Research Publication

Violent Crime, Alcohol & Other Drugs:
A survey of inmates imprisoned for assault in New South Wales

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Preface

The link between alcohol and other drug use with the commission of consequent criminal activity has been well established in the literature for decades. What this study confirms for the first time, using data drawn from New South Wales inmates is the consistent link between alcohol and ***violent*** offences.

This in-depth interview study of inmates imprisoned for assault offences builds on earlier research conducted by the Research and Statistics Unit of the N.S.W. Department of Corrective Services which had already shown that alcohol was the primary problem drug for offenders. What is important is that this study brings into clear focus the implicit need to always investigate the full contextual nature of any offence committed. It does this by drawing upon a spectrum of disciplines including sociology, psychology and criminology to develop an offence profile for those inmates who have committed some type of assault offence. Assault offences committed by male inmates typically involved high intake levels of alcohol prior to the offence and occurred at home or on the street. This directly reflected the victim normally assaulted - sexual partners, strangers or the police attempting to intervene. The self-perceived nature of the violence of the male inmates was expressive or emotional in origin as opposed to instrumental or gain motivated, although qualitative accounts brought to the surface underlying power and control motives in many cases. The violence appeared sudden or impulsive in nature. This in turn reflected the lack of perception by the offender of the risk involved. Often no account was taken of the age or size of the victim, the number of people present, the presence of any weapons or even the likelihood of arrest. There were some indications that a history of head injury or personality disorder were also predictive of future violent behaviour.

This study provides for the development of appropriate treatment strategies. Apart from the need to moderate alcohol and other drug use, these centre on the significance of conflict in the development and maintenance of intimate relationships, attitudes and expectations about the behaviour of female sexual partners and the development and adherence to values favourable to the use of violence.

Although commissioned by Alcohol and Other Drug Services of the Department, this study forms a valuable component of the National Campaign Against Violence and Crime - an initiative of the Commonwealth and State Governments of Australia begun in 1997. The results of the study provide for the prioritising of a broad-based, integrated approach to this very serious problem and form a basis for the work of the N.S.W. Department of Corrective Service's Inter-Departmental Anti-Violence Committee recently established.

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The valuable contribution of the inmates who participated in the study is appreciated.

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Executive Summary

The Alcohol and Other Drugs (AOD) Services of the Department initiated this study into inmates imprisoned for assault offences. The aim was to examine factors associated with assault offending and AOD use and to identify appropriate intervention strategies for this population. Extensive interviews were conducted with inmates imprisoned for assault during 1997.

The achieved sample was 215 (206 males and 9 females). The sample was generally representative of the population of inmates with assault offences who passed through the prison system at the time.

Demographics

- Males were on average 29.1 years of age and the majority (58.3%) reported being married or in a de-facto relationship prior to imprisonment. The median term of imprisonment being served was 5.9 months. Approximately half the sample (49.5%) identified welfare payments as their main source of income prior to imprisonment. The majority (73.8%) had been sentenced to prison on at least one previous occasion with a median of three previous prison episodes.

- The majority of males (64.6%) resided outside the Sydney metropolitan area prior to imprisonment. Those intoxicated by alcohol at the time of offence were significantly more likely to reside outside the metropolitan area compared with those intoxicated by other drugs or those who were not intoxicated.

Offence episode

- Victims of the male sample were most commonly sexual partners (38.3%). After sexual partners, victims were reportedly strangers (26.2%) or police officers (14.6%). Of the sample, 7.3% had assaulted more than one victim.

- The location of the assault was most commonly the offender's own home (36.1%). The street (25.4%) and in or around a hotel (12.7%) were the second and third most common locations.

- The majority of the males reported being intoxicated at the time of their offence (80.1%). Of the sample, 48.5% were intoxicated by alcohol only, 8.3% were intoxicated by other drugs only and 23.3% were intoxicated by both alcohol and drugs. The median quantity of alcohol consumed prior to the offence was reportedly 27 standard drinks. Cannabis was the most commonly cited drug of intoxication (58.5%).

- For the majority of males the origin of the violence was more expressive (emotional) than instrumental (for gain), with 62.0% stating that they had been arguing with the victim/s at the time of the assault. Most stated (61.4%) that they "snapped" or "just lost their temper" just prior to the assault, while an additional 26.7% stated that their actions were "controlled". Only 27.6% reported that they took into account the physical circumstances of the scene, such as size or age of the victim/s, number of people present or the presence of weapons before deciding on either whether to or how to assault the victim/s. When asked if they thought about the consequences at the time of the assault, such as being arrested a slight majority stated that they did not think about any consequences (54.9%).

Associated factors

- Males reported that they were physically violent in pubs/clubs (60.0%), on the street (44.7%), in prison (41.1%), at

home (38.4%), at the home of an ex-spouse/sexual partner (24.0%) and at work (10.6%). With the exception of prison and work, across all the other contexts alcohol was perceived to be related to the violent behaviour for the majority of cases.

- 47.6% of males had undertaken some form of community-based drug treatment in the past. Only 13.1% had ever participated in some type of community-based treatment program for violent behaviour and three-quarters of this group had attended treatment for less than 3 months.

- 13.6% of the male sample reported that they had been hospitalised for a psychiatric/emotional problem in the past. Depression (39.3%) and schizophrenia (35.7%) were the most commonly identified conditions.

- Of the male sample, 63.1% satisfied the diagnostic criteria for Anti-Social Personality Disorder (using DSM III criteria).

- 39.0% of the sample had sustained a head injury at some time in their lives. For those with head injuries, the most commonly identified trauma was a fractured skull (25.0%). Stab wounds had been sustained by 29.9% of the sample and gunshot wounds by 7.9%.

- The prison-based AOD Services had been used (on at least 1 occasion) by 36.9% of the male sample during their current term of imprisonment. Also, 7.8% were current recipients of prison-based methadone treatment.

- Prison-based treatment for violent behaviour had been undertaken by 23.8% of the males during their current term of imprisonment. The most common program undertaken by this group was an anger management course (71.4%).

Female sample

- Nine females (4.2%) were included in the sample. The proportion matched the representation of females in the assault population at the time. Female findings differed markedly to those of the male sample (however, the small number hinders meaningful comparisons). All nine females reported intoxication at the time of offence. Most (n=6) were intoxicated by drugs alone or in combination with alcohol (n=2). Intoxication by alcohol solely was reported by one female. Heroin and methadone were the most commonly reported drugs of intoxication and injecting was the most commonly reported mode of administration. All three of the women who drank alcohol consumed spirits.

- The assault victims were most commonly police/security guards or strangers. Consistent with victim type, location of assault was most commonly a custodial setting or the street. Most stated that the assault followed an argument and most reported that they 'just snapped' or 'lost their temper' prior to the assault.

- All the females had received community-based drug treatment at some time in the past and most had received methadone maintenance. Community-based treatment for violent behaviour was not reported.

- About half of the female sample had used the prison-based AOD Services during their current term of imprisonment and two had undertaken an anger management course to address their violent behaviour. At the time of interview, most were on methadone maintenance and one female reported being on another form of medication.

Recommendations

Service delivery

1. Findings support the treatment integration of AOD programs and violence programs for the majority of this client group.

2. Those who commit violent crimes are commonly in denial, showing resistance and high rates of attrition from treatment. An AOD-related violence program would represent the first tier or motivation raising stage of a more intensive program structure on violent behaviour.

3. A first tier, highly structured group program aimed at addressing general AOD-related violence be devised along cognitive behavioural lines and piloted.

4. For the subsequent more intensive program tiers client and treatment types be matched, allowing for factors, such as nature and level of violent behaviour and co-occurrence of intoxication, severity of AOD problem, learning style and level and responsivity (e.g., psychopathy).

5. As an adjunct to the structured programs, individual treatment be offered at the same time to address individual needs.

6. Culturally sensitive responses for Aboriginal clients be reviewed by the AOD Services and a treatment strategy devised.

7. Findings support the development of a distinct alcohol-related domestic violence program. Alcohol misuse has been related to recidivism in follow-up studies on domestic violence programs. Personal responsibility for violent behaviour be facilitated through addressing and challenging violent behaviour towards partners and beliefs and expectations about the role of partners. Post-release continuation of service, including concurrent service provision to victims would be needed.

8. An interagency committee be established to document guidelines for community based service provision to complement that initiated in prison.

9. Exposure to treatment is seen as necessary for change. Correctional administrators give due consideration to mandating treatment completion as a prerequisite for parole.

Program goals, content and format

10. Acceptance of responsibility for their actions by the program participants, be integral to program structure.

11. Content focus on the community settings to which the program participants will be returning and matched to their learning style and level.

12. A direct, concrete approach rather than abstract approach be adopted in skill development. Skill development be centred on a limited number of behaviours and attitudes requiring modification.

13. Content not only address high risk situations for AOD-related violence and expectancy effects about alcohol & other drugs, but also aggressive beliefs and attitudes. Critical reasoning be facilitated through analysing and challenging such beliefs.

Recommendations cont.

Assessment, research & evaluation

14. Program evaluation studies incorporate realistic outcome measures, such as reductions in frequency, duration and severity of violent behaviour and reductions in arguments. Psychological and physical maltreatment scales may be useful in this regard.

15. A history of being banned from drinking establishments due to alcohol-related fighting may prove to be a useful measure in targeting clients. This measure be added to the AOD screening scale conducted with new receptions.

16. Assessment strategies on alcohol-related violence examine behaviour patterns at a micro-level. When, where and with whom they drink and when, where and with whom they become aggressive needs to be identified. Also relevant is the proportion of time and at what times they are drunk and the proportion of time and what times are they engaged in aggressive acts and finally in what proportion these events co-occur.

17. To facilitate well-targeted programs, treatment providers be trained in brief detection techniques for alcohol-related brain damage. Typically, diagnostic assessment of this condition is both time consuming and expensive. A brief checklist of symptoms be used as a screening procedure. This may include a short mental status test and/or questions on blackouts, seizures, problems with memory loss, organisation and learning new concepts/skills.

18. In risk assessment and prediction of future violence the following factors be considered:

    - frequency;
    - duration;
    - impulsivity;
    - degree of injuries to others and self;
    - victim typology and under what specific circumstances;
    - impaired control over alcohol & other drugs;
    - psychiatric diagnosis.

19. Future investigations include a more precise, temporal reconstruction of the event, including duration of alcohol intake and questioning the respondent on tolerance, such as how much alcohol it takes to make them feel drunk.

20. The design of research to evaluate the magnitude of the effects of alcohol on violent offending be carefully undertaken. The use of current offence episode to compare violent and non-violent offending may be artificial (a current property offender may have a substantial history of violence). Comparison grouping be determined by a criminal history of violence, versus a criminal history devoid of violence, versus a criminal history of both violent and non-violent offending.

Introduction

Violent crimes have a serious impact on the community at large, due to both the real and perceived threat of physical harm. Our current understanding of the causes of violent offending behaviour is not well integrated and this is due to the complexity of this problem behaviour and the corresponding conceptual and empirical difficulties which it presents.

Epidemiological work has suggested that factors, such as early childhood injuries, abuse or neglect, socialisation experiences, lack of economic opportunity, community disorganisation and physical reactions to certain types of drugs are risk factors in the development of violent behaviour[1]. Further, links have been drawn between the psychopathic and sociopathic personality types and alcohol misuse[2,3]. These pathologies are in part defined on the basis of repetitive anti-social behaviour hence the association seems plausible.

According to correlational studies, a number of variables have been found to systematically correlate with violence. The demographics, gender and age are most commonly reported. Young men appear to be more prone to violent behaviour. The role of dispositional variables, such as organic mental disorder, personality disorder (mainly in the form of paranoid delusions directed towards imagined persecutors), impulsivity and suicidal behaviour have also been associated with violent behaviour[4]. Situational variables, such as overcrowding, day of week and time of day have been identified as have state variables, such as alcohol intoxication. Assaults which involve alcohol have been found to occur disproportionately on weekends[5]. The role of both alcohol and violence in the identification and expression of masculinity has also been observed [6,7].

Difficulties in establishing the nature of the link

Not all intoxicated individuals become violent, yet alcohol intoxication has been repeatedly implicated in the perpetration of violent offences. In contrast, current evidence on the connection between illicit drugs and violent offending suggests that the link is for the most part, secondary and based around drug trade transactions. Future studies may identify a more direct link between the psycho-pharmacological effects of drugs, such as amphetamines, anabolic steroids or poly-drug interactions and violent offending behaviour.

The identification of the precise nature of the relationship between alcohol and violence has proved to be problematic. Is the relationship causal or due to the covariance of some third factor, such as the setting or personalities of those who drink or a structural factor, such as unemployment?

It could be argued that the alcohol and violence connection is artificial, only describing when and where the aggression takes place. In addition, increased alcohol-related aggression may be an artefact of social interaction. Increased social interaction could lead to more drinking and more violence. Further, there is the possibility that the role of alcohol has been overestimated because intoxicated persons are more conspicuous and therefore are more likely to be apprehended than those who are not intoxicated. Finally, hospital admissions and arrestees may over or under estimate their drinking level in terms of how they perceive the outcome affecting them.

Murdoch and colleagues[8] in their review of studies on the alcohol and violence link observed that the majority of all cases of homicide and assault involve alcohol use. They concluded that alcohol is over

represented in violent crime where there is a blood alcohol level greater than 0.1%. Analysis showed this finding to be highly significant. In addition, alcohol was more likely to be present when quarrelling preceded the assault. Only six studies reviewed by the above authors provided comparison groups and of these only three used statistical tests.

The pattern of alcohol consumption has been associated with physical marital conflict, however findings have been inconsistent. When perpetrators of domestic violence were heavy or chronic drinkers they were found to be generally violent whether they drank or not. Whereas occasional drinkers tended to be violent only when drinking[9]. Another investigation found that those who were identified as having recent pathological drinking (impaired control) were significantly more likely to report physical conflict within the relationship than either those with a past diagnosis ($p < .001$) or no diagnosis ($p < .001$). This relationship was independent of general hostility and marital satisfaction[10].

The foregoing describes some of the questions and general findings arising from the exploratory work. Findings to date show the prevalence of alcohol intoxication when people are caught in the act of committing crime. The literature generally accepts that alcohol intoxication escalates violence in terms of frequency and level.

Theoretical explanations

Psychological accounts

Psychological explanations of alcohol-related violence have addressed the relevance of learning theory, frustration, belief systems and personal power and control needs. According to Bandura's social learning theory of alcohol-related aggression, alcohol may be seen to instigate aggression in those individuals who have learned aggressive behaviour through observation and reinforcement[11]. The presence of frustration has also been associated with level of aggression. It has been found that a high level of frustration combined with alcohol consumption makes an aggressive response more likely [12,13]. Alcohol was found to have a lesser effect when there was an absence of frustration. Other psychological approaches have been concerned with individual beliefs or expectations. According to expectancy theory an individual's beliefs or expectancies about the effects of alcohol determines how the individual behaves under the influence of alcohol[14]. Further, it has been argued that the motivation to drink is especially important in those men who are preoccupied with power concerns or have a stronger need for personalised power[15]. Pernanen who has produced some of the most extensive work on the topic views alcohol-related violence as a consequence of the direct effects of alcohol on cognitive functioning and ensuing cognitive impairment[16,17,18,19].

Sociological accounts

For some cultures and sub-cultures, violence is a more acceptable way of attaining a goal than others. In this regard, sociological explanations have addressed subcultural or reference group drinking norms, drinking context influences, and the nature of the relationships between drinking event participants[20].

A sociological framework was applied to alcohol-related violence in England[21]. An association was found between changes in beer consumption and violence (this was not found to be the case for other types of alcohol). Beer was found to have a strong positive effect on changes in violence.

Simply stated, economic growth was seen to be associated with increased beer consumption which in turn was associated with increased violence. Specifically, beer drinking was associated with a certain type of lifestyle, involving pubs and clubs and young male drinkers. In this case, the social context for the violence was pubs and clubs on weekend nights. Usually binge drinking was involved.

Biological/pharmacological accounts

Alcohol is a chemical substance that has a biological effect. These accounts view alcohol-related violence as impulse driven and due to some biochemical interaction. Biological work is typically laboratory-based. Recent neurochemical studies have investigated the role of low serotonin, high testosterone, serum glucose and localised brain dysfunction[22]. While making a contribution, these explanations have failed to offer a comprehensive, theoretical base. Biological explanations have not accounted for the effects of cognitions and external stimuli. Such explanations have recently been reviewed [23].

A synthesis

It would seem that alcohol-related violence may be explained through the distillation of a number of explanatory models, as a mixture of personality, socio-cultural and physiological causes. Violence results from alcohol consumption in some situations, under some circumstances, for certain people[24]. Further, in terms of violent offending behaviour young men are disproportionately represented. According to Collins[5], current aetiological knowledge indicates that the alcohol and violence link is primarily accounted for by:

(i) alcohol induced cognitive impairment;
(ii) drinkers' expectancies that alcohol increases aggression; and
(iii) sociocultural beliefs that people are not accountable for their behaviour after drinking.

Treatment programs

Studies undertaken with correctional populations have identified those who commit violent crimes as a population who are particularly resistant to treatment and typically in denial about their behaviour. Traditionally, treatment approaches for violent behaviour have focussed on anger management. In addition to anger management, more recent programs have addressed aggressive beliefs and attitudes. Following is an outline of two of the more recent program evaluations involving criminal justice clients.

The Correctional Service of Canada has implemented a number of programs for violent offenders, including an eight month intensive group program. Participants of this program were educated on the behavioural, cognitive, interpersonal and affective components of violent behaviour[25]. In addition, a combination of psycho-dynamic and cognitive-behavioural techniques were used to address:

- thinking errors;
- anger management;
- empathy;
- communication; and
- relationships.

According to the authors, offenders with substantial problems in the above areas are much more likely to reoffend. Using a matched sample (n=60), to evaluate the effectiveness of the program the treatment group showed less post-treatment offending. However, these findings were not statistically significant. The average follow-up period was 2 years. A re-education program implemented in Scotland for court ordered perpetrators of domestic violence was evaluated over a three year period[26]. The authors reported significant reductions

in violence by program participants (n=27) when compared with a matched sample. Consistent with the Canadian program, this program also applied cognitive-behavioural techniques. Personal responsibility for violent behaviour was facilitated through addressing and challenging violent behaviour towards partners and beliefs and expectations about the role of partners.

A review of the literature failed to identify any treatment programs which systematically address the link between AOD problems and violent behaviour. Typically in treatment programs devised for violent behaviour or anger management, the coverage of AOD issues is minimal and educational in orientation. A recent Australian study attempted to identify the prevalence of overlap in treatment populations by trialing a domestic violence screening procedure with clients enrolled in several community based AOD treatment centres. Rates of physical aggression by clients towards partners ranged between 37.4 and 51.5 (n=200) and three-quarters reported that alcohol intoxication made their aggression worse. Training was provided to staff and resource kits made available to victims and perpetrators[27].

Study rationale

Earlier studies of inmates in N.S.W. found that those imprisoned for assault were most likely to be under the influence of alcohol at the time of their offence and that those with alcohol problems were less likely to use the treatment services when compared to those with other drug problems[28,29]. Data extractions from the Department's Offender Record System showed that about 50.0% of male inmates received with assault offences in N.S.W. were between 18 and 24 years of age and 37% of young male inmates with assault offences were of Aboriginal descent. Further, inmates with assault offences showed high rates of recidivism, in that they were released to the community and returned to prison within a relatively short period of time (2 years), when compared with other offender categories[30]. The current study was commissioned by the Alcohol & Other Drug (AOD) Services of the N.S.W. Department of Corrective Services in 1996. The funding was provided by the National Drug Strategy. The AOD Services recognised a need to collect information on the AOD-related offending patterns of this population and to appropriately address their needs in its core program structure. The study was concerned with the psychological and sociological antecedents of AOD-related violence. The contribution of biological factors (based the direct effects of alcohol on the central nervous system) was not within the realm of this study. In addition to personal background data, this study sought to examine the offence episode in terms of its physical, social and psychological context. The literature had highlighted the need to examine the offence event at a micro-level, by recording the natural history of the assault (i.e., who did what to whom and for what reason). Violence is not typically a discrete event. It evolves out of interpersonal interactions. There is much diversity in the typology of violent crimes committed. A potentially useful method for classifying violent crimes distinguishes offenders by motive[31]:

- Expressive: usually starts with an argument and the primary goal is to hurt the person;
- Instrumental: violence is an acquisition tool to get something from someone else or to hold something over the other;
- Gang-related: when violence is promoted more by gang membership than anything else.

The Correctional Service of Canada has recently adopted the above typology of violence in relation to homicide offenders. It seems logical to separate instrumental from expressive violence.

Methodology

Research questions

The AOD Services of the Department initiated a strategy whereby the needs of those inmates who show high recidivism are addressed through targeted programming. The population of interest was inmates imprisoned for assault offences [common assault; assault occasioning actual bodily harm; grievous bodily harm and malicious wounding]. These groups show high rates of recidivism, in that they are released to the community and then return to prison within a relatively short period of time. Those imprisoned for homicide, manslaughter and sexual assault offences were excluded from the study as they did not fall within this high recidivist category, compared with other offence groups. Those with long sentences, such as homicide offenders are potentially more suited to programs designed for long term inmates.

The present study did not include a comparison group (non-violent) in its methodology. This is because the stated intention of the study was to provide information to be used in treatment planning for those whose violence was AOD-related. Further, rigorous comparison would require sample classification based on a criminal history of violent versus non-violent offences rather than classification based simply on the current offence category. A current property offender may have a substantial history of violent offending.

Following were the proposed research questions addressed by this exploratory study.

Broad aim

To examine factors associated with alcohol, other drugs and assault patterns and to identify appropriate treatment strategies for inmates with AOD-related assault offences.

Specific objectives

- ❒ Examine the context of the assault offence, including intoxication from alcohol and/or other drugs.
- ❒ Investigate the psychological and situational context of both violent behaviour and alcohol consumption.
- ❒ Investigate the self-perceived psycho-pharmacological effects of alcohol.
- ❒ Gather data on additional psycho-social risk factors associated with both violent offending and AOD misuse, such as psychiatric and familial history.
- ❒ Identify the prevalence of Childhood Conduct Disorder(CCD) and Anti-Social Personality Disorder (ASPD). The association between violent behaviour and psychopathy has been documented in the literature.
- ❒ Identify whether the inmates in the assault sample can be distinguished by one of the three motive-based typologies of violence: (i) expressive violence; (ii) instrumental violence; and (iii) gang-related violence[31].
- ❒ Assess the treatment needs of inmates whose assault offences are AOD-related.

Sampling

The sample size [n=215, 206 males, 9 females] was based on previous data. This gave a confidence interval of ± 5% for the AOD sub-sample (see Annex 1). The population was stratified by sentence length to ensure that the sample was representative of the population who were received into the

system with an assault conviction. Proportionate to population sampling was used within each of the stratifications (Table 1). The population frame excluded remandees, appellants (matters still before the courts) and those with sentences of less than 1 month (likely to be missed in fieldwork).

Table 1: Stratification by sentence length

	Population Base=755*	Sample Base=215	
	%	No.	%
1 < 3	30.0	66	30.7
3 < 6	29.5	58	27.0
6 < 12	27.0	59	27.4
12 < 24	8.1	19	8.9
24 +	5.4	13	6.0
Total	100.0	215	100.0

* Assault conviction discharges for 1994

Procedure

Data were collected by way of structured interview. A pilot study was conducted on a sample of 10 inmates with assault convictions (7 males & 3 females) in order to test the survey instrument for any methodological defects and also for setting time-frame estimates. The main study was conducted within a 4 month time-frame during 1997. Sample lists for 14 prisons were extracted from the Offender Record System data base.

Inmates were called up for interview on the day/s the two research interviewers were in attendance at the centres. Participation was voluntary and inmates were paid $5.00 (into their prison buy-up accounts) for their participation.

Given the sensitive nature of the information being collected the respondents were given guarantees of confidentiality and de-linking of data. The length of time required for interview ranged between 1 and 2 hours. The refusal rate was 12.0% of the achieved sample.

Interview instruments

The structured questionnaire included questions on demographics, criminal and drug use histories, offence characteristics and psycho-social background factors. The Diagnostic Interview Schedule (DIS)[32] was used to obtain a diagnosis of ASPD and CCD in accordance with DSM-III criteria. The State-Trait Anger Inventory (STAXI)[33] was used to obtain a measure of the experience and expression of anger. The ICQ-A[34] was used as a measure of impaired control over alcohol intake and the Severity of Dependence Scale (SDS)[35] was used to measure other drug dependency.

Analysis

Data analysis is predominantly descriptive. The median is reported as a measure of central tendency where distributions were found to be skewed. T-tests or Kruskal Wallis tests were applied when testing for differences between sub-samples. Where appropriate, tests of association (χ^2) were conducted on non-parametric variables.

Results

The following survey sample were generally representative of the population of inmates imprisoned for assault as their most serious offence. When compared to inmates in general, those with assault convictions differ in that they are more commonly younger, of Aboriginal descent, married (incl. defacto relationships) and have a prior conviction.

1. Demographics & Criminality

The achieved sample was 215 (206 males and 9 females). While the proportion (4.2%) of females was representative of the population of assault offenders, the sub-sample was too small to make meaningful comparisons. The female data have been reported separately (pg. 22). The following findings pertain to the male sample. To examine whether there were any differences in background data between those who were intoxicated at offence and those who were not, the intoxication measure was re-classified. The re-classification was derived from the following:

1. Alcohol: ≥ 6 std. drinks prior to offence.
2. Drug: drugs prior to offence /or/ both alcohol & drugs but drank < 6 std. drinks.
3. Neither: no alcohol or drugs prior to offence/or / < std. 6 drinks.

Note: While the Alcohol group (1) included those intoxicated by both alcohol and other drugs (who drank 6 or more std. drinks), this sub-group was most likely to use a combination of alcohol and cannabis only.

Findings are reported where the three intoxication groupings vary on background characteristics.

1.1 *Age*

A high majority (77.2%) of the sample were under 35 years of age, with an average of 29.1 years (sd=7.27). Table 2 shows a breakdown of age by AOD intoxication groupings.

Table 2: Age breakdown [Base=206]

	Alcohol (n=143) %.	Drugs (n=18) %.	Neither (n=45) %.	Total %.
18-24	28.0	33.3	28.9	28.6
25-29	28.7	27.8	17.8	26.2
30-34	22.4	22.2	22.2	22.3
35+	21.0	16.7	31.1	22.8
Total	100	100	100	100

1.2 *Ethnicity*

Of the sample, 90.8% were Australian born. Data on first language ever spoken, showed that 91.7% spoke English. Aboriginal dialects (1.5%), Portuguese (1.0%), Italian (1.0%) and Vietnamese (1.0%) were the next most commonly cited languages.

1.3 *Aboriginality*

Of the sample, 41.3% identified themselves as being of Aboriginal or Torres Strait Islander descent.

1.4 *Place of residence*

Prior to imprisonment, the majority of inmates (64.6%) had resided outside the Sydney metropolitan area (Table 3). This pattern is different to the general inmate population of whom the majority reside within the Sydney area. The majority of both the Aboriginal and non-Aboriginal samples resided outside the metropolitan area (77.5% and 57.9% respectively). Those who fell within the alcohol intoxication group were more likely to reside outside the metropolitan area compared to the 'drug' and 'no intoxication' groups (χ^2=9.8, df=2, p<.01). It should be noted that 84.7% of Aborigines in the 'alcohol intoxication group' resided outside the metropolitan area.

Table 3: Place of residence prior to imprisonment

[Base=206]

	Alcohol %.	Drugs %.	None %.	Total %.
Metropolitan	28.7	44.4	53.3	35.4
Non-Metro.	71.3	55.6	46.7	64.6
Total	100	100	100	100

1.5 *Marital status*

The majority of the assault sample reported being married or in a de-facto relationship prior to imprisonment (58.3%). This pattern differs to the general inmate population of whom the majority report to be single.

1.6 *Education*

The majority of the sample (61.6%) reported receiving less than 10 years of education. Further, 3.9% (n=5) had only received education to primary school level. A tertiary qualification had been obtained by 4.4% of the sample.

1.7 *Income & occupation*

Approximately half the sample (49.5%) identified welfare payments as their main source of income prior to imprisonment. Full-time employment was the main source of income for 21.8% and part-time employment for 12.1%. Crime as the main source of income, was identified by 14.1% of the sample. A significant association was identified between intoxication group and main income source (χ^2=22.8, df=4, p<.001). The drug group were more likely to report crime as their main source of income and less likely to report employment or welfare when compared to the 'alcohol' and 'no intoxication' groups. The most commonly cited regular occupation was an unskilled job, such as labourer, farmhand or factory worker (54.0%). Some reported that they had no employment history (13.1%), while 21.9% cited a trade and 4.5% cited some type of professional or business-related occupation.

1.8 *Sentence length*

The median sentence length/term of imprisonment being served was 5.9 months. Table 3 shows a breakdown of sentence length by AOD intoxication groupings.

Table 4: Sentence length

[Base=206]

Months	Alcohol %.	Drugs %.	None %.	Total %.
1<3	34.3	11.1	28.9	31.1
3<6	23.1	44.4	26.7	25.7
6<12	29.4	22.2	28.9	28.6
12<24	8.4	5.6	8.9	8.3
24+	4.9	16.7	6.7	6.3
Total	100	100	100	100

1.9 *Imprisonment history*

The majority of the sample (73.8%) had been sentenced to prison on at least 1 previous occasion with a median of 3 previous episodes. Of the total sample, 27.3% had served more than 4 prior episodes. Just under half the sample, (41.7%) had served time in a juvenile detention centre with a median of 2 juvenile detention episodes.

2. Psycho-Social Background

2.1 Upbringing

2.1.1 *Guardians*

The majority were raised predominantly by both biological parents (51.9%). After both biological parents, either the natural mother or father was most commonly cited as the primary guardian (17.9%). A further 10.2%

were raised by either adoptive/step or foster parents. Grandparents as guardians were cited by 7.8% of the sample and another 7.8% were raised by a biological parent combined with a step parent. An institution was cited by 2.0% as the primary guardian.

2.1.2 *Institutionalisation*

Almost a third of the sample (29.6%) reported that they had been removed from their family of origin by welfare services at some stage during their childhood. The median age of first removal was 7 years of age. Those of Aboriginal descent were significantly more likely to have been removed from their family of origin than those who were not (χ^2=14.355, df=1, p<.05).

2.1.3 *Victimisation from abuse*

Of the sample, 57.8% reported that they had been either sexually or physically abused on at least one occasion in the past. Childhood sexual abuse was experienced by 10.7%. Biological fathers (27.2%) and family friends (27.2%) were the most commonly cited perpetrators. Physical abuse during childhood was cited by 45.6% of the sample. The most commonly cited perpetrators were biological fathers (58.1%) and biological mothers (30.0%). After biological parents the most commonly cited perpetrators were stepfathers (11.8%). Boys Home staff were cited as perpetrators of child physical abuse by 4.3% of the sample.

2.1.4 *AOD family history*

Of the total sample, 56.7% reported a family history of AOD problems. Fathers (38.8%) were most commonly identified as having an AOD problem. After fathers, both parents (26.7%) and mothers (13.8%) were most commonly identified. A further 8.6% identified both parents and siblings as having AOD problems.

2.2 *Medical history*

A high majority of inmates (80.0%) reported that they had experienced at least one serious injury or serious health problem in the past. Based on open-ended responses, head injuries were reported by 39.0% of this sub-sample and of those with head injuries, 25.0% identified the injury as a fractured skull. Stab wounds (29.9%) and gunshot wounds (7.9%) were also reported. Viral pneumonia was reported by 6.7% of the sub-sample.

2.3 *Psychiatric history*

Of the total sample, 13.6% reported that they had been hospitalised for a psychiatric/ emotional problem in the past. Depression (39.3%) and schizophrenia (35.7%) were the most commonly identified conditions. A further 7.1% stated that their hospitalisation was due to a suicide attempt. Of the sub-sample, 42.9% stated that either alcohol solely or in conjunction with drugs was related to their emotional condition at the time. A further 17.9% stated that other drugs (excluding alcohol) were related to their condition at the time.

2.4 *Current dependents*

Of the sample, 75.2% reported that they had children. Over a third of the sample (39.6%) had more than 2 children. The usual guardians were most commonly the inmate in conjunction with his partner (35.2%) or the childrens' grandparents (29.6%). The current guardian was most commonly the biological mother (77.0%).

2.5 *Current cohabitants*

The majority of the sample had been residing either with their sexual partner and

children or their partner alone (55.2%) prior to imprisonment. Only 9.4% reported living alone and 2.0% reported that they had been homeless. Of those who lived with co-habitants prior to imprisonment, 37.8% reported that their co-habitant/s had an AOD problem.

3. Offence Episode

3.1 *Victim type*

As Table 5 shows victims were most commonly sexual partners (38.3%). After sexual partners, victims were most likely to be strangers (26.2%) or police officers (14.6%). Of the sample, 7.3% had assaulted more than one victim. According to inmates' accounts, the majority of victims (60.0%) were well known to them. Data were transformed to examine principal victim type. As expected, the distribution of principle victim matched the breakdown in Table 5 which allowed for more than 1 victim. A family member was most likely to be the principal victim (42.4%) of which the majority were sexual partners (92.0%). Police officers represented 10.2% of principal victims.

Table 5. Victim type [n=206, multiple responses]

Victim	No.	%.
Spouse/ex-spouse/ partner	79	38.3
Stranger	54	26.2
Police	30	14.6
Acquaintance	16	7.8
Friend	15	7.3
Relative	10	4.9
Neighbour	7	3.4
Crime associate	4	1.9
Security guard/ bouncer	4	1.9
Other	2	0.9

3.2 *Location of assault*

In reference to Table 6, the location of the assault was most commonly the offender's own home (36.1%). The street (25.4%) or in/around a hotel (12.7%) were also reported. A custodial setting (police station or prison) represented 4.4% of responses. In a high majority of cases (79.0%) there was more than one person (in addition to the victim/primary victim) present at the time of the assault.

Table 6: Location of assault [n=205, mult. responses]

Location	No.	%.
Offender's home	74	36.1
Street	52	25.4
Hotel	26	12.7
Friend's home	11	5.4
Custody	9	4.4
Sexual partner's home	7	3.4
Victim's home - other	7	3.4
Park	6	2.9
Relative's home	6	2.9
Vehicle	4	2.0
Shop/office	3	1.5
Car park	3	1.5
Party	3	1.5
Institution/Boys' Home	3	1.5
Bush/river	2	1.0
Neighbour's home	2	1.0
Other	2	1.0

3.3 *Intoxication at offence*

As Figure 1 shows, the majority of the sample reported being intoxicated at the time of their offence (80.1%). Of the sample, 48.5% were intoxicated by alcohol only,

8.3% were intoxicated by other drugs only and 23.3% were intoxicated by both alcohol and drugs. Not surprisingly, a hotel was the most commonly cited drinking location (51.4%). The offender's own premises (39.2%) or a friend's premises (20.3%) were also cited. A police station was identified as the drinking location by one respondent (Table 7). Interestingly, for 75.9% of those who cited a hotel as their primary drinking location, the primary location of the assault was somewhere else. Whereas, for those who cited their own premises as the primary drinking location, the majority (71.4%) also reported that the assault occurred at the same location. Table 8 shows beer was by far the most commonly consumed beverage (78.4%) with only 0.7% of the sub-sample of drinkers reporting light beer was consumed. A high majority (92.2%) of drinkers consumed a large quantity of alcohol (> 8 standard drinks) prior to the offence (Table 9). The median quantity consumed was 27 standard drinks (range=2-98). Some inmates reported that they had been drinking continuously for more than 24 hours prior to the assault. Table 10 shows the types of other drugs consumed prior to the offence. Cannabis was cited by the majority (58.5%). After cannabis, amphetamines (29.2%) and heroin (20.0%) were cited. For those intoxicated by both alcohol and drugs, the majority used cannabis in combination with alcohol (70.8%).

Figure 1: Intoxication at offence

Base = total male sample

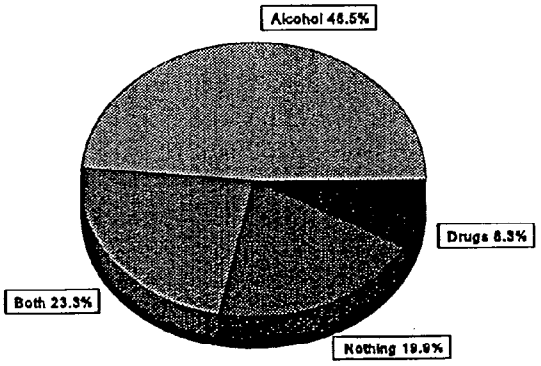


Table 7: Drinking location [n=148, mult. responses]

Location	No.	%.
Hotel	76	51.4
Offender's home	58	39.2
Friend's home	30	20.3
Party	12	8.1
Street	11	7.4
Park	9	6.1
Relative's home	9	6.1
Vehicle	3	2.0
Bush/river	3	2.0
Sexual partner's home	2	1.4
Workplace	2	1.4
Mission	2	1.4
Police station	1	0.7

Table 8: Type of alcohol [n=148, mult. responses]

Type	No.	%.
Beer (full strength)	116	78.4
Spirits	65	43.9
Wine	30	20.2
Port/sherry	10	6.8
Light beer	1	0.7

Table 9: Quantity of alcohol [n=141, missing=7]

Std. drinks	No.	%.
1-4	3	2.1
5-8	8	5.7
9-12	5	3.5
13-16	12	8.5
17-20	17	12.1
21-28	28	19.9
29+	68	48.2
Total	141	100

Table 10: Type of drug

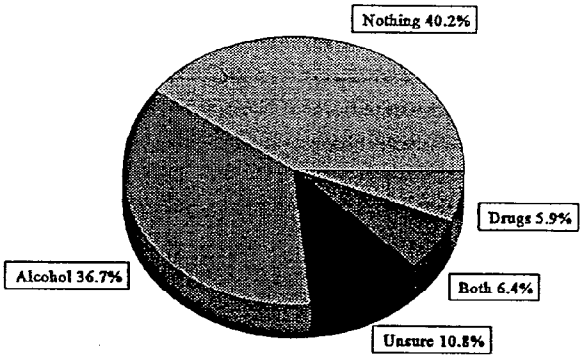
[n=65 cases, set=multiple responses]

Type	No.	%
Cannabis	38	58.5
Amphetamines	19	29.2
Heroin	13	20.0
Pills	12	18.5
Methadone	6	9.2
Cocaine	5	7.7
Hallucinogens	3	4.6

Based on inmate reports, 49.0% of victims were intoxicated, with alcohol (either solely or in combination with other drugs) being most commonly reported (43.1%) (Figure2).

Figure 2: Victim intoxication

Base = total male sample



3.4 *Contextual factors - additional*

It appeared that for the majority of offenders the origin of the violence was more expressive (emotional) than instrumental (for gain). Of the total sample, 62.0% stated that they had been arguing with the victim/s at the time of the assault. In addition, when presented with a nominal range of responses describing their emotional state just prior to assaulting the victim/s, (61.4%) stated that they "snapped" or "just lost their temper" while an additional 26.7% stated that they were "more controlled". Of the total sample, only 27.6% reported that they took into account the physical circumstances of the scene, such as size or age of the victim/s, number of people present or the presence of weapons before deciding on either whether to or how to assault the victim/s. Responses were broad ranging for this question. From those which were able to be coded, the most common factors taken into account were the size of the opponent (25.6%) and the actual number of opponents (24.1%). When asked if they thought about the consequences at the time of the assault, such as being arrested a slight majority stated that they did not think about any consequences (54.9%). Of those who thought about being arrested at the time, 90.7% were of the opinion that there was some chance that the incident would lead to arrest.

The findings did not neatly fit the 3 factor motive-based classification (expressive, instrumental & gang-related). The majority described the origin of their violence as expressive. Yet, their accounts frequently showed a mixture of expressive (emotional) and instrumental (property, power and control) characteristics. Further, only one inmate reported that his violence was gang-related.

4. Patterns of AOD Use & Violence

4.1 *Drug-crime link*

Of the total sample, 70.9% perceived there to be a relationship between their use of alcohol and/or drugs and their current term of imprisonment (Table 11). As expected, the most commonly identified relationship by the sample was intoxication by alcohol (80.8%). A further 14.4% of cases identified intoxication by drugs.

Table 11: Drug-crime link [Base=146, mult. response]

Link	No.	%.
Alcohol intoxication	118	80.8
Drug intoxication	21	14.4
Drug withdrawal	11	7.5
Money to buy drugs	8	5.5
Money to buy alcohol	4	2.7
Drug possession	1	0.7
Other	7	4.8

4.2 *Patterns of AOD use*

Tables 12 to 16 show incidence of lifetime drug use and also patterns of drug use in the 6 months prior to imprisonment. Interestingly, more inmates had tried cannabis (91.7%) than tobacco (90.8%) (Table 12). Further, the majority (55.3%) had tried amphetamines in their past.

Of the sample, about three quarters had used cannabis on a regular (weekly) basis in the past (Table 12). The median age for first regular use was the same for cannabis as for alcohol, that is 16 years. About a third of the sample reported using amphetamines on a regular basis in the past. The most commonly used drugs prior to imprisonment (Table 13) were alcohol (86.9%), tobacco (84.0%), cannabis (70.3%) and amphetamines (24.2%). In addition to tobacco, cannabis (43.2%), alcohol (27.7%) and heroin (11.7%) were the drugs most commonly used on a daily basis (Table 13). The majority of daily drinkers (73.7%) reported drinking more than 12 standard drinks per day (Table 14) and the majority of weekly drinkers (67.1%) reported drinking more than 84 standard drinks per week (Table 15). Table 16 shows the quantity levels for daily and weekly users of cannabis, heroin and amphetamines. For the most part, cannabis users (56.8%) were smoking more than 2 grams per day.

Table 12: First use of drugs: ever & regular (weekly) - as percentages & median ages

	Ever tried (n=206)			Ever used weekly (n=206)		
	%.	No.	Median age	%.	No.	Median age
Alcohol	96.6	199	14	91.8	189	16
Cannabis	91.7	189	15	76.7	158	16
Tobacco	90.8	187	13	89.3	184	15
Analgesics	55.3	114	12	14.6	30	15
Amphetamines	55.3	114	18	38.3	79	18
Hallucinogens	50.9	105	18	17.0	35	18
Benzodiazepines	45.6	94	18	20.9	43	18
Heroin	41.7	86	20	26.2	54	19
Barbiturates	33.0	68	20	16.5	34	20
Cocaine	33.0	68	20	12.1	25	19
Solvents	23.8	49	14	8.7	18	13
Other opiates	15.1	31	21	7.8	16	20
Steroids	4.4	9	25	1.9	4	24

Table 13: Frequency of drug use in the 6 months prior to imprisonment as percentages
(Base=206) - (No inhalant use reported)

	Daily %	> Daily & < Weekly %	Weekly %	Fortnightly %	Less often %	No use %
Tobacco	80.1	3.4	-	-	.5	16.0
Cannabis	43.2	13.1	4.4	2.9	6.9	29.7
Alcohol	27.7	29.6	13.1	7.8	8.7	13.1
Heroin	11.7	2.4	-	1.5	6.4	78.2
Amphetamines	4.4	4.4	1.0	1.5	13.1	75.8
Cocaine	3.4	1.5	1.5	0.5	4.3	88.8
Benzodiazepines	3.4	3.4	1.0	1.0	3.9	87.4
Barbiturates	1.9	1.5	-	0.5	4.0	92.2
Analgesics	1.5	1.0	0.5	0.5	5.4	91.3
Other opiates	1.0	1.9	0.5	-	2.9	93.7
Hallucinogens	1.0	1.0	1.5	0.5	6.4	89.8
Steroids	-	0.5	-	-	0.5	99.0

Table 14: Daily drinkers' consumption levels
[Base=57]

	%
Standard drinks	
4 or less	3.6
5-8	12.3
9-12	8.8
13+	73.7
Unsure	1.8
Total	100

Table 15: Weekly drinkers' consumption levels
[Base=88]

	%
Standard drinks	
14 or less	2.3
15-28	1.1
29-42	2.3
43-56	-
56-84	10.2
85-154	23.9
155+	43.2
Binge (unable to further quantify)	17.0
Total	100

Table 16: Illicit drug users' consumption levels [Base=daily and weekly users of specified drug]

	Cannabis		Heroin		Amphetamines	
Grams (street weight)	Daily (n=88) No.	Weekly (n=36) No.	Daily (n=24) No.	Weekly (n=5) No.	Daily (n=9) No.	Weekly (n=11) No.
< gram	8	10	11	-	2	2
≥ 1 ≤ 2 grams	30	11	11	4	2	4
> 2 ≤ 3 grams	6	5	1	1	2	1
> 3 ≤ 5 grams	18	4	1	-	-	1
> 5 ≤ 7 grams	9	3	-	-	2	
> 7 ≤ 10 grams	3	1	-	-	-	1
> 10 grams	14	2	-	-	1	2

4.3 *Injecting history*

Of the total sample, 48.1% had injected drugs on at least one occasion in the past and of this group, almost half (49.5%) had shared needles on at least one occasion. When asked if they had used drug injecting equipment in the 6 months prior to imprisonment, 28.6% of the sample reported doing so. Of this injecting group, 30.5% had shared equipment on at least 1 occasion during the same period.

4.4 *Problematic AOD use*

AOD-related problems, in the six months prior to imprisonment, were reported by 67.5% of the sample. Table 17 shows the types of drugs identified by this sub-sample as causing problems.

When asked to identify their primary problem drug, the majority (66.4%) of this group cited alcohol, with 15.0% citing heroin and 5.7% citing amphetamines as their primary problem.

Table 17: AOD problem type[n=139*, mult. response]

	No.	%
Alcohol	114	82.6
Heroin	28	20.3
Cannabis	25	18.1
Amphetamines	12	8.7
Pills	9	6.5
Cocaine	9	6.5
Hallucinogens	2	1.5
Tobacco	1	0.7

*1 missing case

In terms of co-habitants, 31.5% of the sample reported living with someone who had an AOD problem, prior to their current imprisonment.

4.5 *Problem severity scales*

Using self-identified problematic drug use (excluding alcohol) as a filter, 23.8% (n=49) were administered the Severity of Dependency Scale (SDS). Figure 3 shows

the distribution of responses for the 5 items which comprise the SDS. The median score obtained by the sub-sample of drug users was 9. In the past a cut-off score of 5 or more has been used to indicate drug dependency and 75.5% of this group satisfied this diagnostic criteria. Those who self-identified problematic alcohol use (n=109, 5 missing cases) were administered the ICQ-A (Impaired Control Over Alcohol Intake). Impaired control is central to the concept of dependency. Figure 4 shows the distribution of responses for the ICQ-A. Of the group, 14.7% obtained the maximum score of 15 and the median score for the group was 10. On all 5 items, the majority showed impaired control on a frequent basis. Those drinking behaviours in which alcohol users showed least control (nearly always/always) were cessation of drinking after 2 drinks (56.9%) and limitation of quantity (< 6) by planning drinking limits (47.7%). Of the group, 60.6% were frequently unable to stop drinking even if other plans were in place (Item 2).

4.6 *Self-perceptions on the psycho-pharmacological effects of alcohol*

Those who were current drinkers (prior to imprisonment) were presented with a series of statements on the effects of alcohol using a Likert type response format. Table 18 shows self-perceptions on the effects of alcohol. It can be seen that 62.1% were of the opinion that their alcohol consumption led to violent behaviour, at least some of the time. When the response categories were collapsed the following incidence rates on the self-perceived effects of alcohol were found:

- impaired judgement (77.2%);
- increased courage (68.4%);
- release of anger (58.8%);
- increased feelings of power (58.4%);
- using it to increase aggression (37.4%).

4.7 *Self-perceptions on the frequency of hostility*

Data was collected on the various contexts in which offenders were involved in verbal (arguments) and physical conflicts (physical fights). When findings on verbal arguments (Table 19) and physical fights (Table 20) are compared it can be seen that frequency rates are comparable when the context is a pub/club or on the street. Therefore, for those who become involved in arguments in these contexts, for the most part, the conflict escalates into physical violence. The response categories were collapsed to examine the incidence of violent behaviour. Of the sample, 81.1% reported that they were physically violent in at least one of the identified contexts. They reported violent behaviour in pubs/clubs (60.0%), at home (38.4%), at the home of an ex-spouse/sexual partner (24.0%), in the street (44.7%), in prison (41.1%) and at work (10.6%). In the majority of cases alcohol was perceived to be related to the violent behaviour, at least some of the time (Table 21). Further, 14.6% of those who were violent, reported exhibiting the behaviour in multiple contexts: at home, in the pub and on the street. Also, of those who were violent, a small number identified context specific violence as follows: pub (8.4%), home (7.8%), home of ex-partner (1.9%), street (3.6%), prison (3.0%) and work location (0.5%).

5. Psychological Measures

5.1 *Anger (STAXI)*

Table 25 (Annex 2) shows findings from the scale selected as a measure of the experience and expression of anger (STAXI). By way of comparison, Table 26 (Annex 2) shows the normative data collected on general inmates in the United States. The mean trait score for the sample (20.2) was slightly lower than

that reported for the normative prison sample (21.7) and only slightly higher than that reported for the general population of males (18.6). The sample was also slightly higher (mean=8.2) on angry temperament (Trait T) when compared to the general population (6.24) and the prison population (7.3). The most common anger traits among the sample were:

- becoming furious when criticised in front of others (79.6%);
- fiery tempered (77.9%); and
- quick tempered (73.8%).

5.2 *Childhood Conduct Disorder*

The Diagnostic Interview Schedule (DIS) was used to apply the DSM III criteria. Using this criteria, 69.4% of the sample satisfied the criteria for Childhood Conduct Disorder (CCD). As Table 27 (Annex 3) shows the most common CCD symptoms among the sample were: truancy (73.2%); theft (63.9%); habitual lying (50.2%); and fight provocation (49.5%).

5.3 *Anti-Social Personality Disorder*

A diagnosis of CCD was essential inclusion criteria for a further diagnosis of adult Anti-Social Personality Disorder (ASPD). Of the total sample, 63.1% satisfied the diagnostic criteria for ASPD. Apart from criminal history which was inclusion criteria for this study, the most common ASPD symptoms among the sample were (Table 27):

- physical fighting (88.2%);
- unstable employment history(72.0%);
- domestically violent (70.6%); and
- procures money illegally (61.4%).

DIS measures of violent behaviour showed the following prevalence rates:

- use of weapons while fighting (41.7%);
- serious property damage (28.1%); and
- unprovoked assaults (27.5%).

A lack of remorse, as the only psychological construct in the DSM III diagnosis, was reported by 27.6% of the sample. Kruskal Wallis tests were applied and it was found that those with an ASPD diagnosis scored significantly higher on both the trait anger measure (χ^2=17.6.1, df=1, p<.001) and the impaired control over alcohol intake measure (χ^2=5.1, df=1, p<.05).

6. Intervention

6.1 *Community-based*

With regards to AOD treatment history, 47.6% of the sample had undertaken some form of community-based treatment in the past. In contrast, only 13.1% had ever participated in some type of community-based treatment program for violent behaviour and three-quarters of this group had attended treatment for under 3 months.

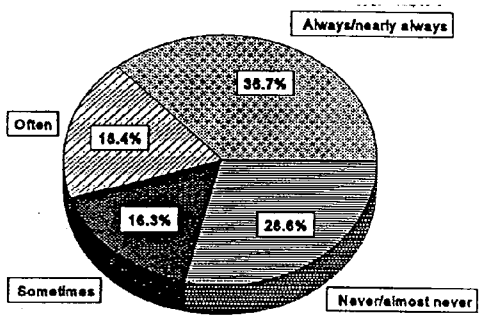
6.2 *Prison-based*

The prison-based AOD Services had been used (on at least 1 occasion) by 36.9% of the sample during their current term of imprisonment. Also, 7.8% were current recipients of prison-based methadone treatment. Prescribed medication (excluding methadone) was currently being taken by 24.8% of the sample. Prison-based treatment for violent behaviour had been undertaken by 23.8% of the sample during their current sentence. The most common program undertaken by the sample was an Anger Management course (71.4%). The STAXI scores of those who completed an Anger Management course were compared to those who had not. There were no significant differences in the mean trait anger scores obtained by the two groups.

Figure 3: Severity of Dependence Scale (SDS)
(Base=49)

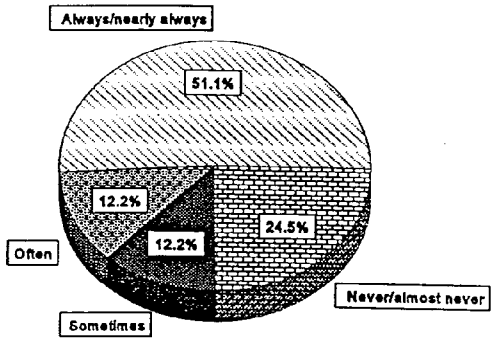
SDS-1

Did you think your use was out of control?



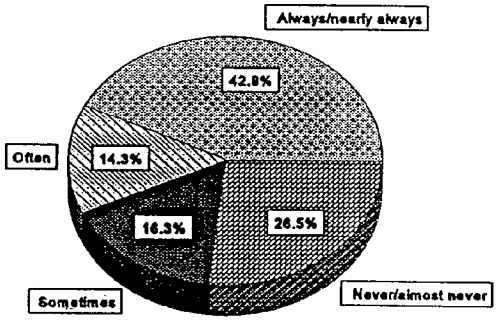
SDS-4

Did you wish you could stop?



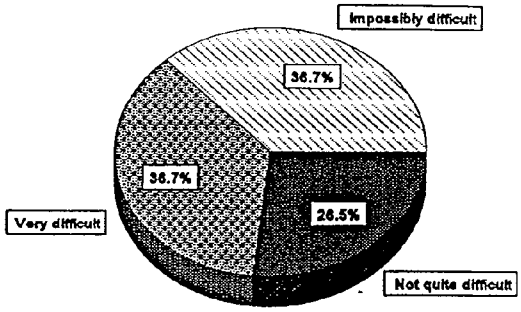
SDS-2

Did the prospect of missing a hit make you anxious?



SDS-5

How difficult did you find it to stop or go without?



SDS-3

Did you worry about your use?

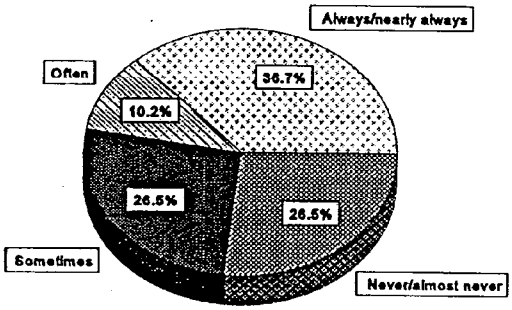
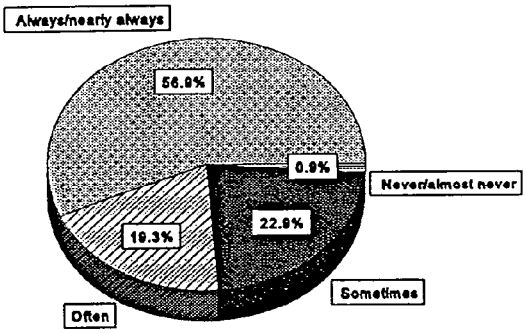


Figure 4: Impaired Control over Alcohol Intake scale (ICQ-A)
(Base=109)

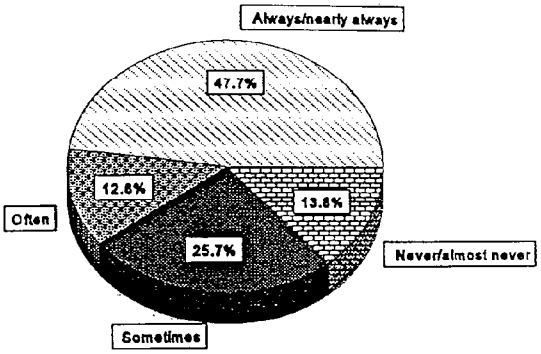
ICQ-A1

After having 1 or 2 drinks, I felt like having a few more



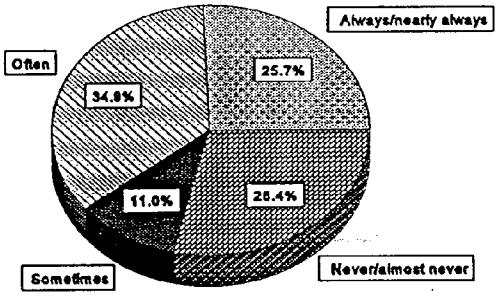
ICQ-A4

When drinking I planned to have at least 6 drinks



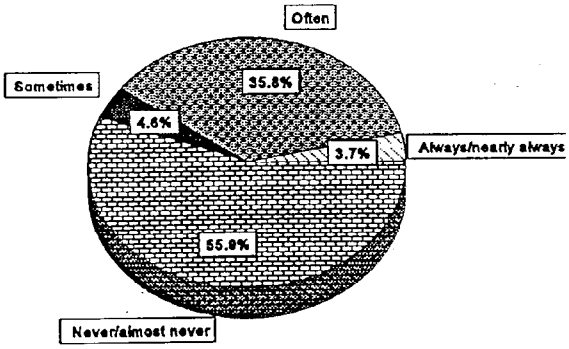
ICQ-A2

After 2 or 3 drinks, I could stop if I had other things to do



ICQ-A5

When drinking, I planned to have no more than 2/3



ICQ-A3

When drinking, I found it hard to stop until fairly drunk

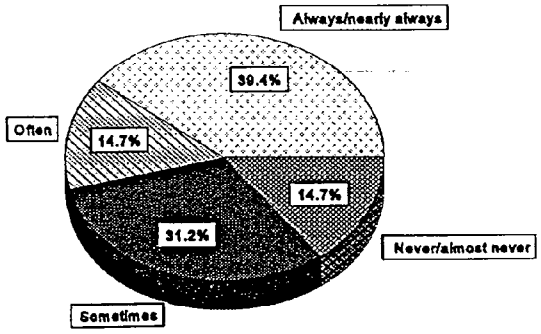


Table 18: Perceptions on the effects of alcohol consumption on mood & behaviour as percentages

	Always	Often	Sometimes	Never	Total
1. When I drink alcohol I become violent	7.3	7.3	47.5	38.0	100
2. The aggression is already there, I use alcohol to tip me over the edge	6.2	5.6	25.6	62.8	100
3. When I drink alcohol I have more courage	16.7	15.0	36.7	31.7	100
4. Alcohol helps me to express my anger	14.4	11.1	33.3	41.1	100
5. Alcohol makes me more relaxed	21.1	21.1	46.1	11.7	100
6. I feel less aggressive when I drink alcohol	10.0	11.7	41.1	37.2	100
7. When I drink alcohol I become more confident	20.0	17.2	39.4	23.3	100
8. Alcohol makes it harder for me to judge a situation	20.6	18.3	38.3	22.8	100
9. When I drink alcohol I feel more powerful	15.0	10.6	32.8	41.7	100
10. Alcohol does not really effect how I feel	11.7	3.3	35.0	50.0	100

Table 19: Patterns of conflict: arguments as percentages

	Pubs/clubs (n=188)	Own home (n=198)	Home of ex-partner (n=119)	Street (n=201)	Work (n=180)	Prison (n=202)
Weekly or more	10.6	28.8	18.5	6.0	4.4	10.9
Fortnightly	4.8	9.6	13.5	7.0	5.0	6.9
Monthly	20.7	21.7	13.5	13.4	7.8	11.9
Less than monthly	24.0	18.7	17.6	18.9	13.3	18.3
Never	39.9	21.2	37.0	54.7	69.5	52.0
TOTAL	100	100	100	100	100	100

Table 20: Patterns of conflict: physical fights as percentages

	Pubs/clubs (n=185)	Own home (n=196)	Home of ex-partner (n=121)	Street (n=195)	Work (n=180)	Prison (n=197)
Weekly or more	6.5	2.6	1.7	4.1	1.7	0.5
Fortnightly	2.7	2.6	5.0	2.1	1.1	0.5
Monthly	20.5	8.7	4.1	15.4	1.1	12.2
Less than monthly	30.3	24.5	13.2	23.1	6.7	27.9
Never	40.0	61.7	76.0	55.4	89.4	58.9
TOTAL	100	100	100	100	100	100

Table 21: Patterns of conflict: alcohol-related physical fights as percentages

	Pubs/clubs (n=117)	Own home (n=67)	Home of ex-partner (n=30)	Street (n=116)	Work (n=21)	Prison (n=77)
Always	62.4	41.8	60.0	31.1	14.3	-
Sometimes	26.5	37.3	26.7	43.3	14.3	3.9
Rarely	7.7	7.5	6.7	6.7	19.0	6.5
Never	3.4	13.4	6.7	18.9	52.4	89.6
	100	100	100	100	100	100

7. Female Sample

The findings arising from the female assault sample (n=9) suggest that as a group they vary markedly to their male counterparts.

Offence event

All the females reported intoxication at the time of offence. However, most (n=6) were intoxicated by drugs alone or in combination with alcohol (n=2). Intoxication by alcohol solely, was reported by 1 of the female sample. Heroin (n=4) and methadone (n=4) were the most commonly reported drugs of intoxication and injecting (n=5) was the most commonly reported mode of administration. All 3 of the women who drank alcohol consumed spirits. The assault victims were most commonly police/security guards (n=4) or strangers (n=2). Consistent with victim type, location of assault was most commonly a custodial setting (n=3) or the street (n=3). Most of the women (n=6) stated that the assault followed an argument and most (n=6) reported that they 'just snapped' or 'lost their temper' prior to the assault. Based on the perceptions of the sample, most of the victims were not intoxicated (n=5). About a third reported that they took into account the physical circumstances of the scene, such as size or age of the victims, number of people present or the presence of weapons prior to assaulting the victim. In all 3 cases it was the number of opponents present.

Background

The majority (n=6) cited welfare payments as their main source of income prior to imprisonment, with crime (n=2) also being cited. Of the women, 4 reported that they had no regular occupation. Prior to imprisonment, 5 reported living with someone who had an AOD problem and 8 stated that they were parents.

Most (n=8) were raised by their biological parents and most reported (n=7) that someone in their immediate family had a AOD problem during their childhood. No one reported a history of psychiatric hospitalisation. In terms of victimisation from prior abuse, 4 reported a history. Two reported being victims of child physical assault and 3 reported being physically assaulted as adults. Being a victim of sexual assault as an adult was reported (n=1), however there were no reports of child sexual assault.

Most of the sample (n=5) perceived there to be a connection between their drug use and current imprisonment and either intoxication or withdrawal from drugs was the most commonly cited type of relationship. Nearly all reported trying heroin (n=8) and benzodiazepines (n=8) at least once in their lives and 5 reported daily heroin use prior to imprisonment. Of the sample, 6 had used drugs intravenously in the 6 months prior to imprisonment and of these 2 had shared needles. Heroin (n=3) and pills (n=3) were the drugs most commonly cited as the primary problem drug, with alcohol being reported by one. Applying the Severity of Dependency Scale showed that 5 of the sample satisfied the criteria for dependency. All 9 had received community-based drug treatment at some time in the past and most had received methadone maintenance (n=7). Community-based treatment for violent behaviour was not reported. One female satisfied the criteria for Childhood Conduct Disorder and Anti-Social Personality Disorder. Of the sample, 2 reported to be physically violent across a variety of contexts and this appeared to be alcohol-related. About half (n=5) had used the prison-based AOD Services during their current sentence and 2 had undertaken an anger management course to address their violent behaviour. At the time of interview, most (n=6) were on methadone.

Tables 22 to 24 provide a more qualitative snapshot of the common themes behind the inmates' accounts of their assault offence. The accounts highlight the significance of antecedent intimate relationships, attitudes and expectations about the behaviour of female sexual partners and the inability to assertively deal with conflict and feelings of hostility. The accounts also demonstrate concomitant high intake levels of alcohol and other drugs.

Table 22: Inmates' accounts of the circumstances of their assault offence, including AOD use (male sample)

WHERE A SEXUAL PARTNER WAS THE VICTIM	
"I was coming down (withdrawing from speed)...I felt jealous and deceived...she wouldn't go home when I told her to (leave the pub)...she made a fool of me...she kept the kid away from me because she thought I'd kill him...people can't be protected by a piece of paper (re. Apprehended Violence Orders)." - also assaulted son (1 gram heroin and > 10 std. drinks)	*"My sister and girlfriend went out all night... I couldn't go to work because of the kids...it got too much, my sister and girlfriend ganging up against me... she pressed the buttons... I should have killed her and got it over and done with."* (no alcohol or drugs taken)
"I found out she (ex-wife) was having an affair with someone while I was in gaol. I was confused, angry, dumb-founded." (> 10 std. drinks)	*"I was feeling jealous...she wouldn't talk to me...I wanted her to talk to me...it took two blokes to put me down."* (> 10 std. drinks)
"She was swearing... and I got sick of it... I told her not to have a drink... I tried to let her know not to have a drink." (> 20 std. drinks)	*"I didn't like her smoking (cannabis)...we were owed drug money and I got stressed about it... took it out on her."* (> 20 std. drinks)
"She was swearing... if you don't hit them, they will be there all night... I told her to get (leave the pub)... I hit her to put her in her place." (> 20 std. drinks, 3 grams cannabis)	*"I caught my fiancee and my mate in bed together. I dragged him outside and hit him and then came back and hit her and then went back to the pub."* (> 20 std. drinks)
"I was hurt and angry...she had an abortion without my permission...it hit me like a ton of bricks... she didn't talk to me about it." (½ gram speed, 2 grams cannabis and > 10 std. drinks)	*"We had an argument about money...I went to a friend's place to drink and then came home and hit her... I just wanted to finish the argument...she argues verbally better than me, but I know I can beat her physically."* (> 10 std. drinks)
"According to the report, I woke up, walked into the living room, punched her and walked back into the bedroom and fell asleep...I also had a gun...I had not been taking my medication (lithium)." (4 grams speed and 3 grams cannabis)	*"We were arguing, she was aggravating me, so I went to bed... she kept on annoying me...I can't remember what happened after that... she said I put a pillow over her face."* (100 mgs methadone and > 20 std. drinks)
"I was really pissed off...wild... when I loose my temper I go to a certain point and then I black out...the alcohol made me do it." ("heaps" of alcohol (unable to quantify))	*"I wanted to get rid of her... break it off... I snapped when she tried to walk away."* (> 20 std. drinks, 1 gram cannabis)
"I was cold-shouldered by my ex outside the pub...blacked out... friend told me what had happened." (> 20 std. drinks)	*"She was trying to argue with me...I ignored her...she hit me with a rock and stuck...then I flattened her...I was wild...got sick of her hitting me...told her to wake up to herself."* (> 20 std. drinks)

Table 23: Inmates' accounts of their assault offence (male sample) cont.

WHERE A STRANGER WAS THE VICTIM	WHERE AN OFFICER WAS THE VICTIM
"Boiling anger and it needed to be released, aggression ...I bumped into someone accidentally outside the pub and was swung at because of it and I hit back." (> 20 std. drinks, also assaulted a police officer)	*"He stopped our car and ordered my daughter out of the car with her hands in the air...I was wild...the officer's attitude was not good...he was holding his hand on his gun as he ordered my daughter out of the car."* (> 10 std. drinks)
"We were arguing over who was going to pay for the next cask (alcohol) ...wanted to teach him a lesson." (> 20 std. drinks)	*"I was being man-handled by the police...didn't like being touched...I snapped."* (> 20 std. drinks, 3 grams cannabis)
"I went to the pub after an argument with my girlfriend and a guy said some offensive things to me...he was carried out of the hotel." (250 mgs methadone (injected), 10 serepax tablets and "a lot" of alcohol (unable to quantify))	*"I had smashed a window in a shop...the police searched and found me...I assaulted 6 of them...just don't like them."* (1 gram heroin, 1 gram cannabis and > 20 std. drinks)
"Other guy got cheeky-racist things...and took the first punch...so I hit him back...snapped straight away, that's what I am like." (> 20 std. drinks)	**WHERE FAMILY OR FRIENDS WERE VICTIMS**
"The guy was a rock spider and the police would not do anything about it, so I did." (½ gram speed, 5 grams cannabis and 8 std. drinks)	*"My young child was chasing cars and getting too close to the wheel. I took him inside and gave him a couple of hits with a strap and accidently clipped him under the eye. I just thought it was another hiding...I didn't want him killed by the cars...I wanted to teach him a lesson."* (no alcohol or drugs taken)
"He tried to chat up my girlfriend at the pub and I later saw him on the street...I wanted him to know not to try it again or it maybe worse." (8 std. drinks)	*"It was a misunderstanding...we were both too drunk to know any better."* (> 20 std. drinks)
"Wanted to give him a warning...he called my partner a slut and told other people...I chucked him on the concrete." (>20 std. drinks)	**WHERE CRIME ASSOCIATES WERE VICTIMS**
"Someone got smart with me in the pub...it was provoked...once I drink spirits I can go off really easily." (> 20 std. drinks)	*"They had come to my property to assault me (dispute over drugs)...I wanted to hurt them...they had caused me a lot of problems...it was building up over a long time...I had to prove to them I wasn't an easy target, so I used a bar (iron bar)."* (no alcohol or drugs taken)
"I held a gun to the guys neck (attempted robbery) and the guy panicked and grabbed it...I felt sorry for the guy...he was in the wrong place at the wrong time." (2 grams of heroin)	*"He owed me money, besides he had raped my wife three years ago.... he laughed at me and I snapped...used an iron bar."* (⅛ gram heroin)
"It was an armed rob attempt and the other person went for me.... I just wanted to get out of there safely." (3 std. drinks and 150 mgs methadone)	

Table 24:
Females' accounts of their assault offence

WHERE A POLICE OFFICER WAS THE VICTIM

"The officer was being smart, calling me names...so I spat at him...he slammed the door and I snapped...I was hurt and angry."
(3½ grams heroin)

WHERE A SEXUAL PARTNER WAS THE VICTIM

"I was angry about supporting his habit...I had heard that he had been using because I was earning money...I wanted to let him know what it was like to have to work constantly."
(> 20 std. drinks)

WHERE A SECURITY GUARD WAS THE VICTIM

"Two security guards took me into an office under suspicion...I hadn't taken (stolen) anything, but was on the nod (intoxicated) ....we argued, he called me a black slut and then I tried to hit him with a hole puncher...I was just standing up for myself...smart arse blokes."
(½ gram heroin and 2 rohypnol tablets)

"He pushed my boyfriend... was calm before then."
(200 mgs methadone)

Discussion

Those imprisoned for assault show high rates of recidivism. The AOD Services of the Department initiated a strategy whereby the needs of those inmates who show high rates of reoffending are addressed through target programming. The present study aimed to examine factors associated with violent offending behaviour and alcohol and other drug use and to identify appropriate treatment strategies for inmates with AOD-related assault offences. Data were collected from 215 inmates imprisoned for assault by way of self-report interview during 1997.

Before discussing the findings a number of methodological limitations should be raised. In addition to the usual caveats concerning self-report data and the reliability of drug use information, it should be noted that methodology is still developing in this area of study. Future investigations will need to include a more precise, temporal reconstruction of the violent event, including the duration of alcohol intake. Also relevant, is the relationship between different drinking situations and the occurrence and escalation of physical aggression. The qualitative aspects of the interview provided additional information which may be used in the refinement of structured interviews with similar prison populations. In some cases, difficulties were experienced in the administration of the Likert type scales, such as the STAXI. To promote reliability, interviewers read the questions aloud and show cards were used to assist respondents in selecting the appropriate scaled response. However, it appeared that for a number of respondents, this type of questioning did not match their cognitive style or learning experience. Therefore, the validity of the STAXI mean scores as reported in this paper may require close attention. Responses were minimal on some of the open-ended questions concerning violent behaviour. This

may reflect a pattern of disavowal of responsibility and/or limited self-awareness. Minimisation of the seriousness of the crime and victim blaming have been identified as common themes in perpetrators' accounts of their violent behaviour [26,36]. Finally, a number of respondents stated that they had been banned from drinking establishments due to alcohol-related fighting. Being banned from drinking establishments may prove to be a valuable measure in short screening procedures for alcohol-related violent clients.

All studies carry some methodological limitations. This study was able to glean a number of general trends with regard to the commission of violent offences. Typically for male offenders, the offence episode occurred subsequent to a social setting which involved the intake of alcohol. The majority were drinking at very high levels just prior to the offence, either at a pub or a private home. Generally, they were in the company of at least one person who they knew intimately and for the most part there were a number of other people present at the time of the episode. In the majority of cases surveyed the context went on to become anti-social (as depicted by the perpetrator's inability to manage anger). These findings are consistent with those arising from a meta-analysis which concluded that heavy drinking and a verbal argument usually precede the violent act [8]. Qualitative accounts of the offence episode suggested that commonly motives comprised of a mix of anger and power and control characteristics.

Categorisation of offences by the three factor motive-based typology (expressive, instrumental and gang-related) was not that meaningful. For the majority, the origin of the violence was reportedly expressive. Less than one tenth of the sample reported that their motive was instrumental (to get something from the victim). Further, only one respondent reported that his offence was based on gang membership. It would appear that the three factor typology may be overly simplistic for the current data as victims were most commonly sexual partners. Generally, there would appear to be an overlap of both expressive and instrumental motives in this group of offenders.

The present findings fail to support the hypothesis that alcohol-related violence is solely an artefact of immediate social interaction. In this study, drinking commonly occurred in one location and the assault event occurred in another.

In some cases the violent event may have been indicative not only of the perpetrator's condition, but also of the prevailing social norms of the setting. Typically there were other people present and there may have been a normative tolerance of alcohol-related violence in at least some of these settings. For the most part, when the respondents were asked about their own victimisation from violence, they expressed a high acceptance of violent behaviour and the injuries they had personally sustained as a result of violence.

Findings indicate that the majority of those with drinking problems held strong expectancy beliefs in relation to the exacerbating effect of alcohol intake on violent behaviour. When violent behaviour was examined in a variety of contexts, respondents perceived there to be a relationship between their intake of alcohol and subsequent violence, at least some of the time. When provided with a series of strong statements which related alcohol consumption either to feelings or expressions of violence, courage and power, the majority indicated that their feelings and behaviours matched the statements. A high majority perceived that alcohol impaired

their judgement. The area of expectancy effects requires further and more precise investigation. The examination of expectancy effects has potential use in cognitive-based interventions, in that the offender's beliefs can be analysed and challenged and critical reasoning facilitated.

The prevalence of self-reported anger in the male sample at the time of the offence combined with high prevalence rates of verbal arguing in more than one context was not supported by comparatively high scores on trait anger. As already stated, the instrument selected to measure the experience and expression of anger may not have matched the cognitive style or learning experiences of a number of the sample. The management of anger is a major treatment issue in programs for perpetrators of violence [36, 37].

The majority of the sample received a diagnosis of Anti-Social Personality Disorder (ASPD). The diagnosis is predominantly based on repetitive anti-social behaviours, with the exception of a single psychological construct. It is not surprising that a prison sample would show a high prevalence of the disorder. However, for correctional professionals who use the diagnoses of ASPD and sociopathy/psychopathy interchangeably, the identified prevalence rate of 63% would be unexpected. A recent study which compared diagnosis rates using the DIS ASPD scale (behavioural constructs) and Hare's Psychopathy Checklist (psychological constructs) identified a marked disparity in diagnosis between the two instruments [38]. Subjects were significantly more likely to receive a positive diagnosis when the DIS ASPD scale was administered than when the Psychopathy Checklist was administered. It appears that more work is required on the operationalisation of the concept and the corresponding validity of measurement devices for this diagnosis.

Findings pertaining to the female sample, though small in number, suggest markedly different patterns to the male sample. All females reported intoxication at the time of their offence and this was most commonly from drugs (excluding alcohol). The victims of female offenders were commonly law enforcement officers assaulted during the course of apprehending the offender on other matters, or strangers. Of the nine females, one appeared to demonstrate problematic alcohol-related violence across a number of contexts. That one third were charged with assault during the course of apprehension, suggests that these findings could be a matter for law enforcement officials to address in terms of appropriate apprehension procedures for intoxicated suspects, including strategies to diffuse conflict.

Program development

The mix of problems around the alcohol and violence relationship may preclude a clear explanation. For the purposes of current program development, it would seem both conceptually and empirically sound to integrate the expectancy hypothesis (beliefs and expectations) with the cognitive impairment hypothesis (impairs a person's capacity to process and interpret information accurately).

The present findings, though preliminary, support the importance of matching client and treatment types. Logically those imprisoned for assault will vary widely and no single paradigm will meet all their needs. Further, the severity of the drinking problem and any sustained damage and also the nature and level of violent behaviour have clear implications for assessment procedures and program goals, content and format.

According to Holcomb & Adams, those who

become violent without alcohol or other drugs should receive treatment and prevention efforts directed towards increasing interpersonal sensitivity and psychological mindedness, but decreasing psychopathic qualities [39]. For those with AOD problems these efforts need to be integrated with AOD treatment. They described the client group as very untrusting and ready to perceive malevolent motives in others. Therefore, program objectives would encompass the improvement of interpersonal perceptions and higher levels of trust.

A two year treatment follow-up study conducted in the United States on a sample of alcohol dependent individuals (n=96) found that those measuring high on sociopathy had better outcomes in cognitive-behavioural coping skills treatment [40]. By contrast, those with cognitive impairment showed better outcomes in interactional treatment. The authors inferred that those with sociopathy performed better in coping skills treatment because it provided specific anger management skills and also because it did not require strong interpersonal relationships among group members. Whereas, those with impaired cognitive functioning found the group interaction more supportive and the coping skills treatment, with the many skills and homework, too complex.

The current findings on victim typology showed that intimate sexual partners were most frequently cited as victims. This pattern combined with the qualitative findings derived from inmates' accounts of the circumstances of their conflict lends strong support for the development of a specific program for alcohol-related domestic violence. The distinct advantage of engaging the perpetrator in treatment while in prison is that the family victim is protected during the course of the program. Understandably interventions for domestic violence to date have focused on victim needs. Yet, as Lehmann & Krupp point out, subsequent to the violence, many victims do not leave the abusive relationship or eventually return to the relationship [41]. Therefore, a broad-based response would not only include victim services, public awareness campaigns and criminal sanctions for the perpetrator, but also rehabilitation. Realistically, given the high level of perpetrator recidivism, a continual focus on the immediate needs of the victim is insufficient to bring about a resolution to this problem.

Not surprisingly, the current state of knowledge on the causes of domestic violence is also at the cross roads of inter-disciplinary integration. In a recent review, Lee & Weinstein argued that no single sociological or psychological theory adequately accounts for those who exhibit the violent behaviour [42]. Rather, the behaviour appears to be potentiated through an interaction of societal mysoginistic values and personality dispositions. This explanation would allow for a combination of power and control and expressive motives. These motives are not seen to be mutually exclusive.

Generally, domestic violence programs specifically address violent behaviour towards partners and beliefs and expectations about the role of partners. Such programs place a direct focus on the behaviour of the perpetrator, his/her violence and responsibility for change. Dobash & Dobash in their program evaluation reported that the development of empathy was crucial for change in this client group [26]. In addition, program participants identified the following components as being most useful in bringing about change:

- group discussions about the minimisation and denial of violence and attitudes towards partners

- discussions aimed at teaching them to recognise the 'triggers' associated with their violent acts.

Alcohol has been shown to be a significant risk factor in sexual partner violence [5]. Further, some evaluations of domestic violence treatment programs have related recidivism to alcohol and drug misuse [42]. In complementing the above strategy, an alcohol-related domestic violence program would reject the notion that alcohol intoxication is an excuse for violent behaviour. Using the same approach, perpetrators ideas about the influence of alcohol could be analysed, challenged and reeducated and the role of alcohol in the escalation of violent acts could be examined.

Differences were found between Aboriginal and non-Aboriginal problem drinkers. Some of the differences, such as higher poverty and unemployment, are structural disadvantages to be addressed by the broader society. Many Aboriginal prisoners reported residing in remote communities and treatment linkage with these communities would promote appropriate treatment responses. Currently, specialised services are offered to Aboriginal prisoners. Culturally relevant service provision should continue with increased linkages to the communities of origin, particularly in terms of pre-release treatment programs. The AOD Services of the Department has already trialed an initiative whereby the elders of various communities were invited to conduct AOD and health promotion groups with prisoners from their communities. The cost of transport and meals was met by the Department and community response was positive. While no formal evaluation was conducted, informal reports indicated a reduction in community displacement for Aboriginal prisoners on release.

There are no documented evaluations showing that the integration of treatment programs for AOD and violence is effective. However, in those cases where there are concomitant AOD and violence problems it seems plausible that there may be benefits for the individual and the larger community through treatment linkage. According to a number of studies, violent behaviour does not cease if the alcohol problem is addressed in isolation [43,44]. In this jurisdiction, there exists a real potential to systematically link alcohol treatment and violence treatment programs as there is not the barrier of differing philosophical treatment perspectives. Many of the violence treatment programs available are based on cognitive-behavioural principles and show compatibility with current practices in the alcohol and other drug treatment field. Typically, violence treatment programs directly address and challenge violent behaviour and associated attitudes, and assist participants to construct more positive methods of dealing with conflict. Where the disease model is the orientation for alcohol treatment there would be a barrier to integrating the programs.

This prison sample was a highly selected sub-group and possibly represented the worst cases of the general population of perpetrators whose violence was AOD-related. A sizeable proportion of the group appeared to be chronic drinkers and some may have sustained a degree of brain damage, either from alcohol consumption or head injuries. These findings have pertinent implications for the integration of alcohol and violence treatment in terms of program development and the appropriate placement of clients. If the prevalence and severity of drinking problems in this assault sample is representative of the population of those imprisoned for assault, then treatment needs go beyond the minimal intervention, alcohol education components evident in many anger management and violence treatment programs currently offered in correctional settings. The tremendous human cost of

violence attests to the need for more attention to this issue, with particular reference to the development well-targeted treatment responses for violent offenders.

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Annex 1

Sample Confidence Limits

The formula for a binomial test gives a 95% Confidence Limit of $\pm t\sqrt{pq}/\sqrt{n}$

For the AOD sub-sample:

$p = 0.80$ $\quad$ $CL = \pm 0.05$

$n = 215$

Where CL $= \pm 1.96\sqrt{.80.20}/\sqrt{215}$

$= \pm 0.05$

Annex 2

Table 25: State & trait anger (STAXI) - current sample [Base=206]

Means, Standard Deviations and Alpha Coefficients							
	State	Trait	Trait/T	Trait/R	AX/IN	AX/OUT	AX/CON
Mean	12.2	20.2	8.2	7.9	16.8	16.6	21.3
SD	3.9	6.3	3.3	2.6	4.2	4.2	5.6
α	.86	.86.	.86	.70	.68	.72	.86

Table 26: State & trait anger (STAXI): U.S. inmates [Base=563]

Means, Standard Deviations and Alpha Coefficients							
	State	Trait	Trait/T	Trait/R	AX/IN	AX/OUT	AX/CON
Mean	15.1	21.7	7.3	9.6	18.1	16.5	24.8
SD	6.6	6.7	3.3	3.0	4.6	4.9	4.9
α	.91	.87	.87	.87	.73	.82	.80

The following definitions have been taken from the STAXI inventory[29]:

State Anger: A 10 item scale that measures the intensity of angry feelings at the time of interview.

Trait Anger: A 10 item scale that measures individual differences in the disposition to experience and express anger. The T-Anger scale has two sub-scales.

Trait-T: A 4 item trait subscale that measures a general propensity to experience and express anger without specific provocation (temperament).

Trait-R: A 4 item trait subscale that measures individual differences in the disposition to express anger when criticized or treated unfairly by other individuals (reaction).

Anger-in(AX/IN): An 8 item anger expression scale that measures the frequency with which angry feelings are held in or suppressed (suppression frequency).

Anger-out(AX/Out): An 8 item anger expression scale that measures how often an individual expresses anger toward other people or objects in the environment (expression frequency).

Anger Control(AX/Con): An 8 item scale that measures the frequency with which an individual attempts to control the expression of anger (control frequency).

Annex 3

Table 27: Childhood Conduct Disorder (1-12) & Anti-Social Personality Disorder(13-46)

1. **History of truancy**		73.2%
	Average age of onset	12
	Age range	4yrs -14yrs
2. **History of fight provocation**		49.5%
	Average age of onset	10
	Age range	4yrs-14yrs
3. **History of intentional use of weapons against others**		20.8%
	Average age of onset	12
	Age range	5yrs-14yrs
4. **History of intentional injury to others**		34.6%
	Average age of onset	11
	Age range	4yrs-14yrs
5. **History of intentional cruelty to animals**		16.6%
	Average age of onset	10
	Age range	4yrs-14yrs
6. **History of leaving home**		43.4%
	Average age of onset	12
	Age range	3yrs-14yrs
	Those who did not return after first run away episode	4.5%
7. **History of habitual lying**		50.2%
	Average age of onset	10
	Age range	3yrs-16yrs
8. **History of theft**		63.9%
	Average age of onset	10
	Age range	7yrs-14yrs
9. **History of robbery/attempted robbery**		10.7%
	Average age of onset	14
	Age range	7yrs-14yrs

Table 27: cont.

10. **History of deliberate destruction of other's property**	21.5%
Average age of onset	13
Age range	7yrs-14yrs
11. **History of deliberate fire starting**	16.6%
Average age of onset	11
Age range	5yrs-14yrs
12. **History of sexual assault**	0%

Adult Anti-Social Personality Disorder

13. **Intentional destruction of property or starting fires**	28.1%
Incident within past 12 months*	5.3%
14. **Arrests**	
Incident within past 12 months*	86.4%
15. **Criminal convictions**	
Incident within past 12 months*	86.8%
16. **Traffic violations** (speeding, running lights, causing accidents-4 incidents)	49.3%
Incident within past 12 months*	31.6%
17. **Sexual conduct** (filter question - ever had a sexual experience)	
18. **Sexual assault**	1.5%
Incident within past 12 months*	0.0%
19. **Inability - fidelity in a relationship**	10.6%
No relationship experience at all	3.5%
20. **Soliciting**	6.9%
Incident within past 12 months*	16.7%
21. **Pimping**	5.9%
Incident within past 12 months*	18.2%
22. **Procuring money illegally**	61.4%
Incident within past 12 months*	36.6%

Table 27: cont.

23. Failure to repay money, including moving premises to avoid paying rent	22.8%
Incident within past 12 months*	20.0%
24. Sued for a bad debt or repossession (more than 2 occasions)	2.0%
Incident within past 12 months*	0.0%
25. Ever married or lived as married (filter question - 91.7%)	
26. Perpetrated domestic violence	70.6%
As party who perpetrated first strike (ever)	45.5%
Incident within past 12 months*	50.0%
27. Perpetration of violence against child	3.0%
28. Fighting (physical blows on more than 1 occasion)	88.2%
Incident within past 12 months*	54.0%
29. Use of weapons when fighting	41.7%
Incident within past 12 months*	29.8%
30. Assault (other than while fighting)	27.5%
Incident within past 12 months*	38.0%
31. Lack of Remorse	27.6%
Blamed victim (of those who lacked remorse)	85.5%
32. Job instability (3 jobs in 5 years)	64.4%
Never employed	4.1%
33. Recent job instability	41.1%
34. Pattern of resigning without ongoing work	26.0%
35. Pattern of absenteeism/lateness	30.7%
36. Unemployment for more than 6 months in previous 5 years	72.0%
37. Use alias or assumed name	30.4%
Incident within past 12 months*	27.4%
38. Habitual lying	27.0%
Incident within past 12 months*	63.6%

Table 27: cont.

39. **Wandering/vagrancy**	41.2%
Incident within past 12 months*	26.1%
40. **Homelessness** (for a month or more)	36.6%
Incident within past 12 months*	29.7%
41. **Ever acted as a parent for a child** (filter)	76.0%
42. **Failure to financially support child dependents while receiving income**	18.2%
Incident within past 12 months*	52.4%
43. **Leaving children under 6 years at home without carer**	1.9%
44. **Failure to feed or care for children overnight**	1.9%
45. **Claims of child neglect** (nurse, social worker or teacher)	0.6%
46. **Failure to financially support family** (money spent on self, including entertainment)	8.6%

* As a percentage of the sub-group who reported the behaviour.