



Crime and Disorder Act 1998 (extract)

1998 CHAPTER 37

Part I Prevention of crime and disorder

5. Authorities responsible for strategies

(1) Subject to the provisions of this section, the functions conferred by section 6 below shall be exercisable in relation to each local government area by the responsible authorities, that is to say—

- (a) the council for the area and, where the area is a district and the council is not a unitary authority, the council for the county which includes the district; and
- (b) every chief officer of police any part of whose police area lies within the area.

(2) In exercising those functions, the responsible authorities shall act in co-operation with the following persons and bodies, namely—

- (a) every police authority any part of whose police area lies within the area;
- (b) every probation committee or health authority any part of whose area lies within the area; and
- (c) every person or body of a description which is for the time being prescribed by order of the Secretary of State under this subsection;

and it shall be the duty of those persons and bodies to co-operate in the exercise by the responsible authorities of those functions.

(3) The responsible authorities shall also invite the participation in their exercise of those functions of at least one person or body of each description which is for the time being prescribed by order of the Secretary of State under this subsection.

(4) In this section and sections 6 and 7 below “local government area” means—

- (a) in relation to England, each district or London borough, the City of London, the Isle of Wight and the Isles of Scilly;
- (b) in relation to Wales, each county or county borough.

6 Formulation and implementation of strategies

(1) The responsible authorities for a local government area shall, in accordance with the provisions of section 5 above and this section, formulate and implement, for each relevant period, a strategy for the reduction of crime and disorder in the area.

Alcohol-related crime and disorder data: guidance for local partnerships (extract)

John Tierney & Dick Hobbs (Home Office Online Report 08/03)

Chapter 3: Data Sources

Accident and Emergency (A & E) Departments could be a primary source of *indirect* data on alcohol-related crime and disorder. Dealing with intoxicated persons is a routine event for A & E staff, the busiest times being post - 11.00 p.m. on Fridays and Saturdays. In most cases, A & E attendance will be the result of some injury or dysfunction, rather than purely as a result of intoxication.

All attendees are initially assessed by a triage nurse, who will record if alcohol is present. To assess the underlying condition patients are routinely asked if they have been drinking and, if so, how much. Indications of a head injury, such as slurred speech, may appear the same as the effects of alcohol, for example. Patient notes are hand-written, but a typed discharge letter is generated for the patient to take to their GP, and this will sometimes mention alcohol. Case notes – both nursing and medical – usually record if a patient has consumed alcohol.

A & E data collection systems are designed for efficient clinical administration. A coding system, based upon four broad category groups, allows doctors to diagnose the precise problem(s) associated with each patient. The first category contains sub-categories, of which the following six are the most likely to be associated with alcohol consumption: 'Accident', 'Deliberate Self-Harm', 'Assault', 'Social', 'Other' and 'Did Not Wait' (an 'alcohol' code is used only for cases of alcoholic poisoning). The 'Did Not Wait' category is interesting in that A & E staff interviewed mentioned the frequency with which intoxicated attendees opt not to wait for treatment. 'Assault' refers to cases where the patient alleges that they have been assaulted, or a person with them, police or ambulance personnel does so on their behalf (A & E staff do not make this judgement). The second broad diagnosis category includes sub-categories defining the more specific nature of the injury or dysfunction. The most common sets of injuries consistent with patients who have been drinking excessively are 'Laceration', 'Abrasion', 'Contusion/Bruise' and 'Fracture'. The remaining two broad categories define the precise location of the complaint(s) on the body. A & E data are of limited usefulness for a *direct* approach. Whilst it is possible to define a broad set of injuries consistent with, say, an alleged or suspected assault A & E data would only reveal that a patient/victim had consumed alcohol, indicating the role alcohol plays in making people more vulnerable to an assault, and an assault with more serious consequences....

An A & E Department can, however, be an excellent source of *indirect* data. In addition to clinical and standard demographic data, coding procedures also pick up extra information relevant to alcohol consumption and its effects - most importantly, time of admittance into A & E and 'Place of Incident' (especially categories 'C'; Pub/Club and 'P'; Public Place). Data can also be broken down by mode of arrival (e.g. ambulance, police, 'walk in'), time elapsed since injury, and type of incident.