequalities and address the social determinants of health through the life-course, most health improvement strategies, including previous alcohol strategies, have focused on intervening downstream and in changing lifestyle behaviours, resulting in 'lifestyle drift', where the responsibility for reducing alcohol related harm rests with the individual. This is because of the pressure to achieve pre-ordained targets or outcomes in a relatively short time frame, or to show value for money in investment. This results in approaches that focus on behaviour change and interventions that are easier to measure their health and impact those which can be numerically or financially quantifiable.

Inevitably, this new alcohol framework will also have a focus on downstream interventions and activities that are evidence based and outcome focused. It is based on the life-course approach proposed by Marmot (DH 2012) and reflected in Dudley's Health and Wellbeing Strategy 2013-2016.

However, because alcohol is a background theme to so many of our lives and celebrations, with the vast majority using and enjoying a legal substance safely, in order to address the misuse of alcohol we need to understand that the causes of alcohol misuse lie in the wider social determinants of health and the social and economic factors that make alcohol affordable, available and socially acceptable. For this reason the framework shows where interventions in the wider social determinants of health will have an impact on reducing alcohol health inequalities.

There is clear evidence that there is a social gradient in alcohol harm. Someone in a lower socio-economic group who consumes the same amount of alcohol as someone in a higher socio-economic group is more likely to be involved in crime and disorder, anti-social behaviour, attend A&E and suffer from more alcohol related conditions and potentially die prematurely.

It is acknowledged that this new framework will be implemented at a time of unprecedented budget cuts and this will make focusing on the key areas of social determinants even more challenging, but focusing on lifestyle change and dealing with the consequences of alcohol misuse, whilst necessary, will not bring about the long term change required to deal with this issue.

# Developing the Strategy

In 2004 the government produced the first Alcohol Harm Reduction Strategy for England (Cabinet Office, 2004). It was the first time that estimates of alcohol harm were given a monetary value and it was estimated by the Strategy Unit at the time to be £20 billion and this figure is still quoted although it is likely to be higher now. The strategy had a clear harm reduction focus and promoted a cross government approach between various government departments, the drinks industry, health and police services, individuals and communities.

The main focus of the most recent Government's Alcohol Strategy (Home Office, 2012) is '*to tackle the scourge of violence caused by binge drinking*'. All of the actions are aimed at reducing the affordability and availability of alcohol through national action and increasing local powers to restrict opening and closing times, control the density of licensed premises and the ability to charge a late night levy to support policing. There has been consultation on the introduction of a minimum unit price for alcohol. Dudley's response was to advocate for a 50p minimum unit price which was suggested to provide the greatest health benefits based on the most reliable evidence available at the time.

In order to take account of the new national strategy a comprehensive alcohol needs assessment was undertaken during 2012-2013 which compiled all the available data at the time. Service reviews were carried out and gaps in provision and knowledge were identified.

A stakeholder and service user consultation was carried out and their views were collated. There was also a series of focus groups engaged to elicit the views of young people, black and minority ethnic groups and focus groups targeted at the known age groups for at risk drinking.

Alcohol was identified as a key issue by the Health and Wellbeing Board and the Clinical Commissioning Group (CCG) and there was a Spotlight event organised by the Health and Wellbeing Board in July 2013 to encourage discussion and debate amongst a varied audience. This was later followed up by an alcohol workshop which identified some key actions that the Health and Wellbeing Board wished to see implemented.

A prioritisation event was also held with members of the alcohol strategy group and other partners to agree on the key deliverables.

All of these findings have been compiled into a set of recommendations (Appendix 1) and the main priorities that emerged can be found in the strategic framework. There are also more detailed implementation plans that partners are committed to delivering that will contribute to achieving the desired outcomes. These actions will be monitored by the substance misuse commissioning group and reported to the Safe and Sound Board and Health and Wellbeing Board as appropriate.

# The Strategic Framework

The strategic framework is based around the life-course and covers priorities for each of the key life stages: 0-11, 12-24, 25-39, 40-59, 60-74, and 75+ years. For each stage the main priorities for action are identified – the 'downstream' actions – and actions to address the wider social determinants of health – the 'upstream' actions. The alcohol action plans will focus on the outcomes of the downstream interventions, but will ultimately be dependent on how successful we can be in tackling the wider determinants of health to reduce health inequalities which necessarily includes premature mortality from alcohol and alcohol morbidity.

# The Life Course and Alcohol related plans

<table>
<tr><th>0-11 years</th><th>12-24 years</th><th>25-39 years</th><th>40-59 years</th><th>60-74 years</th><th>75+ years</th></tr>
<tr><td colspan="2">Children and Young People's Strategy<br>Young People's Substance Misuse Plan</td><td colspan="2">Adult Substance Misuse Treatment plan</td><td colspan="2">Older People's Strategy</td></tr>
<tr><td colspan="6">Alcohol Strategic Framework</td></tr>
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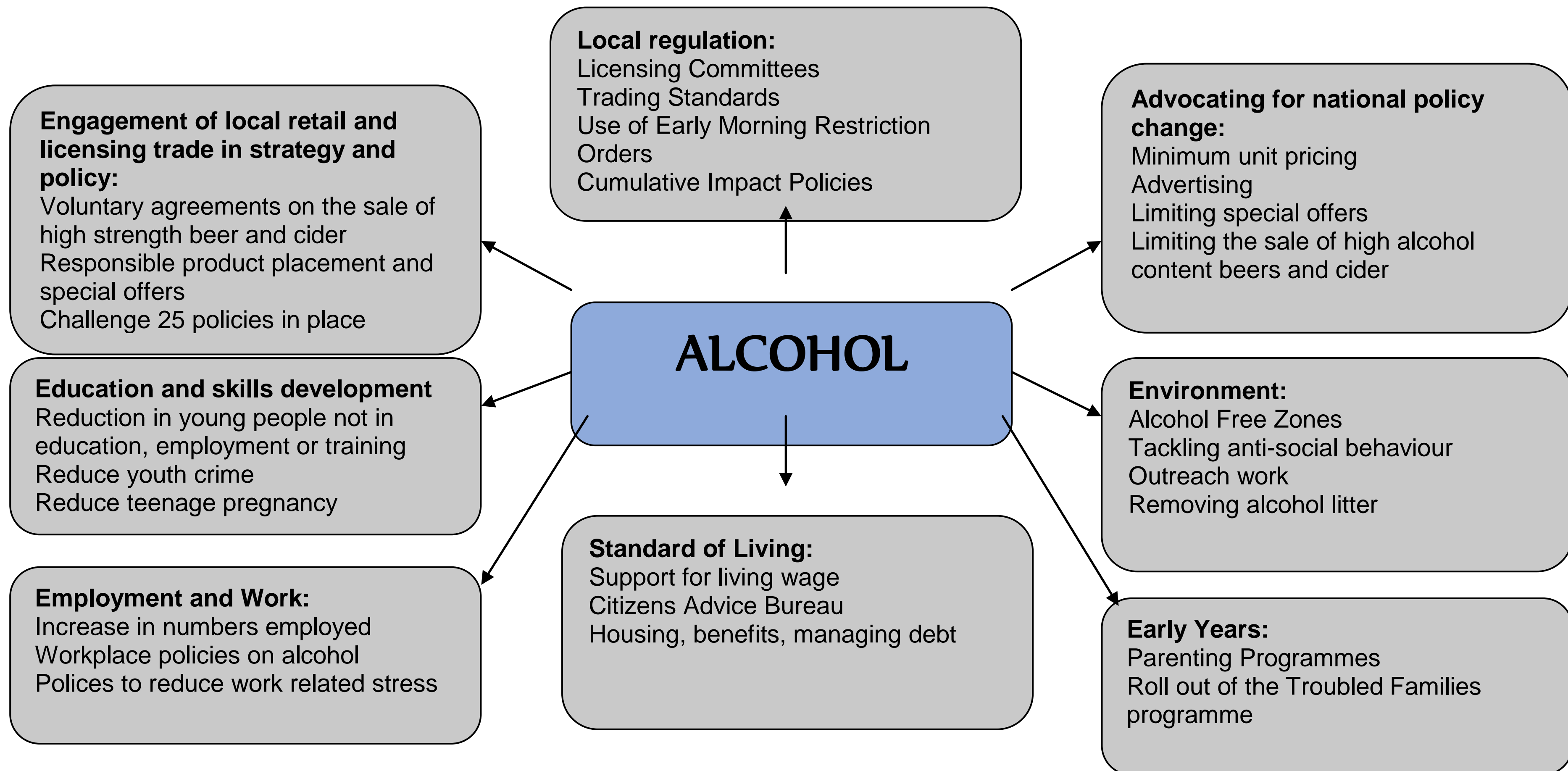
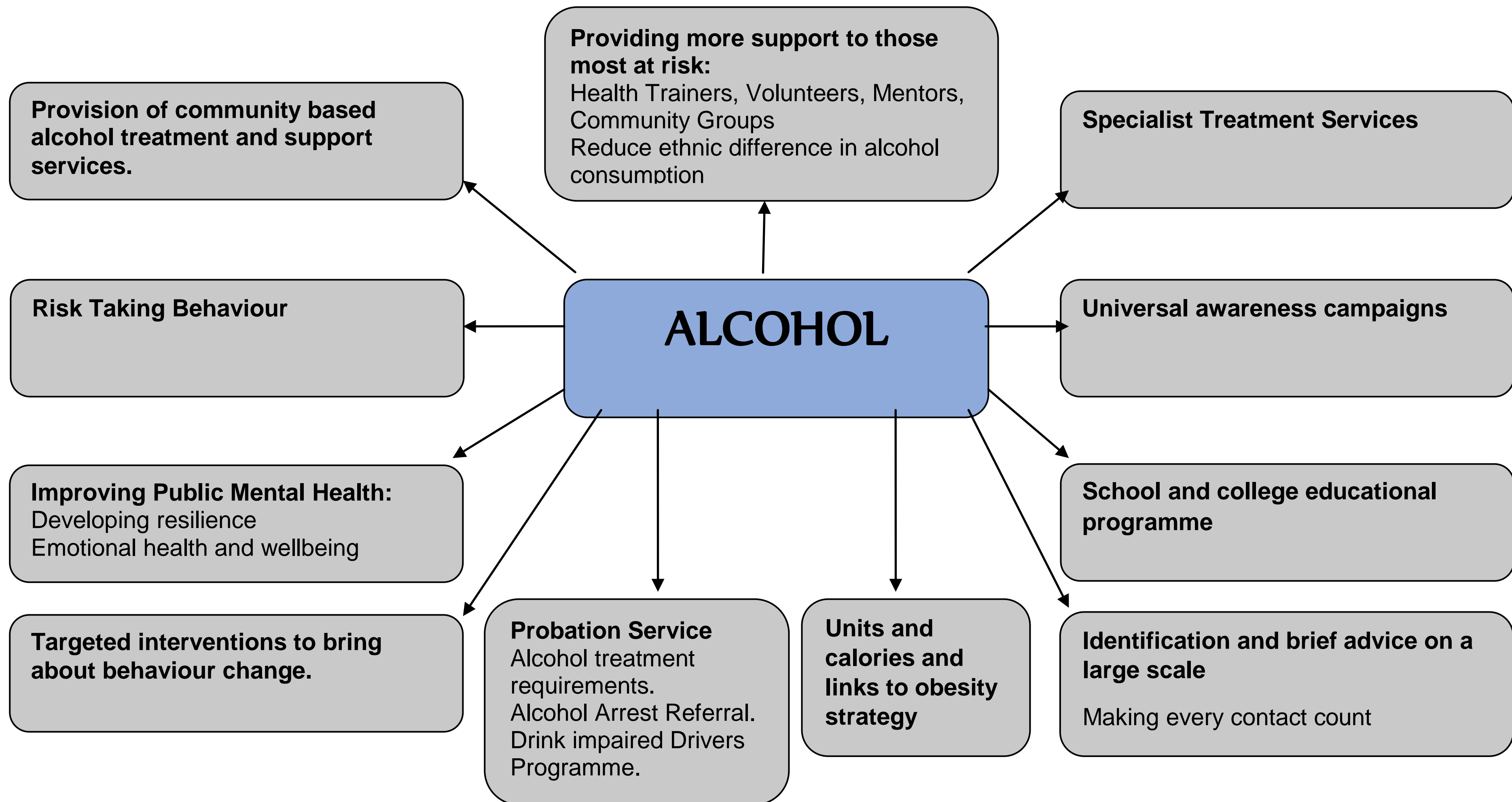
| Community Safety Plan |
| --- |
| Tackling Health Inequalities Strategy |
| Health and Wellbeing Strategy |

# Tackling the Wider Social Determinants



# Downstream Interventions



# Life-stage - 0-11 years

## Pregnancy and Early Years

**Downstream Interventions:**

- Awareness of Foetal Alcohol Syndrome Disorder (FASD) for professionals and parents.
- Guidance on identification and treatment of hazardous and harmful drinking for professionals.
- Awareness of the risks of drinking during pregnancy.
- Identification and brief advice (IBA) delivered in a wide variety of settings to help to reduce consumption to safe levels.

**Wider Social Determinants:**

- Evidence based Parenting Programmes.
- Understanding and intervening in the role of alcohol in Troubled Families.
- Applying learning from the Troubled Families to support other families where alcohol is misused.
- Supporting the Respect Yourself Campaign to reduce teenage pregnancies and reduce the risk of alcohol misuse and unplanned sex.

## Childhood 4-11 yrs

**Downstream Interventions:**

- KS1 and KS2 risk taking programmes.
- Introduction to some alcohol specific work in primary schools.
- Training for teachers - awareness, risks, safeguarding.
- Awareness for parents on how their attitudes to drinking can lead to early experimentation with alcohol.
- Programmes to develop resilience and emotional health and wellbeing.
- Services to support children and parents where alcohol is a problem.

**Wider Determinants:**

- Improvements in educational attainment.
- Evidence based Parenting Programmes.

# Life-stage – 12-24 years

## Discovery Teens 12-15 years

**Downstream Interventions:**

- Risk Taking Behaviour approach, eg. Perceptions work.
- More specific work on alcohol to understand risks and challenge behaviour.
- Training and support for teachers to deliver alcohol education programmes.
- Awareness for parents on the impact of alcohol on developing adolescents.
- Programmes to build on primary school work on resilience and emotional health and wellbeing.
- Provision of services to support children and parents where alcohol is a problem.
- Trading Standards role in preventing under age sales of tobacco and alcohol

**Wider Determinants:**

- Continued improvements in educational attainment. Monitor GCSE results.
- Reduction in number of children leaving school as NEETS (not in education, employment or training)
- Impact of changing the school leaving age
- Reduction in youth crime and those in contact with the youth justice system where alcohol is a contributory factor.
- Reduction in teenage pregnancy where alcohol is a factor.
- Work with the on and off-trade to discourage the promotion of alcohol to young people.

## Freedom Years 16-24 years

**Downstream Interventions:**

- College programmes – still focusing on risky behaviour but including more information on alcohol – units, strength of drinks, and the impact on health.
- Population based awareness campaigns on binge drinking and multiple risk taking e.g. alcohol and crack cocaine
- Targeted interventions to reduce binge drinking.
- Greater use of IBA and promotion of alcohol treatment services.
- Programmes to promote resilience and emotional health and wellbeing, coping strategies for stress and where to get help.

**Wider Determinants:**

- Improve educational attainment.
- Help young people to find training and employment (especially NEETS).
- Support colleges to develop alcohol policies and emotional Health and Wellbeing strategies.
- Work with licensing trade and supermarkets to prevent irresponsible sales, marketing and promotion of alcohol that causes heavy drinking, subsidised bars in colleges and universities.
- Probation service to increase alcohol treatment referrals (ATRs) and offer drink impaired drivers (DiDs) courses.
- Tackling anti-social behaviour.

# Life-stage – 25-39 years

## Younger Settlers

**Downstream Interventions:**

- Population based alcohol awareness campaigns.
- Targeted interventions for identified groups of increasing risk drinking:
    - Young males
    - Young women
    - Pregnant Women
    - Drug users
    - People with mental health problems
    - Identified community groups or vulnerable groups
- Training for professional and a wide range of workers in making every contact count (MECC) and IBA to increase opportunities for early identification and advice.
- Responsive alcohol treatment services for early intervention as well as specialist treatment.
- Accessible services, including outreach.

**Wider Determinants:**

- Local regulation of licensed premises.
- Tackle availability of cheap alcohol.
- Engagement of local licensing and retail trade in strategy and policy.
- Increase the number of people in employment.
- Workplace policies for alcohol and policies to reduce stress at work.
- Advocating for a minimum unit price for alcohol.
- Increase the number of alcohol free zones.
- Tackle anti-social behaviour and make use of local flexibilities in licensing laws and byelaws.

# Life-stage – 40-59 years

## Older Settlers

**Downstream Interventions:**

- Improve screening in primary care and outpatients to identify people with alcohol related conditions.
- Ensure the Health checks provide IBA and referrals to services.
- Responsive services in non-clinical settings.
- Population based alcohol awareness campaigns.
- Targeted interventions for identified groups of increasing risk drinking:
    - Males
    - Females
    - Drug users
    - People with mental health problems
    - Identified community groups or vulnerable groups
- Training in MECC and IBA to increase opportunities for early identification and advice.
- Responsive alcohol treatment services for early intervention as well as specialist treatment.
- Put in measures to deal with treatment resistant drinkers
- Accessible services, including outreach.

**Wider Determinants:**

- Support for debt and housing issues.
- Re-training for returning to work place.
- Local regulation of licensed premises.
- Tackle the local availability of cheap alcohol.
- Engagement of local licensing and retail trade in strategy and policy.
- Increase the number of people in employment.
- Workplace policies for alcohol and policies to reduce stress at work.
- Advocating for a minimum unit price for alcohol.
- Increase the number of alcohol free zones.
- Tackle anti-social behaviour and make use of local flexibilities in licensing.

# Life-stage – 60-74 years

## Active Retirement

**Downstream Interventions:**

- Targeted interventions for identified groups of increasing risk drinking in retirement.
- Campaigns to increase awareness of the risk of drinking for the elderly, slips, trips and falls, fire risks and reduced tolerance to high alcohol concentrations.
- Early identification of at risk drinkers, particularly those regularly presenting in Primary Care or at A&E and provide easy access to community treatment.

**Wider Determinants:**

- Increase opportunities for keeping physically and mentally active.
- Encourage positive social networks to reduce loneliness and depression.

# Life-stage – 75+ years

## Ageing Retirement

**Downstream Interventions:**

- Awareness for professionals of the links with alcohol and memory loss that may be confused with dementia and the possibility of dual diagnosis for alcohol and mental ill health.

**Wider Determinants:**

- Increase opportunities for keeping physically and mentally active.
- Encourage positive social networks to reduce loneliness and depression.

# RECOMMENDATIONS

The following recommendations for action arise from the key findings identified from the needs assessment, stakeholder engagement, service user views and specific focus groups. It also includes responses from the Health and Wellbeing spotlight events. These have informed the priorities for the strategic framework on tackling the scale of the alcohol problem that Dudley faces. The needs assessment identified the progress that has been made since 2008 when alcohol became an important partnership issue to be addressed, However, there now needs to be a step change in activity in order to capitalise on the changes that have already been implemented and to address the gaps that have emerged.

## STRATEGY AND CO-ORDINATION

- Review the terms of reference of the Substance Misuse Commissioning and Implementation groups to reflect an integrated approach to all substance misuse issues.
- Agree a new performance reporting structure in the light of changes in national and regional data collection and reporting and the Public Health Outcomes Framework.
- Develop a revised alcohol strategic framework that reflects the National Alcohol Strategy recommendations; the ambitions of the Health and Wellbeing Board, addresses the wider detriments of health in reducing health inequalities and the role that alcohol plays in achieving the aims of the Crime and Disorder Strategy.

## THE SCALE OF ALCOHOL MISUSE IN DUDLEY

- It is proposed that a risk taking behaviour approach should be taken with young people, starting with Key Stages 1 and 2 in primary School and developing into more specific activities for Key Stages 3 and 4. Targeted interventions focusing on risk taking behaviour should also be developed for 16-24 year old binge drinkers.
- The targeted interventions that have been implemented for at risk male drinkers aged 35-54 should be evaluated and the most effective approaches should be taken forward
- Currently work with females in all categories is underdeveloped and a social marketing approach should be used to better understand the factors that influence female drinking at different life stages and develop specific interventions to reduce hazardous and harmful drinking.

## THE HEALTH IMPACTS OF ALCOHOL MISUSE

- A focused, intensive piece of work is needed to tackle the 60 people with chronic alcohol dependence who have attended A & E on 307 occasions,

mostly by ambulance. This is a difficult group to work with and they consume a disproportionate amount of resource. A review of best practice should be undertaken and implement actions that have been shown to have success elsewhere. The outcomes of the 'Blue Light' project should be agreed with partners and implemented.

- Engagement of Primary Care in early identification and referral is essential and the learning from the single point of contact and the role of a GPwSI for alcohol should be re-considered to take this work forward
- The larger than expected number of unplanned admissions for alcohol related conditions and inadequate arrangements for early discharge suggests that current pathways are not working effectively and should be revisited,
- The programme of awareness of foetal alcohol syndrome for professionals and women of child bearing age should continue to be rolled out.

### THE SOCIAL IMPACTS OF ALCOHOL MISUSE

- The work streams currently in place on alcohol and the criminal justice system need to remain a priority, even though major changes are being planned. The alcohol arrest referral scheme, the use of alcohol treatment requirements and the drink impaired drivers programme are all recommended for continued implementation.
- Work is currently being scoped on the role of alcohol in domestic abuse and the most effective ways to intervene. This should be implemented when the planning is completed.
- The current economic climate may mean that alcohol consumption will increase. It is estimated that a 1% increase in unemployment relates to a 17% increase in alcohol consumption. In an effort to counteract this it is important to address the wider determinants of health that impact on alcohol misuse. It is recommended that action should be taken from the following areas:
    - Gaining skills and qualifications. It is particularly important to address the skills and employment gap for NEETs.
    - Helping people to find employment.
    - Reducing stress at work (uncertainty about employment is linked to increased alcohol consumption).
    - Helping people to cope with housing and debt problems.
- There needs to be better data collection locally to link alcohol with unemployment, uptake of welfare benefits, domestic abuse, teenage pregnancy and sexual exploitation.
- The role of alcohol in troubled families needs to be better understood to ensure appropriate interventions to reduce risk are implemented. The learning from the Troubled Families programme can then be rolled out to other families where alcohol misuse is an issue but the family is not classified as 'troubled'.

### ALCOHOL AND HEALTH INEQUALITIES

- New interventions should be assessed for their impact on health inequalities. Assessments that rely solely on judgements about the amount of alcohol consumed may miss the disproportionate harm that alcohol can do to those in the lowest quintile of deprivation.
- Scoping work should be undertaken to address the ethnic differences in alcohol consumption and ensure appropriate interventions are in place to reduce inequalities.

- Consideration needs to be given to the role of alcohol and mental health, both as a cause of alcohol consumption and as a consequence of mental health problems. There needs to be a co-ordinated approach to health improvement approaches and also earlier intervention to identify where mental health problems are related to alcohol misuse but are not serious enough to require dual diagnosis treatment services.
- New work needs to focus on the marketing and product placement of alcohol in shops and supermarkets. Innovative ways of engaging with supermarkets and the licensed trade need to be developed to limit the sale of high strength lager and cider.
- Consideration should be given to increasing the number of alcohol free zones and to extending the cumulative impact policy.
- Greater use could be made of local flexibilities in enforcement e.g. consider prosecution of landlords for serving someone who is clearly drunk, or imposing early morning restriction orders where there are health or crime and disorder concerns.
- Consider banning alcohol in parks and on-street drinking where there are identified issues with regards to anti-social behaviour. As well as reducing alcohol litter from cans and bottles a cleaner, safer environment contributes to improving people's health and wellbeing.
- Opportunities should be sought to advocate for a 50p minimum unit price for alcohol.

### TREATMENT SERVICES

- Update and renegotiate data sharing protocols in light of recent service changes and availability of data.
- Continue to work on improving data collection from A&E for community safety and public health purposes, whilst acknowledging the work already undertaken to improve data downloads.
- Monitor the changes to young people's treatment services and ensure that agencies refer appropriately and then provide support to young people engaged with specialist services.
- Agree performance monitoring data with providers via contracting arrangements and how that data is shared for service improvements and achievement of Public Health outcomes.
- Improve patient flow along the pathway and ensure there are robust plans are in place for planned treatment exits or step down in treatment prior to exit.
- Develop a zero value framework for the purchase of in-patient detox post April 2014.

### PREVENTING ALCOHOL MISUSE

- Develop an agreed developmental plan for alcohol consumption that takes account of national and regional campaigns and locally identified needs.
- Ensure interventions are evidence based, evaluated and reported and that the lessons learned inform future commissions.

- The work that has been done with cultural groups needs to be further developed and extended.
- The small grants scheme is an effective way of supporting small community projects and is recommended for continuation
- A training programme should be developed with specific alcohol modules where appropriate.
- The work with trading standards and under age sales has proved very effective and should continue to be commissioned.

The Alcohol Needs Assessment can be downloaded from All About Dudley from:-

http://www.allaboutdudley.info/AODB/publications/Alcohol%20Needs%20Assessment%202012.pdf.

The detailed report on the Consultation process is also available on All About Dudley:-

http://allaboutdudley.info/AODB/publications/Dudley%20Alcohol%20Consultation%20Document%202013.pdf

# APPENDIX 2

# REFERENCES

Great Britain. Cabinet Office (2004) *Alcohol Harm Reduction Strategy for England*. London: The Stationery Office

Great Britain. Home Office (2012) The *Government's Alcohol Strategy*. London: The Stationery Office. (CM 8336)

Department of Health (2012) *A Public Health Outcomes Framework for England* [online] Available at: https://www.gov.uk/government/news/public-health-outcomes-framework-sets-out-desired-outcomes

(Accessed: August 2014)

Marmot, M. (2010) *Fair Society, Healthy Lives: a strategic review of health inequalities in England post-2010 - Executive Summary*. London: The Marmot Review

Dudley Metropolitan Borough Council (2013) *Joint Health and Wellbeing Strategy 2013-2016* [online] Available at: http://www.allaboutdudley.info/AODB/publications/Joint_Health_&_Wellbeing_Strategy_2013-16.pdf

(Accessed: August 2014)

Dudley Primary Care Trust (2010) *Dudley Strategy for Tackling Health Inequalities 2013-2016* [online] Available at: http://www.allaboutdudley.info/AODB/publications/Dudley_Strategy_For_Tackling_Health_Inequalities_2010-15_Summary.pdf
(Accessed: August 2014)

Dudley Metropolitan Borough Council (2013) An Alcohol Needs Assessment for Dudley [online] Available at:
http://www.allaboutdudley.info/AODB/publications/Alcohol%20Needs%20Assessment%202012.pdf
(Accessed: August 2014)