Section A: NICE to complete	
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Guidance title:	Drug Misuse Prevention
Committee:	PHAC C
Subject of expert testimony:	Night Time Environment and Local Partners Role in Managing Harm
Evidence gaps or uncertainties:	[Please list the research questions or evidence uncertainties that the testimony should address]
Q - What interventions seem to work, with whom and in what ways. A - Statutory involvement with premises licensed for the on-site sale and consumption of alcohol can reduce levels of harm (Brennan, I.et al. 2011; Moore, S.et al., 2015).	
Q - How transferrable is evidence / learning from other targets groups and settings. A – Learnings from work targeting alcohol-related harm in night time environments may generalise to drug-related harms	
Q - Which individuals, services or organisations are best placed to intervene, where are the statutory requirements and where do responsibilities lie (impact of change to LA from NHS). A – Local Authorities have a broad range of enforcement options that could be better used to challenge problem premises. The NHS has data that could be used to better identify problem premises (Sivarajasingam, V.et al., 2015).	
Q - Who (as in type of organisation) is best placed to intervene and are there any implications with the recent move of public health to local authorities. What is the role of other local bodies, venues and businesses. A – Local Authorities, in particular Environmental Health Officers and Licensing Officers, if properly resourced, are able to provide cost effective interventions targeted at at-risk premises.	
Q - Who should (or most likely to be in a position to) take action / pick up any recommendations that NICE may make. A – Local Government and Local Health Boards and Trusts.	
Section B: Expert to complete	
Summary testimony:	[Please use the space below to summarise your testimony in 250 – 1000 words – continue over page if necessary]

Night time environments characterised by a high density of premises licensed for the on-site sale and consumption of alcohol are responsible for producing heightened levels of harm that require resources in their management, including ambulance, police, and unscheduled care. The leading forms of harm are severe alcohol intoxication (as high as 70% of all attendances during peak periods, Parkinson, et al., 2015) and assault-related injury (Sivarajasingam, V.et al., 2015), however illicit substance misuse is also evident. Licensed premises are obliged, under British legislation, to ensure drug-related activities, severe intoxication and disorder do not occur on-site and are subject to penalties as a deterrence. Encouraging the appropriate management of premises can therefore cause a reduction in harms evident in night time environments (Moore, et al., 2015). In particular, premises are advised to search clientele for illicit substances and prevent access to premises if there is evidence that they might be intoxicated.

There is a need for intelligence to identify premises that might be contributing to levels of harm (Droste, et al., 2014; Sivarajasingam, et al., 2015). Data from unscheduled care (estimated cost of one assault-related events is £33k, Moore, et al., 2015) can help identify the location of last drink for those attending due to severe intoxication, the location of an assault in the cause of an attendance due to assault-related injury and, potentially, recent activities that contribute to attendance through the use of illicit substances. NHS is well placed to collect data from patients attending for alcohol and/or drug related issues and to enquire as to the circumstances that contributed towards the event necessitating clinical attention. These data can be used to inform local services and direct resources towards times and places associated with misuse.

Licensed premises are primarily subject to the 2003 Licensing Act and therefore management through police and local authority licensing officers. However, a recent project (Moore, et al., 2015) in which local authority environmental health officers visited at-risk premises found significant failing in health and safety standards approximately 25% of premises visited. Although premises are also subject to Health and Safety legislation, legislation that requires process that are broadly known to contribute to lower levels of harm (Brennan, et al., 2011), such as staff training, keeping log books and having written polices and procedures. It has also been found that some premises are generally reluctant to enact change unless those changes are required by statutory bodies (Moore, et al., 2015). Further, it was argued that Health and Safety at Work legislation provides a more certain method to bring about change in licensed premises compared to the 2003 Licensing Act. Environmental Health Officers are under-utilised in this area, despite offering a potentially cost-efficient approach to dealing with the causes of harm. It is estimated that a single visit to a licensed premises costs £125 (Moore, et al., 2015).

In summary, premises are viable targets for a range of harm minimisation efforts. However, Local Authorities should make better use of the range of enforcement options available to them in managing problem premises and better use of NHS data should be made to identify those problem premises.

References (if applicable):

Sivarajasingam, V.et al. (2015). Trends in violence in England and Wales 2010-2014. Journal of Epidemiology and Community Health (10.1136/jech-2015-206598)

Moore, S.et al. (2015). All-Wales Licensed Premises Intervention (AWLPI): a

randomised controlled trial of an intervention to reduce alcohol-related violence. Public Health Research 3(10) (10.3310/phr03100)

Droste, N., Miller, P & Baker, T. (2014). Emergency department data sharing to reduce alcohol-related violence: a systematic review of the feasibility and effectiveness of community-level interventions. Emergency Medicine Australasia, 26(4), 326-335.

Brennan, I.et al. 2011. Interventions for disorder and severe intoxication in and around licensed premises, 1989-2009. Addiction 106(4), pp. 706-713

Parkinson, K., et al., (2015). Prevalence of alcohol related attendance at an inner city emergency department and its impact: a dual prospective and retrospective cohort study. Emergency Medicine Journal, doi:10.1136/emermed-2014-204581.