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NDLERF

Managing intoxicated offenders: Best practice
in responding to individuals affected by drugs
and alcohol

Georgina Fuller
Susan Goldsmid
Rick Brown

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Managing intoxicated offenders: Best practice in responding to individuals affected by drugs and alcohol

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Produced by the National Drug Law Enforcement Research Fund (NDLERF)
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Executive summary

Background

In 2013, the National Drug Law Enforcement Research Fund commissioned the Australian Institute of Criminology (AIC) to undertake research examining the response to and management of intoxicated offenders in police custody. The purpose of the research was to:

- develop a best practice framework for the police, outlining principles to help guide police practice, and techniques and strategies to effectively identify and manage intoxicated offenders in a range of scenarios regularly encountered by operational police;
- enhance understanding of the range of responses used by police and frontline service workers to effectively manage intoxicated offenders in each jurisdiction, and facilitate the transfer of knowledge drawn from the practical experiences of police officers and workers from other sectors;
- identify the range of services, delivered by other frontline service personnel, which may be required to better support the police in their response to intoxicated offenders; and
- develop a model for the effective transfer of policies, procedures and strategies adopted by the police in each jurisdiction to deal with intoxicated offenders.

This project was developed in line with the National Drug Strategy 2010–2015 (NDS) which recognises that the police have a role to play under all three pillars of the NDS, those being: demand reduction, supply reduction and harm reduction. This project examined one facet of the role of the police in harm reduction. In particular, it studied police policies and practices aimed at minimising risks to the police, the community and the offender during interactions with intoxicated offenders.

Methodology

The scope of the research questions was broad and best suited a mixed methods approach. The discrete parts of the methodology were:

- review of existing literature;
- detailed case study analysis using data from the National Deaths in Custody Program (NDICP);
- comparative review of police policies and guidelines for managing intoxicated offenders;
- quantitative data analysis to examine substance use profiles of Australian offenders and factors that influence police officers' assessments of intoxication; and
- consultations with police officers, including a number of workshops in metropolitan and regional areas, and a national roundtable.

Intoxication

Intoxication is defined as a condition that follows the administration of alcohol or a drug and 'results in disturbances in the level of consciousness, cognition, perception, judgement, affect or behaviour or other psychophysiological functions and responses' (World Health Organization [WHO] 2014).

A considerable proportion of a frontline police officer's time involves interactions with individuals who are intoxicated or under the influence of alcohol and other drugs. Previous research has demonstrated that between eight and 26 percent of police officers' time involves managing intoxicated offenders.

In the current study, 53 percent of Australian offenders who provided a urine sample tested positive via urinalysis for cannabis, 38 percent for amphetamines, 27 percent for benzodiazepines, nine percent for heroin, three percent for ecstasy and one percent for cocaine. In addition, 46 percent of offenders reported recent consumption of alcohol.

Police management of intoxicated offenders

Police officers must balance a number of competing priorities and tasks when responding to incidents. Police officers' priorities include:

- ensuring the safety and wellbeing of those responding to the incident, the community members present and the offender;
- responding to and dealing appropriately with any offence committed, within the limitations of their powers;
- protecting property; and
- preventing continuation of the crime.

Incidents that involve individuals intoxicated by alcohol or other drugs pose unique risks that police officers must also address. These can be categorised broadly within four phases of intoxicated offender management:

- establishing control of the situation;
- assessing intoxication;
- liaising with other frontline services; and
- managing risks to the offender in custody.

The phases of managing intoxicated offenders are dynamic, with the interaction progressing through the phases in an order determined by the nature of the incident. Reviewing police policies and practices through these four phases of management will help to identify vulnerabilities and risks associated with managing intoxicated offenders.

Control

The first priority of the police when attending an incident is to gain control of the situation to minimise risks to themselves, the community and the offender. Alcohol and other drug use can complicate a police officer's efforts to gain and maintain control. Side effects of intoxication may include cognitive impairment, motor impairment, and increased aggression and hostility.

A review of 41 national deaths in custody cases (where the coroner's report was publicly available, the death occurred between 2002–03 and 2010–11 in police custody, and the offender had alcohol and/or drugs in their system) identified three groups of offenders. These groups could be differentiated based on the level of control police had over the incident.

In the first group, police focused primarily on control. Seven out of 13 offenders died during initial contact or interaction, while the six remaining offenders died during arrest. A higher proportion of offenders in this group were intoxicated by drugs compared with alcohol. Almost all offenders displayed a high level of aggression and/or hostility. Coroners' recommendations supported the actions of police and noted the difficulty associated with controlling aggressive offenders.

In the second group, police focused mainly on management. Five of the 10 offenders died during initial interaction, arrest or transportation and the remaining five offenders died at the watch house (four while occupying a cell). All offenders in this group had alcohol in their system at the time of death, with three of the 10 offenders also having drugs in their system. Unlike group 1 (control focus), only one offender in this group displayed hostility or aggression towards the police. In this case, the offender was aggressive at the watch

house and the police had control over the situation throughout the incident. Coroners' findings supported the police use of force in these cases. Case details document that the police were able to identify and took actions to respond to risks related to intoxication.

The focus of the police in the third and final group was on both control and management. Eleven of the offenders died during initial interaction or arrest, and the remaining seven offenders died at the watch house (six while occupying a cell). Of those who died during initial interaction/arrest, most were intoxicated by only drugs, while the majority of offenders who died at the watch house were intoxicated by alcohol. Risk followed the same progression in all cases. Offenders were initially aggressive and/or hostile and presented a risk to the police and the community. Once the police had control of the incident, the offender's aggression subsided and risk converted to a personal one related to intoxication. Eight of the 18 offenders died as a result of complications arising from the interaction between intoxication and physical exertion. The coroners' findings supported police officers' use of force in these cases, but recommended improvements to police management of intoxication-related risks.

A review of police policies identified a lack of information to guide police management of risks to offenders during arrest. For example, focus group members spoke about their awareness of positional asphyxia and their management of associated risks. However, while policies from the four jurisdictions addressed this issue, the level of detail and approach varied considerably between documents. The NDS guidelines for psycho-stimulant use were examined as a general guide for police handling of intoxicated and aggressive offenders.

Assess

Assessing intoxication and related risks is a continual process during interactions between the police and the offender. Empirical evidence suggests that accurately identifying intoxication and the substance consumed is difficult without objective measures. Focus groups reported relying on a combination of subjective measures of intoxication in the field, and objective measures in the watch house, such as formal questionnaires and breathalysers. Focus groups reported that ability to assess intoxication was learnt 'on-the-job'.

Focus groups expressed greater confidence in detecting alcohol compared with drug intoxication. Police officers reported using the presence of a smell of alcohol, slurred speech and difficulties standing or walking as indicators of alcohol intoxication. For drugs, police officers reported detecting intoxication through the presence of aggression, increased strength, erratic thought processes and behaviour, psychosis and hallucinations. These symptoms are more typical of stimulant drug use, such as methamphetamine, than sedative drug use, such as heroin.

Subjective assessments of intoxication can be hampered by factors that influence or mask alcohol and other drug intoxication, such as substance consumed, an individual's health, gender, weight, age, polydrug use, food intake and dependence on the substance. The ability of police officers to detect intoxication can be influenced by the drug consumed, level of intoxication, training and expertise. Finally, the presence of injuries to the offender, such as head wounds, can mask or mimic intoxication. This potentially increases the risk that the injury will be misidentified as intoxication.

In the current study, police officers' assessments of intoxication were better than chance at correctly detecting self-reported recent alcohol use, but no better than chance at detecting recent drug use. That is, an offender who reported having recently consumed alcohol was more likely than not to be identified by the police as intoxicated. This was not the case for drug intoxication. Recent illicit drug users, as determined by urinalysis, were as likely as not to be identified by the police as intoxicated. Statistical analysis revealed that an offender's level of hostility and stimulation, but not their self-reported level of intoxication, sedation or psychological distress, predicted police officer assessments of intoxication. Stimulation and hostility are associated with alcohol and stimulant use, such as methamphetamine.

Assessing intoxication at the watch house involved completing a formal, structured questionnaire with the offender, discussions with arresting police officers, and information held on police systems. The review of deaths in custody cases undertaken in this study identified that a failure to adequately assess intoxication or

a failure to follow standard protocols for offender management in the watch house created an unacceptable level of risk, which ultimately resulted in deaths in custody. Coroners' recommendations focused on improving collaborations between the police and healthcare services in managing intoxicated offenders and in strengthening watch house processes.

Focus groups identified two strategies that were being trialled to improve assessment of intoxication in the watch house. These were embedding medical personnel, such as nurses or paramedics, in the watch house, and using breathalysers to help identify intoxication. Police officers from the relevant jurisdictions who participated in the national roundtable supported strategies that helped frontline police officers and watch house personnel to identify and manage intoxication. However, at the time of writing this report, the efficacy of these strategies had not been formally assessed.

Liaise

Police officers who participated in both the focus groups and the national roundtable gave their strong vocal support to the proposition that watch houses were inappropriate facilities to care for and manage intoxicated offenders. Police officers stated that risks to the offender from intoxication and withdrawal were difficult to manage in the watch house. The police had limited first aid skills, and cells were not appropriately equipped to manage intoxication-related risks.

Police officers expressed a desire to divert intoxicated offenders from police custody. However, while policies provided by three of the four jurisdictions contained information on diversion from custody, the nature and detail of this information varied considerably.

The NDS advocates a holistic response to managing and responding to alcohol and other drug-affected offenders. Police officers also described a willingness and desire for a close collaboration between the police and healthcare services. Those health services identified as routinely used by the police were nurses, paramedics, ambulance services and hospitals. Police officers reported that they were risk-averse and would engage with healthcare services to seek advice on assessing and managing intoxication. Each jurisdiction reported working under a different collaborative model to manage intoxicated offenders. Only one focus group, in a rural location, reported being satisfied with the existing relationship between the police and local healthcare services.

A review of jurisdictional policies noted that those provided were restrictive in the types of healthcare services mentioned as being able to be accessed by police officers. In addition, policies tended to refer the police to healthcare services when a medical emergency was underway. This was contrary to police officer reports of contacting services at the first sign of risk. Finally, policies contained little or no reference to a formal collaboration between the police and other frontline services.

Roundtable members recognised a need to improve collaboration between the police and healthcare services, in particular by:

- collaborating on the ground, supported by strategic collaboration at higher levels of the organisation;
- effectively sharing information between the police and health services; and
- developing a closer partnership in managing intoxicated offenders.

Manage

The main foci of the police when managing intoxicated offenders in the field were on controlling the situation, managing any risks from offender or bystander aggression and/or hostility, and safely transporting the offender to the watch house. Effective communication by police officers was viewed as vital during this period as it allowed them to assess intoxication, build rapport and exert control over the situation. During arrest and transportation, police officers noted that a sudden change in the offender's level of communication or demeanour, such as difficulty in breathing, could indicate deterioration in the offender's wellbeing. However,

the policies that were provided lacked detail around managing risks during arrest and transportation, with only one jurisdiction covering this in detail.

Policies and procedures relating to managing intoxicated offenders in the watchhouse were prescriptive, adopting a structured approach to risk mitigation. Despite this level of policy detail, police officers reported difficulty in managing chronic alcohol and other drug users in the watchhouse. Chronic users were likely to be at high levels of intoxication and to have a greater likelihood of suffering from withdrawal effects while in custody. The deaths in custody case review undertaken in this study identified that 12 offenders in groups 2 and 3 died from 'other physical' causes such as cardiac arrest or respiratory failure due to intoxication issues related to chronic use. Police officers stated that risks associated with withdrawal were heightened in rural locations, where services were sometimes scarce, and in locations where offenders could be held for several days awaiting court.

A key component of watch house management of offenders was ongoing monitoring. In each jurisdiction, the offender was regularly monitored by closed-circuit television (CCTV) and physical checks. The frequency of monitoring was determined by police assessments of an offender's level of risk. All jurisdictions noted a need for offenders to speak, raise a limb and open their eyes to check for signs of life. However, police officers in some jurisdictions reported that if an offender was asleep they only required observable signs of breathing, such as the rise and fall of the chest. In other jurisdictions, police officers were adamant that offenders needed to be woken to determine signs of life. This inconsistency poses a risk, as an offender in a coma may appear to be sleeping. The deaths in custody case review noted that in a number of incidents watch house policies and procedures were not adhered to; this had increased risks that had contributed to the offenders' deaths.

Focus groups noted that determining when an offender was safe to release from custody was difficult, as it relied on a subjective assessment of an offender's ability to look after their own safety and wellbeing. This judgement is particularly complex when dealing with a chronic user. Detaining a chronic alcohol and other drug user in custody for an extended period of time carries risks in terms of withdrawal, and these must be weighed against risks related to intoxication. Jurisdictional policies provided little or no detail to help police determine fitness for release from custody.

The CALM framework

From this research, a best practice framework was developed, founded in the four phases of intoxicated offender management—control, assess, liaise, and manage (CALM). The framework is designed to underpin the development of police policies for managing intoxicated offenders. It can also be used as an aide memoire to assist police officers, particularly junior officers, to identify, assess and manage risks to the police, the community and the offender during interactions with intoxicated offenders. Upon identifying risks, officers should use jurisdictional policies and procedures, training and their experience in determining the appropriate action to be taken.

Key aspects that officers should consider when attempting to control an interaction are:

- the influence of bystanders;
- managing risks to the police/community through de-escalation techniques or through use of force options;
- using appropriate methods of communication; and
- the risks associated with intoxication and physical restraint.

Key aspects that officers should consider when attempting to assess whether an offender is intoxicated, their level of intoxication and substances consumed are:

- alcohol and drug intoxication identification/assessment options: subjective and objective measures;
- continual assessment of intoxication;
- determining fitness for custody; and
- practical training for probationary officers.

Key aspects that officers should consider when *liaising* with other frontline services to assist in managing intoxicated offenders are:

- protocols for contacting other frontline services;
- mechanisms for sharing information between services; and
- formal liaison at higher levels between the police jurisdictions and between the police and health services.

Key aspects that officers should consider when *managing* intoxicated offenders are:

- changing levels of risk resulting from rising or falling intoxication levels;
- protocols for identifying and responding to alcohol and drug withdrawal;
- guidelines for monitoring intoxication; and
- appropriateness of release, bail and diversion.

To ensure that best practice is developed across policing jurisdictions, national roundtable attendees suggested two mechanisms to formalise the sharing of information and policies:

- working groups; and
- the Australia New Zealand Policing Advisory Agency (ANZPAA).

Conclusion

Based on the findings of the literature review, deaths in custody case review, empirical studies, and focus group and roundtable discussions, this project developed the CALM framework. This is designed to assist police in their efforts to achieve and maintain best practice in managing intoxicated offenders.

Roundtable participants supported the following initiatives as being required to achieve best practice in managing intoxicated offenders:

- applying the CALM framework;
- enhancing collaboration between police jurisdictions; and
- improving collaboration between the police and health-care services.

Introduction and context

Definition of intoxication

Intoxication can be defined as a condition that follows the administration of alcohol or a drug and *'results in disturbances in the level of consciousness, cognition, perception, judgement, affect or behaviour or other psychophysiological functions and responses'* (World Health Organization (WHO) 2014). This is a slightly altered version of the WHO's (2014) definition of acute intoxication by psychoactive substances, and demonstrates how intoxication can lead to increased levels of risk for the individual and those around them. Specifically, disturbances to consciousness, perception and judgement mean that individuals are often not fully cognisant of their surroundings or in full mental or physical control of their actions while intoxicated.

Frequency of police interactions with intoxicated offenders

A considerable proportion of a frontline police officer's time involves interacting with individuals who are intoxicated or under the influence of alcohol and other drugs. Donnelly et al. (2007) conducted two eight-day observation periods monitoring police activities across a representative sample of New South Wales (NSW) Police Local Area Commands and the VIKINGS Unit; a specialist unit in NSW Police that targets street crime and antisocial behaviour. They found that eight percent of police officers' time involved alcohol-related activity and most of that time was spent responding to and managing intoxicated offenders.

Another study examined the activity logs of operational police officers in rural and metropolitan areas in a major Australasian region (Palk et al. 2007). Officers recorded the details of all incidents attended, noting those at which alcohol or illicit drugs were present. Of 31,090 primary incidents, 23 percent were alcohol-related, two percent were drug-related and one percent involved both alcohol and drugs. This study also reported that there was little difference between rural and metropolitan locations in terms of the proportion of incidents that were related to alcohol and other drugs (Palk et al. 2007).

Substance use profile of Australian offenders

Since 1999, the Australian Institute of Criminology (AIC) has monitored alcohol and illicit drug use among Australian police detainees as part of the Commonwealth-funded Drug Use Monitoring in Australia (DUMA) program. Every quarter, AIC personnel and local researchers interview police detainees at select police stations and watch houses across Australia (in this report, the term 'watch house' is used to refer to both watch houses and police stations). Participation is voluntary and confidential. Detainees are asked to complete an interviewer-assisted questionnaire about demographics, alcohol and other drug (AOD) use, past criminal justice system contact and drug attribution data; and, in the first and third quarters each year, to provide a urine sample (see Appendix A for details of methodology). A police detainee is an individual who has been arrested but not convicted and who is in the custody of police (Sweeney & Payne 2012), referred to as an offender in this report.

In quarter 3 of 2014, 533 offenders were interviewed. Of these, 442 (83%) were male and 91 (17%) were female. Offenders were on average 32.3 years of age (standard deviation or SD=10.3) and the youngest was 18, while the oldest was 77 years.

Due to competing operational priorities, police officers' assessments of intoxication could not be recorded for offenders interviewed at the Brisbane watch house (n=203). In addition, police assessments of intoxication could not be recorded for 114 offenders interviewed at the Perth, Adelaide and Kings Cross sites. This resulted in a final sample size of 216 offenders. Of these, police identified 22.2 percent (n=48) as intoxicated and 77.8 percent (n=168) as not intoxicated (see Table 1).

Table 1: Demographic, alcohol and illicit drug use characteristics of offenders, by police assessment of intoxication

	Not intoxicated		Intoxicated		Total	
	n	%	n	%	n	%
Gender						
Male	140	77.0	42	23.1	182	100.0
Female	28	82.4	6	17.7	34	100.0
Age						
18–20 years	15	65.2	8	34.8	23	100.0
21–25 years	43	81.1	10	18.9	53	100.0
26–30 years	26	76.5	8	23.5	34	100.0
31–35 years	30	79.0	8	21.1	38	100.0
36–40 years	25	83.3	5	16.7	30	100.0
41–45 years	15	83.3	3	16.7	18	100.0
Greater than 46 years	14	70.0	6	30.0	20	100.0
Urinalysis						
Cannabis use	54	79.4	14	21.0	68	100.0
No cannabis use	47	77.1	14	23.0	61	100.0
Opiates use	18	78.3	5	21.7	23	100.0
No opiates use	83	78.3	23	21.7	106	100.0
Cocaine use	1	100	0	0	1	100.0
No cocaine use	100	78.1	28	21.9	128	100.0
Amphetamines use	39	79.6	10	20.4	49	100.0
No amphetamines use	62	77.5	18	22.5	80	100.0
Self-report						
Alcohol use	57	58.8	40	41.2	97	100.0
No alcohol use	108	93.9	7	6.1	115	100.0
Total	168	77.8	48	22.2	216	100.0

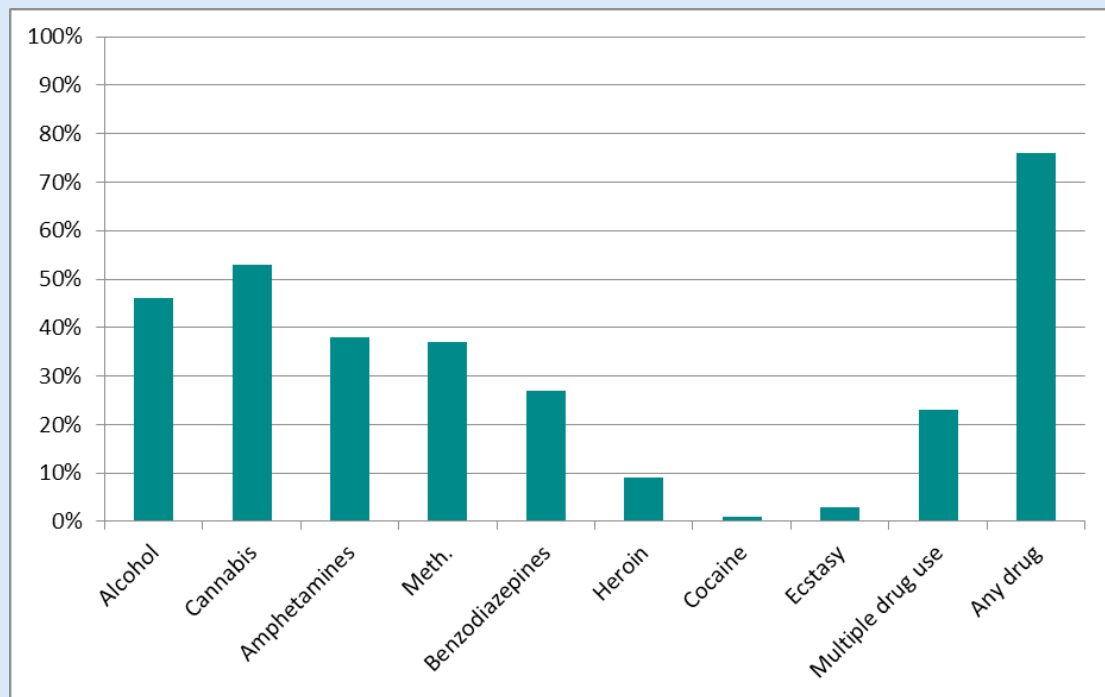
Note: Detainee intoxication status was based on police charge system records

Source: AIC DUMA collection 2014 [computer file]

Of the final sample of 216 offenders, 60 percent (n=129) provided a urine sample. Seventy-six percent of detainees who provided a urine sample tested positive to at least one drug. This information is summarised in Figure 1. The most common illicit drug detected was cannabis (53% tested positive), followed by amphetamines (38%), benzodiazepines (pharmaceuticals such as Xanax: 27%), and heroin (9%). Drugs such as cocaine (1%) and ecstasy (3%) were less commonly detected (see Figure 1).

With regard to alcohol, 46 percent of adult police detainees reported drinking in the 24 hours prior to the event that led to their arrest, with the average quantity of alcohol consumed on the last occasion being 39 standard drinks.

Figure 1: Offender recent alcohol and illicit drug use (%)



Note: Recent alcohol use is based on self-reported use. Recent illicit drug use is based on detection of the substance via urinalysis.

Source: AIC DUMA collection 2014 [computer file]

This indicates a high prevalence of use among offenders. Consistent with other research, it also suggests that a high proportion of police officers' time at the watch house is spent interacting with and managing offenders who are under the influence of AOD.

Police management of intoxicated offenders

Police officers are required to consider several elements when responding to individuals who are affected by AOD. These can include ensuring the safety and wellbeing of the user and other members of the community, responding to an offence (where an offence has been committed), and protecting property and preventing crime (Gray et al. 2006; Spooner et al. 2004). Reviews that have explored issues associated with policing substance misuse (among Indigenous populations—CMC 2009; Gray et al. 2006) and best practice during interactions with offenders (eg Wilson & Braithwaite 1996) have highlighted a number of requirements for the police, including:

- understanding the effects of volatile substances;
- accurately assessing users and their needs;

- appropriately responding to intoxicated users; and
- identifying the nature and limitations of policing powers (Gray et al. (2006).

Gray et al. (2006) also state that proactive solutions to these issues need to be identified.

Interactions between the police and intoxicated offenders can be represented by four phases of management:

- establishing control of the situation to minimise risks to the police, the community and the offender;
- identifying and assessing the presence of intoxication and associated risks;
- liaising with other frontline service personnel to seek guidance and advice to help identify and manage risks; and
- managing intoxication-related risks to an offender in custody.

These four phases do not progress in a structured order, but are determined by the nature of the incident.

A police officer may be required to manage an intoxicated offender through all four phases, or may only be present for certain phases of management. In some cases, police officers may need to revisit a phase previously considered, such as in incidents where control needs to be re-established after a period of compliance, or when medical advice needs to be sought on multiple occasions. The actions required by the police in each phase are situation specific and reflect the policies and practices of the particular police jurisdiction.

Further research is needed to determine techniques and responses required to manage intoxicated offenders that address Gray's (2006) identified requirements as they relate to each phase of interaction (ie control, assessment, liaison and management). Development of a best practice framework to guide and underpin police management of intoxicated offenders would serve as a benchmark for jurisdictional policies and procedures and could be used to ensure that best practice is achieved and maintained across jurisdictions. A best practice framework could also help police jurisdictions determine whether officers have adequate resources and training, which Spooner, McPherson and Hall (2004) identified as essential to the successful management of offenders. A comprehensive best practice framework would also recognise that specific services or facilities that the police require to manage offenders may be located in police settings or they may be in the community (Spooner et al. 2004).

The current research

In 2013, the National Drug Law Enforcement Research Fund (NDLERF) commissioned the AIC to undertake research examining police responses to and management of intoxicated offenders. Its purpose was to:

- develop a best practice framework for the police, outlining principles to help guide police practice and techniques, and strategies to effectively identify and manage intoxicated offenders in a range of scenarios regularly encountered by operational police;
- enhance understanding of the range of responses used by police and frontline service workers to effectively manage intoxicated offenders in each jurisdiction and facilitate the transfer of knowledge drawn from the practical experiences of police officers and workers from other sectors;
- identify the range of services delivered by other frontline service personnel, which may be required to better support the police in their response to intoxicated offenders; and
- develop a model for the effective transfer of policies, procedures and strategies adopted by police in each jurisdiction to deal with intoxicated offenders.

The scope of the research questions was broad and best suited a mixed methods approach. A mix of qualitative and quantitative analysis and consultations with policing personnel was used to gain a well-rounded perspective of the issue. The discrete parts of the methodology were as follows:

- review of existing literature;
- detailed case study analysis using data from the NDICP;
- comparative review of police policies and guidelines for managing intoxicated offenders;

- quantitative data analysis to examine substance use profiles of Australian offenders and factors that influence police assessments of intoxication; and
- consultations with police officers, including a number of workshops in metropolitan and regional areas and a national roundtable.

See *Appendix A* for details of the methodology.

Control

Focus group participants stated that when arriving at any incident, their first priority was to gain control of the situation to ensure their own safety and that of the community. Key to gaining that control was being able to assess and manage hostility. As one officer stated, when the offender is aggressive ‘they’re going to get hurt [through the police officers’ use of force] and we’re going to get hurt’ (R). The identifiers ‘R’ and ‘M’ are used to differentiate between comments made by focus groups in rural and metropolitan locations respectively.

Offender intoxication by AOD presents a number of challenges to the police in their attempts to gain control over an incident. Side effects of intoxication include cognitive impairment, motor impairment and increased aggression and hostility. These side effects may increase the risks to the police, the community and the offender. For example, intoxicated individuals are far more likely to misinterpret environmental cues as hostile and be unable to respond appropriately (Graham et al. 1998).

Widespread epidemiological studies have shown an association between alcohol use and violence, especially in social situations (Parker & Auerhahn 1998). This link is especially apparent in the relationship between alcohol use and violence in the night-time economy. For example, Morgan and McAtamney (2009) found that approximately 40 percent of all assaults occurred in or around licensed premises while the work of Miller and colleagues has shown a correlation between longer venue trading hours, increased patron consumption of alcohol and increases in the rate of physical assault (Miller & Litherland 2015).

Methamphetamine use has also been linked with violence through the inhibition of cues that normally control behaviour (Sommers & Baskin-Sommers 2006; Baberg et al. 1996; Sexton et al. 2009). Side effects of methamphetamine use include increased levels of arousal, difficulties with communication and interpersonal interactions, and intensification of emotions, all of which can lead to hostile or aggressive behaviour (Sommers & Baskin-Sommers 2006). Other side effects of drug use may also lead to aggressive behaviour. For example, preliminary studies found that high doses of marijuana may contribute to temporary psychotic reactions involving hallucinations and paranoia, especially for those who are predisposed (Hall 2006; Hall et al. 2005; Johns 2001; Zammit et al. 2008). Similarly, the behavioural and cognitive disturbances associated with ‘coming down’ from a heroin ‘hit’ may lead to aggression (Hoaken & Stewart 2003).

This section presents some of the results from the deaths in custody case review undertaken in this project (see *Appendix A* for details of the methodology). The review highlighted the vulnerabilities and risks associated with intoxicated offenders and police responses. This section focuses on the findings that relate to police control. The *Assess* section details the findings that relate to police officers’ assessment of intoxication and the *Manage* section explores those findings related to managing offenders.

Deaths in custody case review: The role of control

The AIC's National Deaths in Custody Program (NDICP) was founded in 1992 in response to recommendations made by the Royal Commission into Aboriginal Deaths in Custody in its final report, published in 1991. The database contains information regarding all deaths in custody that have occurred in Australian states and territories since 1980. As well as personal information about the deceased, the NDICP also contains contextual information about their death. This includes the time, location and cause of death, as well as other factors such as the involvement of AOD.

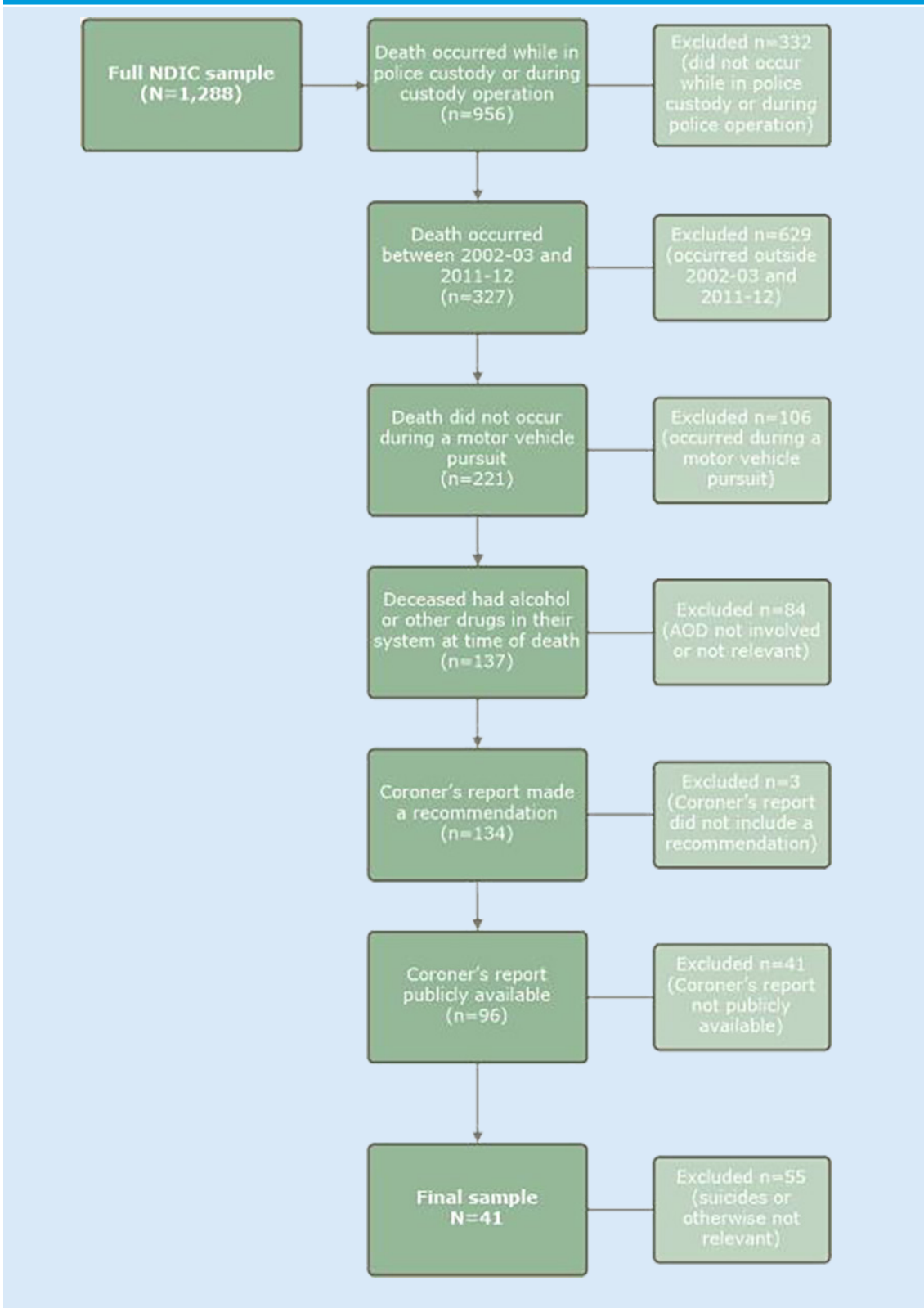
The purpose of this review of deaths in custody cases was:

- to identify the characteristics of incidents involving intoxicated individuals in police custody, including the substances used, cause of death and contextual factors that may have contributed to the death; and
- to review the coronial recommendations made in relation to managing individuals affected by drugs or alcohol in police institutional settings and the apprehension of individuals affected by drugs or alcohol to identify common themes and underlying principles that can guide police practice.

The sample

Presented in Figure 2 is a flow diagram for the selection of included cases. As stated, the NDICP database holds information pertaining to 1,288 cases. After removing cases that did not constitute a death in police custody, 956 cases remained. Of those cases, 327 occurred between the dates of interest, 2002–03 to 2010–11. Excluding cases involving a vehicle pursuit refined the sample to 221 cases. A further 84 cases were removed as the toxicology report did not list alcohol or illicit drugs as present in the offender's system at the time of death. A coroner made a recommendation in 134 cases, however only 96 of those were publicly available. After a more detailed review of these cases, 54 were excluded as they fell outside the scope of this project. This included cases where the offender committed suicide or where police custody was incorrectly defined. This left a final sample of 41 cases for analysis.

Figure 2: Process of case selection and inclusion



Analysis

The characteristics of the 41 deaths in custody cases were extracted from the publicly available coroner's reports. Details of the cases are summarised in Tables 2, 3 and 4. The sample was split into three groups to reflect the foci of the police during that interaction.

- Group 1—incidents where police officers' focus was only on control (n=13). The offenders in this group presented a heightened risk to the police/community because of hostile, aggressive or violent behaviour.
- Group 2—incidents where police officers' focus was only on managing intoxication-related risks to the offender (n=10). Offenders in this group posed little or no threat to the police/community.
- Group 3—incidents where police officers faced challenges in controlling the situation as well as in managing risks to the offender given their level of intoxication (n=18). In these cases the police were aware of and attempted to manage risks to the police/community and intoxication-related risks to the offender.

Most offenders in the sample were aged between 25 to 29 years with a median age of 27 years. The youngest was 15 and the oldest was 66 years. Only one case involved a female offender.

Group 1: Control focus

The deaths in this group occurred prior to or during arrest, as shown in Table 2. Seven out of 13 offenders died during initial contact or interaction (stage 1), while the remaining six died during arrest (stage 2). Most (n=9) were shot by the police.

Table 2: Characteristics of offenders in Group 1 (n=13)

Case	Gender	Age	Alcohol	Drugs	Mixed	Aggression	Stage of death	Cause
1	M	30–39		✓		✓	2	Death related to police restraint
2	M	>50 years		✓		✓	2	Gunshot (police)
3	M	20–29		✓		✓	1	Gunshot (police)
7	M	<20 years	✓			✓	2	Gunshot (police)
9	M	30–39		✓		✓	1	Gunshot (police)
15	M	20–29		✓		✓	2	Death related to police restraint
16	M	40–49			✓	✓	1	Gunshot (police)
19	M	20–29			✓	✓	1	Gunshot (police)
21	M	30–39	✓			✗	2	Other physical
22	M	30–39		✓		✓	1	Gunshot (police)
24	M	20–29		✓		✓	1	Gunshot (police)
26	M	20–29	✓			✓	1	Not determined
34	M	20–29		✓		✓	2	Gunshot (police)

Source: AIC NDICP 2002–2011 [computer file]

Intoxication profile

In this group, a higher proportion of offenders were intoxicated by drugs, compared with alcohol. Autopsy results indicated that 10 of the 13 offenders were under the influence of some form of drug at the time of their death. Where specific toxicology was reported, amphetamines and cannabis were the most common drugs detected (n=6, respectively).

Hostility and aggression

The high proportion of deaths by police shooting in this group can be explained by the degree of hostility and/or aggression displayed by the offender. As shown in Table 2, all but one offender displayed some level of hostility and/or aggression towards the police. The nature of this hostility and its influence on the outcome of the interaction is explored in more detail below.

Not every case was characterised by overt, physical aggression towards officers or bystanders during the initial interaction with the police. Instead, the behaviour of some offenders (n=8) was more hostile and best characterised as a potential risk to the police/community. For example, in the following case the offender came to the attention of the police because of his dangerous driving:

The driver of the [car] says he was simply taking the most direct route to the pawn shop they were heading towards and that required him to make a left turn, the next right and the next left turn in quick succession. It led the police to think that those in the [car] were trying to avoid them and made the officers determined to intercept the vehicle (Case 34).

In this case, the potential for harm to the police/community and the offenders is indirect through the risks associated with erratic driving. Alternatively, in the following case the offender (who was being detained under the Mental Health Act) was not overtly aggressive towards the police during stage one (initial contact/interaction). However, the nature of his behaviour indicated the potential for harm.

There had been no aggression at that point exhibited by [the deceased], but he was nevertheless still demonstrating a large measure of reluctance to leave with police. He continued to say that he had not done anything wrong or that he did not need to go back to the hospital...Once outside of the unit [the deceased] exhibited a number of behaviours that disconcerted police. When repeatedly asked for his house keys, [the deceased] would place his hand in his pocket and pull them out halfway and then remove his hand. There were other instances where he manipulated the rings on his fingers as if to place them in positions that might facilitate the infliction of injury (Case 1).

In five of the cases the offender's hostility was overt and the aggression displayed posed a serious risk to the police/community during initial interaction. All offenders were armed; three with knives and two with firearms. Contrary to the previous examples, in these cases the intention of the offender to cause harm was apparent. This is demonstrated in the following two cases:

[Police officer] observed [the deceased] to exit his unit and to walk up the drive towards him, holding a knife and yelling obscenities...[the deceased], who was seen to be bleeding from the neck and to have blood on his hands, was directed to drop the knife, however, this direction was ignored as he commenced to run at [police officer] (Case 9).

[Police officer] said that when [the deceased] got to the gate he raised an arm and pointed what [police officer] believed at the time was a firearm at him...[the deceased] then withdrew from the gate and walked back into the rear yard in a matter of only seconds (Case 16).

As a result of aggressive and hostile behaviour and the associated elevated level of risk, the police actions during stages 1 and 2 were primarily focused on controlling the threat to the police/community posed by the offenders. The primary method of control used by the police was force. Seven offenders died during stage one (initial contact/interaction), all but one, were shot by the police after presenting as a significant threat to the safety of police/community. For example:

[The deceased] advanced, swinging the swords, raised one above his head and struck the rear window of the police vehicle, smashing the glass...[police officer] continued to yell the command to [the deceased] to drop his weapons. [The deceased] continued to advance on [police officer] with a sword raised and another held in a thrusting manner. [Police officer] discharged one shot from his firearm, striking [the deceased] in the upper torso (Case 3).

Other examples included offenders who opened fire on the police (Case 24), or attempted to shoot (Case 2) or stab the police (Case 7).

In cases where the offender was not shot (n=3), death occurred subsequent to struggles between the offender and the police. In the remaining three cases, offenders died as a result of cardiac arrest or positional asphyxia. Described below is a struggle between the police and an offender, which demonstrates how quickly a situation can escalate:

[The deceased] struggling violently, and then all of a sudden, he could not move anymore, [the witness] states 'then suddenly he couldn't breathe, he stopped breathing' (Case 21).

The following example provides a detailed description of how the interaction between physical exertion and intoxication can result in death (Case 15). The focus of the police was clearly on controlling the offender's aggressive behaviour to minimise risks to the police/community.

During this struggle [police officer] says that on two separate occasions he felt [the deceased] trying to remove his service revolver from the holster on his belt...The officers say that after he was handcuffed, [the deceased] continued to struggle for a minute or so and then his resistance ceased. The officers continued to restrain him, concerned that he might be gathering his strength for another effort until they noticed him making snorting or hawking sounds. They also noticed that his breathing changed suddenly, he seemed to be puffing, and that copious quantities of clear or pinkish brown mucus issued from his nose and mouth. [The deceased] had ceased struggling by this stage and it was then apparent that [the deceased] was unconscious (Case 15).

Regardless of whether the offender was shot or died due to another cause, these cases demonstrate the immediacy of the threat to the police/community posed by the offenders in this group. The primary focus of the police during these interactions was on responding to and controlling the risk of violence to themselves and the community. The only way the police could assert this control was through force. There was no mention in the case summaries of the police identifying or considering intoxication; the primary focus appeared to be on treating the threat or potential threat to the police/the community.

Coroners' recommendations

The coroners' findings and recommendations supported the actions of the police. Where coroners did make recommendations, they highlighted the difficulties associated with controlling aggressive offenders. As one coroner wrote:

When dissecting the actions of the officers on the night in question from the safety and comfort of a courtroom, it is important to reflect on the very difficult and challenging situation the officers suddenly found themselves in. Something that they anticipated to be quite routine quickly turned into something very different (Case 15).

In this instance, the coroner recommended that police training procedures be reviewed in an attempt to 'focus on how the police responses to these situations may be made less dangerous [to police, community and offender]' (Case 15). Similarly in other cases, where coroners recommended improved training around awareness of mental health issues, the actions and response of the police were not criticised.

Group 2: Management focus

Ten cases in the wider sample involved offenders who were classified as having only been at personal risk due to intoxication during their interactions with the police. All but one of the offenders were male; offender characteristics are summarised in Table 3.

Table 3: Characteristics of offenders in Group 2 (n=10)								
Case	Gender	Age	Alcohol	Drugs	Mixed	Aggression	Stage of death	Cause
6	M	30–39			✓	✗	2	Other physical
11	M	40–49	✓			✗	4	Other physical
27	M	>50 years	✓			✓	4	Other physical
28	M	20–29	✓			✗	1	Other (non-physical)
30 ¹	M	20–29	na	na	na	✗	4	Other (non-physical)
35	M	20–29			✓	✗	4	Other (non-physical)
36	M	40–49	✓			✗	2	Death related to police restraint
37	M	40–49	✓			✗	2	Other physical
39	F	>50 years			✓	✗	3	Other (non-physical)
40	M	20–29	✓			✗	2	Other (non-physical)

¹ Toxicology results from the autopsy were not available. In this case, the offender was judged by police to be under the influence of alcohol at the time of arrest

Source: AIC NDICP 2002–2011 [computer file]

There are marked differences between offenders in this group compared with those in the previous group. In particular, aggression was only present in one case and all offenders had consumed alcohol as confirmed through either toxicology results post-mortem or on the basis of officer assessment at time of arrest.

Intoxication profile

Autopsy results revealed that at the time of death, no offender in this group was intoxicated by drugs alone. Alcohol was the most common intoxicating substance, appearing in six out of 10 cases. In three cases, the offender was found to have both alcohol and drugs in their system. The toxicology results were not available in the final case.

In no case was the death caused by a police shooting. Rather, offenders died due to either physical complications associated with intoxication or other causes (injury). Specifically, this group includes two cases where the offender drowned and three cases where death was the result of sustained injuries. While four out of 10 offenders died during arrest, the same number of people in this group died during stage 4 (occupying a cell).

Aggression and hostility

Only one case involved an offender who showed aggression towards the police. However, the aggression occurred after the offender had arrived in the watch house and never presented a serious risk to the police's control of the situation.

Management of risks

In all cases, the police were aware of and responded to risks that intoxication posed to the offender. This was likely aided by the absence of hostility and aggression. In three cases, the police officers were aware that the offender was intoxicated prior to their initial interaction with the offender, due to information provided in the initial call to police. For example, Case 36 involved officers responding to a request from a club to help remove an offender for drunken behaviour.

When this prior information was unavailable, the police officers still identified that the offender was intoxicated in four of the 10 cases. This is likely due to the presence of overt behavioural cues (see the next section). For example, the two excerpts below show that the behaviours exhibited by the offenders were indicative of intoxication:

- difficulties with balance or standing— '[t]he accused was described by these individuals as being drunk, and fell over when called over to the police vehicle' (Case 11); and
- the smell of alcohol— '[police officer] noticed an odour of ethanol on [the deceased]'s breath. He said that smell became more profound when [the deceased] was seated in the back of the police van' (Case 39).

As the offenders were not hostile or aggressive, in three cases the police officers attempted to explore alternatives to arrest or detention in the watch house. In Cases 27 and 11, the police attempted to leave the offender in the care of staff at a sobering up shelter. These cases were characterised by low criminality; the offender was picked up for public drunkenness rather than for a more serious offence. In Case 35, officers sought medical assistance from a hospital prior to the offender being transported to the watch house.

Coroner's recommendations

There were no adverse coroners' findings relating to police use of force in these cases. However, the coroners did make a number of recommendations regarding police management of intoxication-related risks (see *Liaise* section).

Group 3: Control and management focus

Group 3 focused on incidents where the police response required both control and management of the offender. In total, 18 cases involved offenders who at various stages posed a risk to the police/community and themselves. All were male; further characteristics are summarised in Table 4.

Table 4: Characteristics of offenders in Group 3 (n=18)

Case	Gender	Age	Alcohol	Drugs	Mixed	Aggression	Stage of death	Cause
4	M	20–29			✓	✗	2	Other (non-physical)
5	M	20–29	✓			✓	4	Death related to police restraint
8	M	30–39		✓		✓	2	Other (non-physical)
10	M	40–49		✓		✗	2	Other physical
12	M	20–29		✓		✗	2	Not determined
13 ¹	M	30–39	na	na	na	✗	2	Other physical
14	M	20–29			✓	✓	1	Gunshot (police)
17	M	30–39		✓		✓	2	Other physical
18	M	20–29	✓			✗	2	Other (non-physical)
20	M	40–49		✓		✓	2	Death related to police restraint
23	M	20–29	✓			✗	2	Other (non-physical)
25	M	40–49		✓		✓	2	Gunshot (police)
29	M	40–49		✓		✓	3	Other physical
31	M	40–49			✓	✗	4	Other physical
32	M	>50 years	✓			✗	4	Other physical
33 ¹	M	>50 years	na	na	na	✓	4	Other physical
38 ¹	M	30–39	na	na	na	✗	4	Other (non-physical)
41	M	30–39		✓		✗	1	Death related to police restraint

¹ Toxicology results from the autopsy were not available. In these cases, the offender was judged by police to be under the influence of alcohol at the time of arrest

Source: AIC NDICP 2002–2011 [computer file]

Intoxication profile

As with Group 2, offenders in this group most often died in stage 2 (arrest) and stage 4 (occupying a cell). Two of the offenders died in stage 1 (initial interaction), nine in stage 2 (arrest), one in stage 3 (handover to custody manager) and six during stage 4 (occupying a cell).

Clear differences are noted in this group in the type of intoxication experienced by those who died during stage 2 compared with those who died in stage 4. Although the numbers in each of these groups are small, of those who died during stage 2, a larger proportion were intoxicated by only drugs (6 of 10) while at stage 4, it was alcohol (2 of 5). This may indicate a difference in the risk profile of individuals intoxicated by either drugs or alcohol.

Aggression and hostility

Risk followed the same progression in all cases. Due to hostile or aggressive behaviour, offenders initially presented as a risk to the police/community. However, once the police had controlled the situation and the aggression subsided, the risk became personal to the offender in terms of intoxication. In no cases did an offender who originally presented as a risk to the police/community and then progressed to presenting a risk to themselves, revert to presenting a risk to the police/community.

Management of risks

The pattern of interaction between police officers and offenders who were intoxicated with only drugs was similar at stage 2 (8 of 18). These offenders were aggressive towards the police and died as a result of complications due to the interaction between intoxication and physical exertion. As the following two cases demonstrate, the intensity of the struggle between police and the offender is likely to have been a contributing factor:

There was a protracted struggle to control [the deceased], who police described as having super human strength. During at least the first three minutes of [the deceased]'s being restrained on the ground, as evident from the tasercam footage, terrible groans and screams are heard from [the deceased], which clearly show his pain and distress. At about 6:11:40am...he is suddenly seen to be unresponsive and not breathing and is found to be life extinct when ambulance officers arrive as summonsed (Case 12).

[The witness] went down the steps as [police officer] passed him going up. He said that when he last saw the two men [police officer] had appeared to catch [the deceased] and the two were in a scuffle with the former 'laying across or something' the latter. Moments later [the witness] heard someone yell out 'I can't breathe'. He continued on his way out of the car park and while doing so heard a person he presumes was [police officer] yelling for someone to assist him and saying, presumably to [the deceased], 'stop struggling, I'll let you breathe' (Case 20).

In such cases, the focus of the police appeared to be on managing risks associated with the hostile and aggressive behaviour of the offender and not on the potential complications caused by intoxication.

Coroners' recommendations

There were no adverse coroners' findings relating to the police use of force for these cases. However, the coroners did make a number of recommendations regarding police management of intoxication-related risks (see *Assess* and *Liaise* sections).

Table 5: Summary of stage of death across the three groups

	Stage of death	Group one (control focus)	Group two (management focus)	Group three (control and management focus)
1	Initial contact	1 (8%)	-	-
	Interaction	6 (46%)	1 (10%)	3 (17%)
2	Arrest	6 (46%)	3 (30%)	7 (39%)
	Transportation		1 (10%)	2 (11%)
3	Handover to custody manager	-	-	1 (5%)
	Booking/assessment	-	1 (10%)	-
	Transfer to cell	-		-
4	Occupying cell	-	4 (40%)	5 (28%)
5	During investigation/interview	-	-	-
6	Transfer to corrective services	-	-	-
	Release/discharge	-	-	-
Total		13	10	18

Discussion

The results of the qualitative review of 41 deaths in custody cases suggest that when an offender was hostile, aggressive or violent towards the police or the community, the effects of intoxication and associated risks to the offender were a secondary concern to officers. This was supported by focus group participant comments suggesting that effective assessments of intoxication cannot occur until the police have control of the situation. As one participant remarked their aim was to 'fix the problem [the hostile/aggressive behaviour]... then make the assessment on why they're behaving that way' (R) while another emphasised a concern for officer safety stating 'get them cuffed and secure, so I'm secure, they're secure and take it from there' (M).

By their nature, coronial inquests will likely include cases involving the extreme use of force. Examples presented included shooting the offender and enhanced restraint techniques. Deaths that resulted from using restraint techniques highlighted the importance of police officers' understanding and management of positional asphyxia. A total of six deaths across the three groups occurred as a result of the police officers' use of restraint. These cases involved the police or security officers continuing to restrain the offender once handcuffed (Cases 15, 20 & 36) or using more force than is usually required to subdue an offender (Case 1). While using force is necessary for the police to gain control of a situation, the coroner in Case 15 stated that officers needed to be aware of risks posed to the offender when employing such techniques.

Focus group participants from all jurisdictions spoke about their awareness and management of positional asphyxia. Common management strategies discussed included using the minimum amount of force necessary to subdue the offender, and then once the handcuffs were applied, sitting offenders up as soon as possible to assist with breathing. Officers also expressed a preference for establishing control of a situation through de-escalation techniques. Techniques stated by focus group participants to be particularly effective included using calming language and engaging the offender in conversation.

As part of this research, all jurisdictions supplied policies, procedures, training documents and guidelines associated with managing intoxicated offenders. Although requested to provide all relevant material,

subsequent discussions with some jurisdictions revealed that elements related to managing intoxicated offenders (such as transport of prisoners) may have been contained in policies that were not provided. The findings discussed below and in subsequent sections refer only to the policies, procedures and guidelines that were provided.

Analysis of jurisdictional policies revealed a lack of information to guide police management of risks to offenders during arrest. Policies from three out of the four jurisdictions provided information related to the risks to offenders during arrest, with only two of these policies providing specific guidelines around managing positional asphyxia. Both of these policies focused on avoiding placing undue physical pressure on the offender during restraint, and the need for care and continuous monitoring of the offender's welfare. For example:

If a detained person is violent and objects to being searched, you may use reasonable force. Do not, however, use restraints which constrict air supply or arteries/veins, such as 'choke holds', neck restraints or pressure point holds applied above the neck. Use restraint in the most humane way possible.

This jurisdiction also provided examples of de-escalation techniques in one of their substance-specific policies. The primary strategies suggested in this policy were using communication and maintaining a safe distance from the offender until the situation was successfully controlled. This advice is in line with NDS guidelines for managing intoxicated offenders. For example, the policy highlighted how the impairment in the offender's cognitive functioning caused by drug use could impact communication:

Consistent with officer survival training, the first step for police in controlling and containing a situation should always be communication. Consider your options and take time to assess the situation. Given the effects of methylamphetamine, the person may be experiencing paranoia or perceive a threat to their personal safety, so where possible, maintain a distance that is both safe for you and less likely to be perceived as threatening for the person.

The steps provided in these policies serve to increase a police officer's awareness of intoxication and aggression while also serving to enhance their response. However, these were available in only two of the four jurisdictions. Other jurisdictional policies either did not link intoxication and aggression or did not provide sufficient detail to assist the police with their response. Further, no information could be located in any of the policies provided as to the need to conduct an assessment of intoxication after aggression subsides. Two out of the four jurisdictions treated intoxication and aggression as distinct issues meaning that guidelines around the police response also remained separate.

Although the NDS guidelines were developed in response to psychostimulant use, they can provide a general guide to handling intoxicated and aggressive offenders. For instance, the guidelines state that offenders who are displaying acute behavioural disturbances caused by intoxication during arrest should be managed through either calming verbal communication or physical restraint. The guidelines go on to explicitly state that 'special precautions must be taken [when physically restraining an offender] due to the risk of increased body temperature leading to severe medical complications' (Jenner et al. 2004: 9). Specifically:

In a physical restraint situation, the central nervous system is further stimulated leading to increased heart rate, increased blood pressure and increased body temperature. For these reasons, it is essential that physical restraint be undertaken for the shortest possible time, and calming communication should continue to be utilised to reduce agitation (Jenner et al. 2004: 11).

The process of appropriately restraining an intoxicated offender is detailed in 12 steps. These include directions around communicating with the offender and the position of officers in relation to the offender. For example:

- police officers to the side of the offender move to restrain the offender's arms in an arm lock (strong hand of the officer takes hold of the wrist/forearm and the weak hand is placed under the arm of the offender and takes hold of the bicep area and locks the individual's arm against the police officer's body);
- police officers behind the person should support the head and neck, and then lower the individual to the ground (take care to avoid placing fingers/body in a position where the person can bite);

- police officers who are facing the offender move to restrain the legs reaching for the thighs first;
- all officers involved lower the offender to the ground gently so that they lie on their back; and
- rotate the offender's limbs outward and secure to the ground/floor, place the palm of the hand flat facing downwards. Secure limbs at the wrist, elbow, knee and ankle using only the force required to minimise movement and reduce possible escalation of body temperature (Jenner et al. 2004: 10).

Although not designed to replace existing use of force guidelines (not provided), the NDS guidelines provide an excellent example of how a policy can instruct officers on how to manage risks to an intoxicated offender during arrest. Worth noting is that one jurisdiction, after reviewing the final report, noted that they did not support specific restraint techniques being included in drug and alcohol policies. This was because specialists within that jurisdiction provided training and policies on using force.

For the most part, the issues that emerged through reviewing coronial investigations were reflected in the responses provided by focus group participants. However, one element associated with controlling a situation that did not emerge during the review of deaths in custody cases was the influence of bystanders. Focus group participants noted that hostility or aggression could originate from the offender or from bystanders who, if also intoxicated, could present a serious risk to police officers. Focus group participants noted that bystander actions could shift the police focus of the situation back to control and away from management of risks to the offender. Officers from three of the four jurisdictions noted that bystanders could be one of the hardest parts about managing a situation involving an intoxicated offender. Therefore, it is important to consider the role of bystanders as an additional risk when controlling and managing an intoxicated offender.

Key points: Control

- When interacting with an intoxicated offender, hostile and aggressive behaviour poses a serious risk to the officer and the community.
- Police officers can use strategies that escalate or de-escalate the situation in order to gain control.
- Escalation techniques such as using force can be necessary, effective and appropriate when controlling the risk to the police/community, but can leave the offender vulnerable to harm. In particular, offenders can be placed at risk of positional asphyxia.
- De-escalation techniques, including using communication and maintaining a safe distance, can be effective strategies for gaining control of a hostile or aggressive situation.
- Bystanders present an additional risk when dealing with intoxicated offenders, especially in volatile situations.

Assess

Adequate assessment of intoxication and related risks is vital to effectively manage intoxicated offenders. Determining if and how severely an offender is intoxicated heavily influences an officer's response to the situation. Focus group participants reported using a mix of subjective and objective measures to assess intoxication. Subjective measures such as observation or information from third parties were common in the field, while more objective measures were used in the watch house. Yet, regardless of how it was made, assessment of intoxication was continual; beginning with initial contact with the offender and continuing through to release of the offender from the watch house.

Signs and symptoms of intoxication vary by substance and are not always visually discernible, which makes identification challenging. Intoxication is measured by the amount of AOD present in the blood. For example, Blood Alcohol Content (BAC) expresses the amount of alcohol present in an individual's system as grams of alcohol per 100 millilitres of blood. Higher concentrations of alcohol or drug in the blood system lead to higher levels of intoxication. As intoxication increases, most individuals will begin to display overt behaviours that reflect their impaired cognitive and physical functioning. While police officers can accurately identify intoxication using specialised equipment or tests, it becomes more difficult when these tools are not available and officers must rely on behavioural cues.

Assessing intoxication subjectively

Alcohol

Since the 1930s the effect of alcohol on coordination and behaviour has been studied. Early studies (Widmark 1932; Jetter 1938) found that only at very high BACs did participants begin to show marked signs of intoxication. After testing 1,942 participants Widmark (1932) reported that the only signs of intoxication discernible at BACs lower than 80 mg/dl were the smell of alcohol and swaying. Later work conducted between the late 1980s and 1990s supported this finding (Brick et al. 1992; Carroll et al 1988; Compton 1986; Maguire 1986; Sullivan et al 1987; Teplin & Lutz 1985; Wells et al 1997). Further studies have demonstrated that difficulty in identifying alcohol intoxication is pervasive across professions. For example, police officers, bartenders, psychologists and AOD support workers have all been found to struggle to appropriately or accurately identify lower levels of intoxication (Brick & Carpenter 2001; Grossman et al. 1996; Langenbucher & Nathan 1983; Pagano & Taylor 1979; Rubenzer 2011).

In America, Brick and Carpenter (2001) conducted an examination to determine whether 39 New Jersey Police officers could accurately identify whether an individual had been drinking alcohol. Assessments were made based on video presentations of the individuals engaged in social interactions. Although police officers expressed confidence in their ratings of intoxication, the results showed their accuracy was actually quite low. Specifically, while their ability to judge severe intoxication was high, they consistently failed to accurately identify low to medium levels of intoxication.

Thus, the literature supports the position that accurate identification is only possible at high levels of alcohol intoxication. Noting that, the generalisability of findings from some of the studies is limited, as they were not conducted in 'real world' settings, instead being operationalised in laboratories (Pagano & Taylor 1979; Carroll et al. 1988; Brick & Carpenter 2001) or via surveys (Burns et al. 2003; Donnelly & Briscoe 2003). The extent to which this influenced identification accuracy cannot be determined. The manufactured situation may have enhanced identification due to the absence of dynamic stressors often present during police interactions.

Alternatively, identification may have been impeded by a lack of situational cues, such as the presence of alcohol bottles or known histories of offenders.

In the current research, focus group participants were fairly confident in their ability to identify when someone was intoxicated. Officers reported using a variety of signs and symptoms to identify consumption of intoxicating substances. They reported being particularly confident when identifying alcohol intoxication. The most common sign that police officers mentioned of an offender being intoxicated by alcohol was smell. This was followed by slurred speech and difficulties standing and walking. Finally, odd or boisterous behaviour was also mentioned as a key sign of intoxication. Examples included being overly loud, argumentative or getting naked.

Alcohol is a depressant and affects the body by slowing down and suppressing the function of the central nervous system. This results in changes to behaviour and cognitions that result in the observable signs of intoxication mentioned by focus group participants. As the amount of alcohol in the body increases, the depressing effect of alcohol affects the brain's arousal, motor and sensory centres (NSW Department of Health 2008) placing the offender at a greater level of personal risk. Higher doses of alcohol can cause drowsiness, problems with coordination and balance, nausea and vomiting, difficulties processing information and memory retention, poor decision-making, slurred speech, unconsciousness and inhibition of breathing (NHMRC 2009). Further, the chemical effect of alcohol leads to disinhibition that, in turn, increases the likelihood of aggressive behaviour by affecting self-regulation, attention, information processing and decision-making (Graham 1980; Graham et al. 1998).

Illicit drugs

Focus group participants were less confident in their ability to identify drug intoxication. Despite a number of substance specific questions being posed by the focus group facilitators, discussions of drug use continued to be brought back to methamphetamine. This likely reflected the current priorities of operational police. The indicators of drug use mentioned most frequently by participants were aggression, increased strength, erratic thought processes and behaviour, psychosis and hallucinations. Officers in three of the four jurisdictions also identified sweating as an indicator that the individual may be under the influence of drugs and that this symptom was due to difficulties in regulating temperature as a result of methamphetamine use.

Stimulants, like methamphetamine, hasten messages from the brain to the body and result in the user feeling more awake, alert, confident or energetic (ADF 2014) leading to some of the signs and symptoms identified by focus group participants. However, other drugs have different effects on the body and will therefore produce different behaviour in the user. Cannabis has physical, physiological and psychological effects on users that may lead to harm. Apart from the common physical effects of cannabis (a feeling of euphoria, drowsiness, loss of inhibitions), those who consume large doses are at an increased risk of respiratory problems, such as a chronic cough, production of sputum, wheezing and bronchitis.

The difficulties expressed by focus group participants in identifying drug intoxication are supported by the literature. While there is less information regarding the identification of licit and illicit drugs, what is available points to two key differences that make detection more difficult. First, drug intoxication is often characterised by more subtle, physiological indicators than alcohol intoxication. Second, unlike alcohol, drug intoxication is not accompanied by a smell. Once intoxication is identified, substance identification may be further impeded by the fact that symptoms of intoxication are often similar across illicit substances. Shinar and Schechtman (2005) examined the ability of police officers to detect drug impairment in a double-blind study (ie neither the police nor the researcher conducting the research knew which participants were intoxicated). The officers were not allowed to interview the subject, and had to base their assessment of intoxication on observable signs and symptoms. Officers were able to detect drug intoxication at an accuracy rate better than chance, but with a high rate of false positives. This indicated police were adopting a default position of intoxication, regardless of the signs or symptoms present.

Accuracy of judgement of substance consumed was not high (Shinar & Schechtman 2005). Officers were able to correctly identify substance of impairment for eight percent of amphetamine (stimulant) affected subjects, 31 percent of cannabis impaired subjects, 37 percent of codeine (narcotic) impaired subjects and 43 percent of alprazolam (depressant) impaired subjects (Shinar & Schechtman 2005). Misidentification of the substance was not random but reflected a systematic confusion around corresponding signs and symptoms. A detailed examination of the signs and symptoms of intoxication that police officers relied on in making a substance assessment revealed that officers relied on physiological tests (four tests to measure motor control, balance, and the ability to count and estimate time) and horizontal gaze nystagmus tests (eye examination) regardless of substance suspected (Shinar & Schechtman 2005). These tests were applied even when the test was inappropriate for the substance suspected. In determining the substance of intoxication, once intoxication was deduced, officers relied heavily on the presence of only one or two signs/symptoms (eg increased pulse rate for cannabis, raised temperature for depressants, lower temperature and pupil constriction for narcotic, and enlarged pupil and increased horizontal gaze nystagmus for stimulant). This approach may aid the officer's task, but is not sensitive enough and can lead to erroneous conclusions.

Polydrug use

Focus group participants stated that identifying drug intoxication became even more difficult when multiple substances were involved. Urinalysis data collected as part of the AIC's DUMA program in quarter 3 of 2014 showed that 23 percent of offenders tested positive for one or more drugs (Figure 1).

Prior research has identified a number of signs and symptoms that are associated with particular combinations of AOD use. Alcohol in combination with cannabis has been found to cause nausea, vomiting, panic, anxiety and paranoia (NCPIC 2011). On the other hand, alcohol in combination with caffeinated drinks or amphetamines may lead to risk-taking behaviour and an increased risk of overdose, due to the additional stress this combination of substances places on the body. Further, a Swedish study by Hakansson et al. (2011) reported interactions between polydrug use and psychiatric symptoms, in particular suicidal ideation, cognitive problems, hallucinations and violent behaviour.

Methamphetamine users are the most frequent practitioners of polydrug use (Department of Health and Ageing 2008). Studies have reported that users often combat the symptoms felt during the 'come down' or 'crash' phase of methamphetamine use with depressants such as cannabis and pharmaceutical medication (eg benzodiazepines; Darke et al. 2008; Sexton et al. 2009). Frequent use of cannabis, alcohol, or a combination of both substances exacerbates the risks of psychotic symptoms in methamphetamine users (McKetin et al. 2013). Similarly, those who use MDMA (ecstasy) with alcohol, cannabis, opioids, and inhalants are at risk of elevated psychological symptoms and executive dysfunction (Medina & Shear 2007).

Summarised in Table 6 are the signs and symptoms associated with intoxication. These symptoms have been identified through a review of intoxication-based literature as symptoms that are frequently associated with alcohol and/or drug use. Also noted in the table are those signs and symptoms which officers identified during the focus groups (denoted by a check mark). Some signs were identified by multiple officers across a number of focus groups. These are denoted by a star. Restlessness and increased urination were indicators identified in the literature that were not mentioned by officers.

Table 6: Signs and symptoms of AOD intoxication		
	Alcohol	Drugs
Decreased inhibitions		
Argumentative/obnoxious	✓ *	
Aggression	✓	✓ *
Odd behaviour	✓ *	✓
Motor impairment		
Staggering, stumbling, falling	✓ *	
Slurred, mumbled, incoherent speech	✓ *	
Itching/scratching		✓
Restlessness		
Cognitive impairment		
Difficulty concentrating	✓	
Hyperactivity		✓
Anxiety/agitated		✓
Erratic thoughts/psychosis		✓ *
Hallucinations		✓ *
Physiological response		
Sweating		✓ *
Red/glassy eyes	✓ *	
Irregular pupils		✓
Increased urination		

* Denotes instances where the sign was identified by police officers in two or more focus groups

Police officers in the field predominantly relied on visual signs and symptoms to identify whether an offender was intoxicated or not. There was strong consensus among focus group participants that the ability to determine intoxication was learned 'on-the-job'. While training in the academy was noted to have outlined the common signs, symptoms and effects of AOD intoxication, it was felt this was not sufficient to enable probationary officers to effectively identify intoxication. Focus group participants felt that proficiency in detecting intoxication was only learned through interaction with intoxicated individuals, under the guidance and supervision of senior officers.

In addition to visual signs of intoxication, police officers stated that they made assessments regarding the likelihood that an offender was intoxicated based on situational cues. These included the presence of alcohol and drug paraphernalia or the incident occurring in or near licensed premises. One officer stated that the type of crime that the offender was being arrested for could also provide an indication of the likelihood of intoxication. This officer stated that chronic methamphetamine users were often caught for property crime such as low-level petty theft.

Factors affecting the identification of intoxication

Subjective ratings can be further hampered by factors that influence or mask AOD intoxication. These include the quantity of substance consumed, the individual's state of health, gender, weight, age, other substances consumed, food intake and dependence on the substance (WA Department of Racing, Gaming and Liquor 2010). In particular, intoxication can be hard to judge in individuals with a high tolerance to AOD.

Early research did not exclude alcoholics or other individuals with high levels of alcohol tolerance from their samples. These individuals recorded very high, sometimes toxic, blood alcohol content or BAC readings yet showed very few discernible signs of intoxication (Brick & Erickson 2009). For example, Jetter's (1938) research found non-drinkers showed signs of intoxication at much lower BAC readings than alcoholics; highlighting the masking influence of tolerance. This presents a particular challenge for police as alcoholics or other habitual substance users may be at higher personal risk of intoxication but less likely to display identifiable signs of intoxication.

There are four key factors that have been identified in the research as having an impact on a police officer's ability to identify intoxication. The first of these is type of drug consumed, with research indicating that officers may be more skilled at detecting certain drugs over others. For instance, cannabinoids may be more easily detected than amphetamines or opioids (Shinar & Schechtman 2005). The level of intoxication is another factor that may impact on assessments of intoxication. This is particularly the case with alcohol, with higher levels of intoxication being more readily identified than lower levels (Brick & Carpenter 2001). Training of the police officer has also been found to impact assessments of intoxication, with specially trained officers being able to accurately identify intoxication more frequently than officers who have only received basic training (Smith et al. 2002). Finally, the presence of injuries may impede a police officer's ability to identify intoxication (Gentilello et al. 1999). This is especially true if the level of injury sustained is serious or the offender has gone into shock.

Substance use profile of Australian offenders

As part of this research project two studies were conducted via the DUMA program to examine substance use profiles of Australian offenders (see *Appendix A* for methodology). This included an examination of the factors that influence police assessments of intoxication. For details on the statistical analysis undertaken refer to *Appendix B*, study 1.

As described in the Introduction, 216 offenders participated in the first study, of whom, 84.3 percent were male. Offenders were, on average, 31.6 years of age (SD=10.3 years). Twenty-two percent (n=48) of offenders were identified as intoxicated and 77.8 percent (n=168) were identified as not intoxicated based on the police charge system records (see Table 6).

Demographics

Demographic characteristics (eg age, gender) do not predict intoxication categorisations by police officers. This suggests that police officers rely on cues of intoxication, rather than characteristics such as gender or age in making the assessment.

Illicit drug use

Police officers did not appear to be able to detect recent illicit drug consumption (specifically, cannabis, opiates or amphetamines consumption) at a rate better than chance. That is, police officers appeared to be just as likely to categorise a recent illicit drug-using offender as intoxicated as they were to categorise them as not intoxicated.

Alcohol use

Police officers appeared to be able to make judgements of alcohol intoxication with some degree of accuracy. Police identified as intoxicated 41 percent of offenders who reported recent alcohol use. In contrast, when offenders reported not consuming alcohol, only six percent were categorised as intoxicated by police officers (false positives). Police officers' accuracy of assessment appeared to improve at higher levels of alcohol consumption, with offenders identified as intoxicated, reporting, on average, having consumed five standard drinks more than offenders identified as not intoxicated.

These findings should be interpreted in light of the limitations of the study. Using a small sample size may have resulted in some of the statistical analysis being underpowered. Measuring AOD use rather than level of intoxication limits the findings in terms of determining police assessment accuracy. However, the recent use measure was the only practical option, with objective measures of intoxication being costly, invasive and requiring technical skills and equipment. Finally, the DUMA methodology results in some highly intoxicated offenders being excluded from participating. This selection bias may have influenced the findings, resulting in a conservative estimate of the prevalence of alcohol and other drug use in the offender sample.

The findings suggest that accurate identification of intoxication is difficult even for trained or experienced personnel such as the police. It is possible that police officers' accuracy of detection of alcohol use was higher than for illicit drug use due to offenders under the influence of alcohol displaying more observable signs of intoxication such as smell, slurring of words or motor impairment. Furthermore, the presence of BAC readings for some offenders suggests that, at least in some jurisdictions, breath testing is employed to support subjective assessments of intoxication. Using an objective measure of intoxication, such as a breathalyser, would be expected to increase accuracy, particularly if applied to all offenders regardless of the presence of observable signs of intoxication, and in conjunction with other watch house protocols.

In the absence of a comparable cost-effective measure of illicit drug intoxication, it is of interest to examine whether the presence of observable signs associated with illicit drug intoxication (such as sedation, stimulation or hostility) are associated with police officers' assessments of intoxication. Such data may provide insight into police reliance on observable signs when making subjective judgements of intoxication.

This issue is explored further in the study below. As part of this research, 597 offenders were interviewed via the DUMA program (see *Appendix A* for details of the methodology) regarding their self-reported level of intoxication, level of sedation, level of stimulation, hostility or psychological distress. These measures were examined to determine what factors influenced a police officer's assessment of intoxication. Psychological distress was included to determine whether symptoms of mental illness confounded assessments of intoxication. For details on the statistical analysis undertaken refer to *Appendix B*, study 2.

Factors influencing police officers' assessments of intoxication

In quarter 4 of 2014, 597 offenders were interviewed via the DUMA program at four sites across Australia: Perth in Western Australia, Adelaide in South Australia, Brisbane in Queensland and Bankstown in New South Wales. Of these, 474 (79%) were male and 123 (21%) were female. The offenders were, on average, 32.3 years of age (SD=10). The youngest offender in the sample was aged 18 years and the oldest was 72 years.

Police assessments of intoxication status were not recorded for 81 participants. These offenders were removed from the sample. The final sample size was 516 offenders. Of these, 28.1 percent (n=145) were identified as intoxicated and 72.9 percent (n=371) as not intoxicated (see Table 7).

Demographics

While there was no difference in the proportion of males and females categorised as intoxicated or not intoxicated by police assessment, there was a significant association between the offender's age and categorisation by police officers as intoxicated or not intoxicated. Specifically, offenders in the 31–35 year old group were equally likely to be assessed as intoxicated or not intoxicated. In all other age categories a higher proportion of offenders were assessed as not intoxicated compared with intoxicated.

Alcohol use

Consistent with Study 1 findings, police appeared to be somewhat accurate at identifying alcohol intoxication. Police identified as intoxicated 43 percent of offenders who reported recent alcohol use. In contrast, when offenders reported not consuming alcohol, only 18 percent of offenders were identified as intoxicated (false positives). The accuracy of police officers' assessments appeared to improve at higher levels of alcohol consumption, with offenders identified as intoxicated reporting, on average, having consumed five standard drinks more than offenders identified as not intoxicated.

Table 7: Demographic, alcohol and illicit drug use characteristics of offenders, by police assessment of intoxication

Gender	Not intoxicated		Intoxicated		Total	
	n	%	n	%	n	%
Male	295	72.0	115	28.0	410	100
Female	76	71.7	30	28.3	106	100
Age						
18–20 years	48	82.8	10	17.2	58	100
21–years	75	70.1	32	29.9	107	100
26–30 years	70	71.4	28	28.6	98	100
31–35 years	38	52.0	35	48.0	73	100
36–40 years	58	80.6	14	19.4	72	100
41–45 years	41	73.2	15	26.8	56	100
Greater than 46 years	41	78.9	11	21.2	52	100
Self-report						
Alcohol use	118	57.3	88	42.7	206	100
No alcohol use	249	81.6	56	18.4	305	100
Total	371	72.9	145	28.1	516	100

Source: AIC DUMA collection 2014 [computer file]

Factors influencing police officers' assessments of intoxication

When associations between offenders' self-reported level of intoxication, hostility, sedation, stimulation and psychological distress, and police officers' assessments of intoxication were examined (see *Appendix B*, study 2), it was an offender's level of hostility and stimulation that predicted higher odds that police would make an assessment of intoxication. That is, offenders who displayed higher levels of stimulation were more likely to

be classified by the police as intoxicated, as were offenders displaying higher levels of hostility. The higher the level of hostility or stimulation, the higher the likelihood that police officers would assess the offender as being intoxicated.

Police officers' subjective assessments of intoxication do not appear to be influenced by how intoxicated an offender thinks they are, how sedated an offender feels or whether they are experiencing psychological distress.

Conclusion

The results of this study are in line with prior research and focus group responses. Importantly, police officers appear to rely on signs of intoxication and not demographic characteristics when making assessments of intoxication.

Potentially, these results may suggest that police officers would be more accurate in detecting alcohol and stimulant use, such as methamphetamine, than illicit drug use that is associated with a sedative effect, such as heroin. However, it is possible that sedation effects were not associated with assessments of intoxication in this study, as reports of sedation may have indicated intoxication for some offenders but withdrawal from stimulants for others. In support of this explanation, a positive correlation exists between sedation and hostility. That is, higher rates of sedation were associated with higher rates of hostility in this sample. This would be more consistent with withdrawal effects than intoxication with a sedating substance such as an opioid.

Offenders' self-reported levels of intoxication were not associated with police officers' assessments of intoxication. While this finding is counterintuitive it may reflect limitations in the methodology more than the association between offenders' levels of intoxication and police officers' assessments. In this study, offenders were asked about their level of intoxication, stimulation, sedation and hostility at the time of interview, not at the time of arrest. It is probable that the levels of intoxication reported at the time of interview would be lower than those at the time of arrest. This may have led to some inconsistencies between offender-reported levels of intoxication and police assessments. This limitation may have been particularly relevant in jurisdictions where offenders could be held in police custody for a number of days.

A further limitation of these studies was that highly aggressive and highly intoxicated individuals were excluded from participating. Thus, the prevalence of alcohol and illicit drug use among the offenders is likely to be a conservative estimate of the true prevalence. In addition, this methodological limitation means that the current study cannot explore how intoxication, and its associated risks, are identified and managed by the police in highly volatile situations.

Assessing intoxication objectively

Subjective assessments of intoxication suit the unpredictable nature of frontline policing. However, the more structured watch house environment allows time for thorough and objective assessments to be conducted. These assessments allow the police to gain a clearer understanding of the type and magnitude of an offender's intoxication, assisting in the proactive management of personal risks associated with intoxication, and determining fitness for custody (see the *Manage* section).

Determining fitness for custody

An offender who is highly intoxicated is not fit for custody and requires medical attention. This position was stated by focus group participants in all jurisdictions and reinforced in the policies and procedures provided. In addition to liaising with medical personnel (see *Liaise* section), police officers and custody managers relied on objective measures such as using breathalysers or formalised questionnaires to help determine if an offender was fit for custody.

Upon arrival at the watch house (or police station), all jurisdictions required offenders to be assessed for intoxication. In all jurisdictions, part of this assessment involved the completion of a formal, structured

questionnaire, although the content differed between states. Questionnaire items included the offender's most recent AOD use, history of mental health issues and suicide attempts. Along with information from the arresting officers and known history of the offender, answers to the questionnaire were used to determine an offender's level of intoxication and risk. This information assisted custody managers in determining how the offender was to be monitored and managed to minimise the offender's personal risk from intoxication.

The qualitative review of deaths in custody cases found that fatalities in the watch house could occur for a number of reasons. Key among these was a failure to adequately assess the offender upon entry into the watch house or a failure to follow standard protocols. The issues surrounding adherence to standard protocols are discussed in the *Manage* section. The deaths in custody cases where offenders died in a cell due to a failure to adequately assess intoxication or determine fitness for custody will be discussed here. The methodology behind the qualitative review of deaths in custody cases is outlined in *Appendix A*.

Booking and assessment

As no offenders in Group 1 (control only) survived beyond arrest, this discussion only pertains to offenders in groups 2 (management only) and 3 (management and control).

Four cases in Group 2 (management only) involved offenders who died while occupying cells in the watch house. The officially recorded cause of death in two of the cases was complications arising from injury and, in the other two cases, cardiac arrest. Both offenders who died from cardiac arrest had BACs of 0.3 or higher, placing them in the severe alcohol range. The pattern of interaction between the police and the offender was comparable across the four deaths. Upon presentation at the watch house, offenders were assessed as safe to be placed in a cell. After a period of time, police officers became concerned and conducted a physical check at which time it was discovered that the offender was no longer breathing or in some other form of difficulty. The following case involved an offender whose injury (which the police misdiagnosed as intoxication) was not picked up during initial assessment upon presentation at the watch house:

Regular cell checks appear to have been conducted through much of the early morning but after about 4:30am, at a time when police officers were proposing to release the deceased on bail, it was discovered that he was unconscious (Case 30).

Analysis of cases involving death during stage 4 (occupation of cell) identified two issues as being of paramount importance when managing an intoxicated offender: the first centres around completing an assessment of intoxication prior to the offender being left alone in the cell, and the second concerns appropriate monitoring (see *Manage* section).

Coroners' recommendations focused on the utility and effectiveness of the booking and assessment procedures. In all four cases, offenders were assessed prior to or upon entering the watch house. This assessment was either completed by the police or by ambulance or hospital personnel. In the two cases (Cases 27 & 35) where hospital and ambulance staff completed an assessment, police officers did not independently conduct their own assessment of intoxication. In only one of the cases did the coroner state that police had not appropriately monitored the offender and then it was due to inadequate CCTV in the watch house (Case 30).

In Case 27, the coroner recommended more clear and concise guidelines be instituted in order to ensure that ambulance officers and the police conduct independent assessments of intoxication. Specifically, the coroner stated:

If health care providers come to a watch house to assess a prisoner it is essential they are made aware of all relevant information known to police. This should be provided in written form to avoid miscommunication and to be available for audit purposes. It would include any information about trauma suffered by the prisoner before coming into custody, blood alcohol levels, history of drug taking, whether he had deteriorated since coming into custody etc (Case 27).

This statement aligns with that made by another coroner who recommended that a summary of the outcome of a medical assessment be provided to the police.

That the Custody Handover Summary require entry of a summary of any medical treatment or medical assessment made in respect of any prisoner who has been seen by a medical practitioner shortly before being taken into custody or while in custody (Case 30).

Reviewing the detail of these cases, it appears that officers knew that the offenders were intoxicated. This was either overtly stated or expressed through the officers' actions, such as taking the offender to a sobering up shelter. However, it was less clear whether it was the inaccurate assessment of the risks associated with the level of intoxication, or mismanagement of those risks, that led to vulnerabilities in the officers' treatment of the offender. The two riskiest stages for offenders at personal risk were during arrest and while occupying a cell. During arrest, the interaction between physical exertion and their intoxicated state put pressure on their bodies resulting in cardiac or respiratory difficulties. While occupying a cell, the offenders succumbed to complications of intoxication. Had severity of intoxication been known, steps may have been taken to mitigate the risk to the offender. It may not be practicable to assess level of intoxication during arrest (stage 2), but potentially this could be adequately addressed, as per the coroners' recommendations, prior to the offender being placed in a cell (stage 4).

This emphasis on the need for a review of booking and assessment procedures was also found among coroners' recommendations regarding offenders from Group 3 (management and control). Case 31 involved an offender who was on both alcohol and morphine and the coroner believed that the police could have been better prepared to deal with interactions of polydrug use through the inclusion of a specific test:

A high proportion of watch house prisoners are affected by alcohol, prescription drugs, illicit drugs or a combination of those substances. Determining whether a prisoner who appears intoxicated may also be affected by a drug other than alcohol is difficult but important because combining drugs may make them more dangerous. To assist officers in this regard I recommend the Health Questionnaire be reviewed with a view to including separate questions about the ingestion of each of those substances and the inclusion in Appendix 16.12 of the OPMs [Operational Procedures Manual]...a list of clues or signs that indicate drugs other than alcohol might be responsible for the symptoms a prisoner is displaying (Case 31).

This recommendation was made in light of the coroner's belief that the current checklists were not comprehensive enough to ensure adequate assessment of polydrug use. Specifically, the coroner stated, in relation to intoxication by drugs, or by alcohol and drugs, 'It gives no guidance as to how the causes of intoxication may be distinguished and seems to focus on stimulants rather than sedatives, which may be harder to detect.' Further, the coroner believed that '[n]onetheless the decision not to seek medical attention was a reasonable one when considered against an application of the policy. [The deceased] was not so drowsy as to make the exercise of the discretion not to call for a medical assessment unreasonable' (Case 31). However, better tools needed to be applied to ensure that the police were properly assessing and therefore able to respond to incidents of mixed intoxication.

Strategies to assist police in determining fitness for custody

While focus group participants were supportive of using formal questionnaires they did note that the efficacy of this strategy was highly dependent upon the truthfulness of an offender's response. They expressed a preference for using multiple sources of information to determine whether an offender was fit for custody. Two of the strategies commonly employed in watch houses were considered by focus group participants to have been particularly effective in assisting the police with the assessment of intoxicated offenders: the presence of medical personnel in the watch house, and using breathalysers.

Medical personnel in the watch house

In three of the four jurisdictions, nurses and paramedics were present in the watch house, either full or part time. Focus group participants in these jurisdictions expressed overwhelming support for this initiative, stating that medical personnel in the watch house mitigated some of the risks associated with police being

responsible for offender welfare, but only possessing minimal first aid training. When present in the watch house, nurses were heavily involved in offender management; for example, conducting assessments, determining fitness for custody and administering medications. However, financial and human resource issues sometimes hampered this strategy, for example rosters were not always full if nurses became sick or were unable to work. A further limitation was that nurses tended to be located only in metropolitan watch houses. When nurses were unavailable, police officers had to revert to relying on their knowledge or consultations with local GPs, paramedics or hospitals.

Breathalysers

One of the only objective tests available to the police to help them identify intoxication in watch houses is the breathalyser. In three out of the four jurisdictions the police routinely used breathalysers in the watch house to identify and assess intoxication. Police officers noted that breathalysers were a useful tool: to determine whether an offender's BAC was rising or falling, to identify chronic users of alcohol who may appear relatively sober, and to identify offenders who may be at risk due to high levels of intoxication. In addition, some officers used the breathalyser results as a proxy indicator of drug use. When an offender was behaving oddly but had a low BAC, officers would assume that they were either intoxicated by drugs or had some other physical or mental cause (such as diabetes or a head injury) for the behaviour being observed. In conjunction with careful observation, breathalyser results were also used to help determine when an offender was sober enough to be released from custody.

The police had no power to compel an offender to submit to a breath test for these purposes. The breath sample was provided by consent of the offender, who understood that the results were to assist in managing their wellbeing while in custody, and that they would not be used for judicial purposes. If the offender did not consent, police officers had to rely solely on subjective determinations of intoxication.

Discussion

There are multiple ways of assessing intoxication and whether an offender is fit for custody. Police officers use a mix of subjective and objective methods to achieve the most accurate 'snapshot of the individual in their care' (R). Subjective assessments were common in the field, where the nature of police/offender interactions required quick judgements regarding intoxication-related risks. These assessments were based on signs and symptoms commonly associated with intoxication, particularly those associated with alcohol use.

It was not possible to determine whether police officers were accurate in their subjective assessments of intoxication; although a large body of prior research would indicate that accurate identification of AOD intoxication is difficult. Police officers' reliance on objective measures and advice from medical personnel in the watch house suggests a self-identified need for help in determining intoxication. The review of deaths in custody cases revealed that a failure to get an assessment of intoxication correct could lead to mismanagement of the associated risks and ultimately the death of an offender. Focus group discussions identified that the police are actively seeking and desiring greater assistance in identifying intoxication and related risks, particularly in the watch house.

Key points

- Assessment of intoxication and associated risks is a continual process.
- Officers use a mix of subjective and objective methods to identify and assess an offender's level of intoxication and whether they are fit for custody. Using such methods was dependent upon the situation and location, with subjective assessments common in the field and objective assessments common in the watch house.
- An officer's ability to subjectively assess intoxication and risk was learned 'on-the-job', under the guidance of senior police.

Liaise

Officers were unanimous across the focus groups that custody and police cells were an inappropriate facility to manage the personal risks to the offender associated with intoxication. This is reflected in the following statements:

Police should not be dealing with drugs, that is a health problem...cells are designed for offenders not intoxicated offenders (M).

At the end of the day, they're just cells (M).

[Cells are just] four walls and a floor to put someone in (M).

We're not doctors...at best [police officers] have basic first aid skills (R).

Focus group participants preferred to divert an intoxicated offender, where possible, from custody in the watch house. The decision to divert an offender was influenced by the severity of the offence and availability of alternative options.

Three jurisdictions' policies referred to diversion from custody. However, none of the provided policies detailed information on diversion options available to police officers. For example, one jurisdiction only detailed the alternatives to arrest as issuing the offender with a caution, warning, or an infringement, penalty, or court attendance notice. While these options would successfully divert the offender from custody in the watch house, the information provided by the policy was insufficient to assist officers in deciding upon an appropriate course of action based on their duty of care. In the other two jurisdictions, policies stated that those arrested for public intoxication could be taken to a 'place of safety' or an 'appropriate facility'. A 'place of safety' was defined as:

- a hospital;
- a place, other than a hospital, that provides care for individuals who are drunk;
- the company of someone, other than a police officer, who can care for them; or
- the offender's home or the home of a relative or friend.

This list provides police officers with a broad range of options to divert an intoxicated offender from custody. However, it provides little detail to assist the police in selecting the most appropriate option. When the final report was reviewed, two Project Reference Group (PRG) members noted that in some jurisdictions there were few options to divert those who were seriously intoxicated. For instance, it might not be possible for police to take a person directly to a detoxification centre, even when one was available. Access to other safe alternatives such as sobering-up centres could also be extremely limited.

Collaboration between frontline services in managing intoxicated offenders

The NDS advocates a holistic response and encourages close collaboration between the wide range of services that manage and respond to individuals affected by AOD. This includes the police, emergency services, mental health, drug and alcohol treatment workers, disability support, Indigenous, and culturally and linguistically diverse (CALD) groups, the education sector and pharmacists. In particular, the NDS promotes a strong relationship between health services and law enforcement.

Consistent with this, focus group participants did not view themselves as 'isolationist' (R). There was a strong willingness across jurisdictions to work with anyone who could help to manage intoxicated offenders. The types of services that police reported working with or seeking support from included hospitals, ambulances, detoxification centres and sobering-up shelters, local volunteers, Aboriginal and Torres Strait Islander visitors

services and non-government organisations such as St John Ambulance or Red Frogs. Collaboration between services often fell under the following categories:

- helping to identify and assess intoxication;
- advising on managing intoxication-related risks; and
- providing an alternative to custody.

Medical personnel

Medical personnel such as nurses or paramedics in the watch house, hospitals and ambulances were identified as frontline services routinely used by the police to help manage intoxicated offenders. Police officers stated that they were risk averse and so often the first step in their management of an intoxicated offender was to seek a medical assessment.

Ambulance

Police officers reported calling an ambulance if the offender was displaying signs of injury or unconsciousness or was severely intoxicated. Paramedics could also provide an initial assessment of intoxication-related risks or fitness for custody in the field. Recognising the need to document this assessment and advice, some officers would detail the paramedic's recommendation in their field notebook and have the paramedic sign the notebook. However, the degree to which this process was formalised varied between jurisdictions. All jurisdictions required a completed 'Fit for custody' form if the offender had been taken to the hospital, while at least one jurisdiction required such a form when any medical assessment had been conducted, including by paramedics.

Focus group participants also spoke of using ambulance services to expedite an intoxicated offender's assessment at hospital. Some police personnel noted that transporting the intoxicated offender to hospital via ambulance assisted the hospital admissions process and helped to manage intoxication-related risks prior to formal assessment at the hospital.

Hospitals

Police across all jurisdictions spoke about their reliance on hospital staff for advice, assessments of suitability for custody, and care of intoxicated offenders. Officers in two of the rural focus groups reported very good collaboration with medical personnel at the local hospital. However, this was not the case for the six other focus groups. In many jurisdictions, the relationship between the police and hospitals was complex as both were operating on limited resources. Anecdotal evidence was provided of hospitals refusing to admit intoxicated individuals for assessment or tying up police resources through long wait times.

In a number of jurisdictions nurses or paramedics have been placed in the police watch house in an effort to alleviate the pressure that assessment of intoxicated offenders places on hospitals, as well as to minimise police resources used in seeking that assessment. The experience, qualifications and availability of medical personnel in the watch house varied across jurisdictions. However, in all relevant jurisdictions the police resoundingly supported this initiative and felt that it had reduced risks to police and offenders, in terms of the likelihood of a death in custody.

Other services

Focus group participants identified detoxification centres and sobering-up shelters as being very useful as they presented a safe alternative to custody. Such centres are usually staffed by trained volunteers and provide a safe location for offenders to sleep off their intoxication. However, the centres do not admit anyone with a history of violence or anyone with a high level of intoxication. People cannot be compelled to stay. These conditions restrict the number of offenders for whom such a diversion from custody is appropriate. In particular, chronic alcoholics are generally ineligible due to high blood alcohol concentrations. Furthermore, focus group participants emphasised issues with the availability of these services. Limited availability,

particularly in rural locations, meant that apart from the hospital, the watch house was sometimes the only appropriate 'place of safety'.

Officers expressed a need to establish sobering-up shelters with security measures and powers to detain individuals until sober. This would allow a greater number of offenders to be diverted from police custody. At the time of focus group consultations, one jurisdiction was trialling such a centre in a capital city near an entertainment precinct, while another had been using sobering-up centres for a number of years. At the time of writing this report, results on the efficacy of this strategy were not available.

Schoolies

Schoolies in all jurisdictions provided a good case study of effective collaboration between police and other frontline services in managing intoxicated offenders—in this case young individuals. Primary services involved in schoolies included the police, St John Ambulance and Red Frogs Australia. St John Ambulance provided 'chill out zones' and first aid tents. Red Frogs provided pastoral care such as identifying intoxicated people and taking them home or to the chill out zones. These services were often supported by jurisdiction-specific service providers. The presence of such services alleviates pressure on the police, leaving them to focus their efforts on responding to criminal offending.

Focus group participants stated that the key to successful collaboration between services at schoolies was adequate funding as well as a comprehensive agreed-upon strategy and effective liaison at high levels of the police, frontline services and government.

Noting that, one officer stated that it would be unwise to compare schoolies with intoxicated offenders in general. The two situations were characterised by different needs—schoolies often just wanted someone to look after them, while older intoxicated offenders often wanted to be left alone.

Identified vulnerabilities or deficiencies in current level of collaboration

The review of policies and procedures undertaken as part of this project indicated a number of gaps around consultation and collaboration between the police and other frontline services. First, hospitals and ambulance services were the only frontline services routinely referred to in jurisdictional policies. Specifically, 10 policies from four jurisdictions only referred to using ambulance services in managing intoxicated offenders. Second, the stage at which medical advice was specified in policies to be sought was often inconsistent with focus group comments on when advice was routinely sought. Specifically, policies tended to only refer to seeking an ambulance during a medical emergency, whereas police officers reported routinely calling for ambulance assistance at the first sign of a problem or as a precautionary measure.

A further identified deficiency was that jurisdictional policies made little or no reference to formal collaboration between the police and frontline services. This potentially reflects a lack of cohesive collaboration across frontline services, particularly at higher levels. Consistent with this, the police and frontline service attendees at the national roundtable recognised a need for improved collaboration between the police and health services. Effective collaboration was seen as vital in order to respond effectively to the intoxicated offenders in police custody. As one participant emphasised, the right type of information, received at the right time could make a significant difference to an officer's handling of an intoxicated offender; particularly in the case of chronic users of AOD who were regularly in contact with police, healthcare and/or mental health services.

The level of communication and information shared between services varied considerably between and within jurisdictions. Based on comments from police personnel, sharing information appeared to be largely driven by the strength of individual relationships between officers and health workers in that location, rather than policies or procedures. For example, in one focus group, a sergeant stated that he had regular meetings with a representative from a local mental health organisation to discuss individuals who were common to both services. Similarly, rural officers in two jurisdictions stated they worked closely with healthcare providers to

effectively manage certain offenders who were in regular contact with both services. Focus group participants expressed a desire for formal, information-sharing strategies to be implemented to ensure that offenders received the most appropriate level of care while in custody.

National roundtable outcomes

In terms of collaboration between the police and other frontline services, roundtable participants identified a number of areas needing improvement including:

- collaboration on the ground, supported by strategic collaboration at higher levels of the organisations;
- effective information sharing between the police and health services; and
- developing a closer partnership in managing intoxicated offenders.

Some jurisdictions discussed initiatives that were being trialled to try to address these identified needs. Initiatives included installing nurses or paramedics in the watch house, having the police ride along with ambulance officers, developing safe sober centres and co-responding to mental health calls.

Key points

- Police officers identified hospitals and ambulance services as key frontline services that assisted them in managing intoxicated offenders. However, it was felt that at times this collaboration was less than ideal.
- The police, frontline and other services are often dealing with the same people, in different ways. In no jurisdiction did the police report a satisfactory formalised process to encourage engagement and information sharing between services.

Manage

The issue of management has been touched on in previous sections. Managing offenders is a continual process. It starts once control of an offender and/or incident has occurred (see *Control* section), is impacted upon by police officer assessments of intoxication and related risks (see *Assess* section) and is aided or influenced by advice or assistance garnered from other services, particularly medical professionals (see *Liaise* section). This section focuses on the operational procedures that inform police management of the offender in the field and at the watch house.

Managing intoxicated offenders in the field

The first two sections touch on a number of ways in which officers in the field manage an intoxicated offender. In the field, management primarily focuses on controlling hostility/aggression (see *Control* section) and transporting the offender safely to the watch house. In addition to the strategies outlined in the second section, focus group participants identified communication as key to effective management of an intoxicated offender.

Communication

Consensus across jurisdictions was that communication assisted in managing offenders effectively, particularly in eliciting compliance with officer's instructions and in reducing the need for physical restraint. Furthermore, focus group participants noted that communication played a role in assessing intoxication. As stated previously, officers reported relying on the presence of slurred and incoherent speech to assess intoxication (see *Control* section). They also noted that the easiest way to determine the intoxicating substance consumed by an offender was simply to ask. Obtaining this information assisted them in determining their subsequent management strategy.

Effective communication with offenders was reported by one focus group participant to be heavily influenced by the 'humanity of the officer' (M). This means that police officers had to establish some level of rapport with the offender for communication to be effective. Police officers noted that forming or re-establishing rapport could be difficult if the situation had been volatile or if the arrest required physical restraint. In order to re-establish communication and rapport in these situations, officers in two jurisdictions spoke of giving the offender space and/or handing management of the offender over to an officer who was not involved in the arrest.

The policies and procedures provided by two of the four jurisdictions identified the importance of communication. In particular, policies referred to the role that effective communication can have in managing a situation. For example one jurisdiction provided a communication-training module that was taught to new recruits. This module emphasised the importance of assertive communication during interactions with intoxicated offenders because of the behavioural and cognitive disturbance related to using AOD. A policy from one jurisdiction noted that:

After the trauma of arrest, a properly conducted screening of the detained person should settle the person and relieve any concerns they might have. You cannot force the person to respond to questions, but encourage communication by showing respect and a genuine concern for welfare.

Transportation

Focus group participants from all jurisdictions discussed the importance of managing offender welfare and intoxication-related risks during transportation. Monitoring was conducted via visual inspection or via CCTV available in the vehicle. Further, officers from all jurisdictions noted that they were listening for changes in the offender's demeanour—particularly silence. If an offender's demeanour changed dramatically or the offender became silent, officers stated that they would immediately check on the offender's welfare.

Based on officer comments, decisions to transport intoxicated offenders via a car, caged vehicle or van appeared to be influenced more by resource availability, rather than risk mitigation. However, focus group participants in one jurisdiction voiced concerns about transporting unrestrained in vehicles those intoxicated offenders with pronounced motor impairment.

Minimal information was provided in jurisdictional policies regarding procedures or mitigation of intoxication-related risks during transportation of an intoxicated offender. Only one jurisdiction provided a policy that detailed how offenders, including those under the influence of AOD, should be transported. This policy specified that offenders should be constantly supervised, and that the medical and cultural needs of the offender should be considered. The policy also stated that 'escorting officers will communicate with and check on the [offender] on a regular basis or at least every 60 minutes', and that transporting officers must be in possession of all necessary safety equipment including first aid and communications. Finally, the policy required that offenders be handcuffed during transportation only if there is 'reason to believe he or she may attempt to escape or for the safety of the [offender] and escorting officers'.

Managing intoxicated offenders in the watch house

The police policies and procedures became more prescriptive as the interaction between officer and offender moved from the field and into the watch house (or police station). Policies reflected a more structured approach to managing the risks associated with intoxication; particularly regarding offenders who may be withdrawing from AOD.

AOD withdrawal

An offender's level of intoxication does not remain static during their interaction with the police. The amount of AOD in their system will fluctuate depending on the time of their last drink or 'hit'. In all jurisdictions, focus group participants noted that the frequency of monitoring determined upon entering custody at the watch house would be adjusted dependent on the changing needs of the offender. Officers noted that, upon entering custody, the offender might not be at their peak level of intoxication; this may occur at a later time. Thus, it was necessary to manage an offender's changing level of risk during custody and alter the frequency of checks accordingly.

Chronic users of AOD are particularly vulnerable in watch house settings due to the risks associated with withdrawal. The analysis of deaths in custody cases (see *Control* section) identified that 12 offenders in groups two and three died from 'other physical' causes such as cardiac arrest or respiratory failure due to intoxication or issues related to chronic AOD use. For example, within Group 2, cardiac arrest was the cause of death in two cases where the offender died in a cell. In both of these cases, the offender was a chronic alcoholic and had a BAC of 0.3 or higher, placing them in the severe range of intoxication. After a period of time in a cell, police officers became concerned and conducted physical checks whereupon it was discovered that the offenders were no longer breathing.

The heightened risks related to chronic AOD use were discussed by focus group participants who expressed concerns around managing withdrawal in the watch house, particularly in rural locations. In some locations offenders may have to be held in the cells over the weekend in order to appear in court on a Monday. This

provides a considerable time period during which the police must manage risks to the offender related to withdrawal. Officers spoke about managing these risks through increasing the frequency of physical checks and liaison with medical personnel. However, focus group participants felt they were ill equipped to deal with emergencies arising from withdrawal and that repeated trips to a hospital for assessment placed a strain on both police and medical personnel. This is a particular concern in rural locations where such resources can be scarce.

Three of the four jurisdictions provided policies that outlined a strategy to manage AOD withdrawal in the watch house. These policies described the signs, symptoms and risks associated with AOD withdrawal and emphasised that medical professionals should be contacted as soon as withdrawal was suspected.

Monitoring

Watch house procedures in all four jurisdictions required the offender to be assessed before being placed in a cell. Part of this assessment involved a formal questionnaire that examined a number of risk factors in addition to AOD intoxication, including self-harm or prior medical conditions (see Assess section). The offender's answers to these questions assisted the custody manager in deciding whether the individual was at low, medium or high risk. Other information that influenced level of risk came from offender behaviour, police observations and information known about the offender. This risk rating influenced the level of monitoring an offender received.

Across the jurisdictions, 15-minute checks were common for offenders identified as being at high-risk of adverse sideeffects due to intoxication or withdrawal. However, this interval was reduced if the offender's level of risk rose, and could change during the offender's period of custody. If an offender's level of risk was judged to be very high, it was common for them to be left in the observation area or within sight of the custody manager, so that they could be constantly monitored. This practice tended to occur in situations where an assessment was pending, due to aggression or noncompliance, or when police officers were waiting to transfer the offender to hospital for assessment. Officers stated that offenders judged to be at high risk were required to have a fitness for custody assessment conducted by a medical professional prior to entering custody. When an offender was considered to be at low risk, 50 to 60 minute checks were standard across jurisdictions for all detainees. In addition to physical checks, CCTV monitored all offenders. Focus group participants felt that the monitoring of offenders mitigated some of the personal risks to offenders related to intoxication, as it facilitated early identification of medical emergencies or complications.

The nature of the checks varied between jurisdictions. Three states required that officers observe the offender opening their eyes, moving their limbs and talking. For example, one policy required custody managers to 'wake, speak to and assess the sobriety of people intoxicated by drugs or alcohol at least every 30 minutes (or more frequently if your assessment indicates it is necessary) during the first two to three hours of detention'. However, jurisdictions differed in protocols relating to how checks were to be conducted when an offender was asleep. Specifically, officers in two jurisdictions were adamant that waking an offender during the check was the only way to adequately ensure they were not in danger. This requirement was not adhered to in another jurisdiction, where officers were happy to leave an offender sleeping as long as they could observe the rise and fall of their chest. This is a point of vulnerability, as sleep may not be easily distinguished from a coma. The protocols around physical checks were not discussed in the remaining jurisdiction.

Watch house protocols

Adherence to watch house protocols was identified as an issue in analysing deaths in custody cases. Three offenders in group three (both control and management) died when occupying a cell; two had only alcohol in their system and one had both alcohol and drugs—specifically, alcohol and morphine. These three cases were characterised by poor treatment of the offender's intoxication; either by the police or by other services working with the police.

In each of these three cases, the police were aware that the offender could be or was intoxicated. For example:

- during initial contact
 - [M]embers of the group, including [the deceased], began to disperse. As they did so, [police officer] could see bottles of wine, cans of open VB and Bundaberg Rum that had been thrown down or tipped out (Case 5).
 - [Police officer] and her partner arrived at the house. They knocked a number of times and after a minute or so [the deceased] opened the door...[the deceased] can be heard slurring his words, which were on occasions incomprehensible. [Police officer] said he was unsteady and appeared very drowsy, seeming to almost fall asleep on his feet at one stage. In her statement she recorded 'his eyes rolled back a few times' and 'he kept closing his eyes as if he was falling asleep' (Case 31).
- during booking and assessment
 - Despite the very high reading on the Alcotest, [the deceased] was not assessed as being at risk by the charging [police officer]. [Police officer] assessed [the deceased] as 'moderately affected' by alcohol (Case 32).
 - [Police officer] recorded the answers, which include the officer's assessment that [the deceased] was 'very intoxicated—hard to interpret conversations/answers'. He also noted he was 'very slurring, very unsteady on his feet, falling asleep at the counter' (Case 31).

In one case, despite the offender showing signs of severe intoxication, police officers did not call for medical assistance (Case 5). In another case, watch house procedures related to monitoring were not followed:

The evidence in the present case shows that nobody conducted 15-minute checks upon [the deceased] at any time between 2:30 pm when he died and 5 pm when his body was discovered. In all probability, no 15-minute checks were conducted at any time between 1 pm, or thereabouts when he was last seen by [police officer], and 2:30 pm when he died (Case 32).

The coroner's recommendations referenced improving police procedures to include better monitoring of offenders—especially when police were aware that the offender was intoxicated.

Training

Focus groups indicated that one way to improve watch house procedures was to ensure that officers left in charge of offenders were adequately trained. More senior officers in all jurisdictions undertook additional training in watch house and custody management. One jurisdiction employed auxiliary staff members who were specifically trained to manage offenders in custody. Auxiliary staff members who participated in the focus groups felt their training gave them an advantage in minimising the risks to the offender caused by intoxication, while they were in custody at the watch house.

Other jurisdictions required senior officers to complete specific training around managing offenders in the watch house. In one jurisdiction, only officers who had completed this training could be left in charge of offenders in the watch house. However, the primary criticism of this approach was that it relied on there being adequate resources to either send people to the training or roster a trained person onto the shift.

Release from custody

The final stage in managing intoxicated offenders involves ensuring that the offender can be safely released from custody. Officers stated that they principally relied on their subjective assessment that the offender could understand bail conditions and could look after their own welfare in deciding readiness for release. In two jurisdictions where breathalysers were available, officers reported informally applying the following criteria: that the offender was able to understand the bail conditions, and that they had a BAC of 0.01. However, officers identified that this assessment was complicated when the offender was a chronic user of alcohol. In these

instances, allowing the offender's BAC to drop below 0.01 could be life threatening.

There were guidelines in the policies supplied by one jurisdiction as to assessment, requirements or considerations that officers should comply with when determining an intoxicated offender's suitability for release. However, this information was very broad and contained no specific guidance.

Discussion

A number of policy deficiencies were identified relating to managing intoxicated offenders in the field and in the watch house. Specifically, there was little direction provided by policies on risks to be considered or procedures to be followed during transportation. In addition, focus group members highlighted a need for clearer guidelines for releasing intoxicated offenders from custody.

Police policies and procedures were fairly comprehensive and proscriptive regarding the management of intoxicated offenders in the watch house. As outlined in the Assess section, every offender was assessed upon arrival in the watch house and this assessment assisted police in determining their level of risk. Those who did not require immediate medical attention were placed in either an observation cell or a regular cell and monitored by physical checks and CCTV, with the frequency of monitoring determined by their level of risk. This process of regular monitoring allowed the police to proactively manage the personal risks associated with intoxication and withdrawal. However, the review of deaths in custody cases suggests that human error or negligence in adhering to policies and procedures creates a risk to offenders within the watch house.

Key points

- An offender's level of intoxication is not static across their interaction with the police. Effective management of intoxication-related risks requires an understanding of the risks associated with fluctuating AOD levels.
- Offenders who are withdrawing from chronic AOD use are particularly vulnerable within the watch house environment. Protocols are necessary to assist police in identifying and proactively responding to these risks.
- Regular monitoring via physical checks and CCTV is necessary in order to assess an offender's level of risk and proactively respond to any emergencies that may arise.
- Determining when an offender is safe to release from custody is difficult, especially when the offender is a chronic user of AOD.

The CALM framework

Best practice framework

A review of the literature, deaths in custody cases, jurisdictional policies and stakeholder consultations identified risks and vulnerabilities associated with the four phases of police management of intoxicated offenders. This information has been drawn together to produce a best practice framework for police officers responding to individuals affected by drugs and alcohol (see Figure 3). The process outlined in the framework represents the dynamic nature of incidents. The phase at which police officers enter the framework and the order in which they progress through the phases is determined by the nature of the incident. In some cases, police officers may need to revert to a previous phase of management.

In the control phase, police officers need to consider:

Bystanders

- Focus group participants identified that one of the hardest parts of managing an intoxicated offender could be the presence of bystanders. Bystanders who are themselves intoxicated or unruly divert the officer's attention away from managing the intoxicated offender and ensuring the safety of responding police officers and other individuals present at the incident.

Managing risks to the police/community through de-escalation or force techniques

- Policies from each jurisdiction identified a range of use-of-force options that could be employed when managing an intoxicated offender.

Appropriate methods of communication

- Focus group participants identified that one of the most effective methods of control was communicating with the offender. Communication was also seen as crucial in determining risks associated with intoxication, as information about the substance and quantity consumed could often be identified through conversations with the offender or other individuals present. One jurisdictional policy also provided officers with suggestions to enhance the effectiveness of communication, such as providing clear verbal commands.

Considering risks associated with intoxication and physical restraint

- All focus groups identified that positional asphyxia was a risk that needed to be managed when physically restraining an intoxicated person. All focus groups could describe this risk and treatment options, such as listening to the offender talking during restraint and sitting the offender up as soon as possible. However, policies from only two of the four jurisdictions mentioned this risk. Findings from the literature review and deaths in custody analysis also highlighted risks to an intoxicated offender associated with physical exertion, which could be coupled with physical restraint.

In the assess phase, police officers need to consider:

Alcohol and drug intoxication identification/assessment options

- These are both subjective and objective measures. Findings from the literature review suggest that accurate identification of intoxication is difficult. Empirical findings from a study conducted as part of this research that used DUMA data revealed that offender levels of stimulation and hostility predicted police officer assessments of intoxication. Assessments of intoxication tended to be subjective, but were supported in some situations (most commonly the watch house) by objective measures, such as breath analysis.

Continual assessment of intoxication

- All focus groups mentioned that assessment of intoxication was a continual process from initial interactions through to release from custody.

Determining fitness for custody

- Focus group participants noted that any offender who appeared to be highly intoxicated was required to be assessed by a medical professional prior to entering custody. This was supported by jurisdictional policies. However, the deaths in custody case review identified that this process could be flawed, particularly in terms of police providing accurate and complete offender histories to medical professionals, and the documenting of medical advice.

Practical training for probationary officers

- Focus group participants were unanimous in their view that probationary and junior officers were ill-equipped to accurately assess intoxication. They stated that it was only through experience, advice and guidance from senior officers that police developed the skills required to make subjective assessments of intoxication.

In the liaise phase, police officers need to consider:

Protocols for contacting other frontline services

- Focus group participants reported using a range of different services to support their management of intoxicated offenders, including ambulance services, hospitals, sobering-up shelters and jurisdiction-specific services. However, it was noted that police liaison with these services tended not to be formalised in policy.

Mechanisms for sharing information between services

- Focus group and roundtable participants noted that there was a lack of formal mechanisms to support sharing information between services, despite general agreement that this was necessary for the effective management of intoxicated offenders. In particular, officers stated that sharing information would assist in the effective management of chronic AOD users who were common across services.

Formal liaison at higher levels between police jurisdictions and between police and health services

- Roundtable participants noted that formal liaison at senior levels of the police and health services could assist in developing co-management policies and procedures between the two services. It was also noted that collaboration between the police jurisdictions could help in developing a comprehensive and uniform response to this issue.

In the management phase, police officers need to consider:

Changing levels of risk resulting from rising or falling intoxication levels

- All focus groups were aware of this issue and that it was managed through monitoring at the watch house. Monitoring schedules were increased or decreased in response to changes in the offender's intoxication level. However, this issue was only dealt with lightly in some policies.

Protocols for identifying and responding to alcohol and drug withdrawal

- A number of focus groups stated that managing withdrawal in the watch house was of particular concern. Focus group participants felt ill-equipped to effectively manage this risk, particularly for chronic AOD users. Officers did note that the presence of medical professionals in the watch house greatly improved the ability of this issue to be managed appropriately in the watch house.

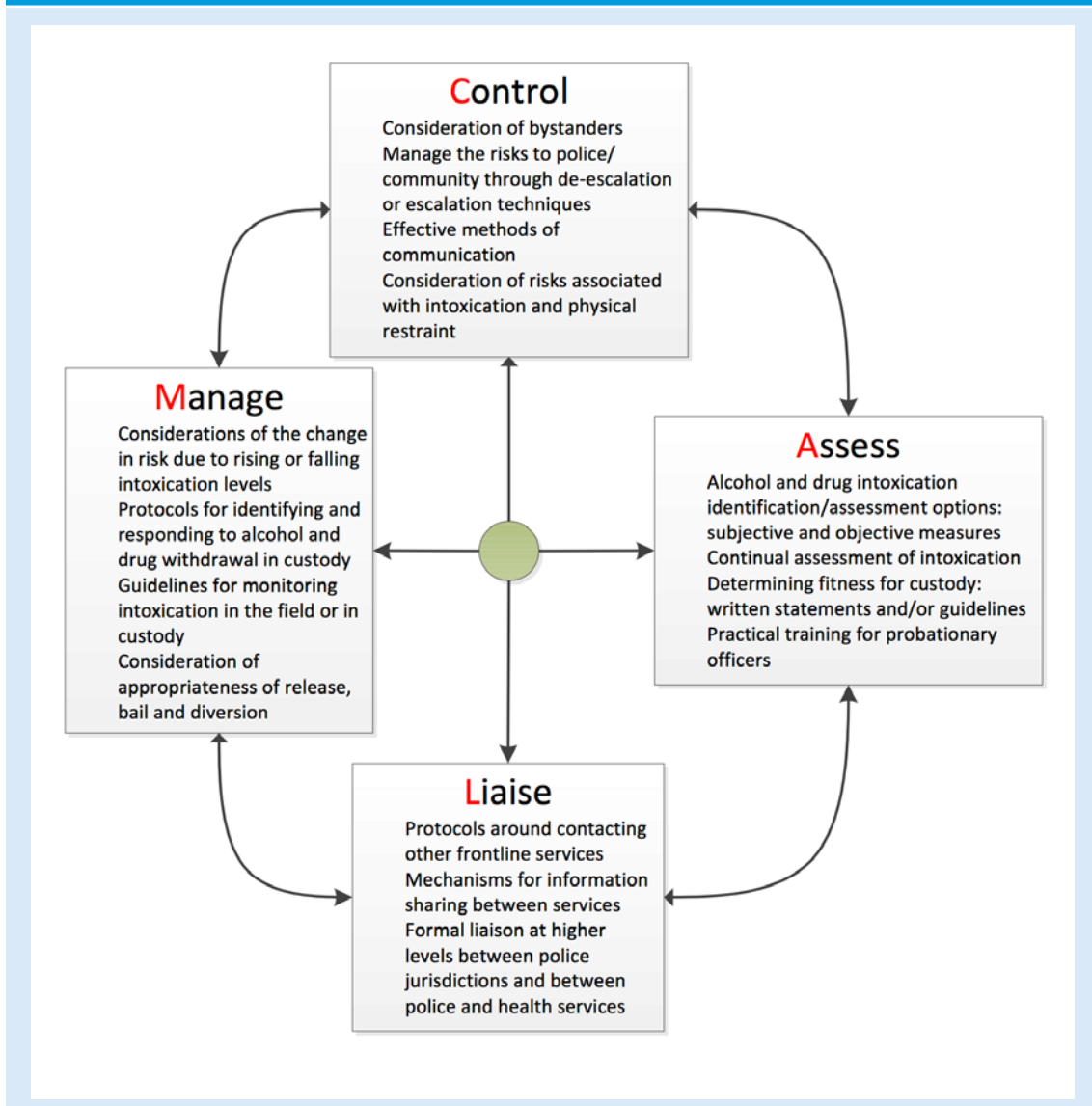
Guidelines for monitoring intoxication

- Guidelines for the frequency of monitoring intoxicated offenders in the watch house were generally consistent between the jurisdictions. Checks for signs of life required officers to ensure the offender could talk, open their eyes and raise a limb. However, the nature of these checks, particularly for offenders who were sleeping, was inconsistent between jurisdictions. Some focus groups reported that it was not necessary to wake offenders to check for signs of life. In light of the findings from the deaths in custody review, this practice presents a risk, as an offender in a coma can appear to be sleeping.

Consideration of appropriateness of release, bail and diversion

- The jurisdictional policies supplied provided little specific detail on diversion options available to police and when they were appropriate for use. Focus group participants spoke of their concern in determining fitness for release from custody. Officers relied on subjective assessments and a base BAC of 0.01 percent to determine an offender's sobriety and ability to understand bail conditions. Minimal information was supplied in the policies provided to help police assess an offender's suitability for release.

Figure 3: Best practice framework for managing intoxicated offenders



The framework is designed to underpin the development of police policies relating to managing intoxicated offenders. The framework can also be used as an aide memoire to assist the police, particularly junior officers, to identify, assess and manage risks to the police, the community and the offender during interactions between the police and intoxicated offenders. Upon identifying risks, officers should use jurisdictional policies and procedures, training and their own experience to determine the appropriate action to be taken.

Model for the effective transfer of policies, procedures and strategies across police jurisdictions

A collaborative approach is needed to develop and maintain best practice in managing intoxicated offenders. Currently, there is no established network for collaboration, and no consistent framework for developing policies. This means that policies lack comparability (ie they differ in the issues covered), they do not reflect 'lessons learnt' in other jurisdictions, and they differ in the level of detail provided to officers. The CALM

framework has been designed to enable information to be shared between jurisdictions. It provides a foundation for establishing and maintaining a harmonised response through policy and practice development.

A formalised process for transferring policies, procedures and strategies across police jurisdictions is needed to develop best practice versions that address the risks identified by this project. Roundtable participants noted that policies and information are currently transferred in a reactionary way in response to a 'flashpoint' or incident requiring immediate attention. This is generally achieved through informal networks across jurisdictions, described by roundtable participants as 'doing a ring around'. Roundtable participants identified this ad hoc approach to sharing information to be less than ideal.

In particular, roundtable participants expressed a need for the regular transfer of deaths in custody case information and resulting coroner's recommendations across jurisdictions. Participants stated that it was an 'obvious choice to coordinate coroner's findings around managing intoxicated offenders...and policies as there are gaps'. Currently, a coroner's finding from another jurisdiction is only accessed if an individual police officer goes looking for it. This would normally occur in response to an identified issue. Regular transfer of this information could assist police jurisdictions to actively identify vulnerabilities in existing procedures and policies. This would also allow for the proactive management of such risks. Roundtable participants noted that 'doing it by [yourself] is really naïve—should be relying on other lessons learned' and that sharing 'lessons learned...should be done'.

Potential mechanisms

Roundtable participants identified the following mechanisms and forums that could be used for the formal, regular transfer of information and policies related to managing intoxicated offenders.

Working groups

Roundtable participants noted that working groups could be an effective mechanism for sharing information. They were commonly used to address specific problems, for example, alcohol and illicit drugs. However, roundtable participants found that in order to be effective, working groups required buy-in from upper levels of police management. As one participant noted, 'If it's not being driven at the higher level, I'd be wary about its utility'. A further identified limitation was that it was not always possible to identify who was the most appropriate person to be invited into a working group due to differences in organisational structure between jurisdictions.

Australia New Zealand Policing Advisory Agency (ANZPAA)

Roundtable participants identified the Australia New Zealand Policing Advisory Agency (ANZPAA) as a potential conduit for effectively transferring between jurisdictions information and policies on managing intoxicated offenders. Every jurisdiction is represented in ANZPAA, with liaison officers acting as conduits between representatives and the wider police force. The agency comprises a number of working groups that focus on particular issues, such as policing practice, illicit drug use, or serious and organised crime. Participants spoke of ANZPAA having a degree of 'corporate oomph' and that it was necessary to corporatise an issue to garner 'speed' and support. However, participants recognised that a problem needed to be 'nationalised' in order to be included in ANZPAA's priorities and that this was sometimes difficult if the issue did not fit neatly into a working group priority.

In sum, roundtable participants acknowledged a need to regularly transfer policies and information on managing intoxicated offenders between police jurisdictions. It was identified that, to be effective, this process had to be supported and formalised at senior levels of police management.

Conclusions

In quarter 3 of 2014, 76 percent (n=280) of Australian offenders who provided a urine sample as part of the DUMA program tested positive to at least one licit or illicit substance. The most common substance detected was cannabis, followed by amphetamines, benzodiazepines and heroin. In addition, 46 percent of offenders reported having consumed alcohol in the 24 hours prior to committing the offence for which they had been detained. While these data do not necessarily indicate intoxication, they serve to highlight that most individuals in police custody have alcohol or other drugs in their system, to some degree. While in custody, police officers are responsible for the safety and wellbeing of offenders and this duty of care includes managing intoxication and withdrawal-related risks.

This research project developed the CALM framework to help police identify and manage risks related to intoxication and withdrawal. The framework was grounded in the four phases of police management: control, assess, liaise and manage. The phases are not sequential. The order in which a phase occurs is determined by the nature of the incident. In some incidents phases may be progressed through rapidly, while in other incidents, some phases may require considerable effort from police. Likewise in some incidents, phases may occur once, while in other incidents police officers may have to revert to a phase that they had previously transitioned through.

The control phase denotes the period in which the police attempt to gain control of the situation to minimise risks to themselves and other responding frontline personnel, and to the community. Compliance from the offender is elicited through communication and using force options. This phase generally occurs when police arrive at an incident, but may reoccur if the offender's level of aggression or hostility increases, or if compliance is lost. In some incidents police may pass through this phase rapidly if the offender is compliant, while in other incidents considerable police effort may be required.

The assessment phase is the period, or periods, in which police officers determine whether the offender is intoxicated by alcohol or other drugs. Police officers report continually assessing offenders' levels of intoxication from initial contact through to discharge from custody. The findings of this research project demonstrated that this task is complex and difficult. In the absence of objective measures of intoxication, such as breathalysers, accuracy of assessments is likely to be low. Focus group participants stated that probationary and junior officers were poorly equipped to judge intoxication, but with 'on-the-job' experience they believed that accuracy improved. The groups reported basing judgements of alcohol use on the presence of a smell of alcohol, staggering gait and speech disturbances. Judgements of methamphetamine use were based on the presence of aggression, erratic behaviour and sweating. Empirical studies undertaken in this research project to examine factors that influence police officers' assessments of intoxication showed that the police were more accurate than chance at detecting alcohol intoxication, but no better than chance at detecting drug intoxication. In addition, police officers' assessments of intoxication were predicted by the presence of stimulation and hostility, but not by offender reported levels of intoxication, sedation or psychological distress. Stimulation and hostility are behavioural effects associated with alcohol and methamphetamine intoxication. Coroners' recommendations suggested that accuracy of assessments of intoxication and identification of substance(s) consumed may be improved by developing tools that explicitly list side effects of intoxication and withdrawal, preferably with prescribed actions to mitigate risks.

The liaise phase is when responding police officers request assistance and advice from other frontline services to assess intoxication or the health and wellbeing of the offender. Focus group and roundtable participants noted that the police's duty of care to an offender was managed through collaboration with other frontline services. Police most commonly sought assistance from the ambulance service and hospitals. Officers stressed the importance of this collaboration in statements, conveying their perception that health-based risks were best managed by health-care professionals, and not by the police. A number of initiatives were being trialled in various jurisdictions to improve collaborative efforts between police and health services. These initiatives included healthcare personnel, such as nurses and paramedics, being stationed in the watch house.

Focus group participants, from the relevant jurisdictions, expressed overwhelming support for the presence of healthcare personnel in the watch house. However, the effectiveness of these initiatives in terms of risk mitigation, efficacy and cost-effectiveness has not been established.

The management phase is the period during which the offender is controlled and compliant and the police are focused on managing the offender. This phase can occur in the field or during transportation, but mainly involves the period when the offender is in the watch house. The obligation of police to care for and manage the offender's health and safety during this period is at the fore, as any threat to the safety of the police and the community has been contained. In periods of management, the offender is most at risk from intoxication and withdrawal-related risks. If not appropriately managed, these risks can be life threatening. Based on the review of deaths in custody cases, it appears that deaths that occur during phases of offender management generally result from a breakdown in monitoring procedures. Policies and procedures supplied by all jurisdictions on managing risks to the offender during phases of offender management in the watch house were comprehensive, prescriptive and detailed.

Risk mitigation

The CALM framework is designed to help police identify risks and considerations related to intoxication during each phase of offender management. In particular, it may aid the review and development of policies, practice and training material. It may also act as an aide memoire, to help police officers to consider risks associated with each phase of management. The aide memoire aspect of the CALM framework may be of particular use to probationary or junior officers, whom focus group participants identified as requiring help with assessing and managing intoxicated offenders. Upon identification of a risk to the police, the community or the offender, the actions of police are determined by the jurisdiction's policies and practices, and the experience of the officer.

A collaborative approach to action

Roundtable participants noted that developing best practice for managing intoxicated offenders could be enhanced through greater oversight of coroners' recommendations across jurisdictions, sharing experiences, and providing details of effective strategies. Participants identified that a lack of collaboration across jurisdictions resulted in a duplication of efforts and posed a risk to the police in terms of a lack of proactive identification of vulnerabilities. They proposed that greater collaboration by establishing a working group or through the ANZPAA.

Focus group and roundtable participants noted that collaboration between the police and health services needed improvement. They described a number of different collaborative models. However, only one focus group, in a rural location, reported being satisfied with their level and method of collaboration with local health services. Focus group participants were particularly concerned about managing the health risks of offenders who were chronic AOD users. Chronic users in the watch house often had high levels of intoxication, which prevented diversion from custody, and increased the risk that the offender would suffer from fatal side effects related to intoxication or withdrawal.

In summary, roundtable discussions accepted that best practice in managing intoxicated offenders might be achieved by applying the CALM framework. This framework was designed to raise awareness of risks to the police, the community and the offender during each phase of management. Roundtable participants also noted that improved collaboration between police jurisdictions, and between police and health-care services, was important to developing and maintaining best practice. Implementing these strategies would help police to proactively identify and address vulnerabilities in jurisdictional policies and practices relating to managing intoxicated offenders.

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Appendix A: Methodology

Literature review

A large body of research exists that examines alcohol and drug related issues in Australia and overseas. Searches for relevant literature were conducted through the JV Barry Library, a specialist criminological library located within the AIC's organisational structure and premises. The library produces the CINCH database, an index of Australian criminal justice information, and houses the most comprehensive library-based collection of criminology and criminal justice material in Australia.

Searches were conducted across multiple databases including the library's own collection, the CINCH database, and a broad range of other Australian and international databases and clearing houses accessible through the library. Searches focused on identifying literature across the following key themes:

- effects of alcohol and illicit drug use (including signs and symptoms, and risk factors);
- subjective and objective measures of intoxication (including efficacy of identification); and
- police responses to intoxicated and/or aggressive individuals.

Review of police policies and procedures

This project reviewed policies, procedures and guidelines (hereafter referred to as policies) for managing intoxicated offenders, provided by four police jurisdictions. Using qualitative analysis, the policies were reviewed to determine how police officers in that jurisdiction were advised/directed to manage risks to the police, the community and the offender during interactions with intoxicated offenders.

Method

Data collection

Between July and October 2014, the AIC was supplied with relevant policies by four police jurisdictions—New South Wales, Queensland, Western Australia and South Australia. Jurisdictions were asked to supply any policies or guidelines used by officers in managing intoxicated offenders. This could have included educational tools, procedural guidelines around arrest, watch house procedures or broader AOD strategies. The type of information received varied by jurisdiction and was subject to availability at the time. Each jurisdiction was provided with an additional opportunity to supply relevant policies, during review of the final report.

Data analysis

The policies were examined using the qualitative data analysis software NVivo 10. Initially, each source was classified according to its demographic information. This included the state of origin, year of publication and whether the focus of the document was procedural, policy or educational. This classification enabled cross-jurisdictional comparisons.

The content of each policy was then analysed for statements relating to the response and management of intoxicated offenders. Statements were categorised into three groups: those that dealt with safety of the officer, the community or the offender. Within each of these groups, statements were further analysed to determine whether they represented a policy statement or an outline of procedure. Policy statements reflected the broader aims or goals of the service, such as statements around maintaining the rights or dignity of the

offender. Outlines of procedure detailed specific steps officers were expected to follow when responding to or managing an intoxicated person. This coding enabled a thorough exploration of the wider jurisdictional approach to intoxicated offenders by incorporating information at both the policy and procedural level.

National Deaths in Custody case review

Data extraction

Data were extracted from publicly available coroners' reports according to a standardised form developed for this research. Extracted data included:

- demographic information;
- ratings of intoxication;
- victim demeanour, characteristics, behaviour and appearance;
- police officers' actions that either directly or indirectly contributed to the death; and
- coroner's recommendations.

Extracted data corresponded to six stages of interaction between the police and the offender. The six stages ranged from initial contact through to release/discharge or transfer to corrective services (Table A1). Coding the data against stages of interaction facilitated the identification and comparison of incident characteristics across cases. In particular, at each stage of police interaction, data was recorded pertaining to how intoxication was being expressed, how police identified intoxication and how the police subsequently responded to and managed risks.

Table A1: Stages of interaction

Level of interaction	
Stage 1	Initial contact
	Interaction
Stage 2	Arrest
	Transportation to place of detention, hospital or shelter
Stage 3	Handover to custody manager
	Booking/assessment
	Transfer to cell
Stage 4	Occupying cell
Stage 5	During investigation/interview
Stage 6	Transfer to corrective services
	Release/discharge

Selection and inclusion of cases

The NDICP database holds information pertaining to 1,288 cases. However, this sample included cases where the offender died while in prison or serving a custodial sentence. Criteria for including a case in this review were:

- (a) death occurred between 2002–03 and 2010–11;
- (b) the offender died while in police custody, as defined by NDICP protocols (below);
- (c) the offender had alcohol or illicit drugs in their system at the time of death, based on the autopsy report;
- (d) the death did not occur as part of a motor vehicle pursuit; and
- (e) the coroner's report was publicly available.

The NDICP uses a broad definition of police custody. Therefore, a death in police custody refers to any incident where the offender died:

- while detained in or during transport to/from an institutional location such as a lockup, police vehicle or station; or
- during a police operation such as an arrest, investigation or siege.

For more information regarding the NDICP protocols see Lyneham and Chan (2013).

Limitations

- This approach has a number of limitations that need to be considered when interpreting the findings. First, the final sample of 41 cases could be considered small. This potentially limits the generalisability of the findings to other situations of deaths in custody that involve an offender intoxicated by AOD. However, as this study involves qualitative analysis, the size of the sample needed to reach saturation point, the point at which no new ideas are generated, is often low. For this reason, the final sample of 41 cases was considered sufficient.
- Second, the sample may be subject to selection bias due to the decision to include only cases where the coroner's recommendations were publicly available. This decision was largely an administrative one. The application to access non-publicly available coroner's reports would have been a time-consuming process. There would also have been restrictions placed on disseminating findings from such analysis, limiting the use of the findings. However, it is unknown whether publicly available deaths in custody cases are representative of non-publicly available cases.

Finally, cases of 'near misses', where offenders under the influence of AOD were at risk but did not die in custody, have not been reviewed. This may have resulted in police procedures that have been implemented to thwart deaths in custody not being realised in this analysis. However, this risk is somewhat mitigated by the review of police policies and practices relating to managing intoxicated offenders conducted as part of this study.

Thematic analysis

Cases were analysed using NVivo 10 (hereafter referred to as NVivo). The NVivo is a software tool designed to facilitate qualitative analysis. This allowed researchers to explore patterns and themes in how police respond to and manage intoxicated offenders.

Cases were analysed in terms of the risks they posed to either the offender (personal risk) or to the police and the wider community. Risks were assessed subjectively by one researcher, based on the information presented in the coroner's report. This assessment was conducted by an AIC research analyst with extensive experience with qualitative analysis. Reliability of the ratings may have been improved by using a second coder.

Risks to the offender focused mainly on the physical and mental health risks associated with intoxication. Risks to the police or the wider community (the police/community) were primarily instances in which the offender was hostile, aggressive or violent.

The results of this review are presented in the *Control*, *Assess* and *Manage* sections.

Quantitative studies of the substance use profiles of Australian offenders – DUMA Program

Sample

Police detainee participation in DUMA is voluntary and confidential. All detainees present during a data collection period are eligible to participate. However, detainees are excluded if they have been in police custody for more than 96 hours; have been in a custodial setting within the 48 hours prior to arrest; are highly intoxicated; are potentially violent; are mentally unfit; or require an interpreter. Police custody managers can also exclude a detainee from participating on other grounds.

Measures

Police detainees are asked to complete an interviewer-assisted self-report questionnaire that gathers demographic, alcohol and illicit drug use and offending data. Each quarter there is an additional two-page survey administered, an addendum, which gathers one-off data about a specific topic, such as domestic violence or acquisition crime. In the third and fourth quarters of 2014, addenda were administered to detainees to collect data in support of this project. Below is a summary of the measures relevant to this research project.

Recent alcohol use

Alcohol consumption in the 24 hours prior to detention was assessed via a self-report response to the item: 'Had you been drinking (DRINK) in the 24 hours before this happened?' Offenders either responded 'yes' or 'no'. This item was asked for beer, wine and spirits separately. In this study responses were combined across substances, such that an affirmative response indicated consumption of any form of alcohol in the 24 hours prior to the event that precipitated their detention by police. Note that for a small minority of detainees this event would have occurred sometime previously and their current detention would have been on warrant for that offence.

Offenders were also asked to provide an estimate of the number of standard drinks consumed in the 24 hours prior to the event that precipitated their arrest. The quantity of standard drinks consumed was asked separately for beer, wine and spirits. In this study standard drinks have been combined across type of alcohol consumed, resulting in a total number of standard drinks consumed in the 24 hours prior to the event. Due to the time of the last drink not being recorded, the level of intoxication at the time of arrest cannot be determined.

Offender self-assessment of intoxication

Offenders were asked to indicate their current level of intoxication: '*[a]t this moment are you drunk, high or intoxicated?*'; response alternatives were yes (1) or no (0). Offenders who responded affirmatively were then asked '*[o]n a scale of 1 to 10, where 1 is completely sober and 10 is so drunk or high that a person would pass out or be unconscious, how drunk or high are you at the moment?*' No offender indicated that they were a one on this scale; confirming that they were intoxicated and experiencing some level of impairment due to that intoxication. Offender responses on the two items were combined to provide a level of intoxication score on a scale of zero (not intoxicated) to 10 (severely intoxicated).

Police officers' assessment of intoxication status

Police officers' assessments of the intoxication status of offenders were recorded based on charge system records, which were either electronic or paper-based.

In all jurisdictions, during booking and assessment an offender is assessed for intoxication. If they are assessed as intoxicated, the substance or suspected substance consumed is often noted. The procedure undertaken to assess intoxication varies by jurisdiction (see the Assess section).

At the end of an interview, the DUMA interviewer reviewed the offender's charge records and noted the offender's intoxication status, as recorded by the police (ie intoxicated [1] or not intoxicated [0]). If intoxication status could not be determined the data were coded as missing. If police recorded the substance consumed, so did DUMA interviewers.

Stimulation and sedation effects of intoxication

The Brief Biphasic Alcohol Effects Scale (Brief-BAES; Rueger & King 2013) provides an assessment of sedation and stimulant effects associated with intoxication. The Brief-BAES was designed to measure effects of alcohol intoxication, but the authors indicated via private correspondence its suitability for assessing sedation and stimulation effects of intoxication by alcohol or other drugs.

The Brief-BAES comprises two scales: the Brief Sedative scale and the Brief Stimulant scale, each of which constitutes three descriptive items (see Table A2). Offenders rated the extent to which the descriptor represented their feelings at the time of interview on an 11-point scale, ranging from not at all (0) to extremely (10). Responses were summed across each scale separately, resulting in a Sedation score and a Stimulation score. Each scale had a range of 0 to 30.

Table A2: Stimulation and Sedation descriptive items from the Brief-BAES

Sedation Items	Stimulation items
Sedated	Energised
Slow thoughts	Excited
Sluggish	Up

Source: Rueger & King 2013

Hostility

Level of hostility was measured through the State Hostility Scale (SHOS) developed by Anderson et al. (1995). This scale has four subscales—feeling unsociable, feeling mean, lack of positive feelings and aggravation (Anderson & Carnagey 2009). Respondents indicated the extent to which they agreed or disagreed with each mood statement on a five-point Likert scale. Response alternatives ranged from strongly disagree (1) to strongly agree (5).

The lack of positive feelings subscale was not administered in this study given that a ceiling effect was likely to be achieved. That is, it was likely that all individuals interviewed would report being similarly lacking in positive feelings, given that they were all being detained by the police. Further, the mood statements *wilful* and *vexed* were removed from the scale as there has been evidence of poor item-total correlations (Anderson 2012).

Scores were summed across the remaining 23 items to result in a total hostility score ranging from 22 to 110. The subscales and items included in the resultant modified SHOS are detailed in Table A3.

Table A3: Modified-SHOS subscales and their corresponding mood statements

Feeling unsociable	Feeling mean	Aggravated
I feel unsociable	I feel mean	I feel aggravated
I feel disgusted	I feel like yelling at somebody	I feel discontented
	I feel cruel	I feel frustrated
	I feel like I'm about to explode	I feel irritated
	I feel burned up	I feel furious
	I feel bitter	I feel stormy
	I feel offended	
	I feel angry	
	I feel outraged	
	I feel enraged	
	I feel like swearing	
	I feel like banging on a table	
	I feel mad	
	I feel disagreeable	

Source: Anderson 2012

Psychological distress

To examine levels of psychological distress the Kessler Psychological Distress Scale (K10) was administered (Kessler et al. 2002). Respondents were asked to indicate whether they had experienced the following symptoms of psychological distress during the past 30 days:

Table A4: Kessler Psychological Distress Scale (K10) items

During the past 30 days, about how often did you feel...	
1.	tired out for no good reason
2.	nervous
3.	so nervous that nothing could calm you down
4.	hopeless
5.	restless or fidgety
6.	so restless that you could not sit still
7.	depressed
8.	so depressed that nothing could cheer you up
9.	that everything was an effort
10.	worthless

Source: Kessler et al. 2002

Response alternatives were coded on a five-point scale, with a range of all the time (1) to none of the time (5). Questions three and six were skipped, when offenders answered none of the time, to questions two and five respectively. Scores are summed across all items.

Urinalysis

In the third quarter of 2014, all detainees who participated in an interview were asked to provide a urine sample. Urine samples were then subjected to urinalysis, which was conducted by an independent toxicology laboratory. Urinalysis screening was conducted for five drug classes: amphetamines, benzodiazepine, cannabis, cocaine and opiates (for further details see Coghlan et al. 2015).

Positive results indicate recent substance use with the exception of cannabis (see Table 1.1; excerpt from Coghlan et al. forthcoming). A positive test result for cannabis can indicate prior use of up to 30 days. Level of intoxication or impairment at the time of arrest cannot be determined via test positive urinalysis results.

Table A5: Cut-off levels and average urinalysis drug detection times

Drug class	Cut off AS 4308 (ug/L)	Average detection time ^a
Amphetamines	300	2–4 days
Cannabis	50	Up to 30 days for heavy use; 2–10 days for casual use
Cocaine	300	24–36 hours
Opiates	300	2–3 days

a: Depends on testing method and equipment, the presence of other drugs, level of drug present and frequency of use

Source: Makkai et al. 2000

The results of this analysis are discussed in the section on *Control*.

Focus group consultations

Operational police are an invaluable source of practical knowledge on managing intoxicated offenders in both field and custody settings. To ensure that the framework was practical and reflected current policing practices, focus groups were held across the four jurisdictions. The focus groups were used to:

- assess how police personnel (sworn and unsworn) respond to various scenarios involving individuals affected by drugs and alcohol (and who is best placed to respond in certain situations);
- identify effective strategies that have been used in each jurisdiction when responding to intoxicated individuals;
- identify issues that relate specifically to regional or metropolitan areas;
- identify the types of services that might be required to better support police in responding to individuals affected by drugs or alcohol; and
- determine the extent to which existing resources (such as the guidelines for police and other frontline services for managing acute behavioural disturbances, developed as part of the National Drug Strategy) are used by police officers.

Procedure

Focus groups were held in one rural and one metropolitan location in each of the four participating jurisdictions over February and March 2015. The locations were selected through discussions with PRG representatives in each jurisdiction and are detailed in Table A6.

Table A6: Location of focus group consultations

	Metropolitan	Rural
New South Wales	Surry Hills	Dubbo
Queensland	Brisbane	Gold Coast
South Australia	Adelaide	Murray Bridge
West Australia	Perth	Bunbury

A total of 61 police officers participated across the eight focus groups. PRG members recruited participants in each jurisdiction. They were requested to invite, where possible, police from across the ranks and sections. Participants included general duty police officers, custody managers and staff, alcohol and drug policy representatives, and officers holding senior ranks.

Focus groups followed a semi-structured format built around four key themes;

- how the police identify intoxication;
- how the police manage intoxicated offenders;
- the utility of the proposed framework; and
- the involvement of other frontline personnel.

The purpose of these discussions was not to determine whether police officers were adhering to jurisdictional policies or procedures, but to examine how they dealt with offenders under the influence of AOD, and to identify what strategies were most effective.

Discussion topic examples

Section 1: Identification of intoxication

During initial interactions/arrest:

- Generally, how do you assess whether someone is intoxicated?
- What signs and symptoms are you looking for?
- What guidelines, policies, experiences, tools or assessments do you use?
- At what stage of the interaction do you assess intoxication?
- How do you assess intoxication when an offender is aggressive?
- How do the signs and symptoms you rely on differ when a person is aggressive to a situation in which a person is not aggressive?
- What factors make the assessment of intoxication easier or harder?
- At what stage of the interaction do you assess intoxication?
- How often do you receive any information prior to arriving on scene regarding the presence or contribution of alcohol or drugs? What type of information is provided?
- To what extent do you rely on past experiences with intoxicated offenders in making an assessment of intoxication by alcohol? Intoxication by drugs?
- To what extent do you rely on procedures, policies, protocols, guidelines or tests in making an assessment of intoxication by alcohol? Intoxication by drugs?
- Outline the procedures, policies, protocols, guidelines or tests used and the phase (initial interaction, arrest, transportation, or custody) at which it is used.

During charging/custody:

- How is intoxication assessed during charging/upon presentation at the police station?

For alcohol:

- If breathalysed, how often are your assessments of alcohol intoxication affirmed through breath analysis?
- In cases where you suspect intoxication but breath analysis does not confirm alcohol intoxication, what follow-up procedures or actions do you undertake to assess for intoxication by drugs?

For illicit and licit drugs:

- How is intoxication by illicit and licit drugs assessed?
- If an offender has a positive BAC reading are they routinely assessed for drug intoxication?
- What more could be done to assist you in identifying intoxication during initial interactions/arrest or charging/custody?

Section 2: Strategies for managing intoxicated offenders

- In your experience what is the best way to manage an intoxicated offender during initial interaction, arrest, transportation and custody? (Discussion to include management of offender intoxicated with alcohol, cannabis, methamphetamine or heroin)
- How does interacting with an intoxicated offender differ from a non-intoxicated offender during initial interaction, arrest, transportation and custody? Do you/how do you modify your behaviour or techniques that you employ during each of the stages?
- When interacting with an offender you either know or suspect to be intoxicated, what key things are you concerned about at each of these stages? (Discussion to include behaviour during initial interaction, arrest, transportation and custody phases)
- What is the hardest thing about effectively managing an intoxicated offender?
- What could assist you in managing intoxicated offenders?

Section 3: Assistance in managing intoxicated offenders**The National Drug Strategy:**

- Part of our research is to examine the utility and relevance of the National Drug Strategy (NDS) to everyday policing, so how familiar would you say you are with the strategies proposed by the NDS?
- How could a national drug strategy best support the work you do at a local level? What information do you think should be included in a guideline on managing intoxicated offenders?

Frontline service personnel:

- Whom do you consider 'frontline service personnel'?
- How often do you involve other frontline services in managing intoxicated offenders?
- What signs and symptoms would an offender display to prompt you to call upon other frontline services for assistance?
- What factors influence your decision to call other frontline services for assistance? (Discussion to involve initial interaction, arrest, transportation and custody phases)
- What type of information or guidance do other frontline services provide to you that assist with the continued management of the intoxicated offender? Is this advice written or verbal?
- The NDS proposes a closer partnership between police and other frontline personnel. In your opinion/experience, in what ways could this be achieved?

Section 4: Managing intoxicated offenders—subgroups

Management of young intoxicated offenders:

- Discussion of techniques and strategies that have been effective in the assessment of intoxication and in managing young intoxicated offenders.
- Lessons learnt from management of young intoxicated offenders en masse (eg schoolies).
- Arrangements between police and other frontline personnel. What works well and what does not work well?

Analysis

- Police responses were recorded via de-identified, handwritten records of the conversation. These notes were subsequently typed up and analysed using the qualitative analysis software, NVIVO 10.
- The results of the focus group consultations are discussed throughout the report.

National roundtable

A national roundtable, Management of Intoxicated Offenders, was held in Canberra on the 21 April 2015. Twenty high-ranking representatives from the police, ambulance and health services attended from each of the four jurisdictions. The aims of the roundtable were to discuss:

- ways in which information and policies can be transferred across police jurisdictions to ensure that best practice is achieved and maintained;
- ways in which frontline service personnel can assist the police in managing intoxicated offenders; and
- ways in which risks, issues and concerns raised by the police regarding the management of intoxicated offenders can be treated.

Appendix B: Substance use profile of Australian offenders (results)

Study 1

Demographics

The findings suggest that demographic characteristics of offenders, such as age or gender, are not related to police officers' assessments of intoxication. Specifically, there was no significant difference in the proportion of males and females ($\chi^2(1) = 0.5, p = \text{ns}$, Cramer's $V = 0.1$) or the proportion of offenders by age ($\chi^2(6) = 4.1, p = \text{ns}$, Cramer's $V = 0.1$) categorised as intoxicated or not intoxicated.

Illicit drug use

Most detainees tested positive, via urinalysis, to cannabis, followed by amphetamines and opiates. Only one offender tested positive to cocaine.

There was no significant difference between the proportion of detainees categorised as intoxicated or not intoxicated by police who tested positive, via urinalysis, to cannabis ($\chi^2(1) = 0.1, p = \text{ns}$, Cramer's $V = 0$), amphetamines ($\chi^2(1) = 0.1, p = \text{ns}$, Cramer's $V = 0$) or opiates ($\chi^2(1) = 0, p = \text{ns}$, Cramer's $V = 0$). These findings may reflect that the sample size was not sufficient to detect a difference. Alternatively, it may suggest that police are as likely to detect consumption of an illicit drug as they are to miss that a drug has been consumed. Limitations in using urinalysis data as a proxy measure for intoxication also may have contributed to the inaccuracy of assessments. This is particularly the case in relation to cannabis, where urinalysis may return a positive result up to 30 days after use for heavy users.

Alcohol use

There was a significant association between consuming alcohol in the 24 hours prior to arrest and police assessment of intoxication ($\chi^2(1) = 37.7, p < 0.001$, Cramer's $V = 0.4$). When alcohol use was present, 41 percent of offenders were identified as intoxicated and 59 percent as not. Whereas when alcohol consumption was not present, the opposite was true, six percent of offenders were classified as intoxicated and 94 percent as not intoxicated.

Due to the small sample size, the number of standard drinks consumed in the last 24 hours cannot be compared between offenders who were identified by police officers as intoxicated ($M = 40.0, SD = 18.1$) and not intoxicated ($M = 34.7, SD = 6.3$). One participant was removed from analysis, as they were an outlier, reporting consumption in excess of 100 standard drinks in the 24 hours prior to arrest. The average number of drinks consumed in the 24 hours prior to arrest was five standard drinks higher for offenders categorised as intoxicated compared with those identified as not intoxicated. This suggests that, with a large enough sample size there may have been a significant difference in terms of recent alcohol consumption, with offenders who had consumed higher quantities of alcohol more likely to be identified as intoxicated than offenders who had consumed smaller quantities of alcohol.

For seven of the 11 offenders who had consumed alcohol and were identified as being intoxicated, a blood alcohol concentration reading was recorded ($M = 0.154$; range = 0.088 to 0.228). For the remaining four

offenders, one had the substance consumed identified as 'Ice', one as 'Drugs', one as 'Alcohol (no reading)' and for one offender no substance was recorded.

Study 2

Demographics

While there was no difference in the proportion of males and females categorised as intoxicated or not intoxicated by police officers' assessment, there was a significant association between the offender's age and categorisation by police officers as intoxicated or not intoxicated: ($\chi^2(6)=21.8, p<0.001$, Cramer's $V=0.2$). Specifically, offenders in the 31–35 year age group were equally likely to be assessed as intoxicated and not intoxicated. In all other age categories a higher proportion of offenders were assessed as not intoxicated compared with intoxicated.

Alcohol use

There was a significant association between consuming alcohol in the 24 hours prior to arrest and police officers' assessments of intoxication: ($\chi^2(1)=36.0, p<0.001$, Cramer's $V=0.3$). When alcohol use was present, 43 percent of offenders were identified as intoxicated and 57 percent as not. Whereas when alcohol consumption was not present, the opposite was true, 18 percent of offenders were classified as intoxicated and 82 percent as not intoxicated.

Due to the small sample size, the number of standard drinks consumed in the last 24 hours cannot be compared between offenders who were identified by police as intoxicated ($M=44.7, SD=19.8$) and not intoxicated ($M=36.5, SD=16.5$). One participant was removed from analysis, as they were an outlier, reporting consumption in excess of 100 standard drinks in the 24 hours prior to arrest. The average number of drinks consumed in the past 24 hours was higher for offenders categorised as intoxicated compared with those identified as not intoxicated.

For only one of the eight offenders who had consumed alcohol and were identified as being intoxicated was a blood alcohol concentration reading recorded (0.115). For six of the other offenders alcohol was recorded as the substance consumed, and for one offender 'alcohol and valium' were recorded as the substances consumed.

Table B1: Demographic, alcohol and illicit drug use characteristics of offenders, by police assessment of intoxication

	Not intoxicated		Intoxicated		Total	
	n	%	n	%	n	%
Gender						
Male	295	72.0	115	28.0	410	100.0
Female	76	71.7	30	28.3	106	100.0
Age						
18–20 years	48	82.8	10	17.2	58	100.0
21–25 years	75	70.1	32	29.9	107	100.0
26–30 years	70	71.4	28	28.6	98	100.0
31–35 years	38	52.0	35	48.0	73	100.0
36–40 years	58	80.6	14	19.4	72	100.0
41–45 years	41	73.2	15	26.8	56	100.0
Greater than 46 years	41	78.9	11	21.2	52	100.0
Self-report						
Alcohol use	118	57.3	88	42.7	206	100.0
No alcohol use	249	81.6	56	18.4	305	100.0
Total	371	71.9	145	28.1	516	100.0

Source: AIC DUMA collection 2014 [computer file]

Statistical analysis

Before conducting logistical regression analysis to determine the association between police officers' assessments of intoxication and offender-reported levels of intoxication, stimulation, sedation, hostility and psychological distress, the descriptive statistics and correlations between the variables were examined (Table B1). In order to determine that logistic regression was appropriate this study examined whether differences in the variables were observed between offenders assessed by the police as intoxicated and not intoxicated. The correlations between the variables were then examined to ensure that the independent contribution of each variable to the prediction of police officers' assessments of intoxication could be determined (ie that inter-correlations were less than 0.8).

Differences between variables, by police intoxication assessment

To examine differences between offenders who were recorded on the police charge system as intoxicated, compared to those who were not, a series of t-test analyses were conducted.

Hostility—Offenders who were assessed by the police as intoxicated self-reported higher levels of hostility than offenders who were assessed as not intoxicated: $t(325)=-2.90, p<0.01, d=-3.89$.

Sedation—Offenders who were assessed by the police as intoxicated reported significantly higher levels of sedation than offenders assessed as not intoxicated: $t(398)=-2.95, p<0.01, d=-4.11$.

Stimulation—There was no significant difference between offenders assessed by the police as intoxicated and not intoxicated on self-reported level of stimulation: $t(406)=-1.26, p=ns, d=-1.79$.

Level of intoxication—There was no significant difference between offenders assessed by the police as intoxicated and not intoxicated on self-reported level of intoxication: $t(436)=-1.79, p=ns, d=-2.04$.

Psychological distress—Offenders who were recorded as not intoxicated reported higher levels of psychological distress than offenders recorded as intoxicated: $t(177)=2.88, p<0.01, d=3.98$.

Correlations between variables

There was a significant correlation between offender self-reported level of intoxication and level of stimulation ($r=0.14, p<0.05$). Higher levels of intoxication were associated with higher levels of stimulation, measured as feelings of being energised, excited and up. There was also a significant correlation between offender self-reported level of intoxication and level of sedation ($r=0.11, p<0.05$). Higher levels of intoxication were associated with higher levels of sedation, measured as feelings of being sedated, sluggish and having slow thoughts. These two findings are not contradictory; they likely represent intoxication by different substances. Consumption of some substances is associated with stimulant effects while others are associated with sedating effects.

There was a small, negative correlation between hostility and stimulation ($r=-0.23, p<0.05$), with lower levels of hostility being associated with higher levels of stimulation. This is contrary to what may have been expected. This finding may be a product of the methodology and may reflect offenders' feelings of hostility at the time of interview and not their propensity to become hostile in the presence of provocation.

Hostility was also significantly correlated with self-reported levels of sedation ($r=0.16, p<0.05$), with higher levels of hostility associated with higher levels of sedation. This association is contrary to expectation, as consumption of substances with sedating effects, such as heroin, is not normally associated with aggression or hostility. However, the levels of sedation in this sample may relate to side effects associated with withdrawal, and not intoxication. If this is the case then higher levels of hostility would be expected to be associated with experiencing higher levels of withdrawal effects, such as sedation.

There was also a positive correlation between psychological distress and stimulation ($r=0.24, p<0.05$), with higher levels of psychological distress being associated with higher levels of stimulation. Psychological distress was also negatively correlated with hostility ($r=-0.42, p<0.05$), that is as psychological distress increased, levels of hostility decreased.

Table B2: Descriptive statistics and correlations between self-reported levels of intoxication, stimulation, sedation, hostility and psychological distress scores

	Mean (SD)		Sample size	Range	Offender's self-reported level of intoxication	Stimulation	Sedation	Hostility
	Not intoxicated	Intoxicated						
Offender's self-reported level of intoxication	0.3 (1.1)	0.5 (1.8)	438	0–10	-			
Stimulation^a	6.5 (6.4)	7.4 (6.3)	408	0–30	0.14*	-		
Sedation^b	8.6 (7.3)	11.1 (7.5)	400	0–30	0.11*	0.01	-	
Hostility^c	56.7 (17.4)	63.3 (19.4)	327	22–110	-0.05	-0.23*	0.16*	-
Psychological distress^d	30.7 (7.8)	27.0 (8.3)	179	11–47	0	0.24*	-0.14	-0.42*

* $p < 0.05$

a Brief-BAES stimulation items (Brief-STIM)

b Brief-BAES sedation items (Brief-SED)

c Total SHOS subscale hostility scores

d Kessler Psychological Distress (K10) scores

Note: sample sizes vary across measures as detainees can refuse to answer individual questions; an interview may be terminated at the detainee's request or due to police requiring the detainee for operational reasons

Source: AIC DUMA collection 2014 [computer file]

Predicting police officers' assessments of intoxication from offender-reported level of intoxication, stimulation, sedation, hostility and psychological distress

To examine which variables (eg offender assessment of intoxication, stimulation, sedation or psychological distress) are associated with police officers' assessments of intoxication, a logistic regression analysis was conducted (see Table B3). In this analysis, if a variable is identified as significantly associated with police officers' assessments of intoxication, it means that the offender's level on that variable predicts whether the police will judge them to be intoxicated or not, with all other variables in the analysis held constant.

Offenders with missing data on one or more of the scales were excluded from the analysis. This resulted in a sample size of 167 offenders.

Level of stimulation (odds ratio 1.10) and level of hostility (odds ratio 1.04) predicted higher odds that the police officer would make an assessment of intoxication. That is, offenders who displayed higher levels of stimulation were more likely to be classified by the police as intoxicated, as were offenders displaying higher levels of hostility.

Offender self-reported level of intoxication, level of sedation and psychological distress were not significantly associated with police assessments of intoxication. That is, police officers' judgements of intoxication do not appear to be influenced by how intoxicated an offender thinks that they are (on a scale of 1 to 10), how sedated a detainee feels or whether they are experiencing psychological distress.

Table B3: Predicting police officers' assessments of intoxication from offender-reported level of intoxication, stimulation, sedation, hostility and psychological distress

	Odds (95% CI)	p-value
Offender's self-reported level of intoxication	0.89 (0.54–1.46)	ns
Stimulation	1.10 (1.02–1.18)	<0.01
Sedation	1.03 (0.98–1.08)	ns
Hostility	1.04 (1.01–1.06)	<0.01
Psychological distress	0.96 (0.91–1.01)	ns

ns—not significant

Note: LR $\chi^2(5)=22.73$, $p<0.001$; Cragg-Uhler (Nagelkerke) $R^2=0.18$; Hosmer-Lemeshow $\chi^2(8)=4.48$, $p>0.05$; % correctly classified=72.46%.

Source: AIC DUMA collection 2014 [computer file]

