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Systematic review of Australian policing interventions to reduce alcohol-related violence — A maxillofacial perspective

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ABSTRACT

Alcohol-related violence remains to be a health concern, and the oral and maxillofacial surgeons are routinely exposed to its impact on the victims and the healthcare system. At a community level, various policing interventions have been implemented to address this violent crime in and around licensed premises. Current study sought to examine the effectiveness of these interventions in Australia. Ten eligible studies, that evaluated the impact of 15 Australian policing interventions on reducing alcohol-related violence in the night-time economy, were included in this systematic review. Due to the heterogeneity of the study designs and the insufficiency of the reported data, quantitative meta-analysis of the findings was precluded. Instead, a critical narrative approach was used. Police-recorded assault rate was the primary outcome measured to assess the level of alcohol-related violence, which was influenced by the level of police duties implemented during the intervention period. The overall evidence base to support Australian policing interventions was found to be poor and was limited by the low-quality study design observed in the majority of the included studies. However, there is some evidence to suggest interventions involving proactive policing to be more effective than traditional reactive policing. There was also an increased emphasis on developing policing interventions in collaborative partnerships, demonstrating the synergistic benefits in crime prevention through community partnerships, where communities were encouraged to take ownerships of their own problems and develop targeted responses to alcohol-related violence rather than a one-size-fits-all approach. Further research is required to define their effectiveness with the use of more appropriate and robust methodologies.

1. Introduction

Violence or interpersonal violence occurring as the result of alcohol intoxication has been well established (Graham & Homel, 2008; Wells & Graham, 2003) and remains a major challenge to all levels of Australian government (Morgan & Mcatamney, 2009). The role of alcohol in maxillofacial injuries is also well recognised, where authors have demonstrated influence of alcohol in 30–60% of all maxillofacial trauma (Edwards, David, Simpson, & Abbott, 1994, Dongas & Hall, 2002; Lee & Antoun, 2009; Lee & Snape, 2008; Verma & Chambers, 2015) and 55–87% of assault-related maxillofacial trauma (Hutchison, Magennis, Shepherd, & Brown, 1998; Laverick, Patel, & Jones, 2008; Lee, Snape, Steenberg, & Worthington, 2007). Indeed, alcohol is often far more commonly involved when the mechanism of facial injury is alleged assault.

While, to our knowledge, no studies to date have directly examined the correlation between alcohol-related violence and maxillofacial trauma, Hutchison et al. (1998) observed 90% of facial injuries occurring in bars to be associated with alcohol consumption. Importantly, O'meara, Witherspoon, Hapangama, and Hyam (2012) have also found that both alcohol consumption and interpersonal violence to be independent predictors for increased severity of facial fractures. Since the maxillofacial region is one of the easiest targets for assailants to select, clinicians at oral and maxillofacial units are often confronted with the aftermath of weekends' night-outs in their Monday morning trauma clinics.

Therefore, oral and maxillofacial surgery is the lead speciality that not only provides care to the injured of alcohol-related violence but also has the opportunity to facilitate its prevention and the surveillance of strategies implemented locally (Warburton & Shepherd, 2002).

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Unpublished internal data from the Royal Brisbane Hospital, Queensland, Australia, highlighted a 28% rise in the rate of alcohol-related maxillofacial trauma in the same 10-month period from 2010 to 2011 (Borgna, 2011). Similarly, at the Royal Hobart Hospital, Verma and Chambers (2015) observed a significant increase of 12% in the proportion of drunken men among mandibular fractures from 1999 to 2013. While the evidence of these reports are limited by their small sample sizes to suggest a true rising trend of alcohol-related violence, there is general consensus that alcohol-related violence remains to be an ongoing public health concern in the Australian communities (Morgan & Mcatamney, 2009; Miller, Tindall, et al., 2012; Navarro, Shakeshaft, Doran, & Petrie, 2013).

To tackle alcohol-related violence, strategies have been developed to target the link between alcohol and interpersonal violence on multiple levels. These strategies include federal, state-wide or local policies to reduce the demand of alcohol by alcohol pricing and taxation, or restricting the alcohol supply by manipulation of trading hours and alcohol outlet density, or prevent its associated harm by policing interventions and enforcing licensing regulations (Jones, Hughes, Atkinson, & Bellis, 2011; Midford et al., 2005; Palk, Freeman, & Davey, 2010; Shakeshaft et al., 2012). In the United Kingdom, police patrols and enforcements of licensing laws have been shown to be effective in reducing alcohol-related violence at the community level (Babor et al., 2010). However, the same evidence for policing interventions has not yet been demonstrated in Australia, raising the question of whether targeting the night-time economy is an effective use of police resources (Miller et al., 2011). In order to answer this important question, current study set out with an objective to examine the evidence in policing alcohol-related violence systematically.

2. Objectives

The primary objective of current study is to systematically evaluate the effectiveness of Australian policing interventions in reducing alcohol-related violence by targeting the night-time economy.

3. Background

Studies have consistently found that alcohol-related violence is significantly overrepresented in the night-time economy or in and around licensed premises (Graham & Homel, 2008; Liang & Chikritzhs, 2011; Martin, Freeman, & Davey, 2012; Mcilwain & Homel, 2009). Hotels, clubs and other licensed premises may allow drinkers to remain and continue drinking for extended periods. The typical clustering of these venues encourages the number of drinkers and the level of intoxication to grow at these venues, turning them into a conduit for violence (Livingston, Chikritzhs, & Room, 2007). Indeed, licensed premises are widely considered hotspots for violence and disorder with over 40% of assaults estimated to occur within the proximity of such places (Mcilwain & Homel, 2009). Furthermore, the severity of injury was found to positively correlate to these hotspots where the odds of major trauma were two times higher at licensed premises than at other locations (Dinh, Bein, Roncal, Martiniuk, & Boufous, 2014).

Various environmental factors in licensed venues are known to contribute to alcohol-related social problems, such as license types, trading hours, density of patron movements, entrance queues, number of security staffs and adequacy of other facilities (Doherty & Roche, 2003; Graham, Bernards, Osgood, & Wells, 2012). Police data indicate that only a small handful of venues are responsible for this disproportionately high rate of alcohol-related violence (Donnelly & Briscoe, 2003; Haines & Graham, 2009; Martin et al., 2012). Thus Doherty and Roche (2003) claim "the predictability of violence in these locations offers an opportunity for violence prevention and an enhanced role for police involvement". An emerging body of research suggests that police are able to do more than just respond to alcohol-related problems (Doherty & Roche, 2003; Fleming, 2008; Graham & Homel, 2008; Mcilwain & Homel, 2009). Rather, effective policing strategies may actually prevent or reduce the harm caused by alcohol-related violence in and around licensed venues.

Policing approaches to this problem include a comprehensive range of tactics which generally fall into one of the three following categories: front-line strategy; monitoring, regulation and enforcement strategy; and collaborative partnership (Fleming, 2008; Smith, Morgan, & Mcatamney, 2011).

Simply increasing police numbers remains one of the standard ways that police can target alcohol-related violence. Commonly referred to as front-line policing, this strategy focuses on providing a visible police presence to act as a deterrent to potential offenders. By increasing numbers, police can respond faster to alcohol-related violence and prevent incidents from escalating (Smith et al., 2011). Front-line police activities include visible, frequent patrols of entertainment precincts and known hotspots, parking police vehicles in highly visible areas and responding to incidents by issuing on the spot fines or arresting and detaining intoxicated offenders (Fleming, 2008).

Importantly, front-line officers are able to use a large amount of discretion in addressing alcohol-related offences. This allows police to discriminate between potentially violent offenders and those who pose no danger or threat to public safety. Studies have considered whether front-line strategies can reduce the occurrence of alcohol-related violence in and around licensed areas. For example, Hopkins (2004) examined the impact of a policing initiative implemented in Nottinghamshire, England which focused on deploying high visibility policing units in identified 'hotspot' licensed premises and surrounding areas. Similarly, Miller et al. (2011) examined the effectiveness of Operation Nightlife 1 in Geelong, where the aim is to maximise police visibility during high-risk hours.

Secondly, police can prevent alcohol-related violence by monitoring, regulating, and enforcing liquor laws in licensed premises, particularly in the high-risk areas. Enforcement strategies place the onus on the premise to ensure responsible service of alcohol and provide a safe drinking environment. Through monitoring and enforcement strategies, police can use intelligence sources to increase the perceived risks associated with breaching the legislation and consequently deter operators of licensed premises and their staff from violating the law.

Enforcement strategies can consist of both randomised and targeted interventions (Graham & Homel, 2008). While randomised enforcement strategies include all or most licensed premises within a certain geographic area (e.g. an entertainment precinct), targeted enforcement draws on police intelligence of particularly problematic venues (Graham & Homel, 2008). Enforcement activities can include 'walk throughs' of venues to collect information on licensees and their staff, allowing police to monitor a venue's compliance with liquor licensing legislation. Yet the effectiveness of enforcement strategies is not straightforward and is reliant upon a number of factors including: the frequency of enforcement, the likelihood of detection, the severity of the penalty and the awareness of the enforcement activity (Graham & Homel, 2008). Indirectly, enforcing activities may also lead to changes in the physical and the social features of the licensed drinking environments, such as better management and improved behaviour of servers and patrons (Doherty & Roche, 2003), acting as a barrier to reoccurrence of such violence and discouraging offending by others.

Collaborative partnership strategies acknowledge that the police cannot be solely accountable for preventing alcohol-related violence. Fleming (2008) argues that while police are often called upon to deal with alcohol-related problems, dealing with health or social welfare issues is far beyond their expertise. Thus collaborative strategies allow police to work with and harness the knowledge of a range of different stakeholders including local governments, regulatory authorities, health departments, medical practitioners, premise managements, peak bodies and the wider community (Graham & Homel, 2008). Indeed, this approach applies police resources in a range of interagency partnerships to tackle alcohol-related problems in a holistic way. For