▶ Alcohol problems in the criminal justice system: an opportunity for intervention.

Graham L., Parkes T., McAuley A. et al.
World Health Organization, 2012.

Based largely on prior research analyses and guidelines from the UK, these international guidelines offer an integrated model of best practice care for problem-drinking prisoners, grounded in research specific to prisons and in potentially applicable research in other settings.

SUMMARY From a team based in Scotland and drawing on UK experience and guidelines as well as international research, these guidelines based on a literature review aim to help prison authorities focus more closely on prisoners with alcohol problems and thereby prevent re-offending after release. They are designed primarily for prison staff, related policymakers, and staff in the community helping prisoners to reintegrate into society after release. This account is taken from the document's own summary.

Despite the limited evidence base on effective interventions to date, the very high prevalence of alcohol problems in the prison population is in itself an opportunity with the potential to deliver a wide range of positive outcomes in addressing alcohol problems in prisoners.

Alcohol problems are best detected with a validated screening tool. There is, however, limited evidence of the effectiveness of screening tools in prison populations, with alcohol problems often subsumed into wider substance misuse and with heterogeneity across studies. Nevertheless, the WHO Alcohol Use Disorders Identification Test (AUDIT) screening tool appears the most promising option in busy settings, given its increasing use in criminal justice settings and its ability to differentiate between different patterns of drinking behaviour.

The evidence base for effective alcohol interventions in prison populations has also been limited. There has been conflation with other substance misuse as well as issues of heterogeneity and the poor quality of studies. An increasing amount of high-quality research has, however, recently been published, particularly relating to women prisoners and young offenders. Overall, the strongest evidence to date relating to alcohol is for brief interventions and motivational interviewing, though variability in length and content of these interventions across studies makes it difficult to be specific about recommendations for implementation.

The essence of a brief intervention is that it is a short, opportunistic intervention delivered in an empathic manner, with motivational elements, by a suitably trained member of staff. This would make brief interventions a suitable option for prisoners who may not have time to access other prison-based alcohol services, either because of the short length of their stays or the nature of their problems. Recent research on brief interventions in other criminal justice settings (such as probation) has shown reductions in alcohol consumption and re-offending. Although there are caveats in generalising these findings to the overall prisoner population, they do suggest brief interventions are promising.

Drawing extensively on work in the United Kingdom, particularly Scotland, an integrated model of care for alcohol problems in prisoners is described together with elements for best practice. The model is built on the principle that health care in prisons should be equivalent to that in the community, and proposes three levels of assessment. Firstly, screening (with AUDIT) followed by triage which helps direct individuals to the most appropriate tier for intervention. Triage should determine the presence of other co-occurring health or social problems as well as risk, and can also prioritise those most in need of intervention when demand is high. Those drinking at hazardous or harmful levels (AUDIT scores of 8–19) would generally be offered one or more tier 1 and 2 interventions. These could include brief interventions and motivational interviewing.

Tiers of intervention

1 Alcohol-related information and advice; screening; simple brief interventions; referral.
2 Open access, non-care-planned, alcohol-specific interventions.
3 Community-based, structured, care-planned alcohol treatment.
4 Alcohol specialist inpatient treatment and residential rehabilitation

Those with AUDIT scores of 20+ are more likely to be dependent and should undergo comprehensive assessment. They can then be offered more intense interventions at tiers 3 or 4, such as psychological therapies. At this third level of assessment, each person's alcohol problem should be assessed individually, treatment goals discussed with them, and wider health and social needs identified. It is equally crucial to ensure continuity of treatment in the community for those who have begun treatment in prison, or referral to community-based services for those identified with a problem but for whom there are constraints (such as length of incarceration) on the delivery of interventions.

Implementation issues

The model presented in this publication has been designed from Scottish research and is based on a UK model of care for the community population. There may, therefore, be questions of translatability when considering its implementation in other cultural contexts. Adequate resources are needed (such as staff for delivery and to enable accessibility) at a time of widespread financial constraint.

Alcohol services have generally been under-resourced both in prisons and in the community, despite overwhelming evidence for their effectiveness. They are one of the recommended areas of effective alcohol policies in the WHO European action plan to reduce the harmful use of alcohol. The prison regimen itself can be both a help and a hindrance. The (general) policy in prison of no alcohol enforces an environment of abstinence. It is, however, artificial and does not, for example, enable prisoners to practise their newly acquired knowledge about drinking in moderation or coping skills for preventing relapse. In addition, the production of illicit alcohol can be harmful to health and result in disorder and unrest. While some prisoners may be unwilling to admit to an alcohol problem, for others prison is a welcome opportunity to do so.

FINDINGS **COMMENTARY** These international guidelines were drafted by a team from Scotland and drew extensively on UK experience, so can double as a good-practice guide for the UK. The report's cover poses the key dilemma. Its subtitle ("An opportunity for intervention") seems belied by the forbidding, barbed wire-topped concrete wall, raising the question of how this environment could host productive intervention, and even if it did, whether the benefits would last beyond the walls. Yet the walls create the 'dry space' in which intervention seems possible.

After acknowledging this seeming contradiction, the guidelines usefully package current thinking about

alcohol interventions and apply these to the prison population. The result is a well grounded and coherent basis for prison health services to arrange their alcohol programmes, an advance on more ad hoc arrangements less likely to identify prisoners who could benefit and/or to offer them an intensity and style of intervention suited to their needs. However, the authors admit they had to make recommendations from a very narrow evidence base specific to prison alcohol treatment, and often drew instead on studies conducted in other settings and populations not under criminal justice supervision.

At the base of the pyramid of need and probably most applicable to the greatest number of prisoners were brief interventions – usually one or two brief face-to-face sessions, often based on motivational interviewing. Evidence of effectiveness meant these were considered promising. They also recommend themselves on feasibility grounds for prisoners on short sentences or who may be moved to another prison, and because they demand less learning, skills and time from prison and healthcare staff than fully-fledged therapies. The combination makes brief intervention a candidate for forming the bedrock of prison alcohol programmes, the reason why the evidence is examined further below.

Brief interventions

Results from the sole randomised prison-based brief intervention study cited in the guidelines, though not entirely negative, were overall unconvincing. Conducted in a US prison complex for women, generally the prisoners continued to frequently drink heavily after release, but at the three-month follow-up, somewhat less frequently if they had been allocated to the two brief intervention sessions. These were, however, the only statistically significant results. There were no such differences at the one-month follow-up and by the six-month follow-up the gap in the proportion of non-drinking days had narrowed to an insignificant 66% among advised women versus 62% in the comparison group not offered brief intervention.

Also unconvincing were the major studies of brief interventions for offenders under community supervision in England and Scotland. The remit for the Scottish study was to establish feasibility – whether brief interventions could be implemented in ways which gave them a chance of working. Staff were ambivalent, often feeling the pilot was not suited to their client groups who faced more serious issues such as money problems and housing. Some said if drinking was a priority, it needed more than a few minutes of brief advice, that their clients were often too extreme in their drinking to be suitable for a brief intervention, and that excessive drinking was too intertwined with other problems to be dealt with in isolation. The AUDIT screening tool was generally seen as easy to apply and by some as a useful way to broach the issue of drinking, while other staff thought it was inappropriate to have to complete it when drink was clearly not a relevant issue. Few staff felt offenders generally had engaged well with the brief intervention.

For the English study in 20 probation offices, only informally presented results are available, but it was by far the largest UK controlled study of alcohol advice/counselling for offenders. As in Scotland, staff scepticism was apparent. Of the nearly 200 staff in the trial, about a fifth did not recruit any offenders to the study, and only about a quarter were able to implement screening and brief intervention as intended without extra help from researchers and specialist alcohol workers. Compared to staff in the two other settings (GPs' surgeries and emergency departments), screening and brief intervention was felt to meld more naturally with routine probation work, but staff were less convinced these procedures would be useful and tended to feel they were best reserved for offenders with obvious drinking problems.

The English study also investigated effectiveness. Results in probation offices were similar to those in the other settings: no great differences between how well the screening methods identified risky drinkers, nor in drinking reductions after three interventions of varying intensity, ranging from a very brief warning to an additional 20 minutes of counselling at (in the probation arm) a further appointment with a specialist alcohol worker.

Probation was, however, a partial exception. At the six-month follow-up and among particularly heavy-drinking offenders offered counselling, there was a fleeting extra reduction in the proportion still drinking at risky levels – one possibly chance positive finding among many negatives. Conceivably, more intense drink problems among offenders than patients in the other arms of the study afforded scope for them to respond better to extended counselling. In turn this may have caused what preliminary results say were significantly fewer reconvictions registered in police records and a relative reduction in health and crime costs associated with counselling – even though only 41% of offenders offered it attended the appointment. But without a no-intervention comparator, there is no way of knowing whether *any* of the interventions were better than doing nothing.

Thanks for their comments on this entry in draft to report author Lesley Graham of the Scottish NHS National Services Information Services Division. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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