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Police Research Series
Paper 146

The Role of the Forensic Medical Examiner with “Drunken Detainees” in Police Custody

*Alison Noble
David Best
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*The views expressed in this report are those of the
authors, not necessarily those of the Home Office
(nor do they reflect Government policy)*

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Foreword

Drunken arrestees pose specific problems for police custody staff, often requiring the attention of the Forensic Medical Examiner (FME). The involvement of the FME presents a unique opportunity for a health professional to address hazardous drinking habits in an otherwise unseen population of 'drinkers'. The provision of a brief health intervention in the custody suite setting, aimed at reducing levels of future alcohol consumption, has the potential to impact positively upon the arrestees' future susceptibility to criminal acts whether that be as perpetrator or victim.

This pilot study investigates the feasibility of the attending FME administering a brief intervention in the custody suite. It examines the views of custody staff and FMEs for the potential for such intervention, and highlights some of the concerns that should be taken into account in considering the future application of custody-based health interventions.

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Executive summary

Background

- 'Drunken detainees' are a significant problem for the police (Robertson et al, 1995), not least because of the risk of death in custody (Johnson, 1982; Giles and Sandrin, 1992). Recent research reports that 25% of all deaths in police custody were a result of detainees using drugs or alcohol (Leigh et al, 1998).
- Up to 80% of the Forensic Medical Examiners' work has some connection with alcohol use or misuse (Hunt, 1996). A recent survey of FMEs in the London Metropolitan police area reported that they had attended 1,196 detainees during their last 24-hour period on call, a mean of 15.8 detainees per FME (Deehan et al, 1998a).
- Brief interventions for alcohol problems have been shown to be effective in populations not seeking treatment, especially among men (e.g. Drummond, 1997; Heather, 1995). They are shorter in duration and lower in intensity than conventional treatment and are ideally suited to non-specialist settings (including primary care, hospitals and custody suites). Brief interventions can be delivered by generalist workers and therefore provided at relatively low cost (Effective Health Care Bulletin, 1993).
- Many FMEs are GPs and will have insight into the applicability of brief interventions in primary care, and are in a position to apply some of the lessons from primary care to the custody suite setting.

Rationale for the feasibility study

- Most 'drunken detainees' are not receiving treatment for alcohol problems, therefore the FME may be the only health care professional with whom they have contact.
- This feasibility study explores the current role of the FME with 'drunken detainees' and examines the potential for the delivery of enhanced and targeted health interventions to alcohol-related detainees in custody.
- The study is an exploratory qualitative investigation examining possible expansions of the FME role to include management and treatment of drunken offenders.

Method

- A sample of FMEs from across the UK was investigated in order to assess knowledge, views and attitudes towards the use of brief interventions in the custody setting. A sample of Principal FMEs (n=14) was interviewed and another sample of FMEs (n=11) completed semi-structured questionnaires.
- A sample of police officers was also asked to complete semi-structured questionnaires in order to obtain similar information. The sample consisted of 15 police officers from two London police stations, including two Chief Inspectors, six Sergeants and seven Constables.

FME results

Dealing with 'drunken detainees'

- FMEs (from both groups) reported two main roles – a therapeutic one and a forensic one. The dominant themes that emerged both for detainees and custody staff related to safety issues (deaths in custody).
- The number of 'drunken detainees' assessed by both groups of FMEs varied substantially, according to location (urban versus suburban/rural), and according to the time of day and day of the week. FMEs (from both groups) outside London reported assessing smaller numbers than their colleagues in the London Metropolitan area.
- Several FMEs (from both groups) commented that they could identify two main groups of 'drunken detainees': young non-alcohol-dependent offenders, who have been detained because of their drinking, and habitual drunkenness offenders, who are more likely to have a chronic alcohol problem. Overall, the 'drunken detainees' presented with a range of problems including, 'being too drunk', vomiting, violence, alcohol withdrawal symptoms and injuries.
- The issue of being called back to re-assess detainees provoked mixed responses. There was a variation in the frequency of being called back, and this disparity was indicative of local protocols and procedures for re-call and patient management.

Providing interventions

- Principal FMEs reported greater knowledge about brief interventions than the FMEs, although their views on the effectiveness of this intervention varied.

- The main concerns expressed by FMEs (from both groups) were the issue of role legitimacy (whether they were the appropriate people to deliver a brief intervention and whether the police station was the right place), as well as role adequacy (whether they were equipped to deliver brief intervention) and the extent of available support. Many believed that the delivery of such an intervention would not be appropriate, and did not fit in with the assessment of 'drunken detainees' and that it would not be well received.
- However, the views of many of the FMEs, at least in part, could be attributed to a misunderstanding concerning the nature of brief interventions. Although many did not use the term, they were already providing something of this nature (a liaison role, advice or information, motivational support), albeit not in a systematic or consistent manner.
- Several FMEs (from both groups) suggested that young binge drinkers might benefit from some kind of intervention. Many reported that they were not sure how much they could help the 'chronic alcoholic' group. A further group of FMEs suggested that all drinkers would benefit from some kind of intervention, especially drink drivers and those detained for domestic violence.
- The majority of FMEs who participated reported that the custody suite might not be the appropriate place for the provision of a brief intervention. The wider issue of appropriate management of 'drunken detainees' was discussed, with the majority reporting that detention in police custody was inappropriate for 'drunken detainees'. Alternative suggestions included the need for specialist centres with medically trained staff, and units attached to A&E departments. However, the problem of cost and resources was recognised.

Training issues and liaison with other professionals

- The samples of FMEs and Principal FMEs reported different levels of training and experience. None of the 11 FMEs possessed the Diploma of Medical Jurisprudence (DMJ), while over half (8/14) of the Principal FMEs possessed the qualification. Most of the Principal FMEs reported high levels of qualification, training and experience. The 11 FMEs expressed that more training on drug and alcohol issues would be helpful, particularly in the areas of assessment, referral and treatment.
- In general, inconsistent communication and liaison with local services were reported. This included liaising with Arrest Referral Scheme workers (ARS). Overall, the FMEs reported good communication and liaison with the custody

staff. However, the majority commented that custody staff did not have enough training to deal with 'drunken detainees'.

Police results

- The majority of the police officers reported that between 40-70% of all detainees brought into the custody suite were under the influence of alcohol. They reported seeing between 2 and 3 'drunken detainees' per shift during the week and 5 and 7 over the weekend. Overall, the 'drunken detainees' presented the police officers with a range of problems including extra monitoring, delays due to detainees being 'too drunk' to interview, safety issues and violence.
- The police officers reported calling the FME, on average, 22 occasions a week and reported that more than 70% of alcohol-related offences were seen by FMEs.
- None of the police officers initially knew what a 'brief alcohol intervention' entailed. Several police officers suggested that young binge drinkers might benefit from some kind of intervention. Many reported that they were not sure how much they would help the chronic alcoholic group. However, the majority reported that the FME might not be the appropriate person to provide a 'brief alcohol intervention'.
- The majority of police officers who participated reported that the custody suite might not be the appropriate venue for the provision of a brief intervention. As with the FMEs the wider issue of appropriate management of 'drunken detainees' was discussed, with the majority reporting that detention in police custody was inappropriate for 'drunken detainees'. Alternative suggestions included the need for treatment centres in a hospital setting, and units with adequately trained staff.
- The police officers argued that detainees brought in for offences such as domestic violence where drinking was involved, drunk and disorderly behaviour, breach of the peace (with alcohol), driving under the influence of alcohol and drunk in charge of a child should be dealt with in police custody. The majority (11/15) suggested that detainees brought in for alcohol intoxication should not be dealt with in police custody.
- Overall, the police officers reported good communication and liaison with FMEs. Only one third of the police officers had ever received any formal training on how to deal with 'drunken detainees' and the majority expressed that more training for custody staff on drug and alcohol issues would be helpful.

Conclusions

- There are disparities in knowledge and awareness amongst Principal FMEs, FMEs and police officers regarding their awareness of brief interventions for alcohol problems and their perceptions of their own training. While most of the Principals were familiar with brief interventions and felt suitably trained to deliver them, this was not the case for most of the other FMEs (who tended to be younger and less experienced).
- A variation in views and attitudes towards brief interventions was expressed, with many Principals and FMEs questioning whether it was part of their role or even whether brief alcohol interventions can work in principle.
- However, many FMEs (from both groups) do provide some form of intervention – advice, referral to local agencies, liaison with arrest referral, motivational enhancement work, although often on an ad hoc and opportunistic basis. Many reported that when detainees were sober enough and there was time available, they would discuss alcohol issues and problems, if they felt this to be appropriate.
- The lack of follow-up opportunities, the intoxication of the detainee and restrictions on time and resources were seen as major obstacles to the systematic provision of treatment-type interventions by FMEs. This combined with the perception that ‘treatment’ was not part of the FMEs’ role was also a significant barrier.
- Increases in specialist training for FMEs and custody officers and in the co-ordination of FME work with local treatment providers and ARS workers would be beneficial. However, the key requirement is a systematic analysis of process and outcome of brief alcohol interventions in the custody suite setting.

Recommendations

- More national data are needed to assess the level of the problem and alternative methods of managing ‘drunken detainees’ need to be considered. More accurate data are required on the number of ‘drunken detainees’ assessed by FMEs and the number of such detainees processed through the custody suite by police officers.
- FMEs need to have a clearer understanding of the effectiveness of brief interventions, and the wider public health impact of such interventions. Also, more training for custody staff dealing with ‘drunken detainees’ is needed.

- A systematic analysis of how brief interventions could be tailored for use in the custody suite setting and of their effectiveness in this setting is needed. This would permit the components of brief interventions (advice, onward referral, information, etc) to be assessed independently as well as in combination and therefore evaluating which of these components are particularly effective. This might result in a range of brief intervention strategies.
- FMEs and custody officers should work more closely with Arrest Referral Scheme workers in police stations that have this facility. This should certainly be the case for those with repeated contact (regular detainees) and those whose offence may make them appropriate for early interventions (such as drink drivers and younger binge drinkers).
- As with the Arrest Referral Scheme, outcome evaluation is required to analyse not only whether FME-delivered brief interventions can be effective, but if so, under what circumstances and for what offender populations.

Contents

	Page
Foreword	(iii)
Acknowledgements	(iv)
Executive summary	(v)
List of tables	(xiii)
List of boxes	(xiv)
1. Introduction	1
Background	1
The role of forensic medical examiners	2
Contact with ‘drunken detainees’	3
Training and role suitability	4
Brief interventions and alcohol	4
Rationale of the study	6
Structure of the report and definitions	7
2. Research study and methodology	9
Aim of the feasibility study	9
Methodology	9
Forensic Medical Examiners sample	9
Police sample	10
3. FME results	11
Forensic Medical Examiners’ demographics	11
The role of FMEs	11
Number of ‘drunken detainees’ assessed by FMEs	12
Issues and problems when dealing with ‘drunken detainees’	12
General issues	13
Problems encountered	13
Assessing ‘drunken detainees’	14
Assessments	15
Calls to re-assess ‘drunken detainees’	15
Prescribing issues	16
Summary	17
4. FMEs and brief interventions	18
Knowledge and attitudes towards brief interventions	18
Provision of brief interventions by FMEs	18
Provision of brief interventions in the custody suite	20

Brief interventions for binge drinkers	22
Brief interventions for individuals with chronic alcohol problems	22
Targeting groups for brief interventions	22
Funding brief interventions	23
Appropriate management of 'drunken detainees'	23
Summary	24
5 . FME training issues and liaison with custody staff and local services	26
Training issues for FMEs	26
Training and brief interventions	26
Development of the role of FMEs	27
FME liaison with custody staff and training needs	27
Liaison with local services	28
Liaison with Arrest Referral Schemes workers	28
Leaflets and information	29
Summary	29
6 . Police results	31
Police demographics	31
Dealing with 'drunken detainees'	31
Police contact with FMEs	32
Knowledge and attitudes towards brief interventions	32
Provision of brief intervention in the custody suite	33
Liaison with FMEs, Arrest Referral Scheme workers and training issues	34
Summary	35
7 . Conclusion	37
Overall findings	37
Study limitations	37
Application of brief interventions for alcohol	37
The problems of providing treatment	39
Training needs	40
Recommendations	40
Appendix: Areas covered by respondents	42
References	43
Recent PRC publications	48

List of tables

Table No.	Caption	Page
1	Sample in the study	10
2	FME demographics	11
3	Problems dealing with 'drunken detainees'	14
4	Assessing 'drunken detainees'	15
5	FMEs' involvement in health provision	19
6	Police demographics	31
7	Police attitudes towards dealing with 'drunken detainees'	32
8	Police views regarding FMEs' involvement in health provision	33
9	Appropriate management of 'drunken detainees'	34
10	Police officers' views on training issues	35

List of boxes

Box No.	Caption	Page
1	Definitions of 'Drinkers'	8
2	FMEs and 'drunken detainees'	17
3	FMEs and brief interventions	25
4	FME training and liaison issues	30
5	Police officers and 'drunken detainees'	36

1. Introduction

Background

Alcohol is the most popular drug in the UK (Royal College of Psychiatrists, 1986). Widely and legally available it gives pleasure to many people when consumed in moderate quantities. However, it is also a major cause of morbidity and mortality. The number of deaths from alcohol-related diseases has been rising. In 1992 there was a total of 3,565 deaths, this rose to 4,907 in 1997, an increase of 38% (Department of Health, 1999). The number of deaths where alcohol is a major cause is much higher and ranges from 25,000 to 40,000 each year (Royal College of Physicians, 1987; Anderson, 1988; Godfrey and Maynard, 1992; Royal College of General Practitioners, 1986). The financial burden of alcohol in terms of lost productivity may continue to be one of the most significant costs of alcohol misuse (Godfrey, 1997). Costs to the medical and social services have been estimated to be in the order of £2,500 million per year, with costs to the health services of £150 million (Godfrey and Maynard, 1992). However, the economic burden extends beyond the health services to include wider costs in terms of social care, costs to employers and the financial burden on the criminal justice system. The last includes the costs of policing alcohol and detaining arrestees who have been drinking, and the subsequent cost to the judicial system, prisons, probation and related criminal justice agencies (Godfrey, 1999).

Alcohol misuse is defined as a level or pattern of alcohol consumption likely to damage the physical and psychological health or social adjustment of the individual drinker, or others directly affected by their drinking (Edwards and Unnithan, 1994). Around 1.7 million men and 0.6 million women are drinking at very high levels (defined as more than 50 units and more than 37 units per week for men and women respectively), 37% of young men (aged 16-24) and 23% of young women regularly drink twice the recommended daily limits (ONS, 2000), and underage drinking is also prevalent (Harrington, 2000). Epidemiological evidence suggests that the risk of developing alcohol-related problems increases above the relatively low level of 21 units per week in men (about 10 pints of beer) and 14 units for women. Therefore, prevention efforts should be directed at a wide spectrum of drinkers rather than only those with severe and chronic alcohol problems (Kreitman, 1986).

Increasing numbers of young women and men are drinking above sensible drinking levels (ONS, 2000), and alcohol misuse in this age group is also rising. Binge drinking is relatively common in this group and may contribute to alcohol-related crimes (Measham, 1996). Health surveys for England and Wales have included questions about drunkenness since 1991. In 1994, 23% of male and 11% of female 'current drinkers' reported that they had been drunk three or more times in the

INTRODUCTION

previous three months (Colhoun and Prescott-Clarke, 1994). Among young male drinkers between the ages of 16 and 24 years, 32% reported being drunk at least once a week on average and 79% at least once in the past three months. Intoxication is therefore common in the general population, and particularly amongst young males.

In England and Wales, the police have powers of arrest when an individual is found drunk in a public place. In 1995, 42,600 individuals were found guilty and cautioned for offences of drunkenness (100 per 100,000 population) (Home Office, 1995). Once arrested these individuals are detained in police custody for their own safety or for the safety of the general public. Several studies have focused on 'drunken detainees' who are a significant problem for the police (Robertson et al, 1995), not least because of the risk of death in custody (Johnson, 1982, Giles and Sandrin, 1992). Recent research reports that 25% of all deaths in police custody were a result of detainees using drugs or alcohol (Leigh et al, 1998), while at least 86% of custody deaths in another study were associated with either recent alcohol consumption or chronic alcohol abuse (Giles and Sandrin, 1992). One study found that 22% of arrests over a six-month period were diagnosed as 'drunk' on arrival at the police station (Robertson et al, 1995). Another study found that 25% of arrestees in police custody tested positive for alcohol (Bennett, 1998). Phillips and Brown (1998) reported that 10% of arrestees showed clear signs of drinking, while a further 4% were too drunk to be dealt with immediately and were confined to a cell until they had sobered up. Saunders (1998) reported that 47% of individuals detained in one police station over a two-month period had consumed alcohol shortly before coming into custody. A recent Home Office study reported that of those ineligible to be interviewed for the research, 29% of detainees were unfit due to alcohol intoxication (Bennett, 2000). Thus alcohol is of importance in two respects:

- offences related to alcohol
- other offences (i.e. unrelated to alcohol) but where the offender is intoxicated.

The role of Forensic Medical Examiners

Forensic Medical Examiners (FMEs) (formerly known as Police Surgeons) are usually general practitioners, who are self-employed, independent and individually appointed to provide their services to relevant police forces (Howitt and Stark, 1999). Their role is varied and includes tasks such as offering care and forensic assessment of detainees in police custody, assessing suspects and alleged victims of crimes, and interpreting findings for the police, courts and social services. FMEs are also sometimes required to provide evidence in court (Howitt and Stark, 1999). The workload and role of FMEs is changing and further changes are likely with

increasing specialisation (Davison, 2000; de la Haye Davies and Stark, 1996), and the need to modernise the service they provide has been acknowledged (Wise, 1998). Principal FMEs have specific responsibilities for a group of FMEs, running the rota, liaising with the police, training newly appointed FMEs and reviewing the professional development of the FMEs within the group.

It is important that individuals in custody who have consumed alcohol are adequately assessed (Brownell and Naik, 2000). FME assessments involve obtaining background information from the detainee, taking a general medical history and making a physical examination. FMEs determine whether detainees are fit to be in custody and whether they are fit to be released, charged, or transferred. FMEs provide assessments of alcohol and drug intoxication and withdrawal, and undertake intimate body searches for drugs (Howitt and Stark, 1999). An increasingly important role of FMEs is to assess and indicate to the police whether detainees are fit to be interviewed (Gall and Freckelton, 1999; Norfolk, 1997; Robertson, 1995). Deehan et al (1998a) reported that 86% of calls were to assess fitness to be detained, while Leigh et al (1998) reported that from their sample only 44% of calls were to confirm this.

In view of the fact that 'fitness to be interviewed' has become an important aspect of work for FMEs, the need for a working definition has been recognised (Norfolk, 1997). An assessment of 'fitness to be interviewed' should incorporate the following: the detainee's general appearance; their pulse rate at the start and end of the examination; examination of their eyes and other signs of intoxication; an assessment of their mental state, reading ability and functional assessment (Norfolk, 1997).

Contact with 'drunken detainees'

Up to 80% of FMEs' work has some connection with alcohol use or misuse (Hunt, 1996). A recent postal survey of 116 FMEs in the London Metropolitan police area (66% response rate) investigated their contact with 'drunken detainees' and their attitudes towards expanding their role to include detection of and brief intervention with 'drunken' offenders in custody (Deehan et al, 1998a). The responding FMEs had attended 1,196 detainees during their last 24-hour period on call, a mean of 15.8 detainees per FME. Over a third of detainees were seen because they had consumed alcohol (Deehan et al, 1998a).

In a survey of 104 FMEs in the Metropolitan Police Service, information from 'Book 83' returns forms was collated (Kelly et al, 1993). These forms record details about tasks undertaken and decisions reached on each FME visit. Four hundred and fifty

forms were assessed to determine reasons for call-out, the average time taken per action, and the nature of the work undertaken. The majority of individual observations (70%) lasted 15 minutes or less, with 20% taking 5 minutes or less. Custody officers and divisional management teams were also interviewed. Overall the police reported high levels of satisfaction with the service provided by FMEs. However, the police were mainly concerned about the delay in FMEs attending a station when called, and the lack of information provided by the FME's report. 'Independence' was another issue, and there were concerns around who should employ FMEs. The report also suggested some areas of dissatisfaction including qualifications, training and the basis on which FMEs certify fitness to be detained or interviewed (Kelly et al, 1993).

Training and role suitability

The training of FMEs so that they are able and competent to provide a high quality service is an important issue. Most FMEs are general practitioners working part-time, rather than specialist practitioners, but increasing numbers are now working as specialists in clinical forensic medicine (Stark, 2000).

Training needs have been addressed in recent years by the Association of Police Surgeons (Stark, 2000). Educational and training material has been developed, along with a practical induction programme for newly appointed FMEs (Evans, 1997) and training packages for the police custody officers (Wall and Stark, 1999). FMEs now undergo induction courses and courses preparing for the Diploma in Medical Jurisprudence (DMJ) (de le Haye Davies and Stark, 1996). However, less than 8% of FMEs nationally (Bradshaw et al, 1994) and only 18% in a London sample (Kelly et al, 1993) possessed the DMJ, the clinical strand of which is arguably the 'specialist' qualification for FME work (Kelly et al, 1993).

In Deehan et al's (1998a) study, only 43% of FME respondents had received any training in alcohol misuse. However, more than three-quarters of the sample reported feeling adequately trained to ask detainees about their alcohol use and to offer advice. Over 40% of the FMEs reported that 'drunken detainees' were more time consuming than an average call and only 18% reported that advice to reduce their alcohol consumption would be taken seriously by a detainee (Deehan et al, 1998a).

Brief interventions and alcohol

There is an extensive literature on the use of brief interventions for alcohol problems in primary care and in general hospital (Drummond, 1997; Bien et al, 1993; Effective Health Care Bulletin, 1993; Heather, 1995; Heather, 1989). Current

evidence suggests that brief interventions for alcohol problems are effective in populations not seeking treatment, especially men (Drummond, 1997), that they are significantly more beneficial than no intervention, and can enhance the effectiveness of subsequent treatment (Bien et al, 1993). Bien et al (1993) outline the principle of FRAMES in which effective delivery is predicated on the combination of six elements:

- Feedback – of personal risk or impairment
- Responsibility – for personal change
- Advice – to change
- Menu – of alternative change options
- Empathy – as a counselling style
- Self-efficacy – enhancement of client's self-esteem.

Brief interventions are shorter in duration and of lower intensity than conventional treatment and are ideally suited to non-specialist settings, including primary care, hospitals and custody suites (Heather, 1995). They can vary in length, structure and substance but usually consist of one or two sessions. Brief interventions can be delivered by generalist workers and the cost of delivery has been estimated at approximately £20 per intervention (Effective Health Care Bulletin, 1993).

The distinction between brief interventions among treatment seekers and non-treatment seekers needs to be emphasised. Over-optimistic and uncritical conclusions have been drawn with regard to their effectiveness, especially among those seeking help for alcohol problems (Heather, 1995). Brief interventions are best reserved for hazardous and harmful (not dependent) drinkers who have been screened opportunistically, a conclusion that may be consistent with custody suite delivery. However, individuals drinking at hazardous and harmful levels are not always readily identifiable, and may not even be aware that their drinking has the potential to cause harm. Generalists should take advantage of the opportunities to screen for alcohol problems when such individuals present to services for other reasons (Marshall, in press). Opportunistic screening should, therefore, be built into the infrastructure of a variety of settings, including primary care, the general hospital and police stations (Marshall, in press). There are several standardised instruments available that can be used to screen for drinking problems. These include: the CAGE, Quantity/Frequency Questions, the brief Michigan Alcoholism Screening Test (BMAST), the Alcohol Use Disorder Identification Test (AUDIT), the TWEAK (Alcoholism screening test developed for women) and the Rapid Alcohol

Problem Screen (RAPS) (Cherpitel, 1997). Identification of hazardous and harmful drinking should be followed by brief interventions. This usually consists of the following:

- an alcohol intake assessment
- information on hazardous/harmful drinking
- clear advice, with booklets and details of local services
- attempt to understand the triggers for drinking and then negotiate around setting realistic goals (Marshall, in press).

For the purpose of this feasibility study, the FMEs and police officers were given the following definition of brief intervention: ‘one-to-one sessions, limited assessments, advice- and leaflet-giving or setting goals’.

Evidence suggests that such interventions are effective in reducing alcohol intake by 20-30% one year following intervention (Wallace et al, 1998; Effective Health Care Bulletin, 1993). However, while they may reduce individual consumption (and are more effective in men than women), their public health value is potentially enormous. Despite evidence for their effectiveness in primary care, it is difficult to persuade GPs to utilise brief interventions as part of routine practice, because of a perceived lack of training and lack of confidence (Deehan et al, 1998b; Deehan et al, 1998c). Education and support from local specialist services have been identified as key factors in improving performance in this area. As many FMEs are GPs some of the lessons concerning the delivery of brief interventions can be applied to pilot work with this population.

Rationale of the study

Alcohol-related crime is a major burden on police resources. Research evidence shows that brief interventions are effective in reducing alcohol consumption in opportunistic settings (Effective Health Care, 1983; Russell et al, 1987; Bien et al, 1993; Hunt et al, 1998; Monti et al, 1999; Richmond et al, 1999; Richmond et al, 2000). They are also compatible with the principle of the Arrest Referral Scheme for drug misusers. FMEs may be the only contact that ‘drunken detainees’ have with health care provision. This feasibility study therefore examined whether it might be feasible to provide brief interventions in the context of police custody and whether FMEs might consider providing such an intervention.

This work is timely given that the Home Office's first action plan – setting out key objectives and priorities for taking forward programmes of work to tackle alcohol-related crime – has recently been developed. The Home Office's aim is to encourage local action to reduce levels of alcohol-related crime, disorder and nuisance. Three specific objectives have been identified: to reduce the problems arising from under-age drinking; to reduce public drunkenness; and to prevent alcohol-related violence. This report is an exploratory qualitative investigation, which examines the parameters for future investigations and development.

Structure of the report and definitions

The next section focuses on the methodology of the study and the FME results are presented in Section 3. Issues regarding brief interventions, attitudes and view around FMEs providing this work will be discussed in Section 4. FME training issues and liaison with custody staff and local service are discussed in Section 5. Section 6 focuses on police attitudes and views regarding FMEs and brief interventions. Conclusions and recommendations are reported in Section 7. Box 1 below defines the terms that refer to different types of alcohol 'drinkers' used in the report.

Box 1: Definitions of 'Drinkers'

(Royal College of Physicians, 2001)

Very heavy drinker: A man who drinks 50 or more units per week or a woman who drinks 35 or more units per week.

Binge drinker: A man who regularly drinks 10 or more units in a single session or a woman who regularly drinks 7 or more units in a single session.

Hazardous drinkers (also called at risk drinkers): Very heavy drinkers and binge drinkers have drinking patterns that pose a considerable risk to their health and may thus be described as hazardous drinkers.

Harmful drinkers (also called problem drinkers): A harmful drinker is one where there is clear evidence that alcohol use is responsible for (or substantially contributes to) physical and psychological harm including impaired judgement or dysfunctional behaviour, which may lead to disability or have adverse consequences for interpersonal relationships. This includes those whose drinking is causing harm to the physical, mental or social well-being of others.

Alcohol Dependence Syndrome: A syndrome is characterised by

- (1) narrowing of the drinking repertoire
- (2) increased salience of drinking
- (3) increased tolerance of alcohol
- (4) repeated withdrawal symptoms
- (5) drinking to avoid withdrawal symptoms
- (6) subjective compulsion to drink
- (7) reinstatement after abstinence.

N.B. Most hazardous or problem drinkers do not have an Alcohol Dependence Syndrome.

2. Research study and methodology

Aim of the feasibility study

The aim of this feasibility study was to explore the current role of the FME with regard to 'drunken detainees' in police custody and to examine the potential for the delivery of enhanced and targeted health interventions to these detainees. The following issues were addressed:

- the feasibility of delivering an intervention in the custody suite
- perceptions of such work by the FME and custody staff
- potential barriers to success.

This report will provide evidence on the scope and potential for future research assessing the design and implementation of a brief intervention for problematic drinkers in custody.

Methodology

Forensic Medical Examiner sample

There are about 2,000 FMEs in the UK, of whom about half are members of the Association of Police Surgeons. Approximately 100 of this number are Principal FMEs (personal communication with the Honorary Secretary of the Association of Police Surgeons, 2000). In order to obtain views, each Principal FME within the 20 groups in London and 10 Principal FMEs around the country were contacted and asked to participate (see Appendix). The sampling strategy was based on a combination of snowballing and opportunistic sampling – with initial key informants asked to identify other FMEs and Principals who they believed had pertinent views in this domain. For those available and willing to participate, face-to-face interviews were arranged. Where the Principal FME was unable to organise an interview time with the researchers, questionnaires were posted to them. Each Principal was also given questionnaires to distribute to FMEs in their group if they felt this was appropriate within the limited time available. The researchers were unable to contact several FMEs. Where contact was made, five FMEs were unable to participate due to time constraints (see Table 1 for sample).

The final sample comprised 25 respondents (19 males and 6 females), of whom 14 were Principal FMEs, and 11 were FMEs. All 14 Principal FMEs (herein referred to as 'Principal FMEs') were interviewed face-to-face, whilst the 11 FMEs (herein termed 'FMEs') completed semi-structured self-response questionnaires. The interviews were audio-taped and later transcribed. Questionnaire data were processed using SPSS.

Police sample

A small sample of police officers from two London police stations was surveyed in order to obtain police views and attitudes towards 'drunken detainees' and in particular the service provided by FMEs. Questionnaires were given to the Chief Inspector to complete and distribute to other staff within their stations. The staff were asked to complete the questionnaires and return them anonymously to the Chief Inspector. The total sample of 15 police officers (12 males and three females) comprised two Chief Inspectors, six Sergeants and seven Constables. The police stations were selected through existing contacts with individual officers. Recruitment was then determined by the opportunistic selection of the key informant at each station. No information is therefore available on refusals to participate by individual officers.

	No. approached	No. in sample
FMEs	40	11 (28%)
Principal FMEs	30	14 (47%)
Police officers	20	15 (75%)

The low rate of FME recruitment (28%) was estimated as a percentage of the total number of questionnaires distributed to Principals, rather than as a function of individuals approached who accepted. Therefore it was not possible to calculate the actual completion rate as a function of the number received by FMEs.

3. FME results

This section of the report focuses on the background of the FME sample. It also reports on the number of 'drunken detainees' FMEs are called to assess, the role of FMEs, and issues and problems dealing with 'drunken detainees'.

Forensic Medical Examiners' demographics

As Table 2 illustrates, the majority of FMEs and Principal FMEs reported that their main occupation was as a general practitioner. Only six described their main occupation as an FME. Participants had been working as FMEs for a mean of 13.9 years. Principal FMEs had been in post longer than the other FMEs. The number of hours spent as an FME and the sessions that they were on call varied. Most reported that in a typical month (defined as a representative month during which the FME was working in that role) they would usually work one or two sessions a week (12 to 24 hours), plus one weekend every 4 to 6 weeks (36 to 48 hours). In a typical month an average of 116 hours were spent working as an FME.

	FMEs (n= 11)	Principal FMEs (n= 14)	Total sample (n= 25)
Male FMEs	8 (73%)	11 (78%)	19 (76%)
Main occupation as GP	10 (90%)	9 (64%)	19 (76%)
Mean time working as an FME	8.6 yrs (range= 1.6-20)	18.2 yrs (range= 3-35)	13.9 yrs (range= 1.6-35)
Number of hours per month spent as FMEs	120 hrs (range= 50-240)	114 hrs (range= 60-168)	116 hrs (range= 50-240)

The role of FMEs

The dominant themes emerging from both groups of FMEs concerned safety, care and the general welfare of the detainees while in custody. These involved ensuring the physical safety of detainees, assessing suitability to be held in custody and offering guidance and advice to custody officers regarding fitness for interview.

Several Principal FMEs commented that they had two roles: a therapeutic one and a forensic one. Several Principals commenting on the dual role reported that their primary role was to ensure that the 'drunken detainees' were fit to be in the police station, protecting the individual in a situation where they were potentially at risk and also to avoid deaths in custody.

Number of 'drunken detainees' assessed by FMEs

The number of 'drunken detainees' assessed by both groups of FMEs varied greatly, according to the areas covered and also to the time of day and day of the week. Friday and Saturday were reported as the busiest nights for FMEs.

FMEs in the London Metropolitan area assessed larger numbers of 'drunken detainees' than those outside London, although many commented that it was difficult to report an actual number. The 11 FMEs reported that in a typical week (defined as a representative week during which the FME was working in that role) they would assess an average of 21 detainees, (6 under the influence of alcohol (range= 1-30, standard deviation (sd)= 8.5) and 15 not under the influence of alcohol (range= 6-50, sd= 12.4)).

The Principal FMEs interviewed in London reported assessing large numbers of 'drunken detainees' during on-call periods. One Principal FME reported that about 10-15% of his/her workload involved assessing 'drunken detainees', another that it was at least 30%, yet another reported that it could be as high as a third or a half of the detainees assessed and that this proportion could rise to 80% of calls on any given day. Another Principal FME reported that an average caseload for 24 hours would be about 20 to 40 cases, and of those the majority would be under the influence of alcohol.

Overall, Principal FMEs interviewed outside of London reported assessing lower numbers of 'drunken detainees'. The Principal FME in Sheffield reported seeing about 500 'drunken detainees' a year, while the Principal FME from Bristol reported assessing around 1000 to 1100 detainees a year (about 5-10% of their workload). However, lower overall volumes in the regions does not automatically mean lower rates of drinking offenders; the Principal FME from Glasgow reported that of a total of 709 detainees assessed in 1999, 25% had been using alcohol. This proportion is similar to that of the Principal FME in Suffolk who reported assessing about 20 to 25 cases a month, of which 25% were 'drunken detainees'.

Issues and problems dealing with 'drunken detainees'

The complex mix of problems that FMEs experience in assessing 'drunken detainees' in a difficult environment is discussed in the context of the contractual responsibilities and the restrictions of time and resource within which FMEs operate. It particularly focuses on general issues and problems encountered, assessing 'drunken detainees' (such as withdrawal/ injuries), violence and police attitudes.

General issues

All FMEs were questioned about their role in dealing with two different types of detainees: young drunken offenders who may not have an alcohol problem but whose drinking has led to their detention, and habitual drunkenness offenders, who are more likely to have a chronic alcohol problem.

FMEs and Principal FMEs held inconsistent views about this issue. Several FMEs and Principal FMEs reported that they did not differentiate between the two groups, but that it was a question of examining the detainee at the time. However, some of the FMEs and Principal FMEs did make a distinction between the two groups, and also mentioned the difficulties posed by not having any previous history or information about them. One Principal FME explained that they advised young binge drinkers on their drinking, but they did not intervene to refer them on if the detainee reported that they were an occasional drinker. Another Principal FME who differentiated between the groups explained that the younger, hazardous, binge drinkers are 'not as worrying as those who are drinking nine cans of Special Brew every day and who have fits when withdrawing'. Similarly, another Principal FME expressed the view that 'drunken alcoholics' had multiple social problems, whereas 'drunkenness' might be a 'one-off' for the younger ones. One FME acknowledged however, that this latter group could be 'chronic alcoholics in the making'.

One aspect that differed in their perceptions of the core role of the FME was concerning alcohol withdrawal in alcohol-dependent detainees, with respect to what immediate actions should be taken to ensure physical safety, medication to prevent delirium tremens and the detainee's general physical welfare.

Problems encountered

FMEs encounter a range of problems in their work with 'drunken detainees'. All 11 FMEs who completed the questionnaires encountered similar problems and issues, with vomiting, violence and aggression occurring frequently. Other problems included the detainee being 'too drunk' or showing alcohol withdrawal symptoms, having an injury that needed to be attended to or urinating in the cells. Assessing and dealing with female detainees was another problem identified, as were negative police attitudes (see Table 3).

The Principal FMEs reported encountering similar problems. Several Principals commented on the issue of their own safety when violence and aggression was directed towards them. They were also concerned for the safety of detainees with other health problems such as epilepsy and diabetes. Several Principal FMEs commented that although violence was possible, it was rare.

Table 3: Problems dealing with ‘drunken detainees’

Problems; n=11 (%)	None	A little	Quite a lot	A lot
Vomiting	–	–	8 (73)	3 (27)
Too drunk	–	4 (36)	6 (55)	1 (9)
Violence	–	2 (18)	5 (45)	4 (36)
Assessing female detainees	2 (18)	4 (36)	5 (45)	–
Alcohol withdrawal	–	7 (64)	4 (36)	–
Injuries	–	5 (45)	4 (36)	2 (18)
Assessing younger detainee*	–	8 (73)	2 (18)	–
Assessing older detainee*	–	5 (45)	3 (27)	2 (18)
Negative police attitudes	2 (18)	6(55)	3 (27)	–

*n=10

Like the FMEs, a number of Principal FMEs also reported that female detainees were often more difficult to assess than the men. They reported that habitual female drinkers often look worse in their appearance and that the younger women are usually sick in the cells. One Principal FME commented on the problem of female detainees taking their clothes off and accusing the doctors of having assaulting them.

Several Principal FMEs commented that ‘drunken detainees’ are at risk of dying in custody and that this problem would continue as long as ‘drunken detainees’ are held in police stations.

Assessing ‘drunken detainees’

Assessment of the ‘drunken detainee’ is an important aspect of the FMEs’ work and both groups of FMEs reported on what this entailed. Details are usually taken from the custody officers and it was common practice to communicate with the arresting officers in order to gain information on the detainee’s behaviour. This included where they were found, level of intoxication, and what had happened to them since their time in custody and their level of alertness. Taking a medical history and conducting a physical examination were accorded high levels of importance by both groups. FMEs and Principal FMEs reported that they rarely contacted GPs of

detainees, largely because of the difficulty in contacting them or for reasons of confidentiality.

Mixed views were expressed by the 11 FMEs regarding discussions with Arrest Referral Scheme (ARS) workers, possibly due to the fact that not all police stations have this facility, and there were inconsistencies in the frequency with which treatment was offered or recommended.

Table 4: Assessing ‘drunken detainees’

N=11 FMEs (%)	Never	Rarely	Sometimes	Often	Always
Talk to arresting officer	–	–	6 (55)	3 (27)	2 (18)
Take details from custody officers	–	–	–	4 (36)	7 (64)
Talk to arrest referral worker (if there is one around)*	2 (18)	4 (36)	–	1 (9)	1 (9)
Contact detainee’s own GP	1 (9)	8 (73)	2 (18)	–	–
Take a medical history	–	–	1 (9)	4 (36)	6 (55)
Conduct a physical examination	–	–	–	5 (45)	6 (55)
Offer treatment	1 (9)	3 (27)	6 (55)	1 (9)	–
Recommend treatment	–	2 (18)	6 (55)	2 (18)	1 (9)

*n=10

Assessments

All FMEs commented that the length of time spent assessing a ‘drunken detainee’ varied according to level of intoxication and injury, how co-operative they were and whether there were any other concerns regarding their drink problems. The majority of the Principal FMEs and FMEs reported that their assessments usually lasted between 10 and 20 minutes.

Calls to re-assess ‘drunken detainees’

Some inconsistencies emerged concerning the issue of FMEs being called back to re-assess detainees. Several Principal FMEs reported that local protocols and procedures for re-call and patient management operated within their patch:

We usually set up an agreement on each patient with the custody officer. The re-calls are either because I asked to be re-called, because I am concerned, or because the patient deteriorated in front of their eyes.

One Principal FME reported that there are certain circumstances for call-backs:

There's a protocol in our group whereby if you can't get any history from someone who is alcohol intoxicated, then we can't make an assessment as to whether they are fit to be detained, we'd do that by clinical observation. As to fitness to be interviewed, we'd always go back.

Other Principal FMEs reported that they rarely get called back, but this was based on the station sergeant's discretion. Another FME estimated that there are very few call backs (approximately 10% of cases) if it is purely alcohol-related, if the detainee hasn't recovered in the appropriate time period.

Several FMEs did not appear to have such a clear procedure, and reported that they were called back to re-assess detainees. Seven of the 11 FMEs who completed the questionnaires reported that between 10-40% of their follow-up assessments were with drinkers, although not all Principal FMEs reported that they did follow-up assessments.

Prescribing issues

FMEs and Principal FMEs reported variability in prescribing practices to 'drunken detainees' in custody. Most would prescribe either diazepam or chlordiazepoxide to an alcohol-dependent detainee showing signs of alcohol withdrawal, or in a situation where the detainee became violent and it was important to 'calm them down'. Detainees suffering severe withdrawal were generally sent to hospital. Prescribing also depended on how long the detainee was likely to be held in the police station.

Other concerns regarding prescribing to 'drunken detainees' were expressed, and focused on the issue of how much the detainee might have had to drink and what other substances they might have taken before they came into custody. There were also concerns about supervising the detainees and whether prescribing would compromise their fitness to be interviewed.

Overall, prescribing to 'drunken detainees' while in custody is a major concern for FMEs, and many emphasised prescribing enough to stabilise the detainee without compromising their fitness to be interviewed.

Summary

The issues discussed in this section are summarised in Box 2.

Box 2: FMEs and 'drunken detainees'

Dealing with 'drunken detainees'

- Assessing 'drunken detainees' is a concern for FMEs in and outside London
- Wide variation in the number of 'drunken detainees' assessed by FMEs
- Two main groups of 'drunken detainees' were identified:
a younger non-alcohol dependent offenders, arrested due to their drinking;
and
an older chronic drinking habitual offender.
- Consensus regarding management of detainees

Assessing 'drunken detainees': problems encountered.

- 'Drunken detainees' present with a range of problems
- Safety issues accorded high priority
- Variation in assessment times
- Exchange of information with custody staff regarding the detainees behaviour considered important
- Obtaining a medical history and conducting a physical examination essential
- Practice of call-back for re-assessment was inconsistent
- Variability in principle and practice of prescribing

4. FMES and brief interventions

This next section of the report focuses on brief interventions: FMES' knowledge and attitudes towards such interventions, the provision of brief intervention in the custody suite and targeting groups of 'drunken detainees' for brief interventions. It also focuses on training issues around brief interventions.

Knowledge and attitudes towards brief interventions

Attitudes and views regarding brief interventions were obtained. The FMES were asked whether they considered themselves the appropriate people to provide brief interventions to 'drunken detainees' and whether they believed that the custody suite was the appropriate venue to provide such an intervention.

Overall, the FMES showed little knowledge regarding brief interventions. Most did not understand the term 'brief alcohol intervention', although, six out of the 14 Principals knew what was meant by the term. Only two of the 11 FMES reported knowing anything about brief interventions. After the term was explained to them, most of the 11 FMES who completed the questionnaires reported never providing brief interventions in the custody suite (5/11) or in general practice (4/11).

Three Principal FMES reported clear views about brief interventions and one outlined their current practice:

Brief intervention is something that I already do. If a patient does want to talk we are able to offer that. I look on this job as a general practitioner in a different environment, and if I can help someone by talking to them and point them in the direction of help I'm happy to do it.

Another Principal FME expressed a similar approach, reporting that they take a history, and highlighted difficulties and follow-up with referrals to similar services. One Principal FME mentioned the idea of helping people by referring them back to their GP or providing them with leaflets.

Provision of brief interventions by FMES

Overall, FMES expressed mixed views concerning brief interventions, while most Principal FMES had clear attitudes and views about brief alcohol interventions and whether they were the appropriate professionals to provide them. However, five of the 11 FMES reported that they would be willing to provide brief interventions in the custody suite.

Table 5 shows the extent to which the 11 FMES believe that they should be involved in providing other services. The majority reported that FMES should be involved in

providing emergency health provision and intervening when a person's health is at risk. Most reported that they should not be involved at all in providing longer-term treatment, and there was little they could do in intervening with habitual drinkers. There were mixed views regarding the provision of brief interventions.

Table 5: FMEs' involvement in health provision

N= 15 (%)	Not at all	A little	Quite a lot	A lot	Don't know
Providing emergency health provision	1 (9)	–	2 (18)	8 (73)	–
Intervening when a person's health is at risk	1 (9)	1 (9)	4 (36)	5 (45)	–
Providing brief interventions	3 (27)	3 (27)	3 (27)	–	2 (18)
Providing longer-term treatment	7 (64)	4 (36)	–	–	–
Intervening with habitual drinkers	2 (18)	7 (64)	2 (18)	–	–

Several Principal FMEs expressed views about whether it was appropriate for FMEs at any level of seniority to provide brief interventions. Although they saw themselves as competent enough to provide them, they questioned whether it was their role, particularly if the detainees had not approached their GP. One Principal FME suggested that provision of nurses in the custody suite was an option, as they would be in a position to offer brief interventions when the detainee had sobered up.

Although Principal FMEs recognised the limitations to providing brief interventions there were some positive responses to their role in this area. One reported that:

You have to take a holistic approach by taking those with alcohol problems and bringing them into an environment where other professionals will see them.

Another Principal compared their role in dealing with 'drunken detainees' with other individuals they assess, and regarded the treatment role as intrinsic to their task:

Some doctors will say it's not my responsibility to do brief intervention as it's not what I'm there for – I think it's wrong. Looking at sexual assaults some don't even see that they have a role of brief counselling at the time. We are doctors and if I can help and stop these people coming it will make my life easier.

This view was supported by another Principal FME who expressed the view that FMEs should at least see what can be done and show the detainee that options are possible. A few commented that patient motivation was an important constraining issue, and that a lot depended on the patients wanting advice.

Although there was some uncertainty about the term ‘brief interventions’ a number of Principal FMEs undertook what could be seen as preliminary work to providing a formalised intervention. A few Principals mentioned that they would do something general or offer basic advice to the detainee about their drinking. Whenever there was an opportunity they would ask whether the detainee had been in contact with local agencies and if they were interested in receiving advice. Another Principal also mentioned that they believed that

A few choice words at an appropriate time could be very effective, especially if the recipient had respect for the advice giver.

However, negative views were also expressed. The most frequent reasons were ‘time constraints’ and having the ‘right opportunities’. Many Principal FMEs commented that the ‘drunken detainees’ were not receptive to advice at the time they were seen by FMEs, because they were still intoxicated. However, they did report that if they saw someone who was sober, or about to be released, they may talk to them about underlying problems.

Provision of brief interventions in the custody suite

Most FMEs (9/11) reported that the custody suite was not the appropriate place to provide brief interventions. However, several Principal FMEs agreed. They argued that interventions should be applied wherever contact with the detainee was made, irrespective of the location. A few Principal FMEs commented positively about the custody suite, viewing it as an asset and reported that some ‘drunken detainees’ were amenable to advice because they are so shocked to be there. Furthermore, detainees are often from hard-to-reach populations and the FME may be the only health care professional with whom they have any contact. If these detainees reappear regularly in custody contexts, this is indicative of a service failure.

Two Principal FMEs commented on relationships they form with those who reappear in custody and for these, there is therapeutic potential. However, this does not appear to be the case for all FMEs. Further problems mentioned included the one-off consultation and the lack of ongoing care, and the fact that advice given in the police station was seen to be unsatisfactory for both parties. Many claimed that brief interventions provided by an experienced worker outside the police station setting

might be effective. The view that any intervention requires ongoing contact was common, if inaccurate, suggesting that FMEs misunderstand the rationale of a brief intervention in public health terms.

One Principal FME commented on consistency of delivery, which he/she related to the FMEs motivation and interest in this topic, and argued that different problems are experienced in different areas of the country. While there might be more scope for brief interventions in outlying police areas, the demands on time in urban situations are so excessive that the FME really has to be motivated.

FMEs gave several suggestions as to how brief intervention might be carried out in the custody suite. These included conducting them during the course of the examination, at the review (where they occur) and generally by giving advice. Although this was not the case for all the Principal FMEs, one commented on when would be the appropriate time:

The opportunity I see is when you go back, because if they get arrested at 9 or 10 o'clock at night, and they are not fit for 4 to 6 hours, they are put into a sleep period and interviewed the following morning, the doctor will often get called for fitness to be interviewed, that is the chance to get in there.

Also, timing for the link role was regarded as critical particularly for referral and the motivation to change which also influences the content of any intervention. If the detainees do not think they have a problem the first task may be to get them to recognise that they do and that they want to do something about it. This may include providing advice, as well as educating them as to what is safe and suggesting that drinking more than the recommended weekly alcohol limit in one night might not be a good idea.

Most FMEs and Principals reported that it was inappropriate to offer brief interventions to detainees who were still intoxicated. Several commented on the kind of interventions that would be appropriate to the custody suite:

- sensible drinking advice
- local services information and advice
- referral to local agencies and services
- follow-up care.

Brief interventions for binge drinkers

Several FMEs and Principal FMEs suggested that young binge drinkers might benefit from some kind of brief intervention. One Principal FME reported that when detainees have sobered up they do try to talk to them, especially to the young binge drinkers, with whom they believed it was possible to do a brief intervention during the 15-20 minutes assessment.

Another Principal FME reported that the younger binge drinkers who had been violent might benefit from this approach because they are often remorseful about being arrested, for being drunk and having spent a night in the cells. At this point the FME reported that it would be appropriate to say 'what if you cut it down to 2 or 3 pints, not 10 or 12 pints'.

In contrast, another Principal FME reported that most young men who are drunk and incapable or aggressive are in no mood for a brief intervention and so no intervention would be appropriate because 'young fit men like to live dangerously and drink to excess'. However, this view is unhelpful for young men who won't seek help for their drinking, as contact with the FME may be the first and only intervention point.

Brief interventions for individuals with chronic alcohol problems

Many FMEs and Principal FMEs reported that they were not convinced that brief interventions in a custody suite would be beneficial for individuals with a chronic alcohol problem. Many Principal FMEs had clear views that brief interventions were inappropriate for this group of drinkers, as they are beyond help and need to contact their GP and be referred for an inpatient detoxification. The overall view was that the 'chronic alcoholic' would not benefit from a brief intervention, but needed ongoing medical treatment and a change of lifestyle, which is more than an FME could offer at an assessment.

However, even though many FMEs and Principal FMEs expressed this view, several commented that this group still needs support. This fundamental motivation to help may be channelled to brief intervention work, especially by linking chronic drinkers to services.

Targeting groups for brief interventions

The majority (8) of the 11 FMEs, reported that 'drunken detainees' would benefit from some form of brief intervention. Most FMEs and Principal FMEs suggested that 'all drinkers' would benefit from some kind of intervention, especially drink drivers

and those detained for domestic violence. Many FMEs and Principal FMEs reported that these groups of drinkers might be more receptive to a brief intervention, because they still have something to lose, i.e. their car, licence or their family.

Some Principal FMEs had some reservations about whether drink drivers might be receptive, because of the difficulties in communicating with drunken individuals. However, one Principal commented that detainees kept in custody for six hours might then be receptive. Another Principal FME suggested it might be more effective for drink drivers to see a counsellor before they got their licence back.

Funding brief interventions

Several Principal FMEs focused on the source of funding for a brief intervention programme in custody suites. One Principal FME reported that their duty was to the police, who may not be amenable to FMEs carrying out this sort of work on a routine basis. Similarly the pressures on FMEs make delivery of extra services problematic. The police would like them to see everyone but at the same time want to reduce funding for their service.

On the other hand a few Principal FMEs commented on the fine balance between medical need and financial gains. Obviously FMEs do not want to be seen to be doing things that are judged unnecessary in order to earn more money. Another Principal commented that a trained nurse could conduct much of their work. This would allow the police to save money, and the FMEs to focus on the important cases.

Appropriate management of ‘drunken detainees’

A wider issue regarding the appropriate management of ‘drunken detainees’ was discussed. There was a general feeling amongst both groups of FMEs that ‘drunken detainees’ should not be held in custody, especially those who were ‘drunk and disorderly or incapable’. Many commented on the fact that the police do not want to charge these individuals and that they are taken to the custody suite as a place of safety. However, the cells are not a place of safety for such individuals. That this was an old argument was emphasised in a comment about a Home Office working party that had recommended 30 years ago that detoxification centres should be set up in order to deal with public drunkenness (Home Office, 1971).

FMEs and Principal FMEs consistently highlighted the need for adequately financed specialist detoxification centres with properly trained medical staff. Another suggestion for improving the situation in police custody was to have full time GPs in the police station who could offer follow-up care. FMEs and Principal FMEs also

suggested custodial care attached to an A&E department, where detainees would be safer. One Principal commented that the Association of Police Surgeons have for many years been recommending, 'properly supervised, structured care of intoxicated people, by expert nursing or medical staff, but in custodial safety for both the detainee and medical staff'. However, the problem of cost and resources involved in such a scheme was recognised as a significant one.

The most radical argument advanced was that 'If you took drugs and alcohol off the agenda you could close most police stations - most of the driving offences are alcohol-related, most of the violence is alcohol-related, be it domestic, petty or whatever, the majority are drug- and alcohol-related crime'. Although the perception is that much of police time is taken up with substance-related issues, it may be more constructive to imagine the reduction in alcohol-related crime management as providing a window for the police to address other forms of crime and more proactive interventions such as crime prevention strategies.

Summary

The issues discussed in this section are summarised in Box 3.

Box 3: FMEs and brief interventions

Knowledge of and attitudes towards brief interventions

- Knowledge about brief interventions varied; mixed views on their effectiveness.
- Although some uncertainty about the term ‘brief intervention’ a number of FMEs were already providing something of this nature.
- Dominant issues concerning the provision of brief interventions in the custody suite included role legitimacy, time constraints and intoxicated state of the detainee.

Targeting groups for brief interventions

- ‘All drinkers’ might benefit from some kind of intervention, particularly: drink drivers and those detained for domestic violence.
- Young binge drinkers might benefit from some kind of intervention.
- Individuals with chronic alcohol problems less likely to benefit.

Appropriate management of ‘drunken detainees’

- Consensus that ‘drunken detainees’ should not be held in custody.
- Suggestions put forward were for: specialist detoxification centres; and units attached to A&E departments.
- Problem of resource constraint was recognised.

5. FME training issues and liaison with custody staff and local services

This section focuses on FMEs' training issues and the developmental role of FMEs. It also focuses on the liaison FMEs have with local services and custody staff and also includes FMEs' views on custody staff training needs.

Training issues for FMEs

Information on previous and current training needs was gathered from the FMEs. None of the 11 FMEs possessed the Diploma of Medical Jurisprudence (DMJ), whereas over half (8/14) of the Principal FMEs possessed the qualification. Several of the Principal FMEs lecture on the course or are DMJ examiners. One Principal FME reported that only 25 of the 130 doctors in the Metropolitan and City group in London have the DMJ qualification. FMEs with the DMJ reported that its drug and alcohol component offered adequate training, and contained enough training for the kind of problems with which they were likely to be presented in the custody suite.

Formal training is also supplemented by experience. Many Principal FMEs commented that being a GP was good background training, as general practice is full of alcohol problems. However, they reported that while GP skills are basic, skills over and above those of a GP are needed in order to carry out the FME role to a high standard. One Principal FME also reported that most of the doctors had been through the Metropolitan police training course, or the FAGIN (Forensic Academic Group in the North) training course, and should have enough knowledge about alcohol to care appropriately for detainees.

The majority of the 11 FMEs had received some kind of formal training in dealing with drunk or alcohol-dependent detainees, (such as: FAGIN and the DMJ study club, local FME training, lectures). Nearly all reported that they would like to receive further training in alcohol (9/11) and drug issues (10/11). Several FMEs reported that training on all aspects of drug and alcohol misuse would be beneficial, particularly focusing on assessment, referral and treatment of alcohol misuse.

Training and brief interventions

Most of the FMEs who completed the questionnaire (7/11) reported that they were not adequately trained to provide brief interventions. The perceptions of the Principal FMEs were, however, very different. Many Principals felt competent and adequately trained, but argued that training was not the key issue. The main concern expressed was that the custody suite was not the appropriate setting for a brief intervention.

Training was highlighted as an important and ongoing issue. There appeared to be a difference of opinion between FMEs and Principal FMEs regarding their own training issues and experience. Clearly this is an area that is currently being addressed by the Association of Police Surgeons.

Development of the role of FMEs

Over recent years there has been increasing debate about the changing role and workload of FMEs, particularly with respect to the issue of increasing specialisation and modernisation (Davison, 2000; de la Haye Davies and Stark, 1996; Wise, 1998).

Comments regarding the development of the FME role included:

- Greater specialisation needed; increased and improved training and development, for example, postgraduate qualification in Clinical Forensic Medicine
- Forensic medicine should be recognised as a speciality with national standards
- More evidence-based medicine required
- More focused approach to substance abuse, better liaison between services needed
- Closer integration with drug and alcohol units and psychiatric services needed
- FMEs not to be employed by the police but by a regional agency such as a teaching hospital.

Both groups of FMEs commented that a more focused approach to substance misuse would benefit them and the service that they provide. They were also clear about the need for better liaison and closer integration with drug and alcohol units in particular and with psychiatric services in general.

FME liaison with custody staff and training needs

All participating FMEs reported very good liaison with the custody staff. Principal FMEs commented on regular meetings with the police, while others commented that the police were supportive and that the custody suite was a more protective environment than general practice, where the doctor is alone.

Overall FMEs and Principal FMEs reported that the custody staff did not have enough training to deal with 'drunken detainees' and that custody staff varied in experience and views regarding individuals in their care. However, it was

acknowledged that the police had considerable experience in this field and that most police officers had the ability to know when detainees are drunk or ill.

The concept of a partnership between astute, experienced, trained FMEs and experienced, astute, trained custody officers looking after 'drunken detainees' when FMEs are not there was emphasised. High expectations are placed on custody staff in relation to monitoring detainees, as FMEs expect the custody staff to assess them, routinely check them and effectively make broad medical observations. However, much of this is based on common understandings of what is required. That is, if the detainee cannot be roused, they should be sent straight to hospital; if they are just roused or in a stupor state for more than four hours, then the doctor should be called.

FMEs and Principal FMEs commented on how liaison with custody staff could be improved with suggestions including multi-skilled workshops, joint training of FMEs and custody officers, multidisciplinary meetings and discussions. Other suggestions by Principal FMEs included improving communication by FMEs regularly attending custody users meeting groups and more joint training sessions. Training is an important area and the communication and liaison between the FMEs and custody staff is crucial.

Liaison with local services

Several FMEs reported that liaison with local drug and alcohol services was not very good, but that liaison with out of hours emergency services teams for mental health problems was good. These links were ad hoc and there were problems in communication links with local services and in the FMEs' perceptions of service effectiveness. However, one Principal FME claimed that while the links were good, this did not always lead to positive outcomes. While referrals are made, there is often a lengthy wait before such individuals are seen.

Although the FMEs and Principal FMEs did not report good links with local services, the majority reported that they routinely referred 'drunken detainees' on to other agencies, such as local community drug and alcohol teams, Arrest Referral Scheme workers and their GPs.

Liaison with Arrest Referral Scheme workers

Several Principal FMEs expressed the view that Arrest Referral Schemes (ARS) should also be extended to alcohol, although it was acknowledged that a few ARS already included alcohol in their remit. FMEs who had experience of the scheme operating in their stations expressed positive comments. Several Principals claimed

that the ARS at their station had been successful and that they met regularly with the worker. However, several commented that the presence of FMEs in the stations rarely overlapped with ARS workers.

This ad hoc nature of provision and the inconsistencies in liaison is an area which could be improved. The varying levels of awareness regarding other services, such as the ARS, should also be addressed.

Leaflets and information

Many FMEs and Principal FMEs reported that they did not carry leaflets around with them, but that there were plenty in the police stations. There was some support for the use of leaflets, although most commented that giving leaflets to intoxicated detainees was not helpful and that timing was important. A few Principals claimed that giving leaflets did not work, because most 'drunken detainees' will throw them away.

In summary, FMEs and Principal FMEs expressed mixed views and attitudes regarding leaflets and information and what they believed to be effective and worthwhile.

Summary

The issues discussed in this section are summarised in Box 4.

Box 4: FME training and liaison issues

FME training issues and developmental role of FMEs

- Wide variation in levels of qualification, training and experience
- Core training on all aspects of drug and alcohol misuse needed; assessment, referral and treatment of alcohol misuse particularly highlighted
- Consensus that a more focused approach to substance misuse was needed
- Better liaison and closer integration with local services
- Mixed views regarding the role of FME in delivering brief interventions

FME liaison with custody staff and perceived training needs

- Good liaison with custody staff was reported
- FMEs' view that custody staff needed specific training to deal with 'drunken detainees'
- Multidisciplinary meetings and joint training sessions recommended to improve communication between the two groups

Local services and information

- Inconsistent communication and liaison with local services
- Varying levels of awareness of other services; e.g Arrest Referral Schemes
- Extension of Arrest Referral Scheme to include alcohol
- Non-availability of Arrest Referral Scheme workers after hours a problem
- Mixed views and attitudes regarding leaflets and information

6. Police results

This section of the report focuses on the background of the police sample and reports on the issues and problems experienced when dealing with ‘drunken detainees’ and their contact with FMEs. It also focuses on police views and attitudes regarding the role of FMEs, brief interventions and training issues.

Police demographics

The police sample consisted of 15 police officers (12 males and 3 females) and comprised of 2 Chief Inspectors, 6 Sergeants and 7 Constables. Participants had a mean age of 35.2 years (range = 22-44, sd = 6.9), had been working in the police for a mean of 14.4 years, and had been in their current posts for a mean of 37.4 months. Chief Inspectors had been in the police longer than the Sergeants and the Constables. Over half of the sample (8), on average, spent between 10-40% of time per shift in the custody suite.

	Chief Inspector (n=2)	Sergeant (n= 6)	Constable (n= 7)	Total sample (n=15)
Male officers	2 (100%)	5 (83%)	5 (71%)	12 (80%)
Mean years in police force	19.5 yrs (range= 18-21)	13.5 yrs (range= 10-21)	13.7 yrs (range= 1-24)	14.4 yrs (range= 1-24)
Mean time in current post	10 mths (range= 2-18)	37 mths (range= 5-120)	46 mths (range= 1.5-180)	37 mths (range= 1.5-37)

Dealing with ‘drunken detainees’

The majority (9/15) of the police officers reported that between 40 and 70% of all detainees brought into the custody suite were under the influence of alcohol and that this peaked during the evenings and weekends. During the week the average number of ‘drunken detainees’ per shift was between 2 and 3 (range = 1-10). This increased to between 5 and 7 at the weekend (range = 1-20).

The police officers reported that the main problems posed by ‘drunken detainees’ related to safety issues, the need for extra monitoring and the delays caused in processing as a result of arrestees being ‘too drunk’ to be interviewed. Further problems included aggression, confrontation and verbal abuse. Additional work experienced by the police officers in dealing with ‘drunken detainees’ included more reviews and monitoring, dealing with aggressive behaviour, calling the FMEs and having to clean the cells.

POLICE RESULTS

The majority (12/15) reported that they do not like working with ‘drunken detainees’ (see Table 7), that this is not a rewarding group with which to work (13/15) and that most (12/15) had suffered injuries in dealing with violent ‘drunken detainees’. Many (9/15) agreed that the 4-hour sleep-off period caused unnecessary blockage of cells in the station. There were mixed views regarding morale and the processing of ‘drunken detainees’ and many (7/15) reported that dealing with this group ‘gets them down’.

N=15 (%)	Agree	Neither	Disagree
In general police officers do not like working with drunken detainees	12 (80)	–	3 (20)
I have suffered injuries from dealing with violent drunken detainees	12 (80)	1 (7)	2 (13)
Alcohol offenders are a rewarding group to work with	1 (7)	1 (7)	13 (86)
The 4-hour sleep-off period causes unnecessary blockage of cells in the station	9 (60)	1 (7)	5 (33)
Dealing with drunk offenders gets me down	7 (46)	4 (27)	4 (27)
Processing drunken offenders has a negative effect on morale	5 (33)	5 (33)	5 (33)

Police contact with FMEs

Almost half of the police officers (7/15) reported that more than 70% of alcohol-related offences were seen by FMEs; 5 reported that between 40-70% were seen, 1 between 10-40% and 2 did not know. The police officers reported that in a ‘typical week’ (defined earlier in the report) they called the FME on a mean of 22 occasions (range= 4-50, sd= 15.7). These calls were mainly related to fitness to be detained and interviewed, concerns about the safety and welfare of detainees and to assess any injuries.

The majority of the police officers reported that the FMEs provide a good service for the police (11/15). Just under half of the police sample (6) reported that the police get good value for money from FMEs.

Knowledge and attitudes towards brief interventions

None of the police sample initially knew what a brief alcohol intervention entailed. After the term was explained to them (defined as ‘one-to-one sessions, limited

assessments, advice and leaflet giving or setting goals), just under half (6/15) reported that FMEs should provide younger drunk offenders with advice. Other police officers supported FMEs providing leaflets (5), referring on to agencies (2), limited assessments (1) and providing talks on risk behaviour (1). Some officers were in favour of referring alcohol-dependent detainees on to agencies (4/15) and of providing leaflets (1). However there was a low level of support for brief interventions for this group (1). Many reported that FMEs should not provide any brief intervention to alcohol-dependent detainees as they were not sure how much this would help. Nearly all officers (14/15) reported that some alcohol-related offenders might benefit from certain forms of intervention. Only one person thought that no alcohol-related offenders would benefit. The majority (12/15) reported that FMEs were not the appropriate professionals to provide an alcohol treatment intervention for 'drunken detainees'. Many suggested that specialist alcohol abuse workers, specifically trained workers, and Arrest Referral Scheme workers would be better able to provide such an intervention.

Table 8 reports the extent to which the 15 police officers believed that FMEs should be involved in providing services. The majority (9/15) reported that FMEs should be involved in providing emergency health provision and most (9/15) reported that they should not be involved in providing longer-term treatment. As with the FME sample there were mixed views regarding the provision of brief interventions, although the majority (8/15) reported that they should be involved only to a small degree.

Table 8: Police views regarding FMEs' involvement in health provision

N= 15 (%)	Not at all	A little	Quite a lot	A lot	Don't know
Providing emergency health provision	1 (6)	3 (20)	5 (33)	4 (27)	1 (6)
Providing brief interventions	2 (13)	8 (53)	2 (13)	1 (7)	2 (13)
Providing longer term treatment	9 (60)	4 (27)	1 (7)	1 (7)	–

Provision of brief intervention in the custody suite

The majority (11/15) held the view that the custody suite was not an appropriate venue for any brief alcohol treatment. More appropriate venues were suggested, such as a treatment centre in a hospital, or a building with adequately trained staff, or community clinics. As with the FMEs, police officers also commented on the wider issue regarding the appropriate management of 'drunken detainees' (see Table

9). The majority (9/15) agreed that ‘drunken detainees’ should not be held in custody and that they should be managed in the A&E department. Also the majority (9/15) disagreed with the statement that ‘the custody suite is the appropriate setting for offenders with alcohol problems’.

Table 9: Appropriate management of ‘drunken detainees’

N= 15 (%)	Strongly agree	Agree	Neither	Disagree	Strongly disagree
Drunken detainees should be managed at A&E and not by the police	6 (40)	3 (20)	3 (20)	3 (20)	–
The custody suite is the appropriate setting for offenders with alcohol problems	2 (13)	1 (7)	3 (20)	3 (20)	6 (40)

Overall, the police officers reported that detainees brought in for offences such as domestic violence where drinking was involved, drunk and disorderly behaviour, breach of the peace (with alcohol), driving under the influence of alcohol and drunk in charge of a child should be dealt with in police custody. However, the majority (11) reported that detainees brought in for alcohol intoxication should not be dealt with in police custody.

Liaison with FMEs, Arrest Referral Scheme workers and training issues

All the police officers reported that good communication existed between FMEs and custody staff. The two police stations from which the sample was drawn had ARS workers. Most viewed the ARS in a positive light, although not all were optimistic about the scheme.

Only five of the police officers had ever received any formal training to deal with intoxicated or alcohol dependent detainees. Neither of the two Chief Inspectors reported receiving any training, while only two of the six Sergeants and three of the seven Constables had. The majority (9/15) of the police officers reported that there should be more training for custody staff dealing with ‘drunken detainees’. There were mixed views regarding dealing with ‘drunken detainees’ and on the adequacy of training to manage drunken offenders (7 agreed; 6 disagreed). Five police officers reported that they did not have enough training while five disagreed (see Table 10).

Table 10: Police officers' views on training issues

N= 15 (%)	Strongly agree	Agree	Neither	Disagree	Strongly disagree
I am adequately trained to manage drunken offenders	2 (13)	5 (33)	2 (13)	6 (40)	–
Police officers do not have the training needed for dealing with drunken detainees	2 (13)	3 (20)	5 (33)	5 (33)	–

Nearly all (11/15) reported that they would benefit from further training on drug and alcohol misuse, in particular treatment and assessment aspects.

Summary

The issues discussed in this section are summarised in Box 5.

Box 5: Police officers and ‘drunken detainees’

Dealing with ‘drunken detainees’

- A large proportion of detainees brought into the custody suite were under the influence of alcohol, the majority of whom were seen by FMEs
- Police reported regular contact with FMEs
- ‘Drunken detainees’ presented with a range of problems

Knowledge and attitudes towards brief interventions

- None of the police officers knew what a ‘brief alcohol intervention’ entailed
- Police officers agreed that younger drunken offenders might benefit from some kind of brief intervention; less support for alcohol dependent detainees
- Police did not consider the FMEs as the appropriate professional to deliver brief alcohol interventions

Provision of brief intervention in the custody suite

- Custody suite seen as an inappropriate venue to carry out any brief alcohol intervention
- Venues recommended for brief intervention included treatment centres in hospitals, units with adequately trained staff, or community clinics

Police liaison with FME, ARS and training issues

- Good communication between FMEs and custody staff was reported
- Minimal training to deal with ‘drunken detainees’ was reported
- Custody staff needed more training in general drug and alcohol issues

7. Conclusion

Overall findings

It is important to note that the number of 'drunken detainees' assessed by the FMEs varies substantially according to location (urban versus suburban/rural), but also that the frequency of contact is contingent on the time of day, and day of the week. These factors influence not only how busy the station is but also the amount of time available to the FME. Overall both groups of FMEs (Principal FMEs and FMEs) had similar views regarding their main role as an FME and similar problems and issues were raised by both groups with respect to dealing with 'drunken detainees'. These included violence and aggression towards them, detainees vomiting and withdrawing and factors related to the state of the detainee. They also reported on the possibility of injuries and the problems encountered in gaining a good medical history. Similar problems were raised by the police officers, although the primary concern for both FMEs and police officers relates to deaths in custody.

Study limitations

The issues raised and addressed in this report are based on a consistent methodology and an open and participative research approach. However, there are a number of limitations in study design that should prevent excessive generalisation of the findings. The first relates to sample size and is a consequence of the inevitable limitations of feasibility studies – only a small proportion of FMEs and Principals participated in the study leading to some doubts about their representativeness, a criticism that could also be levelled at the police sample. Similarly, the method was qualitative and exploratory, and raises the possibility of limitations associated with both the demand characteristics of face-to-face interviews and expectation sets on the part of respondents. Another significant limitation is a lack of clarity about alcohol treatment in general and brief interventions in particular. This may have led to some confusion about what was being discussed and some inconsistencies in interpretation. However, the aims of the study, which are to assess the salience of the issue and to outline some of the possible ways forward, have not been fundamentally compromised by these limitations.

Application of brief interventions for alcohol

There are differences in knowledge and awareness between the Principal FMEs, FMEs and police officers regarding their awareness of brief interventions for alcohol problems and their perceptions of their own training. While Principal FMEs were familiar with brief interventions and felt suitably trained to deliver them, this was not the case for most of the other FMEs and police officers. A variation in views and attitudes towards brief interventions was expressed, with many questioning whether it was part of their role or even whether they in principle should be working with

CONCLUSION

this client group. This was reflected in the suggestion that the task should be delegated to nurses, custody officers or Arrest Referral Scheme workers. However, other Principal FMEs expressed the view that it was something they already provided whenever the opportunity arose and that they were quite happy to do this work. This highlighted an inconsistency concerning the role of the FME, with some offering additional patient care while others were unwilling to do so, although this frequently reflected variations in time available.

There is evidence from Wright et al (1998) that it is possible to provide brief alcohol interventions in a similar environment, such as an A&E department in London. Although the sample was small, almost two-thirds of those with an alcohol problem who were recruited to a brief intervention study showed drinking reductions at six months follow-up. There is further evidence (Peters et al, 1998) that alcohol screening is another possibility in a frantic environment where many of the admissions are intoxicated. Both studies suggest that, while there will be many people who are too intoxicated to be assessed, or to receive a brief intervention, for those who can be included, this form of intervention may have a medium-term positive impact on their drinking.

For those who are unable to receive either screening or a brief intervention at the time of detention, this does not preclude any form of contact although the costs involved may be prohibitive. One possibility would be a follow-up visit or phone call from an alcohol worker which could take the form of both a health check and brief alcohol intervention. Arrest Referral Schemes including alcohol in their remit could potentially follow-up problem drinkers identified by FMEs, assess them and deliver a brief intervention shortly after their departure from the police station.

From the information gathered it is clear that many FMEs do already provide some form of intervention. However, the form that this intervention takes varies widely, and includes the provision of advice, referral to local agencies, liaison with Arrest Referral Scheme workers, and motivational enhancement work. At present, these interventions are often provided on an ad hoc and opportunistic basis. The main concerns expressed by FMEs regarding brief alcohol interventions, were similar to those stated by Deehan et al (1998a). These concerned role legitimacy (whether they were the appropriate people to deliver a brief intervention and whether the police station was the right place), role adequacy (whether they were equipped to deliver brief intervention) and the extent of available support. Deehan et al (1998a) particularly emphasised that the time constraints on FMEs and their perceptions of their role rendered more extensive interventions problematic. FMEs, in this study, also expressed concerns associated with time constraints and the fact that many

detainees were intoxicated when seen by the FME. Many felt that the delivery of such an intervention would not be appropriate, and did not fit well with the assessment of the 'drunken detainees' and that it would not be well received.

A further problem with delivering more intensive interventions relates to safety issues. A proportion of intoxicated detainees, are sent on to A&E soon after they arrive in the custody suite, while those detainees who do not have to go to hospital may manifest levels of intoxication that preclude extensive health interventions. These factors support concerns that the custody suite, in its present form (ie in the absence of medical personnel), may be an inappropriate place for 'drunken detainees' to be housed and, as a consequence, a problematic venue for ensuring the safety of both FMEs and detainees.

The problems of providing treatment

Several of the FMEs in both groups had difficulty in coming to terms with the idea of a brief intervention and many frequently mentioned ongoing care. Alcohol treatment was seen as a long-term project involving repeated contact and the value of brief interventions was not understood (despite the research evidence). This finding reflects their experience in general practice. Those GPs who did not deliver alcohol interventions in custody were also failing to do this work in their own practices. Some GPs clearly regard addiction treatment as a specialist task for secondary services and regard their role as primarily providing primary care. This highlights the need for FMEs and GPs to change their attitudes towards the effectiveness of brief interventions and their own role in their delivery.

The issue of being called back to re-assess 'drunken detainees' provoked mixed views, with many FMEs reporting that they were rarely called back to re-assess someone. This is critical, as a call-back assessment could be an ideal time for an FME to provide a brief intervention, as the detainee is more likely to have sobered up enough to participate. The whole intervention need take no longer than 10 minutes. This would also enable the FME to work in a more relaxed and interactive manner with a more receptive detainee.

However, the wider issue regarding the appropriate management of 'drunken detainees' was discussed by the majority of Principal FMEs, who reported that 'drunken detainees' should not be kept in the police stations. Many Principal FMEs and police officers had clear views on this issue and suggested more appropriate places, such as specialist centres with medically trained staff and units attached to A&E departments, rather than police stations.

Training needs

Training is an issue that needs to be examined for FMEs and custody officers. The Association of Police Surgeons is currently concerned with the variations in qualifications, training and experience among FMEs. Now that more Principal FMEs possess the Diploma of Medical Jurisprudence (DMJ), and several lecture on courses or are DMJ examiners, training may not be the central issue. However, none of the 11 other FMEs possessed the qualification, and nearly all reported that more training on alcohol and drug issues would be helpful, especially focusing on assessments, referrals and treatments. This was also an area of concern for the police officers, as only one third of the sample reported that they had received any formal training to deal with 'drunken detainees'.

Increases in specialist training and in the co-ordination of FME work with local treatment providers and ARS workers would be beneficial. However, the key requirement is a systematic analysis of the process and outcome of brief alcohol interventions in the custody suite setting. There is considerable variation in the provision of brief interventions, which may reflect issues of time, confidence, competence and role perception. However, as this may be the only opportunity for delivering or initiating alcohol treatment to this group, it is imperative that a consistent and effective approach be introduced in custody suites. This would involve assessing the impact of brief alcohol interventions and disseminating the results to FMEs so that, when appropriately trained, they could deliver the most effective intervention possible in the limited time available.

There are concerns about the status and role of the FME that would make the delivery of brief interventions potentially problematic. Especially with regard to the limited nature of the contractual arrangement between the police and the FME, where the primary aim is to assess fitness to detain and interview and to ensure the detainees' safety. However, this does raise a wider ethical issue about the need for appropriate follow-up to ensure ongoing safety that extends beyond the issue of alcohol consumption and dependence to a wider question of the health-promoting role of the FME.

Recommendations

Several recommendations can be derived from this feasibility study. More national data are needed to assess the level of the problem and alternative methods of managing 'drunken detainees' considered. More accurate data are required on the number of 'drunken detainees' assessed by FMEs, and the number of such detainees processed through the custody suite by police officers.

A clearer definition of 'drunkenness' is required. Many less experienced FMEs may benefit from having an operational definition, particularly if this could be linked to a brief and simple screening method to assess the extent of the problem. This could contribute to a Code of Practice for dealing with this population.

A systematic analysis of how brief interventions could be tailored for use in the custody suite setting and of their effectiveness in this setting is needed. At the basic level it is important to know what FMEs do, also under what circumstances and with what impact. This would permit the components of brief interventions (advice, onward referral, information, etc) to be assessed independently as well as in combination and therefore evaluating which of these components are particularly effective. This might result in a range of brief intervention strategies. One model might be to recall detainees shortly after the offence (e.g. one week) for a brief intervention, which could be delivered by a custody officer, an FME or other nominated person.

FMEs should have a clearer understanding of the effectiveness of brief interventions and the wider public health impact of such interventions. Most of this work has been carried out in primary care settings. Therefore, the widespread effectiveness of the brief intervention approach (across a range of contexts and deliverers), and particularly its relatively low demands on providers, should be widely communicated to FMEs. A wider distribution of relevant literature about the structure and effectiveness of brief addiction interventions to FMEs is necessary.

FMEs and police officers should establish better integration with drug and alcohol services, and should work more closely with Arrest Referral Scheme workers in stations that have this facility. This should be particularly highlighted for those with repeated contact (regular detainees) and those whose offence may make them appropriate for early interventions (drink drivers and young offenders).

As with the ARS, outcome evaluation is required to analyse not only whether FME-delivered brief interventions can be effective, but if so, under what circumstances and for what offender populations. There is a general issue of awareness-raising around the range of methods and strategies that would constitute a brief intervention and it is the assessment of the grounded effectiveness of each of these that is urgently needed.

Appendix: Areas covered by respondents

Areas covered by both groups of FMEs interviewed in London included;

- Barnet, and Borehamwood, Hertfordshire
- Hackney, Stoke Newington and Islington, King's Cross
- Ilford, Chingford and Leyton
- Kentish Town
- Redbridge and Waltham Forest
- Sutton, Wimbledon and Wandsworth
- Southwark, Walworth, Peckham, Kennington and Belgravia
- South West London, Kingston, Richmond

Areas of Principal FMEs that responded outside London included;

- Brighton
- Bristol
- Glasgow
- Ipswich
- Manchester
- Northampton
- Sheffield

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