



Public Health  
England

Protecting and improving the nation's health

# **Brief interventions in prison: Review of the Gateways initiative**

January 2017

## About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support the government, local authorities and the NHS in a professionally independent manner.

Public Health England

Wellington House

133–155 Waterloo Road

London, SE1 8UG

Tel: 020 7654 8000

[www.gov.uk/phe](http://www.gov.uk/phe)

Twitter: [@PHE\\_uk](https://twitter.com/PHE_uk)

Facebook: [www.facebook.com/PublicHealthEngland](https://www.facebook.com/PublicHealthEngland)

Prepared by: Arun Sondhi, Alisha Cooper, Kieran Lynch, Ruth McGovern, Dorothy Newbury-Birch, Jenny Seddon and Ed Day.

For queries relating to this document, please contact: [Nino.Maddalena@phe.gov.uk](mailto:Nino.Maddalena@phe.gov.uk)

© Crown copyright 2017

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit [OGI](https://www.ogil.io) or email [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk). Where we have identified any third-party copyright information, you will need to obtain permission from the copyright holders concerned.

Published January 2017

PHE publications gateway number: 2016597



# Contents

<b>Executive summary</b>	4
<b>Glossary</b>	7
<b>Introduction</b>	8
Gateways initiative	10
Aims and approaches	11
Definitions of brief intervention	12
Current epidemiology	14
<b>Review of the literature</b>	22
Overview	22
Literature review method	27
Results	31
Discussion	43
Conclusion	47
<b>Stakeholder discussions</b>	49
Staff interviews	49
Prisoner interviews	55
<b>Implementation</b>	57
Staff satisfaction with training	57
Implementation of brief interventions	59
<b>Suggested next steps</b>	60
<b>Appendix I: Main body references</b>	62
<b>Appendix II: Literature review references</b>	64
<b>Appendix III: Brief intervention fact sheets</b>	69
<b>Appendix IV: Brief intervention manual (title page)</b>	74
<b>Appendix V: Published academic papers (title pages)</b>	75

## Executive summary

This report summarises the work and findings from the implementation of alcohol brief interventions across 10 prisons in the North West of England that form part of the Gateways initiative. The aim of this project was to develop a suite of interventions for non-dependent alcohol drinkers who may be relatively treatment-resistant, but who commit a disproportionate share of crime. The assumption for this project was that reductions in alcohol consumption by offenders (even by small amounts) will have a greater effect on reconviction rates.

---

### Outputs

The following outputs were delivered as part of this project:

- a literature review of the efficacy of brief interventions in a custodial setting
- the publication of fact sheets focusing on studies of brief interventions in prison, probation and police custody settings. An additional fact sheet has been produced examining issues specifically surrounding brief intervention use by any young people in the criminal justice system (in collaboration with Newcastle University – see Appendix III)
- a brief intervention manual modelled on the Routes to Recovery work published by Public Health England (see Appendix IIV)
- the provision of two training events to disseminate best practice in delivering brief interventions and the components of the manual
- the submission of an academic paper discussing issues pertaining to brief interventions in prison (see Appendix V)

## Findings

### Literature review and fact sheet

- the literature review suggests that it is possible to use validated tools as part of the screening process in a prison setting, and that it is best to screen prisoners after a period of time rather than as part of a reception or induction process

- prisons should target younger users, as brief interventions may be more appropriate for this segment of the offender population than more structured interventions
- the literature on brief interventions is weak. Much of the community-based literature may not translate to custodial populations
- brief interventions produce a small but significant impact in the short term, although the message may need to be reinforced within a few weeks of the original contact
- post-release may be the crucial point to intervene. Innovative methods such as the telephone adaptive care model may be more effective in engaging offenders in the community

## Interviews with prison staff

Interviews with staff from nine of the ten prisons suggested the following themes:

- brief interventions tend to be placed within an addiction or recovery context, as opposed to the lifestyle approach that is used in the community
- delivery of a brief intervention should be based at the end of a prisoner's time in prison – at the point of release – and for day-release programmes (such as release on temporary licence)
- use of the alcohol use disorders identification test (AUDIT) is problematic in a custodial setting
- units of alcohol as a focal point for brief interventions are unlikely to work, as they lack a real-world focus

## Focus groups with prisoners

Emerging findings from the ongoing interviews with prisoners included:

- prisoners were exposed very early on to risky drinking habits through parents, family members and peers. The age at which they started drinking was also noted to be very young
- units as a measure of alcohol have little salience. Measurements are made through pints/bottles consumed; the relative state of inebriation at a given point in time, and the money spent on drinking (or left available for a drink)

- prisoners were cognisant of health issues but, in themselves, these were not a driver of change. Prisoners make a stronger connection to drinking's links with offending and this should form part of the brief intervention package
- There was little awareness of support in the community, and what support there is tends to be recovery/addiction services, which may not be appropriate for the segment of prisoners who do not see themselves as addicted
- 'gate happy': the point of release is important for many prisoners – many stated that they would start drinking within moments of release, either in pubs or on trains/buses, to celebrate leaving prison

### Staff survey of satisfaction with training in brief interventions

A total of 101 staff who undertook the brief intervention training completed a bespoke workshop questionnaire: This evaluation found:

- staff were very positive about their future and potential use of brief interventions and visual mapping techniques in their practice, showing a 90–94% rate of satisfaction with the training and materials delivered
- however, only 62% of the staff surveyed expected to use the methods they had been trained in within the next month. Less than half of the staff surveyed (45–46%) believed that their organisations had the required staffing and resources to implement the training
- 58% of respondents were keen to have follow-up training. Telephone conversations (69% agreed) and internet-based support (76% agreed) were seen as positive ways to maintain engagement
- the training was seen to have validity among respondents in that brief interventions/mapping will be effective with their clients. In total, 98% of the staff surveyed agreed that the brief interventions/mapping materials were useful and 88% said they were enthusiastic about using the tools
- over three-quarters (80%) of respondents expect to use the brief interventions/mapping materials at some point in the future

## Glossary

AUDIT	Alcohol Use Disorder Identification Test
ICD	International Classification of Diseases
KLM	Kingdom Life Ministries
MoCAM	Models of Care for Alcohol Misusers
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Health and Care Excellence
RCT	Randomised controlled trial
RMC	Recovery management check-ups
SIPS	Screening and Intervention Programme for Sensible Drinking
WAFU	Workshop assessment follow-up
WEVAL	Workshop evaluation
WHO	World Health Organization

## Introduction

This project follows an initial block of work undertaken by the National Treatment Agency in 2013 examining the use of brief interventions across four prisons in the Midlands region. This project suggested that, while prisons were able to implement screening for problematic alcohol consumption through the use of the Alcohol Use Disorders Identification Test (AUDIT) with prisoners, there was a wide variation in the levels of drinking reported by the prison. For example, across the AUDIT scores of 8 to 19 (suggesting non-dependent drinking), the levels varied from 5% to 37%.

The findings from this project suggest that there were implementation issues surrounding the use of AUDIT within a prison environment, including the best time to screen (eg at reception or later); who should deliver the screening (eg healthcare staff or recovery/addiction teams), and how best to record this information for later use. For one prison (HMP Nottingham), a 'cluster of need' was developed that broadly conformed to the principles of brief intervention [1] by linking an AUDIT score identifying the prisoner's level of need to a tailored range of interventions. Despite this, the overwhelming finding from the project was that, following completion of an initial AUDIT screen, it was unclear what interventions were subsequently provided, with a suggestion that services tended to default to existing programmes and levels of support.

This report is structured over several sections. The first presents an overview of the project and the main outputs. The second provides an overview of the literature as undertaken by the University of Birmingham and King's College London. The second chapter also discusses staff and prisoner perceptions following visits to nine of the ten Gateways prisons and focus groups across four of the prisons. The subsequent chapter will discuss the findings from the training and implementation of the manual, and the final chapter will describe the suggested next steps, with the appendix detailing some of the main products provided for this project (eg the manual).

### The extent of alcohol-related problems in the UK

Drinking alcohol is a popular social activity in the UK, and many people consume alcohol with no associated problems. However, alcohol has toxic and dependence-forming properties, and the physical, psychological and social harm that it causes has been increasingly documented in the past ten years [2]. In 2011/12, there were estimated to be more than 1.2 million hospital admissions where an alcohol-related disease, injury or condition was the primary reason or a secondary diagnosis – a 4% increase on the year before [3]. Alcohol is strongly associated with a wide range of mental health problems, including depression, anxiety, drug misuse, nicotine



dependence and self-harm [4]. Heavy drinking can contribute to anxiety and depression, and can lead to non-compliance with medical treatment for these conditions. Alcohol is often implicated in relationship breakdowns, domestic violence and poor parenting, including child neglect and abuse. It contributes to absenteeism from work, accidents in the workplace and decline in work performance. Heavy drinking can also lead to job loss, and nearly 40,000 people of working age in England were claiming Incapacity Benefit with a diagnosis of alcoholism in 2007 – 2% of all claimants [5]. Alcohol-related harm is estimated to cost UK society £21 billion annually [6].

## Strategies for treating alcohol problems

Since the first national alcohol strategy was published in 2004 [7], a series of policy and guidance documents has helped to create a picture of the ideal treatment system for alcohol problems. The documents present the evidence for effective treatment strategies [2,8,9], how they should be organised and delivered in practice [10,11], and the degree to which the existing treatment system matches the ideal [12]. Models of Care for Alcohol Misusers (MoCAM) was published in June 2006 to provide best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers [10]. It outlined a tiered framework of provision to assist the development of integrated local treatment systems, and identified appropriate interventions and specific treatment options that could be commissioned to meet local need. MoCAM identified four main categories of alcohol misuser who may benefit from an intervention or treatment: hazardous drinkers, harmful drinkers, moderately dependent drinkers and severely dependent drinkers.

**1. Hazardous drinkers:** The World Health Organization (WHO) defines hazardous drinking as “a pattern of substance use that increases the risk of harmful consequences to the user... In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user” [13].

**2. Harmful drinkers:** The WHO International Classification of Diseases (ICD-10) defines harmful use of a psychoactive substance as “a pattern of use which is already causing damage to health. The damage may be physical or mental”. This definition excludes those with alcohol dependence [14].

**3. Alcohol dependence:** Dependence is characterised by an increased drive to use alcohol and a difficulty in controlling its use, despite adverse consequences. More severe dependence is often associated with physical symptoms of withdrawal when alcohol use decreases or stops.

Moderately dependent drinkers may recognise that they have a problem with drinking, even if this recognition has only come about reluctantly through pressure – for example,

from family members or employers. Severely dependent drinkers may have serious and long-standing problems. Typically, they have experienced significant alcohol withdrawal and may have formed the habit of drinking to prevent these symptoms from occurring. They may have progressed to habitual, significant daily alcohol use or heavy use over prolonged periods, or bouts of drinking. In specifying what should be commissioned in local alcohol treatment systems, four tiers of intervention were defined. Drawing on the Review of the Effectiveness of Treatment for Alcohol Problems [9], MoCAM advocated a stepped model of care. In practice, this meant a two-stage process in organising and delivering treatment interventions for alcohol misusers:

1. The provision of brief interventions for those drinking excessively but not requiring treatment for alcohol dependence.
2. The provision of treatment interventions for those with moderate or severe dependence and related problems.

## Gateways initiative

Following this initial exploratory work, NHS England commissioned a project across the Gateways prisons in the North West of England. The Through the Gate (or Gateways) initiative provides a range of bespoke interventions for substance misusers across the North West region and forms part of the government's Transforming Rehabilitation policy. Gateways aims to provide an end-to-end series of interventions aimed at the early identification of offenders arriving into prison with substance misuse issues, rapid access to specialist drug and alcohol treatment interventions, and, crucially, an enhanced level of continuity of care through the gate and back into the community to support the goals of abstinence and sustained recovery. The prisons participating in this initiative are:

- HMP Haverigg
- HMP Kirkham
- HMP Manchester
- HMP Altcourse
- HMP Forest Bank
- HMP Risley
- HMP Preston
- HMP Thorn Cross
- HMP Styal
- HMP Lancaster Farms

## Aims and approaches

The project aimed to increase understanding about the use of brief interventions within a custodial setting. The project had a series of staged approaches:

- an initial examination of the literature on brief interventions used in a custodial setting (delivered in partnership with the University of Birmingham/King's College London)
- the provision of fact sheets summarising the main points of the evidence in relation to the prevalence of alcohol misuse in the criminal justice system; young people's drinking in the criminal justice system, and the prevalence of alcohol disorders in police custody, probation and adult prison settings (delivered in partnership with Newcastle University). These fact sheets are included in the appendices
- the provision of a brief interventions manual and subsequent training to prison staff across the Gateways prisons (delivered in partnership with Newcastle University)
- an assessment of the impact of the manual and training through the completion of a workshop evaluation questionnaire and subsequent, six-month follow-up using the workshop assessment follow-up (WAFU) schedule
- focus group interviews with prisoners across four prisons, including a remand prison (Category B), trainer prisons (Category C) and a female establishment (work in progress)

An initial scoping exercise included interviews with the main stakeholders involved in the delivery of interventions for alcohol misuse (mainly the recovery/addiction services) across the ten prisons. Stakeholders were formally interviewed using a semi-structured interview schedule. Written notes were transcribed and subsequently mapped by theme. The method underpinning the qualitative analysis used visual mind-mapping techniques to identify themes from the transcripts and research notes, as this method has been shown to provide a better understanding of complex and ambiguous problems by illustrating influence or causality between factors [15,16]. The discussion was a shorthand summary record of the focus groups across the ten prisons, which was subsequently mapped by theme. This approach used the five stages advocated in the literature [17]:

- familiarisation through immersion in the available data (eg through reading transcripts) to record emerging thoughts and recurrent themes
- identification of a thematic framework

- indexing codes that link to the themes identified
- charting data by rearranging it according to the part of the theme identified and forming charts
- mapping and interpreting the data by using visual cues (as referenced above) to define concepts and map the range of the nature of the themes discussed

The findings from the scoping exercise are presented below. The information collected during the scoping exercise was then used to help formulate the brief interventions manual and training.

## Definitions of brief intervention

The definition of a brief intervention can vary, encompassing a range of approaches and goals – from ‘simple advice’ to ‘brief lifestyle counselling’ – and can cover things from simple suggestions imparted by a professional to reduce levels of drinking, to a series of bespoke interventions delivered within a more structured treatment setting. Given the nature and sensitivity of the topic, brief interventions can also encompass more detailed discussions or extended brief interventions. For the purpose of this report, the more generic term – brief interventions – will be used, which falls within the wider Cochrane review approach.

Brief interventions for excessive drinking should not be referred to as a homogenous entity, but as a family of interventions varying in length, structure, targets of intervention, personnel responsible for their delivery, media of communication and several other ways, including their underpinning theory and intervention philosophy [18].

A target segment of potentially problematic drinkers includes a mid-range of non-dependent users of alcohol who may only periodically be drinking to excess. This segment may not see the need for formal ‘treatment’ and may be openly resistant to receiving any health promotion message. For a brief intervention to be effective, it requires an initial assessment of drinking patterns and the associated problems resulting from alcohol consumption. Low Risk, Hazardous, Harmful and Dependent are all categories that follow from an initial and brief assessment of an individual’s drinking. Using a validated screening tool such as the AUDIT (but this could include a range of other schedules) will allow for the differentiation of drinking risk and therefore initiate a ‘conversation’ about a person’s consumption habits.

Overall, brief interventions can be considered opportunistic conversations regarding alcohol consumption conducted in almost any setting; they are not considered a substitute for more intensive interventions for dependent users. The mechanism for a brief intervention traditionally revolves around a motivational interview [19] encompassing the FRAMES method:

- feedback that is personalised and non-judgemental
- responsibility for an individual's actions
- advice that is clear and timely
- menu of options
- empathy through reflective listening
- self-efficacy by offering opportunity and hope

The aim of the brief intervention is to raise awareness of alcohol consumption as a potential problem and then to recommend a mechanism to enforce behaviour change – usually through reduced levels of drinking, but this could also include accepting a referral for treatment or recommending some self-monitoring of drinking habits. A menu of strategies is provided to reach the individual's personal goal and they are encouraged to take ownership of any approach agreed. The approach is also predicated on warmth and empathy, rather than being a 'traditional' top-down treatment intervention to help motivate behavioural changes.

## Current epidemiology

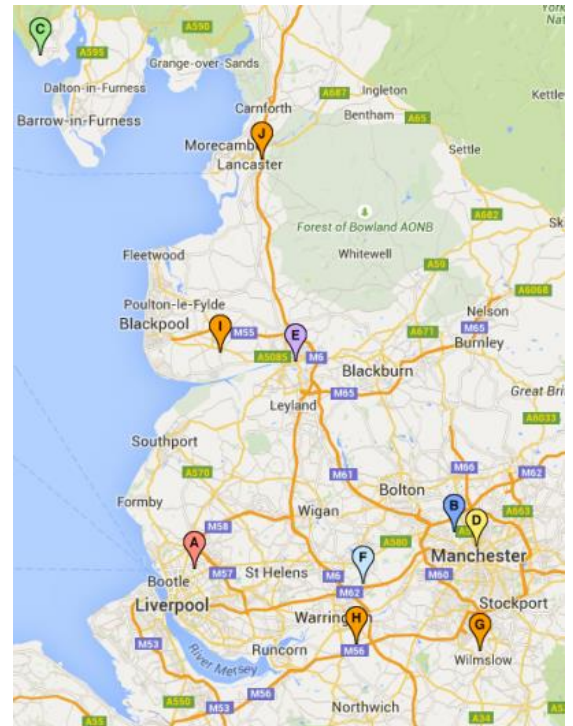
This section summarises the presenting treatment demand across the ten prisons as measured by the National Drug Treatment Monitoring System (NDTMS) over quarter 1 (Q1) and quarter 2 (Q2) 2014/15.

### Participating prisons

The NDTMS captures information on adults (aged 18 years and over) receiving treatment in prisons in England for substance misuse. All individuals in this report have received one or more structured interventions for drug or alcohol use while in prison at one of the 10 establishments in the North West of England listed in Figure 1.

**Figure 1: Participating prisons by role and location in the North West**

Key	Code	Name	Role
A	A3001	HMP Altcourse	Local
B	A3003	HMP Forest Bank	Local
C	A3005	HMP Haverigg	Training
D	A3011	HMP Manchester	Local
E	A3012	HMP Preston	Local
F	A3013	HMP Risley	Training
G	A3014	HMP Styal	Local
H	A3015	HMP Thorn Cross	Open
I	A3017	HMP Kirkham	Open
J	A3018	HMP Lancaster Farms	Young offender institution



## Recording of alcohol treatment on the NDTMS

It is important to note the distinction between structured treatment for alcohol dependency and the delivery of brief interventions to individuals who are consuming alcohol at increasing or higher risk levels. The AUDIT [20] is considered the 'gold standard' screening instrument for measuring levels of alcohol dependency in a community setting and is increasingly being used in a criminal justice setting to screen new receptions [21]. A score of 16+ on the AUDIT indicates harmful or possibly dependent alcohol consumption that may require structured treatment; this is regularly reported to the NDTMS.

Brief interventions are aimed at individuals who are drinking at increasing or higher risk levels (scoring somewhere between 8 and 20 on the AUDIT) and are designed to reduce harmful consumption and prevent such individuals from reaching the dependent stage. There is currently no national or North West data collection system that records information on all the brief interventions delivered in prisons. NDTMS data collection in prisons is focused on structured treatment; therefore, only individuals in receipt of a structured drug or alcohol intervention appear in the dataset. However, the NDTMS is able to capture the brief interventions delivered in prisons to individuals who are also receiving structured substance misuse treatment, so long as the information is recorded by the substance misuse team (even if the brief intervention is delivered by non-substance-misuse staff). The latest full set of NDTMS data that can be reported on is for Q1 and Q2 2014/15.

## NDTMS structured treatment data for Q1–2, 2014/15

Table 1 overleaf shows the total number of healthcare screens delivered in Q1 and Q2 2014/15 (between 1 April 2014 and 30 September 2014) in the pilot prisons. Healthcare screens are used as a proxy for the total number of people entering the prison during the period. In total, there were 11,528 new receptions across nine of the prisons. Data was not returned for HMP Kirkham.

A total of 2,511 individuals commenced structured drug treatment only in the ten establishments (all prisons returned data). The proportion of these varied across the prisons, from 5% (Manchester) to 34% (Thorn Cross). The number commencing structured alcohol treatment only was lower: 343 across the ten establishments. Proportions varied from 0% (Haverigg) to 9% (Thorn Cross). A total of 395 individuals commenced both structured drug and structured alcohol treatments in the same period. Proportions for this cohort varied from 0% (Risley) to 7% (Styal and Forest Bank).



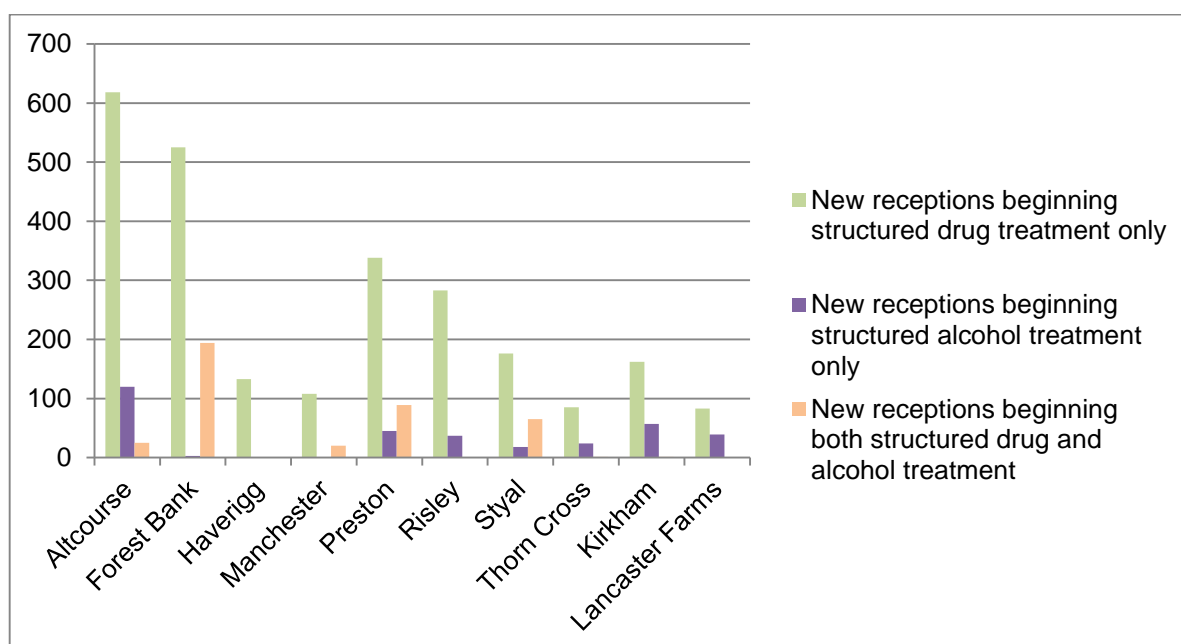
**Table 1: Total number of healthcare screens delivered in Q1 and Q2 2014/15 and the number of new receptions beginning structured drug or alcohol treatment in the same period**

Establishment	Healthcare screens	New receptions beginning structured drug treatment only		New receptions beginning structured alcohol treatment only		New receptions beginning both structured drug and alcohol treatments	
		Count	Percentage	Count	Percentage	Count	Percentage
Altcourse	1,848	618	33%	120	6%	25	1%
Forest Bank	2,894	525	18%	3	0%	194	7%
Haverigg	577	133	23%	0	0%	0	0%
Manchester	2,115	108	5%	0	0%	20	1%
Preston	1,647	338	21%	45	3%	89	5%
Risley	903	283	31%	37	4%	0	0%
Styal	910	176	19%	18	2%	65	7%
Thorn Cross	253	85	34%	24	9%	1	0%
Kirkham	NA	162	NA	57	NA	1	NA
Lancaster Farms	381	83	22%	39	10%	0	0%
Total	11,528	2,511	20%	343	2%	395	3%

(Source: Public Health England NDTMS Q1 and Q2 2014/15)

The number of those screened and commencing structured drug treatment interventions only, structured alcohol treatment interventions only, or both structured drug and alcohol interventions in the 10 prisons is presented graphically in Figure 2 below. Note that individuals recorded on the NDTMS as starting only structured drug treatment interventions may also have received psychosocial support to address any alcohol misuse alongside treatment/support for their primary drug misuse.

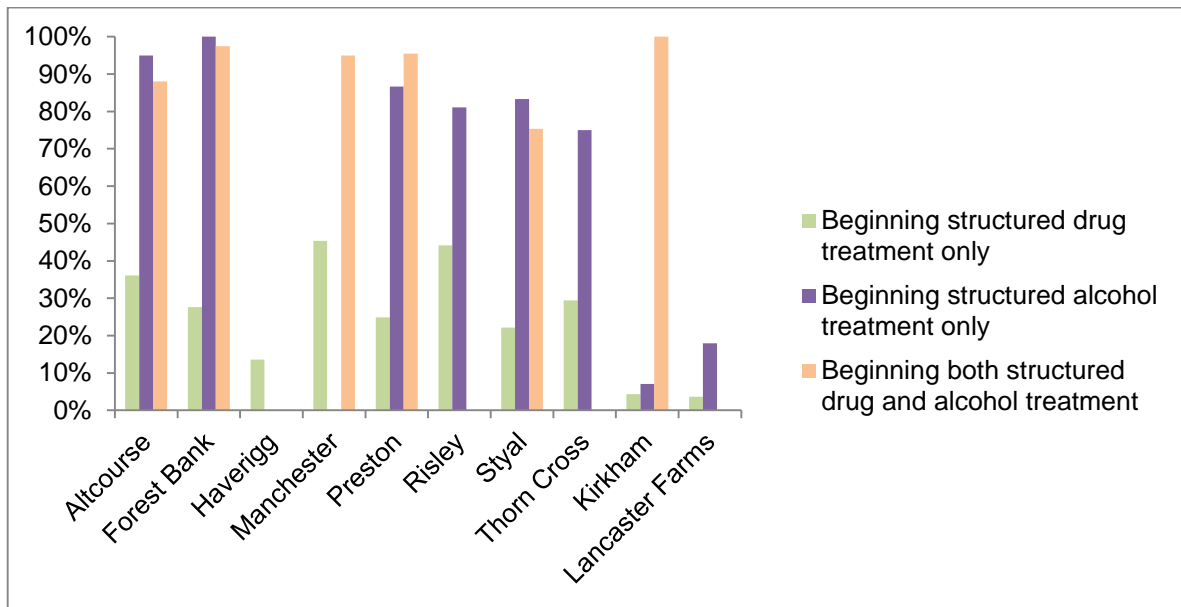
**Figure 2: Total number of new receptions beginning structured drug or alcohol treatment in Q1 and Q2 2014/15**





Of the 343 individuals who commenced structured alcohol treatment only, the majority (n = 230, 67%) self-reported that they were drinking 16 units or more on a typical drinking day (16 units is equivalent to 5 pints of lager or 1.5 bottles of wine). Among the population receiving structured drug treatment interventions, 29% were drinking 16 or more units of alcohol on a typical drinking day (n = 718). Of those starting both drug and alcohol treatment interventions, 92% (n = 363) were drinking 16 units or more (see Figure 3). Structured alcohol interventions should only be recorded on the NDTMS for those whose primary problematic substance is alcohol, or for those receiving a clinical alcohol intervention in addition to structured clinical or psychosocial interventions to address drug misuse; therefore, the latter group is likely to comprise individuals receiving clinical alcohol interventions.

**Figure 3: Proportion of individuals commencing structured drug or alcohol treatment interventions consuming 16 or more units of alcohol on a typical drinking day**



(Source: Public Health England NDTMS Q1 and Q2 2014/15)

The data in Table 2 overleaf suggests that, of the 718 individuals who were receiving drug treatment interventions and reported drinking at high levels prior to custody (ie 16 units or more on a typical drinking day), most were drinking at this level daily (28 days per month) or for 1–14 days per month. The latter could be evidence of binge drinking. Those drinking at high levels daily were not recorded as receiving clinical alcohol interventions, but should have received psychosocial support to address their alcohol use alongside their drug misuse. Assuming that the self-reports of daily drinking at this level are broadly accurate, there appears to be a considerable number of offenders receiving drug treatment interventions in these prisons who show patterns of dependent drinking, and therefore may benefit from clinical alcohol interventions.

At the lower end of the frequency scale, there are a number of individuals who drink at high levels for some of the month, possibly bingeing on a regular basis, who would benefit from brief interventions.

**Table 2: Proportion of individuals commencing structured drug treatment consuming 16 or more units of alcohol on a typical drinking day by number of drinking days in the last 28 days (prior to custody)**

Establishment	Number of drinking days in the last 28 days (prior to custody) where the number of typical units consumed per day was 16 or over, clients in structured <u>drug</u> treatment only					
	0 days	1–7 days	8–14 days	15–21 days	22–27 days	28 days
Altcourse	0	29	31	8	0	155
Forest Bank	0	16	18	11	1	99
Haverigg	7	10	0	0	0	1
Manchester	0	6	6	4	0	33
Preston	3	6	10	4	12	49
Risley	0	36	23	12	3	51
Styal	0	9	3	2	0	25
Thorn Cross	0	7	7	5	2	4
Kirkham	0	1	2	0	0	4
Lancaster Farms	0	3	0	0	0	0
Total	10	123	100	46	18	421

(Source: Public Health England NDTMS Q1 and Q2 2014/15)

Table 3 overleaf shows the number of individuals who received only structured drug treatment interventions and who self-reported drinking between 6 and 15 units of alcohol on a typical drinking day; it also shows how many did so on a daily basis (44). However, most reported drinking at this level for less than half of the month (109 + 47). Brief interventions could focus on the latter group.

**Table 3: Proportion of individuals commencing structured drug treatment consuming 6–15 units of alcohol on a typical drinking day by number of drinking days in the last 28 days (prior to custody)**

Establishment	Number of drinking days in the last 28 days (prior to custody) where typical consumption per day was 6–15 units, clients in structured <u>drug</u> treatment only					
	0 days	1–7 days	8–14 days	15–21 days	22–27 days	28 days
Altcourse	0	11	3	0	0	6
Forest Bank	0	25	19	4	0	14
Haverigg	7	2	0	0	0	0
Manchester	0	6	4	1	0	3
Preston	0	13	4	2	0	9
Risley	0	30	8	2	0	7
Styal	0	7	3	1	1	5
Thorn Cross	1	12	6	2	1	0
Kirkham	0	2	0	1	0	0
Lancaster Farms	0	1	0	0	0	0
Total	8	109	47	13	2	44

(Source: Public Health England NDTMS Q1 and Q2 2014/15)

As expected, the majority of those starting only structured alcohol treatment (ie no problematic drug misuse) and drinking 16 or more units on a typical drinking day were drinking at this level every day in the month before entering prison (see Table 4).

**Table 4: Proportion of individuals commencing structured alcohol treatment consuming  $\geq 16$  units of alcohol on a typical drinking day by number of drinking days in the last 28 days (prior to custody)**

Establishment	Number of drinking days in the last 28 days (prior to custody) where the typical number of units consumed per day was 16 or over – clients in structured <u>alcohol</u> treatment only					
	0 days	1–7 days	8–14 days	15–21 days	22–27 days	28 days
Altcourse	0	8	12	4	0	90
Forest Bank	0	0	0	0	0	3
Haverigg	0	0	0	0	0	0
Manchester	0	0	0	0	0	0
Preston	0	1	2	2	7	27
Risley	1	11	3	3	0	12
Styal	0	0	1	2	0	12
Thorn Cross	0	7	3	4	0	4
Kirkham	0	0	1	0	0	3
Lancaster Farms	0	0	4	1	1	1
Total	1	27	26	16	8	152

(Source: Public Health England NDTMS Q1 and Q2 2014/15)

Unsurprisingly, very few individuals commencing only structured alcohol treatment reported drinking 6–15 units of alcohol on a typical drinking day (see Table 5).

**Table 5: Proportion of individuals commencing structured alcohol treatment consuming 6–15 units of alcohol on a typical drinking day by number of drinking days in the last 28 days (prior to custody)**

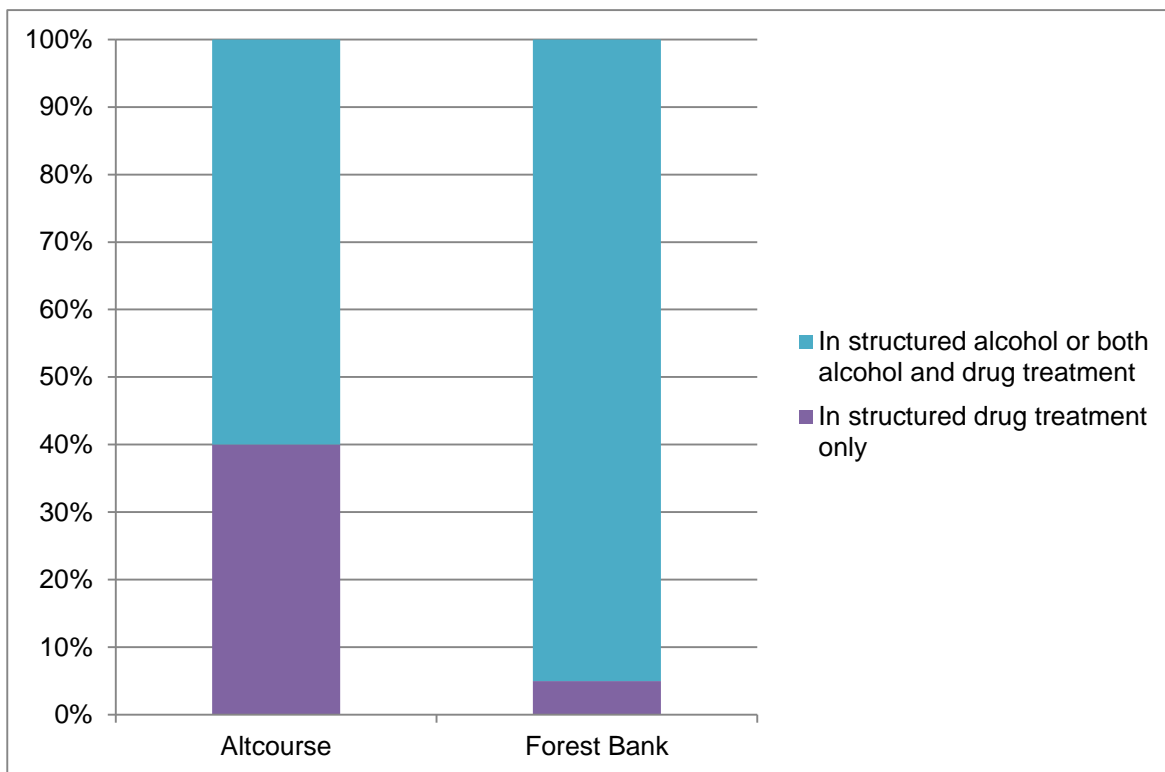
Establishment	Number of drinking days in the last 28 days (prior to custody) where typical consumption per day was 6–15 units – clients in structured <u>alcohol</u> treatment only					
	0 days	1–7 days	8–14 days	15–21 days	22–27 days	28 days
Altcourse	0	0	0	0	0	3
Forest Bank	0	0	0	0	0	0
Haverigg	0	0	0	0	0	0
Manchester	0	0	0	0	0	0
Preston	0	0	0	1	2	3
Risley	0	2	1	0	0	0
Styal	0	1	1	0	0	1
Thorn Cross	0	2	1	0	0	1
Kirkham	0	1	1	0	0	0
Lancaster Farms	0	0	0	0	0	1
Total	0	6	4	1	2	9

(Source: Public Health England NDTMS Q1 and Q2 2014/15)

### NDTMS brief interventions data

The majority of prisons in the North West submitted zero returns for the delivery of brief interventions to the NDTMS. However, Forest Bank and Altcourse recorded 181 and 5 brief interventions, respectively, during the first two quarters of 2014/15. All of the 181 brief interventions recorded by Forest Bank were delivered to individuals receiving structured alcohol treatment, most of whom were receiving both clinical interventions and structured psychosocial treatment

**Figure 4: Proportion of alcohol brief interventions delivered in 2014/15 by treatment type received (recorded on the NDTMS)**



# Review of the literature

## Overview

This chapter will provide a review of the literature that will help to inform:

- Whether brief interventions can be effectively delivered in prison – for instance, when should brief interventions be delivered to a prisoner (on arrival, as part of ongoing treatment and support, or at release)? Also, who is best placed to deliver the brief intervention (healthcare or psychosocial staff?) and can prison officers also be involved?
- Whether implementation leads to behaviour change. Can the evidence base for changes in alcohol consumption in community settings be replicated for offenders?
- Whether there is evidence that reductions in alcohol consumption will lead to reductions in offending and other improvements, such as resulting improvements in health?
- Whether there are certain types of prisoner that will benefit from a brief intervention (remand prisoners, open prisoners)?
- Whether delivery of brief interventions is more cost-effective than using traditional group-based interventions?
- What an effective brief intervention looks like.
- Whether brief interventions should be rolled out as part of a systematic programme of support?

---

## Screening and brief interventions

The National Institute for Health and Care Excellence (NICE) defines screening as “a systematic process of identifying people whose alcohol consumption places them at increased risk of physical, psychological or social problems and who would benefit from an intervention to prevent harm” [7]. The cheapest and most effective way of delivering screening is through the use of questionnaires, and a number of suitable instruments have been developed. The AUDIT was one of the first to be rigorously tested, and consists of

ten questions about drinking frequency and intensity, experience of alcohol-related problems, and signs of possible dependence [14]. The AUDIT has a sensitivity of 92% (that is, it detects 92% of problematic drinkers), a specificity of 93% (that is, excludes 93% of those who are not problematic drinkers), and has been described as the ‘gold standard’ screening questionnaire for detecting hazardous and harmful drinkers [7].

## Brief interventions

There is extensive literature in the alcohol treatment field showing that treatment interventions do not need to be long in duration to be effective [15]. According to Raistrick, Heather and Godfrey (2006), brief interventions:

“...are carried out in the general community settings and are delivered by non-specialist personnel such as general medical practitioners and other primary healthcare staff, hospital physicians and nurses, social workers, probation officers and non-specialist professionals. They are directed at hazardous and harmful drinkers who are not typically complaining about or seeking help for an alcohol problem. They may have been identified by opportunistic screening or some other identification process; therefore brief interventions are sometimes called ‘opportunistic interventions’.” [8]

The simplest form of brief intervention consists of advice about alcohol consumption and how to moderate it that lasts no more than a few minutes. Research evidence shows that this is an effective strategy for reducing alcohol consumption to low-risk levels among hazardous and harmful drinkers in a variety of settings [8,16,17], and such advice should be offered as a first step in treatment [7]. As the complexity of the problem increases, a more elaborate intervention may be necessary; extended brief interventions consist of a more structured therapy that takes 30 minutes or so and usually involves one or more repeat sessions. This approach is often based on the principles of motivational interviewing [18,19]. A brief intervention will address many people’s alcohol-related problems, but those with a moderate to severe level of alcohol dependence are likely to need more intensive specialist help [7].

There is a strong body of evidence to support the use of brief interventions in healthcare settings, with brief interventions associated with significant reductions in the use of alcohol. A meta-analysis of 29 randomised controlled trials (RCTs) of brief alcohol interventions in primary care showed that they are effective at reducing the level of alcohol use, with effects still apparent at one year [17]. Furthermore, the review found some evidence to suggest that even very brief interventions may be effective in reducing alcohol-related negative outcomes. The considerable heterogeneity of interventions in the review made it difficult to assess the cost-effectiveness of brief interventions, although there were some encouraging results for very brief interventions. Promisingly, the review also highlighted that brief interventions can be effectively

delivered by a range of professionals. A separate review commissioned by NICE further supported the use of brief interventions for alcohol misuse [16]. Twenty-seven systematic reviews and meta-analyses were reviewed, with the majority of the primary studies conducted in primary care settings in the USA. The review concluded that brief interventions were effective at lowering the level of alcohol consumption, alcohol-related injuries and consequences, mortality, morbidity and healthcare use.

## Treatment for moderate to severe alcohol dependence

MoCAM made it clear that the main groups of alcohol users who would benefit from specialist alcohol treatment were those who were moderately or severely dependent:

“Hazardous and harmful drinkers without complex needs should be offered simple, structured advice to encourage reduced consumption of alcohol to sensible or less risky levels. If simple or minimal intervention does not succeed, they may be offered an extended brief intervention by a suitably competent practitioner. A small number may also be reassessed as actually needing treatment for alcohol dependence (where it was not initially identified) and would enter the part of the stepped care model for those needing treatment for dependence and related problems. In other circumstances, particular needs may be identified in relation to alcohol use, for example domestic abuse, where more complex, co-ordinated interventions are indicated. Therefore, care is stepped up only as required.” (MoCAM, p.28) [9]

Local treatment systems should therefore provide a full range of alcohol interventions and treatments that could be matched appropriately to the needs of individuals. By providing opportunistic brief interventions, the treatment system should aim to reduce alcohol-related harm and improve overall health and social functioning. A reduction in alcohol consumption will be likely to offer benefits, and may offer a stepping stone to abstinence in the future. Abstinence will be the preferred goal for many problem drinkers with moderate to severe levels of alcohol dependence, particularly for individuals whose organs have already been severely damaged through alcohol use, and perhaps for those who have previously attempted to moderate their drinking without success [9].

Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence (National Clinical Practice Guideline 115) was published by the National Collaborating Centre for Mental Health in 2011, and formed the basis of the NICE Clinical Guideline 115 (CG115) [1]. CG115 highlighted the fact that alcohol service commissioning and provision across England was variable and, in some cases, poorly integrated. Hence, the availability of alcohol services and the extent to which they met the needs of people who misuse alcohol varied across England [20]. The report re-defined and re-stated the evidence base for alcohol treatment, once again setting it in



the context of a stepped model of care involving escalating levels of treatment intensity depending on the extent of the problem.

## Alcohol and crime

Hazardous alcohol use is often associated with crime, and alcohol was cited as a factor in 47% of violent crimes in England and Wales in 2008/09 [21]. The victim believed the offender was under the influence of alcohol in half of all violent crimes in England and Wales in 2009/10 [22]. Alcohol is also implicated in criminal damage, domestic violence, sexual assaults, burglary, theft, robbery and murder. Approximately two-thirds of male prisoners and one-third of female prisoners, and up to 70% of probation clients, are hazardous or harmful drinkers [23].

There is a high prevalence of alcohol use disorders among offender populations. In a study of prisoners in South Wales, hazardous alcohol use (as measured by the AUDIT) was identified in 81% of the 126 male prisoners interviewed, and 50% of the sample were identified as having severe alcohol problems [24]. Similarly, a study involving 266 probation clients and 449 prisoners in the North East of England identified 66% of offenders as having an alcohol use disorder [25] and, in a recent study of 259 male prisoners in Scotland (UK), the prevalence of hazardous alcohol use was found to be 73% [26]. Overall, the rate of alcohol use disorders is much higher among prison populations compared to the general population [25]. Time in prison offers an opportunity for rehabilitation and support for alcohol use problems, and effective treatment may help prevent future offending. This was noted in the 2012 government Alcohol Strategy [5].

## Treatment of alcohol problems in prison

The main thrust of the MoCAM document was treatment services in the community. Prisons were mentioned briefly as potential settings for Tier 1 or Tier 2 interventions – ie the identification of hazardous, harmful and dependent drinkers, information on sensible drinking, and simple brief interventions to reduce alcohol-related harm (Tier 1); and extended brief interventions to help reduce alcohol-related harm, and the assessment and referral of those with more serious alcohol-related problems for specialist, care-planned treatment (Tier 2).

However, there is a lack of evidence regarding the effectiveness of brief interventions within UK prisons despite a high level of need for effective treatment. Recent findings published by HM Inspectorate of Prisons (2010) based on responses from 13,093 prisoners in 144 UK prisons (as well as 72 prison inspection reports and surveys of drug co-ordinators in 68 prisons) indicate a lack of routine screening for alcohol use in prison settings and considerable unmet need for ongoing treatment and support [27].

The report highlighted that prisons in the UK may be failing to identify prisoners arriving with alcohol problems, and there is limited treatment provision for offenders with alcohol misuse problems.

In 2011, the Scottish government commissioned three reports as part of its framework for tackling problematic alcohol use. The Prison Health Needs Assessment for Alcohol Problems contained a needs assessment for alcohol problems experienced by prisoners in Scotland and provided recommendations for service improvement [28]. As part of the report, a rapid review of interventions for identifying and treating prisoners with alcohol problems was conducted. This was split into two sections:

**1. Screening studies:** The review identified 11 studies that evaluated screening tools for alcohol use in a prison setting. Three screening tools in particular were identified as having good reliability for identifying alcohol misuse in prison populations (Minnesota Multiphasic Personality Inventory, MMPI; Texas Christian University Drug Screen, and AUDIT). However, only a minority of studies evaluated the ability of a screening tool to differentiate between hazardous, harmful or dependent alcohol use, and the AUDIT was the only instrument found to do this effectively. The report concluded that, although the AUDIT looks to be the most promising instrument, it was difficult to make a definitive statement regarding the efficacy of screening tools on the basis of the studies included in the review. The existing research was heterogeneous in nature (that is, it used different screening tools with different subpopulations), seldom involved screens for alcohol use separate from drug use, and was usually conducted in North American populations. Furthermore, the authors noted that the timing of screening during the prison journey may be important, with screening on reception less effective at picking up problems than screening a few days into the sentence.

**2. Intervention studies:** The review considered all types of treatment intervention for alcohol problems published from 1995 onwards. A total of 28 studies were identified that evaluated a variety of interventions for alcohol use among offenders in prison, and ten of these studies involved the evaluation of brief interventions for alcohol use. Of the 28 studies included in the review, the studies of brief interventions were found to be the highest quality.

Only four studies explored brief interventions in a prison setting, all of which were based on motivational interviewing. Brief interventions were found to be associated with lower rates of drink-driving and a significant improvement in readiness to change alcohol problems. However, one study failed to find any significant effect of brief intervention for treatment contact post-release from prison, although this study was concerned with evaluating outcomes for substance use rather than outcomes specific to alcohol use.

The remaining six studies of brief intervention were conducted in other areas of the criminal justice system, such as police custody, arrest referral services or probation

services. These studies suggested that brief interventions could be delivered by existing staff, providing there is sufficient training, and may help reduce the level of alcohol use. However, one study found no significant effect of brief interventions on alcohol use or recidivism, and three other studies failed to assess the impact of the intervention on alcohol use or offending. Overall, the authors concluded that it was difficult to assess the efficacy of brief interventions for alcohol use based on the studies included in the review. The report highlighted a lack of evidence for alcohol interventions in prison settings, especially in the UK, and concluded that further research is required to be able to establish the effectiveness of brief interventions in reducing the level of alcohol use and the rate of recidivism for offenders in prison.

The report also outlined a proposed model of care for offenders in prison who present with alcohol problems. This model was based on a stepped-care approach to treatment and recommends assessment for alcohol withdrawal for everyone, followed by the identification of alcohol problems using a validated screening tool such as the AUDIT, and then a tiered approach to advice and intervention depending on the level of alcohol use. This recommendation mirrors the approach adopted in MoCAM, and the authors conclude that the introduction of routine screening and tiered interventions is important to better target and tailor interventions to the level of individual need among offenders in prison. What remains to be established, however, is the efficacy of interventions for alcohol use among prison populations.

The aim of the current review was to provide an updated summary of the evidence for the delivery and efficacy of brief interventions for alcohol use within prisons in the UK. In particular, this review sought to understand: whether brief interventions delivered to offenders while in prison result in reduced negative alcohol-related outcomes; when the optimal time to screen for hazardous alcohol use (and when the best time to implement brief interventions in this setting) is; and whether brief interventions for alcohol use are cost-effective.

## Literature review method

The method is a rapid systematic review of the literature. Rapid reviews often have a simpler process for data extraction and quality appraisal, and involve less exhaustive searching.

### Inclusion and exclusion criteria

This report primarily aimed to review studies that focused on either screening or interventions for alcohol use within a prison setting. However, studies evaluating brief interventions in other criminal justice settings, such as probation or police custody suites, were also considered for inclusion if it was felt they would add to the evidence

base. This review provides an updated review of the evidence published in the Scottish Prison Health Needs Assessment for Alcohol Problems [28], and so only studies published from 2009 were considered for inclusion.

For the purpose of this review, brief interventions were defined in accordance with the definition used in the Cochrane review [17], by which a brief intervention may consist of between one and four sessions of professional engagement with a patient during which the patient receives information and advice on how to reduce alcohol consumption and/or alcohol-related problems. However, while the main aim of this report was to review literature for brief interventions, studies evaluating interventions of a longer duration in prison settings were included if it was felt this would add to the evidence base; these are reviewed in a separate section of the report. Only English language articles published between 2009 and May 2013 were considered for inclusion. Searches were not limited by study design type. All document types were considered, including policy documents, reviews and empirical studies. Unpublished work such as education dissertations were also considered if they were deemed to be relevant. Review articles were only included if the studies contained in the review article were published during or after 2009, and if the studies in the review had not already been identified separately as part of the wider search process.

## Search strategy

The search strategy was developed based on the search terms used in the Prison Health Needs Assessment for Alcohol Problems [28]. The search focused on terms related to alcohol use. It is possible that some studies may have used wider terms, such as substance use, to also include alcohol, and as a result some potentially relevant articles may have been missed. However, including all terms related to alcohol use and substance use would have been too time-consuming and was beyond the scope of this rapid review.

The electronic databases searched included the Cochrane Library, ASSIA (Applied Social Sciences Index and Abstracts), IBSS (International Bibliography of the Social Sciences), Embase, MEDLINE, PsycINFO, and Social Services Abstracts. The reference lists of all articles identified as meeting the inclusion criteria were also searched to identify further literature.

## Selection criteria

The title and abstract of each reference identified by the search were reviewed to determine the relevance of the article. The abstracts of articles that were identified as being potentially relevant were then inspected by another independent reviewer and, if the second reviewer agreed, the full article was obtained.

## Data extraction

Data was extracted for brief intervention studies in relation to the following: author(s), publication date, country, design, aims and objectives, type of intervention, setting, population, participants, measures, and outcome (see Table 6).

## Quality assessment

The methodological quality of interventional studies was assessed in accordance with the criteria set out in the NICE (2009) Public Health Guidance Methods Manual. Interventional studies were categorised according to the study type and the quality of evidence described in Tables 1 and 2. Studies were graded for internal and external validity based on the extent to which potential sources of bias were minimised ('++', '+', or '-'), as well as the relevance and applicability of the research to the UK (graded A–D).

## Data analysis

A narrative synthesis of the evidence is presented. Narrative synthesis involves summarising and explaining the findings of multiple studies in text format. Meta-analysis of the data was considered unsuitable due to the heterogeneity of the studies included for review.

**Table 6: Criteria for categorising the type and quality of intervention**

Score	Type and quality of evidence
1++	High-quality meta-analyses, systematic reviews of RCTs, or RCTs (including cluster RCTs) with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs (including cluster RCTs) with a low risk of bias
1-	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs (including cluster RCTs) with a high risk of bias
2++	High-quality systematic reviews of these types of studies, or individual, non-RCTs, case-control studies, cohort studies, cost benefit analyses, and correlation studies with a very low risk of confounding, bias or chance

2+	High-quality systematic reviews of these types of studies, or individual, non-RCTs, case-control studies, cohort studies, cost benefit analyses, and correlation studies with a very low risk of confounding, bias or chance, and a high probability that the relationship is causal
2-	Non-RCTs, case-control studies, cohort studies, cost benefit analyses, and correlation studies with a high risk – or chance – of confounding bias, and a significant risk that the relationship is not causal
3	Non-analytic studies (for example, case reports or case series)
4	Expert opinion or formal consensus

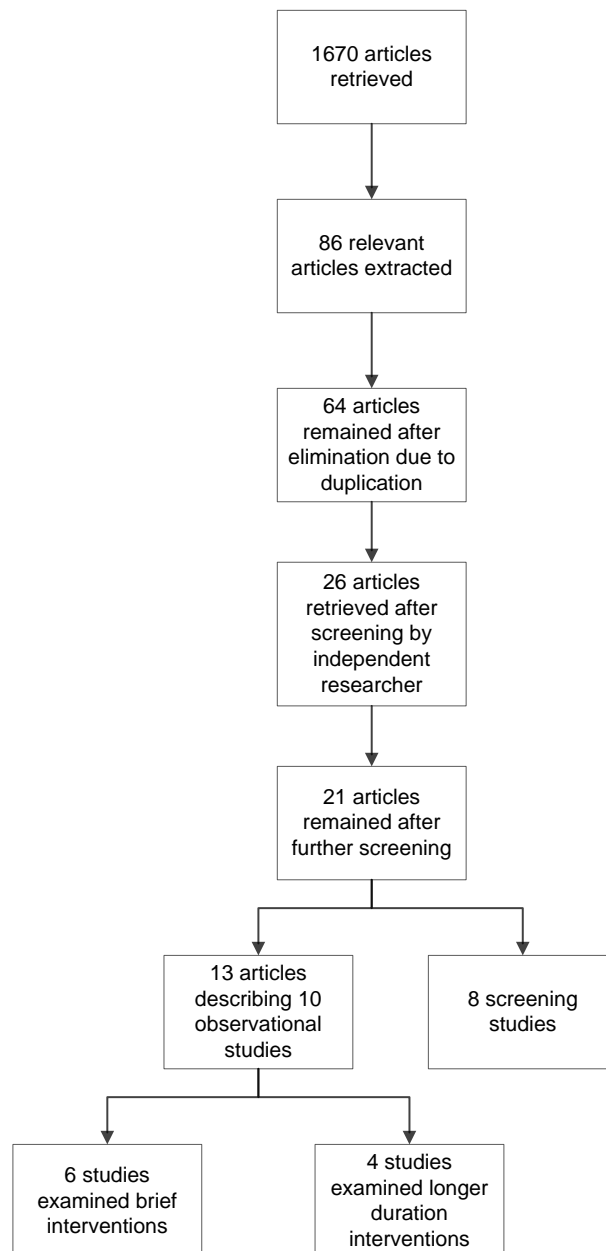
**Table 7: Criteria for categorising the relevance of the intervention to a UK setting**

<b>Score</b>	<b>Applicability of evidence</b>
A: directly relevant	UK-based study
B: probably relevant	Non-UK study but relevant to a UK setting
C: possibly relevant	Non-UK study that may have some application to a UK setting but should be interpreted with caution. There may be strong cultural or institutional differences that would have an impact on the effectiveness of the intervention if applied in the UK
D: not relevant	Non-UK study that is clearly irrelevant to a UK setting (eg legislation that would be unlikely to be implemented)

## Results

A summary of the search strategy is shown below in Figure 5.

**Figure 5: Summary of literature review search strategy**



## Screening for alcohol use in prison populations

Screening and assessment of alcohol use is essential in order to identify the level of support required by the individual, and is the first step in providing interventions that are specifically tailored to the level of need. This review identified eight studies that screened for alcohol use; four studies evaluated the use of the AUDIT [26,29–31]; two studies evaluated other assessment tools for alcohol use [32,33]; and two studies screened for alcohol-related risks and consequences [34,35]. In addition, several intervention studies used a screening tool prior to a treatment intervention, and these studies are described in the next section of the report.

There are a number of measures available to screen for the level of alcohol use, the most widely used of which is the AUDIT. The AUDIT is a 10-item screening tool designed to identify the severity of alcohol use (hazardous, harmful or dependent), with a score of eight or more indicative of hazardous alcohol use. In a UK study of male adult prisoners [26], the AUDIT was administered by trained prison officers to 259 offenders. This highlighted behavioural differences between younger (aged 18–24) and older (aged 40–64) drinkers, with younger drinkers found to have less daily drinking or drinking early in the morning. The results suggest age-related differences in the level of support needed, and the absence of typical behavioural manifestations of problem drinking among younger-age cohorts may mean single screening questions are not sufficient for effectively detecting hazardous alcohol use among young offenders.

A similar finding came from another UK screening study [31], which found less recognition of problematic alcohol use among younger male offenders despite a higher rate of hazardous use. The study involved 257 male prisoners, and participants were defined as ‘younger’ if they were aged 18–20 years ( $n = 100$ ) and ‘older’ if they were aged 21 and over ( $n = 157$ ). Participants were interviewed during their first week after admission, and were screened using the AUDIT. The finding that younger prisoners had a higher rate of hazardous alcohol use but less recognition of problematic use suggests that assessment of alcohol use using a validated instrument is important, especially among younger offenders.

The AUDIT has also been evaluated with a population of offenders with mental health problems. The AUDIT was compared to the Addiction Severity Index-6 in 181 offenders in Sweden, and was found to have good sensitivity (.83) and specificity (.78) using a cut-off score of 13 [30]. Briefer screening tools for alcohol use have been developed based on the AUDIT. The AUDIT-C, AUDIT-3, and the NIAAA heavy episodic drinking criterion (four or more drinks on one occasion for women) were compared with the full AUDIT in a sample of 1,751 women in a combined prison/jail facility in the USA [29]. The AUDIT-C is a three-item measure (the first three items being about alcohol consumption), whereas the AUDIT-3 and the NIAAA heavy episodic drinking criterion are single-item measures. Using a cut-off score of five or more, the AUDIT-C had good



sensitivity (.90) and specificity (.92) and performed better than the AUDIT-3 and the NIAAA heavy episodic drinking criterion in predicting scores using the full (10-item) version of the AUDIT at a cut-off score of eight or more. This study demonstrates that it may be possible to use brief screening tools for alcohol use in prison populations without adversely affecting the level of sensitivity or specificity.

Two studies were identified that evaluated other screening tools for alcohol use. The Screening and Intervention Programme for Sensible Drinking (SIPS) in the UK evaluated the Fast Alcohol Screening Test (FAST) and a modified version of the Single Alcohol Screening Question (M-SASQ) among 205 offenders who were in either police custody, prison or probation settings [32]. The FAST is a four-item screening tool based on the AUDIT, whereas the M-SASQ is a single-item measure. The level of sensitivity for the FAST and the M-SASQ was high (more than 0.9), with acceptable levels of specificity (0.7 and 0.6 respectively). Another study in the USA evaluated the Triage Assessment for Addictive Disorders (TAAD) among a large sample of offenders in prison [33]. The TAAD is a 31-item measure that takes approximately 10–15 minutes to administer, and was found to have acceptable internal consistency and a high level of concurrent validity. However, interpretation of the TAAD is limited to qualified professionals, and this may prohibit its widespread use.

Assessment of alcohol-related problems may also help to inform the level of support required by the individual. Two studies were identified that evaluated alcohol-related consequences among incarcerated offenders [34,35]. Both studies suggest that the risks associated with alcohol use in the year prior to incarceration may predict alcohol use after release in adolescent populations [34]. Furthermore, the social indicators of alcohol-related problems may be different among incarcerated populations compared to the general population, as indicators such as physical fights were much more prevalent compared to the general population [35]. This suggests that the assessment of alcohol-related risks and consequences may be prognostic of future outcomes, but tools designed to assess these issues may need to be specifically validated for use in this population. Research into the assessment of alcohol-related risks and social consequences among incarcerated offenders is still in its infancy, but understanding the adverse impact that alcohol use may have on the individual is likely to aid effective intervention for this population

**Table 8: Summary of selected papers**

Author and country	Design	Aims	Intervention	Setting and population	Participants	Assessment period	Outcomes	Quality appraisal and applicability to the UK
Stein, Lebeau, Colby, Barnett, Golembeske and Monti, 2011 (USA)	RCT	To reduce alcohol and marijuana use	Brief intervention – two sessions of motivational interviewing (MI) or two sessions of relaxation training (RT)	Adolescent offenders in a juvenile correctional facility	Total n = 162 adolescents aged 14–19; MI n = 86; RT n = 76	Baseline (approx. five weeks after incarceration and three months post-release)	At three months post-release, MI was associated with significantly better drinking outcomes compared to RT; effects were moderated by the level of depression	Internal validity ++; external validity +  Applicability: B
Stein, Clair, Lebeau, Colby, Barnett, Golembeske and Monti, 2011a (USA)		To examine the impact of depressed mood on MI for risky substance use behaviour and the consequences			Total n = 181; MI n = 96; RT n = 85		No significant effect of treatment on risks and consequences for alcohol. Trend significance for greater depressive symptoms to be associated with reduced alcohol-related problems	

Author and country	Design	Aims	Intervention	Setting and population	Participants	Assessment period	Outcomes	Quality appraisal and applicability to the UK
Stein, Caviness, Anderson, Habert and Clarke, 2010 (USA)	RCT	To reduce alcohol use	Brief intervention – two sessions of MI compared to a no-treatment control	Hazardously drinking women in a combined jail/prison facility	Total n = 245; MI n = 125; no-treatment control n = 120	Baseline, one, three and six months	A significantly greater number of abstinent drinking days among the MI group at three months; differences not significant at one or six months. No significant difference between groups for the number of drinks per drinking day. MI associated with fewer adverse alcohol consequences at three months.	Internal validity ++; external validity +  Applicability: C
Clarke, Anderson and Stein, 2011 (USA)		To determine predictors of early relapse					No significant difference between groups in the time to first drink following release from jail	

Author and country	Design	Aims	Intervention	Setting and population	Participants	Assessment period	Outcomes	Quality appraisal and applicability to the UK
Begun, Rose, Lebel and Teske-Young, 2009  Begun, Rose and Lebel, 2011  (USA)	RCT	To reduce alcohol use and increase engagement in treatment after discharge	Screening and brief intervention – one session of MI compared to screening and treatment as usual (TAU)	Hazardously drinking women in local jails (i.e. not state or federal prison)	Total n = 729; MI n = 468; TAU n = 261	Baseline and two months post-release	A significantly greater reduction in alcohol use as measured by the AUDIT among the MI group at follow-up. No significant differences between groups for treatment engagement post-release	Internal validity +; external validity +  Applicability: C
Barton, 2011  (UK)	Non-comparative study – exploratory research, mixed methods: quantitative and qualitative	To provide data regarding the number of people presenting as hazardous drinkers	Screening and intervention tailored for severity of alcohol use; general information for low-risk drinkers, more detailed information and brief counselling for hazardous/harmful drinkers, or detailed information and offer of further assessment and signposting to treatment services for moderate to highly dependent drinkers	Detainees in a police custody suite	Total n = 3,900 individuals detained in a police custody suite	Baseline only, no follow-up assessment	No follow-up quantitative data. Qualitative case study data presented for one participant who had engaged in treatment and reported alcohol abstinence of 14 weeks	Internal validity -; external validity -  Applicability: A

<b>Author and country</b>	<b>Design</b>	<b>Aims</b>	<b>Intervention</b>	<b>Setting and population</b>	<b>Participants</b>	<b>Assessment period</b>	<b>Outcomes</b>	<b>Quality appraisal and applicability to the UK</b>
Brown, Newbury-Birch, McGovern, Phinn and Kaner, 2010 (UK)	Non-comparative study – exploratory research, mixed methods: quantitative and qualitative	To examine the feasibility of delivering alcohol screening and brief intervention detained in police custody	Alcohol screening and brief intervention for individuals identified as hazardous drinkers	Detainees in a police custody suite	Total screened n = 176 (total eligible for advice n = 127)	Baseline only, no follow-up assessment	Qualitative data, with detention officers trained to deliver screening and brief intervention	Internal validity -; external validity -  Applicability: A
Newbury-Birch, Bland, Cassidy, Coulton, Deluca, Drummond, Gilvarry... and Shepherd, 2009 (UK)	RCT	To examine screening and brief intervention for hazardous alcohol use in probation services	Brief intervention information leaflet (control) vs five-minute brief advice and leaflet, vs 20-minute lifestyle counselling, brief advice and leaflet	Hazardous drinking offenders in probation services	Total n = 96; leaflet only n = 32; five-minute structured advice n = 32; 20-minute lifestyle counselling n = 32	Baseline, six and 12 months	Study protocol: no published results. The study will examine change in alcohol use, problems, service use, quality of life, motivation to change, and satisfaction with the intervention. Economic data will also be calculated	Internal validity ++; external validity ++  Applicability: A

## Brief interventions for prisoners with alcohol use problems

Brief interventions were defined as “up to a maximum of 4 sessions of professional engagement designed to target alcohol use and related problems”. While the focus of this review was brief interventions for alcohol use in a prison setting, studies set in other criminal justice settings (ie police custody and probation services) were included if it was felt they would add to the evidence base. Six studies were identified that evaluated brief interventions for alcohol use [36–41]; four were RCTs [37,39–41]; and two were non-randomised exploratory mixed methods studies [36,38]. Two studies were conducted in prison settings in the USA [37,41], two in UK police custody suites [36,38], one in a juvenile correctional facility in the USA [40] and one in a UK probation service [39].

Stein et al. (2010) conducted an RCT to evaluate a brief intervention for alcohol use and risky sexual behaviour among women in a combined prison/jail facility in the USA [41]. Women were eligible for the trial if they had consumed alcohol at a hazardous level (four or more drinks on at least three separate occasions in the previous three months, or if they had been identified as a hazardous drinker in the past year using the AUDIT) and if they had engaged in risky sexual behaviour. A total of 1,415 women were screened, of which 245 were randomised to receive either two sessions of motivational interviewing (n = 125) or a no-treatment control (n = 120). The first session of motivational interviewing was delivered while in prison, and the second session took place following release from prison, approximately one to three months later. Participants completed assessments at baseline, one, three and six months, and the majority of the participants had experienced at least one day during which they were not incarcerated at the time of follow-up assessment (90% at three months and 93% at six months). Participants randomised to receive motivational interviewing had significantly fewer drinking days and reported fewer alcohol-related problems at three months, although this effect was not maintained at the six-month follow-up. There was no significant difference between participant groups for the number of drinks consumed per drinking day. The study suggests that brief motivational interviewing may be effective at reducing the frequency of alcohol use in the short term, but further sessions may be necessary to maintain the effect in the longer term. Furthermore, one session of motivational interviewing may not be sufficient to reduce alcohol use, as significant effects were only apparent at the three-month assessment following two sessions of treatment. Despite the improved outcomes in the frequency of alcohol use and alcohol-related problems, the authors acknowledge that participants continued to drink, often heavily, following release into the community. A second analysis of the study data conducted by Clarke, Anderson and Stein (2011) showed that the intervention did not impact the length of time to first alcoholic drink following release from prison [42].

Another study demonstrated that motivational interviewing may also be effective among adolescent offender populations [40]. In an RCT designed to evaluate the impact of brief

motivational interviewing on the use of alcohol and marijuana, 162 young offenders in a juvenile correctional facility in the USA were randomised to receive either two sessions of motivational interviewing (n = 86) or two sessions of relaxation training (n = 76).

The first 90-minute session occurred shortly after baseline assessment, and the second 60-minute session occurred approximately two weeks prior to discharge. At the three-month post-release follow-up assessment, participants who received motivational interviewing reported a significantly lower average number of alcoholic drinks consumed per day, a lower percentage of heavy drinking days, and a lower percentage of days where more than five drinks were consumed. This study had several limitations. Firstly, the absence of a no-treatment control group precludes any comparison with standard treatment. Furthermore, participants were automatically enrolled onto the facility's substance misuse treatment programme, which involved two hours per week of psycho-education for substance use over a period of eight weeks. It is unclear if this may have contributed to the change in the use of alcohol, and the results of this study may not be generalisable to settings in which standard substance use treatment is limited. Lastly, this study had minimal exclusion criteria in relation to previous alcohol use; participants were eligible to take part if they had either i) drunk on at least a monthly basis or drunk heavily at least once (defined as four drinks for girls, or five drinks for boys) in the year prior to incarceration, or ii) consumed alcohol in the four weeks prior to committing the offense or the period of incarceration. The intervention was not targeted at people with hazardous alcohol use and, as a result, the findings may not be generalisable to hazardous drinkers.

There was also some evidence that the effect of treatment was moderated by the level of depression. Compared with relaxation training, motivational interviewing reduced alcohol use in adolescents low in depressive symptoms at the start of incarceration, but the effects did not hold for high levels of depressive symptoms. The authors speculate that this may be because adolescents low in depressive symptoms were more able to attend to the intervention and mobilise resources than those high in depressive symptoms. The potential for depressed mood to impact the efficacy of motivational interviewing among adolescent offenders in this sample was further explored in a separate paper by the same research group [43], where the analysis also focused on the effect of motivational interviewing on alcohol-related consequences. This analysis included an additional 27 participants that had been excluded from the first report [40]. The results indicated a trend for greater depressive symptoms to be associated with reduced alcohol-related problems, although this finding failed to reach significance. Motivational interviewing was not found to significantly affect alcohol-related consequences.

The Women and Jails Project provides further support for the use of motivational interviewing as a brief intervention for alcohol use [37,44]. A total of 1,181 women in two local jails in the USA were screened using the AUDIT to identify hazardous alcohol use

(n = 790), and 92% of the women consented to being randomised to receive either one session of motivational interviewing (n = 468) or treatment as usual (n = 261). Participants were assessed at baseline and at two months following their release from jail. There was a significant improvement in the AUDIT scores for all participants, although there was a significantly greater improvement among participants that had received motivational interviewing when assessed at the two-month post-release follow-up.

This study suggests that a single session of motivational interviewing may be sufficient to significantly influence change in the use of alcohol. However, it is important to note that all participants in the study received screening and brief feedback of their scores, and were provided with a folder containing information about local substance use treatment services available to them after release. This resource folder was found to triple the odds of treatment-seeking, and 55% of the sample reported using it. Therefore, it could be argued that the treatment-as-usual condition did not comprise a non-intervention control group. The study also suffered from a high rate of attrition; only 20.4% (n = 149) of the initial baseline sample of 729 could be traced for follow-up assessment, and there were significant differences in the AUDIT scores and educational attainment between participants that did and did not complete the follow-up assessment. This suggests that the study may suffer from attrition bias and participants in the study may not be representative of the wider prison population. Nevertheless, the results highlight that even brief screening and feedback, coupled with basic information regarding community drug services, may result in significantly reduced AUDIT scores for alcohol use among female offenders, and this may be further improved by only a single session of motivational interviewing.

Two studies conducted in the UK have evaluated the impact of brief interventions for alcohol use within a police custody setting [36,38]. Both of these studies used a mixed methods approach, although neither study included a follow-up assessment with participants, limiting the conclusions that can be drawn from this research. The study by Barton (2011) involved 3,900 offenders detained in police custody [36]. Trained police officers or a specialist alcohol worker screened participants using the AUDIT and the level of feedback was tailored according to the severity of alcohol use. General information was provided to low-risk drinkers; more detailed information, along with brief counselling, was provided to hazardous drinkers; and participants identified as moderate- to high-dependence drinkers were provided with detailed information, plus an offer of further assessment and signposting to treatment services. A major limitation of this study, however, was the lack of a follow-up assessment. Qualitative data is provided for one participant, but the lack of outcome data for the sample limits the evaluation of the impact of the research. Similarly, the study by Brown et al. (2010) involved alcohol screening and brief intervention for 229 detainees in a police custody suite [38]. Participants identified as hazardous drinkers (n = 134) were provided with five minutes of structured advice by police detention officers. Detention officers were



then interviewed by the research team about their experience of delivering the screening and brief intervention. No follow-up data was obtained for participants involved in the study, limiting the evaluation of the intervention on the use of alcohol, and it was found that two-thirds of people that screened negative on the AUDIT were also offered brief advice. The study suggests that it may be possible for existing staff to deliver brief interventions for alcohol use within a criminal justice setting, but comprehensive training may be required.

Finally, a trial of brief interventions for alcohol use in the UK probation service is currently underway [39]. This study aims to randomly allocate 480 hazardously drinking clients to one of two screening tools (FAST or M-SASQ) and one of three intervention conditions: a leaflet-only condition, five minutes of structured advice, or 20 minutes of brief lifestyle counselling delivered by an alcohol health worker. Follow-up assessments will take place six and 12 months after the intervention, and will assess the level of alcohol use using the AUDIT, as well as examining the cost-effectiveness in terms of reduced crime and service use.

In summary, this review identified four RCTs of alcohol brief interventions [37,39–41]. These studies were generally of high quality. Only one was conducted in the UK, and this study was both incomplete, based in a probation setting rather than in prison [39]. The other two brief intervention studies identified in this review [36,38] were UK-based but were of low quality, did not involve a comparison group or any follow-up with participants, and were based in police custody suites rather than prison settings. There is therefore still a need for research to evaluate the effectiveness of brief interventions for use in prison settings in the UK.

### Other interventions for prisoners with alcohol use problems

Four studies were identified that evaluated other interventions for alcohol use among prison populations [45–48]. Two of these studies were RCTs [45,48], one was an unpublished dissertation [47] and one was a qualitative study [46]. One study was conducted in the UK [45], and three were conducted in the USA [46–48].

Bowes et al. (2012) evaluated an intervention for alcohol-related violence within a prison in the UK [45]. Male adult prisoners who had been involved in at least three incidents of alcohol-related violence in the previous two years were approached to take part. Participants were randomly allocated to receive ten sessions of group-based psycho-education and four hours of individual support, plus treatment as usual; or treatment as usual only. Assessments took place at baseline and upon completion of treatment four weeks later. The study found that there was a significantly greater reduction in expectancy for alcohol-related aggression and increased confidence in controlling the frequency and quantity of drinking among participants in the intervention condition. However, the lack of follow-up assessment in the community means that it is not

possible to determine if the intervention had an impact on the level of alcohol use following release from prison. Only 57% of referrals were recruited into the study, as prisoners with alcohol dependence or mental health issues were excluded. Therefore, the results may not be generalisable to the wider prison population. There were also significant differences between participant groups at baseline, as participants allocated to the intervention scored lower in the areas of drinking self-efficacy and expressed anger. It is possible that this may have contributed to the observed differences at follow-up.

The results of a recent study examining the impact of recovery management check-ups (RMCs) for recently released women offenders demonstrate the utility of ongoing support for drug use following release from prison [48]. Adult women offenders with substance problems re-entering the community from a county jail substance abuse treatment programme in the USA were randomised to either RMCs (n = 238) or a control condition (n = 242). Those in the RMC group received monthly check-ups for a period of three months after release, plus more intensive support where necessary (for example, when they were due to enter a detoxification programme). Women in the RMC condition were significantly more likely to return to and participate in substance use treatment sooner, and those that participated in treatment were significantly more likely to be abstinent. The study also found that women who were abstinent were significantly less likely to engage in any illegal activity, be re-arrested or serve time in jail or prison. Although this study focused on substance use rather than alcohol use, the findings suggest that RMCs may be an effective method for dealing with the high rate of substance use relapse and recidivism for women offenders in the short term, and the model may be equally efficacious for use with hazardous drinkers. This study is still ongoing, with RMCs planned to continue for a period of three years post-release. As more data becomes available, a clearer picture will emerge of the longer-term impact of RMCs on substance use treatment engagement, abstinence and the level of recidivism.

The search also identified an unpublished study that examined the impact of a peer-based recovery support programme in a jail in Virginia, USA [47]. The study compared the efficacy of two peer-support-based programmes: Kingdom Life Ministries (KLM) and Belief. The KLM programme provided intensive support, with daily meetings while in prison, as well as housing, clothing, food, and opportunities for education or employment following release from prison. It is unclear what the Belief programme provided in terms of support, although the author argued that the main difference was that Belief did not accept violent offenders and did not provide housing following release from prison. The results of the study indicate that there was a significantly lower rate of recidivism among participants involved in KLM, and a longer time to re-incarceration. However, the lack of a no-treatment control group and the lack of information in relation to the aspects of the Belief programme limit the conclusions that can be drawn from this study.

Evaluating the perceived impact and quality of treatment from the perspective of the participant may help to inform a better understanding of what works in a prison environment, as well as helping to contextualise observed quantitative outcomes. Miller et al. (2012) report a qualitative evaluation of a six-month 'drinking while intoxicated' treatment programme for offenders in a prison facility in the USA [46]. Treatment sessions took place five days per week and participants progressed through six stages of treatment. Participants felt that the treatment intervention would be improved if the intake process were standardised and treatment were individually tailored. It was also felt that the intervention should be delivered by experienced staff, and interventions that use a group format should have a good staff-to-group-size ratio.

## Discussion

### Screening

This review identified eight studies that evaluated screening tools for alcohol use within a prison population, and the AUDIT was used in four of these studies. The findings show that the AUDIT can be effectively administered by trained prison officers [26], and that the AUDIT-C, a three-item measure based on the AUDIT, can also be used to identify alcohol use problems in a prison population [29]. Two studies [26,31] indicate that there may be less recognition of problematic alcohol use among younger prisoners, making comprehensive screening especially important. The review also highlighted that measures such as the FAST and the M-SASQ may also be suitable for identifying problematic alcohol use among offender populations [32]. However, there was less evidence to support the TAAD; this measure was time-consuming to administer and the need for a trained clinician to interpret the measure is likely to prohibit its widespread use.

Lots of screening tools with acceptable sensitivity and specificity in identifying problematic alcohol use compared to more extensive assessments of quantity and frequency or biochemical markers associated with alcohol consumption. Evidence suggests that even briefer screening tools are more likely to be used by clinicians in practice, and the reduction of sensitivity may be offset by more widespread application [32]. There is a small but growing evidence base for the delivery of screening and brief interventions in a prison setting. Parkes et al. (2011) identified 11 studies that evaluated the reliability and/or validity of screening tests for harmful use of alcohol in prisons, and this update review identified a further eight. The AUDIT has been the most consistently used instrument.

There is currently a lack of standardised formal screening for alcohol use in prisons in the UK, despite a high rate of problematic alcohol use among incarcerated offenders. Effective screening is essential in order to ensure that offenders are provided with

treatment that meets their level of need. The screening tool should be able to differentiate between hazardous, harmful and dependent alcohol use, especially as brief interventions are less effective for dependent drinkers. Screening for alcohol use should be done using a well-validated tool that has demonstrated reliability, sensitivity and specificity. It is also important to consider the time and level of training needed to administer the screening tool. The AUDIT is often regarded as the 'gold standard' for the screening of alcohol use, and this review provides additional support for its use in prison settings. The briefer AUDIT-C may also be effective for identifying alcohol use problems among incarcerated populations, although its reliability among male offenders has yet to be established [29].

The SIPS is a research programme funded by the Department of Health in 2006 as part of the national Alcohol Harm Reduction Strategy for England. The SIPS team conducted a survey within a variety of criminal justice settings with the aim of testing the feasibility and acceptability of screening and delivering brief interventions in this population. In setting out to identify which locations alcohol screening and brief interventions should be delivered in, they approached 592 potential participants: in police custody (n = 120), prison (n = 420) and in a probation setting (n = 52). Only 251 (42%) were eligible, including just 35% of the prison population, with the major reason given for ineligibility being that those in question were unable to read or write. However, 94% of this small prison sample consented to being screened – more than the percentage in the other two settings [32].

“When we look at the numbers who screen positive as a proportion of those initially approached, probation services provide more optimal settings than either prison or police custody suites. Police custody suites were busy and often chaotic environments and screening at busy times was difficult in these environments, a finding echoed in other evaluations (Sharp and Atherton, 2006). A further disadvantage related to reasons for ineligibility, with large numbers of those in custody suites ineligible because of intoxication by alcohol or other substances and many in prison settings ineligible due to an inability to read or write English. Further, the enforced abstinence of the prison setting make them less appropriate for interventions aimed at resolving ambivalence and increasing motivation to reduce consumption. The high prevalence of harmful and dependent alcohol consumption, and the confined environment, make prison settings better placed to implement more intensive, tailored intervention approaches.” [32]

## Brief interventions

The review identified six studies (nine reports) that evaluated brief interventions for alcohol use and four studies that evaluated more intensive interventions for problematic alcohol use. The studies suggest that brief interventions may be effective in reducing

the level of alcohol use as measured by the AUDIT [37], as well as the frequency of alcohol use [41], the quantity of use [40] and the level of alcohol-related problems [41]. However, there was also some evidence to suggest that brief interventions may not affect the quantity of alcohol use, the time to first drink following release from prison [42], or the level of alcohol-related consequences [43].

It is unclear how many sessions are required in order to effect change in the use of alcohol, but this review provides some evidence that even one [37] or two [41] sessions of motivational interviewing may be efficacious in reducing the level of alcohol use among prisoners. However, the impact of brief interventions in the long term remains unclear, as the majority of research reviewed in this report involved short follow-up periods of three months or less. The study by Stein et al. (2010) suggests that, while brief interventions may be associated with positive outcomes for alcohol use in the short term (three months), the effect may not be detectable at six months [41]. Re-entry into the community following a period of incarceration represents a vulnerable time in relation to the re-initiation of substance use and hazardous drinking. Evidence suggests that the first week after release from prison may represent a period of high vulnerability for relapse to alcohol among hazardous drinkers [42].

Therefore, interventions that involve booster sessions following release into the community may help to maintain the gains achieved from the brief intervention. RMCs may also be useful in extending the impact of brief intervention, especially as RMCs have been shown to be effective in linking recently released prisoners to substance use treatment services in the community [48]. This review also highlights that even the provision of basic information prior to release from prison regarding treatment services in the community may significantly increase the level of treatment engagement following release from prison [37] and may help to maintain the gains achieved by brief intervention.

Research of this type is often complex, involving a population with varied and complex needs. There may be comorbid substance use and/or mental health problems, as well as wider social problems such as housing issues, domestic violence and unemployment. Ideally, interventions need to be tailored to consider this when providing support for hazardous or harmful alcohol use. Evaluation of interventions in prison settings is also compounded by the heterogeneity of prisons in the UK, and between the UK and other countries. The majority of studies have been conducted in the USA and there is a paucity of data for prison populations in the UK. Caution should be exercised in extrapolating the findings from USA-based studies to a UK setting, as there are significant differences in the judicial system and prison environment between the two countries.

A further difficulty that adds to the complexity of evaluating prison-based interventions for alcohol use is the lack of long-term follow-up, especially following release from

prison. Not all of the studies included in this review conducted follow-up assessments once the participant had been released into the community, and this limits the conclusions we are able to make regarding the impact of interventions on change in alcohol use. Studies that only include follow-up assessments during the period of incarceration, where alcohol is not readily available, may overestimate the success of treatment, and the results of these studies should be interpreted with caution. In addition, among the studies that did include follow-up assessments in the community after release from prison, high rates of participant attrition were an inherent problem.

The heterogeneity in participant samples can also make interpretation difficult in research of this type. Not all studies included in this review targeted hazardous drinkers; indeed, some studies only included participants if they were engaging in risky sexual behaviour and hazardous drinking (Stein et al., 2010) while other studies only recruited participants who had engaged in alcohol-related violence [45]. The study by Stein et al. (2011) included minimal exclusion criteria – participants were eligible to take part if they had consumed alcohol, but the intervention was not targeted at hazardous alcohol users [40] – whereas the study by Bowes et al. (2012) excluded participants if they were alcohol dependent or had mental health problems [45]. The differences in participant samples may limit the generalisability of the research findings to the wider offending population.

The studies in this review do not provide any suggestions on when to screen for alcohol use problems in prison, or indeed when it is best to conduct a brief intervention for hazardous alcohol use. Previous research indicates that screening for alcohol use immediately following admission to prison is likely to result in a lower rate of detection [49], perhaps because alcohol use is less of a priority compared to other issues at the point of admission to prison. Therefore, it is suggested that screening for alcohol use should take place after a number of weeks of imprisonment. In terms of intervention, the optimum timing to implement brief interventions in prison remains unclear. However, it is worth considering that offenders may be released prior to their scheduled release date. If the intervention is timed to occur shortly before an offender is due for release, this may mean that a proportion of individuals are unable to take part.

A key driver of intervention among hazardously drinking offenders is to reduce the rate of recidivism among recently released prisoners. However, despite this, there is a lack of data to determine if interventions for alcohol use reduce the rate of future re-offending. The impact on re-offending was not examined among studies evaluating brief interventions for alcohol use, and further research is required in order to evaluate this. At present, there is not enough evidence to reach a conclusion regarding the effect of brief interventions for alcohol use in this population in the long term. Research is required to further establish the effectiveness of brief interventions for alcohol use among offenders in prison in the UK, the appropriate time to implement the intervention, and the economic impact of brief interventions (eg by reducing the rate of recidivism).

Nevertheless, this review highlights that it is possible to successfully implement brief interventions for alcohol use within a prison setting, and there is some evidence that brief interventions have a significant impact on the use of alcohol. Evidence also suggests that it may be possible for existing criminal justice staff to deliver interventions for alcohol use, provided there is a sufficient level of training [38,39,45]. Screening should not take place immediately upon arrival to prison, but instead should take place after the individual has been in prison for a number of weeks. It is unclear when the best time to deliver brief interventions is in this setting, but evidence from this review suggests that additional booster sessions of brief intervention once the offender has been released from prison may be beneficial. It is recommended that brief interventions are implemented in prison as part of a systematic programme of support. The development of a tiered stepped-care approach to treatment that includes routine screening of alcohol use using a validated tool, followed by intervention that is tailored to the level of individual need, is important in providing effective and appropriate care to offenders with hazardous and harmful alcohol use who may, at present, go untreated.

## Conclusion

The evidence base suggests that it is possible to use screening techniques to detect hazardous, harmful and dependent drinking in UK prisons. However, consideration needs to be given to:

1. When the screening takes place during the prison journey – waiting a week seems to pick up more problematic drinkers than on the day of admission [49]
2. The age of the prisoner – younger prisoners appear to be less aware that they are drinking problematically when questioned about it, possibly because they are less likely to have experienced tolerance or withdrawal, and so would benefit from the use of a screening tool [26,31]
3. Other demographic factors – much of the research has focused on women or adolescent populations, and may not be transferable to the adult male population
4. Other comorbid conditions – the efficacy of both screening and brief interventions is likely to be influenced by comorbid drug misuse and mental health problems. Parkes et al. conclude that a stepped-care model, such as the one advocated by both MoCAM and NICE CG115, is the most appropriate approach in a prison setting [28], and the evidence summarised in this review is consistent with this recommendation

Screening is particularly useful for detecting hazardous and harmful drinkers. The most recent report from HM Inspectorate of Prisons highlights that prisons are best at detecting alcohol-dependent individuals and administering medically assisted

withdrawal, but that screening and brief interventions are less consistently delivered [27]. The SIPS programme has developed materials for delivering screening and brief interventions that could be easily used by prison or healthcare staff. Brief interventions based on motivational interviewing have a small but significant impact on alcohol use and alcohol-related problems on release, and a brief intervention within a few weeks of release is likely to be beneficial.

Brief interventions based on motivational interviewing require appropriate training and supervision, and may be more suited to specialist healthcare staff. The finding that motivational interviewing failed to increase the time to first drink post-release [42], the high rate of attrition from studies post-release, and the recommendation for booster sessions to extend the effect beyond three months post-release [41] all suggest that just as much effort should go into the post-release period.

In this respect, RMCs over the phone appear to be a potentially efficacious and cost-effective strategy of continuing treatment outside the prison walls [48]. The outcome of UK research on delivering screening and brief interventions in probation settings will be important [39].



## Stakeholder discussions

This chapter will focus on stakeholder discussions with staff from nine of the 10 prisons within the Gateways initiative. One prison was not interviewed as the prison felt it did not deliver brief interventions and therefore there was limited value in discussing the topic. The final section of this report will report on discussions with prisoners in focus groups across four prisons – a Category B remand prison; two Category C trainer prisons; and a female establishment. At the time of writing, this was still being implemented and some initial findings are presented as a map below.

---

## Staff interviews

The study interviewed important stakeholders involved in the implementation of brief interventions in prison custody and, overwhelmingly, interviewees were derived from existing recovery/addiction services. The interview topics were themed to examine the process by which a prisoner may receive a brief intervention (in other words, how, when and why); issues relating to the delivery of a brief intervention in a custodial setting; and a discussion on the optimal setting for a brief intervention (that is, at what stage of a prisoner's journey should a brief intervention be utilised). Four key areas were identified during the interview process:

### 1. Brief interventions tend to be integrated within existing addiction/recovery-style interventions rather than within a lifestyle context

The process map of how a prisoner moves across the various establishments was discussed in relation to delivering a brief intervention in practice (see Figure 2). A number of interviewees highlighted that, for many establishments, an initial screen for alcohol consumption was undertaken by healthcare services as part of the induction and reception process. For these establishments, use of the AUDIT-C (a three-question tool) often acted as a referral mechanism to the recovery/addiction services, rather than a point at which an intervention would be delivered. Some healthcare teams used the full 10-item AUDIT-10 screen and referred every prisoner that scored eight or more. It was not always clear what was delivered for prisoners scoring less than eight – one prison suggested that healthcare provided “general advice”, but was not specific on the composition of this advice.

Following referral, all prisoners scoring eight or more on the AUDIT would be linked into the recovery/addiction service, with prisoners who often scored more than 19 being

referred for a clinical intervention. For most interviewees, the AUDIT scores did not result in a tailored or bespoke discussion on alcohol use – rather, prisoners were broadly encouraged to access existing services geared towards dependent drinkers, including group work (for instance, 12-step groups), and specific packages aimed at relapse prevention or generic packages aimed at generating alcohol awareness. Guidance for brief interventions (eg Babor et al., 2001) suggests that brief interventions should be differentiated by levels of drinking – for example, different approaches for hazardous, harmful and higher-risk drinking levels. Drinkers scoring 8–15 on the AUDIT should be given “simple advice”, and those scoring 16–19 given “simple advice plus brief [lifestyle] counselling and continued monitoring” (ibid.). Interviewees suggested that the AUDIT scores did not result in this level of tailored intervention – rather, prisoners were placed into services, which was described by one interviewee as “business as usual”. Put another way, the prisoners who engaged with recovery/addiction services were subject to historical and legacy CARAT interventions rather than approaches that adhered to brief intervention guidance used in the community.

The discussions with staff tended to gravitate towards notions of recovery and addiction, which may not be applicable to drinkers consuming alcohol at sub-dependent levels. In other words, the delivery of brief interventions tended to be placed in the context of addiction and recovery, as opposed to wider lifestyle change. This highlighted a schism in the purpose of the intervention in a custodial setting. Was a brief intervention aimed at reducing drinking to prevent future offending, or should it be seen as a health and lifestyle issue? For many of the stakeholders interviewed, there was a focus on recovery, which encouraged abstinence from drinking; but this may not resonate with the intent underpinning a brief intervention.

Moreover, it was unclear how many prisoners who scored less than 20 on the AUDIT-10 and who were alcohol-only users maintained contact with services following a referral. There was some discussion among prison staff that, unless the prisoner in question had an illicit drug problem in conjunction with using alcohol, prisoners had little or no incentive to engage with services as “it would not be for them”. In other words, prisoners may perceive that their drinking is not problematic and not considered to be an addiction that requires “recovering from”. The use of recovery language may not be considered as conducive in engaging this type of offender. The discussions also included a commentary on the characteristics of this type of prisoner. A number of defining features emerged from the discussions, including i) a younger drinker with no other health issue; ii) there was a perceived correlation with other types of offence, including violent crime encompassing domestic violence; and iii) if there was a link with an illicit drug, it tended to be a recreational (rather than an addictive) use of stimulants such as cocaine. Interviewees suggested that this description differed from the “traditional” service user accessing recovery/addiction services who was older and convicted for “trigger” offences, including shoplifting, burglary and other acquisitive crimes.

Staff interviewed suggested that prisoners would engage for a variety of reasons, including whether accessing an alcohol-specific “course” was part of a sentence plan, but largely there was little incentive for this type of non-dependent drinker to access treatment unless they were compelled to do so. However, for some interviewees, the use of a brief intervention was “our best hope” in reaching and delivering an intervention to a treatment-resistant segment of prisoner.

The study also examined the pamphlets and one-to-one or group-based supporting literature (used in conjunction with key work). Again, there was a difference in tone compared to the community-based brief intervention literature. In the community, the health benefits of reduced consumption are emphasised within the context of a person’s lifestyle. In prison, the literature was described as rather more “apocalyptic”, with an emphasis on the serious consequences of over-consumption that focuses on dependent levels of drinking. We noted instances in the literature that included references to “death” through alcohol poisoning and choking on vomit; “brain malfunction”; and liver disease. There were more references to dangerous activities including drink-driving and risky sexual or drug-using practices, alongside a greater risk of offending through violent crime. The assumption remained that all interventions are focused on dependent levels of drinking. Despite this, staff did highlight other “common sense” approaches to delivering a coherent message about alcohol. This included focusing on real-life examples of when a prisoner would drink and how they could avoid excessive consumption. The use of node-link maps that present and impart information visually was seen as helpful at encouraging prisoners to speak “in their own voice”. For example, one prison (HMP Preston) highlighted the use of a “family impact” map that explained the consequences of drinking on the prisoner’s immediate family, including their partner and children.

## 2. Timing of a brief intervention is perceived as crucial in a custodial setting

The process by which a brief intervention would be delivered was mapped out across the different establishments. For many prisons, an initial healthcare screen would be delivered by a healthcare team at reception, and this would often include the shorter three-item AUDIT-C questionnaire. Prisoners would be referred to specialist recovery/addiction services based on the scores from the AUDIT-C, as highlighted above. In addition, some prisons enhanced the initial AUDIT-C screen delivered by the healthcare team by ensuring that the recovery/addiction teams undertake the full AUDIT-10 within a set period of time (for example, within 15 days of arrival into the prison). For staff interviewed, the timing of delivering an alcohol screen was considered crucial. Many interviewees suggested that a brief intervention at induction and delivered by healthcare teams was not efficient or appropriate.

For interviewees, the health screen at reception was considered very comprehensive and many health messages would be “lost” in the volume of information that needed to be collected as “too much information is required at once”. Healthcare teams were seen as very busy at reception and unlikely to have time to foster a level of rapport to initiate a conversation on excessive alcohol consumption. Moreover, the focus of healthcare is on the medical treatment of the prison population, with a focus on immediate clinical needs. Often, it was suggested, there is little scope for more informal health promotion messages outside of commissioned sessions.

The discussions also included reference to possible alternatives of delivering a brief intervention at reception or early on during a prisoner’s stay in an establishment. Use of peer mentors at induction was discussed as a possible vehicle for delivering a brief intervention. This was deemed problematic by interviewees, as induction was often seen as “an overwhelming experience” for some prisoners, who may not be receptive to discussions on alcohol at this stage. Far better, it was suggested, that the timing of the intervention should be geared towards a period of time when a prisoner was settled within an establishment and “ready to hear” health promotion messages. This period of time included the need for prisoners to develop positive working relationships with staff that would allow a truthful discussion of drinking habits.

Therefore, most interviewees focused on the need to deliver the brief intervention or “teachable moment” at or near to the point of release. Pre-release and release on temporary licence were the crucial points at which to deliver and enhance a health promotion message. Many of the staff interviewed highlighted the phenomenon of prisoners being “gate happy” and celebrating release with excessive alcohol consumption (“time to get blathered”). Specific interventions may be required to address the exact point of release, for example. Staff also suggested that there were opportunities for other prison professionals to deliver a simple health promotion message, including offender managers who work with prisoners prior to release. Staff also suggested that long-term prisoners in open or Category D prisons may face different pressures and, therefore, require a more calibrated response – for example, “the draw of new things” in a bar: staff reflected on prisoner concerns about being released and finding the design of bars to be radically different than before, including innovative use of lighting, seating arrangements, promotions (e.g. happy hours), and new products (such as alcopops). Long-term prisoners were perceived to be curious to try new drinks when out on release.

Discussions also included the need to restate a health promotion message soon after the point of release to ensure that messages conveyed in prison are not “lost”. Interviewees suggested that a mix of “authority figures”, including offender supervisors through community rehabilitation companies and peer mentors, would be a group that could continue with brief interventions and enhancing health promotion activity.

Staff suggested that this approach could offer the opportunity to be innovative – for example, one establishment suggested that brief interventions could link into fitness/boot camps offered by Gateways prisons once a prisoner has been released. There was also some discussion that who delivers the health promotion message may be just as important as what the message is.

Use of peers and mentors was considered a potential resource to deliver a key health promotion message, although there remained potential issues with recruiting the right person for the role. There was no consensus as to whether the peer mentor should be someone in recovery (e.g. a dependent drinker) or whether it is best to mirror the type of prisoner described previously (non-dependent drinker, younger, convicted for violent offences). Discussions also suggested that it may be easier to train an ex-offender to deliver a message of abstinence as opposed to delivering a more nuanced health promotion message aimed at subtle reductions in drinking levels.

### 3. Use of the AUDIT may be problematic in a custodial setting

The study has suggested that use of the AUDIT may be problematic within a prison setting. Interviewees raised some concern over the use of the AUDIT as a screen for offenders:

“It [the AUDIT] is just not designed for use in prison or for criminals, I’d say. It doesn’t pay heed to criminal behaviour and crimes committed when under the influence. That’s what we want to know about and should be the focus of our discussions with them [prisoners]. AUDIT doesn’t allow you to do that.”

The AUDIT scores were seen as “not entirely accurate” or reflective of the level of need. Interviewees cited examples where the scores seemingly understated a prisoner’s level of need. For example, one prison highlighted a prisoner convicted for a domestic violence offence following excessive alcohol consumption who scored two on the AUDIT.

Staff also highlighted specific examples where the questions on the AUDIT are interpreted by prisoners in a certain way. For example, question 10 on the AUDIT covers other people’s concern over drinking, including reference to a doctor – a few of the interviewed staff said that prisoners seem more inclined to focus on the word “doctor” than other words. This of course relies on staff being able to interpret prisoners’ responses and reframe the question to align with the purpose of question, and to disentangle any misinterpretations. For prisoners in resettlement prisons, the wording of the AUDIT questions is affected by their relative length of stay. Long-term prisoners will be unable to reliably answer questions that include recent or current alcohol consumption, as the AUDIT asks a range of questions about “the last year” or “on a

typical day”. For long-term prisoners, this may have been some time ago and may not be reflective of the person that they are now.

For staff working in Category D or open prisons, there was a perception that the AUDIT questions were largely “redundant”.

Virtually all staff interviewed highlighted the potential for prisoners to “blag” their scores at reception. There was a commonly held view that the screening scores for prisoners on arrival were “untrustworthy” or “never honest”. Prisoners reliant on accessing medication were seen to exaggerate their scores to justify or prove an addiction and subsequent access to medicines.

For some interviewees, there was a perception that the more prolific and difficult offenders are “out for what they can get”. For example, there was a suggestion that certain prisoners know they may be eligible for diazepam if they “play up their drinking”. Staff interviewed also suggested the converse of the “blag” – the understatement of actual drinking levels – in that many prisoners will not see themselves as having a problem and therefore will, consciously or unconsciously, lower their scores to justify their behaviour. In a similar vein, there were other instances of some prisoners understating their scores. Staff suggested that some prisoners at the point of entry into prison may be shamed by the role alcohol played in their lives and may downplay its influence.

There was also a wider issue with regard to the collation of AUDIT scores across most establishments. Few, if any, visited prisons routinely collected this information within existing management information systems. This information tended to be held within casefiles and did not always form part of the subsequent discussion on alcohol consumption.

#### **4. Units as a focal point for discussion are problematic: The need for “real world” discussions**

There was broad concern over the salience of the use of alcohol units as a focal point for alcohol-related discussions. For staff working in a young offender institution, the concept of units was perceived as “unhelpful” and irrelevant to young people. The calculation of units was seen as excessively complicated and, for younger offenders, there was a danger that the government advice on drinking was seen as “too preachy” and not couched in a young person’s actual experience of drinking. For female prisoners, while the concept of units had little efficacy, discussions on calorie count were seen as a stronger “hook” to engage prisoners with the health consequences of drinking.

Staff reflected on discussions with prisoners about alcohol units and highlighted a number of issues. The use of community-based literature and pamphlets discusses concepts of “sensible drinking”, yet there was a wider recognition among staff that this was not a concept fully transferrable to offenders where there is a culture of heavy drinking.

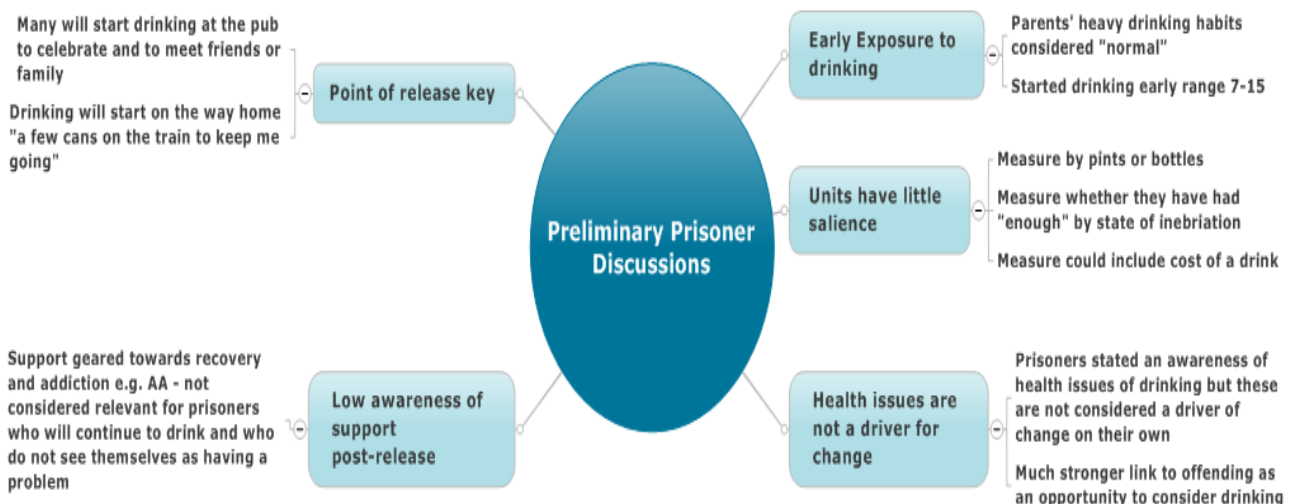
Second, the leaflets provided for community settings (such as GP surgeries) include discussion of drinks and measures that are perceived by prisoners as “not in the real world”. Few prisoners routinely drink wine or sherry, as highlighted in the health promotion literature, and the volume of alcohol is equally not replicable – “that’s not a shot that anyone would recognise”. Finally, for prison staff, the concept of units as the vehicle by which to effect change was not recognised among prisoners. Staff suggested that prisoners either “did not grasp” the concept underpinning units or the concept just did not have any salience with this group of drinker:

“Units are a nice concept. No one I have met will have discussed units before prison or will ever do again when on the outside. We need to think a little more laterally about this if we need to get our point across about helping people with cutting down on their drinking.”

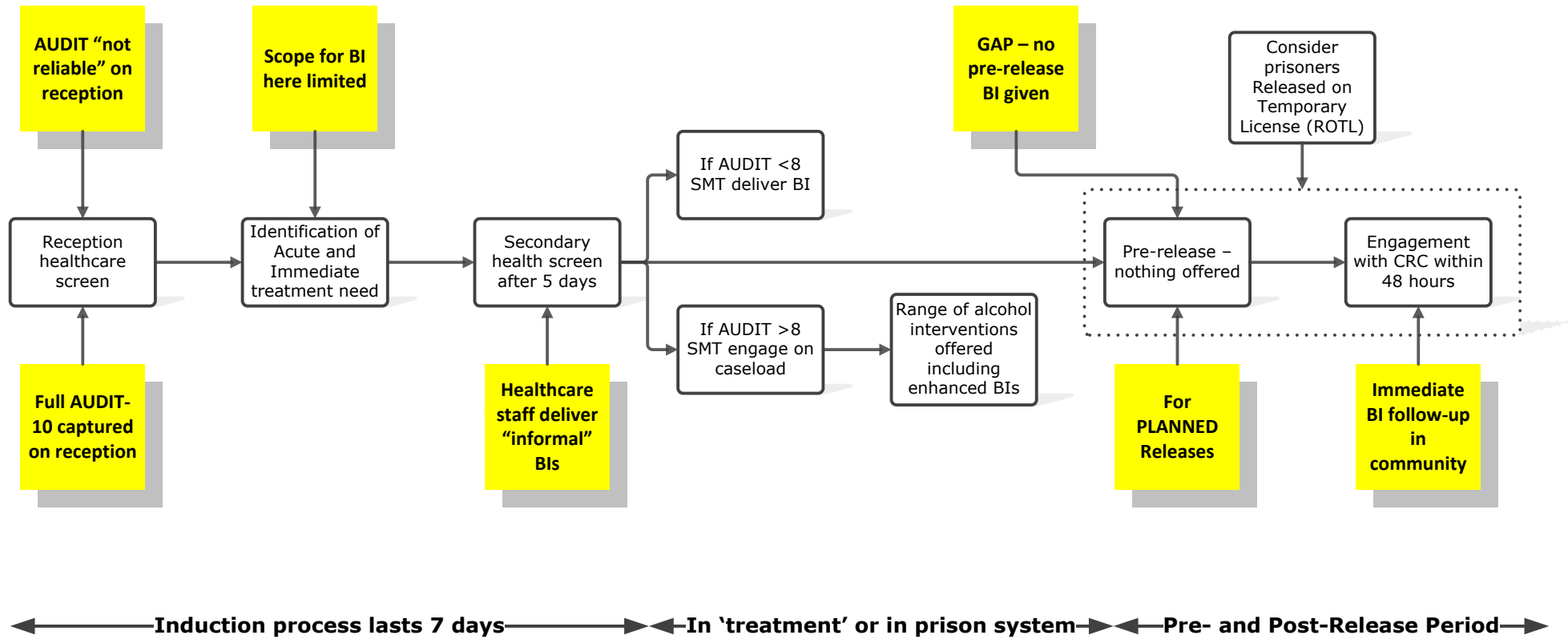
## Prisoner interviews

To be completed following fieldwork across four prisons. A themed map is presented below of the emerging findings.

**Figure 6: Emerging themes from prisoner interviews to date**



**Figure 7: Conceptual model for the delivery of brief interventions**





# Implementation

This chapter will examine the implementation of brief interventions across the prisons through reporting on staff surveys of practice. Two surveys were implemented at the point of training (the workshop evaluation questionnaire) and a subsequent WAFU due to be delivered to staff between three and six months after the initial training. The aim of the WAFU is to assess how well brief interventions have been integrated into practice. A survey was completed of 101 frontline staff (mainly, although not exclusively, community rehabilitation company staff).

## Staff satisfaction with training

**Table 9: Workshop evaluation (WEVAL) schedule (n = 101)**

<b>WEVAL heading</b>	<b>% Agree</b>
<b>Utilisation</b>	
You are satisfied with the manual and materials.	94%
You would feel comfortable using them in your service.	93%
You are satisfied with the methods and procedures that were used in this training course.	96%
The material covered in this training course is relevant to the needs of your clients.	90%
You expect the things you learned in this training will be used in your service within the next month or so.	62%
Your service has used similar material in the past with little success.	28%
You already are using highly similar material and see no reason to change.	29%
<b>Resources</b>	
Your service has enough staff to implement these materials.	46%
Your service has sufficient resources (offices, budget, etc.) to implement these materials.	45%
Other workers in your service would not have enough preparation time available to effectively implement these materials.	36%
You have the time to do the setup work required to use these materials.	67%

**Table 9 continued: Workshop evaluation schedule continued (n = 101)**

<b>WEVAL heading</b>	<b>% Agree</b>
<b>Training</b>	
Workers in your service have adequate background and education to use these materials.	70%
You would find phone consultation with the trainers of these materials helpful when your service begins using them.	74%
Workers in your programme would make use of tutorials or training packages available via the Internet on these materials.	76%
Based on what you learned in this training course, you would be able to train others on these materials.	64%
A follow-up training session supplementing what you learned in this course would facilitate your implementation of these materials.	58%
Some workers in your service might benefit from a follow-up training session on these materials.	69%
It would be a good idea for services throughout England to be trained on these materials.	82%
<b>Support</b>	
All workers at your service will need to agree to use these materials to make it work.	63%
Your service managers or supervisors would support and encourage the use of these materials.	80%
Workers at your service are interested and supportive of new treatment innovations.	77%
It would be helpful to have regular contact with people from other services who use these materials.	80%
You would be interested in email or Internet-based communications as part of a 'users group' to discuss applications of these materials.	70%

The WEVAL is subdivided into sections. The utilisation component suggests that staff who were surveyed were positive in the future and potential use of brief interventions and visual mapping techniques in their practice. However, the survey also showed that less than half of the staff who were surveyed raised issues with staffing and having the resources to implement brief interventions/mapping. Moreover, 58% of respondents were keen to have follow-up training. Telephone conversations (69% agreed) and Internet-based support (76% agreed) were also seen as positive ways to maintain engagement.

**Table 9 continued: Workshop evaluation schedule continued (n = 101)**

<b>WEVAL heading</b>	<b>% Agree</b>
<b>Mapping and changing thinking patterns (with clients)</b>	
How effective will the training be on using BI/mapping with clients?	97%
How useful did you find the BI/mapping information provided?	98%
How often do you expect to use BI/mapping materials in the future?	80%
How enthusiastic are you about using BI/mapping with your clients?	88%
To what extent would you recommend that other workers learn to use BI/mapping?	95%
How effective will the training be on [clients'] changing thinking patterns?	84%
How often do you expect to use information on changing thinking patterns in the future?	85%
How enthusiastic are you about using these materials on changing thinking patterns with your clients?	91%
To what extent would you recommend that other workers learn to use materials on changing thinking patterns?	90%

The training was seen to have face validity among respondents in that brief interventions/mapping will be effective with their clients. Ninety-eight per cent of the workers who undertook the training subsequently agreed that the brief interventions/mapping materials were useful and 88% agreed that they were enthusiastic about using the tools. Over three-quarters (80%) expect to use the brief intervention/mapping materials at some point in the future.

## Implementation of brief interventions

This section is to be completed following the completion of all staff training and the receipt of the WAFU interview schedule.

## Suggested next steps

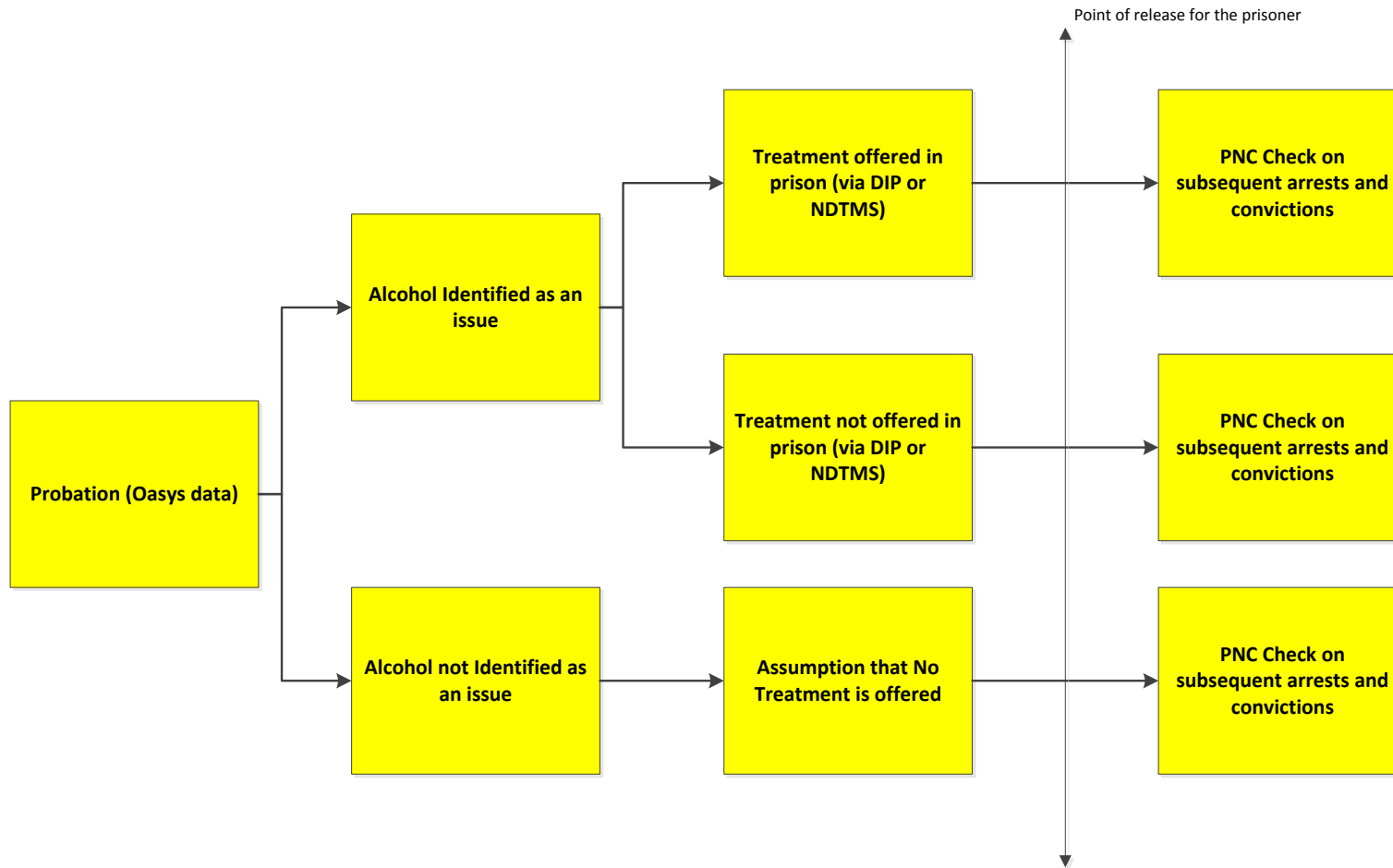
Discussions with staff and other related stakeholders have suggested that the next phase of the study will be to understand the effectiveness of alcohol treatment for prisoners through a bespoke data linkage study. A conceptual model is shown below in Figure 8 overleaf. The conceptual design will be based on a reconviction methodology based on a longitudinal follow-up of individuals leaving prison using Police National Computer (PNC) data.

Although some guidance from the Office for National Statistics has emerged in recent years, there remains no clear overview (from central government) of the detail involved with matching datasets across time and different areas. For example, the study aims to utilise up to five differing datasets:

- Probation OASys data on prisoners assessed to have an alcohol or no-alcohol issue. Preliminary discussions with Ministry of Justice colleagues suggest that there may be some variability in data quality with these assessments for alcohol
- Drug Interventions Programme and/or NDTMS data in prison will allow an understanding of whether an individual with an identified alcohol issue (through OASys) has accessed appropriate services once in prison. These data will also include commentary on the interventions given, the length of treatment and other health or social markers (such as employment or housing status)
- P-NOMIS match – ideally, the match for each individual should include a start and end date for each prison episode. The approach, therefore, is aimed to ensure that any individual has the equal probability of being included in the subsequent PNC (reconviction match) pre- and post-entry into prison. Preliminary analysis using local police force data has found that, for some individuals, there are multiple prison episodes of differing sentence lengths, each of which needs to be taken into account before determining the length at which an individual may be at liberty to commit an offence
- PNC match to determine reconviction, including time-to-offence analyses and monitoring any changes in the seriousness of offences

Further feasibility work is required to test the availability of the above data sources, as are matching protocols and the calculation of pre- and post- samples that are equal and that take into account multiple sentences and wider temporal concerns (e.g. any model will need to be cognisant of an individual moving through the criminal justice system).

**Figure 8: Conceptual model of data linkage**



## Appendix I: Main body references

- 1 Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG: AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care. Geneva, World Health Organization, 2001.
- 2 National Collaborating Centre for Mental Health: Alcohol-use disorders: The NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence. London, The British Psychological Society and the Royal College of Psychiatrists, 2011.
- 3 Health and Social Care Information Centre: Statistics on alcohol: England, 2013. 2013.
- 4 Weaver T, Madden P, Charles V, Timso GS, Renton A, Tyrer P, Barnes T, Bench C, Middleton H, Wright N, Paterson S, Shanahan W, Seivewright N, Ford C, on behalf of the Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study team: Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, 2003;183:304–313.
- 5 Deacon L, Hughes S, Tocque K, Bellis MA: Indications of public health in English regions: 8. Alcohol. York, Association of Public Health Observatories, 2007.
- 6 HM Government: The government's alcohol strategy. London, Home Office, 2012.
- 7 Prime Minister's Strategy Unit: Alcohol harm reduction strategy for England. London, Cabinet Office, 2004.
- 8 National Institute for Health and Care Excellence: Alcohol-use disorders: Preventing harmful drinking: NICE Public Health Guidance. NICE, 2010, PH24.
- 9 Raistrick D, Heather N, Godfrey C: Review of the Effectiveness of Treatment for Alcohol Problems. London, National Treatment Agency for Substance Misuse, 2006.
- 10 Department of Health: Models of care for alcohol misusers (MoCAM). London, National Treatment Agency for Substance Misuse, 2006.
- 11 National Institute for Health and Care Excellence: Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults. Commissioning guide: Implementing NICE guidance. London, NICE, 2011.

- 12 Department of Health: Alcohol needs assessment research project. London, Department of Health, 2005.
- 13 World Health Organization: Lexicon of alcohol and drug terms published by the World Health Organization. World Health Organization, 1994.
- 14 [Anon]: Executive summary of the National Research Council's report 'Informing America's policy on illegal drugs: What we don't know keeps hurting us'. *Addiction*, 2002;97:647–652.
- 15 Langfield-Smith K, Wirth A: Measuring Differences Between Cognitive Maps. *Journal of Operational Research Society*, 1992;43(12):1135–1150.
- 16 Huff A, Schwenk C: Bias and sense making in good times and bad. In: Huff A (ed.), *Mapping Strategic Thought*. Chichester, Wiley, 1990, pp. 89–108.
- 17 Pope C, Ziebland S, Mays N: Analysing qualitative data. *British Medical Journal*, January 2000;320(7227):114–116.
- 18 Heather N: Brief intervention strategies. In: Hester RK, Miller WR (eds): *Handbook of alcoholism treatment approaches: Effective alternatives*. Boston, Allyn & Bacon, 1995.
- 19 Miller WR, Sanchez VC: Motivating young adults for treatment and lifestyle change. In: Howard G (ed.): *Issues in Alcohol Use and Misuse in Young Adults*. Notre Dame, IN, University of Notre Dame Press, 1993.
- 20 Maggia B, Martin S, Crouzet C, Richard P, Wagner P, Balmes JL, Nalpas B: Variation in AUDIT (Alcohol Use Disorders Identification Test) scores within the first weeks of imprisonment. *Alcohol & Alcoholism*, 2004;39:247–250.
- 21 Parkes T, MacAskill S, Brooks O, Jepson R, Atherton I, Doi L, McGhee S, Eadie D: *Prison Health Needs Assessment for Alcohol Problems*. NHS Health Scotland, 2011.

## Appendix II: Literature review references

- 1 National Collaborating Centre for Mental Health: Alcohol-use disorders: The NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence. London, The British Psychological Society and the Royal College of Psychiatrists, 2011.
- 2 Health and Social Care Information Centre: Statistics on alcohol: England, 2013. 2013.
- 3 Weaver T, Madden P, Charles V, Timso GS, Renton A, Tyrer P, Barnes T, Bench C, Middleton H, Wright N, Paterson S, Shanahan W, Seivewright N, Ford C, on behalf of the Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study team: Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *British Journal of Psychiatry*, 2003;183:304–313.
- 4 Deacon L, Hughes S, Tocque K, Bellis MA: Indications of public health in English regions: 8. Alcohol. York, Association of Public Health Observatories, 2007.
- 5 HM Government: The government's alcohol strategy. London, Home Office, 2012.
- 6 Prime Minister's Strategy Unit: Alcohol harm reduction strategy for England. London, Cabinet Office, 2004.
- 7 National Institute for Health and Care Excellence: Alcohol-use disorders: Preventing harmful drinking: NICE Public Health Guidance. NICE, 2010, PH24.
- 8 Raistrick D, Heather N, Godfrey C: Review of the Effectiveness of Treatment for Alcohol Problems. London, National Treatment Agency for Substance Misuse, 2006.
- 9 Department of Health: Models of care for alcohol misusers (MoCAM). London, National Treatment Agency for Substance Misuse, 2006.
- 10 National Institute for Health and Care Excellence: Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults. Commissioning guide: Implementing NICE guidance. London, NICE, 2011.
- 11 Department of Health: Alcohol needs assessment research project. London, Department of Health, 2005.



- 12 World Health Organization: Lexicon of alcohol and drug terms published by the World Health Organization. World Health Organization, 1994.
- 13 [Anon]: Executive summary of the National Research Council's report 'Informing America's policy on illegal drugs: What we don't know keeps hurting us'. *Addiction*, 2002;97:647–652.
- 14 Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG: AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care. Geneva, World Health Organization, 2001.
- 15 Heather N: Brief intervention strategies. In: Hester RK, Miller WR (eds): *Handbook of alcoholism treatment approaches: Effective alternatives*. Boston, Allyn & Bacon, 1995.
- 16 Jackson R, Johnson M, Campbell F, Messina J, Guillaume L, Meier P, Goyder E, Chilcott J, Payne N: Screening and brief intervention for prevention and early identification of alcohol use disorder in adults and young people. Sheffield, University of Sheffield, School of Health and Related Research (SchARR) Public Health Collaborating Centre, 2010.
- 17 Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED: Effectiveness of brief interventions in primary care populations (review). *The Cochrane library*, 4. The Cochrane Library, 2009:Art. No:CD004148.
- 18 Rodrigue JR, Pearman TP, Moreb J: Morbidity and mortality following bone marrow transplantation: Predictive utility of pre-BMT affective functioning, compliance, and social support stability. *International Journal of Behavioral Medicine*, 1995;6:241–254.
- 19 Rollnick S, Butler CC, Kinnersley P, Gregory J, Mash B: Motivational interviewing. *British Medical Journal*, 2010;340:1242–1245.
- 20 Drummond C, Oyefeso A, Phillips T, Cheeta S, Deluca P, Perryman K, Winfield H, Jenner J, Cobain K, Galea S, Saunders V, Fuller T, Pappalardo D, Baker O, Christoupolous A: Alcohol Needs Assessment Research Project (ANARP). The 2004 national alcohol needs assessment for England. London, Department of Health, 2004, pp. 1–31.
- 21 Walker A, Flatley J, Kershaw C, Moon D: Crime in England and Wales 2009/09: Home Office Statistical Bulletin. London, Home Office, 2009.

- 22 Flatley J, Kershaw C, Smith K, Chaplin R, Moon D: Crime in England and Wales 2009/10. Volume 1. Findings from the British Crime Survey and police recorded crime. London, Home Office, 2010.
- 23 Singleton N, Meltzer H, Gatward R: Psychiatric morbidity among prisoners in England and Wales. London, Her Majesty's Stationery Office, 1998.
- 24 McMurrin M: Drinking, violence, and prisoners' health. *International Journal of Prisoner Health*, 2005;1:25–29.
- 25 Newbury-Birch D, Harrison B, Brown N, Kaner E: Sloshed and sentenced: A prevalence study of alcohol use disorders among offenders in the North East of England. *International Journal of Prisoner Health*, 2009;5:201–211.
- 26 MacAskill S, Parkes T, Brookes O, Graham L, McAuley A, Brown A: Assessment of alcohol problems using AUDIT in a prison setting: More than an 'aye or no' question. *BMC Public Health*, 2011;11:865.
- 27 HM Inspectorate of Prisons: Alcohol services in prisons: An unmet need: Thematic report. London, HM Inspectorate of Prisons, 2010.
- 28 Parkes T, MacAskill S, Brooks O, Jepson R, Atherton I, Doi L, McGhee S, Eadie D: Prison Health Needs Assessment for Alcohol Problems. NHS Health Scotland, 2011.
- 29 Caviness C, Hatgis C, Anderson BJ, Rosengard C, Kiene SM, Friedmann PD, Stein MD: Three brief alcohol screens for detecting hazardous drinking in incarcerated women. *Journal of Studies on Alcohol and Drugs*, 2009;70:50–54.
- 30 Durbeej N, Berman AH, Gumpert CH, Palmstierna T, Kristiansson M, Alm C: Validation of the Alcohol Use Disorders Identification Test and the Drug Use Disorders Identification Test in a Swedish sample of suspected offenders with signs of mental health problems: Results from the mental disorder, substance abuse and crime study. *Journal of Substance Abuse Treatment*, 2010;39:364–377.
- 31 Plant G, Taylor PJ: Recognition of problem drinkers among young adult prisoners. *Behavioral Sciences and the Law*, 2012;30:140–153.
- 32 Coulton S, Newbury-Birch D, Cassidy P, Dale V, Deluca P, Gilvarry E, Godfrey C, Heather N, Kaner E, Oyefeso A, Parrott S, Phillips T, Shepherd J, Drummond C: Screening for alcohol use in criminal justice settings: An exploratory study. *Alcohol & Alcoholism*, 2012;47:423–427.
- 33 Proctor SL, Hoffmann NG: A brief alternative for identifying alcohol use disorders. *Substance Use & Misuse*, 2012;47:847–860.

- 34 Stein LAR, Lebeau R, Clair M, Rossi JS, Martin RM, Golembeske C: Validation of a measure to assess alcohol- and marijuana-related risks and consequences among incarcerated adolescents. *Drug and Alcohol Dependence*, 2010;109:104–113.
- 35 Strong DR, Caviness C, Anderson B, Brown RA, Stein M: Assessing the severity of hazardous drinking and related consequences among incarcerated women. *Alcoholism: Clinical and Experimental Research*, 2010;34:907–914.
- 36 Barton A: Screening and brief intervention of detainees for alcohol use: A social crime prevention approach to combating alcohol-related crime? *The Howard Journal*, 2011;50:62–74.
- 37 Begun AL, Rose SJ, Lebel TP: Intervening with women in jail around alcohol and substance abuse during preparation for community re-entry. *Alcoholism Treatment Quarterly*, 2011;29:453–478.
- 38 Brown N, Newbury-Birch D, McGovern R, Phinn E, Kaner E: Alcohol screening and brief intervention in a policing context: A mixed methods feasibility study. *Drug and Alcohol Review*, 2010;29:647–654.
- 39 Newbury-Birch D, Bland M, Cassidy P, Coulton S, Deluca P, Drummond C, Gilvarry E, Godfrey C, Heather N, Kaner E, Myles J, Oyefeso A, Parrott S, Perryman K, Phillips T, Shenker D, Shepherd J: Screening and brief intervention for hazardous and harmful alcohol use in probation services: A cluster randomised controlled trial protocol. *BMC Public Health*, 2009;9:418.
- 40 Stein LAR, Lebeau R, Colby SM, Barnett NP, Golembeske C, Monti PM: Motivational interviewing for incarcerated adolescents: Effects of depressive symptoms on reducing alcohol and marijuana use after relapse. *Journal of Studies on Alcohol and Drugs*, 2011;72:497–506.
- 41 Stein MD, Caviness CM, Anderson BJ, Herbert M, Clarke JG: A brief alcohol intervention for hazardously drinking incarcerated women. *Addiction*, 2010;105:466–475.
- 42 Clarke JG, Anderson BJ, Stein MD: Hazardously drinking women leaving jail: Time to first drink. *Journal of Correctional Health Care*, 2011;17:61–68.
- 43 Stein LAR, Clair M, Lebeau R, Colby SM, Barnett NP, Golembeske C, Monti PM: Motivational interviewing to reduce substance-related consequences: Effects for incarcerated adolescents with depressed mood. *Drug and Alcohol Dependence*, 2011;118:475–478.
- 44 Begun AL, Rose SJ, Lebel TP, Teske-Young BA: Implementing substance abuse screening and brief motivational intervention with women in jail. *Journal of Social Work Practice in the Addictions*, 2009;9:113–131.

- 45 Bowes N, McMurrin M, Williams B, David S, Zammit I: Treating alcohol-related violence: Intermediate outcomes in a feasibility study for a randomized controlled trial in prisons. *Criminal Justice and Behavior*, 2012;39:333–344.
- 46 Miller HV, Tillyer R, Miller JM: Recognizing the need for prisoner input in correctional research: Observations from an in-prison driving while intoxicated reduction program evaluation. *The Prison Journal*, 2012;92:274–289.
- 47 Scarbrough SH: Reducing recidivism in returning offenders with alcohol and drug related offenses: Contracts for the delivery of authentic peer based recovery support services. Richmond, Virginia, Virginia Commonwealth University, 2012, PhD.
- 48 Scott CK, Dennis ML: The first 90 days following release from jail: Findings from the Recovery Management Checkups For Women Offenders (RMCWO) experiment. *Drug and Alcohol Dependence*, 2012;125:110–118.
- 49 Maggia B, Martin S, Crouzet C, Richard P, Wagner P, Balmes JL, Nalpas B: Variation in AUDIT (Alcohol Use Disorders Identification Test) scores within the first weeks of imprisonment. *Alcohol & Alcoholism*, 2004;39:247–250.

# Appendix III: Brief intervention fact sheets

## ALCOHOL SCREENING & BRIEF INTERVENTION IN THE CRIMINAL JUSTICE SYSTEM FACTSHEETS

A series of Factsheets have been produced which summarise the prevalence of alcohol use disorders (AUDs) amongst those in contact with the criminal justice system and the evidence base for screening and brief interventions for those with an AUD in the criminal justice system.

There are 4 Factsheets relating to different areas of the criminal justice system; custody suites, prisons, probation, and young offenders.

### THE FACTSHEETS PROVIDE:

- a summary of the evidence of the association between alcohol use and offending behaviour;
- the prevalence of alcohol use disorders (AUDs) amongst adults and young people in contact with the criminal justice system, with comparisons made to the general population;
- a summary of the evidence base for screening and interventions designed to address AUDs in the criminal justice context.

The intended audience for these Factsheets includes health and substance misuse staff, commissioners, public health professionals, policy makers, academics and researchers.

### THE FACTSHEETS CAN BE USED TO SUPPORT:

- the development of screening and brief interventions for those identified as hazardous or harmful drinkers within a criminal justice setting;
- further research on alcohol interventions in the criminal justice setting;
- policy development.

For more information contact Dorothy Newbury-Birch,  
Professor of Alcohol and Public Health Research, Teesside University:  
[d.newbury-birch@tees.ac.uk](mailto:d.newbury-birch@tees.ac.uk)



# ALCOHOL SCREENING & BRIEF INTERVENTION IN THE PRISON SYSTEM

## BACKGROUND

There is evidence of an association between alcohol use and offending behaviour [1]. Alcohol has been found to be a factor in half of all violent crimes [2]. In England and Wales alcohol-related crime is estimated to cost society £11 billion (2010-2011 costs) [3]. However the precise relationship is complex [4], with an intricate interplay between drinking patterns, the amount of alcohol consumed and individual and contextual factors [5]. Alcohol screening and brief intervention is a secondary preventative approach, which involves the identification via screening of hazardous and harmful drinking and the delivery of an intervention aimed at reducing consumption and associated problems [6].

## PREVALENCE

A systematic review of the literature was conducted that identified studies in the UK that used the AUDIT screening tool to measure alcohol use disorders (AUDs) with adults in the prison system [7]. A score of 8 or more (out of 40) is categorised as an AUD whilst a score of 20+ indicates probable dependency. Five studies were found that were published between 2000 and 2012 [5, 7-10].

■ 51% to 87% screened positive for an AUD [5, 7-10].  
This compares to 20-30% observed in general population [11].

■ 25% to 43% scored positive for probable alcohol dependence [5, 7, 9, 10].  
This compares to 4% observed in general population [12].

## INTERVENTIONS:

A rapid review of the worldwide literature of effectiveness studies of alcohol brief intervention (< 3 hours) was carried out. Four articles were found [13-16]. All studies were carried out in the USA.

**Davis et al, 2003** carried out a RCT of veterans in a USA county jail. Participants were recruited in the month prior to leaving jail. 73 veterans were randomised to either a control condition of usual care (n=37) or an individual session of brief intervention (n=36); 73% males. The average length of intervention was 57 minutes. Participants were followed up within 60 days of being released from jail. 41% of participants were followed up. No differences were found between groups for any alcohol measures. Those in the intervention group were more likely to schedule appointments at a veterans' addiction clinic following their release (31% vs 14%; p<0.08) [13].

**Stein et al, 2010** carried out a RCT to evaluate brief intervention for alcohol use and risky sexual behaviour among women in a USA prison [14]. Women were eligible for the trial if they had consumed alcohol at a hazardous level and if they had recently engaged in risky sexual behaviour. 245 women were randomised to receive either two sessions of motivational interviewing (MI) (n=125) or treatment as usual (n=120). The first session of MI was delivered in prison with the second taking place approximately one to three months after leaving prison. Participants were followed up at three and six months. 76% (n=186); 76% (n=86) and 79% (n=193) of the participants were located and completed follow-up assessments at the one, three and six month follow-ups respectively. Participants randomised to MI had significantly fewer drinking days (OR =1.96, 95% CI 1.17,3.30) and reported fewer alcohol related problems at three-months (b=-4.96, 95% CI -8.91, 1.02, P<0.05), although this effect was not maintained at six month follow-up.

There was no significant difference between participant groups for the number of drinks consumed per drinking day. A second analysis of the study data conducted by Clarke, Anderson and Stein (2011) showed that the intervention did not impact the length of time to first alcoholic drink following release from prison [15].

**Begun et al's (2011)** 'Women and Jails Project' randomised women to either one session of MI (n=468) or treatment as usual (n=261). Only 276 of the 468 (59%) randomised to the intervention group received the intervention. Participants were followed up two months after release from jail. Significant reductions were found in alcohol scores for both groups between baseline and follow-up. The study only followed up 20% of cases so effectiveness could not be ascertained [16].

# ALCOHOL SCREENING & BRIEF INTERVENTION IN PROBATION

## BACKGROUND

There is evidence of an association between alcohol use and offending behaviour [1]. Alcohol has been found to be a factor in half of all violent crimes [2]. In England and Wales alcohol-related crime is estimated to cost society £11 billion (2010-2011 costs) [3]. However the precise relationship is complex [4], with an intricate interplay between drinking patterns, the amount of alcohol consumed and individual and contextual factors [5]. Alcohol screening and brief intervention is a secondary preventative approach, which involves the identification via screening of hazardous and harmful drinking and the delivery of an intervention aimed at reducing consumption and associated problems [6].

## PREVALENCE

A systematic review of the literature was conducted that identified studies in the UK that used the AUDIT screening tool to measure alcohol use disorders (AUDs) with adults in the probation system [7]. A score of 8 or more (out of 40) is categorised as an AUD whilst a score of 20+ indicates probable dependency. Two studies were found [8, 9].

Newbury-Birch et al (2009) found that:

- 67% (69% males; 54% females) screened positive for an AUD [8].
- 33% (35% males; 53% females) screened positive for probable alcohol dependency [8].

Orr et al (2013) found that:

- 59% screened positive for an AUD [9].
- 17% screened positive for probable alcohol dependency [9].

This compares to 20-30% observed in the general population [10].

This compares to 4% observed in the general population [11].

## INTERVENTIONS:

A rapid review of the worldwide literature of effectiveness studies of brief intervention (< 3 hours) was carried out. Two studies were found [8, 9].

Orr et al, (2013) conducted a pilot RCT from February 2010 to April 2011 with offenders given probation or community service orders in Scotland [9]. One hundred and ninety five individual AUDIT forms were completed and 82 (43%) were eligible for the trial. Participants randomised to the control group received a booklet whilst those in the intervention group received a one off brief intervention (no time given) delivered by routine criminal justice staff. Only 22% (n=16) of the sample were followed up therefore no effectiveness data was available [9].

Newbury-Birch et al, (2014) carried out a pragmatic cluster RCT of the effectiveness of two different brief intervention strategies compared to a control condition of feedback on screening outcome and a client information leaflet at reducing hazardous or harmful drinking in the English probation setting [12].

Offender managers were recruited across three geographical regions of England from May 2008 to July 2009; the North East, South East and London. Offender managers were randomised to one of three interventions, each of which built on the previous one: feedback on screening outcome and a client information leaflet control group, five minutes of structured brief advice, and 20 minutes of brief lifestyle counselling. Follow-up rates were 68% at six months and 60% at 12 months. At both time points there was no significant advantage of more intensive interventions compared to the control group in terms of AUDIT status. Those in the brief advice and brief lifestyle counselling intervention groups were statistically significantly less likely to reoffend (36% and 38% respectively) than those in the client information leaflet group (50%) in the year following intervention [12].

# ALCOHOL SCREENING & BRIEF INTERVENTION IN THE CUSTODY SUITE SETTING

## BACKGROUND

There is evidence of an association between alcohol use and offending behaviour [1]. Alcohol has been found to be a factor in half of all violent crimes [2]. In England and Wales alcohol-related crime is estimated to cost society £11 billion (2010-2011 costs) [3]. However the precise relationship is complex [4], with an intricate interplay between drinking patterns, the amount of alcohol consumed and individual and contextual factors [5]. Alcohol screening and brief intervention is a secondary preventative approach, which involves the identification via screening of hazardous and harmful drinking and the delivery of an intervention aimed at reducing consumption and associated problems [6].

## PREVALENCE

A systematic review of the literature was conducted that identified studies in the UK that used the AUDIT screening tool to measure alcohol use disorders (AUDs) with adults in the probation system [7]. A score of 8 or more (out of 40) is categorised as an AUD whilst a score of 20+ indicates probable dependency. Five studies were found [8-12].

- 64%-88% screened positive for an AUD [8-12]. This compares to 20-30% observed in the general population [13]
- 21-48% scored positive for probable alcohol dependency [8-12]. This compares to 4% observed in the general population [14].

## INTERVENTIONS:

A rapid review of the worldwide literature of effectiveness studies of brief intervention (< 3 hours) was carried out. Three publications were found [8, 11, 12]. None of the studies showed effectiveness.

Hopkins and Sparrow, (2006) evaluated the use of alcohol screening and brief interventions in the custody suite setting in Nottingham [8]. Of the 805 detainees screened, 67% received information/brief intervention. The research team looked at arrest data for included participants for the time period between April 1995 and April 2002 and identified that 15% of participants arrested for alcohol-related offences were re-arrested in the three months after intervention. Of the 186 participants who had only been arrested once for an alcohol-related offence in the three months before intervention, 11% were re-arrested within three months after intervention. Four of the 14 participants who had been arrested twice or more for alcohol-related offences in the three months before intervention were re-arrested in the three months after intervention [8]. The authors acknowledge that the numbers are low and without a comparison group it is impossible to show effectiveness [8].

Blakeborough and Richardson's (2012) study was carried out across 12 police forces in the UK between 2007 and 2010 [11]. The pilot scheme was able to deliver brief interventions (less than 30 minutes) in custody suites after the arrest or in a non-custody venue. The session could either be voluntary or mandatory. Arrest data was compared against a matched group from the same police force in a previous time period to when the study was conducted. The study did not show any evidence of reduced reoffending for individuals arrested for alcohol-related offences [11].

McCracken et al (2012) followed on from the work of Blakeborough and Richardson (2012) [12]. The study was carried out across 8 police forces in the UK between 2009 and 2010. Between one and three brief interventions sessions were offered across the sites in the police custody setting or a non-custody venue. Like the pilot, the scheme was made up of voluntary or mandatory sessions. Arrest data was compared against a matched group from the same police force in a previous time period to when the study was conducted. Those under a mandatory route were more likely to attend the first appointment (65%) compared to those in the voluntary sessions (28%). Like the pilot study there was no evidence of reduced offending for individuals when compared to a matched group [12].



# ALCOHOL SCREENING & BRIEF INTERVENTION FOR YOUNG PEOPLE IN THE CRIMINAL JUSTICE SETTING

## BACKGROUND

Evidence shows that drinking amongst adolescents under the age of 18 years, especially frequent drinking is associated with criminal and disorderly behaviour [1]. Alcohol consumption amongst adolescents aged 10-17 years is estimated to be responsible for 80,640 violent offences per year [2] and to cost in excess of £5 million per year for criminal activity to the Criminal Justice System (CJS) [3]. Adolescents who drink are more likely than non-drinkers to be both perpetrators and victims of violence [4]. Alcohol is likely to cluster with other risks in vulnerable young people's lives. Drinking may not be the greatest single risk but it threads between other vulnerabilities such as mental health and educational issues [5]. These data have culminated in a joint health and criminal justice policy focussing on identifying and tackling youth drinking and social disorder in the UK [6, 7].

The Chief Medical Officer for England has provided recommendations on alcohol consumption in young people [8] based on a review of the risks and harms of alcohol to young people [9]. The recommendations state that children should abstain from alcohol before the age of 15 and those aged 15-17 are advised not to drink, but if they do drink it should be no more 3-4 units and 2-3 units per week in males and females respectively, on no more than one day per week [8].

The AUDIT screening tool has been shown to be the most effective at screening with young people [10] and recent work has shown that a score of 3+ (from a score of 12) on AUDIT-C (the first three questions on AUDIT) should warrant an alcohol brief intervention and information about specialist alcohol services [11]. If the young person scores 6+ on AUDIT-C a formal referral to a specialist substance misuse service for a comprehensive assessment should be made [12]. Standardising of screening tools and interventions is important in the CJS and is being implemented across England and Wales for young people with AUDIT as the preferred alcohol screening tool.

## PREVALENCE

A systematic review of the literature was conducted that identified studies in the UK that used the AUDIT screening tool to measure alcohol use disorders (AUDs) with young people in the CJS [13]. One study was found [14]. Newbury-Birch et al (2014) surveyed young offenders aged between 11-17 on community orders with Youth Offending Teams and Youth Offending Institutions over a one-month period in 2008 [15]. Results showed:

### AUDIT Adult cut-offs

(8+ AUD; 20+ probable dependence) [13].

- 64% screened positive for an AUD
- 30% screened positive for probable alcohol dependency

### AUDIT-C cut-offs

(3+ AUD, 6+ referral to services) [12].

- 80% screened positive for an AUD
- 67% scored 6+ on AUDIT-C [16]

## INTERVENTIONS:

A rapid review of the worldwide literature of effectiveness of brief intervention (< 3 hours) was carried out. One study (described in two papers was found) [17, 18].

Stein et al, (2011) carried out a RCT to evaluate the effects of depressive symptoms on reducing alcohol and marijuana use in a USA juvenile correctional facility [17]. Participants were randomised to receive either two sessions of motivational interviewing (MI) (n=86) or two sessions of relaxation training (n=76). Eighty six percent (n=162) provided data at follow up. At three-month post-release follow-up participants who received MI reported a significantly lower average number of alcoholic drinks consumed per day, a lower percentage of heavy drinking days, and a lower percentage of days where more than five drinks were consumed. A follow-up paper from this study further found that the effects of MI were not moderated by depressive symptoms [18].

## Appendix IV: Brief intervention manual



Public Health  
England

### **Routes to Recovery**

via criminal justice

Brief Lifestyle Counselling  
Brief Interventions

Alcohol

## Appendix V: Published academic papers

# A rapid systematic review of what we know about alcohol use disorders and brief interventions in the criminal justice system

Dorothy Newbury-Birch, Ruth McGovern, Jennifer Birch, Gillian O'Neill, Hannah Kaner, Arun Sondhi and Kieran Lynch

Dorothy Newbury-Birch is based at Alcohol and Public Health Research, Health and Social Care Institute, Teesside University, Middlesbrough, UK.

Ruth McGovern and Jennifer Birch, both are based at Institute of Health & Society, Newcastle University, Newcastle upon Tyne, UK. Gillian O'Neill is based at Durham County Council, Durham, UK. Hannah Kaner is based at Institute of Health & Society, Newcastle University, Newcastle upon Tyne, UK.

Arun Sondhi is based at Therapeutic Solutions (Addictions), London, UK. Kieran Lynch is based at Public Health England, London, UK.

Received 3 August 2015  
Revised 29 September 2015  
Accepted 13 October 2015

© Dorothy Newbury-Birch, Ruth McGovern, Jennifer Birch, Gillian O'Neill, Hannah Kaner, Arun Sondhi, Kieran Lynch. Published by Emerald Group Publishing Limited. This article is published under the Creative Commons Attribution (CC BY 3.0) licence. Anyone may reproduce, distribute, translate and create derivative works of this article (for both commercial & non-commercial purposes), subject to full attribution to the original publication and authors. The full terms of this licence may be seen at <http://creativecommons.org/licenses/by/3.0/legalcode>

Funding for the work was provided by Therapeutic Solutions.

### Abstract

**Purpose** – The purpose of this paper is to review the evidence of alcohol use disorders within the different stages of the criminal justice system in the UK. Furthermore it reviewed the worldwide evidence of alcohol brief interventions in the various stages of the criminal justice system.

**Design/methodology/approach** – A rapid systematic review of publications was conducted from the year 2000 to 2014 regarding the prevalence of alcohol use disorders in the various stages of the criminal justice system. The second part of the work was a rapid review of effectiveness studies of interventions for alcohol brief interventions. Studies were included if they had a comparison group. Worldwide evidence was included that consisted of up to three hours of face-to-face brief intervention either in one session or numerous sessions.

**Findings** – This review found that 64–88 per cent of adults in the police custody setting; 95 per cent in the magistrate court setting; 53–69 per cent in the probation setting and 5,913–863 per cent in the prison system and 64 per cent of young people in the criminal justice system in the UK scored positive for an alcohol use disorder. There is very little evidence of effectiveness of brief interventions in the various stages of the criminal justice system mainly due to the lack of follow-up data.

**Social implications** – Brief alcohol interventions have a large and robust evidence base for reducing alcohol use in risky drinkers, particularly in primary care settings. However, there is little evidence of effect upon drinking levels in criminal justice settings. Whilst the approach shows promise with some effects being shown on alcohol-related harm as well as with young people in the USA, more robust research is needed to ascertain effectiveness of alcohol brief interventions in this setting.

**Originality/value** – This paper provides evidence of alcohol use disorders in the different stages of the criminal justice system in the UK using a validated tool as well as reviewing the worldwide evidence for short (< three hours) alcohol brief intervention in this setting.

**Keywords** Criminal justice system, Substance abuse, Young offenders, Offender health, Public health, Harm reduction

**Paper type** Literature review

### Introduction

In the UK, 24 per cent of the general population are reported to have an alcohol use disorder, whereas higher rates of alcohol misuse have been found in the criminal justice system (Fazel *et al.*, 2006; Parkes *et al.*, 2011). In 2008, it was estimated that alcohol was a factor in half of all violent crimes in the UK (Flatley *et al.*, 2010) and that there were approximately 950,000 incidents of alcohol-related violence in the previous year (Kershaw *et al.*, 2008). Although the relationship is complex, there is evidence of an association between alcohol use and offending behaviour



## Exploration of delivering brief interventions in a prison setting: A qualitative study in one English region

Arun Sondhi<sup>1</sup>, Jennifer Birch<sup>2</sup>, Kieran Lynch<sup>3</sup>, Aisha Holloway<sup>4</sup>, and Dorothy Newbury-Birch<sup>2</sup>

<sup>1</sup>Therapeutic Solutions (Addictions), Communication House, 26 York Street, London, UK, <sup>2</sup>Health and Social Care Institute, Teesside University, Middlesbrough, UK, <sup>3</sup>Public Health England, London, UK, and <sup>4</sup>School of Health in Social Sciences, University of Edinburgh, Edinburgh, UK

### ABSTRACT

**Aims:** There is evidence that alcohol is strongly correlated with offending. This qualitative study explored the views of staff on the efficacy of alcohol brief interventions within a prison setting. The perceptions of prisoners in relation to non-dependent drinking were also examined. **Methods:** Nine prisons in one English region took part in this research. Five focus groups with 25 prisoners were undertaken with prisoners alongside focus group discussions with 30 professionals. Discussions were recorded using shorthand notation and the main themes were thematically mapped using visual mapping techniques. **Findings:** The use of the Alcohol Use Disorder Identification Test (AUDIT) was perceived as problematic. Prisoner drinking norms differed widely from community consumption patterns. There were also operational issues that reduced the salience of a brief intervention for prisoners. **Conclusions:** The delivery of screening and brief interventions within a prison setting is highly nuanced and fraught with inconsistencies. Despite these challenges, there are opportunities to develop coherent and tailored brief interventions for a custodial environment that should focus on developing three key areas around: (a) interventions for the point of release; (b) enhanced content around family impact and offending; and (c) forward-looking goal-setting as motivational tools to facilitate change.

### Keywords

Alcohol, prison, screening and brief intervention

### History

Received 15 February 2016  
Revised 14 April 2016  
Accepted 24 April 2016  
Published online 16 May 2016

### Introduction

There is evidence that alcohol use is strongly correlated with offending, with alcohol cited as a factor in nearly half (47%) of all violent crimes in England and Wales (Walker, Flatley, Kershaw, & Moon, 2009). The relationship between the two, however, is complex when it comes to looking at drinking patterns, linking the amount of alcohol consumed alongside individual and contextual factors. Alcohol is also implicated in criminal damage, domestic violence, sexual assaults, burglary, theft, robbery and murder. Offenders have been identified as having a higher prevalence of alcohol problems compared to the general population (Newbury-Birch, Harrison, Brown, & Kaner, 2009). In a recent survey, 70% of prisoners admitted drinking when committing the offence for which they were imprisoned (Alcohol & Crime Commission, 2014). National UK prison-based surveys (across Scotland, England and Wales) emphasise this higher prevalence (Carnie, Broderick, & McCoard, 2014; Light, Grant, & Hopkins, 2013; Stewart, 2008). In a survey of 1,435 adult prisoners nearly one-third (32%) of all respondents who admitted drinking, did so on a daily basis (Light et al., 2013). In this survey, prisoners drank a mean of 14 days per month

consuming an average (mean) of around 16 units in the four weeks prior to custody (ibid). The prevalence rate of alcohol consumption has been shown to be even higher among young offenders in custody aged between 18 and 20 years, with nearly half (49%) of all offenders in one survey determined as binge drinkers (Williams, 2015).

Smaller scale studies also show similar prevalence rates. One study of prisoners in South Wales suggested that 81% of male prisoners interviewed, and half (50%) of the whole prison sample was identified as having severe alcohol problems (McMurran, 2005), with nearly three-quarters (73%) of a study of male Scottish prisoners identified as having an alcohol use disorder (AUD) (Graham, Heller-Murphy, Aitken, & McAuley, 2012).

A key segment of potentially problematic drinkers include a mid-range of non-dependent users of alcohol who may only periodically drink to excess. These drinkers may not perceive the need for formal "treatment" and may be resistant to health promotion messages. Prison-based services for AUDs have been viewed as limited, pointing toward considerable unmet need for on-going treatment and support (HM Inspectorate of Prisons, 2010). In England and Wales, the prison system comprises different categories. Categories A-C are "closed" prisons based on the seriousness of the offence. Category A houses high-security prisoners on long-term sentences. Category B includes prisoners held on remand

Correspondence: Mr Arun Sondhi, Therapeutic Solutions (Addictions), 44 Cornwall Avenue, London N22 7DA, UK. E-mail: arun.sondhi@therapeutic-solutions.org.uk