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RESEARCH ARTICLE

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Opportunities for intervention for alcohol and other drug use problems for men before prison: A qualitative study

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Abstract

Research into opportunities for prevention including health promotion information about alcohol and other drugs (AoD) harms for people who go to prison is sparce. This is despite there being ample research reporting how much and how frequently AoD have been used by people who go to prison. This article describes results from a qualitative thematic analysis of interviews with 31 men in a Sydney prison, about where they first received health promotion information about AoD-related harms and their first-ever treatment episode. No participant reported receiving education on AoD harms or treatment support services in primary school or high school. Only one participant received their first treatment episode through a health service (in his case from a doctor) and none reported being screened for AoD use at a health service. Almost all (n = 27) participants had their first session with a trained AoD professional through the criminal justice system. Pro-active screening in health services for AoD use disorders and referral to appropriate health services is needed.

KEYWORDS
alcohol and drug treatment, health promotion information, inmate, prevention, prison

1 | INTRODUCTION

Alcohol and other drug (AoD) use problems, poor mental health and chronic diseases are more common in the prison population than the general Australian population.[1] People in prison also tend to have had multiple disadvantages when in the community, including housing instability and difficulty finding employment.[2,3] For many of this population they come from a childhood background of disadvantage that continued into adulthood.[4,5] This can mean that, for some people, prison is a place where they can access regular meals, a roof over their

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head and a bed to sleep in. One can also access health promotion information or health care services, including mental health care and be referred into AoD treatment programs while in prison.[6]

At least two thirds of people in prison have had some form of AoD use problem in the community prior to prison.[1,7,8] AoD treatment programs are available in prison and there are post-release support programs that can potentially be accessed.[6,9] Courts also have AoD programs which aim at diverting people away from prison into treatment.[10,11] Although some prison-based, post-release support and diversion AoD programs have been evaluated.[6,12,13] With such a large proportion of people in prison having some form of AoD use problem there is a need for further research into these programs to augment them to better meet the needs of this population.

The research into the prevention of AoD use problems for people who go to prison in Australia is sparce. Prison-based AoD treatment programs are in a sense tertiary treatment, as such, what were the opportunities to prevent AoD use, or to treat use before regularity and quantity used increased. This study describes the first AoD health promotion information/education received, and the first treatment episode attended for a group of 31 men in a prison-based AoD treatment program. The aim of this study was to gain a better understanding, of men who go to prison that have AoD use problems, their experiences of first learning about AoD issues and their experiences of first AoD treatment.

2 | METHODS

Thirty-one men, of whom 14 identified as Aboriginal, participated voluntarily in an in-depth interview in 2014, conducted by the first author at a Sydney prison. Participants were told the research was part of the first author's PhD project.[14] The first author had not met any of the participants previously. He introduced himself as being Aboriginal and discussed his interest in AoD treatment approaches in prison which included having family members affected with these issues; and having worked with Aboriginal men in prison and post-release while he was an Aboriginal Health Worker in Aboriginal Community Controlled Health Services. The original PhD study used a grounded theory approach to develop understanding of prison-based AoD treatment,[14] other data from the PhD are reported elsewhere.[4,15] This paper presents a thematic analysis of a subset of the original data.

Ethics approval was granted from Corrective Services NSW (CSNSW) Research Ethics Committee and the Aboriginal Health and Medical Research Council of NSW, Human Research Ethics Committee.

2.1 | Recruitment

The size of the proposed sample had to be nominated at the time of the ethics application to CSNSW. A sample size of 30 was proposed as it would be large enough to gain meaningful data for analysis. The final sample of 31 is because two men both wanted to participate on the final day of the interviews. At the time of the interview, the participants were enrolled into, but had not started, an intensive 6-month AoD treatment program and were unaware that this research project was taking place.[16] Eligibility for the AoD program required that participants; i) had not been diagnosed with acute mental ill health; ii) were medium or low-security classification; and iii) were assessed as having used AoD at levels appropriate for treatment.[16] The only study specific selection criterion were having capacity to provide informed consent. The sample was recruited by the first author, with potential participants approached in consecutive order from the first arrival at the treatment program. There were only seven refusals to take part and as per ethics requirements, these men were not asked why they refused.[17] Participants were not compensated because at that time it was not allowed by CSNSW, but nonetheless were willing to participate because it might lead to improved AoD treatment approaches for people in the criminal justice system.

2.2 | Data collection

The open-ended interview guide was developed through a process of consultation with health professionals and corrective services staff, and after reviewing existing AoD treatment program literature and questionaries.[18–20] There were eight subjects/questions in the interview, other than demographics, AoD use and offence data. The data presented here arose from the question "Have you ever been referred to and/or attended AoD treatment before prison?" The conversation was free flowing, and prompts were usually not necessary. Interviews generally lasted 45 to 60 minutes and took place in an interview/counselling room with only the participant and the first author present. Interviews were audio-recorded and professionally transcribed.

2.3 | Analysis

There was a three-stage analysis process. Stage 1) was a review of the data from the original analysis related to AoD use, education and treatment prior to criminal justice system involvement. Stage 2) involved recoding the reviewed data. Stage 3) analysis of recoded data to identify the patterns/themes.[21] The process was led by the first author who revisited the original transcripts from the 31 participants frequently to ensure that the meaning of the extracted data was consistent with the meaning in the original interview. The software program NVivo 11 was used to assist with the analysis.[22] Pseudonyms have been used to help protect the identity of participants.

3 | RESULTS

3.1 | Participant characteristics and alcohol and drug use

Participants were aged between 18 and 47 years, with nearly half being under the age of 30. The majority were from Sydney

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TABLE 1 Participants' living arrangement before prison (n = 31)

Parent/s	Parents and extended family	Partner	Partner and children	Between parents and partner	Living alone
9	5	3	8	2	4

(n = 18) with there being six from regional cities and five from towns in New South Wales, with two participants from interstate capital cities. Prior to imprisonment, nine men lived with their parents and four lived alone including one man who was homeless (Table 1).

Fourteen of the men had current partners (all women), with another nine being estranged from their previous partner/s (all women), of these 23 men, 22 had children. There was also one man who had a child with a woman he had not had a relationship with. Proportionally about the same number of Aboriginal and non-Aboriginal men had children. Of the men without children, only the Aboriginal men spoke of other family child-caring responsibilities, either caring for younger siblings or helping with the care of their nieces and nephews.

Three men were serving their first prison sentence, nine their second and 18 had been in prison three or more times. The offences for their current term in prison varied and included driving while under the influence of alcohol, stealing (food), assault, break and entry, and robbery. All but one believed their AoD use was a major contributing factor to their offence and subsequent imprisonment.

Twelve men spoke of growing up around dysfunctional alcohol consumption and cannabis use by parents and other adult relatives. Five of the men had been removed by government services from their families as a child; with parental AoD use possibly being a contributing factor toward their removal. Mark spoke about his mother's drinking:

> Mark: like my mum's an alcoholic, you know, so she was never at home. She was always at the pub.

Mark discussed his family and said his siblings were removed by the Department of Community Services (DoCS).

> Mark: DoCS got involved and like I got, I got deemed ward, ward of the state or some shit. … … you know what I mean.

In relation to their own AoD use, their first alcohol consumption was around the age of 13, with cannabis used shortly afterwards. Heroin and amphetamine use began for most between the ages of 16 to 20 years. The most commonly used substance when last in the community (excluding tobacco) were heroin and alcohol. Polydrug use was common with one-third of the men using a combination of alcohol, cannabis, amphetamine or heroin, and whatever else was available, which included cocaine and non-prescribed buprenorphine (Table 2).

3.2 | First information/education on alcohol and or other drug harms

Participants all discussed where, and from whom, they received their first information/education about harms from AoD use. As part of this section of the conversation they also discussed, or were prompted if needed, about receiving information/education about harms from AoD use in school. None of the participants had received education, including health promotion information while in either primary or high school. When Luke asked said, "Not that I remember" and Jim thought back to when in school and said:

> Jim: There was, unless I've forgotten, there wasn't much in schools. There wasn't much programs. There wasn't anything like that, you know.

However, many of the men only attended school sporadically which may have limited the opportunity for AoD education.

Two of the men received information, while in out-of-home care, at what they described to be 'a boys home'. Ten participants first received AoD harms information while in prison (Table 3). Six received their first information about AoD use harms from court staff, although the interaction may have been more of a referral, than actual education, to an AoD service. Four participants (two of whom were Aboriginal) were first told by their parents, two by their fathers, one by their mother and one by both parents together. Jim's, who is one of the Aboriginal participants said his mother spoke to him but not in detail about AoD.

> Jim: My mum had talks with me about it, you know. [Yeah] My mum wasn't, wasn't stupid.But to have detailed information, nuh.

Seven others reported having had a conversation about AoD harms with parents but only after they had received information from other sources. Adam's parents spoke to him together because drug use was already a problem with his sister:

> Adam: Like my parents know about drugs, you know, 'cause my sister she's a heroin addict.She was using in front of me since I was five years old. So … they tried to steer me in the right path.

For two men their uncles were their first source of information, both of these men were Aboriginal. Rob spoke about his uncle:

> Rob: The first time anyone talked to me about drugs is, Dave – my dad's first cousin. … … … He said a good

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TABLE 2 Most commonly used alcohol and or other drugs when last in the community (excluding tobacco)

Primarily used (n = 21)	Alcohol 4	Cannabis 2	Amphetamine 4	Heroin 11
Primary with other (n = 10)	Alcohol + other 3	Cannabis + other 2	Amphetamine + other 4	Heroin + other 1

TABLE 3 First information/education on alcohol and or other drug harms (n = 31)

Source of information	Number of participants
Prison	10
Court staff	6
Parents	4
Other family members	2
Out of home care	2
Alcoholics Anonymous	2
Aboriginal men's group	1
Adult residential rehabilitation	1
Youth residential rehabilitation	1
Peer drug user	1
Television	1
School	0
Total	31

TABLE 4 First AoD treatment episode for alcohol and other drugs with a trained professional (n = 31)

Location	Number	Provider
Prison	12	CJS
Court ordered community-based treatment	7	CJS
Treatment in or as a condition of release from juvenile detention	5	CJS
After court appearance, community-based one-to-one	2	CJS
Residential rehabilitation—adult	2	Community
Residential rehabilitation—youth	1	Community
Doctor	1	Community
Never previously attended treatment	1	N/A
Total	31	–

> percentage of people who grow up around people who smoke pot (cannabis) or take needles, or drink alcohol, they're gonna be exactly the same.

Rob's uncle, Dave, went on to warn him about how drug use can make life hard and that it is best not to use drugs. Rob was 28 at the time of interview but he remembered the conversation with his uncle well:

> Rob: I was young. About seven or eight, or something. I remember when he said it to me 'cause I was sitting in the room. He come in with his glass eye. F.... Dave ..."Yeah, and drugs, drugs make things hard and f... people up don't take them."

Another two received their first information about harms from alcohol at alcoholics anonymous (AA) meetings. Each attended AA with a male relative while they were still in their adolescence, though neither remained in AA. Dan talked about his experience:

> Dan: Like for Kooris (Aboriginal people) they go and do AA meetings and stuff like that ...My uncle took me to one.

At the time Dan had been summonsed but had not yet appeared in court for an offence related to alcohol, he wanted to take a proactive approach by going to AA. Three other places where participants received their first information were mentioned: an Aboriginal men's group, an adult residential rehabilitation service and a youth residential rehabilitation service. The man who attended the Aboriginal men's group, Ed, met an AoD specialist doctor there:

> Ed: Used to go there [Aboriginal men's group] and participate with the, with the elders. And it was funny because they had a doctor come along.

Ed, later attended an appointment with the doctor and was put on naltrexone (opiod substitution treatment). None of the men spoke of being screened for AoD use at a health service. One of the men had quite a different experience, Sam received his first information from a peer drug user:

> Sam: The person that introduced me to the heroin was saying, "Look, you've gotta slow down. You're gonna get a habit." I didn't know what a habit was ... I'm going, "No, it's all right, you know. ... when I wanna stop, I'll just ... stop" And they're going, "No, you can't. It's not like that with heroin." And I said, "No, it's all in your mind," ... I didn't realise that it wasn't all in your mind, that your physical symptoms, you get sick, you know.

There was just one participant who reported he received his information from media, in this case television. It appears that as adolescents transition between care environments whether it be home, foster care, juvenile detention or a boys home was common for the participants. Three of the Aboriginal men received their first education about AoD harms from uncles or Elders, which highlights the culturally different approach Aboriginal families have to caring for younger members of the family.

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3.3 | First treatment episode for alcohol and other drugs with a trained professional

The first treatment episode for AoD with a trained professional was usually not the same place where they received their first information about AoD-related harms (Table 4).

Only four of the participants had attended their first treatment episode, whether a facilitated group program or one-to-one consultation with a health professional, independent of the criminal justice system. Each of the four men spoke about being pressured or made by family members to do something about their AoD use. Of the four, one man went to a medical doctor, one was sent to a youth residential rehabilitation service, two self-referred (under pressure from family) to adult rehabilitation services. Owen described how he was pressured by his then partner to go into residential rehabilitation:

> Owen: It was more my family pushing me into it, 'cause that was … … the mother of my kids, and I had one kid and then the next was on the way … She was pregnant with my boy and the family are going, "Oh we know that you're a … drug addict and, you're shooting up.We found out. And it's about time to fix it."

3.3.1 | Treatment while in or as a condition of release from juvenile detention

Five participants attended their first treatment while an inmate or as a condition of release from juvenile detention. Tom spoke about how he went to a youth AoD rehabilitation unit so he could get out of juvenile detention:

> Tom: Through juvenile, like through, like I'd go to juvie and then I'd get bailed to … like the only way I could get bail is to a rehab, so I'd just take the opportunity of getting bailed to a rehab … just so I could get out of gaol.

At the time of interview Tom had been through the process of going to detention/prison and getting bailed to go to a rehabilitation unit several times.

3.4 | Court ordered or directed community-based AoD treatment

Two participants were compelled to attend community-based treatment by family members after they had been to court. Joe was pressured by his mother to go to a psychologist whom she had sourced:

> Joe: I went to a psych and talked to her. It was through my mum … they get given some sort of help [by employer] for themselves and for family members. I got them six sessions for free but I only used two.

Seven attended treatment in the community after being told to do so by the court under threat of imprisonment. Three of the seven men were before the Drug Court, which aims to give offenders opportunity for treatment prior to sentencing.[11]

Jack was told at a court appearance to get help for his drug use, but neither he nor his partner had any knowledge of where to go. They looked for a number to call in the phonebook:

> Jack: When I was charged with the offence. I came clean to my family that I was on drugs. They asked me to go to rehab or leave the house. I signed up to a rehab. … … My wife said, "Get off the drugs or I'm leaving you". …. My wife, called the hospital …First author: How did you find that number?Jack: I think the drug, one of the drug counselling numbers… 1800 or 1300 or something.In the Yellow Pages [printed telephone directory].

Unlike Jack, the other men were given AoD service contact details by court staff, and then these men had to make their own arrangements directly with the AoD services. The three who went to Drug Court were given information and referrals to counsellors by Drug Court staff. Adam had not had any previous AoD treatment and was referred to treatment by Drug Court staff:

> Adam: Well I've never, done like drug counselling or nothing like that before. You know what I mean? … they put me on, I was on Drug Court. I only lasted two weeks 'cause an incident happened there. And I got kicked off Drug Court.

3.4.1 | First treatment episode in prison

Twelve of the participants attended their first-ever behavioural AoD treatment episode in prison. Two of these men had been ordered to community-based treatment but did not attend and were subsequently imprisoned. In court, Jess had been placed on the Magistrates' Early Referral Into Treatment (MERIT)[10] program as a condition of bail:

> Jess: Yeah, but I got put in like through court and MERIT, and all that, but … I just didn't go … … I just got on drugs.

Jess did not attend any sessions and was subsequently sentenced to prison where he had his first group treatment episode.

For several of the men going to prison brought about access to treatment. Sam discusses his experience:

> Sam: I was sick when I come in. Like they ask ya, "Are ya affected by any drugs?Are you hanging out from

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> any drugs?" and that's when I said, "Yeah, I've … got a heroin habit, you know. I need help … I need to get on the methadone or something." And they offered me the methadone

Sam had wanted to access treatment previously but was unsure of the process; going to prison provided an opportunity to start methadone treatment.

Alex was told by the court he needed to undertake AoD counselling. He was placed on bail and told about an AoD service by court staff.

> Alex: Like I just went and signed up for it. It was just, I think it was a drug and alcohol program in I think … it's next to the … … Hospital. I think maybe Kogarah (a Sydney suburb) or that area

Alex did not attend his first appointment and at the time of interview had never attended an AoD treatment episode.

4 | DISCUSSION

There were early missed opportunities for health promotion information aimed at preventing hazardous AoD use. For the majority of participants, these missed opportunities included home-based education from parents or carers including other family members, general health promotion information through the media and targeted health promotion information in school. In terms of missed opportunities for a treatment episode, including a brief intervention with a health professional, none of the men spoke of being screened for an AoD use problem while attending a health service. One man did get help from a medical doctor, but he was there specifically to discuss his drug use with that doctor. It appears that in this population the criminal justice system may well be the default AoD treatment service provider.

Six of the men were provided information about AoD harms by family members, four of these six were Aboriginal men. In the context of our findings, Aboriginal families are more likely to speak to or educate their children about AoD harms than non-Aboriginal families. In terms of the first-ever treatment episode with a trained professional, 26 participants had their first treatment episode with a health professional arranged through the criminal justice system. In the general population it takes on average 18 years for help to be sought for alcohol dependence.[23] Criminal offending is a recognised catalyst for treatment,[24] for the men in this sample and possibly many others in a similar situation, going to prison has likely brought about treatment earlier than otherwise may have occurred.

4.1 | First health promotion information/education about AoD harms

Parents for many people are the first source of information about AoD harms and the first influence on social views and behaviours when using AoD.[25] Information and education from parents to children about AoD harms can reduce the likelihood of future harmful use.[26,27] Four of the participants were informed about AoD use harms as a warning by parents and another two men, both Aboriginal, had been warned by other family members, in both cases uncles. Culturally, uncles play a role similar to a father in Aboriginal families and often provide education and guidance to children. There were five other men who said they had a conversation with their parents about AoD use harms but only after they had already received information from other sources.

It appeared that many of the men had difficult childhood environments with overuse of AoD being common within their families. Not every child raised by parents who drink alcohol excessively or use cannabis and possibly other drugs takes up such use themselves, however, unfortunately, intergenerational AoD use problems are not uncommon.[4,28] The provision of support and treatment for parents with AoD use problems could help reduce stress on the household and provide parents with information and education that they can potentially share with their children.[29] Twenty-three of the men had children of their own, which is common for most men in prison, this represents an opportunity to support these parents and provide them with educational material that could help them speak to their children about AoD use harms. It is not clear if such work is already undertaken in Australian prisons, and research to better understand this is required.

For five of the participants (all Aboriginal), the AoD use by their parent/s was of such concern that it apparently contributed to them being removed from their families when they were young children. The risk of intergenerational AoD use problems for young people in the care of government departments is already known.[30] Interestingly though, there was no indication from any of these men about receiving any information or health promotion messages about AoD harms from the government department, either by staff or foster parents. One of these men was warned about AoD use by his parents who he said were under the influence of alcohol at the time, and another was one of the men spoken to as a child by an uncle. The important role of Aboriginal men's groups discussing AoD use is shown here, because the Men's group was the first place one of the men who had been removed had received information. The other two Aboriginal men received their first AoD harms information through the criminal justice system.

Government departments that are responsible for child protection should, when a child is deemed at risk or is removed from their family of origin, ensure that age-appropriate preventive measures, including information/education is provided to the child. There are many resources developed to help parents speak to their children about AoD use weather such use be experimental or ongoing,[26]; these resources could be used by foster parents or departmental case workers. Departments should also consider if they need to refer children into one-to-one counselling about AoD use.

None of the participants recalled receiving health promotion information at school about harms of alcohol and/or drug use. School-based AoD education can have an effect on later behaviour, for example, school-based alcohol prevention has been found to reduce drinking frequency.[31] Education with an emphasis on social

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learning, and programs which increase young people's connectedness at school have shown particular promise.[32,33] As most of the men left school relatively early it could be that they missed opportunities at the time to attend any AoD health promotion information/education programs. It is important to find alternatives to school to provide timely and meaningful health promotion information such as youth groups, youth outreach services or in juvenile detention.

4.2 | First treatment episode for alcohol and other drugs with a trained professional

None of the participants decided to attend their first treatment episode of their own volition. The men had been pressured by family or forced/coerced by the criminal justice systems to attend treatment, as such AoD use problems were well progressed before they received help. Attending AoD treatment involuntarily has been found to be less likely to lead to effective treatment than attending voluntarily.[34,35] It can be difficult for an individual to come to the realisation themselves of having an AoD use problem. Difficulty with family relationships and trouble with the law are recognised as catalysts for change as it could mean the individual reflects on their AoD use.[24,36]

Once an indervidual decides they want help for AoD use problems, it can be difficult for them to access treatment and support services in the community. There are limited numbers of withdrawal support and management beds in the health system and it is not unusual to have to wait several days, or possibly longer for a place.[37,38] Furthermore, it can take a week or a couple of weeks for a placement in a residential rehabilitation service.[37,38] For those wanting to go from a withdrawal management unit into a residential rehabilitation service, coordination and the timing is often difficult, with there being delays of days or even weeks between leaving one service and entering the other, which is a vulnerable time for relapse.[37,38] In contrast, after prison intake assessments, referral pathways can be triggered for education, group or individual treatment programs.[39] There are few places in the community where withdrawal services, one-to-one counselling, group programs as well as accommodation are all provided.[6,12] In the community, withdrawal support, education programs and residential care are usually offered by separate services.[6,40,41] Continuity of care between these services can be a problem, and gaps between each are additional opportunities for relapse to AoD use.[6,40,41] There is a need for greater coordination of the existing community-based services and for there to be more services that can offer both clinical withdrawal as well as behavioural treatment for AoD use problems.

A common way to be referred into AoD treatment in the community is by a doctor in general practice.[42] Only one of the men in this study met an AoD doctor, and that was at an Aboriginal men's meeting and he later attended an appointment with that professional. Men do attend health services, albeit generally less than women, and screening for AoD use should occur on a regular basis at health services.[43,44] Clearly this was not the experience of the men in this study. Assessment and screening by doctors for the men in this study, could have resulted in brief interventions and/or referrals into AoD treatment which would have been an opportunity to intervene at an earlier stage.

4.3 | Limitations

This work is not representative of the entire prison population given it is a sample of men who were accepted into an intensive prison-based AoD treatment program. The data collection was from one site in NSW and the sample is men only, with there being no attempt to stratify recruitment by age. This may limit the generalisability of these findings. Finally, there could be recall bias as participants are recalling events that may be months or years ago.

5 | CONCLUSION

The accounts of these men suggest there were many missed opportunities to provide health promotion information about AoD harms, including information about access to treatment services and supports for people in this population. There are missed opportunities to provide early intervention and AoD treatment in the community before involvement in the criminal justice system. Media health promotion information campaigns may make information about AoD use harms more readily available including where to find support and treatment services. There needs to be further work with primary health care providers including general practitioners, so that they regularly screen for possible AoD use problems and provide the appropriate treatment or referrals as needed. Together these measures may help interrupt the journeys men have into the criminal justice system and prison.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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