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▸ Alcohol screening and brief interventions for offenders in the probation setting (SIPS trial): a pragmatic multicentre cluster randomized controlled trial.

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Alcohol and Alcoholism: 2014, 49(5), p. 540–548.

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The probation arm of the largest alcohol screening and brief intervention study yet conducted in Britain found that the proportion of offenders drinking at risky levels fell just as much after the most minimal of screening and intervention methods as after more sophisticated and longer alternatives.

SUMMARY The SIPS project embraced three trials of brief interventions in different settings in England. This account focuses on the trial in probation offices; there were also trials in emergency departments and GPs' surgeries.

First this account describes the common features of the three SIPS trials, based primarily on formal accounts of their methodologies (1 2 3). Then results from the probation trial are described, drawing mainly on the featured report and the relevant methodology article. The commentary also draws on preliminary findings released by the SIPS project on its web site in the form of factsheets and conference presentations rather than peer-reviewed articles in academic journals. These were the basis of an initial Effectiveness Bank analysis of the probation office trial.

Key points

From summary and commentary

The SIPS trials were the largest real-world trials of brief interventions yet conducted in the UK. This account focuses on the trial in probation offices.

In all the trials the expected extra impacts on drinking of more extensive advice and counselling did not materialise, and implementation required aid from research staff. However, in probation offices the longer interventions apparently helped reduce reoffending.

The trials seem to justify merely offering written information and a warning about the patient's risky drinking, but more was or might have been involved.

Common features of the SIPS trials

The project was funded by the UK Department of Health in 2006 to evaluate the effectiveness and cost effectiveness of different ways to identify risky drinkers through routine screening, followed by different forms of brief advice to prompt them to reduce risk. Another aim was to assess the feasibility of implementing such procedures in typical practice settings.

Conducted in three English regions (London; South East; North East), the project conducted three trials: one in emergency departments, another in general practices, and another in probation offices. All three involved random allocation of practices, departments or offender managers to different variants of screening and intervention. Staff seeing adult patients or offenders for usual purposes in these settings asked them to consent to screening and basic data collection. Those whose screening results indicated risky drinking and who met other criteria were then asked to join the study. This entailed further assessment (including a version of the AUDIT questionnaire to identify the severity of their drinking and related problems) followed by one of the three interventions. Usually these were to delivered by the same staff after training by the study.

To assess changes in their drinking and related problems, patients and offenders were re-assessed six and 12 months later. The main yardstick of effectiveness was the proportion of patients who six months later did not score as hazardous (or worse) drinkers on the AUDIT questionnaire, a figure adjusted (among other factors) for any differences in baseline scores. AUDIT scores are based on alcohol consumption and indicators of alcohol-related problems.

Screening methods

Three quick ways to identify hazardous or harmful drinkers were tested for feasibility and accuracy, the latter defined by how well they duplicated corresponding results from the AUDIT screening questionnaire.

▸ Single question The simplest and quickest method was to ask,"How often do you have eight (or for women, six) or more standard drinks on one occasion?" Monthly or more was considered a positive screen.

▸ FAST Alcohol Screening Test As used in the study, this begins with the question above and registers a positive screen if the response is weekly or more often. Otherwise three further questions are asked. Scores in response to the four questions are summed to determine whether to proceed with intervention.

▸ Paddington Alcohol Test (PAT): Used only in the emergency department trial.

The brief interventions

Patients and offenders identified as risky drinkers by these screening methods were all offered feedback/advice of some kind, so the study could not assess whether these options were better than doing nothing, only how their impacts differed. All were given a standard alcohol information and advice booklet, with a sticker giving contact information for local treatment services. This was supplemented

by one of three different types and degrees of advice/feedback

by one of three different types and degrees of advice/feedback:

- Brief feedback At its most basic, the booklet was accompanied only by very brief feedback from the practitioner who did the screening that the results showed the patient or offender was drinking "above safe levels, which may be harmful to you".
- Brief advice The next level supplemented booklet and feedback with five minutes of advice closely related to the booklet. This was based on a leaflet which the worker left with the drinker after working through it with them according to a set protocol which included comparing their drinking to typical drinking levels across the population. Though not always the case, ideally this would be seamlessly delivered by the person who did the screening and handed over the booklet.
- Brief lifestyle counselling The longest of the interventions added what was intended to be about 20 minutes of lifestyle counselling to the brief advice described above. This too was based on a leaflet, but practitioners could adapt the intervention to the needs of the drinkers and their willingness to think about further controlling their drinking. Staff were trained to use techniques from motivational interviewing and health behaviour change counselling to lead the drinker to consider the pros and cons of their drinking and their readiness to cut down, before (if appropriate) formulating a plan for doing so and overcoming possible obstacles. This counselling was done at an appointment made after the brief advice phase of the intervention.

The probation trial

Probation was chosen as the criminal justice setting on the basis of a pilot study of this setting plus prison and police stations. It found that offenders seeing probation officers were most likely to agree to join such a study, and that this setting offered the highest study recruitment rate. This pilot also found that offenders in these settings were three times as likely as the general population to be problem drinkers.

In 2008–2009, 20 probation offices and 227 offender managers working in those offices agreed to join the trial. Within each region, offender managers were randomly allocated to one of the six possible combinations of two screening methods (the single question or the FAST Alcohol Screening Test) and the three interventions for those screening positive.

Probation staff were first to give offenders the alcohol advice leaflet to read. At the next appointment, consent was sought for screening, screening was completed, and positive-screen offenders were asked to join the intervention phase of the study. Depending on their offender manager's allocation, those who consented were then given brief feedback, brief advice, or an appointment to see the alcohol health worker for brief lifestyle counselling.

Of the 227 offender managers randomly allocated to the screening and intervention options, 172 were trained to conduct these. Of these, 131 recruited at least one offender to the trial. Over 16 months, 976 offenders were approached about the study of whom 860 were eligible to participate. Of these, 574 screened positive and 525 agreed to join the trial. Typically white men, they averaged 31 years of age and an AUDIT score just within the range indicative of high severity drinking problems, a range which accounted for 43%.

Main findings

Virtually all the offenders allocated to brief feedback or advice received this plus the alcohol advice booklet, the full intended interventions. This was not the case for those allocated to lifestyle counselling; though nearly all received the five-minute brief advice and booklet delivered immediately after screening, only 41% attended a later appointment for more extended counselling.

Despite all screening positive for risky drinking, at the start of the study about 13% of the offenders scored as non-hazardous drinkers on the AUDIT questionnaire. Among those who could be followed up, six and 12 months later the proportions of non-hazardous drinkers were overall 24% and 31% respectively. Neither on this measure nor on average AUDIT scores, alcohol-related problems, readiness to drink less, or health-related quality of life, had there been significantly greater changes after one type of intervention than another, and the offenders were equally satisfied with all the options. Broadly these results held whether the analysis included all the offenders in the trial or just those who actually received their allocated interventions. The expected extra impacts of more extensive advice and counselling had not materialised.

However, an indicator of criminal recidivism did significantly and substantially favour the longer interventions. Available for almost the entire sample, police records revealed that over the next 12 months offenders offered either of the more extended interventions were significantly less likely to be reconvicted (36% and 38% v. 50%) than offenders offered only brief feedback.

The authors' conclusions

Among these offenders, at 43% the proportion drinking at a harmful or probably dependent levels was much higher than the 4% in the general population in England. The results of this study and of the pilot study suggest that even if unasked for, screening for risky drinking and associated interventions are acceptable in this population. In this study as in studies in health settings, a minority of offenders attend follow-up counselling, which in this study was voluntary and not part of routine probation work.

On alcohol-related measures, the more extended and complex (but still brief) interventions gained no extra benefits, so these cannot be recommended for probation settings. Nevertheless, the large proportion of offenders drinking at the higher end of the AUDIT spectrum suggests a need to develop and evaluate interventions to address the more severe cases.

Without a no-intervention control group, it is not possible to say for sure that any of the interventions had any impact, though in the context of other research, the magnitude of the reductions is consistent with an effect. That this effect was equally evident after brief feedback may have been because it included active ingredients of behaviour change such as screening, assessment, feedback and awareness-raising via the written information and details of local treatment services. Possibly too, the more extended interventions were not implemented as intended – but if this was the case, it is likely also to be the case in routine practice.

In contrast to the alcohol-related measures, criminal recidivism (indicated by convictions) was significantly less likely after the two more extended brief interventions than after brief feedback only. Unexpectedly, this extra reduction in recidivism was not accompanied by a correspondingly greater

reduction in drinking. If a real effect, it could be due to the more extended interventions not only

reduction in drinking. If a real effect, it could be due to the more extended interventions not only addressing how much was drunk overall, but also promoting awareness of the risks of excessive drinking, including offending under the influence of alcohol. Perhaps increased awareness led to a change in offending behaviour, and/or offending is linked to particular patterns of drinking (such as risky, single-occasion high-intensity drinking) rather than overall consumption.

Only 58% of offender managers (but 76% of those trained) recruited at least one offender to the study. Most were supportive of the study and saw working with alcohol issues as a legitimate part of their job. Some however were less interested, due perhaps to seeing drinking as less important in their workload, information overload, workload pressures, and feeling aggrieved that they had been required by team leaders to take part in the study.

FINDINGS COMMENTARY This commentary first offers more information on the probation trial, before setting it in context by exploring common themes across all three settings. Comments on the trials as a whole and their policy implications are expanded on in the analysis of the primary care trial.

The probation trial

Taking in all information available to date including preliminary reports, it seems that given financial incentives, training and specialist support, offender managers can implement alcohol screening and brief intervention, but in the circumstances at least of a research trial, they often need extra help. Just over 4 in 10 of the offender managers recruited no one to the trial and presumably too screened and intervened with not a single offender.

Preliminary reports indicate that just 45 of the 227 offender managers were able to implement screening and brief intervention as intended without extra help from researchers and the specialist alcohol workers. Barriers to implementation cited by staff included workload pressures, lack of knowledge, and lack of follow-up treatment services. Compared to staff in the other two settings (primary care 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. Perhaps because risky drinking is so common among their caseloads, and because their focus is on intoxication-related crime rather than long-term disease, probation officers were interested mainly in the most problematic drinkers. Implementation was more successful where research staff were able to engage with and provide ongoing support to individual staff, and where they and the alcohol health workers were more often on site. In line with these findings, a report on alcohol-related work by probation in England and Wales found that while in theory widespread, screening is not the norm, and that on-site specialist alcohol workers are an important resource.

FAST Alcohol Screening Test was a better screening tool (92% of risky drinkers were identified) than the single question (81% identified), and significantly better at identifying people whose AUDIT scores indicated a high severity of alcohol problems. The results confirm the (not statistically significant) trends in favour of FAST in the preceding pilot study in prisons and police stations as well as probation.

FAST's advantage may have been clearer in probation than in the other settings because it asks about symptoms of the kind associated with intoxication-related impairment and lack of responsibility. However, FAST may not meet the perceived need to identify high severity drinkers, for which AUDIT (the most commonly used screening tool in probation) may still be preferred. Whether screening is best implemented universally or targeted at certain offenders was not tested in the probation setting, but the prevalence of risky drinking was such that universal screening seems the most sensible option.

The authors cast some doubt over the validity of the "unexpected" finding that the two longer interventions were followed over the next year by a lower proportion of offenders being reconvicted. With so many outcomes tested, this could be a chance finding due to a relatively high reconviction rate among the brief feedback offenders. Though several other possible influences were accounted for, these did not include propensity to reoffend; possibly by chance, brief feedback offenders were from the start more likely to reoffend.

Preliminary reports showed the costs of the interventions averaged £1.04 per offender for brief feedback, £8.55 for brief advice, and £32.45 for lifestyle counselling. However, if the reconviction findings were a valid reflection of impacts on crime, the two longer interventions may save society enough to justify their extra costs. One preliminary report recorded that the annual costs of the offenders' health service use and crime fell by significantly more after the most extensive option (the offer of counselling) than after brief feedback.

Messages from all three trials

Across the three settings, the general picture from formally published and from preliminary reports is that implementation often required specialist support, there were no great differences between how well the screening methods identified hazardous drinkers, and no significant differences between how well the interventions prompted them to reduce drinking and related problems. Brief feedback, consisting of an unadorned warning plus information booklet, intended as a 'control' condition against which scientifically developed and longer interventions could shine, turned out instead to be the better option; subsequent clinical gains were just as great but it cost the least in money and time.

These findings cast doubt over the potential for screening and intervention in these settings to make a significant contribution to public health; numbers reached may simply be too low and effectiveness too uncertain.

However, while the results seem to argue against doing more than screening plus offering a booklet and a few sentences of feedback, they did not prove this is all it takes to get whatever benefits are available. Additionally patients and offenders had for research purposes been quizzed about their drinking and related problems and their readiness to do something about these, possibly thought-provoking interventions in themselves. Also, whether brief feedback really was as terse as intended is unknown.

For these reasons the message taken from the studies that only the very briefest contact is needed may be misleading. But with no convincing reason to spend more money and time, hard-pressed staff and austerity-hit commissioners will be tempted to do the least seemingly justified by trials on which the government itself said it would base its policy decisions.

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Across the three settings there was a remarkable uniformity in trends in drinking among the risky drinkers who agreed to join the trials. Compared to pre-intervention figures, six months later the proportions of non-hazardous drinkers had fallen by 11–13%, 12 months later, by 18%. With one minor and possibly chance exception, on this primary yardstick an alcohol advice booklet plus a few sentences of feedback alerting someone to their risky drinking was not improved on by adding more extended and individualised interventions.

In all three settings, even when the analysis was confined to people who had actually received their allocated intervention, still the extra 20 minutes of counselling made no significant difference to the proportions of risky drinkers. In these analyses, not only did counselling have the intended advantage of time and its supposed active ingredients, it also had the presumed advantage of being tested only on patients/offenders concerned and diligent enough to return for counselling, while the other two interventions were delivered to nearly all the intended recipients.

As the researchers have acknowledged, this does not necessarily mean the interventions were equally effective; they may have been equally *in*effective. Without a no-intervention comparator, there is no way of knowing whether the interventions played any hand in the outcomes. Even before the interventions, 28% of emergency patients, 38% in primary care, and 57% of offenders in the probation study, said they were trying to reduce their drinking or had decided to do so. Reinforcing doubts over the impact of the interventions is the general finding (1 2) that many control groups in alcohol brief intervention studies who received no or minimal intervention on average reduced their drinking by amounts equal to or greater than AUDIT score reductions in the SIPS trials.

Set against this is the overall positive record of brief interventions in previous primary care trials. However, this record left considerable doubt over whether such reductions (internationally and in Britain in particular) would survive once intervention was 'scaled up' to practices in general, and applied by the general run of doctors to the general run of patients.

Cost may be decisive

Some data on costs and benefits can be found in preliminary reports, subject to confirmation when these results are formally published. Even if equally effective, it seems the interventions differed greatly in cost, likely to be a persuasive factor given equivocal or no evidence that spending more gained more. Not only did the briefest intervention directly cost least, but on the health service's primary yardstick – quality-adjusted life years – in both probation and primary care, it gained most years for each £ of social costs incurred by the drinkers. Only in emergency departments did the longest intervention have the edge, but this was minimal, and may have been partly due to these patients starting the study with the lowest quality of life of the three intervention groups and catching up somewhat in a natural levelling process.

Last revised 10 July 2015. First uploaded 18 September 2014

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