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Alcohol and substance screening and brief intervention for detainees kept in police custody. A feasibility study

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ABSTRACT

Background: Screening and brief intervention programs related to addictive disorders have proven effective in a variety of environments. Both the feasibility and outcome of brief interventions performed in police custody by forensic physicians are unknown. Our objectives were to characterize addictive behaviors in detainees and to evaluate the feasibility of a brief intervention at the time of the medical examination in police custody.
Methods: This prospective study included 1000 detainees in police custody who were examined by a physician for the assessment of fitness for detention. We used a standardized questionnaire and collected data concerning individual characteristics, addictive disorders, and reported assaults or observed injuries.
Results: 944 men and 56 women (94–6%) were studied. We found an addictive disorder in 708 of 1000 cases (71%), with the use of tobacco (62%), alcohol (36%), cannabis (35%), opiates (5%), and cocaine (4%) being the most common. A brief intervention was performed in 544 of these 708 cases (77%). A total of 139 of the 708 individuals (20%) expressed a willingness to change and 14 of 708 (2%) requested some information on treatment options. The main reasons why brief interventions were not performed were aggressive behaviors, drowsiness, or fanciful statements by the detainee.
Conclusion: Brief interventions and screening for addictive behaviors in police custody are feasible in the majority of cases. The frequent link between addictive behaviors and the suspected crimes highlights the value of such interventions, which could be incorporated into the public health mission of the physician in police custody.

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1. Introduction

Police custody is detention in response to a suspicion of crime or if the police have 'reasonable grounds' to suspect that someone has committed an offence. Three facets of medical intervention in police custody have been identified: first, the role of a medicolegal expert for the law enforcement agency; second, the role of a treating physician; third, the examination and treatment of detainees who allege that they have been mistreated by the police (The Lancet, 1993). When caring for detainees in police custody, the doctor is expected to protect the detainee's health, physical and mental integrity, and dignity (British Medical Association, 2009; Chariot et al., 2008). Medical intervention in custody should include the detection of signs related to acute intoxication or withdrawal and the continuity of care regarding psychoactive drugs and opiate replacement therapy. Routine screening for alcohol dependence to prevent withdrawal syndrome is also recommended. Medical data related to addictive disorders in police custody are scarce across countries (Ceelen et al., 2012; Heide et al., 2012; Lepresle et al., 2012; Payne-James et al., 2010). Screening and brief intervention programs related to alcohol misuse and other addictive disorders have proven effective worldwide (Aveyard et al., 2011; D'Onofrio and Degutis, 2010; Humeniuk et al., 2012; Kaner et al., 2009). These programs have received increased attention in a variety of environments, including primary care, occupational medicine, and the criminal justice system (Hermansson et al., 2010; Kaner et al., 2009; Lapham, 2004; Webb et al., 2009). Although police custody and cells can be a hostile environment, the hours after an arrest may present a teachable moment because arrestees may be more receptive to intervention (Hopkins and Sparrow, 2006). Both the feasibility and outcome of brief alcohol or drug interventions in police custody are largely unknown. Several categories of intervention providers have been considered in this setting. Forensic

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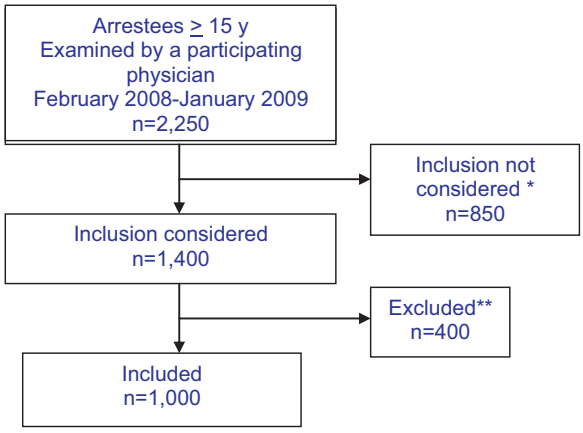

Fig. 1. Flow diagram. *Busy schedule on a given day; **Insufficient knowledge of French or English, aggressiveness or delusional state.

physicians have been thought to be in an ideal position to screen for alcohol problems and to deliver brief interventions (Noble et al., 2001). However, when asked about their knowledge and attitudes regarding brief interventions, London forensic medical examiners doubted the legitimacy of their role and questioned whether brief interventions were within their responsibilities (Noble et al., 2001; Best et al., 2002). Violence and victimization are common in detainees, which could hinder the efficacy of a brief intervention in this setting (Gahide et al., 2012). To date, the feasibility of a brief intervention for alcohol and substance abuse performed in police custody by forensic physicians has not been evaluated. The objectives of the present study were as follows: (1) to characterize the addictive behaviors of detainees kept in police custody, whether or not the detention was related to the reported addictive behaviors, and (2) when an addictive behavior was characterized, to evaluate the feasibility of a brief intervention at the time of the medical examination in police custody.

2. Methods

We conducted a descriptive study based on the patients' reports of their substance use and addictive disorders, on the suspected offence, and on the medical examination.

2.1. Study population

We conducted a prospective study in a suburban area near Paris. Physicians from this unit examine arrestees from the whole district of Seine-Saint-Denis, a department with a population of 1.5 million people. A total of 2250 detainees aged 15 or older were examined by the participating physicians during the study (February, 2008–January, 2009). All detainees aged 15 or older and examined by a physician for the assessment of fitness for detention were eligible for inclusion. In cases where the physicians' schedules did not allow for assessments on that day, the detainees who arrived were not considered for inclusion in the study (850 of 2250; 38%). A total of 1400 of 2250 detainees (62%) were considered for inclusion. We excluded patients who had an insufficient knowledge of French or English for the medical interview, aggressive or threatening patients, patients with medical instability (i.e., abnormal vital signs), and patients in a delusional state (400 of 1400, 29%). We prospectively evaluated a series of 1000 detained men or women (Fig. 1). The patients' characteristics are presented in Table 1.

2.2. Participating physicians

Seven physicians from the Department of Forensic Medicine in Jean-Verdier Hospital (93-Bondy, France) participated in the study. The principal investigator was also a specialist in addiction medicine and attended specific training on brief interventions. Prior to the beginning of the study, all participating physicians received information from the principal investigator on the aim and the content of brief interventions and how they could be performed in various contexts, such as emergency medicine, occupational medicine, and general practice. The physicians were trained to screen for addictive behaviors and to deliver brief structured advice on substance use and drinking risk levels. They received information and support on the aims, the content, and the evaluation of brief interventions in custody before and during the study. All physicians had undergone specific two-year training in clinical forensic medicine, followed by a minimum of 3 years' practice (range = 3–20 yrs, median = 3 yrs). Two of the seven physicians had also graduated in addiction medicine after two years of training and ongoing practice in the field. Forensic physicians who were also specialists in addiction medicine were considered forensic physicians, in conditions identical to others. The information given to the detainees and the duration of the intervention were similar in the two groups. Neither the examined detainees nor the police officers were informed of any specific qualifications of the attending physician.

2.3. Screening

During the medical examination, we used a standardized questionnaire and collected data concerning individual characteristics, addictive disorders (using a DSM IV-based evaluation), the individual's own experience of police custody, and reported assaults or observed injuries, as recommended during a national consensus conference (Chariot et al., 2008) and applied in our department (Briffa et al., 2013). We recorded the detainees' self-reports of perpetrated violence and victimization prior to being arrested, at the time of the arrest, or during custody. The project (N°2013-03-21) was reviewed and approved by the Institutional Review Board (IRB 00001072) of Ile-de-France 2 (Paris, France).

General data included age, sex, the medical care that detainees received after the onset of custody, the existence of a medical problem, and participation in an ongoing therapy. Data collected on the addictive behaviors focused on the consumption of alcohol, tobacco, tranquillizers, cannabis, cocaine, opiates, and other illicit substances in the last month. We also recorded the intention and attempts to quit, and past or current addiction treatment. Data collected on the course of the detention included the suspected crime and the relationship between the addictive disorders and the arrest, as perceived by the physician. Data collected on the outcome of the medical examination included the therapeutic measures taken, the effectiveness of the dialog on the addictive behaviors, the request of information, the willingness to change, and the reluctance to talk about their addictive disorders. Breath alcohol testing was not performed at the time of medical examination and delivery of the brief intervention. Information on the levels of intoxication of offenders was not available.

2.4. Intervention

The brief intervention was defined as providing information on the risks associated with addictive behaviors identified in the examined person, in conjunction with a patient-centered counselling session aimed at changing substance use and a proposal for therapy (Babor et al., 2007). The performance of the brief intervention was guided by the use of a structured questionnaire that was completed at the time of examination. The duration of the intervention was 5–15 min and the total duration of the medical examination and intervention was 20–30 min. The brief intervention was considered as not performed when the physician examined a person presenting with an addictive disorder and did not evaluate the substance use, the associated risks, the patient's readiness to change and the available therapeutic options. The addictive disorder was detected by the detainee's report or by a positive breath alcohol test or a positive urine drug test performed on the request by judicial authorities. A dialog was considered effective when the examined person talked about the possibility of modifying their addictive behaviors.

2.5. Statistical analysis

The statistical analysis was essentially descriptive and focused on the characteristics of alcohol and substance use, the suspected offence, and the results of the medical interview, examination, and brief intervention. We compared the rates of perpetrated violence and victimization according to the detected addictive behaviors. We also compared the outcome of the brief interventions, whether or not the physician involved was qualified in addiction medicine. Tests of significance included Fisher's and chi-square tests, as appropriate. Multivariate analyses (logistic regressions) were conducted to further test the associations between reported assaults and substance abuse while accounting for potential biases such as sex, age and suspected offences. Univariate analyses were performed with GraphPad InStat 3.1 software, San Diego, CA, and multivariate analyses were performed with Stata/SE 11.2 software, College Station, TX. The results were considered significant for P values below 0.05.

3. Results

3.1. Patients' characteristics (Table 1)

The 1000 patients studied included 944 men (94%) and 56 women (6%). The median age was 23 (range: 15–84, interquartile range: 18–33). No data were missing related to the patient's characteristics. A total of 272 patients (27%) reported a current health problem and 243 (24%) were undergoing current treatment prior

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