



Counting the Cost

The measurement and recording of alcohol-related violence and disorder



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SIRC for the The Portman Group

The Portman Group's purpose is to promote sensible drinking; help prevent alcohol misuse; foster a balanced understanding of alcohol-related issues; and encourage responsible marketing. Companies supporting TPG include Bacardi-Martini; Campbell Distillers Pernod Ricard Group; Diageo; H P Bulmer; Interbrew UK; Scottish & Newcastle and Six Continents.

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This research report was conducted by the Social Issues Research Centre for The Portman Group. It was directed by Dr Peter Marsh and managed by Simon Bradley. Felicity Peck acted as full-time researcher. Additional research was conducted by Anna Carnibella.

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FOREWORD

In a survey commissioned for The Portman Group by MORI in 2000, a quarter of respondents said they had been the victim of alcohol-related violence. In most cases, this violence had taken place in a pub. Furthermore, over half the respondents believed that alcohol-related violence in the pubs and on the streets was increasing. Only a handful of people took the opposing view. But what is the true situation? How far do perception and reality co-incide?

The answer is, we don't know. Because although we are forever reading statistics on the prevalence of alcohol-related disorder, we cannot be sure that everyone is defining and measuring the problem in the same way. With no agreed protocol, it could be that statistics quoted are misleading and that comparisons, both between areas and across time, are invalid. This could also mean that many of today's attempts to measure the effectiveness of different crime-reduction initiatives are fundamentally flawed.

The Portman Group therefore commissioned the Social Issues Research Centre to investigate how different agencies approach the problem of defining and measuring alcohol-related disorder. We also asked SIRC to suggest ways in which greater accuracy and consistency could be achieved in the future, thus putting an end to the guesswork.

Don't get me wrong. Alcohol clearly contributes to unruly behaviour. But if we are serious about reducing this problem, we must first of all make sure that we all agree on how the problem is defined and measured. We can then stop relying on anecdotal evidence and hunches for our information and instead start using cast-iron, objective data.

JEAN COUSSINS

Director
The Portman Group

February 2002

Executive Summary

This report concerns research commissioned by The Portman Group and conducted by the Social Issues Research Centre between March and October 2001.

The research examined in detail the current procedures used by police, hospital accident and emergency (A&E) departments, town centre managers, representatives of crime reduction partnerships (CRPs) and others to record and collate information on alcohol-related violence and disorder. Attention was paid to the varying definitions of alcohol-related that were employed.

Quantitative methods, in the form of interviews, focus groups and discussions with the major stakeholders in this area, including representatives of drinks trade bodies, were used throughout England, Scotland and Wales to provide balanced and representative perspectives. Three questionnaire studies and a telephone survey were also conducted to provide quantitative data. A small comparative study was conducted in The Netherlands.

Principal Findings

Police data

- There is very widespread variation in both the definition and the recording of alcohol-related violence and disorder among police forces and command units. Methods vary from direct computer database input to entries on printed forms and officers' notes.
- The data that are available contain substantial sources of potential error and inconsistency because of the methods employed and are collated for policy or strategic purposes in only a minority of cases.
- Only 10% of police forces are able to compare their data directly with those collated by other forces.
- Interpretation of police data is often very difficult because both offenders and the victims of alcohol-related assaults are included in the figures and the sources of the information vary from reports of crime to arrest records.
- Data relating to offences in and around licensed premises, while often collected in a more systematic fashion, are prone to a number of errors and include offences which may not be alcohol-related in any meaningful way.
- Due to these and other factors, claims that 70% or 80% of all late-night violence in town centres is

attributable to alcohol consumption cannot be empirically substantiated by police data. This was acknowledged by many officers themselves.

Accident and emergency data

- A&E data concerned with injuries sustained in alcohol-related incidents are recorded and collated in ways that are even more variable than those employed by police officers. They vary from routine assessments using clinical or blood alcohol concentration (BAC) tests to occasional diagnosis when perceived as clinically relevant. The manner in which the data are recorded ranges from computer form entry to clinical notes.
- Comparability of data across A&E departments is very restricted by variations in recording practices and data retrieval systems.
- Integration of A&E data with that obtained by police forces is hampered by incompatible methods and systems and by perceived data protection concerns.
- A&E data relate almost entirely to the victims of violence rather than to alcohol-related offending.
- The large majority of A&E consultants felt that the procedures for assessing alcohol consumption and data recording were in need of substantial improvement.
- While A&E consultants typically thought that between 70% and 80% of violent injuries might be related to alcohol consumption, empirical studies conducted within hospitals suggest that the figure is substantially lower.

Crime reduction partnerships

- For the large majority of CRPs the amount of work directed at alcohol-related issues amounted to less than 30% of their total activity.
- Where the reduction of alcohol-related violence and disorder was seen as a priority, the lack of empirical evaluation methods very often made it difficult to assess the true effectiveness of initiatives in this area.
- Less than one quarter of partnerships had formal documents outlining their aims, objectives and measures of achievement.
- The lack of proper evaluation of partnership activities makes it almost impossible to identify examples of best practices which might be recommended for inclusion in future schemes.

Town centre management

- Town and city managers have a particular role to play in the reduction of alcohol-related violence through their function in planning and development issues, their involvement in CRPs and their management of closed circuit television systems.
- In the majority of cases around 10% of town centre managers work was devoted to alcohol-related issues.
- Fewer than 5% of town centre managers compiled reports of alcohol-related incidents in order to allow objective evaluation of measures aimed at combatting such problems.

Drinks trade bodies

- In contrast with the views expressed by police, A&E consultants and others, a number of representatives of trade bodies felt that alcohol-related disorder was probably decreasing.
- Some felt that there was insufficient recognition of the role that their organisations had played in initiatives aimed at reducing such problems.
- Most organisations were of the strong view that current sources of data concerned with the scale and pattern of alcohol-related violence and disorder were inaccurate, unreliable and open to varying interpretations.
- They felt that the concept of alcohol-related, which often implied direct cause and effect, was misleading.
- Clarification of definitions and improvements to existing recording and data collation methods were seen as being essential to the development of more appropriately targeted initiatives aimed at the reduction of alcohol-related problems.

Conclusions and Recommendations

- It is clear from our research that current data recording practices are quite inadequate to enable the nature and scale of alcohol-related violence and disorder to be assessed with any degree of accuracy. The varying definitions of 'alcohol-related' add further confusions.
- This lack of reliable and valid data similarly makes objective evaluation of initiatives aimed at the reduction of alcohol-related problems very difficult and, in some cases, quite impossible.
- The collating and publishing of existing data is unsystematic and is sometimes motivated by quite

separate concerns e.g. as a means of opposing liquor licence applications or to make a case for increased resources.

- The extent to which those who consume alcohol are over-represented among the category of violent offenders is unknown. In most town centres on Friday and Saturday nights it is clear the large majority of people have consumed alcohol, but only a small minority commit offences.
- Given that the causal connection between alcohol and violence cannot be defined on the basis of current evidence, the claim that between 70% and 80% of all violence and disorder in town and city centres is related to alcohol consumption is quite meaningless.

Recommendations

- In the light of the points noted above, the report makes four specific recommendations.
- 1. **Model recording procedures**, which demonstrate objective assessment, systematic recording and ease of data retrieval and analysis, should be developed for both police and A&E departments. Such models should be tested in pilot schemes in various parts of the UK with assistance from external specialists and appropriate resources. Revised models derived from these experimental trials should, after appropriate consultation with relevant stakeholders, be considered by appropriate government departments for implementation nationwide.
- 2. In parallel with Recommendation 1 **specific evaluation models**, based on existing, well-developed professional guidelines, should be developed for use within CRPs. After experimental trials which demonstrate the utility of such models, their deployment should be seen as a condition for public funding of CRP initiatives.
- 3. **Research** that directly measures the degree to which alcohol is a risk factor in violent crime and injury should be conducted. This would compare the alcohol consumption levels of offending and non-offending groups in town centres on Friday and Saturday nights. It would enable the issue of cause and effect to be examined more clearly and would identify the specific types of individual who may present a risk following drinking. This, in turn, would enable initiatives aimed at tackling the problems to be more clearly and appropriately targeted.

4. In order to avoid the ‘selective use’ of data on alcohol-related violence and disorder, whether derived from existing or improved procedures, **publication** of such data should be undertaken at fixed intervals in consistent formats. These reports should be available to all relevant stakeholders as a matter of course.



Dr Peter Marsh

1 Introduction

1.1 Background

Alcohol is routinely thought to be a major cause of violence and disorder in the UK. Media coverage⁽¹⁾ of the issue would certainly lead us to this conclusion, along with police statistics which regularly purport to show that between 60% and 80% of all violent crime is alcohol-related. In addition, a recent survey conducted by Alcohol Concern and *Police Review* indicated that 70% of police officers viewed alcohol as causing them greater problems than drug misuse.

There is nothing new about these claims. When MCM Research undertook fieldwork which led to the publication of *Drinking and Public Disorder* over 10 years ago, the work was conducted against a similar background of blaming alcohol consumption for a very large proportion of social ills and violent behaviour in particular.

Despite all of this it is still the case, as the Home Office and others have noted, that we still do not have any precise ways of even estimating the real impact that alcohol has on patterns of violent and anti-social behaviour in our society. We certainly know that there is, indeed, a problem of alcohol-related violence. It is apparent on even the most cursory examination of activity in and around town centre bars and clubs on Friday and Saturday nights what is now referred to as the ‘night-time economy’. But as Anne Deehan noted⁽²⁾

“... there are no official statistics collected systematically making it impossible to gain a true picture of the role of alcohol in crime at a national level. Statistics prepared by Accident and Emergency departments in major hospitals also tend to lack consistency in both measurement and definition and are not collated on a national basis.”

Not only are there serious gaps in data collection and collation methods, there are more fundamental problems of definition. The term ‘alcohol-related’ is sometimes taken to imply a direct causal relationship between the chemical ethanol and certain types of behaviour. Such an assumption is rarely supported by empirical evidence or theoretical perspectives. More often the term ‘related’ is used to indicate a partial causal factor, with alcohol interacting with other

individual, social and environmental factors to predispose certain behaviours. At the other end of the scale ‘alcohol-related’ refers to the fact that a violent disturbance simply involved one or more participants who had been drinking. In most cases - e.g. police and A&E department data - it is this latter definition which is implicitly used, making interpretation of the figures quite problematic. Data from ‘official’ sources also rarely distinguish between the perpetrators of violence and those who are the victims of such acts, adding further to the difficulties of interpretation.

These problems relating to the definition and recording of alcohol-related violence and crime and, therefore, the unreliability of much that passes for ‘evidence’ in this area have been recognised for a long time. Like any other crime measure it is also the case that reported statistics reflect police policies and levels of activity as much as they do the actual patterns of behaviour. High-profile policing in town centres, for example, coupled with a ‘zero tolerance’ of rowdy, inebriated behaviour, will result in a greater apparent problem of alcohol-related disorder than a more softly, softly approach. Even the recent figures from the British Crime Survey, which indicate a 29% rise in violence inflicted by strangers, may reflect increasing sensitivity to such issues and a greater willingness now to define relatively minor incidents as ‘violent’ compared with previous years⁽³⁾.

Given all of these inherent problems it is unrealistic to expect that completely valid, reliable and unequivocal data can ever be obtained to measure the true scale and patterns of alcohol-related violence and disorder. There is an inherent ‘wooliness’ in the concept of ‘related’ and the definitions of ‘violence’ and disorder are also far from clear-cut. Nevertheless, it was clear at the outset of this study that improvements to the present methods were clearly required if more meaningful conclusions concerning alcohol’s negative role in patterns of social behaviour were to be drawn, even if complete clarity might never be realised.

We were also concerned with identifying not only potentially more accurate ways of assessing alcohol-related problems at national and regional levels, but

1. A sample of recent press coverage of alcohol-related violence and disorder issues can be found on SIRC’s web site at http://www.sirc.org/resources/media_alcohol_violence.shtml

2. Deehan, A., Home Office Briefing Note (9/00)

3. See also: Burrows, J., Traling, R., Mackie, A., Lewis, R and Taylor, G. (2000) Review of police forces’ crime recording practices. *Home Office Research Study 204*.

also with developing better ways of evaluating initiatives aimed at reducing such problems. As we noted earlier, we recognise that there is a problem of alcohol-related disorder in urban centres and elsewhere, even if we cannot really tell, on the basis of current evidence, how much. Given this, what seem to be the best ways of tackling such problems? Which initiatives appear to work better than others? How can budgets for crime reduction strategies in this area best be targeted? Without reliable definitions and measures of levels of alcohol-related problems we can only guess the answers to such questions.

1.2 Theoretical perspectives

Theoretical perspectives concerning the relationship between alcohol and aggression, disorder and crime have been discussed and evaluated extensively in previous reports and by several other authors - e.g. Marsh and Fox (1991), Fox and Marsh (1995), Parker (1998), etc. We do not, therefore, propose to deal with these issues in depth in the current report. We take as our perspective the notion, which has wide support in the academic and research community, that violent and disorderly behaviour is often associated with alcohol consumption primarily because of cultural traditions, social expectations, environmental factors and individual predispositions. There is little support for the idea that the chemistry of alcohol (ethanol) alone has any single, specific type of effect on behaviour.

An annotated bibliography of recent papers relating to the central issues of this report can be found on SIRC's web site at www.sirc.org/resources/alcohol_violence_biblio3.shtml Reference to some empirical studies is made in this section of the report - particularly where they provide results that contrast with the perceptions of police and A&E informants.

1.3 Aims of the research

The principal aims of the research were as follows.

1. To elicit and clarify the views and perceptions of major stakeholders regarding the definition, measurement and recording of alcohol-related violence and disorder.
2. To identify at a national level the varying assumptions by the major stakeholders regarding the nature of the relationship between alcohol and anti-social behaviour.

3. To identify specific areas of inconsistency and misreporting in this context, both between different agencies and authorities and within single authorities at a national level.
4. To study in greater depth the above in six regions of the UK, including Scotland.
5. To recommend improved procedures for the definition, recording and collation of information from various sources relating to alcohol-related problems.
6. To propose concrete methods of evaluating the effectiveness of initiatives aimed at reducing alcohol-related violence and disorder.

1.4 Methods

In order to achieve the aims outlined above the research was designed to identify and subject to scrutiny the data recording practices of police, health and local government agencies. A series of consultations, both formal and informal, with the major stakeholders, including government departments and trade bodies, on all aspects of alcohol-related violence and disorder was also included.

More in-depth interviews and discussions were planned which aimed to elicit perceptions of the limitations of current recording practices, to identify potential ways of improving such practices and to explore means for more widespread data sharing and integration. This stage of the research was initially envisaged as comprising work in six regions of the UK. As we note later, however, this phase of the work was extended to cover a number of other locations and national bodies.

Additional work was undertaken for comparative purposes in The Netherlands (see Section 2.5).

The final stage of the research consisted of questionnaire surveys administered to samples of police licensing officers, town centre managers and crime reduction partnerships. A telephone interview was also designed for A&E consultants.

The project was directed by Dr Peter Marsh and managed by Simon Bradley. Felicity Peck acted as full-time researcher. Additional research was conducted by Anna Carnibella.

1.5 Respondents

The following individuals from a range of agencies, bodies and organisations were included in the qualitative research and consultation. We acknowledge their valuable assistance.

Richard Absalom - Safety and Risk officer, London Ambulance Service

Richard Adams - Crime Strategy Officer, Oxford City Council

Sergeant Carole Ajinkya - Licensing Officer, Bridewell, Bristol

Mr Ian Anderson - A&E consultant, Victoria Infirmary, Glasgow

Mr Asbury - Licensing Justice, Manchester Magistrates Court

Mark Beale - Project Lion

Diana Beard - STAG

Sergeant Steve Beety - Crime reduction officer, Devon & Cornwall Police

Chief Inspector Colin Benson - Bristol Police

Burt Bieleman - INTRAVAL

Paul Bird - Police Licensing Officer, Basildon

Nick Bish - ALMR

Chris Brereton - Operations Manager, Environmental & Public Protection, Cardiff

Alan Brown - Head of the Partnership Development Performance and Strategic Management Unit for the Police and Crime Reduction Group, Home Office

Peter Bourn - Harlow District Council

Mr Bryant - A&E consultant, Royal Sussex County Hospital

Roger Butterfield - Chairman, SELP

Wouter Buwalder - Landelijk Platform Tegen Geweld Op Straat (National Platform Against Street Violence)

Philip Carpenter - Chelmsford Borough Council

Paul Catley - Oxford Brookes University

Rebecca Chanellor - NHS Direct

Peter Chown - Licensing Officer, Basildon

Jon Collins - BEDA

Jim Connelly - A&E Consultant Nottingham

Sue Cooper - Assistant Police Licensing Officer, Chelmsford

Mick Corton - East Kent Health Authority

John Cousins - Community Policing Team, Epping

Sergeant Nigel Cruttenden - Crime Reduction Unit, Thanet Police

Wim van Dalen - Nationaal Instituut voor Gezondheidsbevordering en Ziektepreventie

PC Bill Denver - Thames Valley Police, Oxford

Simon Fisher - Police Licensing Officer, Harlow

Sergeant Lyn Gooding - Project Amethyst leader, Devon & Cornwall Police

Trevor Gwillam - Force Licensing Officer, Devon & Cornwall Police

Judy Hadfield - Hope Hospital, Salford

Sergeant Jo Hadley - Community Safety Headquarters, Chelmsford

Inspector Kevin Harris - Crime Reduction Officer, Devon & Cornwall Police

Mr John Hayworth - A&E consultant, Southampton General

Kevin Hemsworth - Rayleigh Community Policing Team

Mr Phillip Hornbrey - Senior Consultant, A&E, John Radcliffe Hospital, Oxford.

PC Gary Howarth - Licensing officer, Leeds Police

Stacey Howes - Epping Forest Council

Peter Hudson Clacton - Police Licensing Officer

Inspector Gordon Hunter - Edinburgh Police

Keith Jackson - London Ambulance Service

Sharon James - Project Support Nurse, A & E Unit, UHW

Sister Jamison - A&E, Royal Infirmary of Edinburgh

Mr Graham Johnson - Head clinician, St James Hospital, Leeds

Dr Alan Jones - A&E Consultant, Margate

Rita King - Deputy Director of Retail, BLRA

Bernard Lane - Head of Cross Cutting Crime, Action Against Crime & Disorder Unit, Home Office

Denise Langman - City Centre Manager, Cardiff County Council

Marcus Laphorn - Oxford Town Centre Manager

Dr Keith Little - A&E consultant, Royal Infirmary of Edinburgh

Angus Livingston - Senior Solicitor, Glasgow

Mr Lockhart - Solicitor, Glasgow

Ian McConnell - Head of licensing, Southampton Magistrates Court

Stuart Macleod - Police and Reducing Crime Unit

Mr Mann Liquor - Licensing clerk, Manchester Magistrates Court

Superintendent David Martin - Strathclyde Police

Mr Millington - A&E consultant, Charing Cross Hospital

Tony Mernaugh - Town Centre Manager, Brighton

Nick Newman - Manager Berlins, Chair of Cardiff Licensees Forum

Julie Notts - NHS Direct

Roy Osborne - Police Licensing Officer, Southend

Dr OSullivan - A&E consultant, Bristol Royal Infirmary

Phil Phillips - BHA

Diana Potgieter - Licensing Clerk, Cardiff Magistrates Court

Kareen Plympton - Licensing Officer, Brighton Police

Steve Radburn - Government Office of the East Midlands

Martin Rawlings - Director of Retail, BLRA (BBPA)

Detective Chief Inspector Andrew Rhodes - Lancaster Police

Inspector John Richards - Bristol Police

Inspector Robin Rickard - Thames Valley Police, Oxford

Martin Reed - Chairman of Licensing Officer Forum, Chelmsford

Inspector Gary Roberts - Isle of Man Police

Marcus Roberts - NACRO

Ian Rothwells - City Centre Manager, Southampton

Sergeant Phil - Sanders Hammersmith Police

Professor Jonathan Shepherd - Maxillofacial surgeon, University of Wales College of Medicine

Roy Simmons - Assistant Directorate Manager, A&E Unit, Cardiff

Julian Skeens - Director, BISL

Mr George Sneddon - City Centre Manager, Glasgow

Graham Stevens - Brighton & Hove Drug Action Team

PC Linda Stevens - Licensing officer, Leeds Police

Mr Jimmy Stuart - Consultant A&E, North Manchester General Hospital

Victoria Swainson - South Wales Police, Project Data Analyst, TASC

Vicky Tanner - British Transport Police

Alan Tolmie - Tendring District Council

Mr Robin Touquet - A&E consultant, St Marys Hospital, Paddington

Sergeant Ian Tumelty - South Wales Police, Project Training Sergeant, TASC

Superintendent Kevin Tumelty - South Wales Police, Project leader, TASC

Georgina Wald - BII

Ann Waters - Data analyst, Bristol Police.

Alan Watts - City Centre Manager, Hammersmith

Colin Weston - Deputy Chair of Licensing Magistrates, Cardiff

Janet Witheridge - Deputy Director, Health & Social Issues, BLRA (BBPA)

Professor David Yates - Professor of Emergency Medicine, Hope Hospital, Salford

2 Qualitative Research

Interviews and discussions of both a formal and informal nature were conducted with a wide range of respondents representing the key stakeholders. The principal aims of these were to identify current practices regarding the definition, recording and collating of information on levels and patterns of alcohol-related problems. In addition, the interviews focused on perceived problems inherent in such practices with regard to validity, reliability, accuracy, etc. The final parts of the interviews and discussions were concerned with identifying potential improvements to such systems and their potential for integration with measures of alcohol-related violence deriving from other sources.

We have to say from the outset that, although we expected to find a considerable degree of inconsistency in recording practices, both between the various agencies and in different parts of the country, we were unprepared for the pattern which emerged in the very early stages of the research. Put simply, we have been unable to discover any extant procedures that can provide anything more than rough indications of the level and pattern of alcohol-related violence and disorder in even the most localised contexts. All existing procedures, in our view, have such serious conceptual and methodological weaknesses that they are unable to provide truly objective and reliable data in this context.

We noted earlier that given the imprecise conceptual status of the term ‘alcohol-related’ it is unlikely that any measurement and recording procedures will yield data which are unequivocal. Nonetheless, it is clearly recognised by most of the stakeholders themselves that improvements to existing systems are urgently required if the debate on the patterns of alcohol-related problems is to become meaningful, and if appropriate measures for ameliorating these problems are to be developed and properly targeted.

2.1 Police data

2.1.1 Lack of data

A number of our interviews and discussions with police officers in different parts of the country highlighted the fact that a substantial number of forces and command units keep no records at all of the extent to which certain types of crime are deemed to be ‘alcohol-related’. This was

confirmed by the questionnaire survey data showing an absence of record keeping in this context in nearly 30% of cases (see Section 3.1.1). The lack of data was most evident in Scotland. At a meeting of senior officers from all of the Scottish forces none was able to say that they could provide accurate statistics on alcohol-related crime in their areas.

In the UK generally there was a tendency among a number of police officers to refer to data which related to ‘street crime’ - certain types of assault and public disorder offences. Such crimes were, in their opinion, largely alcohol-related (up to 80%) and changing levels of alcohol-related crime could, therefore, be gauged from such figures. This argument that ‘street crime’ statistics can somehow stand in place of those measuring alcohol-related offences is, however, clearly spurious since the role played by alcohol in these crimes remains unclear. A number of officers, when asked to justify assertions that up to 80% of these offences were attributable in part to the consumption of alcohol, either admitted that it was just a guess or referred vaguely to experience.

This widespread lack of data arose from two main factors. In some cases the consumption of alcohol was not recorded on either report notes or charge sheets. Some custody officers went so far as to claim that it was impossible for them to obtain such information from those in their charge since it would constitute an ‘interview’ - something which they are not permitted to do. In other cases a note of whether an offender had been drinking was made on charge sheets or custody records. The form of the notes, however, was inconsistent and did not involve formal coding, making collective data impossible to retrieve.

This pattern is very similar to that observed in the original *Drinking and Public Disorder* project conducted over 10 years ago. In the majority of cases we found it impossible to obtain meaningful indications of how many offenders had consumed significant amounts of alcohol prior to their offending without hand sorting paper records and notes. Even then the variations in notes provided by different officers made objective evaluation difficult.

A number of senior officers and licensing officers accepted that the current situation was unsatisfactory for a number of reasons. The lack of data, for example, made policy decisions regarding proactive policing of certain areas very difficult. In other cases they referred to the difficulty of evaluating their own initiatives aimed at curbing alcohol-related crimes. In the Isle of Man, for example, the inspector who had worked to support the recent relaxation of licensing hours on the island was concerned that it would be very difficult to demonstrate the true benefits of such ‘liberal’ approaches in the absence of objective data.

2.1.2 Inconsistent data

While it is true that a majority of forces and command units did keep records of one sort or another concerning the involvement of alcohol in offending, it was difficult to detect any consistent pattern in such recording. This, again, was acknowledged by police officers themselves:

“There is a definite lack of standardisation. There is no common reporting system for all police forces, so data are not collated in a reliable way.”

This sentiment has also clearly been expressed by HM Inspector of Constabularies in the *On the Record* report. This notes that, in an earlier report, *Review of Crime Recording Procedures* (1996), many forces had no identifiable individual with responsibility for crime recording. Four years later, little improvement in this area was observed. These serious inconsistencies in crime recording generally are greatly magnified in the area of alcohol-related crimes where there is not even a commonly agreed means of defining and subsequently noting such types of crime.

The only exceptions to these inconsistencies arose when alcohol consumption was part of the formal definition of the crime itself - e.g. drink-driving, drunk and disorderly, etc. In these cases there is a formal code to identify the crime that can be entered quite simply on existing reporting forms and computer database input screens. Alcohol-related violence and disorder, however, has no such formal code and many reporting systems are not designed to enable recording of this information.

2.1.3 Measuring and recording tools

Many of the problems noted above derive not only from the lack of clear responsibility for maintaining accurate records of alcohol-related crime, but from the lack of usable recording systems. Many command units employ distinctly dated computer systems such as PAYFEC and Blue 8, described succinctly by a number of people we spoke to as “crap”. These often include GIS mapping routines for the identification of ‘hot spots’ of offending. They are, however, relatively poor data analysis tools because of their inflexible formats. (One police force had been able to purchase only one half of a system, the part which produced GIS maps, but not the one that enabled any other data analysis at all.) This means that, even if there is systematic recording of alcohol-related crime data at a local level, retrieving such information for subsequent analysis and reporting is far from straightforward.

The need for more ‘user-friendly’ computer systems, shared by all police forces, which would enable more systematic recording of relevant data, was identified by the large majority of officers with whom we spoke. We return to this subject in Section 2.3.5.3.

2.1.4 Lack of resources

Police officers frequently referred to the lack of resources as the main reason why reliable data on alcohol-related offences were often unavailable.

“The ability to record data will depend on resources, and it’s unlikely that these will increase.”

Lack of manpower and high staff turnover were seen as directly responsible not only for the lack of maintenance of adequate reporting systems but also for the failure to obtain relevant information in the first place. They referred to ‘time lags’ in the transfer of data within the organisation and inefficient inter-departmental communication systems. Many patrol officers, for example, with first-hand information about the contexts and nature of alcohol-related incidents, were often prevented by time constraints in passing this on to those responsible for more formal crime recording. Shift patterns within some command units also made ‘hand-overs’ of relevant information problematic.

2.1.5 Problems of definition

It was clear from the research that police officers differed widely in what they felt was meant by the term ‘alcohol-related’. Some thought that the term should only be applied if alcohol consumption was ‘relevant’ to the offence. This, however, begged the question of what was meant by ‘relevant’. Others saw the term as applying to all crimes where the perpetrator or the victim or both had consumed alcohol. Yet another group thought that ‘alcohol-related’ applied when an offence was committed by someone who was drunk.

This lack of consistency regarding definition leads to further inconsistencies in recording of crime. In some cases arrest records include a ‘Sober’ / ‘Had Drink’ / ‘Drunk’ category box. Others simply had a tick-box marked ‘Alcohol’ while some required a free text entry if prior drinking was to be indicated. Elsewhere, other sources of ambiguity were evident:

“The current form which is submitted upon the arrest of an individual has a tick box which states alcohol, yes or no. This is ambiguous as officers tend to tick yes if it’s theft of a bottle of beer and to damage of an off-licence window for example. New forms expected 2001.”

None of the definition and recording procedures that we encountered made any reference to the causal role of alcohol. As one officer put it:

“Unless the offence is specific to drinking - i.e. drink-driving - it is very difficult to quantify the effect of alcohol as a causation factor.”

Most officers felt that simply recording whether an offender was inebriated was about the best that could be done. Anything else would require unacceptable time and effort and rely ultimately on the ‘judgement calls’ of individual arresting officers. None thought that it would be possible to establish any degree of consistency in such judgements. As one senior officer put it:

“A large amount of data rely on judgment calls of individuals and so are not always accurate or standardised. The best system in the world would be defeated by this. Bobbies are not good at judgment.”

The most senior officers we interviewed tended towards the most pessimistic prognoses for developing more meaningful definitions and subsequent recording of alcohol-related crime. There was a consensus that simply obtaining a reasonably objective assessment of whether or not an offender was ‘under the influence’ was probably the limit of any procedure.

2.1.6 Data loss and distortion

Many police officers emphasised that much data relating to alcohol-related offences was ‘lost’ at one point or another. Firstly, many alcohol-related incidents are never reported to the police in the first place and so no possibility of recording exists. This ‘hidden’ figure is impossible to quantify, although a number of officers thought that the recorded data might represent only 10% of all alcohol-related violence and disorder. Drunken violence within the home was thought to be particularly prone to under-reporting.

There was also a number of ways in which data on alcohol-related offences can be lost even when such offences have been reported to the police. In the past there has been a tendency within some police forces to ‘overlook’ a number of reported crimes when, for example, the offender is not apprehended, or when a complaint is not pursued. This practice was criticised by the HM Inspector of Constabulary, Keith Povey, in his July 2000 report *On the Record*. He was quoted¹⁾ as suggesting that many police forces massaged their crime figures and detection rates to ‘put them in the best possible light’ and called for an end to the practice.

While this source of data loss has been largely remedied, some rather spurious increases in alcohol-related violence and disorder have appeared in reports generated from police statistics. A senior Lancashire Constabulary officer, for example, was of the view that, prior to the Povey report, up to 20% of all reported alcohol-related incidents had gone unrecorded because they never reached the stage of being defined as crimes. Unsurprisingly, therefore, figures generated using the new system, which includes such reports, appear to indicate an apparent rise of around 20% in alcohol-related

1. ‘Police told not to massage crime rate’, *Guardian*, August 1st 2000

offences in many parts of the country. The fact that these ‘illusory’ rises have been used by some police forces to justify policy and strategy changes is clearly regrettable.

Other sources of data distortion arose from changes to operational procedures in some police forces. In a few cases, for example, proactive policing policies had been introduced to intervene in drunken and rowdy behaviour in town and city centres at an earlier stage. This often involves making arrests for relatively minor offences (which previously might have been overlooked) with a view to preventing more serious incidents occurring later in the night. The net result of such procedures, however, has been an apparent increase in alcohol-related minor assaults and public order offences.

As we noted earlier, crime statistics obtained from police forces always reflect policing policy as well as patterns of criminal behaviour. It is difficult to see how this factor could ever be removed from data sources or even controlled for in any systematic way. Local policing strategies must always be guided to some extent by local conditions and issues. Indeed, one of the most useful functions of data on alcohol-related offending is to guide such policies and ensure targeted police responses. We return to this issue in Section 4.

2.1.7 Agenda-driven data

There was an implicit recognition by a number of police officers that the extent to which alcohol-related crime data were obtained and recorded depended on a number of ‘policy’ factors. The point noted above regarding the interpretation of apparent increases in alcohol-related violence is one clear example of such agenda-driven use of data.

In other cases it appeared that in a few police forces and command units the encouragement to record and collate data in the first place derived from, for example, a determination to ‘crack down’ on certain licensed premises or to demonstrate the need for increased resources. It also appears that in at least three cases the figures relating to alcohol-related offences have only been collated and published in order to support oppositions to new liquor licence applications.

While the development and use of police statistics for such purposes may be justified on a number of grounds, the practice strongly mitigates against the potential for standardisation of recording and reporting practices. The integration of data at regional and national levels can only be achieved if they are obtained in a routine and systematic manner and are demonstrably independent of the uses to which they might be put. We discuss this issue further in Section 4.6.

2.1.8 Licensed premises data

Recording and collation of data relating to offences committed in or near to licensed premises was conducted by the majority of police forces and command units that we visited. This is also borne out by the questionnaire data (see Section 3.1.7). A number of the recording systems also used GIS mapping programmes, allowing easy identification of ‘hot spots’ and particularly troublesome venues. In most cases the licensing officer was responsible for obtaining and collating this type of information, ensuring a degree of consistency over time and standard practices within a command unit.

These data, however, while considerably more detailed and systematic than those relating to alcohol-related offences in general, are still not without problems. Firstly, there is often no direct way of telling whether the offences to which the data relate did, in fact, involve alcohol consumption. The fact that they occurred in or around licensed premises may suggest that they were more likely to be alcohol-related to some degree, but some offences clearly might not be so related.

A second problem, noted by a number of senior police officers, arises from the source of the data. This is often in the form a crime report which has the location of the incident noted. If a licensed premises is mentioned in the report, it is collated by the licensing officer. In a number of cases, however, it is unclear whether the offence was in any way related to the nearby premises or, indeed, was alcohol-related in any way. In town centres on Friday and Saturday nights the easiest way to describe to the police where a disturbance is occurring is to refer to easily available landmarks - e.g. the pubs and clubs which occupy much of our urban centres. (We note in passing

that in giving directions to the SIRC office we describe it as being next door to the Angel and Greyhound pub.)

A further problem was identified by a number of police officers which arose even when a reported offence occurred within licensed premises or by people entering or leaving the premises. This was to do with the readiness of management to report such offences in the first place. It was generally agreed that the best-run premises were not necessarily the ones which appeared to have fewest incidents of violence and disorder, but those where the management was prepared to liaise effectively with the police to deal responsibly with such incidents. Less responsible operators might simply ‘deal’ with the offenders themselves rather than reporting them to the police. The distortions created by these factors may be quite substantial. Where data collated by licensing officers are used to create a ‘points system’ for pubs and clubs, providing material which the police might use at licensing sessions, there are clear disincentives for some operators to report incidents of violent or disorderly behaviour to the police.

Other sources of data relating to incidents in and around licensed premises are sometimes collated from arrest reports when those charged with alcohol-related ‘street offences’ were asked where they had been drinking. The reliability of these, however, was also questioned by a number of police officers and even some licensing officers themselves. The temptation for offenders to ‘mislead’ the police with regard to their local drinking places is clearly present.

2.1.9 Recommendations

Many police officers, particularly when speaking ‘off the record’, were highly critical of the procedures employed in gathering data on alcohol-related offences. Several acknowledged that their own figures could not accurately reflect the ‘real’ problems that they faced in routine policing activities and saw an urgent need for more reliable and integrated recording systems. A number of senior officers, however, felt that this would not be achieved without firm directives from ‘on high’:

“A Home Office initiative requiring all police forces to supply information in a standard form is required if we are to get meaningful figures.”

Others emphasised the desirability of consistency between police forces:

“Any system for recording and collating [alcohol-related crimes] should be standardised nationally to enable direct comparisons to be made. It can then act as a barometer of change to gauge the effect of initiatives.”

“We need more standardised computer records with a specific, mandatory field for entry of details about drinking.”

In addition to such standardisation, however, some officers pointed out the need for better assessments of the role of alcohol and clearer definition. One, for example, suggested that the concept of ‘alcohol-aggravated’ offences might be more meaningful than the current notion of ‘related’. Others felt that more qualitative information regarding either a victim’s or an offender’s drinking prior to incidents would be more helpful than a simple tick box, providing courts and other agencies with better insights into the role that alcohol might have played.

In addition to specific ideas for improving the value of alcohol-related offence data a number of officers pointed to the need for integrating more fully better recording methods into operational procedures. Not only should there be more reliable figures, but they should be used in more intelligent ways. Proper analysis of the data on, say, a weekly basis, should be used to guide the deployment of resources, activities of licensing officers and proactive approaches to identified trouble spots.

2.1.10 Empirical studies

There are few empirical studies that have examined levels of alcohol consumption among persons detained by the police. Perhaps the most significant and relevant is the Home Office-funded study by Graham Robertson and his colleagues at the Institute of Psychiatry in London². This focused on offences of drunkenness, but also assessed the states of intoxication of those arrested for a number of

2. Robertson, G. et al. (1995) Drunkenness among police detainees. *Addiction*. 90:793-803

“...there are currently 18 different opportunities to record data relating to the prior alcohol consumption of patients and 26 different ways to record it.”

“...it was seemingly possible to enter data relating to alcohol consumption, but not get it out again.”

other offences in a Metropolitan Police district. The assessments were based on visual examination and, therefore, subject to some degree of error. The results, however, are most interesting. Of a total of 186 offenders charged with assault, only 15% were judged to be suffering from any alcohol impairment and only in 5% of cases was there any ‘definite’ or ‘major’ impairment. The proportions were higher for grievous bodily harm, with 31% impaired to some degree by alcohol consumption and 14% suffered from ‘definite’ or ‘major’ impairment.

These findings raise a number of important issues. While the methods used in the study may be seen as rather ‘unscientific’, they are little different from those employed by the majority of police officers. It is also important to note that Robertson and his colleagues were not simply measuring whether offenders had consumed any alcohol prior to their arrest, but rather whether such consumption had resulted in any degree of obvious impairment of cognitive or motor functioning. In Section 4.5 we discuss more fully the implications of the two types of measure in establishing the role of alcohol in patterns of offending.

2.2 Accident and emergency data

While there is currently no formal directive that police forces record and collate data on alcohol-related issues, there is even less requirement for accident and emergency (A&E) departments to do so. Nonetheless, the telephone survey of A&E consultants showed that the large majority do, in fact, record information about patients’ alcohol consumption either on a routine or case-by-case basis (See Section 3.2.1).

2.2.1 Perceptions of alcohol-related problems

A&E consultants were deeply divided in their views concerning the extent to which alcohol consumption was a factor in the aetiology of injuries. Some were of the view that the majority of injuries treated on Friday and Saturday nights resulted, either directly or indirectly, from states of intoxication. Some put the proportion as high as 70% or more:

“We have recently calculated that over 75% of trolley cases are alcohol-related.”

Others, however, took a very different view:

“Everyone has the impression that A&E is swimming with drunks on a Saturday night, it’s not really that bad.”

“A figure of 70% is rubbish. Maybe 60% have drunk alcohol but they have not been involved in violent incidents - maybe it’s a pedestrian knocked over - all are lumped together as alcohol-related, but this is not a meaningful figure.”

These variations in perception could not be explained in terms of the regional settings of the hospital departments or the local populations that they served. Rather, the views seemed to reflect more the types of recording practices employed and the forms of data presentation. It was our clear impression that A&E consultants who made the highest assessments of the number of cases that were alcohol-related tended to have what were, in our view, the weakest recording procedures.

2.2.2 Variations in data collection

There was widespread variation in terms of the measurement of alcohol consumption, the point at which assessments were made (and by whom) and in the manner in which data were recorded. In some hospitals assessments were made by nurses at the triage stage. Elsewhere assessment of prior drinking was made by doctors or consultants, often some time after admission.

At a recent meeting of A&E professionals at senior executive level in Lewisham it was identified that there are currently 18 different opportunities to record data relating to the prior alcohol consumption of patients and 26 different ways to record it.

2.2.3 Variation in definitions

The definition of an alcohol-related injury was seen as problematic by a number of clinicians. The simple fact that a patient might have been drinking alcohol prior to their attendance at an A&E department was seen by many as being insufficient to establish the notion of ‘related’:

“Do you put in ‘alcohol-related’ if someone has had a glass of wine with a meal or when behaviour has been altered by alcohol? Doctors need to be more accurate when defining an injury as being ‘alcohol-related’.”

Other consultants, however, insisted that all one could do was use an objective measure of whether alcohol had been consumed - anything else would involve subjective judgements. In some cases the location of the incident which led to the injury was seen as the defining factor. If the injury had been sustained in or near licensed premises then it was reasonable to class it as alcohol-related. Other A&E consultants disagreed strongly with this approach, with one describing it as ‘quite mad’.

There was also considerable disagreement concerning whether the injury to a sober A&E attendee inflicted by a drunk assailant should be classified as alcohol-related. Many consultants viewed their obligations as being solely directed toward the patient and his or her well-being. They were not police officers and, thus, such antecedents of the injury or the state of the assailant were not their concern. Others, however, felt that in order to compile meaningful records details such as these should be ascertained.

2.2.4 Variations in measurement

The forms of assessment varied from simple inspection - e.g. ‘smells of alcohol’ or ‘slurred speech’ - to the use of diagnostic tests (CAGE, PAT³, etc.) and alcometers. Recording procedures similarly varied from written notes to designated field entries on computer records.

The use of BAC estimates such as breath tests was seen as very controversial by the large majority of A&E consultants. In two departments such testing was conducted routinely as part of normal admissions and diagnostic processes. One consultant said that taking a breath test was just like measuring blood pressure. Elsewhere, however, consultants thought that patients would resent BAC testing and some even thought it might raise legal and human rights issues. From research evidence⁴, however, it is clear that few patients actually refuse alcometer tests and such

tests, some consultants argued, are essential for distinguishing between intoxication and head trauma.

2.2.5 Variations in recording procedures

The use of tick boxes to record the presence of alcohol, either on written forms or, more frequently, computer input procedures, was the more common approach in A&E departments. Here, however, there were further sources of inconsistency. In some cases the box could be ignored if it was felt to be not relevant, while in others a positive or negative response was required in all cases. Some consultants felt that systems in which the alcohol assessment was not required by a compulsory entry often led to underestimations of the number of patients who had been drinking - either because the nurse or doctor simply forgot to enter a code or, pressed for time, ignored it.

In a number of hospitals no formal recording systems were used at all. Instead, the prior consumption of alcohol was recorded only if it was seen as relevant and entered on a patient’s notes.

2.2.6 Variations in data retrieval and analysis

There were one or two systems in operation in A&E departments where it was seemingly possible to enter data relating to alcohol consumption, but not get it out again. A number of other systems had very limited analytical procedures and were primarily oriented around the retrieval of individual case notes.

“Our current computer system does not allow us to access data as a whole, only individual records. So we are not able to view alcohol-related attendances as a group.”

“At the moment our computer system contains masses of data, but no meaningful analysis. A more advanced system would allow more effective access to our data.”

With computerised note systems it was sometimes possible to retrieve data by free text searching for terms such as ‘alcohol’, ‘drinking’ etc. In most cases, however, this was difficult and rarely were analyses of this type conducted.

3. CAGE is an assessment questionnaire developed by the Bowles Centre for Alcohol Studies, University of North Carolina. PAT is Paddington Alcohol Test.

4. Yates, D.W. et al. (1987) The detection of problem drinkers in the Accident and Emergency department. *British Journal of Addiction*, 82:163-176

“...collating and analysing the data will require not only improved computer software but also staff with time to undertake such tasks.”

2.2.7 Resource limitations

Many A&E consultants and doctors referred to limited resources as a reason for limited data recording and/or analytical procedures.

“We do have a computerised records system but we don’t have the resources with which to accurately record and input alcohol-related attendances.”

“Resources are already stretched - if you want to collect more data you need to pay staff more - needs leadership to ensure accurate and reliable data.”

“At present, it would be impossible to get the nurses to do more and so I would question the reliability of data collected by triage. A possible way of initiating data collection systems would be to contract individuals for that specific task - run these as pilot schemes. The problem arises that once staff have been upgraded then they can’t then be downgraded.”

Other consultants pointed to the relatively high levels of staff turnover in A&E departments as being an obstacle to developing more reliable recording systems:

“A major problem with data collection is staff turnover. The department has 20 to 30 full-time doctors who tend to change over every 6 months. No sooner has one brigade been trained to diligently collect data, than the team moves on and data become inconsistent.”

It was quite evident from these and other comments from consultants and from our own observation of activity in A&E departments that the development of more accurate, reliable and meaningful data on alcohol-related injuries will have some resource implications. While the task of recording data may be accommodated within existing triage and diagnostic procedures, collating and analysing the data will require not only improved computer software but also staff with time to undertake such tasks.

2.2.8 Violence against A&E staff

There has been considerable publicity in recent years regarding violence and aggressive behaviour by intoxicated A&E attendees directed towards staff in those departments. In our interviews with consultants and doctors, however, this issue was rarely seen as being of particular significance. Some consultants mentioned that staff sometimes received verbal abuse from drunks and, on occasions, threats of violence. Physical assaults, however, were very rare. Attendees who had consumed drugs rather than alcohol were generally seen as presenting a greater risk.

2.2.9 Information sharing

A&E consultants again varied widely both in their motivation to share data with the police on alcohol-related injuries and concerning the ways in which this might be done. A number of consultants felt that only in cases where serious crimes appeared to have been committed should doctors release information to the police. Others, however, felt that a more cooperative role in data sharing could help to tackle some of the root causes of the injuries that they saw on a regular basis.

This sharing of data to tackle specific problems most often took the form of identifying specific pubs and clubs which were associated with a disproportionate level of injury or intoxication:

“I have personally telephoned police about a succession of underage girls who were drinking too much. All came from same pub, which has now been closed. I saw 16 in a period of a week - vomiting, bumped heads, minor injuries etc.”

In other cases data-sharing with the police was conducted on a more formal basis and there were a few hospitals in the UK where this was done routinely. In most cases the aim was to add to existing police data an indication of the level of alcohol-related violence which had been unreported and undetected in order to provide more comprehensive information. Some of these initiatives had received special funding from government and other agencies. (See also the A&E telephone interview data presented in Section 3.2.)

The issues of confidentiality and data protection regulations were raised by almost all consultants and many were concerned about the implications of the Caldicott Committee report⁵. While some felt that these imposed serious constraints on sharing data with other agencies, others thought that simply removing patients’ names from the records could suffice.

Further discussion on inter-agency data sharing and integration is contained in Section 4.

2.2.10 Recommendations

Many consultants and doctors saw the need for improved methods of recording data on alcohol-related injuries. More efficient and flexible computer systems that could generate data reports in formats compatible with other systems were often mentioned. Virtually all, however, as noted earlier, saw such developments as being difficult to achieve within current staffing and resource levels. A number implied that there were, perhaps, more important things for A&E departments to be doing.

The idea of pilot schemes and/or external audits of alcohol-related injuries, conducted within a sample of A&E departments, was mentioned by a number of consultants - particularly those who had been involved in academic studies of alcohol-related issues. Through these, they felt, one could obtain much more systematic and meaningful data than in even the best of routine, in-house procedures where several different nurses and doctors are responsible for data recording.

We consider these recommendations more fully in Section 4.2.

2.2.11 Empirical studies

In contrast to the very variable and often clearly inaccurate recording of alcohol-related injury data in many A&E departments, a few empirical studies have been conducted which indicate that it is possible to establish more robust procedures.

A study by Little et al. (1980)⁶ involved breath alcohol analysis of patients attending the A&E department of a large teaching hospital during the evening. This revealed that 40% of patients

had consumed alcohol prior to attending and 32% had BACs exceeding the limit for driving.

These figures are of some interest since they are considerably lower than the often quoted ‘70% drunk’ level. The highest levels of intoxication were found not only among the age group that most frequently is to be found in town and city centres in the evening but also among older patients in the 40-49 age category. In fact, the average BAC level varied little across the 20-59 years range.

There were, as we might expect, higher numbers of intoxicated patients on Friday and Saturday nights, but here the maximum was 44% - again contrasting with anecdotal reports of those attending at this time being ‘universally’ drunk.

Studies by Professor Yates at the University of Manchester⁷ provide similar figures. While 60% of all assaulted patients had consumed some alcohol, a significantly smaller proportion (35%) had BACs in excess of 80 mg/100 ml, the upper limit for legal driving.

A recent report by the Scottish Trauma Audit Group (STAG) analysed data relating to alcohol consumption by a large sample of A&E patients attending between 1994 and 1996. The assessment of alcohol consumption was more subjective than in the Little *et al.* study, often relying on clinical examination, and no BAC levels were reported. It was found that 26% of all injuries had been preceded by alcohol consumption. The age group most likely to have consumed alcohol prior to injury was 40-49 years and males were more highly represented than females. These proportions, however, increased significantly on weekend nights, reaching a maximum of 52%.

The STAG study, like that of Little *et al.*, again indicates that even basic measurement of alcohol consumption levels and unsophisticated analysis of the data can generate useful information which is much more consistent than the anecdotal reports of consultants and nurses. Alcohol is clearly highlighted as a factor in the aetiology of injury, but at a lower level than many might imagine.

5. The Caldicott Committee: *Report on the review of patient-identifiable information*. Department of Health, 1997

6. Little, K. et al (1980) Alcohol and the emergency service patient. *BMJ*. 281:638-640

7. Yates, D.W., Hadfield, J.M., Peters, K. (1987) Alcohol consumption of patients attending two accident and emergency departments in north-west England. *Journal of the Royal Society of Medicine*. 80: 486-489

“...just tackling the alcohol component does not always lead to significant change in the level of the crime itself, only the extent to which the crime is alcohol-related.”

The sharp increase in alcohol consumption among attendees at weekend nights, shown in both of these studies, has to be considered in the context of alcohol consumption levels among the populations as a whole at these times. We should note here the finding of Jonathan Shepherd⁸ that young male victims of assault may not be distinguishable from other young males on the basis of habitual or binge alcohol consumption. This is an issue which we consider in Section 4.5.

2.3 Crime reduction partnerships and projects

Crime reduction partnerships (CRPs) have been developed in most areas of the country and aim to draw together relevant local agencies to combat crime more effectively. They typically consist of forums of police officers, local authority officials and voluntary agencies. In some areas trade associations, resident's associations and A&E departments are also involved.

A substantial number of CRPs, particularly those in rural areas, had relatively little on alcohol-related crime and disorder. Rather, their efforts are directed towards the particular types of crime which are more typical in the neighbourhoods, which might be anything from shoplifting to sheep rustling. Our qualitative work was directed, therefore, towards CRPs and specific projects where a concern for reducing alcohol-related problems was a dominant focus, leaving a more general survey of CRPs to the quantitative questionnaire study (see Section 3.4).

2.3.1 Types of CRP strategies

From our interviews and discussions it was clear that there were two distinct types of CRP initiative that aimed to reduce alcohol-related violence and disorder. First, there were those initiatives that included broad approaches such as the coordination of Pubwatch and Doorwatch schemes, Door Supervisor registration, etc. Secondly, there were smaller-scale initiatives which relied heavily on local knowledge and increased cooperation between local agencies. Examples of these included responses to hot spots identified by police GIS mapping. In one case moving a late-night kebab van to a different location had resulted in a dramatic reduction in

the number of offences committed in its immediate vicinity. In another city, having refuse collectors remove bottles from public rubbish bins during Friday and Saturday evenings had resulted in a similarly marked effect.

2.3.2 Data-sharing

At a more general level, of course, the CRPs provide a valuable opportunity to exchange ideas and perspectives on alcohol-related problems among the main stakeholders and coordinate activities in sensible ways. Where A&E departments were involved in the partnerships, additional information concerning alcohol-related assaults - many of which might not come to the direct attention of the police - became available.

In very few cases, however, were we able to identify any significant sharing of quantitative data on alcohol-related problems within the partnerships. In one city plans were being made by the CRP for combining available A&E and police data in a single report as a way of monitoring the effectiveness of specific initiatives. Elsewhere there were some attempts to use police data in more meaningful ways - e.g. directing planning and environmental considerations. In most cases, however, there were either no objective data available within the CRPs or what data there were did not relate in any direct way to the activities of the partnerships.

Members of CRPs, however, argued that, while numerical data might not always be available, the sharing of local knowledge, perceptions and views by participants in the partnerships enabled more 'intelligence-based' initiatives to be undertaken. They also tended to view this as adding to the potential to evaluate the effectiveness of both large- and small-scale initiatives (but see Section 2.3.4 over).

2.3.3 Best practices

In the past the CRPs have tended to set their own agendas and pursue their own targeted initiatives. This, indeed, is still the case in many areas. There are, however, now more clearly defined guidelines issued by the Home Office.

The Crime Reduction Toolkit, for example, offers extensive advice to CRPs and provides an indication of best practices and a focus on violent crime is seen as being one area of best value and is strongly encouraged. The increased uptake of such guidance should lead to greater uniformity in partnership composition and activity, while still enabling a focus on specific, localised issues.

2.3.4 Evaluation of CRP activity

It was striking that very few of the members of Crime Reduction Partnerships with whom we met described evaluation procedures which involved truly objective methods. Some referred to police data concerning alcohol-related crimes, but conceded that these were rarely used in a formal evaluation context. Most relied on internal and often quite subjective assessments of the effectiveness of initiatives provided by the members of the CRPs themselves. This picture was confirmed by the questionnaire survey (see Section 3.4.5) with fewer than 20% of partnerships setting measurable performance targets.

Where objective evaluation of CRP initiatives was undertaken using, for example, police crime statistics, further problems were evident. Principally, the design of the CRP programmes and the evaluation studies were such that it was difficult to demonstrate that any changes in levels of offending were directly attributable to the CRP initiatives.

This point concerning the proper design of evaluation studies is cogently made in the excellent paper by Michael Hough and Nick Tilley at the Home Office Police Research Group. While they focus on in-house police evaluations their points apply equally to evaluation of CRP effectiveness, where the procedures are, in fact, mostly carried out by the police as members of those partnerships. They noted that:

“Even when real changes in crime occur, accurately attributing cause and effect is hard. Minimally, one needs some form of comparison groups against which to compare trends in the crime problem, and some form of circumstantial evidence about the mechanisms which brought on the effect. Where a fall in crime can be

attributed to a preventative strategy, some checks are needed to see whether the crime has simply been displaced across place, time or offence type.”
(Hough and Tilley, 1998:39).

The points made by Hough and Tilley are particularly relevant in the context of evaluations of initiatives aimed at reducing alcohol-related crimes. In some cases it appeared that the focus was not so much on the crimes themselves, but on the extent to which they were alcohol-related. The point here is that just tackling the alcohol component does not always lead to any significant change in the level of the crime itself, only the extent to which the crime is alcohol-related.

A good example of this effect was observed in a study by MCM Research in 1990, commissioned by the Home Office and the West Midlands police. A bye-law prohibiting drinking in public was introduced in June 1989 in Coventry - the first of its kind in the country. Police data indicated a significant decrease in alcohol-related crimes of violence and disorder following the introduction of the bye-law. The level of the offences themselves, however, irrespective of whether they were alcohol-related or not, had continued to rise at exactly the same rate that would have been predicted from previous trends. It is difficult to see, therefore, what had really been achieved by way of crime reduction.

The large majority of CRPs, of course, are not concerned with alcohol-related crime *per se*, but with a wide range of patterns of offending. Evaluations of their effectiveness, therefore, are unlikely to be quite so distorted as that of the Coventry bye-law. Nonetheless, it was clear from both our qualitative and quantitative research that more professional and scientific evaluation methods need to be employed in order to determine their effectiveness in tackling, among other things, alcohol-related violence and disorder, and to identify the specific 'best practices' in this area.

8. Shepherd, J.P. et al (1989) Alcohol consumption among victims of violence and among comparable U.K. populations. *British Journal of Addiction*. 84:1045-1051

“...we are surprised that a project of this scale (£900,000) did not have objective evaluation procedures built in to its design from the outset.”

2.3.5 Specific projects

In addition to activity of the several hundred CRPs around the country a number of projects have been developed which focus specifically on alcohol-related violence and disorder. These, like the broader CRPs, involve partnerships between a variety of agencies. Notes on examples of projects that we visited in the course of our research are provide below.

2.3.5.1 Project Amethyst

This project aims to reduce both the incidence and fear of violent crime and disorder associated with the misuse and abuse of alcohol within the county of Cornwall and the Isles of Scilly. It received substantial funding (£900,000) from the Government’s Crime Reduction Programme.

The principal partners in this project are the police, probation departments, youth service, youth offending team, health workers, together with other bodies and agencies.

The police maintain a searchable database of alcohol-related offences and prior to the start of the project claimed that 63% of all persons arrested between the ages of 18 and 34 were under the influence of alcohol. Details concerning the measurement of such ‘influence’ were not provided.

Project Amethyst has set as its target a reduction by 30% of violent crime committed by identified repeat offenders in licensed premises. It also seeks to reduce the number of violent crimes committed in public places between the hours of 10 pm and 4 am by 10%. Further objectives include a reduction in criminal damage and the number of repeat referrals to A&E departments by chronic drinkers.

Included in the list of ‘proposed targets’ is the rather confusingly worded: ‘Develop a set of appropriate multi-agency targets to monitor the impact of the project to alcohol related issues’. In the most recent project report, however, we find the statement:

“... we now await a decision concerning the funding of an independent research programme into the effects of Project Amethyst, as the project will no longer be centrally evaluated.”

We have to say that we are surprised that a project of this scale did not have objective evaluation procedures built in to its design from the outset. It would seem that if additional funding for such purpose is not forthcoming it will be extremely difficult to learn any lessons or identify potential best practices from what is otherwise a valuable project.

2.3.5.2 TASC

‘Targeting Alcohol-related Street Crime’ is a project focused on the city centre and bay areas of Cardiff. It is operated by a partnership of South Wales Police, Cardiff County Council, the A&E department, licensing magistrates, licensees forum and others. The project employs the services of a support nurse who conducts follow-up interviews with attendees at A&E whose injuries were thought to be alcohol-related. It also has a dedicated data analyst who is responsible for collating data and presenting reports.

The main aims of the project are those of “implementing and evaluating various measures designed to a) reduce levels of violence, b) increase the chances of violent offenders being brought to justice and c) increase access for victims to Victim Support and mental health services”.

A further element of the project is to identify the extent to which police data under-represent the true scale of alcohol-related violence. For this purpose, there is close data-sharing between police and the A&E department. This appears to show, according to one source within the project, that police are aware, either through crime report or arrest data, of 86% of all attendance at A&E for alcohol-related injuries. Some other sources, however, suggested that the figure was rather lower. There is, however, some doubt cast by TASC’s data on the claim by Jonathan Shepherd (Shepherd *et al.*, 1989) that as much as 75% of all alcohol-related violence is undetected by the police.

TASC serves as a very useful model of focused inter-agency cooperation and intelligent use of data. There is, however, a major obstacle to evaluating its effectiveness that was not identified at the outset. The number of licensed premises in Cardiff has increased quite substantially in recent years, resulting in larger numbers of people

frequenting the city centre on Friday and Saturday nights. No accurate measures of the changing population sizes are available. This means that it is very difficult to interpret the statistics of alcohol-related violence and disorder collated by the data analyst. Increased numbers of people will inevitably result in increased numbers of crime since there are more people available to be either the perpetrators or victims of crime. (For this reason it always necessary to express crime figures as a proportion of population.)

In a recent TASC report this inability to undertake empirical evaluation is quite evident in the ‘General Synopsis and Discussion’ section:

“In the light of the evidence discussed it is reasonable to tentatively conclude, despite raw figures suggesting otherwise, that the interventions implemented by TASC have had a relatively positive effect on alcohol-related incidents of violence and public order.”

This is clearly, to a large degree, akin to guesswork. In the absence of comparable data from prior to the beginning of the project to the present time, no objective evaluation can be undertaken. And for data to be comparable the sizes of the population at whom the TASC initiatives are directed need to be known.

Another obstacle to evaluation which is evident in the case of TASC is presented by initiatives which seek to encourage people to report alcohol-related incidents to the police, including those attending A&E departments. If the initiative is successful then police figures based on such

reports will appear to show a rise in alcohol-related crimes. It is very difficult, therefore, to evaluate the success of parallel initiatives aimed at reducing alcohol-related crimes since one cannot identify which of the reported incidents would have gone unreported prior to the implementation of the initiative.

2.3.5.3 Project Jupiter

This project, *Joined Up Partnerships in the East Midlands Region*, is a Government Office for the East Midlands initiative to create a data exchange and crime mapping network across 40 East Midlands partnerships. It is focused primarily on ways in which data can be recorded, collated and shared between agencies involved in crime reduction initiatives. In this regard it relies heavily on the work of Stephen Radburn, *Data Exchange and Crime Mapping*.

The project has examined the priorities of CRPs in the East Midlands region and at a national level with a view to identifying what data sources are required in order to target initiatives most effectively. We can see from Figure 2.1, taken from *Feasibility Study for Information Exchange - Final Report*, that alcohol-related violence and disorder ranked as a priority for over half of CRPs. However, in Figure 2.2, derived from a survey of CRPs conducted by Project Jupiter, only 15% of partnerships receive data relating to this type of crime.

Commenting on the current state of data availability and reliability the Project Jupiter report concludes:

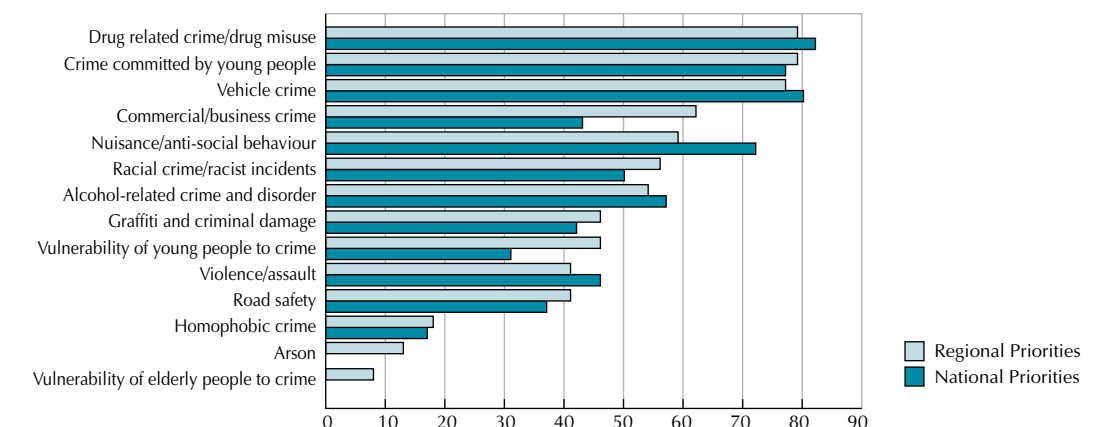


Figure 2.1 National and Regional Strategic Priorities set in 1999 (Source: PRCU)

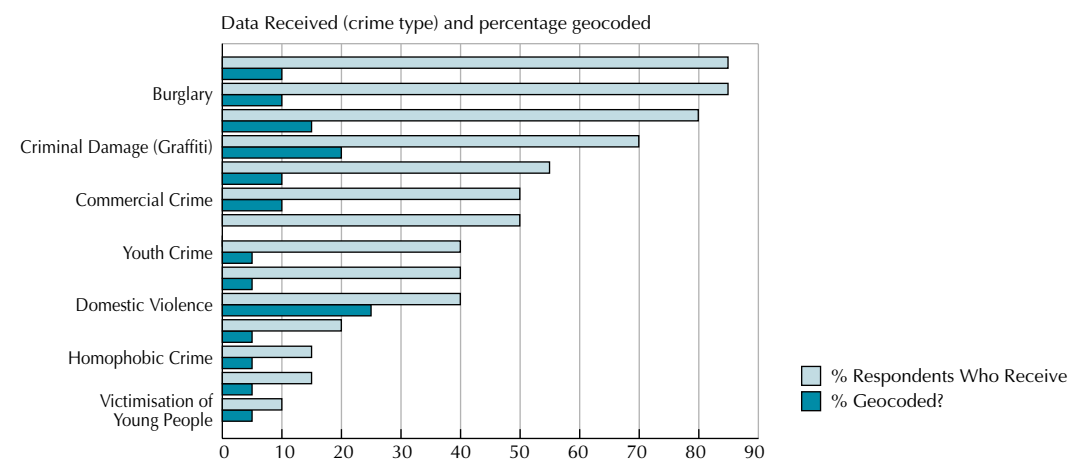


Figure 2.2 Data Received (by Crime Type) and Percentage Geocoded

“The lack of data availability questions the degree to which strategic decisions reflect the real issues facing partnerships. Much of the data collected by partnerships are incompatible owing to differences in time periods, geography (coterminosity) or data format (both unit of collection e.g. beat, ward and media e.g. electronic, paper) Partnerships need to collect benchmarking data in addition to local data with significant potential for unnecessary replication of effort across a region. By empowering local ownership of the data collection and analysis process you also encourage diversification - while this might be applauded in conducting audits, it has significant implications for developing common data exchange and G.I.S.”

By way of remedy for the current fragmented approach to data collection and sharing the report proposes:

“An alternative solution would be for all the Partnerships/County councils involved to access a single server running a single copy of the required applications by modem dial-in with all users sharing a central data repository and software. This will then eliminate the need for data transfers as all updates will be applied directly to the central database and allow the whole application to scale according to future demand. The central database can be configured to allow each partnership to view/update their own data or even allow them to view each of the other partnerships data.”

Project Jupiter represents a very significant advance in thinking about the ways in which data can be ‘cleaned’, distributed and used more effectively in the evaluation of crime reduction initiatives. Ultimately, however, the value of systems designed to achieve these ends will depend very much on the quality of data which is entered in the first place. Given that the definition of alcohol-related violence and disorder is not without significant problems, inaccurate or irrational measurement of such crimes will not be remedied by even the most sophisticated of shared data servers.

2.3.5.4 Project LION

This project (London Information On the Net) is currently at the ‘proof of concept’ stage and has focused almost entirely on the Borough of Lewisham. A further five London boroughs have now been included.

The project again seeks to facilitate the exchange of crime data between the relevant agencies. The aims are:

- to define how to achieve joined-up working
- to specify what data are required to support joined-up working
- to house those data in a database

The partners involved in the scheme are police, probation officers, healthcare workers, social services and others concerned with crime reduction.

On our visit to Project LION at New Scotland Yard the main benefits of the project seemed to be the integration of several data sets relating to crime or injuries in a particular area, aided by mapping programmes. One could examine, for example, ‘hot spots’ indicated by police data, ambulance reports and other sources of information.

While the project exists primarily as a demonstration of what might be achieved through data sharing in this way, it has already shown that agencies which are sometimes reluctant to pass their data on to others can be persuaded to do so by the merits of a system that has several built-in safeguards to preserve privacy and anonymity.

The major problem encountered by Project LION is the need for extensive data cleaning and integration of information contained in very different types of database. Software is being developed for this purpose.

At the moment the only source of alcohol-related incident data available to the LION database is that provided by the ambulance service. This, unfortunately, is not the most systematic or reliable of data sets. There is also the problem noted with regard to Project Jupiter of data which might derive from inconsistent or inappropriate measures of, say, the extent to which acts of violence or injuries were alcohol-related.

Despite these problems Project LION indicates the potential to develop much more detailed information regarding alcohol-related crime and disorder than currently exists. The project is to be evaluated by academics at the London School of Economics but no details of the methods to be used have yet been released.

2.4 City and town centre managers

There has been a growing emphasis on the safety of city and town centres over the past 15 years. The development of the night-time economy has contributed to an increased fear of crime and disorderly behaviour. Many centre managers, therefore, are involved in CRPs and other initiatives aimed at reducing street crime, assaults and anti-social conduct.

2.4.1 Perceptions of alcohol-related problems

Managers were generally consistent in their perceptions of the level of alcohol-related problems in their towns and cities. While most recognised that there were problems on Friday and Saturday nights, their greatest concerns were with issues such as retail theft and commercial development. Some saw the rise of the night-time economy as making a positive contribution to their town and city centres, at least in commercial and revenue terms. This consensus is consistent with questionnaire data indicating that most managers viewed alcohol-related violence as being above the ‘medium’ level but rarely in the ‘serious’ category. See Section 3.3.1.

Glasgow is an example of a city centre that has become increasingly fashionable, due in a substantial degree to the expansion of the ‘night-time economy’. The style of drinking establishments and the clientele that they attract has changed markedly and the number of licensed premises has increased dramatically in the last 10 years. Such development was again seen as being beneficial, although the problems that it presented were also recognised. A number of managers elsewhere felt that failure to tackle predictable problems of late-night disorder was often due to a lack of resources and police under-manning. In some areas, it seemed, the developments had risen at a pace which had outstripped any increases in such resources.

In Brighton, however, the town centre manager had a rather less sanguine view of alcohol-related problems. He was of the view that half of all violence occurred on the streets of Brighton and felt that most of this was associated with drinking. Despite this, he was in favour of the proposals for 24 hour licensing and felt that more focused initiatives to combat alcohol misuse were the way forward.

2.4.2 Sources of data on alcohol-related problems

Relatively few city centre managers collected statistics on alcohol-related violence and disorder, although some had access to such data through their involvement in partnership schemes. This is consistent with the questionnaire data reported in Section 3.3.3. In a few cases the CCTV camera

“...most managers viewed alcohol-related violence as being above the ‘medium’ level but rarely in the ‘serious’ category.”

operators supplied information directly to managers which included reference to drunkenness and similar incidents. Rarely, however, were such data systematically recorded.

2.4.3 Work with partnerships

All of the managers interviewed in the qualitative research were involved in some degree of work with other agencies and bodies that included a focus on alcohol-related problems. Many were active in Pubwatch and Clubwatch schemes, anti-violence steering groups, restaurateurs’ organisations and similar bodies. Elsewhere there was involvement in local transport initiatives, including those to ensure that late-night drinkers had the means to get home. Some managers saw the ability to empty the town and city centres at night as a critical factor in reducing alcohol-related crime.

2.4.4 Measures to combat the problem

By far the most common strategy supported by town centre managers was the introduction of CCTV systems and their expansion to meet the demands of the night-time economy. Most such schemes were run jointly with the local police force, although quite often staffed by civilians. There was a consensus that police monitoring of the CCTV system was preferable since they tended to be more crime aware as a result of their experiences on the beat. Lack of police resources, however, meant that it was often impossible to release officers for such duties.

While the introduction of CCTV was generally thought to have a positive effect, few town centre managers could provide data to support such a claim. In many cases no evaluation had been undertaken at all.

In one case (Oxford) evaluation had been undertaken by an independent researcher at Oxford Brookes University. He noted the commonly experienced effect of an apparent rise in street crime immediately after the installation of the cameras. This, however, is most easily attributed to the increased detection of crime that the system provides rather than any change in the level of criminal behaviour itself.

A particular focus of the evaluation study was on

the extent to which CCTV systems reduce the levels of fear of crime in city centres. The logic is that people will feel safer if they see cameras that they believe might act as deterrents to crime. Examination of people’s fear of crime both 6 months before the installation of cameras and 6 months after, however, showed no significant change. Nor was it possible to conclude that the cameras had significantly increased the detection of crimes and the apprehending of offenders. The issue of geographical displacement of crime, often used as a criticism of CCTV systems, was also not included in the Oxford evaluation.

2.5 The Netherlands

Research in The Netherlands was included in the original study conducted 10 years ago to establish some comparisons with the UK in terms of levels and patterns of alcohol-related problems and the method of tackling them. It is generally thought that the Dutch and the British have similar cultural traditions and styles of drinking and this was evident from our, admittedly limited, research there.

It was partly on the basis of our examination of the liberalisation of licensing hours in The Netherlands that we recommended similar changes in the United Kingdom - recommendations which have now been acknowledged and adopted in the government’s White Paper, *Time for Reform*. The purpose of the more recent visit was to obtain first-hand accounts of current alcohol-related problems and the methods employed to tackle them. We were also particularly interested in identifying data collection procedures and evaluation methodologies.

2.5.1 Respondents

Interviews were conducted with senior representatives of the three main agencies in The Netherlands that are directly concerned with alcohol misuse and violence⁹. These were as follows:

- Wouter Buwalda of the *Landelijk Platform Tegen Geweld op Straat* (LPTGS) (Platform Against Street Violence). He advises the government and provides information on levels and patterns of street violence. This is, of course, a very broad theme and alcohol is just one of many concerns.

- Dr Burt Bieleman of *INTRAVAL* - an independent bureau that carries out social scientific research. The research is concerned with socially relevant questions which demand clear answers in a short time period. The main focus of the bureau has in the past always been on ‘drug nuisance’ - which includes violence, crime and disorder relating to drug use. The department continues to do research in this area. The minister of health, however, has now placed greater emphasis on the role that alcohol plays in violence and disorder, reflecting a shift towards perceptions of alcohol as a public problem more generally.
- Wim van Dalen of the Nationaal Instituut voor Gezondheidsbevordering en Ziektepreventie (NIGZ). The National Health Institute has a specific focus on alcohol-related issues and has recently been centrally involved in the training and certification of all those working in the drinks retail trade.

2.5.2 Perceptions of alcohol-related problems

Wouter Buwalda pointed out that there has been a political shift to the right in The Netherlands in recent years. At the same time a large degree of ‘liberalism’ exists, reflected in the 24 hour opening of shops and bars. There is, he suggests, an increased trend towards viewing these liberal aspects of society as being problematic. Alcohol-related disorder, for example, is now less tolerated, even though there is no evidence to suggest that it has increased either in the last decade or as a result of the more liberal approaches to licensing. He thought that alcohol had now overtaken drugs as a perceived cause of social harm, including violence.

Wim van Dalen generally agreed with Bouwalda’s assessment but stressed that at present it is not possible to tell if there is an actual increase in alcohol-related problems or just an increase in public concern. Nonetheless, he was personally convinced that ‘most individuals who are the source of problems have been drinking a lot’.

2.5.3 Data (un)availability

While van Dalen was clear that little or no quantitative evidence concerning alcohol-related crimes was available to his department (NIGZ), Buwalda (of LPTGS) insisted that the work by

NIGZ clearly showed that alcohol-related crime had significantly increased. He also referred to data derived from police records. There has, however, only been one piece of research conducted and that looked at the amount of police time spent on alcohol-related matters rather than changes in offending rates. We were unable to discover any research which relied on systematic recording of alcohol-related offences.

Buwalda commented that lack of measurement is a common and crucial problem in all crime research but added:

“To me it is not important if the figures are 30%, 60% or 90% - there is an issue anyway - all scientists look for best practices and figures, but in my opinion the effectiveness of measures must always be seen within a social and cultural context of a particular country or population.”

This view was very familiar to us from previous research on alcohol-related issues in The Netherlands. Substantial weight is attached to public perceptions of crime while less attention is given to generating empirical data. Essentially, the notion is that if people think there is a problem, then there *is* a problem and ways of tackling it must be developed.

Dr Burt Bieleman produced a report of qualitative research conducted by INTRAVAL on youth, drugs, alcohol and aggression. The research involved interviews with both customers and owners of bars, cafes, discos, etc. It showed that 15-23 year olds tend to be the highest consumers of alcohol. This is reflected in trends among this age group to have more disposable income and to visit bars more often.

The report also indicated mixed drinks were becoming increasingly popular, as was drinking in the home before going out. There was also reference to ‘fighting intentions’ when going out drinking among males in this group.

Bieleman emphasised, however, that quantitative data was largely unavailable and that which existed was problematic. Police reports, he suggested, were more representative of what the police were doing rather than what was actually happening in bars and on the streets. In addition, very few hospitals record alcohol-related details in any systematic manner.

9. The interviews were conducted in The Hague, Woerden and Rotterdam. We are grateful to Khee Liang Phoa of STIVA for identifying two of the respondents for us and to Simone Hamburg for making all the necessary arrangements for the visits.

He pointed to further difficulties in interpreting police reports, including the inability in many cases to distinguish between offenders and victims in recorded alcohol-related incidents. There was also the problem of subjectivity in recording procedures: 'Who defines *what* as aggressive?' Bieleman also referred to familiar problems in researching alcohol-related violence - it is actually quite hard to *find* violent incidents at night, even when specifically looking for them.

Bieleman noted inconsistencies between what the police measure and record and what they tell the newspapers. Their files, he claimed, contain very little about alcohol- and drug-related violence, yet they readily blame disorder on young people drinking. He gave an example of trouble after a recent football match, instigated by visiting fans, where local people out drinking in bars in the city were blamed.

Finally, he noted that there are very few mechanisms for data collection on a national basis in The Netherlands. The country is much more regionalised than the UK with greater powers being delegated to local government. He is currently trying to encourage these local governments to collect data in formats which will, ultimately, enable a national picture to be established. He noted in this context, however, that some regions would be reluctant to record alcohol-related offences in this way because they were more motivated to have their local policies appear effective.

Wim van Dalen thought that it was not difficult to identify sources of useful data on alcohol-related issues. The new legislation, for example, which requires much more stringent checking of age in bars means that more people are in a position to identify and quantify problems. It was the lack of a clear policy requiring such data to be collected that was the real problem. He suggested that it would be quite easy, given the political will, to require hospitals to collate the information many already have on the alcohol level of patients on admission. 'We will be more able to confront and solve problems when we have better figures.'

2.5.4 Tackling the problems

As noted above the minister for health affairs has increased the enforcement of existing legal measures such as those relating to the serving of intoxicated people and under-age drinkers. The latter is a special priority given the increased level of alcohol consumption - both in terms of quantity and strength of drinks among youth in The Netherlands.

Wouter Buwalda referred to current discussions regarding proposals to increase the rate of VAT on alcoholic drinks. A recent NIGZ conference on alcohol had concluded that the best way of reducing the negative consequences of alcohol was to limit its availability or increase its price.

He was also in favour of what many might see as a rather strange change in licensing laws. 'In my opinion the age limit should be developed according to the aggression potential - i.e. the aggression related to a specific drink'. He argued that it was wrong that the legal drinking age for beer (16) was lower than that for whisky (18) when aggressive males mainly drank beer rather than spirits. It was, he opined, the CO₂ in beer that leads to greater intoxication and should, therefore, be restricted to older drinkers.

A somewhat less controversial approach was advocated by Dr Burt Bieleman. He felt that it was necessary to obtain more objective measures of the problem, perhaps on a small, local scale. Initiatives based on such more evidence-based assessments could serve as pilot schemes which could then be evaluated and best practices identified.

Wim van Dalen was generally of a similar view and identified specific issues such as those relating to door staff training and transport facilities. He conceded, however, that with the current density of pubs and bars in some areas it might be difficult to achieve change immediately. For that reason a focus on the 'reform' of offenders might be the way forward. He referred to schemes in place in some parts of the country where those arrested for alcohol-related offences are given the opportunity to seek advice or go on a course instead of being charged.

Dr Burt Bieleman recognised that it was much easier to control customer behaviour in discos and clubs than on the streets. What happened in such venues had a direct impact on activity in the streets after they left the premises. This was why current strategies had been directed towards improving the operation of the premises themselves.

Clubs in Amsterdam now have the option of closing later (7 am), but the last 2 hours are now defined as 'cooling' down time. In these 2 hours they are not permitted to serve alcohol and lights have to be turned up, music levels down etc. As an unforeseen result of this, however, clubs tend to try and get people out as soon after 5 am as possible, since they are not selling any drinks and many customers, in fact, want to leave anyway if there is no alcohol. This has created a new problem of people hanging around on the streets for longer, waiting for taxis, etc.

2.5.5 Nuisance law

In most regions of The Netherlands there exist what are rather quaintly known as 'nuisance laws'. Such laws enable the mayor of a city to close down a pub or club or restrict its hours of operation if it can be established that it is causing a nuisance. This occasionally happens, but usually only following a serious incident such as a stabbing.

It is possible that legislation along these lines might be seen as appropriate in some parts of the UK, with local authorities exercising powers similar to those of Dutch mayors. New British legislation already allows for police officers of the rank of inspector or above to close premises for 24 hours in certain circumstances. Although this is very much a controversial issue we may be able to learn some lessons from the Dutch experience, in the way that we followed their lead in working towards 24 hour licensing.

2.5.6 Summary

There was little in what we encountered in The Netherlands which surprised us. While data recording and collating procedures with regard to alcohol-related problems might be deficient in the UK, they are almost non-existent in The

Netherlands. In that country, however, there is greater recognition that approaches to alcohol are primarily political. They are based on people's perceptions of what the problems are rather than on what objective measures might reveal those problems to be.

From what we could gather there has been little change in either the patterns or the levels of alcohol-related violence and disorder in The Netherlands during the past 10 years. What has changed, however, is popular tolerance of such behaviour. It is now *seen* as being of greater concern and that is sufficient to warrant new strategies.

It is our view that what we see quite clearly in The Netherlands is a phenomenon which is also very characteristic of the UK, but less often made explicit. Our concerns with alcohol-related violence and disorder are less driven by objective information but by our increasing, and at times irrational, fears of crime. We return to this point in the concluding Section 4.

2.6 The industry view

Towards the end of the 6 month project interviews were arranged with representatives of the major drinks industry bodies and associations⁽¹⁰⁾. The intention here was to obtain comment on the issues which had arisen in the course of our research and to elicit perceptions of the problems and the best ways of tackling them.

2.6.1 Perceptions of the problem

There was a general perception, expressed particularly by the BLRA, that alcohol-related disorder was probably decreasing. It was accepted, though, that the police would probably state the opposite. The ALMR felt that there was no real evidence one way or the other. It was emphasised, however, that was also little evidence of a *direct* causal connection between alcohol and violence. The ALMR also felt that many of the current problems arose from off-licences etc. as much as from pubs and bars. Comment was also made regarding some published research on alcohol-related violence which was seen as 'unsophisticated' but 'headline grabbing'.

10. Brewers and Licensed Retailers Association (BLRA), British Institute of Innkeeping (BII), British Entertainment and Discoteque Association (BEDA), Society of Entertainment Licensing Practitioners (SELP), Association of Licensed Multiple Retailers (ALMR), British Hospitality Association (BHA). The BLRA is now known as the British Beer & Pub Association

There was a general consensus that more meaningful definitions of ‘alcohol-related’ needed to be established - ones which made clearer the causal connection or lack of it between alcohol and violence. There was also concern that often the source of the alcohol that was supposed to be related to violent and disorderly behaviour was often unknown. It was felt, particularly by the BII, that it was unreasonable to blame the pub trade for the problems if, in fact, the drinks that had been consumed had come from, for example, cheap smuggled imports.

The BII recognised the need for more systematic and consistent methods of recording alcohol-related violence and disorder which, in turn, would enable more focused approaches to tackling the problems. Reference was made to the Institute’s ‘social responsibility initiative’. The BII clearly recognises that alcohol-related crime is an issue, but they argue that local authorities and the police do not have any solid, reliable figures with which to work. Instead, these groups rely on the ‘saturated market argument’, claiming that there are too many pubs and clubs, without recognising the positive role that can be played by responsible operators.

The issue of alcohol-related disorder was not seen as a core issue for members of the BHA. Fast food outlets are the sector most likely to encounter problems of this nature but the BHA is hoping that the extension of licensing hours may go some way to resolving this issue

The SELP argued that it was difficult to assess whether disorder in and around licensed premises was due to alcohol or other factors. They stressed that the general perception of the society was that incidents of alcohol-related disorder were decreasing due to measures such as bus and taxi provision, staggered closing and door staff registration schemes.

The representative of BEDA claimed that since the launch of the White Paper *Time for Reform* there had been a steady flow of ‘bad news’ about alcohol-related problems, including the British Crime Survey. BEDAs members, particularly those in cities such as Manchester and Liverpool, recognised that there were substantial problems of alcohol-related violence, but these were not helped by policing policies and resources. There

was, they claimed, a lack of police manpower to deal adequately with the increased numbers of people in city centres on Friday and Saturday nights.

There was also an increasing trend of problems arising from people being refused entry to clubs because they were already drunk when they arrived. The problems, as BEDA might be predicted to say, often arose more from excessive drinking in pubs than in the nightclubs of their members.

2.6.2 Industry reputation

The BII stressed that they had a duty to their members to defend the reputation of the industry and to counteract the distorted image that often prevailed. They suggested that if we were to believe everything that we read about the drinks industry then we would conclude that it existed simply to sell shots of liquor for 50p to 16 year olds.

Representatives of the other bodies also felt that there was a need for a more balanced view of the industry. They accepted that there were problems from time to time and were determined to tackle them. But they felt that not enough recognition had been given to the initiatives that they had already undertaken to reduce alcohol-related violence and disorder.

On a more positive note the BII welcomed the move of licensing matters from the Home Office to the Department for Culture, Media and Sport (DCMS). This, they felt, indicates that the government now recognises that alcohol is not just something which is associated with crime but with entertainment, tourism and other forms of enjoyment.

2.6.3 Specific causes of problems

The issue of the discounting of drinks in pubs was noted by BEDA who were seeking to have the practice regulated by government. They claimed that most licensees are reluctant to sell alcohol at discount prices, partly because it attracts the wrong sort of people. The market, however, is so competitive that they often feel left without choice.

The BLRA have debated the idea of fixing a minimum price in a given geographical area in order to curb irresponsible promotion practices.

They thought, however, that this might lead to accusations of cartel behaviour and price fixing from the Office of Fair Trading. Instead they have published a guide: *Promotions and Happy Hours: A Good Practice Guide for Pub Owners and Licensees*.

There was also recognition by trade bodies that other ‘unhelpful’ trading patterns, particularly in venues catering almost exclusively for young people under the age of 25, were sometimes evident - the result of highly competitive conditions. They felt that the role of their organisations was to cooperate with other agencies in raising standards of professionalism and to eradicate such practices.

2.6.4 Working with partnerships

The BLRA hosted a feedback seminar on its partnership initiative in June of 2001 which was chaired by Assistant Chief Constable Robert Taylor of ACPO. The views were quite mixed. There was often, it was felt, confusion about the role of the industry bodies within the schemes. The BLRA chief executive concluded that there needed to be a clearer focus for the industry and the role that it played - e.g. liaising with local authorities and the police, as opposed to involvement with health and alcohol treatment.

Local authority partnerships were often primarily concerned with town centre pubs and the disorder associated with specific outlets. The industry bodies accepted that they had a significant role to play in ensuring better management practices, but felt that local authorities, transport companies and the Home Office, etc., needed to do their part as well. The general consensus was that partnership schemes were a positive development but there was a suggestion that some had a tendency to get ‘carried away’.

Among specific suggestions that had been made within crime reduction partnerships was that the drinks industry should sponsor police officers on a local level. There have been very mixed responses to this idea.

One issue which the BII felt was overlooked by most crime and disorder partnerships was that of ‘bootleg booze’. According to the BII the illegal importation of drinks across the Channel results

in each local authority in the UK having the equivalent of 1 million pints of beer per year in addition to that sold through legitimate outlets. A greater emphasis on removing this factor could lead to reduced levels of alcohol-related street disorder.

The BII are particularly keen to be involved more in local partnership schemes that seek to reward pubs that have a good record of preventing alcohol-related violence. An example of such a scheme is the ‘Wandsworth Safer Pubs Committee’. They also see the development of qualifications such as their door supervisors ‘passport’ as being of significant benefit. (They are currently applying to the Qualifications and Curriculum Authority (QCA) to make this a fully recognised scheme.)

A number of representatives of trade organisations were concerned about the difficulties of evaluating CRP initiatives in which they played a role. It was noted that when a partnership scheme is put in place there is often encouragement given to licensees to call the police when violent or disorderly incidents arise. There was concern that this should not be taken to indicate that the number of incidents itself had increased. Licensees should also not find themselves receiving ‘black marks’ from the police for reporting such offences

SELP sees its role as working with police licensing officers, solicitors, barristers, other trade organisations and local authority licensing departments. It is, therefore, less involved in CRPs than some other bodies.

While most trade bodies welcomed the opportunity to be involved with other agencies in seeking to reduce alcohol-related problems, some felt that many of the partnerships lacked proper structure and did not necessarily focus on the most important issues. More extensive guidance from bodies and departments such as the Home Office was required to ensure greater consistency and properly targeted initiatives.

“Of the 29% of forces which did not keep any records of alcohol-related crime, 69% said that they had no intention of doing so in the future.”

“Only 10% felt that their data were an accurate reflection of the real problem.”

3 Questionnaire and Telephone Surveys

On the basis of extensive meetings and interviews with key stakeholders three questionnaires were designed for administration to police licensing officers, town centre managers and coordinators of crime reduction partnerships (CRPs). In addition, a telephone survey protocol was developed for lead consultants in accident and emergency (A&E) departments of NHS Trust hospitals. Copies of these procedures are contained in Annex A.

The data derived from these procedures are summarised below.

3.1 Police data

Questionnaires were sent to 89 police licensing officers covering all of the main police districts, of which 61 were returned a relatively high (69%) response rate.

3.1.1 Recording of alcohol-related crime

Of those licensing officers returning questionnaires, 71.4% reported that they kept records of offences which were deemed to be alcohol-related. Over a quarter of all police forces, therefore, keep no records at all in this context.

The form of data recording for offenders who had been charged is summarised in Figure 3.1 below.

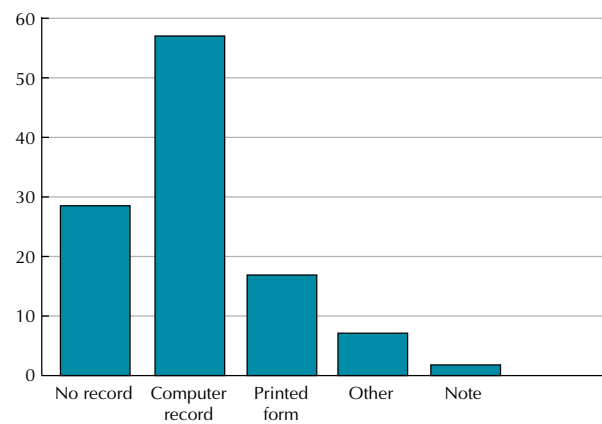


Figure 3.1 Method of recording for those charged with alcohol-related offences

From Figure 3.1 we can see that a small majority (57%) of police forces use some form of computer database for the purpose of recording alcohol-related arrests. We should note, however, that the types of database vary widely and many are incompatible with those used in other regions (see section 3.1.3).

Of the 29% of forces which did not keep any records of alcohol-related crime, 69% said that they had no intention of doing so in the future. Where recorded systems were planned, all indicated that these would take the form of a computerised system.

The recording of reports of alcohol-related offences, as opposed to actual arrests, is summarised in Figure 3.2. Here we can see a broadly similar pattern to that shown in Figure 3.1, but with fewer licensing officers recording data of this type. The frequency of computer databases was also slightly lower in this context (53.6%). Reservations about the reliability of these measures must be expressed since determining whether alcohol was a factor in a reported crime where the offender is not apprehended is always very difficult.

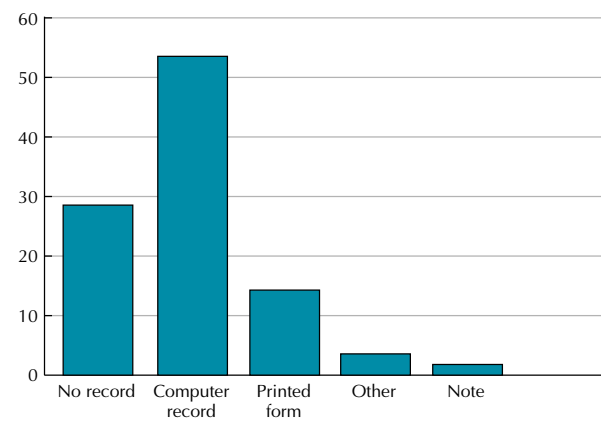


Figure 3.2 Method of recording reported alcohol-related crimes and disturbance

3.1.2 Definitions of ‘alcohol-related’

Police licensing officers varied in their definition of the label alcohol-related as shown in Figure 3.3.

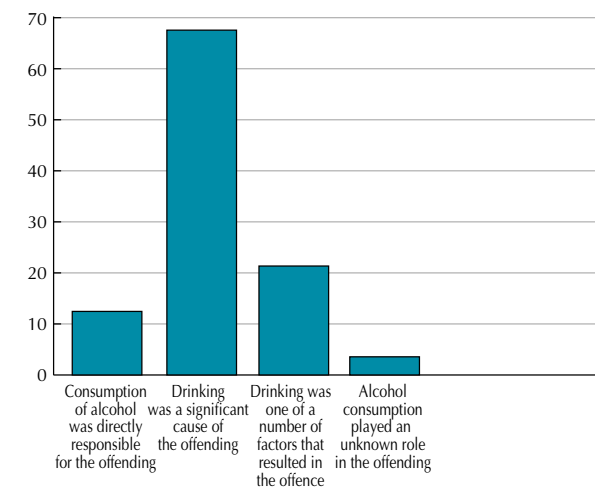


Figure 3.3 Definitions of ‘alcohol-related’

While a majority (68%) felt that the term meant that drinking was a significant cause of the offending, others felt that it was just one of a number of factors. Only 12% felt that the term referred to alcohol as being directly responsible for the offences. These varying definitions add to difficulties in interpreting police data, as discussed in Section 4.1.

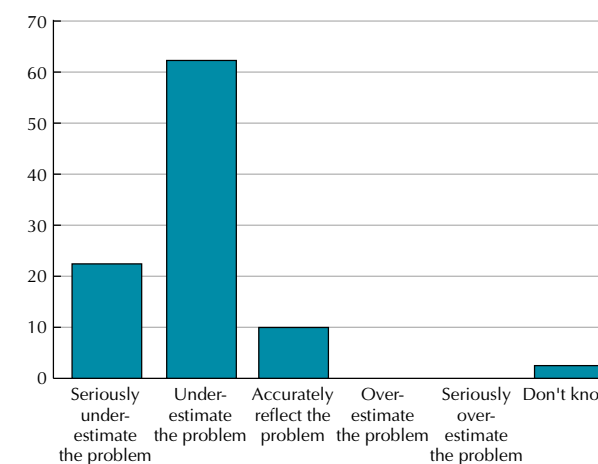


Figure 3.4 Perceived reliability of records

3.1.3 Perceived reliability of records

The majority of police licensing officers felt that their records underestimated the true level of alcohol-related crime and disorder, as shown in Figure 3.4. Only 10% felt that their data were an accurate reflection of the real problem. None, however, felt that their data over-estimated the seriousness of the problem.

These responses are very much in line with the qualitative material derived from meetings with licensing officers. The majority felt that many alcohol-related incidents went unreported and unrecorded. Very few, however, were able to say what the margin of this under-recording might be.

3.1.4 Comparability of records

Police licensing officers were asked about the extent to which they were able to compare their own figures with those collated by other police forces.

We can see from Figure 3.5 that in only a small minority of cases (10%) was there any direct comparability between the sets of data. In 35% of cases a degree of indirect comparison was possible, but in 45% of cases no comparisons were possible at all.

These findings illustrate very clearly the wide variation in recording and collating practices which currently exist among police forces. The practices differ not only in terms of the format of forms and computer databases which are used but also in the definitions of alcohol-related, the types of crime that are included, whether they are based on crime reports or charge sheets and a number of other factors. As we discuss in Section 4, a more definitive and reliable guide to the nature and pattern of alcohol-related violence and disorder at national and regional levels will require substantially greater comparability of data from individual police forces and, indeed, from basic command units within police forces.

“The large majority of police forces (96%) were involved... with partnership schemes aimed at the reduction of alcohol-related problems.”

“In the majority of A&E departments (60%) alcohol consumption was recorded routinely, while in 38% of cases such consumption was noted in special cases.”

3.1.5 Reporting of alcohol-related crime data

We noted above that over one quarter of police licensing officer’s collect no data at all on levels of alcohol-related crime and disorder. Of those who do collate such information, only 30% present this information in accessible reports. This is consistent with the findings from our interviews and discussions with police officers. Unless there is a specific reason to present such data - e.g. when opposing the grant of a liquor licence or when seeking the revocation of a licence - the information is often not used for any strategic purpose.

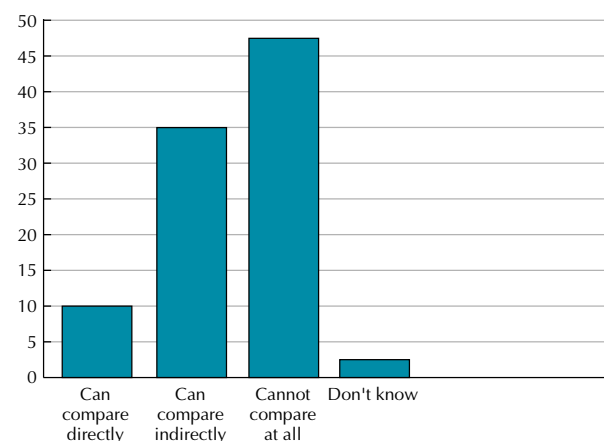


Figure 3.5 Comparability of data

3.1.6 Percentage of crimes deemed to be alcohol-related

Due to the inconsistencies and potential sources of unreliability noted above and to the fact that relatively few police forces collate their data in the form of reports, only 10% of licensing officers were able to provide an estimate of the extent to which crime and disorder is related in one way or another to the consumption of alcohol. Such estimates varied between 30% and 85%.

This finding is quite surprising given the frequency with which statements concerning alcohol’s role in crime causation are made by police officers. It is clear that bold assertions, such as those which suggest that up to 80% of all violent crimes and disturbances are alcohol-related, are based on scant and often unreliable evidence.

3.1.7 Recording of offences in and around licensed premises

While many police forces did not keep records of crimes deemed to be alcohol-related, the majority (82%) did maintain records of crimes and disturbances committed in and around licensed premises in their areas. This enabled them to identify trouble spots and take appropriate action. This finding is consistent with the interview and discussion material with licensing officers. Most see their role as being focused on licensing-related matters rather than on alcohol-related crime in general.

3.1.8 Partnership schemes

The large majority of police forces (96%) were involved in one way or another with partnership schemes aimed at the reduction of alcohol-related problems. As we can see from Figure 3.6, these most typically involved liaison with local authorities, town centre management and trade organisations. A significant number, however, were also involved with residents and voluntary organisations and with hospital A&E departments. A further 11% of police licensing officers were directly involved in Pubwatch schemes.

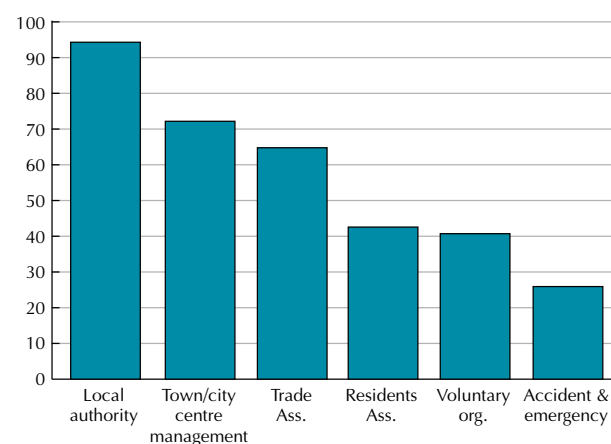


Figure 3.6 Involvement in partnership schemes

3.1.9 Town centre visitors and drinking

Estimates of the number of additional visitors to town and city centres on Friday and Saturday evenings varied widely, reflecting the size of towns and cities themselves and the extent of the night-time economy. The highest was an additional 80,000 people and the lowest a mere 150. The average figure was 11,700.

Whatever the accuracy of these estimates it is clear that night-time economies attract very significant numbers of people at weekends, particularly those in the 18-26 year old categories. This has to be borne in mind when interpreting crime and disorder statistics and particularly those where alcohol-related crimes are recorded. Of the 11,700 additional people it is very likely that the large majority will have consumed alcohol on their visits. Police licensing officers in the survey themselves typically estimated that 70% of these visitors would have BACs in excess of the limit for driving by 11.30 pm. Any offences committed by this population would, therefore, most likely be recorded as alcohol-related. The distortions which can arise from such data are discussed in Section 4.5.

3.1.10 Police awareness of data limitations

It was clear from both the questionnaire survey and from the extensive interview and discussion material that many police officers and licensing officers in particular were well aware of the limitations of their own data. Almost all recognised that there was a need for improved recording and collation practices and for more systematic definition of alcohol-related crime and disturbance. The suggestions made by the questionnaire respondents included the following:

- National norms to guide the recording of alcohol-related offences.
- New or improved computer systems.
- Better assessment and recording of arrested persons.
- Specific teams of analysts.
- Home Office requirements to collect data.
- National standardisation of data collation.
- Recognition of the difficulty of quantifying alcohol as a causal factor.

Concerning the last point below, many officers emphasised that, even with the most sophisticated of recording and collating systems, the causal role of alcohol could never be established with any certainty.

3.2 Hospital accident and emergency data

Telephone interviews were conducted with 70 A&E consultants in NHS Trust hospitals in various regions of England, Wales and Scotland.

3.2.1 Recording of patients’ alcohol consumption

In the majority of A&E departments (60%) alcohol consumption was recorded routinely, while in 38% of cases such consumption was noted in special cases. In fewer than 2% of departments there was no recording of whether patients had been drinking.

In those departments where consumption was recorded only sometimes, the reasons given for the recording are shown in Figure 3.7.

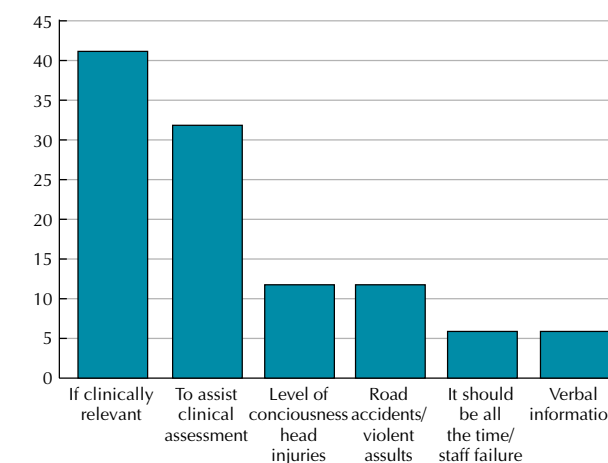


Figure 3.7 Recording of patients’ alcohol consumption

In many cases assessments of alcohol consumption were made only if it was seen as clinically relevant or was necessary for clinical assessment or if road accidents or violent assaults were involved. Others undertook such assessments where there were grounds for referral to alcohol counselling services or in cases where erratic patient behaviour was observed. In some instances, however, consultants felt that the fact that assessments and recordings were only conducted sometimes was due to pressures on staff and should, in fact, be undertaken routinely.

“In the majority of cases (78%) the assessment of alcohol consumption was based on visual determination but over half (54%) of the departments also used breath testing in some or all cases.”

3.2.2 Methods of testing

In the majority of cases (78%) the assessment of alcohol consumption was based on visual determination but over half (54%) of the departments also used breath testing in some or all cases. Both doctors and triage nurses were equally involved in the assessments.

3.2.3 Need for improvement

The large majority of A&E consultants (80%) felt that procedures for assessing alcohol consumption needed to be improved. In particular they felt that more systematic methods were required for recording and collating data in this area, including improved computer systems. Twenty percent of consultants also felt that breath testing or some other objective means of quantifying BACs was required. Others felt that there should be more concern for long-term alcohol dependency problems as well as acute intoxication and identified the need for diagnostic tools such as CAGE¹⁾ and other procedures.

3.2.4 Identifying the location of drinking

Consultants were asked if they would be prepared to ask patients who presented with alcohol-related symptoms where they had consumed their alcohol. A majority (79%) said that they would be prepared to do so and 15% said that they already did. Many felt that it would help in joint initiatives with the police and the licensed trade to identify trouble spots and to tackle more effectively alcohol-related violence and disorder.

3.2.5 Estimates of ‘alcohol-related’ violent injuries

A&E consultants varied quite widely in their estimates of the proportion of violent injuries which were assessed as being alcohol-related, as shown in Figure 3.8.

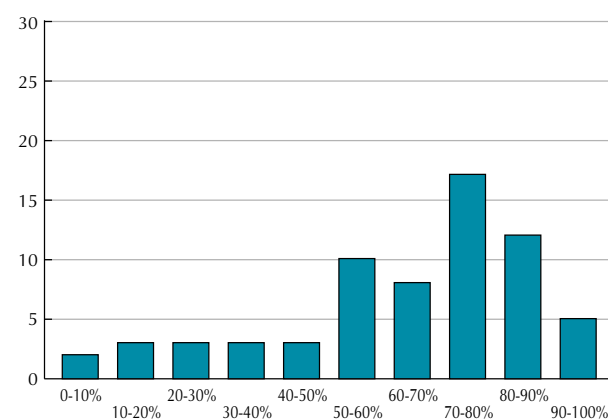


Figure 3.8 Estimates of ‘alcohol-related’ violent injuries

From Figure 3.8 we can see that the most typical estimate was that 70-80% of all violent injuries were alcohol-related. We should note, however, that very few consultants had objective data to support their estimates which, in most cases, were based on experience. In Section 2.2.11 we noted that, where objective data are available, the proportion of injuries that are classed as alcohol-related tends to be substantially lower.

3.2.6 Increased patient level at weekends

A&E departments typically receive between 100 and 200 patients per day. The majority of consultants (78%) reported that patient numbers increased substantially on Friday and Saturday nights by percentages summarised in Figure 3.9. Here we can see that the most typical increase was by up to 10%, with 40% of consultants reporting this figure, although in a few cases the increase was over 50%.

Such increases are often seen as confirming the extent to which alcohol is implicated in violent, physical injuries. Some caution, however, must again be employed in interpreting these figures. The night-time economies which operate on Friday and Saturday evenings result in substantial additions to the local populations. The more people there are in the area the greater the likelihood of higher numbers of injuries, of whatever nature. This need to control for population sizes, which applies to the interpretation of both police and A&E data, is discussed in Section 4.5.

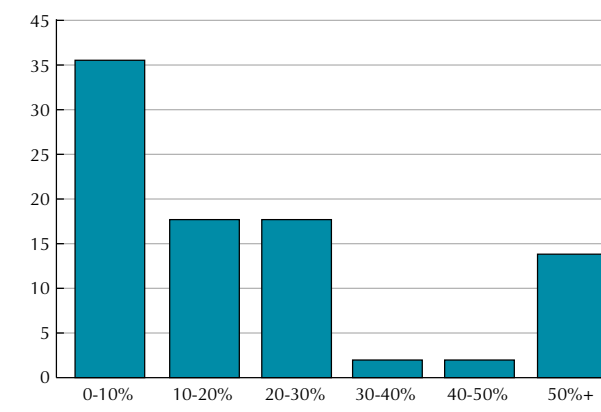


Figure 3.9 Increased patient level at weekends

3.2.7 Information supplied to the police

There were some clear divisions concerning whether information about violent injuries should be passed to the local police. Over one quarter of consultants (28%) said that they did not pass any patient details or records to the police, while the same proportion said that they did so on a regular basis. Of the 44% who said that they would supply patient information to the police only on specific occasions, their reasons for doing so are summarised in Figure 3.10.

From Figure 3.10 we can see that the dominant reason for contacting the police was that of ensuring public safety. Other consultants supplied information only when requested to do so while others would supply information only if the individual patient could not be identified or if the patient consented.

The implications of these findings in the context of improving data sharing and collation are discussed in Section 4.2.

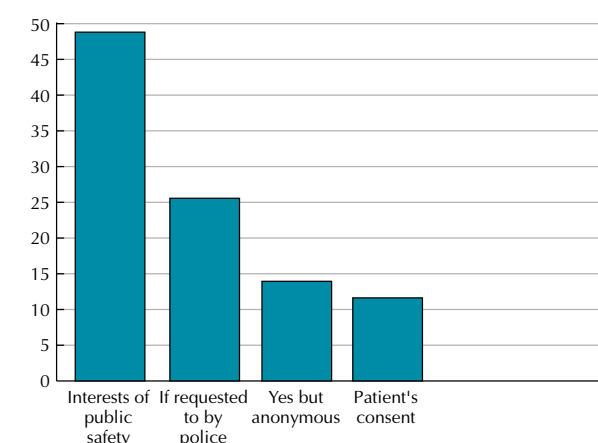


Figure 3.10 Reasons for passing information to police

3.3 Town centre managers’ data

Questionnaires were sent to 135 town and city centre managers, of which 51 were completed. While this was a relatively modest return rate (38%), the data represent the majority of the large urban centres in the UK.

3.3.1 Perceptions of alcohol-related problems

The managers were divided regarding the seriousness of alcohol-related violence and disorder in their towns and cities. Their responses when asked to rate their perceptions on a 10 point scale ranging from ‘no problem’ to ‘serious problem’ are summarised in Figure 3.11 below.

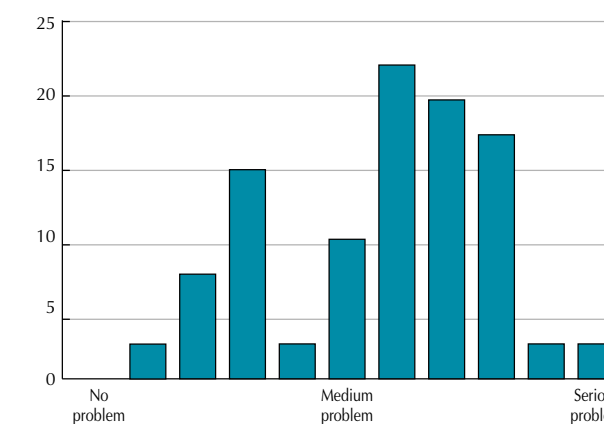


Figure 3.11 Perceptions of alcohol-related problems

From Figure 3.11 we can see the majority of managers rated the level of problem as being between the medium and serious categories. The most frequent response was a score of 6 out of 10 on the ‘seriousness’ scale.

3.3.2 Changing levels of violence and disorder

The majority of managers felt that alcohol-related violence and disorder was either increasing or was constant, as shown in Figure 3.12. In a minority of cases (10%) there had been a perceived decline in the level of problem.

1. A commonly used assessment questionnaire developed by the Bowles Center for Alcohol Studies, University of North Carolina. See also PAT (Paddington Alcohol Test) and MAST (Michigan Alcohol Screening Test).

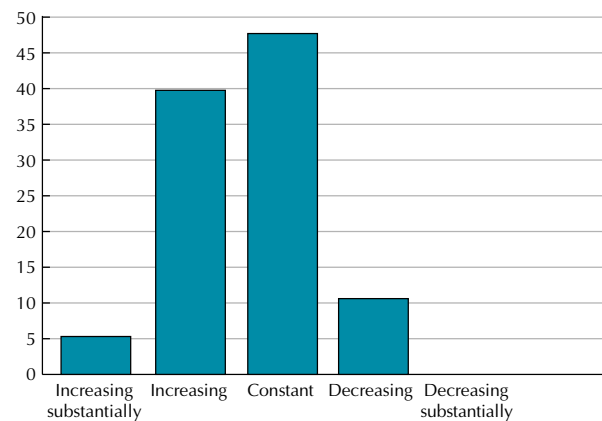


Figure 3.12 Changing levels of alcohol-related problems

3.3.3 Data collection

Although all of the managers, with one exception, were able to provide a perception of the seriousness of alcohol-related problems in their local areas and to indicate whether the problems had risen or declined in recent times, less than a quarter (24%) had any numerical data available to them in this context. Of those who did have some data to guide their judgements, most relied on statistics and reports provided by the police.

3.3.4 Measures to combat alcohol-related problems

The majority of town and city centre managers (73%) felt that a relatively small amount of their work was directed towards dealing with alcohol-related violence and disorder - less than 10% of their time. Most of this was related to the development of specific measures aimed at combatting the problems. These are summarised in Figure 3.13.

The most common (92%) strategy aimed at reducing alcohol-related violence was the introduction of CCTV cameras in town and city centres. The use of radio links by security staff and police and both Pubwatch and Clubwatch schemes were also commonly reported. Among the other measures mentioned were bye-laws, door staff registration schemes and safer trading forums.

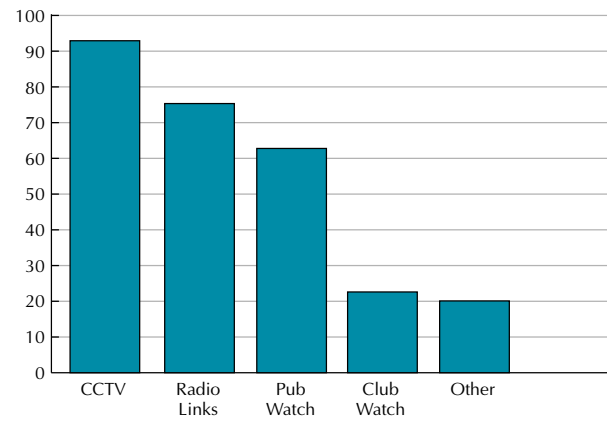


Figure 3.13 Measures to combat alcohol-related problems

3.3.5 Impact of measures on levels of alcohol-related problems

While the majority of respondents felt that these measures had been effective to some degree or another, fewer than 5% of town centre managers compiled reports of alcohol-related incidents to allow objective evaluation.

3.4 Crime reduction partnerships data

A geographically representative sample of 138 CRPs was obtained.

3.4.1 Perceptions of alcohol-related problems

Representatives of the CRPs were asked to give their views of the seriousness of alcohol-related problems both prior to the work of the partnerships and currently. These are summarised in Figure 3.14.

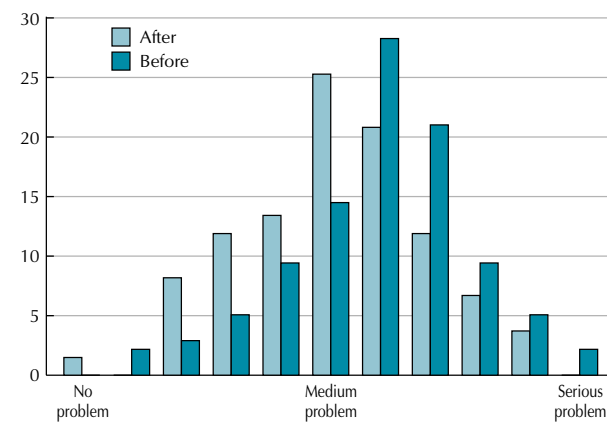


Figure 3.14 Perceptions of alcohol-related problems

The views of the CRPs concerning levels of alcohol-related crime and disorder prior to the establishment of the partnerships were broadly consistent with those of town and city centre managers. Most felt that the levels of alcohol-related crime and violence were initially between the medium and serious levels. Their perceptions of current levels of seriousness, however, showed a distinct shift towards the less 'serious' end of the scale. Whereas 66% of respondents rated the level of seriousness as 6 or higher on a 10 point scale prior to the CRP, this had fallen to 43% for current perceptions. This difference is statistically very significant ($\chi^2 = 14.2$, $df = 1$, $p < .0001$).

Such perceptions of the relative decline in the seriousness of alcohol-related problems might be seen as evidence of the effectiveness of CRPs. Equally, however, such views may be founded on false optimism or clouded judgement. We note below in Section 3.4.5 that there is often a distinct lack of rigorous evaluation of CRP activities and their impact on objective measures of alcohol-related violence and disorder. This point is further discussed in Section 4.4.

3.4.2 Work concerned with alcohol-related problems

CRPs varied in the extent to which their activities were focused on alcohol-related violence and disorder, as shown in Figure 3.15.

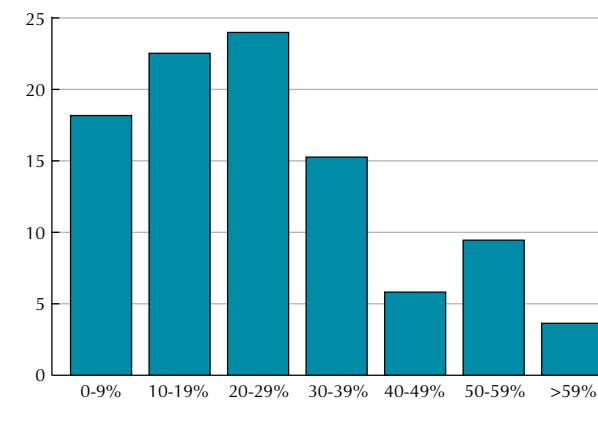


Figure 3.15 Work concerned with alcohol-related problems

From Figure 3.15 we can see that for the majority of CRPs the amount of work devoted to alcohol-related issues amounted to less than 30% of total activities. In some cases, however, the concern with alcohol-related problems was considerably higher.

3.4.3 Organisations involved in CRPs

The majority of CRPs involved police, local authorities and voluntary organisations, as shown in Figure 3.16. Trade associations, residents' associations and A&E departments were also regularly involved. Among the 'other' category were most frequently probation departments and health workers. Most of these groups had been in existence for about 3 years although some had been started up to 10 years ago. The majority of CRPs met on a monthly to quarterly basis.

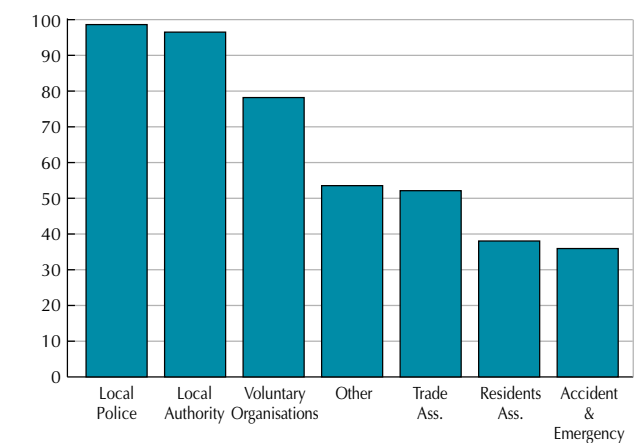


Figure 3.16 Organisations involved in CRPs

3.4.4 Funding of CRPs

The majority of CRPs relied on limited funding from the member partners - most typically the police and local authorities. In only 16% of cases were grants received from government bodies such as the Home Office, Welsh Assembly, etc. A further 17% of partnerships were currently making bids for such funding.

3.4.5 Evaluation

When asked how the activities of the CRPs would be evaluated, many gave relatively vague replies, referring to ‘meeting targets’, ‘evaluation of performance’, ‘surveys’, etc. Only 19% of the CRPs used crime statistics as a performance benchmark and only the same proportion was subject to external audit and evaluation. Even here, however, the precise nature of the methods and measures employed in such evaluation was rarely specified.

It was also the case that nearly one quarter (23%) of all CRPs had no formal documents outlining the aims and objectives of the partnership or its achievements. This apparent lack of role definition and accountability of CRPs is discussed in Section 4.4.

4 Conclusions and Recommendations

As we emphasised at the start of this report, there clearly exists an association between the consumption of alcohol and violent and disorderly behaviour, particularly in town and city centres on Friday and Saturday nights. The evidence is before one’s eyes. It does not require social scientists to demonstrate the existence of what, in our society, is the modern manifestation of a timeless and enduring problem.

It is, however, clearly the case that the large majority of people who go out drinking in the many pubs, bars and clubs that now constitute the night-time economy do not get into fights; they do not engage in rowdy and anti-social behaviour; they do not commit acts of vandalism and criminal damage. Instead, they enjoy themselves without causing offence to others.

We have avoided detailed discussion of the theoretical perspectives concerning the nature of the relationship between alcohol and violent behaviour. These issues are dealt with in depth elsewhere both by SIRC/MCM Research and by many others. Our concern in this relatively modest 6 month programme of research has been first, with the size of the relationship between alcohol and violence, rather than the complex elements which create the connection and with how it can best be measured. Secondly, our concern has been with ways in which initiatives taken to attenuate the relationship and ameliorate the problems can accurately be measured and tested in order that the most effective strategies can be identified. In short, we can see that there is a problem. How big is it? What can be done about it?

4.1 Police data

Sections 2 and 3 of this report have clearly shown, on the basis of both qualitative and quantitative evidence, that we are still some distance from being able to answer either of these questions with any degree of certainty. We simply do not have data of sufficient quality, even at local levels, to do more than hazard a few informed guesses. Since the true scale of the problem is ill-determined, the true impact of crime reduction strategies in this area remains closed to objective scrutiny since changes in the scale of alcohol-related offending are similarly ill-defined. If our society is serious about its determination to reduce problems of drunken violence and if it is to commit very substantial financial budgets to such an

end, we will need to make decisions less on the basis of the speculation which currently surrounds the phenomenon and much more on the basis of reliable, objective evidence and unequivocal measures.

We have identified in this report quite clearly the lack of consistency and robustness in much of what currently passes for data on alcohol-related crime and disorder. Police figures, which are perhaps the most commonly quoted sources of supposed evidence in this area, are rarely without both conceptual and methodological flaws. We have noted, of course, in Section 3.1.1 that over one quarter of local police forces do not maintain any records of alcohol-related offences at all and, of these, nearly 70% have no intention of doing so in the future. Of those forces that do collate information of this type, it is difficult to find any two that do so in the same, consistent manner - measures of alcohol consumption vary substantially, along with both recording and collating practices. In summary, the following limitations of police data are evident:

1. The measure of an offender’s level of alcohol consumption is often not determined. The judgement that alcohol is related to the offence might be based on the fact that he or she seems drunk or partially intoxicated, reports having consumed alcohol, was in or near a licensed premises at the time of the offence or was involved in an incident in which others were intoxicated.
2. The form of recording such consumption is often unsystematic, even within a single local police force. Some data are based on reports to incident rooms, while others relate to offenders who have been charged with a crime. The recording of the presence of alcohol might be in the form of a simple tick-box, a written note, a reference on a charge sheet or an item on a custody record
3. The collation of alcohol-related data, in whatever form they are recorded, is often not undertaken. Some computer systems permit the entry of alcohol-related data but have no analysis tools. Only 30% of police forces present their data in reports. Where the data *are* collated, the responsibility for the procedure is often not assigned to a single individual, leading to further sources of inconsistency.

4. The manner in which the data are recorded and collated varies to such an extent between police forces that only 10% are able to compare directly their figures with those obtained elsewhere.
5. Collated data often do not distinguish between offenders and victims. The number of alcohol-related offences includes both those who have committed violence and disorderly acts while intoxicated and those who, while they were the target of a drunk assailant, might have been unaffected by drink themselves.
6. Data relating to reports of offences in the vicinity of licensed premises are routinely classified as ‘alcohol-related’ even though there may be no direct evidence regarding consumption of alcohol by those involved.

4.2 A&E data

Similar limitations are evident in data recorded by hospital A&E departments (see Sections 2.2 and 3.2). These are as follows:

1. The occasions on which alcohol-related data are recorded vary from ‘routinely’ to ‘only when required for clinical assessment’.
2. Assessments of alcohol consumption vary from breath testing to questionnaires and physical inspection.
3. The manner in which the data are recorded varies from a prescribed form entry to clinical notes.
4. The retrieval and collation of alcohol-related data is often hampered by both lack of resources and outdated computer systems.
5. Comparability across A&E departments is severely restricted by variations in methods and recording practices.
6. Integration of A&E data with that obtained by the police is strongly hampered by incompatible databases and data protection concerns.
7. Where data are shared it is often difficult to identify overlapping cases i.e. those which have been recorded by both the police and the A&E department.
8. A&E data relate primarily to victims of assault and wounding, rather than to alcohol-related offending.

4.3 Improving data collection methods

The limitations of current data sources noted above are recognised by both police offices and A&E consultants themselves. Most are of the view that more accurate and reliable measures are required, but point to the lack of resources and expertise with which to achieve such improvements. They also point to the lack of guidance and direction from the relevant government departments on this issue. Where there is no formal requirement to collect reliable alcohol-related data in the first place and where there is no set of nationally agreed, formal procedures for doing so, the current pattern of inconsistency and inaccuracy is likely to remain.

The current situation, however, is unlikely to be remedied simply by the imposition on police forces and A&E departments of untried and potentially problematic procedures. While there are examples of extant practices which appear to be substantially better, in terms of rationale and consistency, than others, there is no single, clear best practice model which emerges from our research. We therefore make the following recommendation.

4.3.1 Recommendation 1

One or more model recording and reporting procedures should be developed for both police and A&E departments that seek to overcome the limitations noted above. They should demonstrate objective assessment, systematic recording and ease of retrieval and analysis. They should also enable meaningful and ethical integration of data from the two sources. In this context we recommend that attention be paid to the work conducted by Project Jupiter (see Section 2.3.5.3).

Such models should be tested in pilot schemes in a number of regions of the UK with the help of guidance from external specialists and appropriate resources. Clear benchmarks for evaluating the viability, reliability and validity of the models should be established from the outset.

Revised procedures based on the results of experimental trials should, after detailed consultation with relevant stakeholders, be

considered by the relevant government departments for implementation nationwide.

4.4 Crime reduction partnerships

We have noted in Sections 2.3 and 3.3 the difficulties faced by crime reduction partnerships (CRPs) in evaluating their contributions to reducing alcohol-related violence and disorder. In the absence of reliable measures of alcohol-related crime, which might allow quite modest changes and variations to be detected, it is difficult to see how this aspect of their work can be assessed with any degree of empirical rigour.

The potential benefit of the many CRPs that have been established all over the country is the identification of effective best practices - perhaps quite simple initiatives which appear to yield good results for relatively small financial and resource investment. Some of these are already evident without the need for sophisticated evaluation tools. In many areas, however, identification of such ‘successes’ is severely restrained both by a lack of reliable data and by inadequate programme evaluation procedures within the partnerships. We have noted in Section 3.4.5 and elsewhere that nearly one quarter of all partnerships appear to have no formal documents outlining their aims and objectives and only 19% rely on statistical data in their internal evaluations.

Very clear models for the evaluation of activities such as those routinely initiated by CRPs are currently available. The work of Michael Hough and Nick Tilley¹ at the Home Office, for example, while concerned primarily with the evaluation of police crime prevention activity, contains both a cogent critique of the limitations of current evaluation methods and clear direction on what good procedures should look like. The work of Ray Pawson and Nick Tilley² is an even more comprehensive guide to the application of sound social science in evaluation procedures.

Given the quality of this material we do not suggest that we should try to reinvent the wheel in this context by examining further how evaluation of CRPs might be made more objective. Rather, we make the following recommendation:

4.4.1 Recommendation 2

In parallel with the actions proposed in recommendation 1 and in the same geographical areas, evaluation models should be developed with regard to the principles identified by Tilley, Hough, Pawson and others and negotiated with the major stakeholders involved in partnership schemes which have, as part of their aim, the reduction of alcohol-related crime.

Appropriate professional expertise and resources should be provided for this purpose and it would be desirable for an external evaluator to attend partnership meetings.

Sources of data deriving from recommendation 1 might profitably be used as dependent measures in the evaluations.

A ‘meta-evaluation’ - i.e. an evaluation of the practicality and ease of implementation of the evaluation procedures themselves - should be conducted after an appropriate time interval.

The results of these activities should be analysed in order to identify model evaluation procedures for implementation, where appropriate and with regard to local concerns, at a national level. Inclusion of such models, in addition to the guidance already provided, in the Crime Reduction Toolkits might be a suitable medium for dissemination.

It is also our view that central funding of CRPs should be dependent upon the existence of clear, objective evaluation procedures.

4.5 Alcohol and violence - cause and effect

As we have noted earlier (see, for example, Section 2.2.5 and Section 3.1.2) the term ‘alcohol-related’ is imprecise. Its use varies from the simple observation that an offender or patient suffering from an injury had previously consumed alcohol, to the belief that

1. Hough, M. and Tilley, N. (1998) *Getting the Grease to Squeak: Research Lessons for Crime Prevention*. Home Office Police Policy Directorate
2. Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. Sage Publications

“In the real world it is difficult to find very many people in town and city centres late on weekend evenings who have not been drinking.”

“...it is a determination to ‘crack down’ on certain pubs and clubs... that often motivates the data-publishing process.”

the consumption of alcohol had directly caused the person to commit the offence or sustain the injury. A fundamental problem with existing data and, indeed, with data that might be provided by improved recording procedures’ is that it is impossible to identify the level of causality that can be attributed to alcohol. This is because the necessary comparison and control samples are almost entirely unavailable.

We know that of people drinking on Friday and Saturday nights in town centres, even those consuming excessive amounts, only a small proportion commit acts of violence. In addition, a substantial proportion of those who do commit such offences are unaffected by alcohol. The question, therefore, is to what extent are people who have consumed alcohol over-represented in the category of violent offenders or injury victims? To answer this and subsequently establish the causal role that alcohol might play, we need information about the levels of consumption of non-offenders in the same contexts.

One of the few researchers to address this issue in the past has been Professor Shepherd in Bristol and then only in the context of victims of assault. Shepherd concluded:

“This finding indicates that young male assault victims may not be distinguishable from the young male population at large solely on the basis of alcohol consumption, and therefore suggest(s) that other risk factors are involved”
(Shepherd, J.P., 1989b:1050).

While some of the methods used by Shepherd, including the choice of his comparison sample, might be seen as having some weaknesses, he is clearly correct in identifying the need for such comparisons if the level of risk presented by alcohol is ever to be discovered.

In the real world it is difficult to find very many people in town and city centres late on weekend evenings who have not been drinking. That is, primarily, why most of them have gone there. The fact that a large proportion of those arrested for violent or disorderly offences at these times have consumed alcohol is not, therefore, very surprising. Nor is it too surprising to find that the number of violent incidents increases at these times compared with other days of the week. Given the significantly expanded population of people on Friday and Saturday nights, a majority in the age and socio-

economic categories most likely to commit offences whether drunk or sober, an increase of some level would be expected. In this context, therefore, we make the following recommendation:

4.5.1 Recommendation 3

Research should be conducted which directly aims to measure the degree to which alcohol is a risk factor in violent crime and injury. A pilot project should initially be developed in a major urban setting that compares the consumption patterns and levels of known offenders with those of a non-offending comparison sample. Similar comparisons should be made with regard to injuries.

BAC levels should be established for an anonymised sample of offenders apprehended for relevant offences by the police on Friday and Saturday nights. The same measures should be obtained from a random and equally anonymised sample of non-offending visitors during the same times. This might be achieved using disposable alcometers which could be dropped by testees into a sealed box. Additional questionnaire data might also be obtained from both samples. Estimates of the total number of visitors in the potential risk category to the town centre at various times of the week would be the final data element required.

Data from such a pilot study would immediately provide a much better indication of the true role played by alcohol in offending and the degree to which it is a risk factor. It would, probably for the first time, allow an estimation of the true proportion of crimes and disturbances which would not have occurred *but for* the consumption of alcohol.

The study would also identify the age and other characteristics of those most likely to be influenced by alcohol in this way. (See the studies by Holt and STAG noted in Section 2.2.11 which suggest that it is men in the age category 40-49 years who were over-represented in attendances for

alcohol-related injuries.) By enabling ‘at-risk’ groups to be more clearly defined it would have direct implications for the targeting of initiatives aimed at reducing alcohol-related problems.

4.6 The uses and abuses of data

In the way that our tabloid newspapers routinely fill our lives with the bad news rather than the good, so too there is a tendency for statistics to be made public only when they show that things are getting worse, or when they are employed in the pursuit of political and other agendas. This appears to be particularly the case when we encounter published data concerned with alcohol-related violence and disorder. On occasions we have found, for example, that local police data have only been collated and tabulated when there was a need to support their objection to a proposed new licensed premises. Elsewhere, as we noted in Section 2.1.7, it is a determination to ‘crack down’ on certain pubs and clubs, or to make a case for more police resources that often motivates the data-publishing process.

In order to preserve the perceived ‘neutrality’ of data on alcohol-related crime we therefore make the following recommendation.

4.6.1 Recommendation 4

All data on alcohol-related violence and disorder, whether derived from existing or improved procedures, should be collated and published at fixed intervals in consistent formats. Such data should be available to all relevant stakeholders on request as a matter of course.

4.7 The role of the drinks and entertainment industry

Few people would argue with the suggestion that the quality of management and style of operation of pubs, bars, clubs and other venues has a significant impact on levels of violence and disorder, both on the premises and subsequently in the immediate vicinity. With increasing competition in the night-time economy there are clearly occasions when the professionalism of this area of the retail trade ‘slips’ a little. Irresponsible promotions and discounting, which lead to excessive or acute patterns of alcohol consumption and the serving of underage customers, are just two of the many indicators of such management failings.

From our discussions with trade bodies and organisations it is clear that the industry is very aware of the need to maintain high levels of professionalism and integrity among those at its retail front line and the activities of the BII and BLRA are of particular significance in this context. So too are programmes developed by The Portman Group, such as those which seek to reduce underage drinking and the educational campaigns targeted at secondary school students.

There is, however, an indication that the role of the alcohol industry at a local level is not sufficiently defined (see Section 2.6.4). We make no specific recommendations in this context, but clearly the increased involvement of representatives of the major trade bodies in local crime reduction and prevention initiatives which have a particular focus on alcohol-related issues is both desirable and expedient.

Annex - Questionnaires and Interview Forms

Police - 1

Alcohol-related violence & disorder survey

- Do you currently record whether certain offences involve alcohol consumption?

YES →

NO ↓

• Do you have any plans to introduce such a recording system?

YES → What form will these take?

NO

Computer Record

Printed Form

Note

Other

(If other - please specify)

• What form does this take for those charged?

Computer Record Printed Form Note N/A Other

(If other - please specify)

• What form does this take for crime reports?

Computer Record Printed Form Note N/A Other

(If other - please specify)

• To what extent do you think that your data accurately reflect the level of alcohol-related problems?

Seriously under-estimate the problem Under-estimate the problem

Over-estimate the problem Accurately reflect the problem Seriously over-estimate the problem

• To what extent are you able to compare your figures on alcohol-related crime and disorder with those produced by other police forces?

Can compare directly Can compare only indirectly Cannot compare at all

• Do you compile regular reports on alcohol-related offences?

YES → What percentage of crimes of violence and disorder are deemed to be alcohol-related?

NO %

- Do you keep records of offences that occur in or around specific licensed premises? YES NO

- Can you identify alcohol-related "trouble spots" from your records? YES NO

- Are you involved with co-operative partnership schemes that deal with alcohol-related problems?

YES →

NO

• With which types of organisation are you involved?

Local Authority Voluntary Organisations Accident & Emergency Trade Associations

Town/City Centre Management Residents Associations Other

(If other - please specify)

Please turn over...

- In your estimation how many people visit the town/city centre on a Friday and Saturday night?

- In your estimation what percentage of these are over the legal BAC for driving by 11.30pm?

- Which of these statements best describes your definition of an alcohol-related offence?

"Consumption of alcohol was directly responsible for the offending"

"Drinking was a significant cause of the offending"

"Drinking was one of a number of factors that resulted in the offence"

"Alcohol consumption played an unknown role in the offending"

- Please use the box below to provide any additional comments you might have regarding ways of improving the definition, recording and collating of such offences.

- Please use the box below for notes about any current initiatives that you are undertaking to reduce alcohol-related crime and disorder in your area, or approaches that you have found particularly useful and effective.

- Do you think that alcohol-related disorder in your area over the past 5 years has

Reduced Substantially

Reduced

Stayed about the same

Increased

Increased Substantially

Please complete and return to the Social Issues Research Centre,
28 St Clements, Oxford OX4 1AB in the FREEPOST envelope provided

Crime Reduction Partnerships - 2

Alcohol-related violence and disorder survey

- On a scale of 0 to 10, what is your perception of the level of alcohol-related crime & disorder in your town/city centre prior to the introduction of the Partnership?

(where 0=no problem and 10 represents a serious problem)

0 1 2 3 4 5 6 7 8 9 10

- Do you keep any figures on alcohol-related crime?

YES NO

Who supplies you with this information?

Voluntary Organisations Trade Associations Local Police

Accident & Emergency Residents Associations Other

- How much of your work is concerned with alcohol related disorder?

0-9% 10-19% 20-29% 30-39% 40-49% 50-59% 60-69% 70-79% 80-89% 90-100%

- Which of the following organisations are involved in the partnership?

Local Police Accident & Emergency Trade Associations Residents Associations

Voluntary Organisations Local Authority Other

(If other - please specify)

- How often does the partnership meet?

Weekly Bi-weekly Monthly Bi-monthly Quarterly

- When did the partnership start?

- How is the work of the partnership to be evaluated?

(Please give details below in the space provided)

- How is the partnership funded?

(Please give details below in the space provided)

- Do you have any documentation that outlines the goals and achievements of the partnership?

YES NO

Would it be possible to forward a copy of this/these report(s)?

YES NO

- What is your current perception of the scale of alcohol-related disorder in your area on a scale of 1 to ten ? (where 0=no problem and 10 represents a serious problem)

0 1 2 3 4 5 6 7 8 9 10

Please complete and return to the Social Issues Research Centre, 28 St Clements, Oxford in the FREEPOST envelope provided

City Centre Managers - 3

Alcohol-related violence and disorder survey

- Approximately how many licensed premises are there in the town/city centre?

0-50 50-100 100-150 150-200 200-250 250-300 300-350 350-400 400+

- What is your perception of alcohol-related crime and disorder in your town/city centre on a scale of 0-10 where 0=no problem and 10 represents a serious problem?

0 1 2 3 4 5 6 7 8 9 10

- Are you involved with co-operative partnership schemes that deal with alcohol-related problems?

YES NO

With which types of organisation are you involved?

Voluntary Organisations Accident & Emergency Trade Associations Residents Associations

Local Police Local Authority Crime Reduction Partnerships Other

- Do you keep any figures on alcohol-related crime?

YES NO

What form do these take? (If other - please specify)

Computer Records Written Files Other

- How much of your work is concerned with alcohol related disorder?

0-10% 11-20% 21-30% 31-40% 41-50% 51-60% 61-70% 71-80% 81-90% 91-100%

- What measures do you have to help combat alcohol-related crime

CCTV Pub Watch Club Watch Radio Links Other

- In your estimation how many people visit the town/city centre on a Friday and Saturday night?

- Does your department produce any reports that document alcohol-related disorder?

YES NO

Would it be possible to forward a copy of this/these report(s)?

YES NO

- In your opinion, which of these statements best describes current trends?

Alcohol-related disorder is decreasing substantially Alcohol-related disorder is decreasing Alcohol-related disorder is constant Alcohol-related disorder is increasing Alcohol-related disorder is increasing substantially

Please complete and return to the Social Issues Research Centre, 28 St Clements, Oxford in the FREEPOST envelope provided.

A&E Telephone Survey - 4

A&E QUESTIONNAIRE		Yes=1 No=0 Sometimes= 2
Do you currently record whether a patient has consumed alcohol?		
If Sometimes		
Under what circumstances?		
If Yes		
What form does this take?		
	Visual assessment	
	Breathalyser	
	BAL	
	other	
Who makes the assessment?		
	Triage nurse	
	Doctor	
	Receptionist	
	other	
What is the primary purpose of recording alcohol consumption?		
Do you think this system could be improved?		
How?		
If No		
Would you be prepared to do so?		
What advantages/ disadvantages would you say there were?		
Who would be the best person on the team to do so?		
	Triage nurse	
	Doctor	
	Receptionist	
	other	
Why?		
What would you envisage being the most appropriate form of assessment?		
	Visual assessment	
	Breathalyser	
	other	

All		
Would you be prepared to ask where the patient had last consumed alcohol?		
What proportion of violent injury admissions are related to alcohol?		0-10%
		10-20%
		20-30%
		30-40%
		40-50%
		50-60%
		60-70%
		70-80%
		80-90%
		90-100%
Can you give an average daily figure for A&E attendances?		0-50
		50-100
		100-150
		150-200
		200-250
		250-300
Does this figure increase on Friday and Saturday nights?		Yes
By what proportion?		0-10%
		10-20%
		20-30%
		30-40%
		40-50%
		50%+
Do you pass information on to the police?		
Under what circumstances?		

