Lincolnshire Alcohol Health Needs Assessment 2014
Acknowledgments

A number of people a range of partner agencies gave up their time to contribute to this report, including the provision of local data. Special thanks are due to:

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Executive Summary and Recommendations

Alcohol can play a positive role in society and is an important part of our national culture. However, while the majority drink safely and sociably, excessive consumption by a minority is causing significant problems of ill health, crime and disorder and impacts on our society and economy. The impact of alcohol misuse is widespread and growing. Excessive drinking is a major cause of disease and mortality. The social impacts are also significant and include domestic violence, homelessness, teenage pregnancy, family breakdown and anti-social behaviour.

National comparator data tells us that whilst Lincolnshire as a whole has lower rates of alcohol related admissions to hospital than the England average; both Lincoln and Boston are above the national rate. Similarly, alcohol-related crime and violent crime rates show that the county is below the England average, however Lincoln and Boston are above the national rate.

Some of these trends can be explained by the composition of Lincoln and Boston's population as compared to the rest of the county, with a younger age profile than the other districts. Alcohol related violence is more prevalent amongst younger age groups. Furthermore, the higher levels of deprivation in Lincoln and Boston may be a contributing factor to their higher than national average hospital admission rate.

A number of information gaps are revealed in this document, including a lack of data on the prevalence of alcohol misuse amongst children and young people, particularly regarding where they obtain their alcohol and where they are drinking. Sharing of data and intelligence between partners could also be improved, including the sharing of Cardiff Model data from United Lincolnshire Hospital Trust.

The range and level of harm caused by alcohol across Lincolnshire is shown to be significant and wide-reaching, impacting on a range of statutory, non-statutory and third sector partners. A number of strategic recommendations are made in conclusion to this assessment to directly inform the development of the Lincolnshire Alcohol and Drug Strategy 2014-2019 and the associated Delivery Plan.

Summary of key findings

- It is estimated that there are over 17,000 people across Lincolnshire classified as dependent drinkers, a further 25,000 people are drinking at harmful or higher risk levels and over 106,000 people are drinking at a level that is an increasing risk to their health
- Alcohol cost the NHS in Lincolnshire an estimated £41.6 million in 2010/11, equating to £72 per adult in the county
- Costs to the local economy due to crime, lost productivity and wider social issues are likely to be considerably higher
- Alcohol-related hospital admissions have been increasing in all parts of the county over the last five years, though there was a slight drop in some areas from 2011/12 to 2012/13. The highest rates of hospital admissions are seen in Lincoln and Boston.
- There is a link between higher rates of admission and more deprived areas, reflecting national evidence that people in lower socio-economic groups are more likely to suffer harm due to alcohol, despite the fact that those in higher socio-economic groups are more likely to drink regularly and above recommended limits
• Alcohol-related mortality rates are lower in Lincolnshire than nationally and regionally, but they have increased from 2009 to 2012, particularly amongst women
• From 2009 to 2013, there were over 16,000 alcohol-related criminal offences and incidents. About a third of these were assaults and around a sixth were traffic incidents
• Key locations, particularly in Lincoln city centre and Skegness, see a large proportion of alcohol-related crime and specifically of violent crime
• Almost a fifth of alcohol-flagged offences were domestic, but this is likely to be an underestimate. Repeat victimisation is also under-recorded and data related to victims is poor
• Street drinking is difficult to quantify and appears to be under-reported
• Information on the effects of alcohol on Lincolnshire’s children and young people is very limited. Alcohol-related hospital admissions in under-18s are below the national average, except in Lincoln where they are much higher than average

Summary of key recommendations

• The development of effective partnership working is crucial; this should be embedded with the production of a clear strategy setting out a shared local vision for reducing alcohol harm.
• The development of a core intelligence base for alcohol-related issues, including:
  o Improving the sharing of data between agencies, including information from United Lincolnshire Hospital Trust (Cardiff model), community safety, East Midlands Ambulance Service, Lincolnshire Police etc.
  o Improved recording of alcohol data by partner agencies
  o Undertake further analysis of the location of alcohol-related violence, particularly proximity to licensed premises and the main routes from town centres towards residential areas and transport hubs
  o Develop links between local methods of recording data and Lincolnshire Police’s central incident recording system
  o Develop the gathering of data and intelligence by Police Community Support Officers and Urban Rangers on the location of street drinking in order to consolidate local knowledge
  o Improve the recording of incidents of street drinking, by directly stating if it is (or has been) taking place when officers are recording an offence or incident
• Identifying lead professionals in all relevant local agencies such as Social Services, the Police, elected members and a named Consultant as ‘alcohol lead’ within each acute hospital.
• A review of current education programmes should be undertaken to reduce the duplication of effort across local agencies
• Advice should be available to support parents to introduce their children to alcohol in a safe and sensible way
• Strengthening the training of health professionals on alcohol identification and brief advice as part of the MECC (Making Every Contact Count) programme
• Links should be made with national campaigns, such as Alcohol Awareness Week and Change4Life, to promote sensible drinking
• Public Health to use data and intelligence to inform and challenge licensing applications and licensing applications, utilising powers granted in The Licensing Act 2003
• The development of a brief intervention programme within pharmacies to identify those drinking at harmful and hazardous levels and increase the number of being referred to treatment services
• The development of a coherent and co-ordinated approach to identifying and supporting people with alcohol-related problems, including shared referral pathways
• The development of a better understanding of hidden drinkers, i.e. those at home not presenting to services
• Undertaking a multi-agency approach to those repeatedly presenting to 'blue light' services
1. Scope, Aims and Methods

The purpose of this health needs assessment is to bring together key evidence on the effects of alcohol in Lincolnshire and give a broad overview of the issues alcohol creates in the county. This has helped to inform the development of a county-wide strategy and action plan to prevent and reduce alcohol harm, developed by the Lincolnshire Substance Misuse Strategic Management Board and involving a range of partners, as identified in the Health Needs Assessment. It does not look at other forms of substance misuse, or undertake a detailed assessment of treatment services.

Aim

To develop an understanding of the health and broader social and economic impacts of alcohol across Lincolnshire, in order to shape future strategy and service planning.

Objectives

- To give an overview of the scope and scale of health, social and economic impacts caused by alcohol across Lincolnshire
- To consider the impact on key groups, including children and young people
- To describe existing services which aim to prevent and reduce alcohol harm and review the evidence regarding effective interventions
- To engage and seek the views of key stakeholders
- To identify priorities for future service planning and strategy related to alcohol (including additional work required to address gaps in knowledge)

Methods

Health

Some data was obtained from the Local Alcohol Profiles for England (LAPE), a national alcohol dataset from the North West Public Health Observatory (now part of Public Health England). These profiles have been produced on an annual basis since 2006 and contain 25 alcohol related indicators for every Local Authority.\(^1\)

More current local data was obtained from the Secondary Use Service (SUS). Data was analysed between April 2009 and December 2012 examining the volume, rate and type of alcohol related hospital admissions. Further analysis was carried out to look at the gender and age of patients admitted to establish any trends. The data was also projected to March 2013 in order to estimate an increase or decrease between financial years. This was calculated by dividing the total number of alcohol specific hospital admissions by 9 (i.e. April – December 2012 is 9 months). The result was then multiplied by 12 to give an estimate for the full 12 months.

In general, indicators for alcohol harm are based on alcohol-specific conditions, in which every case is caused by alcohol, and alcohol-attributable conditions, which includes alcohol specific conditions \textit{and} those where alcohol causes some (but not all) of the cases. For mortality, the National Statistics definition of alcohol-related deaths is very similar to, but not exactly the same as, the list of alcohol-specific conditions. It includes all deaths from liver fibrosis and cirrhosis (except biliary cirrhosis). It is intended to allow for consistent comparisons over time for those deaths most clearly associated with alcohol consumption. A full list of these conditions can be found in Appendix A.\(^2\)
Ambulance data was obtained from East Midlands Ambulance Service (EMAS). The data analysed covered the time period July 2010 to October 2013. EMAS do not record if a 'call out' was alcohol related at the time of pick up and there are no specific data fields that allow the recording of alcohol related pick-ups. Therefore in order to estimate the level of alcohol related ambulance call outs in Lincolnshire the following estimation was applied to the data.

- Time of reporting: 1600 to 0600 (the time has been extended from the commonly used 2100 to 0600 to emphasise the pattern of pick-ups over time)
- Incident category – "Chief Complaint" falling within five categories:
  - Overdose / ingestion / poisoning
  - Psychiatric / suicide attempt
  - Assault
  - Falls / back injuries
  - Unconscious / passing out

The results from this are discussed in the Health section.

**Crime and disorder**

Crime data was provided by Lincolnshire Police from searches of the Niche records management system and analysis of the quantity, type, location and timing of offences for the period August 2012 to July 2013 and the totals and spread of offences from April 2009. Both victim and offender information was analysed.

Lincolnshire Police noted a number of limitations relating to this data; particularly that alcohol involvement or the domestic nature of an incident may not always be flagged on the recording system, and may be under-recorded. The numbers reported are therefore likely to be an under-representation. In addition, a number of records had missing data on victims and offenders’ dates of birth, nationalities and occupations.

Further information on rates of violent crime was provided by Public Health England. This is based on proportions of certain types of offence which are considered attributable to alcohol, which has been determined nationally.\(^3\)

Information was also obtained from Lincolnshire Probation Trust in relation to offenders who were identified as having alcohol-related problems. The information was extracted from the Oasys system and IAPS database which is used by the probation service to audit alcohol programmes and other group work interventions.

Data on breathalyser results from road traffic collisions in the last three years was provided by Lincolnshire Road Safety Partnership.

**Social and economic**

Information on the economic effects of alcohol was obtained from a literature search carried out by Lincolnshire Knowledge and Resource Service (LKRS), and modelled data produced by Alcohol Concern.\(^4\)

Information on children and young people was obtained from a number of sources including the Lincolnshire Joint Strategic Needs Assessment, data provided by Children’s Services on school exclusions and information provided by Trading Standards in relation to underage sales. Information on economic migrants was obtained from a literature search conducted by LKRS.
Literature review

Given that this assessment encompasses a very broad range of types and degrees of alcohol-related harm, it was not feasible to conduct an in-depth review of all the programmes and interventions available for prevention, reduction and treatment. Therefore a summary of national guidelines and high-level reviews (such as Cochrane Reviews) was produced, based on evidence overviews compiled by Lincolnshire Knowledge and Resource Service. It is anticipated that further in-depth literature searches may be needed to inform future work.

Stakeholder analysis

An event was held on 29th October 2013 to engage with stakeholders from a range of organisations. Participants took part in three discussion sessions on the impacts of alcohol relating to health, crime, and social and economic issues. In each session, they were asked to identify the key issues which their organisation encounters in relation to alcohol, which were the highest priorities, and what action was already being taken. Each group was then asked to identify three key priorities for Lincolnshire. A summary of the key themes identified is included in Appendix B.
2. Background and Policy Context

50 years ago, the United Kingdom had one of the lowest levels of alcohol consumption in Europe. Today, alcohol is part of our daily lives and national culture. Most people drink responsibly and enjoy alcohol for relaxation and socialising. However drinking to excess has become increasingly socially acceptable, leading to increasing health, social and economic impacts. There is an overwhelming body of evidence for the health risks of alcohol misuse, including acute alcohol poisoning, unsafe sex and unintentional injuries. In the long term, alcohol is associated with a number of illnesses including chronic liver disease, heart disease and stroke. There is also an increased risk of certain types of cancer. In 2011/12 there were 1.2 million alcohol-related hospital admissions.

Alcohol is also associated with a range of social problems. It is linked to almost 1 million violent crimes per year – 44% of all violent crime – as well as other forms of anti-social behaviour. Domestic abuse, relationship breakdown, homelessness, unemployment and productivity losses can all be associated with alcohol or with certain patterns of drinking.

Overall, alcohol-related harm is estimated to cost £21 billion per year to the UK economy. It is clear that alcohol has an impact across society, and poses a huge challenge for the public, private and voluntary sectors.

This report brings together key evidence on the effects of alcohol in Lincolnshire. The purpose is to inform the development of a county-wide strategy and action plan to tackle the challenges alcohol creates for people across Lincolnshire. It is hoped that this will result in an effective, co-ordinated, partnership approach from all organisations with a role in the prevention, reduction and mitigation of alcohol-related harm.

Definitions

A number of different terms are used to describe the different amounts of alcohol consumed and the potential effects on health. In terms of an individual's health, alcohol problems can be described by the pattern and level of drinking:

- **Lower risk drinking** is drinking in a way that is unlikely to cause significant harm to yourself or others. This means drinking no more than 3-4 units per day for men, and 2-3 units per day for women. Drinking even less than this is advisable in certain circumstances, such as when driving, operating machinery or pregnant.

- **Hazardous drinking** is drinking above safe limits in a way that increases the risk of harm. This is often equated with increasing risk drinking, regularly drinking between 22 and 55 units per week (men), or between 15 and 35 units per week (women). Drinking at this level increases the risk of damaging your health when compared to non-drinkers, in addition hazardous drinkers may suffer from fatigue, depression, weight gain and poor sleep.

- **Harmful drinking** is drinking above safe limits causing physical or mental harm such as injuries, acute alcohol poisoning, liver disease or depression.
This is often equated with **higher risk drinking**, regularly drinking more than 50 units per week (men) or more than 35 units per week (women). Drunk in this level means there is a much higher risk of developing alcohol-related medical conditions, including liver cirrhosis, cancer and high blood pressure.

- **Binge drinking** is drinking more than twice the recommended daily limit in one session (8 units for men or 6 units for women).

- **Dependent drinking** is characterised by a craving or "inner drive" to drink alcohol despite harmful consequences and withdrawal symptoms on stopping drinking.

**National Policy Context**

The most recent Government Alcohol Strategy was published in March 2012. The strategy focuses on preventing alcohol-related harm by reducing the number of people drinking to excess and making "less risky" drinking the norm, both through local and national action. This is expected in turn to reduce the impacts of alcohol on health, crime and other areas.

Following consultation on the Alcohol Strategy, the key policies will focus on strengthening mandatory licensing conditions, challenging the alcohol industry to encourage responsible drinking and supporting local authorities to take action locally.

The National Institute for Health and Care Excellence (NICE) has published a briefing for local authorities recommending a range of actions they can take to implement the national strategy locally. This includes influencing where alcohol is sold through planning regulations, ensuring licensed premises operate responsibly, enforcing laws on underage sales, commissioning alcohol treatment services and being responsible for the assessment of alcohol as part of the NHS Health Check programme.

**Local Context**

Lincolnshire is a large, rural county with an estimated population of 718,800 in 2012. The county has a diverse geography with large rural and agricultural areas, urban areas and market towns and a long Eastern coastline. The population density in the county is just 121 persons per square kilometre (less than a third of the average for England and Wales).

In the 10 year period between the 2001 and 2011 censuses the population increased by around 10%, higher than the rate of growth observed nationally. The population of older people increased proportionally faster and according to the ONS 2012 mid-year population estimates, 21.6% of the Lincolnshire population are aged over 65, compared to 17% in England and Wales. The population increase in recent years has been predominantly fuelled by in-migration of older people and retirees to the east coast and of international workers to the agricultural industries particularly in the south east of the county. The population of Lincolnshire is projected to increase to around 796,500 by 2021; and the proportion of people aged over 65 is expected to reach over 24% in the county in the same year.
Deprivation

Across the county, 12% of people live within the 20% most deprived areas of England. However, although this ‘average’ deprivation is lower than nationally, there are differences across the county. In Lincoln City 28.4% of people live within this national quintile of deprivation, followed by 22.3% in East Lindsey and 19.5% in Boston Borough. Nationally, deprivation tends to be associated with pockets of urban areas, which in Lincolnshire can be found in the areas of Lincoln, Gainsborough and Boston for example, however with relatively poor transport and broadband infrastructure the county also suffers from wide areas of rural deprivation.

Figure 1: Deprivation – quintile of deprivation in England per LSOA

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Source: Dept for Communities and Local Government (DCLG)

Employment and skills

Average unemployment is lower than nationally, however there are pockets of long term unemployment as well as seasonal employment and unemployment in the major industries of agriculture and tourism. Unemployment among the younger
The population (aged 24 and below) is higher than the national average. The predominantly low-wage and low-skilled economy encourages the outflow of more highly educated residents and the general levels of education among adults are below the national and regional levels according to the ONS.

Table 1: Summary of demographic and socio-economic characteristics in Lincolnshire

<table>
<thead>
<tr>
<th>District</th>
<th>Population (1)</th>
<th>Proportion of 65+ (2)</th>
<th>Projected increase by 2021 (3)</th>
<th>People in deprivation (4)</th>
<th>Unemployment (5)</th>
<th>Youth unemployment (6)</th>
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<td>Boston</td>
<td>64,800</td>
<td>20.5%</td>
<td>17.0%</td>
<td>19.5%</td>
<td>2.4%</td>
<td>4.5%</td>
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<td>East Lindsey</td>
<td>136,600</td>
<td>27.1%</td>
<td>11.4%</td>
<td>22.3%</td>
<td>3.3%</td>
<td>6.5%</td>
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<td>Lincoln</td>
<td>94,600</td>
<td>14.5%</td>
<td>1.4%</td>
<td>28.4%</td>
<td>4.1%</td>
<td>4.3%</td>
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<td>North Kesteven</td>
<td>109,300</td>
<td>21.7%</td>
<td>11.3%</td>
<td>0.0%</td>
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<td>South Holland</td>
<td>88,500</td>
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<td>90,000</td>
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<td>Lincolnshire</td>
<td>718,800</td>
<td>21.6%</td>
<td>10.8%</td>
<td>11.7%</td>
<td>2.7%</td>
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Key to Table 1:
1) ONS, 2012 mid-year population estimate
2) Proportion of the 2012 population aged 65 or over; ONS 2012 mid-year population estimate
3) Total population increase based on the difference between 2012 mid-year estimates and the 2021 projected population estimates; ONS
4) Percentage of population living in 20% most deprived areas in England, based on 2012 population estimates and 2010 IMD scores.
5) Claimant count as proportion of working age population, November 2013
6) Claimant count for ages 18-24, November 2013

Ethnicity and country of birth

At the 2011 census, the non-white population made up 2.4% of Lincolnshire residents compared to 1.4% in 2001. Despite the increase, the rate remains lower than the national non-white population of 14%.

Between 2001 and 2011 the number of Lincolnshire residents who were born outside the UK more than doubled. According to the ONS 2011 population census, the proportion of foreign-born residents in Lincolnshire stood at 7.1% (compared to 13.8% nationally). The majority of recently arrived international migrants came from Eastern and Central Europe and tended to be younger and more economically active than the UK-born residents of Lincolnshire.

General Health

Based on the 2011 census, the proportion of people who declared having bad or very bad health was slightly higher in Lincolnshire than in England (5.9% compared to 5.5%). The data from the census shows a link between poor health and an ageing population, and also suggests a link between poor health and deprivation (although IMD scores themselves do include aspects of health). East Lindsey district had the highest proportion of self-reported poor health among the Lincolnshire districts across the entire adult population. The proportion of people of all ages whose day-to-day activities are limited is also greater in Lincolnshire than in England (20.4% compared to 17.6%).
In Lincolnshire, it is estimated that there are 17,160 dependent drinkers, whilst 29,949 people drink at higher risk levels, and over 106,000 at levels of increasing risk. Existing data shows that hospital admissions due to alcohol are lower than the national average. However, problems due to alcohol are not evenly distributed across the county, and in Lincoln hospital admissions are considerably higher than the national average.18

Current Service Provision

A number of programmes have been undertaken in recent years by different partners across Lincolnshire to tackle issues around alcohol harm. Past activities have included training of frontline NHS staff, funding of alcohol liaison nurses in acute hospital settings, a number of police operations focused on alcohol-related crime and licensing, media campaigns on drink-driving and counterfeit alcohol, and road safety campaigns.

There is also a large amount of work undertaken co-ordinating and liaising through a number of different forums, such as partnerships between Lincolnshire Police, Lincolnshire Safer Communities and district councils, and communication between statutory and voluntary bodies such as the Street Pastors.

Public Health commissioned projects include:

- A pilot of Payment by Results is being run in Lincolnshire, supporting service users on their wider wellbeing needs.

Lincolnshire Police projects include:

- An operation where officers meet and greet members of the public who are on a night out in Lincoln city centre. As pubs begin to close, officers carry out high-visibility patrols near premises, engage with the public and take action when required. As nightclubs close, officers aim to deter disorder as people make their way home or at locations such as taxi ranks and fast food outlets.
- An operation targeting street drinking in Spalding which has also involved community liaison, use of social media to gauge public opinion on the issue and work with local MPs. Regular multi-agency meetings take place with South Holland District Council, the Outreach team, health workers, DART, Addaction and the UK Borders Agency. Spalding has been selected as a case study for national guidance when new powers under the Anti-social Behaviour Crime & Policing Bill are introduced.
- Another street drinking operation is currently ongoing in Boston, with similar operations in Grantham and Lincoln, and operations in North and South Kesteven which emphasize licensed premises’ checks including door staff accreditation.
- Partnership work with Lincoln City Council on the Lincoln Street Drinking Strategy to reduce alcohol-fuelled antisocial behaviour and daytime crime, and signpost pathways to support those involved.

Safer Communities projects include:

- Underage sales test purchasing operations on an intelligence-led basis
- Operations to tackle the supply of illicit and counterfeit products
Local authority/district council projects include:

- The “Purple Flag” initiative in Lincoln, increasing safety in the night-time economy, and taking positive action against drink-related disorder.
- Approved taxi firm information given out by Street Pastors and wardens.
- Pubwatch in Lincoln, limiting alcohol related crime through a consistent approach to individuals that cause or threaten damage, disorder, violence and nuisance (via non-recurrent funding from the Lincoln Business Improvement Group).

Lincolnshire Road Safety Partnership projects include:

- Road Safety Officers delivering road safety programmes to secondary schools and colleges covering subjects including being an independent road user, introduction to becoming a motorcyclist or driver, passenger rights, drivers’ charter, drink and drug driving and ‘2fast2soon’.
- Road Safety Advisors deliver road safety programmes to primary schools including pedestrian training, traffic and environmental trails and general road safety.

Treatment

In 2012/13, 1,125 adults accessed treatment services for alcohol in Lincolnshire, of whom 867 (77%) were new clients. In addition, 17% of those in drug treatment reported additional alcohol problems (351 adults). Government guidance suggests that treatment services should have sufficient capacity for 15% of the dependent drinker population. Based on the estimate of 17,160 dependent drinkers across the county, current numbers in treatment equate to approximately 6.5%.

The average age of people in treatment was 42 years. The majority of clients in treatment were male (61%) and in terms of ethnicity 95% of the clients were ‘White British’. 80% of those in treatment were drinking at higher risk levels in the month prior to treatment, and 38% had drunk over 600 units in the previous month (this equates to over 21 units per day). In terms of other drug use, 3% were also using opiates or crack cocaine, 10% were using cannabis and 7% were using other drugs. In terms of socio-economic factors, 20% were unemployed at the start of treatment and 12% had a housing issue. 39% were receiving treatment from mental health services for reasons other than substance misuse.

75% of clients waited less than three weeks to start treatment, which is above the national average of 62%. The average length of treatment was 151 days, with 41% spending less than three months in treatment (national average 39%). Of those leaving treatment, 58% had successfully completed treatment (national average 63%). Of all clients in the calendar year 2012, 34% successfully completed treatment and did not return within 6 months (national average 36%). Only 1% attended residential rehab (compared with the national average of 4%).

When looking at referrals into treatment, the highest percentage of clients referred by themselves or via family and friends (55%). Other routes were much less common, with 9% being referred by their GP, 8% from the criminal justice system, 3% from hospitals and 10% from other health sources. An inference may be made that the referral pathways into treatment should be considered to ensure the need for treatment is addressed and referred via the correct pathway.
3. Evidence of what works

Given the broad remit of this HNA, it is not feasible to provide a detailed review of the evidence on all of the diverse approaches and techniques for prevention, identification and management of alcohol misuse. This section will therefore give a brief overview of high-level evidence and national guidance on tackling alcohol issues. It is expected that further in-depth reviews of the evidence will be needed when planning and commissioning services for different aspects of alcohol harm.

A wide range of services and interventions are available to reduce and manage alcohol-related problems, ranging from education in schools to specialist treatment of alcohol dependence. For the purpose of this overview, the evidence and guidance has been divided into four sections:

1. General approaches to alcohol-related harm
2. Reducing alcohol consumption and preventing alcohol problems
3. Identifying, reducing and treating alcohol problems
4. Reducing and managing alcohol-related crime and social problems

General approaches to alcohol-related harm

Published in 2009, *Signs for improvement* provided guidance from the Department of Health on commissioning interventions to reduce alcohol-related harm.¹⁹ It was originally aimed at primary care trusts in the old NHS structure. As well as specifying processes for effective commissioning, it identifies 'high impact changes' for reducing alcohol harm. Three of these are 'enabling' changes that 'set the scene for progress' and bridge all aspects of alcohol harm:

- Work in partnership across local organisations to assess need as part of the Joint Strategic Needs Assessment (JSNA), set priorities and agree a local vision
- Develop activities to control the impact of alcohol misuse by making use of all existing powers such as the Licensing Act (2003) and the Violent Crime Reduction Act (2006), managing the night-time economy and tackling alcohol in local planning frameworks.
- Influence change through advocacy by high-profile champions within all relevant local agencies, such as Social Services, the Police, elected members and a named Consultant as alcohol lead within each acute hospital.

Reducing alcohol consumption and preventing alcohol problems

Guidance from NICE recognises the importance of a population-wide approach to alcohol, with the aim of reducing the average level of alcohol consumption and hence reducing the number of people with problems caused by alcohol.⁷ Population-level approaches can:

- Reduce the number of people who start to drink at hazardous or harmful levels
- Help those who are not in contact with services
- Help those who have been advised to reduce their intake by building an environment that encourages and supports less risky drinking

Individual approaches are also important to make people aware of risks they may be taking and find ways of changing their drinking behaviour before harm occurs, or to
minimize and prevent further harm. In general, a combined approach is recommended.7

Children, schools and young people

A number of systematic reviews by a small group of authors have examined programmes which aim to prevent alcohol misuse by targeting children and young people.22-23 These found a number of problems with the evidence base, including poor reporting and wide variation in the results of studies which in some cases made it difficult to draw firm overall conclusions. Many studies were conducted in the United States, and may not be directly applicable to the UK setting. However, the authors suggested that family-based programmes had a small but consistent effect, and that school-based and "multi-component" programmes can be effective in some settings.22,24,25 Web-based and face-to-face feedback on social norms with university students were thought to be probably effective.23

Based on the evidence that is available, NICE has issued guidance on interventions in schools to prevent and reduce alcohol use, which recommends that:

• Schools should provide alcohol education as an integral part of the curriculum, including the damage alcohol can cause, attitudes to alcohol, assertiveness skills, self-esteem and how the media, parents, peers and society can influence alcohol use
• Alcohol education should be tailored to age and appropriate to children's learning needs
• A whole school approach to alcohol should be adopted, involving staff, parents and pupils and covering all aspects of school life including policies, training and physical environment
• If a child or young person is thought to be drinking harmful amounts, they should be offered brief advice, referral to specialist services should be considered and child protection issues should be taken into account.
• Local organisations should develop partnerships to support alcohol education, integrate it with community activities and involve families in planning.26

Education and awareness

There are a number of methods for increasing understanding and awareness of alcohol in the whole community, not just children and young people. As noted above, NICE recommends that alcohol education in schools is coordinated with wider community initiatives.26 One of the high impact changes from Signs for improvement is local social marketing activity which builds on and amplifies messages from national social marketing around alcohol.19 Current national activity includes campaigns such as Alcohol Awareness Week and links with Change4Life.

Licensing

Guidance from NICE on preventing harmful drinking recommends that local authorities, including Trading Standards departments, work with the police and other local organisations to minimise alcohol-related harm through licensing legislation, procedures and policies, by:

• Using crime and trauma data to map problem areas before developing a licensing policy which takes into account the "cumulative impact" of licensed
premises and limits the number of new premises if necessary, particularly in saturated areas.

- Ensuring that adequate resources are available to prevent underage and other illegal sales (for example, sales to people who are intoxicated or illegal imports of alcohol) through means such as test purchases
- Identifying premises making illegal sales and ensuring sanctions are fully applied, in particular against those that regularly or persistently make underage or other illegal sales.

Identifying, reducing and treating alcohol problems

*Models of care for alcohol misusers* (MoCAM) provides best practice guidance for planning and delivering an integrated treatment system for adults affected by alcohol, across the spectrum of hazardous, harmful and dependent drinking. It identifies four "tiers" of service:

**Tier 4**
- Residential, specialised alcohol assessment and treatment including prescribing, psychosocial therapies, support and aftercare
- Medical staff who specialise in substance misuse

**Tier 3**
- Community-based, specialised alcohol assessment and treatment including prescribing, psychosocial therapy and support within a care plan
- Specialised drug and alcohol practitioners and input from medical staff

**Tier 2**
- Open-access and outreach services providing alcohol advice, assessment, extended brief interventions and brief treatment in a range of settings
- "Shared care" with Tier 3/4 services

**Tier 1**
- Alcohol information, screening and brief advice in a wide range of settings*
- "Shared care" with specialist alcohol services.

*Tier 1 services may be provided in a wide range of non-specialist settings such as primary care, A&E, mental health services, social care, police, criminal justice settings and education. Tier 1 also includes "shared care" with specialist alcohol services by other services with a high proportion of alcohol-related problems, such as liver disease units or inpatient mental health units.

Specifically, it advises that commissioners ensure provision of screening, brief advice and brief interventions for hazardous and harmful drinkers, and more specialised treatment for moderately or severely dependent drinkers or those with complex problems. It also gives detailed quality criteria for the commissioning and provision of all of these services. More recent quality standards and commissioning guidance have been produced by NICE.
Screening, brief advice and brief interventions

A systematic review and meta-analysis by the Cochrane Collaboration found that brief interventions in primary care reduced alcohol consumptions by 4 to 5 units per week on average. Although the benefit was not clear for women, this may have been due to the small numbers of women included in the studies. Guidance from NICE recommends that professionals in all organisations who regularly come into contact with people at risk of harm from drinking offer screening using a validated tool such as AUDIT, AUDIT-C or FAST. In NHS settings it is recommended that, if feasible, screening is offered routinely to all adults. In non-NHS settings including social care, criminal justice and the voluntary sector, the focus should be on high-risk groups such as those involved in crime, at risk of domestic abuse or with drug problems. Following screening, professionals should take appropriate action:

- For people identified as hazardous or harmful drinkers, offer structured brief advice lasting around 5 to 15 minutes and based on an evidence-based resource which covers potential harms caused by drinking, barriers to change, strategies for change and setting goals
- For people who may be dependent on alcohol, refer to specialist services.

Screening and brief advice is one of the high impact changes identified by Signs for improvement, specifically for new patients and high-risk groups in primary care, as well as A&E departments and specialist units such as sexual health or fracture clinics. Signs for improvement also recommends provision in criminal justice settings, though it notes that evidence for this is more limited.

NICE states that for those who have not responded to brief advice, staff with appropriate training should offer an extended brief intervention over 20 to 30 minutes, using an approach such as motivational interviewing. People who receive extended brief interventions should be followed up and offered further sessions, or referral to specialist services if they have not benefited. Dependent drinkers and those with alcohol-related health problems should be referred to specialist services.

For children and young people aged 10 to 15 years, any professionals in regular contact with this group should undertake comprehensive assessment and appropriate action if they are thought to be at risk from their alcohol use. Referral to other services should be considered and the child’s capacity to consent should be assessed. Young people aged 16 to 17 who are at increased risk of alcohol-related harm should be offered screening, extended brief interventions and referral to specialist services if appropriate, taking into account capacity to consent.

NICE also highlights the importance of ensuring that professionals have sufficient time, resources, training and supervision to provide routine screening and structured brief advice. Commissioners should also ensure that resources are in place to cope with increased referrals to specialist services.

Specialised treatment for harmful or dependent drinking

NICE recommends that staff in NHS services which work with people who may be harmful or dependent drinkers should be competent to assess them using an appropriate tool and including risk assessment. For people referred to specialist services, assessment should include setting goals and brief triage. A more comprehensive assessment should be undertaken for likely dependent drinkers (for example, people scoring more than 15 on AUDIT) including detailed history of their
alcohol use, drug use, other health problems, cognitive function and readiness to change.31

All interventions should promote abstinence or moderation and prevent relapse, and should be delivered by appropriately trained and competent staff. This may include:

- Community-based interventions in most cases
- Intensive structured community-based interventions for moderately or severely dependent drinkers with very limited social support, complex co-morbidities or no response to initial community-based interventions
- Residential interventions for up to three months for homeless people.

Signs for improvement includes two high impact changes relating to treatment:

- Appoint a dedicated Alcohol Health Worker or Alcohol Liaison Nurse to work with the alcohol lead in each major acute hospital, to support the management of patients with alcohol problems and liaise with community services as well as providing education to staff and implementing screening and brief advice within the hospital
- Increase effectiveness of treatment services and provide capacity for at least 15% of dependent drinkers, including reviewing access times and potential "blockages" to access.19

Reducing and managing alcohol-related crime and social problems

Signs for improvement also considered controlling the impact of alcohol misuse to be a high impact change, and recommended making use of all existing powers such as the Licensing Act (2003) and the Violent Crime Reduction Act (2006) and taking measures to manage the night-time economy. As seen in the local figures, alcohol and the night-time economy are particularly associated with violent crime. Factors which have been implicated in alcohol-related violence include:

- the density of licensed premises,
- pre-loading with alcoholic drinks at home before a night out,
- vertical drinking establishments where drinking is an end in itself rather than an accompaniment to a meal, particularly in premises with issues like crowding, inadequate seating, dim lighting, discounted alcohol promotions, no food service, poorly trained staff or a permissive attitude to antisocial behaviour.

Reducing violence by reducing drinking

An evidence briefing by the World Health Organisation (WHO) suggests that, although evidence is limited, reducing the availability of alcohol by reducing the number of licensed premises, restricting hours of sale or raising prices is likely to be an effective way of reducing alcohol-related violence.32 It also states that there is some evidence that brief interventions and treatment for problem drinkers can reduce violence. A review of evidence on reoffending by the Scottish government noted the relationship between alcohol and violence in young people and the potential to reduce violence by reducing alcohol consumption, but did not assess whether interventions were effective.33
Preventing and tackling violence associated with drinking

The WHO also states that programmes which have aimed to improve drinking environments using methods such as staff training, codes of practice, strict enforcement of licensing laws, and community mobilisation have shown reductions in violence. However, in 2007, a Cochrane review found insufficient evidence to determine the effectiveness of initiatives in licensed premises, as very few studies measured the impact on number of injuries. A programme in Cardiff based on sharing data on assaults to enable effective enforcement in violence hotspots ("the Cardiff model") appeared to reduce the number of assaults over and above national reductions. Legal tools currently available to tackle alcohol-related crime and disorder include:

- Designated Public Place Orders (DPPOs)
- Drink Banning Orders (DBOs)
- Alcohol Treatment Requirements (ATRs)

There are also a number of voluntary schemes such as Purple Flag, which awards towns and cities that manage the night-time economy effectively to reduce crime and antisocial behaviour and increase the safety and wellbeing of visitors. Pubwatch aims to help licensed premises achieve a safe, secure and responsibly led social drinking environment and hence reduce alcohol-related crime.

Tackling reoffending

In terms of initiatives targeting those already involved in crime, an evidence summary for the Ministry of Justice in 2013 found that, unlike drug treatment, there was insufficient evidence to determine the impact of treatment for alcohol misuse on reoffending. It also noted that a trial of brief interventions following arrest for alcohol-related offences did not reduce re-arrest rates, though this was based on only one evaluation. It found mixed/promising evidence on prevention of further drink-driving by drink-driver education programmes, particularly those with multiple elements of education, psychotherapy/counselling and follow-up contact.

These conclusions were partially based on a systematic review in 2007 which identified very mixed evidence for the effectiveness of alcohol interventions in offender settings in reducing alcohol consumption and reoffending and found there was no consistently conclusive evidence for a particular approach.

Other issues

A briefing by the Alcohol Academy (an organisation which supports local alcohol leads) suggests that street drinking is a complex issue where there are no quick wins and many related, complex issues. It also argues that effective management should balance enforcement and support for the individual. Strategies for enforcement include the use of DPPOs and powers to require people to leave an area in response to alcohol-related disorder or environmental changes such as relocating benches.

Engagement with treatment and abstinence may be extremely difficult to achieve in street drinkers, and a broader approach may be more effective. Possible approaches might include a multi-agency case conferencing group, use of ATRs where there is criminal behaviour or unofficial alternative spaces for drinking, though these do not tackle the cause of the problem but simply relocate it.
4. Alcohol and Health in Lincolnshire

Summary

- Alcohol-related hospital admissions have been increasing in all parts of the county over the last five years, though there was a slight drop in some areas from 2011/12 to 2012/13.
- The highest rates of hospital admissions are seen in Lincoln and Boston.
- Men account for 70% of admissions for conditions directly caused by alcohol, and the highest rates of admission are seen in 35- to 44 year-olds.
- There is a link between higher rates of admission and more deprived areas, reflecting national evidence that people in lower socio-economic groups are more likely to suffer harm due to alcohol, despite the fact that those in higher socio-economic groups drink are more likely to drink regularly and above recommended limits.
- The most common reasons for admissions directly due to alcohol are mental and behavioural disorders, alcoholic liver disease and ethanol poisoning.
- Alcohol-related mortality rates are lower in Lincolnshire than nationally and regionally, but they have increased from 2009 to 2012, particularly amongst women.
- The most common causes of alcohol-related mortality locally are alcoholic liver disease and fibrosis and cirrhosis of the liver.

Hospital admissions

In terms of health, alcohol-related harm is defined as physical or mental harm caused either entirely or partly by alcohol. Nationally, two different measures are used to assess hospital admissions due to alcohol. One looks at alcohol-specific conditions where all cases of the condition are directly caused by alcohol. This includes both:

- Acute problems like alcohol poisoning (drinking a toxic amount of alcohol over a short period causing symptoms such as confusion, vomiting, hypothermia and even unconsciousness, seizures and death)
- Long-term conditions like alcoholic liver disease (gradual damage which can eventually cause scarring of the liver and life-threatening complications such as internal bleeding, build-up of toxins in the brain, kidney failure and also liver cancer)

However, there are many conditions where alcohol is known to cause (or contribute to) some cases, but it is not involved in all cases of that condition. This includes problems like high blood pressure, some types of cancer (such as bowel cancer), falls and some other types of accident. The proportion of these conditions which is thought to be due to alcohol has been determined nationally. These admissions, combined with the admissions for alcohol-specific conditions, are called alcohol-attributable admissions and give a broader picture of the number of hospital admissions caused by alcohol. A complete list of these conditions can be found in Appendix A.

Between April and December 2012, 2,369 (3.2 per 1,000 population) people across Lincolnshire were admitted to hospital for treatment of an alcohol-specific condition. There were a further 11,695 (15.8 per 1,000 population) hospital admissions in that period which were attributable to alcohol.
Alcohol-attributable hospital admissions

The rate of alcohol-attributable hospital admissions is slightly lower in Lincolnshire than the regional and national average. However, as might be expected there is considerable variation across the county. Lincoln sees the highest rates, with Boston second, and both these areas are above the national average. The lowest rates are in North Kesteven and West Lindsey, which fall well below the regional and national averages.

Over the last five years, there has been a generally increasing trend in alcohol-attributable hospital admissions for both the county as a whole and for all of the district council areas. This has been seen even in those areas where alcohol-attributable admissions are lower than the national average, such as North Kesteven. However, comparisons over time are difficult as they may have been affected by improvements in recording of secondary reasons for admission. Nationally it is thought that there has been a 50% increase in alcohol-attributable admissions since 2002/03, after adjusting for changes in recording.40

However, since 2011/12, it appears that there has been a small decrease in alcohol-attributable admissions in many parts of the county, including East Lindsey, North Kesteven and West Lindsey and the largest drop in Lincoln. On the other hand, the increase appears to have continued in South Holland, South Kesteven and particularly in Boston district, where there has been an increase of 7%.

Figure 2: Alcohol attributable admissions in Lincolnshire (European Age Standardised rate per 1,000 population)

National trends follow a similar pattern to those seen in Lincolnshire over the last five years, with a general increase followed by a slight drop. The rate of admissions in Lincoln is the only district that is higher than the rate in England.
Out of all conditions which are wholly or partially attributable to alcohol, the most common reasons for admission were:

- hypertensive diseases (problems related to high blood pressure)
- cardiac arrhythmias (irregular heartbeat)
- epilepsy, (which may include a range of disease from a brief seizure to status epilepticus, prolonged seizures that cannot be controlled)\(^4\)

Table 2: Number of alcohol-attributable admissions from 2009 to 2012 for the three most common conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13 (Estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertensive diseases</td>
<td>6,341</td>
<td>7,546</td>
<td>8,090</td>
<td>7,814</td>
</tr>
<tr>
<td>Cardiac arrhythmias</td>
<td>2,646</td>
<td>3,210</td>
<td>3,532</td>
<td>3,406</td>
</tr>
<tr>
<td>Epilepsy and status epilepticus</td>
<td>1,167</td>
<td>1,367</td>
<td>1,505</td>
<td>1,441</td>
</tr>
</tbody>
</table>

Source: Secondary Use Service data (Public Health Intelligence Team – Lincolnshire County Council)

**Alcohol-specific hospital admissions**

Looking solely at alcohol-specific conditions (those considered to have been caused entirely by alcohol), the number and rate of hospital admissions is also following an upward trend, with a slight decrease again seen from 2011/12 to 2012/13. For these conditions, admission rates are again highest in Lincoln, where they are considerably higher than the next two areas, Boston and East Lindsey.

Table 3: Number and crude rate per 100,000 of alcohol-specific hospital admissions from 2009 to 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13 (Estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2,837</td>
<td>3,084</td>
<td>3,446</td>
<td>3,159</td>
</tr>
<tr>
<td>Rate per 100,000 population</td>
<td>391</td>
<td>422</td>
<td>471</td>
<td>428</td>
</tr>
</tbody>
</table>

Source: Secondary Use Service data (Public Health Intelligence Team – Lincolnshire County Council)

Table 4: Alcohol-specific hospital admissions by district (crude rate per 100,000 population)

<table>
<thead>
<tr>
<th>District</th>
<th>Alcoholic-specific hospital admissions (rate per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010/11</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>422</td>
</tr>
<tr>
<td>Boston</td>
<td>336</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>449</td>
</tr>
<tr>
<td>Lincoln</td>
<td>919</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>267</td>
</tr>
<tr>
<td>South Holland</td>
<td>269</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>339</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>383</td>
</tr>
</tbody>
</table>

Source: Secondary Use Service data (Public Health Intelligence Team – Lincolnshire County Council)
Out of all alcohol-specific conditions, the highest numbers of admissions were caused by:

- mental and behavioural disorders due to the use of alcohol (this includes a wide range of problems from acute drunkenness to chronic alcohol dependence, alcohol withdrawal, hallucinations, memory loss and other conditions)\(^{12}\)
- alcoholic liver disease (gradual damage which can eventually cause scarring of the liver and life-threatening complications such as internal bleeding, buildup of toxins in the brain, kidney failure and also liver cancer)\(^{19}\)
- alcohol poisoning (symptoms such as confusion, vomiting, hypothermia and even unconsciousness, seizures and death due to consuming a large amount of alcohol over a short period)\(^{38}\)

**Hospital admissions by age, gender and deprivation**

Approximately 70% of alcohol-specific hospital admissions in Lincolnshire were amongst males. When examining the type of conditions seen in males and females, there was no clear distinction.

Figure 3 shows rates of alcohol-specific hospital admissions according to age and gender. It illustrates that males aged 35 to 44 have the highest rates of hospital admission for alcohol-specific conditions in Lincolnshire. Amongst females, this age group also has the highest rate of admissions.

Figure 3: Age Specific Rate per 1,000 population for alcohol-specific hospital admissions by age and gender

As noted in the background section, levels of deprivation vary across the county. At a national level, it is known that more deprived groups are more likely to suffer negative consequences of alcohol consumption, despite the fact that people with higher incomes and in managerial or professional jobs are more likely to drink regularly and above the recommended safe levels. NICE suggest that this may be because people from less affluent groups are affected by multiple factors such as poor diet which mean they are less able to protect themselves from the negative
effects of alcohol. Nationally, mortality from alcohol is much higher amongst those working in routine occupations and living in more deprived areas.

It was also found that there were a higher number of alcohol-attributable hospital admissions from the most deprived areas in Lincolnshire between April 2009 and December 2012. The most deprived area had 5524 admissions compared to 1415 in Quintile 5 (least deprived). The majority of these admissions were from Lower Level Super Output Areas (LLSOAs) within Lincoln District. An inference may be made that further alcohol prevention work is required within Lincoln district with particular focus in these LLSOAs.

At a local level, there is a clear relationship between the rate of hospital admissions wholly attributable to alcohol and the level of deprivation as classified by the Indices of Multiple Deprivation 2010. A higher IMD score indicates a higher level of deprivation, based on a number of factors such as employment, level of education, health and levels of crime within an area.

Figure 4 illustrates that the relative risk of being admitted for an alcohol-attributable condition increases with the level of deprivation a person/patient resides in. The graph was produced by taking the rate of admissions by deprivation quintile and then dividing that result by the Lincolnshire rate. The findings show that you are four times as likely to be admitted for an alcohol-attributable condition if you reside in the most deprived areas in Lincolnshire compared to the least deprived areas.

Figure 4 Relative risk of admission for an alcohol-attributable condition by IMD 2010 deprivation quintile

Source: Secondary Use Service data (Public Health Intelligence Team – Lincolnshire County Council) & Indices of Multiple Deprivation 2010

Mortality

According to data from the ONS, males accounted for two thirds of alcohol-related deaths in England in 2011, and mortality rates were the highest in the 55-59 age group for both genders. Overall, mortality rates doubled from 1992 to 2008, but since then have been more variable. Rates amongst women have remained relatively stable in the last ten years, with more fluctuation amongst men.
Figures for Lincolnshire are also available for 2012. In total, there were 330 alcohol-related deaths in Lincolnshire between 2009 and 2012. Table 5 shows that mortality rates are generally lower in Lincolnshire than in England and the East Midlands, but they have increased from 2009 to 2012. It is difficult to compare the local trend to that seen nationally, as national data is not yet available for 2012.

Table 5: Age-standardised alcohol-related death rates (per 100,000 population) for England, East Midlands and Lincolnshire 2009-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>England</td>
<td>EM</td>
<td>Lincolnshire</td>
<td>England</td>
<td>EM</td>
<td>Lincolnshire</td>
</tr>
<tr>
<td>2009</td>
<td>15.8</td>
<td>14.8</td>
<td>11.5</td>
<td>7.7</td>
<td>7.9</td>
<td>5.6</td>
</tr>
<tr>
<td>2010</td>
<td>16.1</td>
<td>16.3</td>
<td>13.1</td>
<td>7.5</td>
<td>6.8</td>
<td>6.0</td>
</tr>
<tr>
<td>2011</td>
<td>15.9</td>
<td>15.5</td>
<td>12.2</td>
<td>7.6</td>
<td>7.3</td>
<td>5.5</td>
</tr>
<tr>
<td>2012</td>
<td>-</td>
<td>-</td>
<td>12.8</td>
<td>-</td>
<td>-</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Source: Primary Care Mortality Database

Mortality rates are much higher amongst males than amongst females, as seen nationally. However, there was an increase observed in the female mortality rates between 2011 and 2012. Over the whole period from 2009 to 2012, there appears to have been a greater increase in female mortality rates than male. In terms of age, mortality rates were the highest among people aged 65 to 74 in Lincolnshire, slightly older than the peak age group nationally.

The most common causes of alcohol-related deaths in Lincolnshire are alcoholic liver disease, fibrosis and cirrhosis (scarring) of the liver. These problems usually result from gradual damage due to excessive drinking over a long period of time, and around 70% of people with alcohol-related liver disease have an alcohol dependency problem. Death can occur due to internal bleeding, build-up of toxins in the brain, kidney failure and also liver cancer. In severe cases, a liver transplant may be the only effective treatment, but is only possible if the person is well enough to survive a major operation and can commit to abstaining from alcohol for the rest of their lives.39

**East Midlands Ambulance Service**

Using the estimation measure described in the methodology there were 35,711 alcohol related ambulance call outs between July 2010 and October 2013 in Lincolnshire. Table 6 below shows the rate per 1,000 population by district in Lincolnshire.

Table 6. Alcohol related ambulance call outs (crude rate per 1,000 population)

<table>
<thead>
<tr>
<th>District</th>
<th>No. of ambulance call outs</th>
<th>Rate per 1,000 pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln</td>
<td>7736</td>
<td>79.8</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>7990</td>
<td>56.0</td>
</tr>
<tr>
<td>South Holland</td>
<td>4089</td>
<td>45.0</td>
</tr>
<tr>
<td>Boston</td>
<td>3017</td>
<td>42.8</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>5395</td>
<td>38.8</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>3480</td>
<td>38.0</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>4004</td>
<td>37.5</td>
</tr>
<tr>
<td>Grand Total</td>
<td>35711</td>
<td>48.4</td>
</tr>
</tbody>
</table>

Source: East Midlands Ambulance Service
The majority of alcohol related ambulance callouts were from Lincoln district. An inference may be made that this is related to the night time economy.

Temporal analysis found that 6,479 (18.1%) of the call outs were on a Saturday in Lincolnshire. Lincoln district has a higher proportion of call outs on a Saturday compared to the rest of Lincolnshire. This analysis also showed that Lincoln district had more call outs in the early hours of the morning than the rest of Lincolnshire. (Figure 5)

Figure 5 – Comparison of call out days/times for alcohol related ambulance callouts between Lincoln district and the rest of Lincolnshire.

Source: East Midlands Ambulance Service (Analysis by Public Health Intelligence Team, LCC)

Stakeholder Feedback

The stakeholder event on 29th October 2013 identified some key areas during the health discussion. Including improving the brief intervention skills of frontline health and social care professionals, encouraging early intervention and ensuring they have the knowledge and skills to talk to service users about alcohol and how to enjoy it responsibly. Clear referral pathways should also be in place for those requiring the support of treatment services.

Stakeholders also highlighted the need to improve links between hospital and treatment services, both for new and current clients when admitted and discharged. Improved working practices also need to be developed between mental health services and treatment providers, ensuring those patients with a dual diagnosis receive effective treatment. Work around alcohol and drug misuse should be linked together.

Consideration should also be given to the intergenerational impacts of alcohol misuse, including the impact of parental drinking on children. There are also wider societal impacts of alcohol misuse, not just the individual. Concerns were also highlighted around the strength of alcohol and the low cost of some drinks.
5. Alcohol, Crime and Disorder in Lincolnshire

Summary

- From 2009 to 2013, there were over 16,000 alcohol-related offences and incidents. About a third of these were assaults and around a sixth were traffic incidents.
- Key locations, particularly in Lincoln city centre and Skegness, see a large proportion of alcohol-related crime and specifically of violent crime.
- Levels of alcohol-related violence have risen since 2009, but now appear to be falling compared to last year. Seasonal peaks occur in August, October and December.
- Alcohol-related violence is linked to the night-time economy in towns across the county, with high risk periods during late evening and early hours at the weekend.
- Almost a fifth of alcohol-flagged offences were domestic, but this is likely to be an underestimate. Repeat victimisation is also under-reported and data related to victims is poor.
- Alcohol was considered to be an influencing factor in offending for 36.2% of male offenders and 31.1% of female offenders.
- Street drinking is difficult to quantify and appears to be under-reported.
- In the last three years, there have been 45 positive breathalyser tests on drivers involved in fatal or serious accidents, and 204 in slight accidents.

Types of incident and trends

Lincolnshire Police provided data from April 2009 to July 2013. In this period, there were over 16,000 offences and incidents related to alcohol, in almost 8,000 different locations. There were 189 different types of crime or incident. Of these, 36.0% were assault, and 15.7% were alcohol-related traffic incidents. Overall, 19.4% of all alcohol flagged offences and incidents were also flagged as domestic. Public order offences (such as affray and use of threatening words or behaviour), anti-social behaviour (such as drunken behaviour) and criminal damage were also common. Shoplifting was the seventh most common alcohol-related offence.

Table 7: Top ten categories of alcohol flagged crimes and incidents from April 2009 to July 2013

<table>
<thead>
<tr>
<th>Offence Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of crimes and incidents</td>
<td>16,350</td>
<td></td>
</tr>
</tbody>
</table>
If considering violent offences only, almost 60% were assault occasioning actual bodily harm (assaults which cause harm or injury, but with no complications or intent to cause serious harm – see glossary) and 31% were common assault (assaults which cause no mark or injury – see glossary). Almost 50% of all alcohol related violence offences were undetected and only 36.0% were detected, and between 5% and 6% were no crimes, unresolved or resolved. Within the offence category of Section 47 assault the greater proportion are undetected, 47.5% and this is also the case for Section 39 assault with 53.1% undetected.

Table 8: Top six alcohol related violent offences in Lincolnshire from April 2009 to July 2013

<table>
<thead>
<tr>
<th>Offence</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault occasioning actual bodily harm (ABH)</td>
<td>3,473</td>
<td>59.1%</td>
</tr>
<tr>
<td>Common assault</td>
<td>1,826</td>
<td>31.1%</td>
</tr>
<tr>
<td>Grievous bodily harm with intent</td>
<td>160</td>
<td>2.7%</td>
</tr>
<tr>
<td>Grievous bodily harm without intent</td>
<td>91</td>
<td>1.6%</td>
</tr>
<tr>
<td>Possession of an offensive weapon</td>
<td>53</td>
<td>0.9%</td>
</tr>
<tr>
<td>Less serious grievous bodily harm without intent</td>
<td>53</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Source: Lincolnshire Police

Figure 6 shows a noticeable increase in violent offences from January 2010 onwards, with further increases in 2011 and 2012. The reason for this is unclear, but it should be noted that recording depends on alcohol being flagged as a factor and this may not always be consistent.

Figure 6: Alcohol related violent offences in Lincolnshire between April 2009 and July 2013.
Seasonality

There is also a seasonal trend in violent offences. Offences peak in the summer (generally August), with smaller peaks in October and December, and the lowest numbers are recorded in February and November. Summer peaks may be associated with increased alcohol consumption and high numbers of visitors and tourists. The pattern varies by town, with Skegness experiencing particularly high levels in the summer months and a considerable spike in August. In Lincoln, spikes are seen in December, with increases in the summer in 2010/2011, but a decrease from June to October in 2012. Further analysis found that the highest risk periods for an alcohol related offence are during weekends, suggesting a link with the night-time economy.

Figure 7: Day of the week on which alcohol-related violent offences commenced during the period August 2012 to July 2013

Although peak times varied by town, this pattern was seen even in smaller towns. It was particularly noticeable in Lincoln, where Saturdays saw more than double the offences of any other day except Sunday (Sunday includes crimes in the early hours following on from Saturday night). Mid-week peaks varied by town. For example, there was a peak on Wednesday in Lincoln, coinciding with traditional student night on Tuesday night and hence the early hours of Wednesday. High risk times tend to coincide with pub and nightclub closure. For example, on Friday night in Lincoln, the number of offences increases between 10 and 11pm, and is highest from 11pm to 3am, falling slightly for the period from 3 to 4am. The pattern of offences indicate that the night time economy on a Friday and Saturday night are resulting in triggers which result in higher levels of alcohol related violent offences.
Table 9: Periods of higher risk of a violent alcohol related offence split by town for the period 1/8/2012 to 31/7/2013.

<table>
<thead>
<tr>
<th>Day Of The Week</th>
<th>Location</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boston</td>
<td>0100-0200</td>
<td>0000-0100</td>
<td>2200-0000</td>
<td>0300-0400</td>
<td>2100-0200</td>
<td>0400-0500</td>
<td>2100-0500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2100-2300</td>
<td></td>
<td></td>
<td>0400-0500</td>
<td>2100-0500</td>
<td>0000-0300</td>
<td>1900-2000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0000-0100</td>
<td>2200-0000</td>
<td>0300-0400</td>
<td>2100-0200</td>
<td>0400-0500</td>
<td>2100-0500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0400-0500</td>
<td>2100-0500</td>
<td>0000-0300</td>
<td>1900-2000</td>
</tr>
<tr>
<td></td>
<td>Bourne</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2100-0400</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gainsborough</td>
<td>2100-2200</td>
<td>2100-2200</td>
<td>0000-0300</td>
<td>1900-2000</td>
<td>2200-0300</td>
<td>0400-0500</td>
<td>2100-0500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0000-0300</td>
<td>1900-2000</td>
</tr>
<tr>
<td></td>
<td>Grantham</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lincoln</td>
<td>0000-0400</td>
<td>0100-0300</td>
<td>2000-0400</td>
<td>-0400-2000</td>
<td>-0300-2100</td>
<td>2100-0500</td>
<td>0500-0600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2000-2300</td>
<td>2000-2200</td>
<td>0200-0500</td>
<td>0000-0300</td>
<td>1900-2000</td>
<td>0500-0600</td>
<td>0500-2200-2300</td>
</tr>
<tr>
<td></td>
<td>Louth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mablethorpe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skegness</td>
<td>0000-0300</td>
<td>2300-0300</td>
<td>0300-2300</td>
<td>0100-0200</td>
<td>0400-0500</td>
<td>2200-0300</td>
<td>0400-2100-2200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2000-2200</td>
<td>2000-2200</td>
<td>0200-0500</td>
<td>0000-0300</td>
<td>1900-2000</td>
<td>0500-0600</td>
<td>0500-2200-2300</td>
</tr>
<tr>
<td></td>
<td>Sleaford</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spalding</td>
<td>2300-0000</td>
<td>0300-0400</td>
<td>2200-2300</td>
<td>2100-0300</td>
<td>0400-2100-2200</td>
<td>0600-2200-2300</td>
<td>0500-0600</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stamford</td>
<td>0000-0100</td>
<td>2200-0400</td>
<td>-0400-2000</td>
<td>2200-0300</td>
<td>-0300-2100</td>
<td>-0400-2200</td>
<td>2200-0000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Lincolnshire Police

**Location of incidents**

Data from Public Health England shows that Lincoln has a very high rate of alcohol-related crime and violent crime compared to the national average, whilst Boston is somewhat higher than average. All other areas are lower than average. However, when compared to similar areas, both Lincoln and Boston district council areas have very high rates of alcohol-related crime. South Holland also has high rates of alcohol-related crime compared with similar areas, but this is less marked for violent crime, and rates are slightly raised in East Lindsey. In most areas, alcohol-related crime has been decreasing, but the trend in Boston has been increasing, and there were also increases in South Holland and West Lindsey.20

From police data, the highest raw numbers of offences and incidents – by some distance – were in Carholme ward in Lincoln (1,675) and Abbey ward in Lincoln (1,055). Third highest was Scarbrough ward in Skegness (674) followed by Central ward in Boston (533). Within these wards, specific streets can be identified as having the highest numbers of incidents.
Almost one-fifth (19.4%) of alcohol-related incidents and offences were flagged as domestic, but this proportion varied across the county. Some of this variation may be because wards with high numbers of visitors and a large night-time economy have more non-domestic incidents than those that are largely residential. The wards with the highest numbers of domestic incidents were again Abbey and Carholme in Lincoln, but this only represented 15.6% and 7.3% of overall incidents in these wards. Moorland and Birchwood wards (Lincoln) had over 39% of incidents flagged as domestic, and fifty-one wards had over 30%. However, the overall number of offences in these wards was generally low (less than 50).

In terms of violent offences, the top three wards were again Carholme (11.6%) and Abbey (5.7%), and Scarborough ward in Skegness (5.4%). Lincoln city centre and Skegness also contributed substantially to trends in violent offences for the county overall. Carholme and Abbey are busy areas for Lincoln’s night-time economy, and Scarborough attracts high numbers of holidaymakers, so it may be that many offences are committed by non-residents of these wards.

Figure 8 also illustrate that in addition to weekend offences in towns, some rural areas experience more offences at the weekend.

Figure 8: Lower Super Output Areas of Lincolnshire and the time period they are subject to alcohol related violent offences

Looking at the characteristics of the top six LSOAs with the highest number of alcohol related violent offences identified that two were ranked in the worst 10% on the Indices of Deprivation for Employment in 2010. A third was in the worst 20% and half were in the worst 25% of areas for employment. The number of LSOA which fall within the worst ranked on the Indices of Deprivation increases when the offences are considered for the period Monday to Thursday, with 3/10 in the worst 10% rising to 6/10 in the worst 25%.
Table 10: Lower Super Output Areas with the highest number of alcohol related violence offences and the highest number of offences Monday to Thursday with the corresponding rank for Employment Deprivation.

<table>
<thead>
<tr>
<th>Local authority name</th>
<th>LSOA Code</th>
<th>Total Number alcohol related violent offences</th>
<th>Alcohol Related Violent Offences Monday to Thursday</th>
<th>Employment Rank, 1 most deprived</th>
<th>Worst 10% for employment</th>
<th>Worst 20% for employment</th>
<th>Worst 25% for employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln</td>
<td>E01026143</td>
<td>89</td>
<td>27</td>
<td>14,403</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lincoln</td>
<td>E01026122</td>
<td>73</td>
<td>18</td>
<td>7,723</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>E01026093</td>
<td>65</td>
<td>18</td>
<td>929</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>E01026069</td>
<td>45</td>
<td>17</td>
<td>1,876</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Boston</td>
<td>E01026006</td>
<td>44</td>
<td>10</td>
<td>6,529</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincoln</td>
<td>E01026176</td>
<td>41</td>
<td>17</td>
<td>5,208</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Source: Lincolnshire Police

The areas with the highest number of offences overall also have the highest number committed Monday to Thursday and there is some indication that the level of unemployment might be a contributory factor as suggested by the offender profile of all alcohol related crimes. Four out of these six LSOA's are also within the worst LSOA's for alcohol attributable hospital admissions mentioned in the health section.

**Offenders**

Named offenders were listed on 11,474 of the alcohol related crimes and incidents, of these there were 8,285 different offenders, 22 linked to 10 or more offences and 157 linked to 5 or more offences. Repeat offenders were extremely common within the data with the top 6 offenders recording 131 crimes and incidents in the analysed period. Offenders were more likely to be male (84.6%) and from the United Kingdom (78.4%).

Table 11: Offender age and gender breakdown for alcohol related violence (April 2009 to July 2013).

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14 years</td>
<td>8</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>15-24 years</td>
<td>598</td>
<td>3,593</td>
<td>4,191</td>
</tr>
<tr>
<td>25-34 years</td>
<td>421</td>
<td>2,953</td>
<td>3,374</td>
</tr>
<tr>
<td>35-44 years</td>
<td>410</td>
<td>1,778</td>
<td>2,188</td>
</tr>
<tr>
<td>45-54 years</td>
<td>255</td>
<td>935</td>
<td>1,190</td>
</tr>
<tr>
<td>55-64 years</td>
<td>59</td>
<td>287</td>
<td>346</td>
</tr>
<tr>
<td>65 years and over</td>
<td>12</td>
<td>105</td>
<td>117</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,736</td>
<td>9,678</td>
<td>11,441</td>
</tr>
</tbody>
</table>

Source: Lincolnshire Police

The majority of the offenders were male (84.6%). Over 36% of all offenders were aged between 15 and 24 years. A high proportion of offenders were unemployed (37.8% of males and 47.8% of females). 56 of the offenders either did not state their
age or gender or it was classed as indeterminate. Amongst men, factory work (11.4%), construction (5.9%) and farming (4.0%) were the next most common occupations. For women, factory work and being a student were next most common, both at less than 5%. Male offenders were slightly more likely than females to be involved in a domestic offence or incident (16.3% compared with 13.1%).

Information from Lincolnshire Probation Trust showed that between September 2010 and July 2013 there were 5,011 offenders dealt with by the Probation Service. Information was analysed for 4,984 offenders as some of the records were potential duplicates or incomplete records. The majority of offenders were male, and the most common age group was between 25 and 34 years. Over a third of offenders had alcohol identified as an influencing factor for their offending behaviour. The proportion is highest amongst young women aged 18-24 and male offenders aged 25 to 44.

Table 12: Gender and age of all offenders identified with alcohol as an influencing factor

<table>
<thead>
<tr>
<th>Age group</th>
<th>All offenders</th>
<th>Offenders with alcohol as an influencing factor</th>
<th>All offenders</th>
<th>Offenders with alcohol as an influencing factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>1025</td>
<td>359 (35.0%)</td>
<td>120</td>
<td>46 (38.3%)</td>
</tr>
<tr>
<td>25-34</td>
<td>1489</td>
<td>565 (38.0%)</td>
<td>208</td>
<td>57 (27.4%)</td>
</tr>
<tr>
<td>35-44</td>
<td>951</td>
<td>367 (38.6%)</td>
<td>154</td>
<td>46 (29.9%)</td>
</tr>
<tr>
<td>45-54</td>
<td>556</td>
<td>203 (36.5%)</td>
<td>110</td>
<td>33 (30.0%)</td>
</tr>
<tr>
<td>55+</td>
<td>323</td>
<td>78 (24.1%)</td>
<td>36</td>
<td>13 (36.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>4344</td>
<td>1572 (36.2%)</td>
<td>628</td>
<td>195 (31.1%)</td>
</tr>
</tbody>
</table>

Source: Lincolnshire Probation Trust

Between April 2009 and July 2013, 181 offenders completed an alcohol programme, of which 109 were drink-impaired driver programmes and 72 low-intensity alcohol programmes. In the same period, 285 offenders received an Alcohol Treatment Referral (ATR) order, of whom 33 (11.6%) received more than one ATR during the time period. Assuming that similar numbers of offenders had alcohol identified as an influencing factor between April 2009 and September 2010, this equates to about 7% completing an alcohol programme and about 11% receiving an alcohol treatment order. There may therefore be potential to offer alcohol interventions to more offenders.
Victims

Details of the victim’s name were listed on 8,219 offences, but information on 506 records such as date of birth, nationality and occupation was not recorded consistently. From the data available, 47% were male and 53% were female. Female victims were more likely to be involved in domestic incidents (55.3% compared to 12.3%). Over a third of male and female victims were aged between 15 and 24 years.

Table 13: Victim age and gender breakdown for alcohol related violence (April 2009 to July 2013).

<table>
<thead>
<tr>
<th>Age band</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14 years</td>
<td>102</td>
<td>91</td>
<td>193</td>
</tr>
<tr>
<td>15-24 years</td>
<td>1333</td>
<td>1319</td>
<td>2652</td>
</tr>
<tr>
<td>25-34 years</td>
<td>1042</td>
<td>898</td>
<td>1940</td>
</tr>
<tr>
<td>35-44 years</td>
<td>855</td>
<td>603</td>
<td>1458</td>
</tr>
<tr>
<td>45-54 years</td>
<td>562</td>
<td>478</td>
<td>1040</td>
</tr>
<tr>
<td>55-64 years</td>
<td>129</td>
<td>183</td>
<td>312</td>
</tr>
<tr>
<td>64 and over</td>
<td>62</td>
<td>56</td>
<td>118</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4085</strong></td>
<td><strong>3628</strong></td>
<td><strong>7713</strong></td>
</tr>
</tbody>
</table>

Information on nationality was only recorded in 60% of cases, but where it was recorded, 83.3% of victims were from the UK. Self-defined ethnicity was recorded more frequently, and 79.2% of victims described themselves as White British with 9.4% stating that they were in the White Other group. Ethnicity was not stated for 8.2% of victims and all other categories were less than 1%.

Occupation was listed for less than 50% of victims. As for offenders, there were high percentages of unemployed people (41.8% of females and 30.1% of males). Other common occupations included housewife, student, retail and factory work for women;
for men, student, factory work, building/construction and retail were common, as well as taxi drivers, bar staff and security staff.

In a quarter of cases where a victim was recorded, the victim experienced more than one offence in the period, a total of 771 repeat victims. Females represented 477 (61.7%) of repeat victims. Six victims were subjected to between eight and fifteen offences in the period, with almost 90% of these being an assault. In addition, almost 90% were flagged as domestic. This suggests that repeat victims of alcohol-related crime may be linked to domestic incidents, and reductions may have a positive impact on the overall number of assaults.

Repeat female victims were most likely to be aged around 30 to 43. For men, there was a higher percentage of victims in the younger age group (around 20 to 33) compared to women. In addition, a lower proportion of male repeat victims were involved in domestic incidents, suggesting there may be more involved in incidents outside the home, perhaps associated with violence after a night out.

Street drinking

Alcohol consumption in public places (other than licensed premises) is generally termed street drinking. It has been an issue of political and public concern in relation to anti-social behaviour and nuisance. To examine the extent of street drinking in Lincolnshire, police records were searched for incidents which included reference to 'drunken behaviour', 'inconsiderate behaviour', 'street drinking', 'concern for safety', and 'shouting and swearing'. However it was difficult to establish the extent of this due to reporting and recording issues primarily linked to under reporting.

Operations which have specifically targeted street drinking have gathered much more information. An operation focused on alcohol-related street enforcement in Boston from October to December 2012, working in partnership with Boston Town Rangers and Boston Borough CCTV. Evaluation identified that 111 people were spoken to, and where full details were known, 63% were foreign nationals. The evaluation concluded that the operation had reassured the public, that enforcement may not be the most effective solution to resolve the problem, and that recording needs improvement to fully understand the problem and the success of interventions.

Counterfeit and illegal alcohol

Counterfeit or fake alcohol poses a serious risk to health as it may contain an array of hazardous chemicals with a range of effects on the body, from nausea and vomiting to liver and kidney problems. In some cases, counterfeit alcohol has been found to contain methanol, which can cause permanent blindness. In addition, it may be much stronger than legally produced alcohol and drinkers may therefore be unaware of how much alcohol they are consuming.

It is difficult to know the extent to which counterfeit alcohol is being sold, as it often goes unnoticed and undetected, but at a national level sales are said to have increased in recent years. In Lincolnshire, a joint initiative between Lincolnshire Safer Communities, HMRC and Lincolnshire Police has been actively enforcing the law on counterfeit and non-duty-paid alcohol and tobacco since 2011. According to information provided by Trading Standards, enforcement visits were carried out at twenty-two premises across the county between March 2011 and March 2013. Over 270 litres of counterfeit or non-duty-paid alcohol were seized and seventeen premises had their licenses revoked (although a handful of these were due to illegal
sales of tobacco only). There have been several successful prosecutions for illegal alcohol and tobacco sales.44

Road Safety

Alcohol misuse also plays a significant role in road traffic collisions and affects all types of road users. Combinations of law enforcement and sustained publicity campaigns have substantially reduced the number of alcohol related collisions over the last twenty years. Nevertheless, more than 65 people a year provide a positive breathalyser result following a slight collision. In addition, around 15 people each year involved in a fatal or serious accident provide a positive result.

However, the true number of accidents where alcohol contributed may be higher than this, as in some cases breath tests were not requested or not provided (for example, for medical reasons). In the three years up to June 2013, there were 310 collisions where a responding police officer felt that alcohol contributed to the incident. In 296 of these, including 63 fatal or serious collisions, the officer felt that alcohol was one of the top three factors contributing to the collision.

Stakeholder Feedback

The stakeholder event on 29th October 2013 identified some key areas during the crime and disorder discussion. Including ensuring multi-agency working across crime prevention and health providers continues to improve. Work to improve the intelligence base around alcohol misuse should be developed, such as implementing the Cardiff Model across Lincolnshire. The impact of anti-social behaviour, violent crime and other criminal activity resulting from alcohol misuse should also be measured. A clear definition of 'street drinking' is needed.
6. Alcohol, Social and Economic Issues in Lincolnshire

Summary
- Alcohol cost the NHS in Lincolnshire an estimated £41.6 million in 2010/11, equating to £72 per adult in the county.
- Costs to the local economy due to crime, lost productivity and wider social issues are likely to be considerably higher.
- A large proportion of homeless people have alcohol problems and they are much more likely to die of an alcohol-related condition, but they may be less likely to access “mainstream” services.
- Information on the effects of alcohol on Lincolnshire’s children and young people is very limited. Alcohol-related hospital admissions in under-18s are below the national average, except in Lincoln where they are much higher than average.

Economic and financial effects of alcohol

Alcohol Concern estimates that alcohol costs to the healthcare system in Lincolnshire were approximately £41.6 million in 2010/11, equating to £72 per adult.4 This can be broken down to:

- £8.1 million for attendances at A&E
- £25.5 million for inpatient hospital admissions
- £8 million for outpatient hospital visits.

Hospital admissions wholly attributable to alcohol (such as those due to alcoholic liver disease) cost Lincolnshire £3.9 million and admissions partially attributable to alcohol cost £21.6 million in 2010/11. This does not include the cost of consultations in primary care, such as with GPs or practice nurses. In previous studies nationally and in other regions, costs in primary care were much less than hospital costs, but nevertheless significant.45,46

Other costs include ambulance journeys and social services, particularly the cost of children’s services associated with parental alcohol problems, which may be considerable.45

Moreover, the costs to the healthcare system are swamped by costs due to crime and other social problems. Nationally the government estimates that:

- Costs to the NHS are £3.5 billion per year
- Costs due to crime are £11 billion per year
- Costs due to lost productivity are £7.3 billion per year.11

Similarly a study in Leeds found that costs to the criminal justice system, the workplace and costs due to wider social problems were each considerably greater than the health and social care costs.45 It is likely that this pattern is reflected in Lincolnshire.

Homelessness

Alcohol has been recognised as both a cause and a consequence of homelessness. According to NICE, it has been estimated that 38 to 50% of homeless people have alcohol problems, and many also have chronic physical or mental health conditions.
It is often particularly difficult for this group to engage with services, and they also have poorer outcomes. Homelessness encompasses not only people sleeping rough on the streets, but also those in bed and breakfasts, hostels, squats or on the sofas and floors of friends and family.

National research undertaken for the homelessness charity Crisis found that 14.4% of deaths amongst homeless people were due to alcohol, compared to 1.3% in the general population. In a survey for Crisis, 36% cited alcohol use as one of the reasons they first became homeless, and only 1 in 3 homeless dependent drinkers had accessed treatment services in the last year. Alcohol was also a common factor in people being banned from homelessness services such as shelters and hostels.

Figure 10: Statutorily homeless households in Lincolnshire (rate per 1,000 households)

Figure 10 shows that the highest rates of homelessness are in South Kesteven and Lincoln. The rates in these two districts are higher than the rate for East Midlands and England for 2011/12. In the other districts and in the county as a whole, homelessness is lower than the national average. However, this only includes “statutorily homeless” households, who have applied to the local authority for help, and been recognised as entitled to housing. To achieve this, households must fulfil a number of criteria, including showing that it was not their fault that they became homeless and that they have a “priority need” such as pregnancy, dependent children, mental illness or disability.

Therefore these numbers are unlikely to include many single homeless people, and will also exclude many immigrants. The numbers of people who are actually homeless are therefore likely to be higher, and further work would be needed to estimate this more accurately.
Children and Young People

The Chief Medical Officer recommends that children should not drink alcohol until at least the age of 15, as drinking at a young age is associated with numerous physical and mental health problems, as well as difficulties at school, antisocial behaviour and unsafe sex. Nationally, self-reported drinking amongst young people has fallen in recent years. In 2012, 10% of 11 to 15-year-olds reported drinking in the last week, compared to 26% in 2003. However, the numbers drinking – and the amount that they drink – remains well above the European average. In the same national survey, pupils were much more likely to drink if they lived with other people who drank alcohol, and if they thought their parents would not mind them drinking.50

At a local level, it is difficult to establish the number of young people experiencing problems with alcohol. Hospital admissions in under-18s for conditions directly caused by alcohol may give some indication of the scale of the problem compared with other areas. Based on data from 2008/09 to 2010/11, the rate of hospital admissions amongst under-18s in Lincolnshire was 46.5 per 100,000, lower than the regional and national average. In Lincoln, however, the rate was much higher at 87.2 per 100,000, ranking 280th out of 326 local authority areas nationally (where a lower ranking represents a worse performance).1

In the 2012/13 school year, there were 27 fixed term exclusions and 5 permanent exclusions from schools in Lincolnshire due to alcohol. Most of these related to students in Year 9 and Year 10 (aged around 13 to 15).51 Table 12 shows the number of young people that the Youth Offending Service (YOS) have dealt with over the past three years and how many had alcohol identified as a problem within their life.

Table 14: Number of Young People the YOS have dealt with that have alcohol identified as a problem within their life.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Young People</th>
<th>Alcohol Mentioned</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>898</td>
<td>234</td>
<td>26%</td>
</tr>
<tr>
<td>2010</td>
<td>796</td>
<td>101</td>
<td>13%</td>
</tr>
<tr>
<td>2011</td>
<td>445</td>
<td>40</td>
<td>9%</td>
</tr>
<tr>
<td>2012</td>
<td>240</td>
<td>16</td>
<td>7%</td>
</tr>
<tr>
<td>2013 (7m)</td>
<td></td>
<td>71</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Children's Services, Lincolnshire County Council

The Joint Strategic Needs assessment also notes that there is a lack of robust intelligence available to assess the number of young people living with a parent, carer or loved one who is misusing any substances.52 This is known as hidden harm. In Lincolnshire, 28% of adults accessing alcohol treatment in 2012/13 were living with a child.20 A national report by the Children's Commissioner found that the scale of the problem is not clear, but it is likely that many more children are affected by parental alcohol use than drug use. One estimate has suggested that 30% of children live with a binge drinker, 22% with a hazardous drinker and 2.5% with a harmful drinker.53 The effects on children, particularly at lower levels of consumption, are not clearly understood, but issues such as family conflict and domestic abuse are likely to be important.53

Underage sales of alcohol are another concern in relation to children and young people. In Lincolnshire, Trading Standards and Lincolnshire Police work together to
conduct test purchases in premises where underage sales are suspected. Between 2010 and 2013, 425 test purchases were attempted, and on 61 occasions (14%) resulted in a sale. 39 out of 321 (12%) test purchases at off-licence premises such as shops resulted in a sale, and 26 out of 104 (25%) at on-licence premises such as bars and pubs. This led to 53 fixed penalty notices being issued, 13 licences reviewed or other action being taken. 44

Only a small number of young people access treatment services for alcohol in Lincolnshire. Out of 232 young people who presented to substance misuse services during 2012/13, 11 were for alcohol only, and 93 reported a combination of cannabis and alcohol misuse. Nearly all of these young people were aged 14 or over, and 58% of those using both cannabis and alcohol were aged 16 or 17. Referrals to young people’s substance misuse services (including both alcohol and drugs) came mainly from youth justice, education, children’s and family services or from self, family and friends. 20

**Stakeholder Feedback**

The stakeholder event on 29th October 2013 identified some key areas during the social and economic discussion. Including improving messages to target ‘hidden drinkers’, i.e. those drinking at home and not presenting to services. Evening economies should not have a sole focus on alcohol. Work should be undertaken with employers to ensure effective alcohol policies are developed to reduce the negative impact alcohol can have on the workplace. Links need to continue to be developed for wider issues such as housing and mental health.
7. References


21. Information provided by Strategy and Performance Team (Lincolnshire County Council Public Health Directorate).


23. Moreira MT, Smith LA, Foxcroft D. Social norms interventions to reduce alcohol misuse in university or college students. Cochrane Database Syst Rev. 2009 Jan;CD006748.


29. National Institute for Health and Clinical Excellence. Services for the identification and treatment of hazardous drinking, harmful drinking and
alcohol dependence in children, young people and adults. Commissioning


44. Information provided by Lincolnshire Trading Standards.


51. Information provided by Children’s Services.


Appendix A: Alcohol-related conditions

Alcohol-specific conditions

For these conditions, it is assumed that every case is directly caused by alcohol consumption. These are:

- Alcohol-induced pseudo-Cushing’s syndrome
- Mental and behavioural disorders due to use of alcohol
- Degeneration of nervous system due to alcohol
- Alcoholic polyneuropathy
- Alcoholic myopathy
- Alcoholic cardiomyopathy
- Alcoholic gastritis
- Alcoholic liver disease
- Chronic pancreatitis (alcohol induced)
- Ethanol poisoning
- Methanol poisoning
- Toxic effect of alcohol, unspecified
- Accidental poisoning by and exposure to alcohol

Alcohol-attributable conditions

These include all the alcohol-specific conditions and those where alcohol is believed to cause some (but not all) of the cases. Each condition has an “alcohol-attributable fraction”, or proportion of cases that are due to alcohol, which is then used to determine how many hospital admissions are due to alcohol. The fractions are determined nationally and used in the production of Local Alcohol Profiles for England (LAPE), although the methods are currently under review. The conditions are:

- Malignant neoplasm of lip, oral cavity and pharynx
- Malignant neoplasm of oesophagus
- Malignant neoplasm of colon
- Malignant neoplasm of rectum
- Malignant neoplasm of liver and intrahepatic bile ducts
- Malignant neoplasm of larynx
- Malignant neoplasm of breast
- Epilepsy and status epilepticus
- Hypertensive diseases
- Cardiac arrhythmias
- Heart failure
- Haemorrhagic stroke
- Ischaemic stroke
- Oesophageal varices
- Gastro-oesophageal laceration-haemorrhage syndrome
- Chronic hepatitis (not elsewhere classified) and fibrosis and cirrhosis of liver
- Acute and chronic pancreatitis
- Psoriasis
- Spontaneous abortion
- Pedestrian traffic accident- hospital admission
- Pedestrian traffic accident- death
• Road traffic accident (driver/rider) - hospital admission
• Road traffic accident (driver/rider) - death
• Water transport accidents
• Air/space transport accidents
• Fall injuries
• Work/machine injuries
• Firearm injuries
• Drowning
• Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract
• Fire injuries
• Accidental excessive cold
• Intentional self-harm/event of undetermined intent
• Assault

**Alcohol-related deaths**

The National Statistics definition of alcohol-related deaths includes those caused by:

• Mental and behavioural disorders due to use of alcohol
• Degeneration of nervous system due to alcohol
• Alcoholic polyneuropathy
• Alcoholic cardiomyopathy
• Alcoholic gastritis
• Alcoholic liver disease
• Chronic hepatitis (not elsewhere classified)
• Fibrosis and cirrhosis of liver (excluding biliary cirrhosis)
• Alcohol induced chronic pancreatitis
• Accidental poisoning by and exposure to alcohol
• Intentional self-poisoning by and exposure to alcohol
• Poisoning by and exposure to alcohol, undetermined intent
Appendix B: Stakeholder Event

An event was held on 29th October 2013 to engage with stakeholders from a range of organisations. Participants took part in three discussion sessions on the impacts of alcohol relating to health, crime, and social and economic issues. In each session, they were asked to identify the key issues which their organisation encounters in relation to alcohol, which of these were the highest priorities, and what action was already being taken. Each group was then asked to agree three key priorities for Lincolnshire. The feedback included in this document is based on these group priorities.

Attendees

Organisations represented at the event included:

- Acis Housing
- Addaction Lincolnshire
- Bala House Homeless Hostel (Grantham)
- City of Lincoln Council
- DART
- East Lindsey District Council
- Framework
- Leap
- Lincolnshire Action Trust
- Lincolnshire County Council (including Public Health, Trading Standards, Youth Offending Service)
- Lincolnshire Partnership Foundation Trust
- Lincolnshire Police
- Lincolnshire Road Safety Partnership
- NACRO
- Renew Louth
- Street Pastors
- United Lincolnshire Hospitals NHS Trust
- West Lindsey District Council

Feedback

Across all topics, there were a number of issues that were similar:

- Improve partnership working
  - Effective links between partners including acute hospitals, community health services, probation, housing support services and so on.
  - Improving links with treatment services including clear pathways for referral and when to refer (harmful, hazardous, dependent drinkers?)
  - Improving alcohol element of "Making Every Contact Count" training for frontline staff

- Develop intelligence
  - Implement the Cardiff model
  - Develop an intelligence base for alcohol-related information from partners in different fields such as health and crime.
  - Undertake profiling to understand how best to encourage behaviour change
Develop understanding of "hidden drinkers" (those at home not presenting to services)

- Improve awareness / prevention
  - Workplace health
  - Improve understanding of units and health implications of drinking
  - Impact on family and society, not just the individual

- Street drinking

- Availability of alcohol
  - Reduce the strength campaign (Ipswich model)
  - Licensing regulations including opening hours and sales to intoxicated people

Feedback on specific topics is included in the main body of the document under health, crime and social and economic issues.
## Appendix C: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol poisoning</strong></td>
<td>Drinking a toxic amount of alcohol over a short period causing symptoms such as confusion, vomiting, hypothermia and even unconsciousness, seizures and death.</td>
</tr>
<tr>
<td><strong>Alcohol-attributable conditions</strong></td>
<td>Alcohol-specific conditions and those where alcohol causes some (but not all) of the cases, including problems like high blood pressure, some types of cancer and falls. A complete list of these conditions can be found in Appendix A.</td>
</tr>
<tr>
<td><strong>Alcohol-specific conditions</strong></td>
<td>Conditions where all cases are caused by alcohol, such as alcoholic liver disease or alcohol-induced mental and behavioural disorders. A complete list of these conditions can be found in Appendix A.</td>
</tr>
<tr>
<td><strong>Alcoholic liver disease</strong></td>
<td>Gradual damage which can eventually cause scarring of the liver and life-threatening complications such as internal bleeding, build-up of toxins in the brain, kidney failure and also liver cancer.</td>
</tr>
<tr>
<td><strong>Assault occasioning actual bodily harm (ABH)</strong></td>
<td>This is an assault which leads to injuries such as grazes, scratches, bruising, swelling, black eye, broken nose, broken teeth, broken fingers or toes, but there are no complications or intent to commit serious harm. Non-visible injuries which cause substantial pain or discomfort may also fall into this category.</td>
</tr>
<tr>
<td><strong>Common assault</strong></td>
<td>This includes slaps, punches or other types of attack which leave no mark or injury, or a passing moment of pain. Common assault can occur even if there is no physical harm.</td>
</tr>
<tr>
<td><strong>Repeat offender or victim</strong></td>
<td>In this analysis, a repeat offender or victim is anyone who was linked to more than one offence in the period April 2009 to July 2013.</td>
</tr>
<tr>
<td><strong>Street drinking</strong></td>
<td>Alcohol consumption in public places (rather than at home or in licensed premises).</td>
</tr>
</tbody>
</table>