



# Research Bulletin

## **The Alcohol and Other Drug Screen with Inmate Receptions in New South Wales:**

**A Pilot Initiative.**

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**Research Bulletin No.19  
May 1997  
ISSN 0729 2422**

**NSW Department of Corrective Services**

# Table of contents

<b>Acknowledgements</b> .....	iv
<b>Introduction</b> .....	1
<b>Methodology</b> .....	5
<b>Results</b>	
1. Process .....	7
1.1 General overview .....	7
1.2 Background operational initiatives .....	7
1.3 Preliminary consultations .....	8
1.4 Implementation .....	9
1.5 Post-pilot follow-up .....	11
1.6 Summary .....	13
2. Outcomes .....	13
<b>Discussion</b> .....	39
<b>Endnotes</b> .....	42
<b>References</b> .....	43
<b>Annexes</b> .....	44
Annex A .....	44
Annex B .....	49
Annex C .....	50

# List of Tables

Table 1: AOD withdrawal at reception (AODS: Q10, pg 45) .....	19
Table 2.1: Patterns of AOD use in the past year (AODS: Q1, pg 46) .....	19
Table 2.1.1: Heroin .....	20
Table 2.1.2: Amphetamines .....	21
Table 2.1.3: Cocaine .....	22
Table 2.1.4: Cannabis .....	23
Table 2.1.5: Benzodiazepines .....	24
Table 3: Patterns of cigarette use (AODS: Q2, pg 46) .....	25
Table 4: Needle use and needle sharing in the past year (AODS: Q3, pg 46) .....	25
Table 5: Problems related to AOD use (AODS: Q4, pg 46) .....	26
Table 6: Intoxication at time of offences/charges (AODS: Q5, pg 46) .....	26
Table 7: Relationship between AOD use and criminal activity (AODS: Q6 pg 46) .....	27
Table 8: Medication use (AODS: Q7i, pg 46) .....	27
Table 9: Patterns of medication use (AODS: Q7iii, pg 46) .....	28
Table 10: Methadone treatment (AODS: Q8, pg 46) .....	28
Table 11: AOD-related health problems (AODS: Q9, pg 46) .....	28
Table 12: Type of AOD-related health problems (AODS: Q9, pg 46) .....	29
Table 13: Prior treatment for AOD problems (AODS: Q10, pg 46) .....	30
Table 14: AUDIT Q1. How often do you have a drink of alcohol? (AODS: pg 47) .....	31
Table 15: AUDIT Q2. How many standard drinks do you have on a typical day when you are drinking? (AODS: pg 47) .....	31
Table 16: AUDIT Q3. How often do you have six or more drinks on one occasion? (AODS: pg 47) .....	32
Table 17: AUDIT Q4. How often during the past year have you found that you were not able to stop drinking once you had started? (AODS: pg 47) .....	32
Table 18: AUDIT Q5. How often in the past year have you failed to do what was normally expected from you because of drinking? (AODS: pg 47) .....	33
Table 19: AUDIT Q6. How often in the past year have you needed a drink in the morning to get yourself going after a heavy drinking session? (AODS: pg 47) .....	33
Table 20: AUDIT Q7. How often in the past year have you had feelings of guilt or regrets after drinking? (AODS:pg 47) .....	33

Table 21: AUDIT Q8. How often during the past year have you been unable to remember what happened the night before because you had been drinking? (AODS: pg 47) .....	33
Table 22: AUDIT Q9. Have you or somebody else been injured as a result of your drinking? (AODS: pg 47) .....	34
Table 23: AUDIT Q10. Has a relative, a friend, a doctor or other health worker been concerned about your drinking or suggested you cut down? (AODS: pg 47) .....	34
Table 24: AUDIT Score .....	34
Table 25: Duration of AODS interview .....	35
Table 26: Further AOD assessment to be undertaken by AOD Worker at centre of classification - male sample .....	35
Table 27: Further AOD assessment to be undertaken by AOD Worker at centre of classification - female sample .....	36
Table 28: Reason initial rating was amended using stated criteria for further assessment - male sample .....	36
Table 29: Reason initial rating was amended using stated criteria for further assessment - female sample .....	37
Table 30: Further AOD assessment requested by inmate .....	37
Table 31: Centre by total number of referrals to other corrections-based services .....	38
Table 32: Type of referral by centre .....	38
Table 33: Age .....	50
Table 34: Aboriginality .....	50
Table 35: Marital status .....	50
Table 36: First language of country of birth .....	51
Table 37: Pregnancy status .....	52
Table 38: Location from which received .....	52
Table 39: Imprisonment status .....	53
Table 40: Appellant status .....	53
Table 41: Sentence length .....	53
Table 42: Imprisonment history .....	54
Table 43: Offences/charges: type .....	54

Table 44: Next court appearance: number of weeks remaining .....	55
Table 45: Type of court - next appearance .....	55

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## *Acknowledgements*

This report was requested by the Alcohol and Other Drug Services of the NSW Department of Corrective Services. The funding for the research was provided by the National Drug Strategy and this was administered by the NSW Drug & Alcohol Directorate. Thanks are due to Bruce Flaherty of the Directorate who supported this project and to Kate Conigrave of the Early Intervention Unit, Royal Prince Alfred Hospital who provided training assistance.

Special thanks to Alison Bell who contributed to the development of the screening protocol, designed and conducted the training program and contributed to the co-ordination of the fieldwork. Gratitude is also due to the AOD (Alcohol and Other Drug) Workers and inmates who participated in the pilot.

The support and advice of Deborah Allen and Martin Clements of the Alcohol and Other Drug Services is much appreciated. Special thanks to Margaret Bowery, Simon Eyland, Barbara Thompson, Antonia Barila, Fiona Hastings and Fiona Campbell of the Research & Statistics Unit who provided editorial assistance.

# *Executive Summary*

The Department's Alcohol and Other Drug (AOD) Services initiated this pilot of the Alcohol and Other Drug Screen (AODS) to improve the level and quality of information on new inmate receptions. The specific aim of the study was to develop and pilot a front-end, standardised and systematic screening procedure for accurately detecting inmates with alcohol and other drug (AOD) problems. In addition to assessing the utility of the scale itself, the study aimed to examine the potential feasibility of the AODS procedure as the first tier in a state wide approach in the identification and treatment of inmates with AOD problems.

## **PROCESS REVIEW**

The AODS procedure was administered by way of personal interview. It was undertaken by staff (AOD Workers) responsible for AOD screening at the time.

- The pilot involved far more time and consultation than anticipated in the methodology for the study. The projected time-frame for the pilot fieldwork was 3 months. The actual time taken for completion was 12 months.
- Generally, it was the operational component of the pilot (rather than the form and content of the AODS instrument) which protracted the process. Institution-based restructuring, staff turnover, some staff opposition, capital works projects and overlapping lines of authority all contributed to the delay. Some consultations were devoted to arguing for the continuation of the AODS pilot.
- Despite substantial reservations in the early stages of the pilot, most AOD Workers expressed satisfaction with the AODS procedure on follow-up. Subsequent to the fieldwork, key informants indicated fairly favourable responses to the AODS, including the length of time required for administration.
- During an evaluation workshop, the workers who participated in the pilot endorsed the inclusion of the WHO AUDIT alcohol screen

as a component of the AODS, subject to certain modifications. Most modifications, as requested by AOD Workers, have been incorporated into the current AODS prototype.

- The findings of the AODS pilot, whilst painting a picture of a protracted process and compromise on some of the initial objectives, show promise in the accurate detection of inmates with AOD-related problems. This represents the first step in the process of classifying inmates for further intervention according to need or risk using a standardised and systematic approach.

## **OUTCOMES**

- The total sample comprised of 395 inmate receptions (293 males and 102 females). The majority of the male sample were newly sentenced receptions (86%) and the majority of the female sample were remanded to custody (50%). The number of refusals was reportedly low (n=19) or 5%. The mean length of time required to complete the AODS was 26 minutes.
- Of the sub-sample of sentenced receptions 31% of males and 44% of females had further court appearances scheduled.

### **Presenting state**

- 20% of males and 37% of females reported to be withdrawing from alcohol and/or other drugs at reception.
- 29% of males and 42% of females reported being on prescribed psychoactive medication at the time of reception.
- Of those who were drug users (excluding alcohol) the majority had last used more than a week before. About 10% or less had used within the past 24 hours.
- Of the female sample, 34% were benzodiazepine users and more than half of this group had used within the previous fortnight. For daily benzodiazepine users,

more than half reported using 10 or more tablets per day.

### **Intoxication at time of offence**

- 71% of males and 79% of females reported being intoxicated at the time of offence/s.

### **Injecting drug users**

- 37% of males and 70% of females reported to have used needles within the past year. Of these, 26% of males and 23% of females reported that they had shared needles.

### **AOD-related problems**

- 73% of males and 83% of females stated they had recently experienced problems related to their alcohol and/or other drug use.
- 36% of males and 53% of females stated that they had recently experienced AOD-related health problems.

### **AOD treatment**

- 12% of males and 39% of females were current methadone recipients. 41% of males and 54% of females had received prior community-based AOD treatment.

### **Patterns of alcohol use**

- In terms of WHO AUDIT findings, 47% of males and 27% of females reported drinking 10 or more standard drinks on a typical drinking day.
- 31% of males reported that either themselves or someone else had been injured as a result of their drinking in the previous year.
- 21% of males reported not being able to control their drinking on a daily basis.
- 47% of males obtained a total score of 13 or more on the AUDIT. According to AUDIT guidelines this score was a general indication of alcohol dependency.
- Of the Aboriginal males, 76% obtained a total score of 13 or more on the AUDIT and 76%

reported drinking 10 or more drinks on a typical drinking day.

### **Positive cases**

- 86% of males and 95% of females satisfied the criteria for a follow-up AOD assessment, with 56% of both males and females requiring a priority assessment. For exploratory reasons broad assessment criteria had been set, whereby if an inmate scored positive on any of the drug-related indices, s/he met the criteria for a follow-up assessment.
- Of those who met the criteria for a further AOD assessment about 30% of both males and females refused a further assessment .
- Of the 293 AODS procedures, 125 referrals were issued to other corrections-based agencies. Referrals were fairly evenly spread across psychological, welfare and medical services.

### **Reliability estimates**

- The AUDIT was tested for internal reliability by the application of Cronbach's Alpha and the value obtained (0.95) indicated very good internal consistency.
- Some of the AUDIT items were compared to other AODS items (alcohol-related crime, alcohol withdrawal, alcohol-related problems). A strong association (statistically significant) was identified in all cases tested.
- Generally, the AODS findings were found to be consistent with normative knowledge (previous research) about AOD problems in the inmate population.
- The AUDIT scores were used for examining interviewer effect by the application of ANOVA. A significant effect was identified.
- Caution should be exercised in interpreting the pilot findings, particularly in terms of projecting estimates on the basis of a single reception cohort. Further population representative cohort studies would be needed before future case load trends could be considered reliable.

# *Recommendations*

## **AODS instrument**

- Criminal behaviour and subsequent imprisonment be viewed as a drug-related harm. Therefore, the final AODS prototype needs to address the link between AOD use and criminal behaviour.
- The final AODS prototype to be used on males include specific questions on alcohol intake patterns and levels. Prior research has found that many male inmates do not self-identify alcohol-related problems despite harmful consumption levels. Findings support the inclusion of a modified version of the World Health Organisation AUDIT alcohol screen.
- Due to the sizeable proportion of inmates with AOD problems, it appears that the criteria for further assessment as set out in the AODS guidelines needs to be more stringent. Increased stringency would result in more manageable case load levels.
- Additional risk criteria, such as proneness to violence when intoxicated or repeated drug use whilst in custody could be used to make the existing criteria more stringent.

## **Implementation**

- The AOD Services proceed with the statewide 'front-end' screening strategy. The outcomes of the AODS be used as the first tier in prioritising and assigning inmates to further diagnostic assessment and AOD programs.
- To overcome the problem of access to AODS documents on Case Management Files, AOD Services management negotiates with Programs Managers on an appropriate mechanism for information exchange between AOD Workers and Case Managers.
- Until such time that the AODS information in the Case Management Files is easily accessed by AOD Workers, the AOD Service maintain a dedicated AOD file, to which a copy of the AODS is attached at the centre of reception. The file be located with the AOD Worker at the centre where the inmate is held and will accompany the inmate as s/he is transferred.
- Once the Inmate Development Services computerised data base is operational, provision be made to record the AODS information on the data base.



- Additional training on the administration and scoring of the AODS be provided to the AOD Workers. Training should aim to ensure that the workers not only have a good working knowledge of the scale, but also the accompanying instruction manual.

To this end, training should have an evaluation component, including a knowledge test which specifically addresses the criteria for referring inmates for an AOD assessment.

### **Treatment intervention**

- Due to limited resources, it is not feasible to extend intensive interventions to all inmates who fall within the case load criteria. Progressively higher levels of treatment need to be offered. Those with low level problems should be offered minimal interventions through to those with high level problems being offered intensive treatment. In this way the number of inmates flagged for more intensive treatment (such as, ongoing 1 to 1 counselling or a therapeutic unit) would represent a more manageable number.
- Inmates at high risk of repeated drug-related crime and serving short sentences (under 6 months) be targeted for priority treatment.

### **Pilot projects**

- When AOD Workers are called upon to implement new initiatives, such as the AODS pilot, a managerial representative of AOD Services should attend any briefing meetings. This would demonstrate to the AOD Workers a managerial commitment to the new initiative.
- Generally, clinical workers are not called upon to collect data for research purposes. Pilot studies should provide site-based supervision and support to promote methodological precision.
- The prison environment is undoubtedly

volatile. If staff are experiencing a high level of stress they will not be able to establish new initiatives. Strategies should be put into place which specifically address work-related stress issues for AOD Workers.

### **Data collection**

- Further population representative cohort studies would be needed before future case-load trends could be considered meaningful.
- A follow-up validation study be conducted on the AODS to assess its reliability and validity, with particular examination of the scale's sensitivity and specificity with this population.
- Data collection which aims to derive normative estimates on AOD-related behaviours in the inmate population continue to be collected by those with training in data collection, such as research interviewers.

# Introduction

The project was initiated by the Alcohol and Other Drug Services (AOD Services) of the NSW Department of Corrective Services and the NSW Drug and Alcohol Directorate (DAD). The funding for this project was provided by the National Drug Strategy.

The drug-crime link is extensively documented and researched. Debate has been evident in the identification of the precise nature of the link. There appears to be some agreement that criminality occurs prior to dependency, with dependency acting as a multiplier of crime (Dobinson & Ward, 1984; Nurco, et al., 1985; Miner & Gorta, 1986; Indemaur & Upton, 1988; Stathis et al., 1991; National Institute of Justice, 1991; Correctional Service of Canada, 1991). Noteworthy is that meta-analysis of outcomes of prison-based interventions with drug users has shown reductions in recidivism (Andrews, et al., 1990)

Several locally-based studies have recommended that inmates on reception to NSW correctional centres be routinely screened for the presence of AOD problems with a view to identifying risk cases for referral to treatment programs (Miner and Gorta, 1986; Stathis, et al., 1991; Kevin, 1992; MSJ Keys Young, 1992).

The above notion of routine AOD screening is founded on sound principles. Treatment resources are limited. For service delivery to be effective, the extent and severity of the problem among the target population needs to be assessed and systematic measures for accurate case identification and appropriate placement need to be put into place.

In a review of publications few prison-based standardised screening procedures were identified. There may be such approaches in existence in other jurisdictions, however this search was limited to those screening procedures on which findings have been reported. Those identified follow:

- Computerised Lifestyle Screening Instrument (CLSI) - Correctional Service of Canada; and
- The Inventory of Substance Use Patterns, Third Edition (ISUP3) - Florida.

## CLSI

To date, the most well documented screening program has been that undertaken by the Correctional Service of Canada with the pilot of the Computerised Lifestyle Screening Instrument, 1990 (CLSI). The authors, Robinson, Porporino & Millson (1991) developed this instrument in response to a recognised need to screen newly received inmates for assignment to appropriate substance abuse treatment programs.

The screening instrument was described as a comprehensive substance abuse assessment. It included the Drug Abuse Screening Test, 1982 (DAST) and the Alcohol Dependence Scale, 1982 (ADS). Both of these scales had been widely used in the AOD field and had been validated for different populations. In addition, the following lifestyle factors associated with substance abuse were assessed:

- physical health;
- nutrition;
- mental health;
- quality of functioning in family and social relationships;
- criminal behaviour patterns; and
- readiness for treatment enrolment.

The CLSI is self-administered using a micro-computer. In support of this approach the authors argued that respondents are less inhibited and more truthful on computer than in an interview situation. Completion time was reported to be under 2 hours and feedback was in the form of a printout summarising an inmate's responses. A more comprehensive printout was forwarded to the inmate's correctional case manager.

The pilot of the CLSI consisted of 503 male inmates received over a 1 year period. The total non-response rate was 12%. The refusal rate

was 8.4%. A further 1.5% were identified as illiterate and 0.8% were identified as non-English speaking born.

Both the DAST and the ADS classified each respondent into one of the following categories:

- none;
- low;
- moderate;
- substantial; or
- severe abuse problems.

Using the ADS and DAST criteria the CLSI pilot classified 37% of inmates as having 'moderate to severe' AOD dependencies which required intervention. An additional 30% were flagged as having low level problems for minimal intervention, such as education.

In recognition that it would not be feasible to provide all those identified as 'moderate to severe' cases with intensive treatment, further criteria was set for classifying an inmate to intensive treatment. The following additional criteria were used:

- (i) intoxication at time of offence;
- (ii) chronic long term use;
- (iii) drug users - polydrug users who were involved in the use of more than 1 type of drug in the 6 months prior to imprisonment; and
- (iv) alcohol users - alcohol caused them to be more physically aggressive or violent.

Using the foregoing two-tiered screening procedure a total of 17% of the entire sample were selected for priority treatment. Therefore, a systematic procedure had been developed for flagging intensity levels for treatment. These treatment levels were as follows:

- (i) priority treatment ('moderate to severe', plus 3 additional criteria);
- (ii) intermediate treatment ('moderate to severe');
- (iii) low intensity treatment group; and
- (iv) no apparent problem - prevention group.

The motivational levels were examined for the sub-group who were classified for priority treatment. The majority of this group were described as being highly motivated for treatment using a number of measures.

The reliability of the CLSI was tested in terms of internal consistency using Cronbach's Alpha. The indices obtained were high (.91 for the DAST and .95 for the ADS). The findings were compared to a previous Canadian study (Lightfoot & Hodgins, 1988) which used the DAST and the ADS. The previous study found that of 275 inmates, 47% were categorised as having 'moderate to severe' dependency problems. The authors of the present study argued that the discrepancy was due to a self-selection sampling bias operating in the Lightfoot & Hodgins study. Evidently, the sampling procedure in the previous study called for volunteers.

One shortcoming of the CLSI pilot was that it only provided data for male inmates.

### ISUP3

The Inventory of Substance Use Patterns, Third Edition (ISUP3) was developed by Gary Whittenberger of the Federal Bureau of Prisons, Tallahassee, Florida (cited by Wallace, et al., 1990). The ISUP is a 100-item questionnaire that derives a profile of the inmate's use of 12 different drugs for the 6 month period prior to arrest. It measures frequency of use, daily duration of use and perception of degree of abuse.

It was designed for self-completion. Many of the questions in the ISUP were derived from criteria set out for substance abuse and dependency in the DSMIII-R (1987).

The ISUP3 is scored across 5 scales. The scales which are used as a basis to determine program decisions, follow:

- (i) chemical dependency measure using DSMIII-R criteria for 6 months prior to arrest;

- (ii) current substance preoccupation - measures whether an inmate is preoccupied with thoughts/feelings about drugs. A high score indicates whether an inmate will have difficulty in adjusting to the correctional environment due to drug deprivation;
- (iii) motivation to enrol in treatment measure; and
- (iv) a validity measure - questions left blank, multiple responses or inconsistent responses.

The ISUP3 was piloted on inmates received (newly sentenced and transfers) into federal prisons in 1990. Originally 2808 sentenced inmates from 74 institutions were asked to participate. Of these 84% (n=2359) completed the form. Valid information was provided by 74% (n=1736) of those who completed the form. There was a 10% refusal rate and 6% were exempt for some other reason. The ISUP3 was administered during admissions and orientation.

Wallace, et al., (1990) reported on the findings of the 1165 inmates who were new admissions (as opposed to transfers). Using the ISUP3 profile, 52% of receptions were identified as having either substance abuse or substance dependency problems. This was based on DSMIII-R criteria (21% met the criteria for substance abuse and 31% for substance dependence). Of those who were identified as having a substance abuse or dependency problem 44% indicated interest in seeking treatment.

When compared to males (30%), females demonstrated greater severity of impairment with 38% meeting the criteria for dependence. In terms of other special populations native North American receptions showed the highest substance abuse rate at 79%.

McCarthy, et al., (1990) combined the ISUP findings from 3 institutions (n=639) with information from official records, such as pre-sentence reports, breach reports and disciplinary reports. The information obtained from these records was used to provide a placement on an abuse severity continuum named The Substance Abuse Signs Checklist (SAC). Specifically, the SAC is a behavioural checklist based on

documented history.

It was found that 44% of inmates (including transfers) were classified as having an abuse problem using the SAC checklist. ISUP3 and SAC data matched in 78% of cases. The authors argued that the remaining lack of collateral validity was possibly due to incomplete records, or denial or lying on the part of the inmate.

The authors did not test the ISUP3 for internal consistency and did not report on previous validation studies.

### Guidelines

The following conclusions can be gleaned from the pilot programs:

- Duty of care provisions indicate that inmates with AOD problems need to be accurately identified and offered appropriate treatment options using a standardised and systematic approach;
- Given limited resources, a measure of problem severity needs to be incorporated into inmate screening as a way of determining when and at what intensity treatment will be provided;
- Extent and severity levels should be flagged on special populations (such as women & Aboriginals) so that appropriate responses can be implemented;
- Other factors which may be drug-related, such as physical and mental health, need to be included in detection and diagnosis.

An apparent oversight evident in both the CLSI and the ISUP3 was the omission of measures pertaining to harmful drug practices (i.e., needle sharing) associated with the transmission of blood-borne viruses, such as HIV and Hepatitis C. Considering the ramifications of needle sharing, any risk assessment should flag such cases for priority intervention. In addition, neither study provided details of any methodological

difficulties encountered when implementing the respective pilot procedures.

### **Rationale**

Targeting of cases at risk represents more effective utilisation of the limited resources available to the AOD Services. Further, the targeting of high risk cases (those who are heavily involved in alcohol and/or other drugs and who are long term recidivists) has been associated with positive post-release outcomes, such as reduced recidivism and reduced drug use (Andrews, et al., 1990). An examination of the reach of drug treatment in the NSW prison system found that those with alcohol-related problems were less likely to enrol in treatment than those with other drug problems (Kevin, 1993). At the time, new receptions to NSW prisons were briefly screened by the medical service (Corrections Health Service) for signs of withdrawal from alcohol and/or other drugs. However, these findings were neither:

- (i) systematically recorded;
- (ii) shared with AOD Services; or
- (iii) had any bearing on contact with the drug treatment programs (excluding methadone & other medication regimes).

Inmates were possibly also screened by the AOD Services, however the approach was neither standardised or systematic. At the main metropolitan reception centre for men a locally designed 10 item AOD screen (see Annex B) was administered to all inmates on reception by AOD Workers. However, AOD Workers at centres to where inmates were classified reported that they did not find the information recorded on the screen useful in treatment planning. It was evident that no objective criteria had been set in relation to classifying inmates to treatment (Kevin, 1993). Further, the screen failed to address the problem of lack of self-identification of alcohol-related problems, as identified in previous research.

In 1993 the Department developed a general screening procedure for inmates on reception entitled the Contact Screening, Referral and

Induction Program. The AOD Services initiated the Alcohol and Other Drug Screen procedure to correspond with the initiatives being put into place by the Department proper.

Prior to the development of the AODS, a selection process conducted by the research team failed to identify a screening instrument which measured both alcohol and other drug use. In relation to detecting people with alcohol-related problems, the World Health Organisation's instrument, AUDIT (Alcohol Use Disorders Identification Test) was selected. The advantage of the AUDIT is that it is a brief instrument with impressive predictive validity (Conigrave, et al., 1995). Conigrave and colleagues reported that after a three year follow-up on 250 individuals the AUDIT was a significant predictor of social and medical harm from drinking. The AUDIT also overcomes some of the problems evident in subjective scales which rely solely on self-awareness and acceptance of problems. This is because the majority of the AUDIT items are behavioural indices. At the time of the pilot the AUDIT had not been tested on an inmate population. Further, the AUDIT was designed for self-administration. In contrast, research has recommended that the optimal method for collecting drug use data in prisons is by way of personal interview (Pedic, 1990; Kevin, 1992).

In addition to the AUDIT, questions pertaining to other drug use and associated criminogenic and demographic factors were developed by the research team.

The major priority of any correctional centre is safety and security. Operational management includes many regulations and procedures to which the AOD Services is required to comply. Hence, the pilot was initiated not only to test the scale but also examine the operational feasibility of administering the procedure in NSW correctional centres.

# Methodology

## Aim

The aim of this project was to develop and pilot a standardised and systematic screening procedure for detecting inmates with AOD-related problems (particularly those whose drug use was related to their criminal activity) so as they could be targeted for further assessment and intervention.

The study also aimed to examine the potential utility of the initiative in terms of the responsiveness of both inmates and AOD Workers.

## Specific objectives

- (i) examine the suitability of the scale with an inmate population, (specifically, form and content);
- (ii) examine the accuracy of the scale in detecting AOD problems in the inmate population;
- (iii) assess whether the AUDIT which was designed for self-completion could be effectively administered as an interview procedure;
- (iv) assess whether the time required for administration and scoring of the scale would generally allow for the screening of all receptions. It was unlikely that the population of new receptions would occur as a steady flow;
- (v) examine whether the procedure was feasible and appropriate for the AOD Workers to administer.

## Population frame and data collection

The 2 centres selected to pilot the scale on male inmate receptions were those which showed on

average, the largest number of receptions for the previous 3 months. These were the main metropolitan reception centre for men and the largest country centre for men. The largest correctional centre for women was also included.

It was anticipated that the screening procedure would be piloted over a 3 month period to allow for an adequate sample size to be obtained. A minimum sample size of 300 inmate receptions was predicted.

The pilot aimed to include the entire population of receptions from the 3 centres for a specified 3 month period (as was reasonably possible and without causing undue impact to the day to day running of the centres involved).

The pilot study was scheduled to commence in April, 1994. However due to various operational difficulties at the 3 centres the pilot did not commence until some months later and each centre commenced the pilot at a different point in time.

## Instrument

The screening procedure was to be administered to inmates on reception to the correctional system for the purpose of identifying risk cases requiring further assessment. Due to the high numbers of inmates being received into the system it was considered necessary for the scale to be of short duration without compromising accurate detection. To this end the following protocol was developed for inclusion in the Alcohol & Other Drug Screen (AODS):

- ▶ The WHO AUDIT is a 10-item scale consisting of questions on the three central conceptual domains; intake, dependence and problems. The National Campaign Against Drug Abuse (1989) reported that AUDIT showed good validity and was the first instrument to be compatible with the revision of the International Classification of Diseases.
- ▶ In terms of other drug use (excluding alcohol) no scale was identified which addressed the

drug-crime relationship, injecting practices and consumption patterns and problems. Hence, additional items were developed by the research team to detect other drug-related harm.

The AODS specifically addresses the relationship between criminal activity and drug use. It includes 21 alcohol/drug-related items and 8 demographic and criminal history items (see Annex A).

Procedure

#### Inmate reception phase

The AODS procedure was designed to be administered by way of personal interview. It was to be undertaken by staff currently responsible for AOD screening (AOD Workers). Training was conducted with the workers involved in the pilot of the AODS. Training on the WHO AUDIT component was conducted by a specialist involved in training and research on the scale. This specialised training was only provided to the metropolitan workers. In addition to the training, the workers were provided with an instruction manual including coding, scoring and interpretation guidelines.

Subsequent to administering the scale with an inmate, the AOD Workers scored the scale and completed referral instructions to correctional Case Managers, AOD Workers and other professional services, including the Corrections Health Service where indicated. A photocopy was made of the completed scale and the copy was placed in a secure place for collection by the research team. The original was attached to the Case Management File. Upon collection the researchers checked the completed scales and provided feedback to the AOD Workers. The information was collated and entered onto a data base maintained by the research team.

The AOD Workers were also asked to seek feedback from the inmates on their opinions of the procedure.

The researcher sat in on the some of the screening sessions and at the completion interviewed inmates on their opinions of the scale (n=10). In addition, the researcher administered the AODS to a small sample of inmates (n=5) and once again sought feedback from this group. The inmates were asked about their general opinion of the scale. In addition, they were asked questions concerning:

- (i) the level of the content;
- (ii) the length of the interview; and
- (iii) any concerns about the information collected.

#### Key informant phase

At the completion of the pilot the AOD Workers responsible for administering the AODS were asked to complete a short interview in relation to any methodological problems identified with the procedure and their general opinion on the suitability of the scale, particularly how it compared with others they had used. In addition, AOD Workers at the centres to which inmates were classified were interviewed by telephone in relation to the usefulness of the scale in treatment planning.

Optional data collection

The concurrent validity of the AODS was to be measured by administering other scales at the same time as the AODS. Scales, such as the Drug Abuse Screening Test (DAST) and the Short Michigan Alcohol Screening Test (SMAST) were mooted. This option was abandoned.

Analysis

This was mainly in the form of descriptive statistics combined with some parametric and non-parametric tests of significance where appropriate. Psychometric analysis tested for internal consistency using Cronbach's Alpha.

# RESULTS: Process

## 1.1 General overview

AOD Services initiated the pilot of the AODS to improve the level and quality of information on inmates being received into the correctional system. It was anticipated the Case Management system as a whole would benefit. To this extent, the pilot of the AODS was a clinical initiative. AOD Services management considered it essential to identify any refinements required to the instrument, the protocol and the training program before the AODS procedure was to be launched as a statewide initiative.

The pilot commenced in June, 1994 and was completed by September, 1995. A total of 395 inmates were included in the pilot sample.

The implementation of the pilot involved far more time and negotiation than anticipated in the methodology for the project. Generally, it was the operational component of the pilot, in terms of adapting to the day to day operation of the correctional centre, (rather than difficulties with the AODS protocol/instrument) which protracted the pilot process.

## 1.2 Background operational initiatives

During the term of the pilot the Department was in the process of introducing institutional reforms. Operationally, these reforms were evidenced by the strategies of Case Management and the associated Contact Screening, Referral and Induction Program.

### Case Management

Case Management represented a new approach in the management of inmates. Under Case Management a Case Manager was responsible for extensively monitoring and documenting the individual progress of a group of inmates. The Case Manager was typically a correctional

officer. It was the stated intention of Case Management that through the co-ordination of programs and individual counselling, inmates were to be assisted in adjusting to the reality of their sentence, address the causes of their offending behaviour and form goals for the future (taken from Alcohol and Other Drug Services Strategic Plan, May 1996).

Following are the dates that the Case Management strategy became operational at each centre involved in the pilot:

- Main metropolitan reception centre for males - June 1995;
- Largest country centre for males - not operational;
- Largest centre for females - August 1994.

### Contact Screening, Referral and Induction Program

The Contact Screening, Referral and Induction Program was designed to take place the day the inmate is received into custody. A professional staff member administered a general screening procedure which addressed any special needs for immediate attention (suicide/self harm risk and welfare problems). At this time, information was collected, documented and placed on a file (Case Management File) to assist in the management and placement of the inmate (Case Management Profile). The Case Management File followed the inmate through the correctional system.

Subsequent to the contact screen (usually within 4 days) education officers and AOD Workers administered a follow-up screen to provide more information within these 2 domains. The follow-up screen information was also placed on the Case Management File. The Case Management Files were usually located in the offices of Case Managers.

Following are the dates when the Contact Screening and Induction Program became operational at each centre:

- Main metropolitan reception centre for males - June 1993;
- Largest country centre for males - January 1995;
- Largest centre for females - February, 1994.

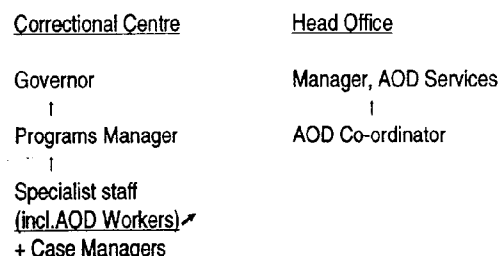


The AOD screen being administered by the AOD Workers at the metropolitan reception centre for males, prior to the commencement of the pilot, was seen by AOD Services management as not adequately addressing the wider needs of Case Management.

Line of Authority

The AOD Services sets out professional guidelines and provides clinical supervision for AOD Workers. AOD Services management, is based at the metropolitan head office. The direct supervision of the AOD Workers is provided by Programs Managers within the correctional centre in which they practice. The Programs Manager reports to the Governor of a centre and is responsible for managing and co-ordinating the delivery of professional services (AOD Services, education, psychology and welfare) within a centre. Custodial Case Managers also report to the Programs Manager. All correctional centres are managed operationally under a regional framework.

**Line of Authority**



**1.3 Preliminary consultations**

Collaboration with the medical service

Initially this project was conceived as being a collaborative venture with the Corrections Health Service (CHS). Correspondence was forwarded to the head of the CHS and a subsequent meeting was held with key personnel concerning the piloting of a standardised withdrawal screen by the nursing staff at the main metropolitan reception centre for males. AOD Services management also sought to clarify the role of

AOD Workers in terms of the following:

- withdrawal identification and management; and
- the sharing of case information between the services.

CHS representatives declined involvement in the project pointing to the lack of staff to support the initiative. They also raised concerns about the impact of administering a battery of tests to inmates on the day or night of their reception. Reportedly, inmates were frequently in a state of distress on being received into custody. At the time of these preliminary consultations, the CHS was conducting a medical screen on new receptions which included some coverage of AOD issues.

Instrument selection

In relation to the selection and design of the instruments, discussions were held with representatives of the NSW Drug & Alcohol Directorate, the Early Intervention Unit of Royal Prince Alfred Hospital and the National Drug & Alcohol Research Centre (NDARC).

Departmental consultations

Several consultations were held with screening and induction management personnel at the metropolitan reception centre for males. At the time, these personnel endorsed the pilot initiative. At the remaining two centres, Programs management personnel were consulted on one occasion and the initiative was endorsed.

Prior to pilot implementation, the project was canvassed at the AOD Services State Conference. All AOD Workers employed around the State, were provided with written notification that the pilot was commencing. At this time the AOD Workers were asked to access AODS documentation (from the Case Management Files) and assess its utility in terms of appropriate treatment planning.

Training program

It was necessary to obtain approval from centre-

based Programs Managers in order for participating AOD Workers to be released to undertake pilot training. The training program was delayed as it was necessary to identify a particular day on which all participating AOD Workers could be released from regular duties. The AOD Workers were provided with full-day training on the administration and scoring of the AODS. Due to delays experienced in commencing the pilot and staff attrition a further training session was provided.

On request from the AOD Workers at the main metropolitan reception centre for males some amendments were made to the AODS protocol subsequent to the training. These were:

- methadone status of inmate added to cover page;
- AUDIT contains filters for non and occasional drinkers;
- increased space on cover page so as safety issues are properly addressed;
- AODS printed on blue paper so as it can be identified in the Case Management File by Classification and Placement Committee.

#### 1.4 Implementation

##### Unforeseen difficulties

As already stated, centre-based day to day operational issues protracted the pilot process. In addition, some staff opposition was evident. From the outset of the pilot, it was necessary for AODS Services management to strongly promote the introduction and maintenance of the pilot initiative with centre-based screening and induction personnel. AOD Services considered it essential to allow the new initiative to run for sufficient time in order to assess its appropriateness and feasibility.

In terms of length of time required for administering the AODS and the associated through-put of receptions, the pilot procedure was to have greatest impact at the metropolitan reception centre for males. This centre received more sentenced reception inmates than any

other centre (n=1622) or 30% of the total number of sentenced receptions in NSW for 1994.

The consultation process was hindered by the existence of 2 tiers of supervision, head office and institutional. Reportedly, at the metropolitan centre for males setbacks occurred due to intervention by personnel involved in the general screening and induction program. At one point screening and induction management instructed the AOD Workers to discontinue using the AODS protocol and to resume using the original screen.

In response to the above, AOD Services management strongly urged centre-based personnel to allow for a settling-in period in relation to the new protocol. Subsequent to a new Programs Manager being appointed at this centre the pilot progressed relatively smoothly.

Due to the difficulties experienced in the preliminary phase of the pilot, some compromises were made in relation to research concerns, such as the cross validation component, accurate through-put appraisal and data quality. In managing the fieldwork, these research concerns became secondary to circumventing the project from derailing.

Interruptions also occurred at the other centres, however these were not due to breakdowns in the consultation process. At the country centre for males setbacks occurred on several occasions. These were reportedly due to disruptions caused by capital works projects and AOD staff turnover.

Interruptions at the correctional centre for women reportedly occurred due to management restructuring and AOD staff turnover.

In summary, some staff opposition, staff attrition, organisational restructuring and capital works projects all contributed to the time extension necessary for the completion of the AODS pilot.

##### Catchment

The pilot was interrupted at the 3 centres at

various points in time for various reasons. Hence, because the AODS data was not collected for a set and continuous period of time, it was not possible to measure whether the entire through-put of reception inmates, for each centre, actually received the AODS procedure.

The pilot was interrupted at the main metropolitan centre for males on 3 occasions. Some approximate data are provided as an indication of the pilot's catchment. At this centre the majority of the AODS procedures were administered in October, 1994. Therefore, the numbers in the October sample can be compared to actual reception population numbers for that period.

The total number of inmates received into that centre between 4 October, 1994 and 3 November, 1994 was 151 (a daily average = 4.87 inmates). When known refusals (n=5) were subtracted from this total (n=146) it appeared that the pilot reached 85% of those received into the main metropolitan centre. The shortfall of 22 inmates may be explained by the following:

- transfers to other institutions prior to AOD Worker contact;
- fine defaulters serving a 24-48 hour term; or
- unknown refusals.

Due to capital works projects and staff attrition the data collection process at the country centre was so sporadic that comparison of sample data and reception population data would be meaningless.

At the centre for females, the majority of AODS procedures were administered during the months of May and June, 1995. The female sample numbers were not able to be compared to reception population data base as the pilot sample included inmates who had already been remanded to custody before being received as sentenced inmates.

#### Feedback from participating AOD Workers

In the early stages of the pilot the opposition

demonstrated by the personnel responsible for general screening and induction at the main metropolitan reception centre for males was matched by the AOD Workers participating in the pilot. AOD Workers at this centre contacted AOD Services management on several occasions to express concerns in relation to the AODS pilot. The workers questioned the need for such an initiative, not only the substitute screen (AODS), but also the research component. Their concerns included the following:

- time required for photocopying (an extra copy of each screen was required for research purposes);
- more time was required to administer the AODS compared with the previous screen;
- AUDIT was inappropriate as it was inciting anger in some inmates;
- confidentiality concerns pertaining to questions on needle sharing and in turn this information being placed on the Case Management File; and
- AODS inappropriate and it should be replaced and the pilot discontinued.

#### Comments included:

*(Re. AUDIT) "We have well established drinkers... heavy drinkers who know they have problems".*

AOD Worker (AODS pilot)

*"I don't really know whether it (AODS) serves the purpose of identifying whether the inmate is at risk on his 2nd day in custody as the blue form (prior drug & alcohol screen) did".*

AOD Worker (AODS pilot)

In response to the above objections, AOD Services management advised the AOD Workers to complete the AODS pilot in the original form. In addition, a decision was made to retain the needle sharing questions on the basis that this was essential criteria on which to flag inmates for harm minimisation interventions. Notwithstanding the above, some workers did appear to show a pattern of non-completion in relation to the questions which they perceived were inappropriate.

Noteworthy, is that the opposition to the AODS

pilot appeared to diminish over time. To some extent the early opposition can be accounted for in terms of a process of settling-in.

AOD Workers - role clarification & autonomy

According to policy inmates would spend no more than 4 days at the main metropolitan reception centre for males before being classified to another correctional centre. The AOD Workers at this centre reported that their role was crisis intervention whereby the first few days of imprisonment are regarded as a potential crisis in a newly received inmate's life. Under duty of care provisions the AOD Workers expressed their role in terms of assessing self-harm or suicide risk and other issues pertaining to classification and placement. To this end, they would draw upon their professional insight when screening inmates. They contended that the previous screen provided more open-ended options and more scope for clinical interpretation.

In view of the above, the AOD Workers appeared to show less appreciation of their role in the transfer of clinical information to other AOD Services providers in the system. However, the AOD Workers at classification centres required standardised and pertinent information on which to base a follow-up assessment and treatment plan. Prior to this, AOD Workers around the State had worked fairly autonomously and had self-selected screening and assessment procedures. This resulted in duplication, in terms of inmates being repeatedly screened and assessed every time they sought treatment from a new AOD Worker. Inmates are transferred between centres as a matter of course. It can be said, that the AODS screening initiative, to some extent, represented a loss of autonomy to the workers.

Prior to the commencement of the pilot at the centre for females, AOD Workers negotiated with AOD Services management to exclude most of the AUDIT items from the protocol to be used with the female sample.

Data quality

During the early stages of the pilot the researcher/s made two on-site visits to participating AOD Workers in order to obtain feedback and address data quality concerns. In addition, subsequent to checking a sample of completed AODS documents, written feedback was provided on areas of concern and data quality.

The AOD Workers who took part in the pilot were not experienced data collectors. Their priorities by definition of their role were more clinically based. In some cases, despite follow-up on questions which showed a pattern of missing information, the pattern continued. This pattern appeared to be due to dissatisfaction with particular questions.

## 1.5 Post-pilot follow up

Participating AOD Workers

Once the pilot was completed at a centre the AOD Workers were interviewed in relation to its effectiveness. Despite substantial reservations in the early stages of the pilot most workers were fairly satisfied with the AODS protocol when interviewed.

One worker stated that administering the AUDIT was still problematic when an inmate presented in an emotionally unstable state. Another worker reported that the needle sharing question was rarely asked because of concerns in relation to confidentiality. A worker from the country centre for males was of the opinion that more on-site contact/support from the researchers in the initial stages of the pilot was required.

Despite earlier concerns about the length of time required for administration, the majority of workers did not report this to be a problem on follow-up. The workers were unanimous that the scale should not be shortened. Generally, the workers stated that they were satisfied with the AODS, particularly those based at the country

centre for males.

Comments included:

*"The AUDIT being the instrument of the World Health Organisation, gives the reports we do, just that extra bit of credibility".*

AOD Worker (AODS pilot)

Post-pilot modifications put forward by participating AOD Workers

- flag AOD dependency prior to the previous year;
- include duration of drug use;
- include quantity of drug used on last occasion of use for identification of possible withdrawal syndrome;
- needle use recorded as any history, rather than previous year.

Inmate feedback

During the pilot follow-up, AOD Workers were asked about inmate reactions to the AODS procedure. The majority reported that the inmates reacted favourably with a few exceptions. One worker reported that an inmate stated that the question pertaining to needle sharing was a violation of his civil liberties. Another stated that at times inmates would inquire as to where the information was going. As already mentioned, a further worker reported that the AUDIT questions were inciting anger in some inmates.

One of the researchers also interviewed a small sample of inmates (n=10) on their perceptions of the AODS. The inmates were asked: whether they understood the questions; how they felt about the duration of the screen; whether they thought the questions were appropriate; and finally, whether they had any concerns. All inmates responded in a fairly favourable manner (fine or okay).

AOD Workers at classification centres

When AOD Workers at centres of classification were contacted concerning the usefulness of the AODS, most reported that they had not viewed the AODS. This was reportedly due to the inaccessibility of the Case Management Files (locked in filing cabinets at other locations within the centres) to which the AODS documents were attached. The workers further stated that they had no contact with Case Managers in relation to AOD referral instructions. This finding was surprising, as both Case Managers and AOD Workers report to Programs Managers for supervision.

An attempt was made to verify these reports through checking official records (Case Management Files). A random sample of 45 files, located at a central holding bay, was examined to determine what action, if any, had been taken subsequent to an inmate's reception.

Most Case Management Files had blank forms attached (Monthly Review Form and Case Review Form). The Monthly Review Form contained an AOD section. A further form which appeared in the majority of the files examined was entitled Program Pathways. However, in the majority of cases these forms were not completed. The examination of the 45 files showed the following:

- no further information subsequent to screening documentation 36% (n=16);
- minimal information (notes by Case Manager on interviewing inmate) 31% (n=14);
- completed Monthly Review Forms 11% (n=5);
- completed Program Pathways<sup>1</sup> forms 9% (n=4);
- completed Case Review Forms 4% (n=2).

Further, 9% (n=4) of the files did not include the AODS document even though inmates had been administered the procedure.

None of the files examined showed evidence of discussions/referrals between Case Managers,

Programs Managers and other professional staff. A few files included case notes whereby it was evident that the Case Manager had discussed AOD issues and treatment with the inmate.

The above findings should be treated with caution and not generalised to the operation of Case Management at the time. Reportedly, there may have been more than a single Case Management File in the system per inmate. This practice was not consistent with policy. However, inmates are frequently transferred between centres and a new file may have been prepared for an inmate even though there was already a file in existence containing pertinent case information.

The abovementioned practice of file duplication could effect the reliability of the findings reported on the Case Management File follow-up. Notwithstanding, it does appear that at the time of the AODS pilot Case Management was still in the preliminary phase and not fully implemented in accordance with policy.

Hence, the problem reported by the AOD Workers concerning access to Case Management Files and minimal referrals appeared to be verified by the pattern of nil/minimal records in the Case Management Files.

### 1.6 Summary

Despite unforeseen delays and breakdowns in the consultation process in the early stages of the pilot, once the AODS protocol had been operational for some months it appeared to be endorsed by the participating AOD Workers. Some workers reported that centre-based Classification and Placement Committees were describing the AODS as a most useful resource. The barriers encountered by other AOD Workers in accessing Case Management information was outside the jurisdiction of the research team. However, it appears that the process of information exchange between Case Managers, Programs Managers and AOD Workers requires review.

## Results 2: Outcomes

### Sample

The total sample size was 395 (293 males and 102 females).

Refusals were reportedly low: metropolitan centre for men, n=5; country centre for men, n=4; centre for women, n=10. However, AOD Workers reported that this data was not totally reliable as inmates may have refused to participate in the screening program (Contact Screening, Referral and Induction) at an earlier stage and the workers may have had no knowledge of these inmates. Therefore, the above numbers represent those inmates who refused to participate once contact was made with an AOD Worker.

Tables 33 to 45 (Annex C) provide demographic and criminality data pertaining to the sample. The representativeness of the sample is not able to be compared to the population of receptions for the year as the population data base is a record of reception incidences rather than individuals. Hence an individual's details (including remand and sentenced reception incidents) may be recorded on a number of occasions throughout the year on the population data base.

### Duration of AODS interview

Table 25 shows the length of time taken to complete AODS for both male and female samples. The mean interview length was 26 minutes. Information on this variable was missing for 9% of the male sample and 12% of the female sample.

### Upcoming court appearances

Of the total sample of males, 34% had additional court appearances scheduled for outstanding matters. Of these, the majority were required to make a court appearance within the next month. Of sentenced males 31% had additional court appearances scheduled.

Of the total sample of females, 68% had additional court appearances scheduled for outstanding matters. Of these the majority were required to make a court appearance within 2 weeks. It should be noted that the majority of the female sample were remanded to custody. Of sentenced females, 44% had additional court appearances scheduled.

AOD withdrawal on reception

Of the total sample, 20% of males and 37% of females reported to be withdrawing from drugs and/or alcohol (Table 1). Both males (12%) and females (32%) most commonly reported that they were withdrawing from drugs (not including alcohol).

Patterns of AOD use

As Table 2.1 shows, the most commonly used drugs prior to imprisonment, as reported by the male sample were alcohol (54%), cannabis (43%) and heroin (30%). Those drugs most commonly used by the female sample were heroin (54%), benzodiazepines (34%) and alcohol (31%). When compared to males (7%) a much higher percentage of females (27%) reported cocaine use. Male and female users of illicit drugs were most likely to be daily users. Most daily heroin users (both males and females) used 1 gram or more of heroin per day (Table 2.1.1). These self-reported patterns of AOD use are not able to be compared to previous findings as the data was collected using a different form of response set.

Of the sample, 76% of males and 96% of females reported that they smoked cigarettes.

Last episode of drug use

Findings pertaining to males and females cannot be compared in relation to this variable as 50% of the female sample were remandees (more likely to have been received into prison from police cells or the street). Of the male sample 7% were remandees.

Most male heroin users (57%) last used more than a week ago with 8% reporting heroin use within the last 24 hours and a further 26% reporting use within the last week.

Tables 2.1.2 to 2.1.5 show that most male users of amphetamines, cocaine or benzodiazepines last used more than a week ago. For each of these drug groups a small proportion (<10%) reported using the drug within the past 24 hours. About 1/3 of amphetamine, cocaine and benzodiazepine users had used within the previous week.

Most female heroin users had last used more than a week ago (51%) with 7% reporting use within the previous 24 hours (Table 2.1.1). Of these female heroin users, 47% had used within the previous week.

Most female cocaine users last used more than a week ago (59%, n=15). Of benzodiazepine users 14% (n=5) reported use within the past 24 hours. In total, 66% (n=23) of benzodiazepines users had used within the previous fortnight. Reportedly, 10 tablets or more was the usual quantity used by more than half (n=14) of daily benzodiazepine users (Table 2.1.5).

Needle use

When compared to males (37%), a higher percentage of females (70%) reported to have used needles in the past year. Of those who used needles 26% of males and 23% of females reported sharing behaviour (Table 4). For the male sample, 7% showed missing information on this question.

AOD-related problems

In terms of self-reported AOD problems, 73% of males and 83% of females stated they had experienced problems. Males (32%) and females (59%) most commonly cited drugs (not including alcohol) as causing problems (Table 5).

Intoxication at time of offence

Of the total sample, 71% of males and 79% of females reported being intoxicated at the time of offence (Table 6). Of the male sample, 27% reported intoxication from drugs, 25% from alcohol and 19% from both alcohol and drugs. Of the female sample, 56% reported intoxication from drugs, 11% from alcohol and 12% from both.

Drug-crime relationship

Using a closed response set of drug-crime options (excluding intoxication), 41% of males and 55% of females reported that their crime was drug-related. The most commonly identified relationship by males was obtaining money to pay for drugs (25%). Similarly, obtaining money to pay for drugs was the most commonly identified relationship by females (38%) and experiencing withdrawal from drugs was reported by 25% of females (Table 7).

Medication use

Of the total sample, 29% of males and 42% of females reported being on prescribed psychoactive medication at the time of reception (Tables 8 & 9). When asked how often they consumed more than the prescribed amount 8% of males and 26% of females stated that they did so, either sometimes, often or always.

Methadone status

Of the total sample, 12% of males and 39% of females reported that they were current recipients of methadone treatment (Table 10). The interviewers classified this question as not applicable for 84% of males and 55% of females. However, 30% of males and 54% of females had reported heroin use in the past year. Therefore it appears, at least an additional 14% of the male sample and 9% of the female sample should have been asked this question.

AOD-related health problems

When asked if they experienced AOD-related health problems, 36% of males and 53% of females stated that they had experienced problems (Table 11). As Table 12 shows, males most commonly cited psychological problems (24%) whereas females most commonly cited Hepatitis C (38%).

Prior treatment

In terms of community-based treatment 41% of the total sample of males and 54% of the total sample of females had received treatment (Table 13). Of those who had been imprisoned before, 49% of males and 37% of females had used the AOD Services (Table 13).

WHO AUDIT

Only the first 3 AUDIT questions were asked of the female sample. Of the total sample, 19% of males and 37% of females reported that they were non-drinkers.

Of the total sample, 28% of males and 11% of females reported that they drank 4 or more times in a week (Table 14). Further, 47% of males and 27% of females reported drinking 10 or more standard drinks on a typical drinking day (Table 15). When asked how often they drank more than 6 drinks in an occasion 24% of males and 12% of females reported doing so on a daily basis.

According to the authors of the AUDIT, a total score of 4 or more for women and 5 or more for men, on questions 1 to 3, suggests a level of drinking which is hazardous. Using the AUDIT criteria for this cluster of questions, 59% of males and 46% of females would be classified as hazardous drinkers.

The authors report that a combined score of 4 or more on questions 4 to 6 suggests that an individual may be psychologically or physically dependent on alcohol. Using the criteria for this cluster of questions, 31% of males would be classified as possibly dependent.



Of the total male sample 21% reported not being able to control their drinking on a daily basis and an additional 18% reported a lack of control weekly to monthly (Table 17). Further, 13% reported that they needed a drink in the morning on a daily basis and 5% reported the need for a morning drink on a less than daily to weekly basis (Table 19).

The AUDIT criteria for interpreting questions 7 to 10 states that a combined score of 4 or more suggests that significant problems already exist. Under the criteria for this cluster of questions, 67% of males would have significant problems.

Disturbingly, 31% of males reported that either they or somebody else had been injured as a result of their drinking in the previous year (Table 22). In addition, 37% of males stated that someone had expressed concern or suggested they reduce their drinking in the past year (Table 23).

As Table 24 shows 75% of males obtained a total AUDIT score of 7 or more and 47% of males obtained a score of 13 or more. The mean score for males was 15.98. According to the AUDIT guidelines a total score of 7 or more is an indication of hazardous alcohol use and a total score of 13 or more, while not being a definitive cut-off score, is a general indication of alcohol dependency. (Information Sheet No.1/93, Early Intervention Unit, Centre for Drug & Alcohol Studies, Royal Prince Alfred Hospital, Sydney).

A pattern of non-completion was evident in the AUDIT scales of the male sample (7%, n=21). Follow-up with some workers identified the problem as being resistance to using the AUDIT. A trend was evident whereby if the AUDIT component was left blank, notes on the cover page showed that some questions had been asked about alcohol consumption. This was without reference to the AUDIT scale. Non-completed items were coded as "no information" as shown in Tables 14 to 24.

#### Aboriginal inmate receptions

When data was compared between Aboriginal and non-Aboriginal females, there more similarities than differences evident. However, there was an exception. Although Aboriginal females, like non-Aboriginals, were most likely to be intoxicated by drugs at the time of offence, they were more likely to be intoxicated by alcohol than non-Aboriginals. Meaningful interpretation is hindered by small cell numbers.

Differences were evident between Aboriginal and non-Aboriginal males. Of Aboriginal males, 76% obtained an AUDIT score of 13 or more and 76% reported drinking 10 or more drinks in a typical drinking occasion. The Aboriginal male sample obtained significantly higher AUDIT scores ( $t=4.0$ ,  $p<.001$ ) when compared to non-Aboriginals. When Aboriginal males were asked if they or someone else had been injured as a result of their drinking, 54% stated that this had happened within the past year.

Aboriginal males were significantly more likely to be intoxicated by a combination of alcohol and other drugs at the time of offence than non-Aboriginals ( $\chi^2=11.8$ ,  $p<.01$ ).

In addition, while Aboriginal males show the same prevalence of withdrawal at reception as non-Aboriginals, they were significantly more likely to be withdrawing from alcohol compared to other drugs ( $\chi^2=12.7$ ,  $p<.02$ ). Aboriginal and non-Aboriginals showed similar prevalence rates in terms of needle use.

#### Referral instructions - positive cases

Table 26 shows the AODS-based referrals for a further AOD assessment for the male sample. As there was a marked discrepancy between the number of referrals in the respective categories made by the interviewers and the numbers derived from the AODS criteria set out in the guidelines both have been presented in the Table 26.

Using the AODS criteria 86% of male inmates

met the criteria for a follow up AOD assessment, with 56% requiring a priority assessment. The AOD Workers recommended that 44% of inmates receive a follow up assessment with 7% requiring a priority assessment. This represents a 42% discrepancy between the actual rating coded and the AODS criteria rating and a 49% discrepancy on whether the assessment should be prioritised. It appeared that AOD Workers were setting their own criteria rather than applying the AODS guidelines.

Table 28 shows that 29% of male inmates received accurate referral ratings. The most common reason for the discrepancy between the AODS criteria and the workers ratings was that the AUDIT score was not taken into account (22%). A further 15% of the screen questionnaires showed missing information in the referral section.

Table 27 shows the AODS based referrals for the female sample. According to the AODS criteria 95% of females required a follow up AOD assessment, with 56% requiring a priority assessment. Whereas, AOD Workers recommended 72% of the sample for an AOD assessment, with 48% requiring a priority assessment. This represents a 23% discrepancy between actual rating and the AODS criteria rating for further assessment, but only an 8% discrepancy on whether the assessment should be prioritised.

Table 29 shows that 56% of the female sample received an accurate referral rating. The most common reason for the discrepancy was in relation to consumption levels and/or self-reported problems not being taken into account.

Therefore, the referrals for the female sample (56%) were markedly more consistent with AODS guidelines than those for the male sample (29%).

#### Referrals to other services

Tables 31 and 32 show the numbers of referrals made to other corrections-based services. The

correctional centre for females and the country centre for males showed about the same level of referrals (47% & 45% respectively). The metropolitan centre for males showed referrals at just 17%. This was possibly due to the fact that new reception inmates usually spend only about 4 days at the centre before being classified to another centre. At the centre for females, referrals were most likely to be made to the medical service (Table 32). At the country centre for males they were most likely to the welfare service and at the metropolitan centre for males they were most likely to the psychology service.

#### Reliability

The internal consistency of the AUDIT was tested using the reliability coefficient Cronbach's Alpha. The alpha value obtained was 0.95 (coefficients range in value from 0 to 1.0). This indicates very good internal reliability. To test whether the alpha value of the scale was inflated by those who reported no alcohol use, zero scores were eliminated and the data was recomputed. The reliability coefficient remained relatively stable at 0.88.

In addition, the AUDIT indices (total score and total score classification index) were compared to findings on the related AODS items for consistency. The total AUDIT score was found to be significantly different ( $t=14.22$ ,  $p < .001$ ) for those intoxicated by alcohol and those intoxicated by drugs. Those who were classified as dependent drinkers (score  $\geq 13$ ) on the AUDIT were significantly more likely to be intoxicated by alcohol at the time of offence ( $\chi^2=110$ ,  $p < .00001$ ). All those who reported to be withdrawing from alcohol on reception were classified as dependent drinkers by the AUDIT ( $\chi^2=25$ ,  $p < .0001$ ). Further those who stated that they had an alcohol problem were more likely to be classified as hazardous drinkers ( $\chi^2=107$ ,  $p < .0001$ ).

The AUDIT was examined for interviewer effect by the application of Analysis of Variance and a significant difference was identified at both the

metropolitan centre for males and the country centre for males ( $F = 4.1, p < .01$  &  $F = 6.14, p < .01$  respectively).

Some of the AODS items were drawn from a previous survey conducted with inmates on discharge (Kevin, 1992). Hence, the pattern of responding to these items as recorded by the 2 studies, can be compared to provide some indication of reliability.

A comparison of findings for males in relation to intoxication at time of offence showed that 71% of the AODS sample reported intoxication versus 67% of the discharge study (Kevin, 1992). The figures compared favourably, however when type of intoxication was examined the discharge sample showed a higher prevalence of intoxication by alcohol alone (34% versus 25%) and the AODS sample showed a higher prevalence of intoxication by both drugs and alcohol (19% versus 10%). A possible explanation for this could be that the AODS sample comprised predominantly of metropolitan intakes (67%). It should be noted that the findings of the discharge study (Kevin, 1992) were highly consistent with a study conducted 2 years prior on reception inmates (Stathis, et al, 1991).

In terms of self-reported AOD problems, the AODS sample and the discharge sample showed equivalent prevalence (74%). When the nature of the problem was examined the AODS sample showed a higher prevalence of 'other drug' problems compared with the discharge sample (32% versus 18%) and a lower prevalence of alcohol problems (21% versus 36%).

Of the discharge sample, 66% reported that their crime was drug-related (when combined with intoxication at time of offence) compared with 74% of the AODS sample. The structure of this question varied between the 2 studies. The discharge structure was open-ended, whereas the AODS provided a series of closed response options.

Of the AODS sample, 41% had previously

received community-based treatment for AOD problems. This finding compared favourably with the discharge study which found that 39% had received treatment.

A pattern of missing information was evident with some AODS items and/or scoring. This pattern was more pronounced in the male sample:

Males:

- needle sharing question (7%)
- AUDIT questions (8%)
- assessment recommendations (15%)
- request for assessment (19%)

Females:

- assessment recommendations (8%)
- location from which received (25%).

**Table 1: AOD withdrawal at reception (AODS:Q10, pg 45)**

Type of withdrawal	Males		Females		TOTAL	
	No.	%	No.	%	No	%
alcohol	13	4.4	2	2.0	15	3.8
drugs	36	12.3	33	32.4	69	17.5
both	7	2.4	2	2.0	9	2.3
anticipated withdrawal	2	0.7	1	1.0	3	0.7
no withdrawal	223	76.1	56	54.9	279	70.6
unsure	4	1.4	7	6.9	11	2.8
no information	8	2.7	1	1.0	9	2.3
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 2.1: Patterns of AOD use in the past year (AODS:Q1, pg 46)**

[response set=openended]

Drug type	Males		Females		TOTAL	
	No.	%	No.	%	No	%
alcohol	157	53.6	32	31.4	189	47.8
cannabis	127	43.3	27	26.5	154	39.0
heroin	88	30.0	55	53.9	143	36.2
amphetamines	46	15.7	14	13.7	60	15.2
benzodiazepines	24	8.2	35	34.3	59	14.9
cocaine	19	6.5	22	21.6	41	10.3
hallucinogens	11	3.8	1	1.0	12	3.0
methadone	11	3.8	8	7.8	19	4.8
analgesics	5	1.7	-	-	5	1.3
anti-depressants	2	0.7	-	-	2	0.5
ecstasy	1	0.3	-	-	1	0.3

Note: The drug categories listed are based on inmate's self-selected responses. Inmates were not asked about their use of each specific drug listed. They were asked to nominate the 4 drugs they used most frequently in the past year. The information was collected in this way due to time constraints pertaining to screening all inmates on reception.

**Table 2.1.1: Heroin**

(a) how often did you use heroin; (b) how much did you use; and (c) when did you last use?

Grams	Heroin use (quantity by frequency)														TOTAL			
	Daily				Weekly				Less than weekly				Unsure					
	M		F		M		F		M		F		M		F		no.	%
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
< 1	30	46.9	18	39.1	4	66.7	2	100.0	7	53.8	1	25.0	1	20.0			63	44.0
≥ 1 < 2	17	26.5	14	30.4	2	33.3			2	15.4	2	50.0			1	33.3	38	26.6
≥ 2 < 3	11	17.2	7	15.2													18	12.6
≥ 3 < 4	3	4.7	4	8.7													7	4.9
≥ 4 < 5	-	-	-	-													-	-
≥ 5 < 7	2	3.1	2	4.3					1	7.7			1	20.0			6	4.2
≥ 7 < 10	-	-	1	2.2													1	0.7
≥ 10	1	1.6	-	-													1	0.7
unsure	-	-	-	-					2	15.4	1	25.0	2	40.0	2	66.6	7	4.9
no inf.	-	-	-	-					1	7.7	-	-	1	20.0			2	1.4
<b>TOTAL</b>	<b>64</b>	<b>100.0</b>	<b>46</b>	<b>99.9</b>	<b>6</b>	<b>100.0</b>	<b>2</b>	<b>100.0</b>	<b>13</b>	<b>100.0</b>	<b>4</b>	<b>100.0</b>	<b>5</b>	<b>100.0</b>	<b>3</b>	<b>100.0</b>	<b>143</b>	<b>100.0</b>

Time frame	Last occasion of heroin use					
	Males		Females		TOTAL	
	no.	%	no.	%	no.	%
within last 24 hours	7	8.0	4	7.3	11	7.7
within last 3 days	15	17.0	10	18.1	25	17.5
within last week	8	9.1	12	21.8	20	14.0
within last fortnight	6	6.8	8	14.5	14	9.8
more than a fortnight	44	50.0	20	36.4	64	44.8
unsure	6	6.8	1	1.8	7	4.9
no information	2	2.3	-	-	2	1.4
<b>TOTAL</b>	<b>88</b>	<b>100.0</b>	<b>55</b>	<b>100.0</b>	<b>143</b>	<b>100.1</b>

**Table 2.1.2: Amphetamines**

(a) how often did you use speed; (b) how much did you use; and (c) when did you last use speed?

<u>Amphetamine use (quantity by frequency)</u>																
Grams	Daily				Weekly				Less than weekly				Unsure		TOTAL	
	M		F		M		F		M		F		M		F	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
< 1	2	10.5	2	18.2	5	45.5	1	100.0	7	63.6	1	100.0			18	30.0
≥ 1 < 2	6	31.6	2	18.2	3	27.3			2	18.2			1	20.0	14	23.3
≥ 2 < 3	5	26.3	4	36.4	2	18.2							1	20.0	11	100.0
≥ 3 < 4	3	15.8	-	-											3	5.0
≥ 4 < 5	-	-	1	9.1											1	1.7
≥ 5 < 7	-	-	1	9.1											1	1.7
≥ 7 < 10	1	5.3	-	-					1	9.1					2	3.3
≥ 10	-	-	-	-												
unsure	1	5.3	1	9.1	1	9.1			1	9.1			1	20.0	5	8.3
no inf.	1	5.3	-	-									2	40.0	3	5.0
<b>TOTAL</b>	<b>19</b>	<b>100.0</b>	<b>11</b>	<b>100.1</b>	<b>11</b>	<b>100.1</b>	<b>1</b>	<b>100.0</b>	<b>11</b>	<b>100.0</b>	<b>1</b>	<b>100.0</b>	<b>5</b>	<b>100.0</b>	<b>11</b>	<b>100.0</b>

<u>Last occasion of amphetamine use</u>						
Time frame	Males		Females		TOTAL	
	No.	%	No.	%	No.	%
within last 24 hours	4	8.7	1	7.1	5	8.3
within last 3 days	6	13.0	-	-	6	10.0
within last week	1	2.2	7	50.0	8	13.3
within last fortnight	7	15.2	1	7.1	8	13.3
more than a fortnight	22	47.8	5	35.7	27	45.0
not sure	3	6.5	-	-	3	5.0
no information	3	6.5	-	-	3	5.0
<b>TOTAL</b>	<b>46</b>	<b>100.0</b>	<b>14</b>	<b>100.0</b>	<b>60</b>	<b>99.9</b>

**Table 2.1.3 Cocaine**

(a) how often did you use cocaine; (b) how much did you use; and (c) when did you last use?

Cocaine use (quantity by frequency)																
Grams	Daily				Weekly				Less than weekly				Unsure		TOTAL	
	M no.	F %	M no.	F %	M no.	F %	M no.	F %	M no.	F %	M no.	F %	no.	%	no.	%
< 1	3	27.3	4	22.2		1	50.0	2	66.7	1	100.0				11	26.8
≥ 1 < 2	1	9.1	5	27.8	1	33.3									7	17.1
≥ 2 < 3	3	27.3	3	16.7											6	14.6
≥ 3 < 4	1	9.1	4	22.2	1	33.3					1	50.0			7	17.1
≥ 4 < 5	-	-	1	5.5											1	2.4
≥ 5 < 7	2	18.1	1	5.5											3	7.3
≥ 7 < 10	-	-	-	-											-	-
≥ 10	-	-	-	-				1	33.3						1	2.4
unsure	1	9.1	-	-	1	33.3	1	50.0					1	100.0	4	9.8
no inf.	-	-	-	-									1	50.0	1	2.4
<b>TOTAL</b>	<b>11</b>	<b>100.0</b>	<b>18</b>	<b>99.9</b>	<b>3</b>	<b>99.9</b>	<b>2</b>	<b>100.0</b>	<b>3</b>	<b>100.0</b>	<b>1</b>	<b>100.0</b>	<b>2</b>	<b>100.0</b>	<b>41</b>	<b>99.9</b>

Last occasion of cocaine use						
Time frame	Males		Females		TOTAL	
	No.	%	No.	%	No.	%
within last 24 hours	1	5.3	-	-	1	2.4
within last 3 days	3	15.8	5	22.7	8	19.5
within last week	2	10.5	4	18.2	6	14.6
within last fortnight	2	10.5	4	18.2	6	14.6
more than a fortnight	9	47.4	9	40.9	18	43.9
not sure	2	10.5	-	-	2	4.9
no information	-	-	-	-	-	-
<b>TOTAL</b>	<b>19</b>	<b>100.0</b>	<b>22</b>	<b>100.0</b>	<b>41</b>	<b>99.9</b>

**Table 2.1.4 Cannabis**

(a) how often did you use cannabis; (b) how much did you use; and (c) when did you last use?

Cannabis use (quantity by frequency)																		
Grams	Daily				Weekly				Less than weekly				Unsure		TOTAL			
	M		F		M		F		M		F		M		F			
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%		
< 1	7	9.1	7	35.0	8	29.7	1	20.0	4	26.7			4	50.0	1	50.0	32	20.8
≥ 1 < 2	21	27.3	2	10.0	7	25.9	1	20.0	3	20.0			2	25.0			36	23.4
≥ 2 < 3	18	23.4	3	15.0	2	7.4	1	20.0	2	13.3							26	16.9
≥ 3 < 4	11	14.3	4	20.0	1	3.7			1	6.7			1	12.5			18	11.7
≥ 4 < 5	3	3.9	-	-	-	-											3	1.9
≥ 5 < 7	2	2.6	-	-	1	3.7											3	1.9
≥ 7 < 10	3	3.9	3	15.0	2	7.4											8	5.2
≥ 10	5	6.5	1	5.0	2	7.4											8	5.2
unsure	5	6.5	-	-	2	7.4	2	40.0	4	26.7			1	12.5	1	50.0	15	9.7
no inf.	2	2.6	-	-	2	7.4			1	6.7							5	3.2
<b>TOTAL</b>	<b>77</b>	<b>100.1</b>	<b>20</b>	<b>100.0</b>	<b>27</b>	<b>100.0</b>	<b>5</b>	<b>100.0</b>	<b>15</b>	<b>100.1</b>			<b>8</b>	<b>100.0</b>	<b>2</b>	<b>100.0</b>	<b>154</b>	<b>99.9</b>

Last occasion of cannabis use						
Time frame	Males		Females		TOTAL	
	No.	%	No.	%	No.	%
within last 24 hours	8	6.3	4	14.8	12	7.8
within last 3 days	32	25.2	11	40.7	43	27.9
within last week	18	14.2	7	25.9	25	16.3
within last fortnight	11	8.7	3	11.1	14	9.1
more than a fortnight ago	48	37.8	2	7.4	50	32.5
not sure	6	4.7	-	-	6	3.9
no information	4	3.1	-	-	4	2.6
<b>TOTAL</b>	<b>127</b>	<b>100.0</b>	<b>27</b>	<b>99.9</b>	<b>154</b>	<b>100.1</b>



**Table 2.1.5 Benzodiazepines**

(a) how often did you use; (b) how much did you use; and (c) when did you last use?

Benzodiazepine use (quantity by frequency)																
Tablets	Daily				Weekly				Less than weekly				Unsure		TOTAL	
	M no.	F no.	M %	F %	M no.	F no.	M %	F %	M no.	F no.	M %	F %	no.	%		
≤ 1													1	25.0	1	1.7
> 1 ≤ 2	1		7.7						1		25.0		1	20.0	3	5.1
> 2 ≤ 4	-	3	-	11.5		1		25.0		2		40.0			6	10.2
> 4 ≤ 6	2	2	15.4	7.7											4	6.8
> 6 ≤ 10	2	4	15.4	15.4		1		25.0							7	11.9
> 10 ≤ 15	1	3	7.7	11.5											4	6.8
> 15 ≤ 20	1	1	7.7	3.8		1		25.0							3	5.1
> 20	3	10	23.1	38.5		1		25.0	2	1	50.0	100.0	1	25.0	18	30.5
unsure	3	3	23.1	11.5	2		100.0						1	25.0	9	15.3
no inf.	-	-	-	-					1		25.0		2	40.0	1	25.0
TOTAL	13	26	100.1	99.9	2	4	100.0	100.0	4	1	100.0	100.0	5	100.0	4	100.0

Last occasion of benzodiazepine use						
Time frame	Males		Females		TOTAL	
	No.	%	No.	%	No	%
within last 24 hours	1	4.2	5	14.3	6	10.2
within last 3 days	3	12.5	7	20.0	10	16.9
within last week	5	20.8	9	25.7	14	23.7
within last fortnight	2	8.3	2	5.7	4	6.8
more than a fortnight ago	9	37.5	9	25.7	18	30.5
not sure	2	8.3	2	5.7	4	6.8
no information	2	8.3	1	2.9	3	5.1
TOTAL	24	99.9	35	100.0	59	100.0

**Table 3. Patterns of cigarettes use (AODS: Q2, pg 46)**

Packets <sup>1</sup>	Males		Females		TOTAL	
	No.	%	No.	%	%	%
none	42	14.3	4	3.9	46	11.6
< half pack	30	10.2	5	4.9	35	8.9
≥ half pack < 1 pack	75	25.6	29	28.4	104	26.3
1 pack	123	42.0	46	45.1	169	42.8
> 1 packet < 2 packs	18	6.1	16	15.7	34	8.6
> 2 packs	5	1.7	2	2.0	7	1.8
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

Note: A packet represents between 20 and 30 cigarettes

**Table 4: Needle use and needle sharing in the past year (AODS: Q3, pg 46)**

	Males		Females		TOTAL	
	No.	%	No.	%	No	%
used needles, did not share needles	81	27.6	55	53.9	136	34.4
used and shared needles	28	9.6	16	15.7	44	11.1
no needle use	163	55.6	29	28.4	192	48.6
unsure	1	0.3	-	-	1	0.3
no information	20	6.8	2	2.0	22	5.6
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 5: Problems related to AOD use (AODS: Q4, pg 46)**

	Males		Females		TOTAL	
	No.	%.	No.	%	No	%
drugs	93	31.7	61	59.2	154	38.9
alcohol	61	20.8	10	9.7	71	17.9
both	60	20.5	14	13.6	74	18.7
nothing	61	20.8	15	14.6	76	19.1
unsure	8	2.7	-	-	8	2.0
no information	10	3.4	2	2.0	13	3.3
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>99.9</b>

**Table 6: Intoxication at time of offences/charges (AODS: Q5, pg 46)**

	Males		Females		TOTAL	
	No.	%	No.	%	No	%
drugs	80	27.3	58	56.3	138	34.9
alcohol	74	25.3	11	10.7	85	21.5
both	55	18.8	12	11.7	67	17.0
nothing	80	27.3	20	19.4	100	25.3
unsure	-	-	1	1.0	1	0.3
no information	4	1.4	-	-	4	1.0
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 7: Relationship between AOD use and criminal activity (AODS: Q6, pg 46)**

	Males		Females		TOTAL	
	No	%	No.	%	No	%
obtaining money to buy drugs	75	25.6	39	38.2	114	38.9
obtaining money to buy alcohol	21	7.2	3	2.9	24	8.1
withdrawing from drugs	16	5.5	25	24.5	41	14.0
withdrawing from alcohol	9	3.1	2	2.0	11	3.8
charge	21	7.2	13	12.7	34	11.6

Notes:

1. The data presented in the above table is in multiple response format (the respondent is provided with the opportunity to select more than one response) hence the percentages do not total to 100.
2. Only 41% (n=108) of the male sample (excl. missing cases) identified a their criminal activity as drug-related. When this sub-sample was combined with the sub-sample who were intoxicated at time of offence 74% (n=218) were identified as having drug-related crime.

**Table 8: Medication use (AODS: Q7i, pg 46)**

Medication	Males		Females		TOTAL	
	No.	%	No.	%	No	%
psychoactive	86	29.4	43	41.7	129	32.6
other	6	2.0	9	8.7	15	3.8
none	189	64.5	50	48.5	239	60.5
TOTAL	293	100.0	102	100.0	395	100.0

**Table 9: Patterns of medication use (AODS: Q7iii, pg 46)**

[Base = those on psychoactive medication]

Frequency	Males		Females		TOTAL	
	No.	%	No.	%	No.	%
always	4	4.7	4	9.3	8	6.2
often	2	2.3	4	9.3	6	4.7
sometimes	1	1.2	3	7.0	4	3.1
rarely	8	9.3	4	9.3	12	9.3
never	52	60.5	28	65.1	80	62.0
no information	19	22.1	-	-	19	14.7
<b>TOTAL</b>	<b>86</b>	<b>100.1</b>	<b>43</b>	<b>100.0</b>	<b>129</b>	<b>100.0</b>

**Table 10: Methadone treatment (AODS: Q8, pg 46)**

Methadone status	Males		Females		TOTAL	
	No.	%	No.	%	No.	%
current	36	12.3	40	39.2	76	19.2
involuntary discharge	2	0.7	1	1.0	3	0.8
voluntary discharge	5	2.0	5	4.9	10	2.5
not applicable	246	84.0	56	54.9	302	76.5
no information	4	1.4	-	-	4	1.0
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 11: AOD-related health problems (AODS: Q9, pg 46)**

	Males		Females		TOTAL	
	No.	%	No.	%	No.	%
yes	106	36.2	54	52.9	160	40.5
no	179	61.1	47	46.1	226	57.2
unsure	-	-	1	1.0	1	0.3
no information	8	2.7	-	-	8	2.0
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 12: Type of AOD-related health problems (AODS: Q9, pg 46)**

[Base=total sample]

Problem	Males		Females		TOTAL	
	No.	%	No.	%	No	%
hepatitis C	39	13.3	39	38.2	78	19.8
psychological	25	23.5	1	1.0	26	6.6
hepatitis B	14	4.8	7	6.9	21	5.3
other	8	2.7	10	9.8	18	4.6
liver	7	2.4	4	3.9	11	2.8
injuries	9	3.1	-	-	9	2.3
sleep	4	1.4	2	2.0	6	1.5
hepatitis A	3	1.0	3	2.9	6	1.5
memory	3	1.0	3	2.9	6	1.5
chest	5	1.7	-	-	5	1.3
digestive	4	1.4	1	1.0	5	1.3
ulcers	3	1.0	1	1.0	4	1.0
blackouts	3	1.0	-	-	3	0.8
asthma	2	0.7	1	1.0	3	0.8
teeth	1	0.3	2	2.0	3	0.8
convulsions	1	0.3	2	2.0	3	0.8
weight	1	0.3	2	2.0	3	0.8
heart	2	0.7	-	-	2	0.5

- Notes: 1. The above question was in opened-ended format, therefore the categories of health-related problems are derived from the inmates' responses.
2. The data presented in the above table is in multiple response format (the respondent is provided with the opportunity to cite more than one response) hence the percentages do not total to 100.

**Table 13: Prior treatment for drug problems (AODS: Q10, pg 46)**

(i) Base=total sample

	Males		Females		TOTAL	
	No.	%	No.	%	No	%
AOD Services	43	14.7	7	6.9	50	12.7
community-based	57	19.5	32	31.4	89	22.5
both	63	21.5	23	22.5	86	21.8
nothing	119	40.6	40	39.2	159	40.3
no information	10	3.4	-	-	10	2.7
Total	293	100.0	102	100.0	395	100.0

(ii) Base=those who had a prior imprisonment

	Males		Females		TOTAL	
	No.	%	No.	%	No	%
AOD Services	38	20.1	6	7.7	44	16.5
community-based	36	19.0	27	34.6	63	23.6
both	55	29.1	23	29.5	78	29.2
nothing	56	29.6	22	28.2	78	29.2
no information	4	2.1	-	-	4	1.5
TOTAL	189	100.0	78	100.0	267	100.0

**Table 14: AUDIT Q1. How often do you have a drink of alcohol? (AODS: pg 47)**

	Males		Females		TOTAL	
	No.	%	No.	%	No	%
≥ 4 times a week	82	28.0	11	10.8	93	23.5
2-3 times a week	45	15.4	9	8.8	54	13.7
2-4 times a month	47	16.0	14	13.7	61	15.4
monthly or less	42	14.3	30	29.4	72	18.2
never	55	18.8	38	37.3	93	23.5
unsure	2	0.7	-	-	2	.5
no information	20	6.8	-	-	20	5.1
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 15: AUDIT Q2. How many standard drinks of alcohol do you have on a typical day when you are drinking? (AODS: pg 47)**

Standard drinks	Males		Females		TOTAL	
	No.	%	No.	%	No	%
> 20	66	22.5	10	9.8	76	19.2
10 - 20	72	24.6	18	17.6	90	22.8
7 - 9	19	6.5	13	12.7	32	8.1
5 - 6	19	6.5	7	6.9	26	6.6
3 - 4	21	7.2	7	6.9	28	7.1
1 - 2	19	6.5	9	8.8	28	7.1
non-drinker	53	18.1	38	37.3	91	23.0
unsure	2	0.7	-	-	2	0.5
no information	22	7.5	-	-	22	5.6
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>



**Table 16: AUDIT Q3. How often do you have six or more drinks on one occasion?**  
(AODS: pg 47)

	Males		Females		TOTAL	
	No.	%	No.	%	No	%
daily/almost daily	71	24.2	12	11.8	83	21.0
weekly	53	18.1	12	11.8	65	16.5
monthly	28	9.6	7	6.9	35	8.9
less than monthly	43	14.7	20	19.6	63	15.9
never	19	6.5	13	12.7	32	8.1
non-drinker	53	18.1	38	37.3	91	23.0
unsure	3	1.0	-	-	3	0.8
no information	23	7.8	-	-	23	5.8
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 17: AUDIT Q4. How often during the last year have you found that you were not able to stop drinking once you had started?** (AODS: pg 47)

Frequency	Males	
	No.	%
daily/almost daily	60	20.5
weekly	33	11.3
monthly	19	6.5
less than monthly	19	6.5
never	85	29.0
non-drinker	53	18.1
unsure	1	0.3
no information	23	7.8
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

**Table 18: AUDIT Q5.**

How often in the past year have you failed to do what was normally expected from you because of drinking?  
(AODS: pg 47)

Frequency	Males	
	No.	%
daily/almost daily	38	13.0
weekly	21	7.2
monthly	14	4.8
less than monthly	26	8.9
never	118	40.3
non-drinker	53	18.1
no information	23	7.8
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

**Table 19: AUDIT Q6.**

How often in the past year have you needed a drink in the morning to get yourself going after a heavy drinking session? (AODS: pg 47)

Frequency	Males	
	No.	%
daily/almost daily	39	13.3
weekly	14	4.8
monthly	6	2.0
less than monthly	20	6.8
never	136	46.4
non-drinker	53	18.1
unsure	1	0.3
no information	24	8.2
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

**Table 20: AUDIT Q7.**

How often during the past year have you had feelings of guilt or regrets after drinking?  
(AODS: pg 47)

Frequency	Males	
	No.	%
daily/almost daily	40	13.7
weekly	27	9.2
monthly	20	6.8
less than monthly	37	12.6
never	94	32.1
non-drinker	53	18.1
unsure	1	0.3
no information	21	7.2
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

**Table 21: AUDIT Q8.**

How often during the past year have you been unable to remember what happened the night before because you had been drinking? (AODS: pg 47)

Frequency	Males	
	No.	%
daily/almost daily	33	11.3
weekly	32	10.9
monthly	21	7.2
less than monthly	46	15.7
never	87	29.7
non-drinker	53	18.1
no information	21	7.2
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

**Table 22: AUDIT Q9.**

**Have you or somebody else been injured as a result of your drinking? (AODS: pg 47)**

Frequency	Males	
	No.	%
yes - during the last year	91	31.1
yes, but not in last year	34	11.6
no	94	32.1
non-drinker	53	18.1
no information	21	7.2
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

Note: Of the total male sample 31% report that they or someone else has been injured as a result of their drinking within the previous year.

**Table 23: AUDIT Q10.**

**Has a relative, a friend, a doctor or other health worker been concerned about your drinking or suggested you cut down? (AODS: pg 47)**

Frequency	Males	
	No.	%
yes - during the last year	109	37.2
yes, but not in last year	19	6.5
no	91	31.1
non-drinker	53	18.1
no information	21	7.2
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

**Table 24: AUDIT Score**

TOTAL SCORE	Males	
	No.	%
40 - 41	20	6.8
21 - 39	78	26.6
13 - 20	41	13.9
8 - 12	27	9.2
1 - 7	47	16.0
0	54	18.4
incomplete	5	1.7
no information	21	7.2
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>

- Notes: 1. Non-drinkers (filtered out in Question 2 ) are included in Table 10 with an assigned score of zero and are included in the calculation of the mean score.
2. The shaded area highlights the percentage of inmates who obtained a score of 13 or more on the AUDIT which according to interpretation guidelines is a general indication of dependency.

**Table 25: Duration of AODS interview**

Minutes	Males		Females		TOTAL	
	No.	%	No.	%	No.	%
1 - 10	29	9.9	6	5.9	35	8.9
11 - 20	85	29.0	39	38.2	124	31.4
21 - 30	94	32.1	26	25.5	120	30.4
31 - 40	34	11.6	9	8.8	43	10.9
41 - 50	19	6.5	6	5.9	25	6.3
51 - 60	4	1.4	1	1.0	5	1.3
61+	3	1.0	3	2.9	6	1.5
no info./incomplete	25	8.5	12	11.8	37	9.4
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.1</b>

Note: Average length of time taken to complete the screen was 26 minutes for both male and female samples.

**Table 26: Further AOD assessment to be undertaken by AOD Worker at centre of classification - male sample**

	Males (Amended ratings according to screen guidelines)		Males (Actual ratings by AOD Workers)	
	No.	%	No.	%
yes priority - within 2 weeks	165	56.3	21	7.2
yes - within 3 months	87	29.7	108	36.9
no	40	13.7	120	41.0
no information	1	0.3	44	15.0
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>293</b>	<b>100.1</b>

**Table 27: Further AOD assessment to be undertaken by AOD Worker at centre of classification - female sample**

	Females (Amended ratings according to guidelines)		Females (Actual ratings by AOD workers)	
	No.	%	No.	%
yes priority- within 2 weeks	57	55.9	49	48.0
yes- within 3 months	40	39.2	24	23.5
no	5	4.9	21	20.6
no information	-	-	8	7.8
<b>TOTAL</b>	102	100.0	102	100.0

**Table 28: Reason initial rating was amended using stated criteria for further assessment - male sample**

	No.	%
<u>Reason rating was amended</u>		
accurate - no amendment required	84	28.7
AUDIT score	63	21.5
no information	44	15.0
general-problems/consumption	35	11.9
withdrawal syndrome	18	6.1
AUDIT score + withdrawal	17	5.8
shared needles	12	4.1
AUDIT score + general	11	3.8
withdrawal syndrome + shared needles	6	2.0
no problem/false positive	3	1.0
<b>TOTAL</b>	293	100.0

**Table 29: Reason initial rating was amended using stated criteria for further assessment - female sample**

	No.	%
<u>Reason rating was amended</u>		
accurate - no amendment required	57	55.9
general-problems/consumption	21	20.6
withdrawal syndrome	9	8.8
no information	8	7.8
shared needles	3	2.9
withdrawal syndrome + shared needles	2	2.0
AUDIT questions	1	1.0
AUDIT questions + general problems	1	1.0
<b>TOTAL</b>	<b>102</b>	<b>100.0</b>

**Table 30: Further AOD assessment requested by inmate**

[Base=those who were classified as being suitable for further assessment]

	Males		Females		TOTAL	
	No.	%	No.	%	No	%
yes	126	50.0	60	58.8	186	53.3
no	79	31.3	32	33.0	111	31.8
no information	47	18.7	5	5.2	52	14.9
<b>TOTAL</b>	<b>252</b>	<b>100.0</b>	<b>97</b>	<b>100.0</b>	<b>349</b>	<b>100.2</b>

**Table 31: Centre by total number of referrals to other corrections-based services**

Centre	Total no. interviews	Total no. referrals	No. referrals as % of no. interviews
metropolitan centre for males	197	34	17.3
country centre for males	96	43	44.8
centre for females	102	48	47.1
<b>TOTAL</b>	<b>395</b>	<b>125</b>	<b>31.6</b>

**Table 32: Type of referral by centre**

Service	Centre							
	Metropolitan centre for males		Country centre for males		Centre for females		TOTAL	
	No.	%	No.	%	No.	%	No.	%
medical service (CHS)	11	32.4	6	14.0	23	47.9	40	32.2
welfare	4	11.8	19	44.2	15	31.2	38	30.6
psychology	17	50.0	10	23.2	6	12.5	33	26.6
education	-	-	3	7.0	1	2.1	4	3.2
probation and parole	-	-	-	-	-	-	-	-
chaplain	1	2.9	3	7.0	-	-	4	3.2
legal aid	1	2.9	-	-	3	6.3	4	3.2
unit correctional officer	-	-	2	4.6	-	-	2	1.6
<b>TOTAL</b>	<b>34</b>	<b>100.0</b>	<b>43</b>	<b>100.0</b>	<b>48</b>	<b>100.0</b>	<b>125</b>	<b>100.0</b>

## Discussion

As stated in the introduction, the AOD Services of the NSW Department of Corrective Services initiated this pilot of the Alcohol and Other Drug Screen (AODS). The general aim of the pilot was to assess both the utility of the instrument in detecting AOD problems and also the feasibility of the procedure before launching it as a systematic and standardised statewide initiative. The AOD Services screening program would represent the first tier in a statewide approach in the identification and treatment of inmates with AOD problems. Prior to the pilot, an AOD screen (10 item scale) was being administered at the main metropolitan reception centre for men. However, this information was not being utilised in service delivery once an inmate had been classified to a correctional centre. Also the validity of the existing scale had been questioned, particularly in relation to the detection of alcohol-related problems. AOD Services management identified the need for a simple, rapid, cost effective procedure which would provide increased sensitivity<sup>2</sup> in detection.

### Methodological difficulties

The projected time period for the pilot to be conducted at 3 correctional centres (the largest metropolitan and country centres for males and the main reception centre for females) was set at 3 months. The actual time taken to complete the pilot at the 3 centres was approximately 12 months.

It was the operational component of the pilot, including site-based cultural elements (rather than the items and form of the instrument) which caused most delay. Specifically, institution-based restructuring, staff turnover, some staff opposition and capital works projects all contributed to the delay.

A confounding factor was the existence of 2 lines of supervision. Clinical supervision was provided by head office AOD Services management and operational supervision was provided on-site

within correctional centres.

In the early stages of the pilot many consultations were held with key personnel in order to prevent the pilot from derailing. AOD Services management considered it essential to allow the pilot run for sufficient time to enable meaningful review. Implicit to this notion was that the staff would require some time to settle into the new procedure.

Most of the opposition to the procedure emanated from the main metropolitan reception centre for males. This was not surprising as the pilot was to have greatest impact at this centre. This centre receives more new sentenced receptions than other centre in NSW (30% n=1622 in 1994). In addition, unlike the other centres, there was already a standardised AOD screening procedure in place at this centre.

The opposition demonstrated by centre-based middle management and some AOD Workers to the pilot initiative and the AODS instrument had not been anticipated by the study team. To some extent, the pilot represented a loss of autonomy to the staff, who had been exercising a high level of control over the screening and induction procedures adopted in the respective centres at which they were based.

Loss of autonomy was not the only factor which may have lead to dissatisfaction. It appeared that AOD Workers at the main metropolitan reception centre for males saw their role as quite distinct to that adopted by other AOD Workers in the system. These AOD Workers described their role in terms of immediate crisis intervention with inmates on their second day in custody. The workers stated that they needed to assess whether inmates were at risk of self-harm at this time.

Reportedly, some inmates present in a state of emotional distress and often wish to discuss issues, such as the centre to where they will be classified, at what security level they will be placed and personal welfare. It was common practice for the AOD Worker to be present at the



meeting which determined an inmate's security classification and centre of placement.

As the AOD Worker is often the first contact person to interview inmates on their second day in custody at this centre, it is not surprising that inmates raise their fears and welfare concerns. During the training, AOD Workers from this centre stated a preference for informally questioning the inmate rather than asking the direct questions on the AODS scale. The direct questions and closed response structures were seen to be at odds with the establishment of a therapeutic relationship. Notwithstanding this, the inmates were only at this centre for induction and would be placed at another centre usually within 4 days.

In summary, the priorities assumed by the AOD Workers at the main metropolitan reception centre for males were described more in terms of crisis intervention than the first tier of a statewide approach in the identification and treatment of inmates with AOD-related problems.

The AOD Workers and the management personnel at the remaining 2 centres involved in the pilot showed minimal opposition. The exception to this was that AOD Workers at the correctional centre for females negotiated with AOD Services management for the WHO AUDIT scale to be deleted from the female version of the AODS. The workers argued that a dedicated alcohol screen was not appropriate for females.

Both the country centre for males and the metropolitan centre for females showed prolonged delays mainly due to internal restructuring.

The study team was unable to exercise direct operational supervision over the pilot as the centre-based operational structure showed overlapping lines of authority and associated responsibilities.

To some extent the setbacks were exacerbated by the fact that the project was managed off-site. At times during the pilot, both AOD Workers and

researchers expressed frustration when attempting to align clinical concerns and research concerns. The clinical workers were not experienced research data collectors, however they were being called upon to provide methodological precision. Should further pilot projects be initiated it is recommended that the study team be based full-time on-site in the initial stages to provide support and feedback to the workers and also to circumvent any setbacks. Prison environments are undoubtedly volatile. Therefore, any future pilot programs will need to address work-related stress issues. If staff are feeling overwhelmed they will not be able to properly establish new initiatives.

Of note is that once the procedure was operational for some months it appeared to be endorsed by participating staff.

### **AODS outcomes**

The findings obtained from the AODS were consistent with normative knowledge about AOD problems in the inmate population (Stathis, et al., 1991; Kevin, 1993). The exception to this was that when compared to previous studies, the pilot showed a lower prevalence of alcohol intoxication at time of offence in males and a higher prevalence of intoxication by other drugs. This was possibly due to the fact that the pilot sample was a predominantly metropolitan intake sample (67%). There was also the possibility of data bias.

The reliability measures obtained from the AUDIT point to the robustness of the scale. Reliability estimates for the AUDIT had not before been reported for inmate samples. Some interviewer effect, in terms of a pattern of non-completion was identified. Follow-up interviews indicated that this was most likely due to interviewer attitudes and possibly the lack of immediate supervision by the research team.

Findings pertaining to alcohol use in the female sample indicate that the AUDIT (with filters for non-drinkers) or some equivalent should be piloted with female receptions.

The criteria for identifying a positive case as set down by the AODS guidelines yielded a sample of 86% males and 95% females. In terms of priority assessments 56% of males and 56% of females met the criteria.

It should be noted that in setting the criteria for a follow-up AOD assessment a broad net was cast, whereby if inmate scored positive on the WHO AUDIT or any other question on the scale (Annex A) s/he was classified as a positive case.

When criteria are used to determine whether a person should receive treatment then the choice of definition should be considered carefully since each definition produces a different estimate of the number of individuals requiring treatment.

Previous research has shown that about 50% of inmates with AOD problems receive some form of treatment from the AOD Services during the term of their sentence (Kevin, 1993). This estimate of service utilisation was obtained prior to the introduction of increased group based programs and inmate support groups. Hence, it could be argued that it is feasible to provide a follow-up assessment to more than 50% of inmates with AOD problems.

In view of the estimated reach of AOD Services, the AODS criteria for a further assessment was adjusted to be more stringent as follows:

#### Priority Assessment (within 2 weeks)

- ▶ experiencing/anticipating withdrawal syndrome.

#### Assessment (within 3 months)

- ▶ intoxication at time of offence/or
- ▶ drug-related crime/or
- ▶ current needle use/or
- ▶ daily users of heroin, amphetamines, cocaine or pills (for non-medical purposes)/or
- ▶ AUDIT score of 13 or more for males and a pattern of drinking 6 or more drinks on a daily basis or more than 6 drinks on a typical drinking day for females.

Using the above criteria 80% of the male sample and 93% of the female sample met the criteria for a follow-up assessment. The revised

assessment criteria did not markedly alter the prevalence estimates for further assessment. However, the revised criteria did alter the prevalence estimates for priority assessment (20% of males and 37% of females). Therefore, these revised criteria while reducing the number of priority assessments had a negligible impact on the prevalence who met the general criteria for further assessment.

Approximately 30% of both males and females refused to participate in a follow-up AOD assessment. When the refusal levels (using the more conservative estimate of 20%) were factored into the number of inmates to be given a follow-up AOD assessment, the following sub-samples were derived:

- ▶ males (60%)
- ▶ females (73%).

This would represent a more achievable target for the AOD Services. Further, the proportion requiring a follow-up assessment would also be reduced if those whose sentences were under 1 month were also excluded from the sub-sample.

Should such estimates not represent a manageable number, the AOD Services may choose to introduce additional criteria for selection, such as an index of dependency combined with an intoxication-violence or other drug-crime relationship.

Notwithstanding the above, caution should be exercised in interpreting the pilot findings particularly in terms of projecting estimates on the basis of a single reception cohort. Further population representative cohort studies would be needed before future case load trends could be considered meaningful.

#### **Current state of AODS screening**

The AODS pilot has laid the groundwork for implementing front-end screening for the detection of inmates with AOD problems, including drug-related crime. The AODS continues to be administered at the main

metropolitan reception centre for males on a systematic basis.

Given that about a third of sentenced inmates had additional court appearances, further consideration is needed in relation to the AODS screen. If an inmate has already been administered the AODS screen within the past 6 months and is subsequently received as a new reception then the point at which s/he meets the criteria for re-screening should be defined.

In relation to the AODS items, certain modifications, as documented in the Results section, have been incorporated into the final prototype. Anecdotal feedback from the AOD Workers has indicated support for the current prototype. Further, AOD Workers at centres of classification are reportedly using the AODS with inmates who seek treatment and for whom the Case Management File is not easily accessed. As reported in the Results section, Case Management did not appear to be operating fully in line with policy.

As further stated in the Results section, research concerns such as the proposed cross-validation component, accurate through-put appraisal, reliable refusal rates and data quality became secondary to the task of circumventing the project from derailing. At times negotiations with some staff members were strained, therefore it was not appropriate to make further demands of them.

Those staff responsible for administering a procedure, such as the AODS should feel confident that it measures what it purports to measure and also feel comfortable in administering the protocol. If staff are not comfortable with a procedure they may inadvertently collude with clients who are in denial. In short, the approach of the interviewer may actually bias the response of the client.

It is recommended that further training on the AODS be conducted to promote information quality. Any future research pilots involving data collection by clinical staff should administer a

pre-test expectation scale to staff prior to the pilot so as attitudes can be accurately assessed.

Recent anecdotal reports indicate that some of the AODS questions are being used by the Classification and Placement Committee in the determination of an inmate's security rating. This practice may bias the information put forward by the inmates, in that they may feel they will be adversely effected (given a higher security rating) by the information they provide during the AODS interview.

The findings of the AODS pilot, whilst painting a picture of a protracted process and compromise on some of the initial objectives, show promise for the accurate detection of inmates with AOD-related problems.

It has been shown that the AODS has potential as a front end screening procedure. It represents the first step in the process of classifying inmates for further intervention according to need or risk using a standardised and systematic approach.

It is clear that more research is required to fine tune and maintain valid criteria for the assignment of inmates to treatment.

Given scarce treatment resources and the sizeable proportion of inmates with drug-related problems, future research needs to address the question of which inmates will most benefit from treatment interventions with respect to health and correctional goals.

## Endnotes

1. Program Pathways: Is a concept of inmates progressing through the correctional system in a planned and structured way. The purpose is to ensure that there is a co-ordinated approach which will allow inmates to progress through various correctional centres without interruption to their planned program/s in order to assist reintegration into the community.
2. Sensitivity: sensitivity and specificity are related to validity and are key properties of screening tests. Sensitivity refers to a tests accuracy in identifying individuals who have problems and specificity refers to the tests effectiveness in identifying individuals who do not have a problem.

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# ANNEX A

CONFIDENTIAL

## ALCOHOL AND OTHER DRUG SCREEN (AODS)

Alcohol & Other Drug Services  
N.S.W. Department of Corrective Services

**Instructions to the interviewer:**

- ☞ Please ensure that you have a copy of the instruction manual that accompanies this screening test.
- ☞ The inmate needs to be informed of the purpose of the screening and the issue of confidentiality before the screening commences (see instruction manual).

-----  
Date of interview: \_\_ day \_\_ month \_\_ year    Start time \_\_\_\_    Finish Time \_\_\_\_

Inmate name: \_\_\_\_\_    Min. No. \_\_\_\_\_

Received from: \_\_\_\_\_  
(N.B.: If inmate is a transfer, check if screening was completed at initial reception centre; if so, do not continue)

### RECOMMENDATIONS FOR AOD WORKERS AND CASE MANAGERS

☺ Further AOD assessment to be undertaken by AOD Worker at gaol of classification:

1. **Yes/priority** (within 2 weeks)    2. **Yes** (within 3 months)    3. **No**

☺ Further AOD assessment/treatment requested by inmate:    1. Yes    2. No

☺ On community/prison **METHADONE PROGRAM**:    1. Yes    2. No

☺ Date AOD assessment completed by AOD Worker: \_\_ day \_\_ month \_\_ year

☺ Referral to other services recommended:

Service(s): \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Interviewer name: \_\_\_\_\_

Inmate name: \_\_\_\_\_ Inmate min. no: \_\_\_\_\_

1. Sex: 1. male 2. female 3. transgender

1a. (If female): Are you currently pregnant? 1. yes 2. no 3. not sure

2. Date of Birth: \_\_\_ day \_\_\_ month \_\_\_ year

3. What country were you born in?: \_\_\_\_\_

4. Are you of Aboriginal or Torres Strait Islander descent?  
1. yes-Aboriginal 2. yes-Torres Strait 3. no 9. unsure

5. Are you now? 1. single 2. married 3. defacto r'shp 4. divorced 5. widowed 6. separated

6. Are you on sentence or remand? 1. sentence 2. remand 3. fine defaulter

7. When does your sentence finish/when do you appear in court?

(i)a. Full sentence: \_\_\_ day \_\_\_ month \_\_\_ year

(i)b. Appellant: 1. yes 2. no

(ii) Parole: \_\_\_ day \_\_\_ month \_\_\_ year

(iii)a. Next court appearance: \_\_\_ day \_\_\_ month \_\_\_ year

(iii)b. Where: \_\_\_\_\_  
1. Local 2. District 3. Supreme

(iii)c. Reason for Appearance: \_\_\_\_\_

8. What are the most serious offences/charges you are currently in prison for?

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

9. (i) Have you ever been to prison before?  
1. yes 2. no 9. unsure

If yes: (ii) How many times? \_\_\_\_\_

10. Are you withdrawing (do you feel sick) from a lack of drugs or alcohol at present?

1. alcohol 2. drugs 3. both 4. no, but I expect to 5. no 9. unsure

1. What drugs have you used the most in the past year? (see Instruction Manual)

(a) Name of Drug	(b) How Often?	(c) How Much?	(d) Last Used?
1.			
2.			
3.			
4.			

2. How many cigarettes do you smoke per day? (write number) \_\_\_\_\_ (if nonsmoker code as 0)

3. (i) In the past year have you used needles when taking drugs?  
(If yes) (ii) Have you shared needles with anyone in the past year?

1. yes-used needles    2. yes -used and shared needles    3. no    9. unsure

4. In the past year has your use of drugs or alcohol caused you any problems?

1. drugs    2. alcohol    3. both    4. nothing    9. unsure

5. Were you under the influence of drugs or alcohol when you committed, or allegedly committed, any of the offences/charges you are currently in prison for?

1. drugs    2. alcohol    3. both    4. nothing

6. At the time of committing, or allegedly committing, any of these charges/offences were you:

1. doing so to get money to buy drugs    3. withdrawing from a lack of drugs  
2. doing so to get money to buy alcohol    4. withdrawing from a lack of alcohol  
5. charged with possession of drug/implements    6. other





7. (i) What medication(s) are you on at present? (write name/s) \_\_\_\_\_

1. none (- Q.9)    2. psychoactive    3. other (- Q.9)

(ii) What are you on the medication for? \_\_\_\_\_

(iii) (If psychoactive) How often do you take more than the prescribed amount?

1. never    2. rarely    3. sometimes    4. often    5. always

8. Are you on a methadone program or have you been discharged from a program in the last 3 months?

1. current    2. involuntary discharge    3. voluntary discharge    4. not applicable

9. Do you have any health problems related to your alcohol or drug use?    1. Yes    2. No

10. Have you ever used the AOD Services in N.S.W. gaols (excluding Prison Methadone Program) or tried drug/alcohol treatment in the community (including methadone services)?

1. AOD Services    2. community-based    4. both    5. nothing





## **AODS INTERPRETATION**

### **1. Criteria for further assessment by AOD Worker at classification centre**

An inmate is identified for further assessment if he is positive on ANY of the following question numbers:

Pages 2 & 3: Page 2 - Qs.10 (withdrawal). Page 3 - Qs. 3 (*IV use*), 4 (*problems*), 5 (*intoxication*), 6 (*drug/crime r'shp*), 7iii(2-5) (*medication misuse*), 8 (*methadone*) 9 (*health problems*).

OR

Page 3, Q.1: Positive on the following:

- ▶ weekly or more use of heroin, cocaine or amphetamines;
- ▶ weekly or more use of pills and more than 2 tablets per occasion;
- ▶ daily use of cannabis.

OR

Page 4: A score of 10 or more for men on the AUDIT/ women= more than 4 drinks on a typical occasion or binge drinking - monthly to daily (Q3c).

### **2. Criteria for priority assessment: (2 weeks)**

- ▶ In withdrawal/anticipated withdrawal (e.g., users of long acting diazepam, such as Valium);
  - ▶ shared needles in previous year;
  - ▶ alcohol dependent (score of 14 or more on AUDIT);
  - ▶ experiencing emotional distress due to alcohol and/or other drug use.
-

# ANNEX B

Screening instrument used at the main metropolitan reception centre for males prior to AODS pilot

## Drug & Alcohol Screening

1. Is this your first gaol sentence?  
Yes <> No <>
2. Was your offence drug and/ or alcohol related? (If no, go to Q.9)  
Yes <> No <>
3. What do you mainly use?  
Alcohol <> Benzodiazepines <>  
Heroin <> Barbiturates <>  
Amphetamines <> Cannabis <>
4. How long have you been using?  
\_\_\_\_\_ Years \_\_\_\_\_ Months
5. Are you currently withdrawing from any drug and/or alcohol?  
Yes <> No <>
6. Are you on methadone?  
Yes <> No <>
7. Have you ever attended any community based counselling or support services for drug/and or alcohol problems?  
Yes <> No <>
8. If you have been to gaol before have you used the AOD Services?  
Yes <> No <>
9. Do want to use AOD Services when you get to your gaol of classification?  
Yes <> No <>
10. Do you have any problems with the gaol environment that you would like to talk to me now about?  
Yes <> No <>

Comments \_\_\_\_\_

Referrals: 11. Do you require to be interviewed by:

- |               |              |
|---------------|--------------|
| Psychology <> | Education <> |
| Parole <>     | Chaplains <> |

# ANNEX C

Table 33: Age

Years	Males		Females		TOTAL	
	No.	%	No.	%	No	%
17 - 20	41	14.0	12	11.8	53	13.4
21 - 24	80	27.3	22	21.6	102	25.8
25 - 29	64	21.8	35	34.3	99	25.1
30 - 34	56	19.1	21	20.6	77	19.5
35 +	52	17.7	12	11.8	64	16.2
TOTAL	293	99.9	102	100.1	395	100.0

Table 34: Aboriginality

Aboriginality	Males		Females		TOTAL	
	No.	%	No.	%	No	%
Aboriginal	45	15.4	26	25.5	71	18.0
Torres Strait Islander	1	0.3	2	2.0	3	0.7
neither	247	84.3	74	72.5	321	81.3
TOTAL	293	100.0	102	100.0	395	100.0

Table 35: Marital status

Marital status	Males		Females		TOTAL	
	No.	%	No.	%	No	%
single	150	51.2	34	33.3	184	46.6
married	25	8.5	10	9.8	35	8.9
de-facto	84	28.7	44	43.1	128	32.4
separated/divorced	30	10.3	13	12.7	43	10.9
widowed	3	1.0	1	1.0	4	1.0
no information	1	0.3	-	-	1	0.3
TOTAL	293	100.0	102	100.0	395	100.1

Table 36: First language of country of birth

Language	Males		Females		TOTAL	
	No.	%	No.	%	No	%
English	252	87.0	99	97.1	351	89.3
Arabic	6	2.1	-	-	6	1.5
Vietnamese	5	1.7	-	-	5	1.3
Croatian/Bosnian/Serbian <sup>1</sup>	3	1.0	1	1.0	4	1.0
Spanish	3	1.0	-	-	3	0.8
Cantonese/Mandarin <sup>1</sup>	3	1.0	-	-	3	0.8
Italian	3	1.0	-	-	3	0.8
Turkish	2	0.7	-	-	2	0.5
Romanian	2	0.7	-	-	2	0.5
Finnish	2	0.7	-	-	2	0.5
other African	2	0.7	-	-	2	0.5
Armenian/Farsi	1	0.3	-	-	1	0.3
Bahasa	1	0.3	-	-	1	0.3
Khmer	1	0.3	-	-	1	0.3
other Eastern European	1	0.3	-	-	1	0.3
Fijian	1	0.3	-	-	1	0.3
Samoaan	1	0.3	-	-	1	0.3
Tongan	1	0.3	-	-	1	0.3
Greek	1	0.3	-	-	1	0.3
Thai	-	-	1	1.0	1	0.3
Flemish	-	-	1	1.0	1	0.3
TOTAL	291 <sup>2</sup>	100.0	102	100.0	393	100.0

Notes: <sup>1</sup>In extracting country of birth data from the Offender Record System it was not possible to separate these languages

<sup>2</sup>Information missing for 2 cases

**Table 37: Pregnancy Status**

Pregnancy status	Females	
	No.	%
pregnant	6	5.9
not pregnant	85	83.3
unsure	11	10.8
TOTAL	102	100.0

**Table 38: Location from where received**

Location	Males		Females		TOTAL	
	No.	%	No.	%	No	%
court	194	66.2	22	21.6	216	54.7
police cells	67	22.9	52	51.0	119	30.1
transfer	13	4.4	1	1.0	14	3.5
street	4	1.4	-	-	4	1.0
other	9	3.1	2	2.0	11	2.8
no info./incomplete	6	2.0	25	24.5	31	7.8
TOTAL	293	100.0	102	100.1	395	100.0

**Table 39: Imprisonment status**

Status	Males		Females		TOTAL	
	No.	%	No.	%	No	%
sentence	252	86.0	43	42.2	295	74.7
remand	20	6.8	51	50.0	71	18.0
fine defaulter	21	7.2	8	7.8	29	7.3
TOTAL	293	100.0	102	100.0	395	100.0

**Table 40: Appellant status** (base = sentenced inmates and fine defaulters)

Appellant	Males		Females		TOTAL	
	No.	%	No.	%	No	%
yes	40	14.7	15	29.4	55	17.0
no	233	85.3	36	70.6	269	83.0
TOTAL	273	100.0	51	100.0	324	100.0

**Table 41: Sentence length** (base = sentenced and fine defaulters)

Length	Males		Females		TOTAL	
	No.	%	No.	%	No	%
< 1 month	36	13.2	15	29.4	51	15.7
1 mth < 3	35	12.8	12	23.6	47	14.5
3 mths < 6	56	20.5	11	21.5	67	20.7
6 mths < 1 yr	66	24.2	10	19.6	76	23.5
1 yr < 2 yrs	38	13.9	2	4.0	40	12.3
2 yrs plus	42	15.4	1	2.0	43	13.3
TOTAL	273	100.0	51	100.1	324	100.0

**Table 42: Imprisonment history**

Imprisonment history	Males		Females		TOTAL	
	No.	%	No.	%	No	%
prior imprisonment	189	64.5	78	76.5	267	67.6
no prior imprisonment	104	35.5	23	22.5	127	32.1
no information	-	-	1	1.0	1	0.2
<b>TOTAL</b>	<b>293</b>	<b>100.0</b>	<b>102</b>	<b>100.0</b>	<b>395</b>	<b>100.0</b>

**Table 43: Offences/charges: type**

[multiple response: allowed for a maximum of 4 offences/charges per inmate]

Offence	Males		Females		TOTAL	
	No.	%	No.	%	No	%
property	121	41.3	56	54.9	177	44.8
order	96	32.8	43	42.2	139	35.1
assault	77	26.3	14	13.7	91	23.0
driving	45	15.4	8	7.8	53	13.4
drug	38	13.0	20	19.6	58	14.7
warrants	29	9.9	20	19.6	49	12.4
robbery	28	9.6	9	8.8	37	9.4
malicious damage	27	9.2	3	2.9	30	7.6
sexual assault	22	7.5	-	-	22	5.5
other	15	5.1	6	5.9	21	5.3

Note: This table includes the 4 most serious charges/offences for which an inmate was currently imprisoned.

**Table 44: Next court appearance: number of weeks remaining**

Weeks	Males		Females		TOTAL	
	No.	%	No.	%	No	%
≤ 1 week	24	24.0	31	44.9	55	32.5
> 1 ≤ 2 weeks	13	13.0	7	10.1	20	11.8
> 2 ≤ 4 weeks	24	24.0	16	23.1	40	23.7
> 4 ≤ 12 weeks	26	26.0	13	18.8	39	23.1
> 12 ≤ 26 weeks	9	9.0	-	-	9	5.3
> 26 weeks (6 mths)	4	4.0	-	-	4	2.4
no information	-	-	2	2.9	2	1.2
<b>TOTAL</b>	<b>100</b>	<b>100.0</b>	<b>69</b>	<b>99.8</b>	<b>169</b>	<b>100.0</b>

**Table 45: Type of court - next appearance**

Court	Males		Females		TOTAL	
	No.	%	No.	%	No	%
local	74	74.0	49	71.0	123	72.8
district	22	22.0	19	27.5	41	24.3
supreme	4	4.0	1	1.5	5	3.0
<b>TOTAL</b>	<b>100</b>	<b>100.0</b>	<b>69</b>	<b>100.0</b>	<b>169</b>	<b>100.1</b>