

Prison health needs assessment for alcohol problems

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Executive Summary

Background and rationale

Alcohol problems are a major and growing public health problem in Scotland with the relationship between alcohol and crime, in particular violent crime, increasingly being recognised. The consequences affect individuals, their families, the health and emergency services, and wider society. The current policy context includes a strategic approach to enhancing the detection, early intervention, treatment and support for alcohol problems across Scotland, as well as efforts to reduce re-offending. This study is part of a wider Scottish Government funded alcohol research programme in criminal justice settings which also includes a pilot of the delivery of alcohol brief interventions and a scoping study of alcohol interventions in community justice settings. It is anticipated that the study findings will inform broader health service development such as the integration of prison health care into the NHS and the update of core alcohol treatment and support services. These developments are set within a policy and practice context which acknowledges alcohol problems in the population and increasingly so the alcohol problem in offenders, along with the importance of applying a person-centred, recovery orientated approach underpinned by the NHS commitment to quality of services.

Aims and objectives

The aim of this study was to undertake a needs assessment of alcohol problems experienced by prisoners and provide recommendations for service improvement including a model of care. The central objectives were to:

1. Conduct a rapid review of the relevant literature on effective interventions for identifying and treating offenders with alcohol problems in prison.
2. Report on the epidemiology of alcohol problems experienced by prisoners in Scotland compared to the general population and other offenders.
3. Undertake an assessment of alcohol problems among offenders within an individual prison.
4. Map current models of care in the Scottish Prison Service (SPS) and how they interface with community care models, including assessing aspects of treatment continuity and finding examples of best practice.
5. In a case study setting, explore and report on attitudes towards the delivery and effectiveness of current alcohol interventions.
6. Conduct a gap analysis between current service provision, best practice, effective interventions and national care standards for substance misuse.

Methodology

The study involved both quantitative and qualitative information being gathered through document retrieval and analysis as well as primary data collection. It was conducted according to ethical principles essential in research with vulnerable groups. The study benefited from internal research team advisers and an external Project Advisory Group representing the Scottish Government, SPS, Information &

Statistics Division and NHS Health Scotland. To ensure representation of other interests, such as prisoners and their families, two further organisations reviewed and commented on the draft report.

Findings

A number of general trends in alcohol consumption and harm in the Scottish population can be noted from current evidence. There has been a rise in alcohol consumption over the past decades with a consequent rise in alcohol related harms. A high proportion of the population drink excessively across all ages and socioeconomic groups, although drinking patterns and levels between groups and ages vary. Young men are the highest alcohol consumers and more likely to 'binge' drink. Scotland has the highest prevalence of alcohol related health problems in the UK and amongst the highest in Western Europe. There is, however, emerging evidence that some specific alcohol related harms may be stabilising in Scotland.

The prisoner population in Scotland is younger than the general population and predominantly male. Data indicate a high prevalence of alcohol problems in this population for both men and women, and a higher prevalence of alcohol problems amongst remand prisoners than amongst sentenced prisoners.

A rapid review was undertaken to inform the primary research components of the study. Three screening tools were identified as having good reliability with offending populations, although no single screening tool was identified as superior. AUDIT was found to be most promising and is being used in several UK interventions related to offenders currently being evaluated. More than one screening tool may in fact be required for this diverse population. There is also some indication that timing of screening may be an issue, with very early screening post-imprisonment not being as effective.

The review also indicated that the current evidence is limited for most interventions in prison settings. In addition, many studies conflate alcohol and drugs making it difficult to identify specific alcohol-related outcomes. There is also a particular lack of published research from the UK, although several relevant studies are currently in progress. While there is evidence of the effectiveness of therapeutic communities this is only the case for people with alcohol use *in addition* to drug misuse, and studies report that they are costly and time intensive. Alcohol brief interventions (ABIs) have the highest quality evidence base but effectiveness in this setting is still to be established. There is some evidence that addiction interventions have an economic benefit through the reduction of reoffending. Overall, there is a need for more research in the area of effectiveness of alcohol interventions in prison populations, in particular in identifying screening tools that work with this population, more information on what is effective, on the optimum timing for both screening and interventions, and the potential economic benefits of screening and interventions.

As part of the study, universal screening for alcohol problems was undertaken in a male prison over 12 weeks, based on the AUDIT screening tool. This exercise found that 73% of prisoners had scores indicating a degree of alcohol problems (8+ AUDIT score), including 36% possibly dependent (20+ AUDIT score). The highest

proportion of 20+ AUDIT scores were in the 18-24 and 40-64 age groups, but drinking patterns differed, with those in middle age more likely to show features of dependency than younger prisoners. Higher AUDIT scores were notable among those with shorter sentences (less than 6 months). This was a predominantly young population with a high prevalence of social exclusion factors, in particular unemployment and low education achievement, many of which were on remand or short sentences. Over 1 in 4 reported their current offence to be a violent crime and four fifths had been in prison before. Alcohol was self-reported to be a factor in the offence in 40% of cases (50% for violent crime) and, of these, nearly half of those giving further information said drugs were also involved.

A mapping exercise was undertaken of the current alcohol interventions across the Scottish prison estate, including the community interface. This was based on interviews undertaken with key informant stakeholders and staff members involved in alcohol service delivery across all prisons. Currently there is no formal alcohol screening using a validated instrument. A range of interventions are available to address alcohol problems in the context of offending but there is no alcohol specific model of care. There was variation in capacity for Addiction Nurses to deliver interventions. Not all alcohol interventions are available to those on short sentences or remand (a large proportion of those with alcohol problems). Overall, the research found there to be limited accessibility to alcohol specific interventions, with far greater numbers accessing general substance misuse interventions.

In-reach into prisons was also limited, although this was viewed as developing and continuity of care is more difficult if a prisoner is released to a different geographic area. Alcohol interventions are being delivered by different providers within the prison so there can be limited awareness of overall service provision and care pathways among relevant staff. There is also a lack of outcome evidence and information to inform planning and service improvement.

In order to give more depth to the study, a case study incorporating qualitative focus groups with prisoners and interviews with internal and external staff was undertaken in one prison. This found that there were broadly convergent understandings of alcohol issues among prisoners and staff, with both groups recognising links between alcohol and offending, including violent offending, and drug use. There was a general perception that alcohol interventions are not as well resourced or as prominent as drug interventions. Initial support is often limited and related to alcohol dependency and physical health needs, with few interventions addressing wider behaviour change and interrelated social problems. Staff also highlighted the challenge to deliver effective interventions for remand and short term prisoners.

Prisoners spoke about alcohol problem assessment on admission as an 'aye or no' question, asked at a time of competing concerns and when taking in new information can be difficult. Key aspects identified were an empathetic approach and some separateness from the discipline regime. Prisoners also wanted more involvement of 'outsiders' and peers/ex-prisoners/those with experiences of alcohol problems in the delivery of interventions.

Implications of findings for a model of care and care pathway

There are many implications from the research undertaken in this study for a model of care for alcohol for Scottish prisoners. Some of the most significant are

- that limited evidence on the effectiveness of alcohol interventions in prison settings makes it important to use wider literature from community settings to inform a gap analysis and model of care for the SPS
- the importance of tailored interventions including those to address violence and alcohol, and co-occurring drug and alcohol problems
- the need for interventions that address alcohol in the wider context of social problems, such as social exclusion and unemployment
- that good assessment, including use of a validated screening tool, is necessary in order to ensure prisoners that need them are offered relevant needs-led opportunities to address alcohol.

A model of care, or treatment framework, outlines the provision necessary to have a meaningful impact on prisoners with a range of alcohol-related needs. The findings of this study contributed to an enhanced understanding of the importance of implementing a full model of care in the SPS representing treatment pathways that address all four tiers on the Models of Care for Alcohol Misuse (MoCAM) guidance, with the SPS being viewed as a “treatment system”. The planning and development of tiered interventions is an important mechanism in being able to better target and tailor interventions to prisoner need. The approach taken in creating the model of care was also informed by the principle of equivalence where standards of health care for people in custody are the same as for those in the wider community. Figure 1 outlines what is currently delivered in the SPS, where the gaps are and what is needed to fill gaps, drawing on the MoCAM model.

Figure 1 Tiered delivery – current and proposed delivery for Model of Care

Tier 1
Currently delivered
<ul style="list-style-type: none"> • Limited screening (yes or no question) • Alcohol advice and information (Enhanced Addiction Casework Service (EACS)) • Overdose Awareness Session (has alcohol component) • Referral of those requiring more than above for specialised alcohol treatment (to EACS)
What is needed in addition to above
<ul style="list-style-type: none"> • Universal screening with validated tool for increased detection of alcohol problems • Verbal self-referrals due to literacy issues • Piloting and evaluation of simple brief interventions for hazardous and harmful drinkers accessible to all who need them including short term (under 31 days) and remand prisoners¹ • Interventions offered that are meaningful to prisoners, are person-centred, meet their needs and are credible.
Tier 2
Currently delivered
<ul style="list-style-type: none"> • Alcohol-specific information, advice and support (EACS Alcohol Awareness session, SPS approved activity Alcohol Awareness) • Alcohol-specific assessment (health assessments) and referral of those requiring

¹ Based on emerging evidence on the effectiveness of such interventions, see Section 4.

<p>structured or more intensive support and interventions (EACS) or treatment (prison health care)</p> <ul style="list-style-type: none"> • Triage assessment (Addictions Nurse) • Mutual aid groups (Alcoholics Anonymous)
<p>What is needed in addition to above</p> <ul style="list-style-type: none"> • Universal screening with validated tool for increased detection of alcohol problems • Extended brief interventions and brief treatment to reduce alcohol-related harm among hazardous/harmful drinkers and possibly mildly dependent drinkers • The provision of personalised feedback, often part of brief interventions, could be used to enhance motivation for action • Provide a range of interventions that will meet the high level of need and/or demand e.g. one-to-one and group interventions, and some level of choice • Increased interventions drawing on peer support or provided by peer approaches • Interventions offered that are meaningful to prisoners, are person-centred, meet their needs and are credible.

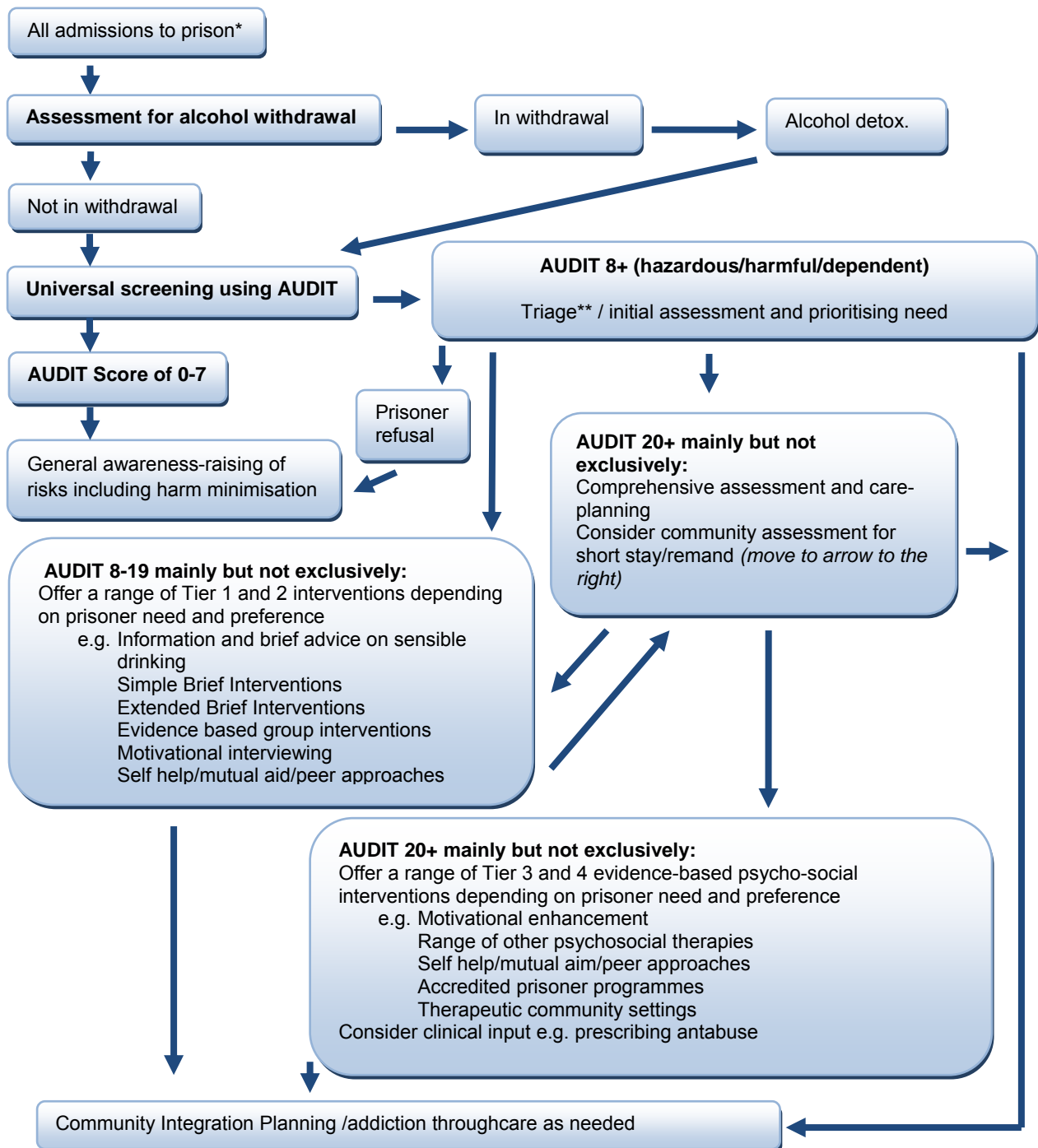
Tiers 3 and 4²
<p>Currently delivered</p> <ul style="list-style-type: none"> • Comprehensive substance misuse assessment (but effective detection is missing) • Care planning and review for those in structured treatment • Case management • Evidence-based prescribing interventions (alcohol withdrawal/detox) and prescribing interventions to reduce risk of relapse • Structured evidence-based psychological therapies (e.g. SPS prisoner programmes) that address alcohol and co-existing conditions (i.e. alcohol and offending behaviour - SROBP, alcohol and other substance use) • Liaison services for acute medical and psychiatric health services • Pre- and post-release work including community integration
<p>What is needed in addition to above</p> <ul style="list-style-type: none"> • Enhanced detection using a standardised tool, prior to comprehensive assessment • Enhanced capacity for additional structured evidence-based psychological therapies including counselling approaches – provide access to meet need • Better access to all interventions for short term prisoners whether in community or prison • Interventions offered that are meaningful to prisoners, are person-centred, meet their needs and are credible. • Increased interventions drawing on peer support or provided by peer approaches • Interventions/therapies/treatment targeting specific groups (i.e. levels of dependency) and diversity issues – i.e. women, co-existing mental health problems/dual diagnosis, learning disabilities, and social problems such as homelessness and literacy • Enhanced work on community and external provider linkages for communication and service access including in-reach • Emphasis on throughcare for all prisoners with identified alcohol problems.

Alcohol Care Pathways (ACPs) are locally agreed templates for best practice that map out the local help available at various stages of a treatment journey for alcohol. A flow diagram is outlined below showing the key decision points in a high level

² Tiers 3 and 4 have been collapsed because the major difference is residential versus community settings which is not a useful distinction in prison services.

pathway of care that has been designed to be a subject for dialogue in local areas when planning and commissioning appropriate alcohol services for the prison population.

Figure 2 Integrated Alcohol Care Pathway for Scottish Prisoners



* At any point in a prisoner's stay if they/others think they have an alcohol problem they can enter the start of the process.
 ** Triage is a critical part of the decision making process and includes determining the presence of other co-occurring social and health problems and the prioritisation of those that most need interventions in the context of high demand.

Conclusion

Prison presents an opportunity to address alcohol issues among a particularly marginalised group of people. The prevalence of alcohol problems amongst prisoners in Scotland is far higher than in the general population. This study identifies a considerable proportion of individuals in the SPS who could benefit from interventions that address alcohol consumption and alcohol-related harm and while a range of alcohol-related interventions exist, many prisoners who could potentially benefit from such interventions are being missed. The planning and development of tiered interventions, based on detection with a validated screening tool and subsequent comprehensive specialist assessment when appropriate, is an important mechanism in being able to better target and tailor interventions to prisoner need.

Integrated Alcohol Care Pathways in the SPS are an important part of this process and likely to be best developed as a result of multilevel discussions amongst a range of stakeholders. The integration between SPS and NHS Health Care services, due to take place in Autumn 2011, will be of particular relevance to the further development of this work. It is hoped that this report will add to current awareness of alcohol-related problems amongst individuals in prison in Scotland and contribute to building on the achievements made thus far.

1. Introduction

1.1 Background and rationale

Alcohol problems are a major and growing public health problem in Scotland and the relationship between alcohol and crime, in particular violent crime, is increasingly being recognised. Forty-five per cent of prisoners are likely to have an alcohol problem on admission to prison (as defined by two or more positive answers to the CAGE questionnaire) (Scottish Prisoner Survey 2008 cited in Information Services Division, 2009) compared to 16% of the general Scottish male population (Reid, 2009³). Other surveys, using the AUDIT screening tool, have also indicated a higher prevalence of hazardous drinking in offenders when compared to the general population (Singleton, Farrell and Meltzer, 1999). Recent surveys show that half of all prisoners (50%) in Scotland reported being drunk at the time of their offence (Scottish Prison Service (SPS), 2009a), more so for young offenders (77%) (SPS, 2010a). There has also been a rise in the proportion of young offenders who consider that alcohol has contributed to their offending, from 48% in 1979, to 58% in 1996 and 80% in 2007 (McKinlay, Forsyth and Khan, 2009).

In terms of violent crime, the Scottish Crime and Justice Survey (MacLeod, Page, Kinver *et al.*, 2009) reports that in 58% of violent crime victims said that the offenders were under the influence of alcohol. Alcohol is closely associated with domestic abuse in Scotland (Hamlyn and Brown, 2007) and alcohol is a known risk factor in the social patterning of assault in Scotland (Leyland and Dundas, 2010) and facial injury (Conway, McMahon, Graham *et al.*, 2010). Seventy per cent of assaults in Accident and Emergency may be alcohol-related (SEDAA Group, 2006a), the majority of these involving young men. Alcohol is also a known factor in homicide cases. According to the Homicide in Scotland 2008-2009 statistical release, 30% of those accused in homicide cases were reported to be drunk at the time, with another 6% reported to be both drunk and on drugs⁴ (Scottish Government, 2010a) and 1 in 6 deaths on British roads are caused by drink driving (Department for Transport, 2008).

The consequences of alcohol misuse affect individuals, their families, the health and emergency services and wider society. Overall costs of alcohol misuse in Scotland are estimated to be £3.6 billion (based on mid-point estimates), with alcohol-related crime accounting for over £700 million (Scottish Government, 2010b).

Prisoners in Scotland are predominantly young men from disadvantaged backgrounds, many of whom have substance misuse problems (Graham, 2007). The Scottish Health Survey 2008 (Reid, 2009⁵) showed that young men were the group most likely to drink to excess and that men in the most deprived categories are likely

³ SHeS 2008 data was the latest available at the time of writing.

⁴ 16% were reported not to have been under the influence of drink or drugs and drink/drug status was not known for the remaining 43%: the figures are much higher when only those cases where the status of the accused is known are considered.

⁵ SHeS 2008 data was the latest available at the time of writing.

to drink the most. Richardson and Budd (2003) described binge drinkers as those most likely to offend. Alcohol treatment was a condition of 10% of probation orders in Scotland in 2008/2009 (Scottish Government, 2010c). Alcohol-related problems in offenders are linked to a range of co-morbidities including concurrent drug-related and mental health problems as well as a range of other health and social problems (Graham, 2007; HM Inspectorate of Prisons, 2010; Singleton, Farrell and Meltzer, 1999; Singleton, Meltzer, Gatward *et al.*, 1998).

The population in prison represents an otherwise hard to reach group so prison-based services may enable alcohol-related services to be made more accessible and address the substantial health inequalities that exist for this population.

The economic benefits or cost-effectiveness of alcohol treatment is also important to note. Alcohol treatment has both long and short term savings. The UK Alcohol Treatment Trial (UKATT) study (UKATT Research Team, 2005), for example, suggests that for every £1 spent in evidence-based treatment, the public sector saves £5. The conclusion of the National Treatment Agency for Substance Misuse review of effectiveness of treatment for alcohol problems therefore suggests that providing effective treatment is likely to reduce significantly the costs relating to alcohol, as well as increase individual social welfare (Raistrick, Heather and Godfrey, 2006).

A health care needs assessment carried out in the Scottish Prison Service (SPS) identified key areas for service development in SPS healthcare services (Graham, 2007). These included more services for those on short term sentences and on remand and the strengthening of links with community services and agencies, both on the way into prison and on liberation. These findings also apply to services for alcohol problems. More specifically the assessment recommended more formal screening for alcohol problems on admission and for the piloting and evaluation of brief interventions for those with mild to moderate alcohol problems staying for short periods. It also identified the need for better integration between healthcare and substance misuse specialist services both within the prison estate and en route into and out of prison.

1.2 Current service delivery context

In 2008 Scottish Ministers approved the transfer of responsibility for the health care of prisoners to the National Health Service Scotland. The transfer is intended to ensure that prisoners receive as equal an opportunity to benefit from NHS care as that offered to the general population and is scheduled to take place in Autumn 2011.

1.3 Policy context

Scotland Performs is the Scottish Government's overarching performance framework and is underpinned by delivery on five Strategic Objectives⁶: to make Scotland

⁶ <http://www.scotland.gov.uk/About/scotPerforms/objectives>

Wealthier and Fairer, Safer and Stronger, Healthier, Smarter and Greener. The Strategic Objectives are supported by 15 national outcomes⁷ which describe in more detail what the Scottish Government wants to achieve. There is recognition that policies to tackle alcohol misuse can make a positive contribution to delivering over half of these (Scottish Government, 2009a). Several national indicators directly relate to the reduction of alcohol-related harm, such as the reduction of alcohol-related hospital admissions by 2011, as well as re-offending⁸.

In their Action Plan for *Better Health, Better Care* (2007a), the Scottish Government also acknowledged the importance of alcohol problems in Scotland. This document set out NHS Scotland's HEAT⁹ performance management system based around targets that feed into the Scottish Government's overarching objectives. A HEAT target was set to carry out almost 150,000 alcohol brief interventions in the priority settings of primary care, antenatal care and Accident and Emergency Departments between 2008/9 and 2010/11. Given the potential downstream impact on services from the alcohol brief interventions target, and the need to ensure improved access to specialist alcohol services more generally, a HEAT alcohol services waiting target is being developed and will be in place by April 2011 (see Scottish Government, 2010d). This expands on the current HEAT waiting times target for drug services.

The *Better Health, Better Care* Action Plan outlined the need to improve prison health services, to tackle health inequalities and to consider what more could be done to ensure continuity of care during the transition between prison and the community. The Scottish Government's ministerial task force report on health inequalities, *Equally Well* (Scottish Government, 2008a), also identified offenders as one of a number of particular groups in need of targeted interventions to address alcohol misuse.

In addition, *Reducing Re-offending: National Strategy for the Management of Offenders* (Scottish Executive, 2006a) has as its core aim the reduction of re-offending. The strategy recognised that better health and wellbeing can contribute to a reduction in re-offending and included sustained or improved physical and mental well-being and reduced or stabilised substance misuse, in the core outcomes for offenders. The Youth Justice Framework (Scottish Government, 2008b) also makes a commitment to develop evidence-based interventions for young people whose offending is linked to substance misuse.

The national alcohol strategy document, *Changing Scotland's Relationship with Alcohol: A Framework for Action* (Scottish Government, 2009a) outlines the Government's commitment to conducting a review of current plans and practice for the identification and treatment of offenders with alcohol problems in criminal justice settings and the identification of good practice.

⁷ <http://www.scotland.gov.uk/About/scotPerforms/outcomes>

⁸ <http://www.scotland.gov.uk/About/scotPerforms/indicators>

⁹ HEAT targets derive their name from the four strands in the performance framework: the Health of the population; Efficiency and productivity, resources and workforce; Access to services and waiting times; and Treatment and quality of services.

The study reported here is therefore informed by the evidence described above and is set in a policy context for alcohol and offending in Scotland which includes a strategic approach to enhancing the detection, early intervention, treatment and support for alcohol problems across Scotland, as well as efforts to reduce re-offending. The study is part of a wider Scottish Government funded criminal justice alcohol research programme which also includes a pilot of the delivery of alcohol brief interventions in community justice settings and a scoping study of alcohol interventions in community justice settings¹⁰. It is hoped that the study findings will inform future service development including the integration of health care into the NHS.

1.4 Aims and objectives of the study

The aims of this study were to support recent policy by undertaking a needs assessment of alcohol problems experienced by prisoners and provide recommendations for service improvement including a model of care of effective interventions to reduce alcohol problems. The objectives of the study were to:

1. Conduct a rapid review of the relevant literature on effective interventions for identifying and treating offenders with alcohol problems in prison¹¹.
2. Report on the epidemiology of alcohol problems experienced by prisoners in Scotland compared to the general population and other offenders using the literature, surveys and routine data.
3. Undertake an assessment of alcohol problems among offenders within an individual prison using appropriate screening tools to build on earlier work conducted in the SPS and tease out potential sub-groups with differing problems, reasons for drinking and needs etc.
4. Map current models of care in the SPS and how they interface with community care models e.g. scoping of existing care pathway(s).
5. Assess aspects of treatment continuity with that (previously) received in the community prior to admission, that received in prison and that planned for the community on release.
6. Identify examples of best practice through the mapping fieldwork.
7. Conduct a gap analysis between current service provision, best practice, effective interventions and national care standards for substance misuse.
8. Explore and report on the attitudes (within an individual prison) towards the delivery and effectiveness of current alcohol interventions in this setting through interviews with prison staff, prisoners and internal/external service providers.
9. Identify and report on the perceived workforce development requirements from the evidence and key informants.
10. Identify and report on organisational barriers to the delivery of current/proposed models of care.
11. Explore and report on the resource and cost implications of implementing alcohol interventions in the prison setting addressing both existing provision and alternative models¹².

¹⁰ <http://www.healthscotland.com/topics/health/alcohol/offenders.aspx>

¹¹ This objective was narrowed down to the prison population during the rapid review because of the need to ensure high relevance of the studies included to the rest of the project objectives.

¹² This was not possible to achieve within the resources and timeframe of the project.

12. Provide recommendations for service development including a model of care.

1.5 Guide to the report

The objectives above are reported in a slightly different order in the following report for ease of reading. A glossary of terms has been included in Appendix 1.

2. Methodology

The study involved both quantitative and qualitative information being gathered through document retrieval and analysis as well as primary data collection. Further detail on the methods for each aspect of the study is documented in respective sections.

2.1 Ethical and access issues

The study was conducted according to ethical principles essential in research with vulnerable groups. Because this research was undertaken in the Scottish Prison Service (SPS) it was reviewed by the SPS Research Ethics Committee prior to commencement. The need for further National Research Ethics Service (NRES) ethics clearance was checked prior to study commencement: due to prison nurses and clinicians being employed by the SPS, not the National Health Service, this was not required. In addition, the study was taken through an ethical review at the Institute for Social Marketing, University of Stirling for approval of the primary data collection stages to ensure additional scrutiny.

A letter was sent by the study's Project Advisory Group to prison governors before the study started to inform them of the aims and policy significance of the research, and to ask for their support. The research was also discussed at key SPS senior management meetings to ensure that governors and their staff were well briefed prior to the start of the study.

Informed consent was sought in all cases prior to the telephone service mapping interviews, screening activities, focus groups, in-depth and key informant interviews. Relevant information sheets were devised, as usual in such research. Anonymity and confidentiality was ensured at all times.

Regarding prisoner data collection, attention was given to the confidentiality limitations of any focus group and to excluding any information that was legally required to be passed on to the relevant authorities. These limitations on confidentiality were made clear to participants. Given the real and potential power differentials when working with current prisoners, particular care was taken to ensure that participants clearly understood the nature of their involvement in the study. It was essential that all prisoner participants were aware of the aims and purposes of the research and were clear that neither participation nor non-participation would be to their detriment.

2.2 Epidemiology and rapid review

For this part of the study there was a focus on collating accessible and relevant documentation from a wide range of sources in order to write up a comprehensive review of what is currently known about the extent of alcohol problems in the Scottish prisoner population compared to the general population. Data was requested from the SPS in the form of the original data from the 2008 annual survey

in order to undertake a comparison of prisoner self-reported alcohol problems, using the modified CAGE screening tool, with the 2008 Scottish Health Survey. The methods used in the rapid review are detailed in Appendix 4.

2.3 Strategic interviews and service mapping

This stage involved gathering specific information regarding current practice in the prison estate, including community interface issues, and then analysing this information in terms of existing, potential or ideal care pathways. Both quantitative and qualitative information was gathered. Further details on the methodology are provided in Section 6.

2.4 Case study: screening and in-depth exploration

The choice of case study site was negotiated by the Project Advisory Group. The prison incorporates a high turnover of admitted prisoners, short and long term as well as remand prisoners, and the potential for inclusion of young offenders (16-21 years¹³). No female prisoners were included in the case study because it is a male-only establishment, reflecting the predominance of male prisons and prisoners in the SPS estate. Women's alcohol-related needs were included in the mapping aspect of the study. The methodology for the case study is provided in Sections 5 and 7.

2.5 Advisers and representation of wider stakeholder interests

Three research advisers were recruited to the study to ensure the research team was well guided in the conduct of the study. The study also benefited from an external Project Advisory Group put in place by the project Commissioners and representing the Scottish Government, Scottish Prison Service, Information Services Division and NHS Health Scotland who are also all represented on the National Alcohol and Offenders Advisory Group, responsible for overseeing and directing the Scottish Government funded criminal justice alcohol research programme. All data collection tools (e.g. interview schedules) were provided to the Project Advisory Group for scrutiny and comments prior to being used. To ensure representation of other interests, such as prisoners and their families, two organisations were involved in reviewing and commenting on the first full draft report: Families Outside¹⁴ and User Voice¹⁵. Almost all reviewer comments were attended to in preparing the final version of this document.

2.6 Consideration of equality and diversity issues

Consideration of different equality groups was taken in the design and delivery of services from both the rapid review and comparative information gathering, and in terms of mapping current SPS service delivery/interface and continuity issues. There

¹³ Only those aged 18 or over were included in the study for ethical reasons.

¹⁴ For more information on this organisation see <http://www.familiesoutside.org.uk/>

¹⁵ For more information on this organisation see <http://www.uservice.org/>

were limits to representation, however, such as the research team being unable to include prisoners who did not speak English. Given the small numbers of participants, the sampling and recruitment methods used, and the geography of the case study, minority groups were unable to be adequately represented. As described above, the case study component was also unable to be inclusive of women. Nevertheless, the findings arguably reflect the majority of the prison population in Scotland.

3. Epidemiology of alcohol problems in prisoners in Scotland

3.1 Introduction

This section of the report addresses the following objective:

- to report on the epidemiology of alcohol problems in prisoners in Scotland compared to the general population and other offenders using the literature, surveys and routine data (objective 2).

Firstly, definitions used to describe the different types of drinking behaviours are discussed alongside subsequent outcomes that are commonly subsumed within the term 'alcohol problems'. Issues concerning measurement and identification of problematic drinking behaviours are also briefly outlined. An overview of alcohol consumption and alcohol-related harm in the Scottish population is then provided before describing the epidemiology of alcohol problems within the Scottish prison population. Data was requested from the Scottish Prison Service (SPS) in the form of the original data from the 2008 annual Scottish Prisoner Survey in order to compare prisoner self-reported alcohol problems, using a modified CAGE screening tool, with the 2008 Scottish Health Survey (SHeS).

3.2 Definitions

Excess consumption of alcohol and associated health and social harms are measured in a variety of ways. Consumption can be measured using alcohol sales data or self-report population surveys. Alcohol-related harm can be measured from routine mortality and morbidity data and from social and crime sources. This report adopts the definitions from the World Health Organization's (WHO) International Classification of Mental Disorders (10th Revision; 1992). This classifies Alcohol Use Disorders (AUDs) into three categories of increasing risk and harm associated with alcohol consumption:

- *Hazardous drinking* is a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. Hazardous drinking patterns are of public health significance despite the absence of any current disorder in the individual user.
- *Harmful use* refers to alcohol consumption that results in consequences to physical and mental health. Some would also consider social consequences among the harms caused by alcohol.
- *Alcohol dependence* is a cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated alcohol use. Typically, these phenomena include a strong desire to consume alcohol, impaired control over its use, persistent drinking despite harmful consequences, a higher priority given to drinking than to other activities and obligations, increased alcohol tolerance, and a physical withdrawal reaction when alcohol use is discontinued (see also Babor, Higgins-Biddle, Saunders *et al.*, 2001).

A wide range of measurement and screening/identification tools have been developed examining different dimensions of alcohol problems (Connors and Volk,

2003). Section 4 of this report describes in more detail those that have been studied in offender populations. These can measure both levels and patterns of consumption including drinking over recommended limits and potential AUDs. Others may include the impact of alcohol consumption.

UK Government guidance currently recommends that men should not regularly drink more than 3-4 units (one unit = 8 grammes of pure alcohol) a day (and no more than 21 units per week), and women no more than 2-3 units per day (and no more 14 units per week) (Department of Health, 1995).

3.3 Alcohol use in the Scottish population

This section provides an overview of trends in alcohol consumption and harm in the Scottish population.

3.3.1 Alcohol consumption

Consumption of alcohol is best estimated from national sales, production and/or taxation data since population surveys invariably underestimate total alcohol consumption (World Health Organization, 2000; Catto and Gibbs, 2008). This can come from sales and supply data (i.e. data on production and trade such as Food and Agriculture Organization of the United Nations (FAO) and World Drink Trends (WDT) (World Health Organization, 2004) or tax receipts (e.g. Her Majesty's Revenue and Customs (HMRC) data in the UK). Not all alcohol released for sale or sold will necessarily be consumed, or consumed by individuals residing in the country of purchase. However, this may be counterbalanced by alcohol consumed abroad, home production or alcohol brought in from abroad for personal use, and so on. Population survey data is needed to understand drinking levels and patterns by different sub-groups of the population, such as age, gender and socio-economic group (World Health Organization, 2000). However, compared to supply data, population surveys where alcohol consumption is self-reported usually show overall consumption figures which are much lower, quite often by as much as half of supply-based estimates (Catto and Gibbs, 2008).

Alcohol consumption in the UK, as measured by HMRC 'released for sale' data, has more than doubled since 1950, with a significant increase occurring in the 1990's (Tighe, 2007). Alcohol sales data from the Nielsen Company suggests that average weekly sales of alcohol units per adult over the age of 16 in Scotland in 2009 were estimated to be 22.9 units, with little change in per capita sales since 2005. The data also suggest that the Scottish population are, on average, consuming almost 4.5 units (24%) per person per week more alcohol than their counterparts in England and Wales (Robinson, Catto and Beeston, 2010).

The Scottish Health Survey (SHeS) is based on self-report and includes questions on alcohol consumption and its effects¹⁶. The most recent survey at the time of drafting the report, from 2008 (Reid, 2009), indicated that almost a third of the male

¹⁶ Questions were asked relating to quantities of alcohol consumed (over a week and on the heaviest drinking day in a week), indicators of problem drinking, and on the context in which alcohol was consumed.

population (30%) and one in five of the female population (20%) consumed above recommended weekly unit limits. Amongst respondents aged 16 years and over, 27% of men and 18% of women were identified as binge drinking (defined as more than 8 units consumed on the heaviest drinking day of the week for men and 6 units for women) during the week prior to survey.

The SHeS 2008 (Reid, 2009) showed that mean weekly consumption levels declined with age. Men aged 16-24 years consumed an average of 23.5 units. The mean for those aged between 25 and 64 years ranged between 17.8 and 19.4 units, whilst for those aged 65-74 years it was 13.8 units, falling to an average of 8.3 units among those aged 75 years and over. Women's mean weekly consumption followed a similar pattern by age: those aged 16-24 years consumed 16.2 units on average. It then declined and ranged between 7.2 and 9.9 for those aged 25-64 years, and was lower again for those aged 65-74 and 75 years and over (5.4 units and 2.7 units respectively). The 16-24 year old age group were also the most likely to exceed weekly recommended limits and to binge drink.

Differences are also evident between different socio-economic groups within the Scottish population. Three measures of socio-economic status are included in the 2008 SHeS with their association with alcohol consumption. While excessive consumption is prevalent across all socio-economic groups there are a number of important variations in alcohol consumption and income category that are worth noting. A Scottish Government Health Analytical Services Division (2010a) analysis, drawing on data from the SHeS 2008 and presented as evidence to the Health Committee as part their consideration of the Alcohol etc. (Scotland) Bill, includes data of relevance to these issues and is summarised here:

- A significantly higher percentage of those with the lowest equivalised household incomes do not drink alcohol. 7% of those in the highest income quintile do not drink compared to 23% in the lowest income quintile.
- Around 80% of the lowest income quintile either do not drink or drink moderately, the highest percentage of all income groups.
- Those with the highest incomes are the most likely to drink at hazardous levels (defined as over 21-50 units for men and over 14 to 35 units for women). 26% drink at this level compared to 12% of those within the lowest income quintile.
- The relationship between household income and harmful drinking (over 50 units per week for men and over 35 units for women) is less clear. Those with the lowest incomes are the most likely to drink at harmful levels (9%) followed by individuals with the highest incomes (7%).
- In terms of drinking levels among moderate drinkers, those in the lowest income quintile drink the least (an average of 4.9 units per week) and those with the highest incomes drinking the most (7.2).

The SHeS 2008 also includes a six item CAGE¹⁷ questionnaire aimed at measuring potential 'problem drinking'. Problematic drinking in this context is defined as two or more positive responses on the CAGE questionnaire. SHeS 2008 found that 15% of men and 9% of women were potentially problem drinkers, with 10% of men and versus 5% of women selecting one or more of the three physical dependency items (Reid, 2009). These data also show that the drinking habits of younger people appear to be potentially more problematic than those of older people, for both men and women. Problem drinking, according to the SHeS, has increased over time in the whole population.

3.3.2 Alcohol-related harm

Alcohol is not an ordinary commodity (Babor, Caetano, Casswell *et al.*, 2010): it is a psychoactive, potentially toxic and addictive substance and is a contributory factor in over fifty different causes of ill health and mortality, from stomach cancer and strokes to assaults and road deaths (Grant, Springbett and Graham, 2009). The WHO has described alcohol as the second highest risk factor for ill health (using DALYs¹⁸) in high-income countries behind only tobacco (World Health Organization, 2009: 12). The Chief Medical Officer has added alcohol liver disease to the list of Scotland's 'big killers' alongside heart disease, stroke and cancer.

There is strong evidence from systematic reviews to show that consumption levels in a population are closely linked to harm: the more alcohol that is drunk, the greater the risk of harm (Babor, Caetano, Casswell *et al.*, 2010; Anderson and Baumberg, 2006). As overall consumption has increased in Scotland over recent decades so have the resultant harms. In 2008-2009 there were almost 42,000 alcohol-related general hospital discharges in Scotland, around 115 a day (Information Services Division, 2010). Over the period 2004/05 to 2008/09 the number of alcohol-related discharges from general acute hospitals increased by 9% (*ibid*) (with the increase significantly higher over the last decade). Research estimates that one in twenty of all deaths (2,882 across Scotland) in 2003 were attributable to alcohol, meaning one person in Scotland dies every 3 hours as a consequence of alcohol misuse (Grant, Springbett and Graham, 2009). In the 35-44 years age group, one in four male deaths and one in five female deaths were estimated to be from an alcohol attributable cause (Grant, Springbett and Graham, 2009). It is those living in the most deprived communities who suffer most, with alcohol-related hospital discharge rates being 6.5 times more likely in the most deprived 20% of communities (Information Services Division, 2010).

¹⁷ The CAGE questionnaire, developed for use in clinical settings but suitable for administration in general population surveys, is a validated screening tool commonly used to measure potential problematic drinking patterns. The CAGE questionnaire typically includes four screening questions used to detect potential problem drinking; the Scottish Health Survey (SHeS) includes an additional two questions on physical dependence.

¹⁸ Disability Adjusted Life Years: The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability, definition from http://www.who.int/mental_health/management/depression/daly/en/

While alcohol-related mortality and morbidity rates in the UK have appeared to have flattened off over the last 5 to 10 years (albeit at historically high levels), mirroring trends in consumption, Scotland has the highest prevalence of alcohol-related health problems in comparison to the rest of the UK or Western Europe (Leon and McCambridge, 2006; Breakwell, Griffiths, Jackson *et al.*, 2007). Over recent decades Scotland has had one of the fastest growing chronic liver disease and cirrhosis death rates in the world at a time when rates in most of Western Europe are falling. Scotland's chronic liver disease and cirrhosis death rates among 45-64 year old men have increased dramatically in the 1990s and early 2000s and are now twice as high as in England and Wales. Moreover, rates for women in Scotland are now as high as those for men in England and Wales (Scottish Government, 2008c).

The harm caused by alcohol misuse extends beyond the health of the individual drinker. A recent systematic review found there to be a consistent and statistically significant effect of alcohol on violence and injury at even quite low levels of consumption (Booth, Meier, Stockwell *et al.*, 2008). At least 70% of assaults presenting to Emergency Departments may be alcohol-related, with the majority of these being concentrated at weekends and involving young men (SEDAA Group, 2006b). Strathclyde Police data showed that, of the 5,000 individuals processed by one Glasgow police station in 2006-07, over 60% were under the influence of alcohol and/or drugs. Of those detained for violence, two-thirds were under the influence of alcohol (Strathclyde Police, unpublished data cited in Scottish Government, 2008c). Alcohol misuse also impacts on young people, putting themselves and others at greater risk of harm. The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2008 found that 31% of 15 year olds and 11% of 13 year olds drank alcohol in the previous week (Black, MacLardie, Mailhot *et al.*, 2009). Almost a quarter (23%) of 15 years olds who had drunk alcohol in the previous year reported getting into trouble with the police and 18% said they had tried drugs as a consequence of drinking alcohol (*ibid*).

There is also a link between alcohol and mental health problems. About 50% of those who committed suicide since 1997 had a history of alcohol misuse, with 20% having had a primary diagnosis of alcohol dependence (Scottish Government, 2007b). Problem drinking can also be a factor in family break-up. Marriages where one or both partners have an alcohol problem are twice as likely to end in divorce as marriages where alcohol problems are absent (Prime Minister's Strategy Unit, 2003; 2004).

This section has aimed to provide an overview of some of the significant harms related to alcohol experienced by the Scottish population. It should be noted that there is some emerging evidence that some specific harms related to alcohol in Scotland are no longer rising: they appear to be stabilising. Alcohol-related hospital admission rates (Information Services Division, 2010), liver disease rates (ScotPHO, 2010) and the alcohol-related mortality rates (General Register Office for Scotland, 2010) all suggest such a flattening.

3.4 Alcohol problems in Scottish offenders

3.4.1 Evidence on alcohol problems in prisoners

Before turning to Scotland there are two studies from the wider UK context of note. A comprehensive survey of substance misuse by prisoners in England and Wales was undertaken by the Office of National Statistics in 1999 (Singleton, Farrell and Meltzer, 1999). It explored alcohol and drug use for prisoners in the 12 months before entering prison using the AUDIT screening tool (see Appendix 2 for explanations of AUDIT scores). Figures in Table 3.1 indicate that the proportion of hazardous drinkers in prison were nearly twice as high as in the general adult male population at the time (32%) and more than double the proportion of adult female hazardous drinking (15%) (Singleton, Farrell and Meltzer, 1999). Thirty per cent of both male remand and male sentenced prisoners had AUDIT scores of 16 and over.

Table 3.1 Prevalence of hazardous drinking and harmful drinking in year prior to entering prison (adapted from Singleton, Farrell and Meltzer, 1999: 17)

	Male remand	Male sentenced	Female remand	Female sentenced
AUDIT score	Percentage of the population (%)			
Score: 0-7	42	37	64	61
Score: 8-15	27	33	16	20
Score: 16-23	13	16	6	8
Score: 24-31	10	10	6	7
Score: 32-40	7	4	8	4
Hazardous Drinking (Score 8+)	58	63	36	39
Harmful/Dependent Drinking (Score 16+)	30	30	18	19
<i>Base</i>	<i>1243</i>	<i>1120</i>	<i>187</i>	<i>581</i>

A more recent study conducted in the North-East of England by Newbury-Birch, Harrison, Brown *et al.* (2009a) aimed to determine prevalence of hazardous, harmful and dependent drinking (AUDs) in a sample of clients from prison and probation settings using the AUDIT screening tool. Findings indicate high levels (63%) of AUDs within both prison and probation settings using this tool, much higher than the 26% recorded in the English population. In the male prisoners, 59% scored 8 and over, similar to the earlier findings of Singleton, Farrell and Meltzer (1999). The percentage of female prisoners with an AUD, however, was considerably higher. Further breakdown of AUDIT scores for male prisoners in Newbury-Birch and colleagues' (2009a) study showed that:

- increasing risk (hazardous) (AUDIT score 8-15) = 19%
- higher risk (harmful) (AUDIT score 16-19) = 4%
- possibly dependent (AUDIT score 20+) = 36%.

In Scotland, an unpublished study conducted in 2008 also showed high levels of alcohol problems among prisoners (Graham, 2010, personal communication). Prevalence rates for AUDs were found to be slightly higher than those in the English

studies with 65% of convicted prisoners and 73% of remand prisoners with AUDIT scores of 8 or above. Further breakdown of scores is shown below in Table 3.2.

Table 3.2 Graham et al., 2010 unpublished AUDIT data

AUDIT score category	Remand No (%)	Convicted No (%)	Total No (% of Total)
Low risk: 0-7	26 (27)	12 (35)	38 (29)
Hazardous: 8-15	24 (25)	7 (21)	31 (24)
Harmful: 16-19	5 (5)	5 (15)	10 (8)
Possibly Dependent: 20+	41 (43)	10 (29)	51 (39)
Total	96 (100)	34 (100)	130 (100)

While not a study of prisoners, research conducted in Aberdeen with individuals in police custody (Gibbons-Wood, Tait and Morrison, 2009) also used AUDIT to measure AUDs. It reported a total of 85% of respondents having an AUDIT score of 8 or above. More specifically 15% were low risk, 28% were hazardous, 11% were harmful, and 45% scored as possibly dependent drinkers.

McKinlay, Forsyth and Khan (2009) explored the relationships between lifestyles and offending with the specific population of young offenders using both quantitative and qualitative research. Self-completion questionnaire surveys undertaken in 1979 (on drinking behaviour), 1996 (on drinking and drug use) and 2007 (on drinking, drug and weapon use) indicate changes in the proportions of young offenders who considered that alcohol had contributed to their previous offending, rising from 47.9% in 1979, to 58.4% in 1996, to 79.6% in 2007. The proportion that blamed their current offence on drinking rose from 29.5% in 1979, to 40.0% in 1996, to 56.8% in 2007, and those blaming alcohol not in association with other drugs rose from 22.5% (1996) to 36.3% (2007). In terms of the qualitative interviews conducted in 2008, however, all interviewees linked alcohol to their offending, in some cases to every one of their previous offences. A majority proportion (76%) of young offenders also reported being drunk at the time of their offence (McKinlay, Forsyth and Khan, 2009).

In this same study, the proportion of young offenders in each survey's sample who stated that they get 'drunk daily' rose from 7.3% (1979) to 22.6% (1996) to 40.1% (2007). This pattern of drinking was confirmed in the 2008 qualitative interviews. Of those who blamed illegal drugs for their current offence, in the 2007 survey the most frequently cited drug was diazepam which was usually blamed in conjunction with alcohol use. The qualitative interviews confirmed this pattern indicating that illegal drug use was more of an extension of drinking behaviours than an alternative lifestyle choice. Most (80.5%) young offenders in the 2007 survey who had used a weapon to injure someone stated they had been under the influence of alcohol at the time. Interview data implied that 'alcohol use (either on its own or in conjunction with diazepam) was a factor in turning weapon owners into weapon carriers and weapon carriers into weapon users' (McKinlay, Forsyth and Khan, 2009: v).

In summary, this research found that current young offenders engage in 'frequent drunkenness, group disorder, weapon carrying and other violence' (ibid: vi). Data indicate that this differs from the 1996 group surveyed where distributed non-violent crime was much more common. The report also summarises findings by asserting that alcohol interventions should be rebalanced towards hazardous and harmful drinkers rather than towards dependency.

3.4.2 Scottish Prison Service annual surveys

In addition to the studies reported here, annual prisoner surveys conducted by the SPS have included questions on alcohol since 2005. The Prisoner Survey uses a modified version of CAGE, a set of four questions that ask participants about their perception of problems caused to them by their alcohol consumption. The SPS provide an overview of the methods used to collate their 2008 survey in their recent summary of findings (SPS, 2008). Every prison in Scotland was visited between May and July 2008 and all prisoners, both sentenced and on remand, were given a questionnaire form and an envelope which they could complete in their own cell. These were then returned to survey team members in sealed envelopes. The response rate for 2008 was 62% (SPS, 2008), lower than in some previous years of the survey¹⁹.

The 2008 Prisoner Survey²⁰ indicates that 45% of all prisoners had an alcohol problem, as defined by answering two or more CAGE questions positively (Scottish Prisoner Survey 2008 cited in Information Services Division, 2009). The figure is high but credible given findings from surveys conducted in other prison systems, as described above. Trends from the Prisoner Survey indicate an increasing proportion of prisoners who report being drunk at the time of offence: between 2005 and 2009 there has been a 10% increase in the numbers of prisoners who reported being drunk at the time of their offence (SPS, 2010b).

Interestingly, the SPS Prisoner Survey in 2005 found little difference in the prevalence of alcohol problems between males and females, with the exception of males being more likely to have been drunk at the time of their offence (SPS, 2005²¹), a finding similar to those drawn from the 2008 survey reported in following sections of this report. According to Ramsey (2003), problem alcohol use is high amongst women involved in the criminal justice system and this may be connected to high rates of concurrent drug use, histories of abuse and high rates of violence/trauma-related mental health problems (see Scottish Consortium on Crime and Criminal Justice, 2006).

Alcohol problems appear to be particularly marked amongst another two groups: those who have been in prison multiple times and young offenders (SPS, 2005). Young offenders were indicated as having an alcohol problem in virtually every

¹⁹ Additional response rates from survey years: 2005 – 77%, 2006 – 73%, 2007 – 74%, 2008 – 62%, 2009 – 62%.

²⁰ The 2008 SPS Prisoner Survey is used to be consistent with the 2008 SHeS survey.

²¹ The 2005 survey report has the most detailed figures where data on alcohol problems is concerned and hence we draw on this rather than more recent rounds of the survey.

question of a set in the SPS 2005 survey, for example, young offenders were more likely than adult prisoners to:

- consider alcohol to have been a problem on the outside (52% compared to 30% of adult prisoners)
- have had a drink in the morning (35% compared to 21%)
- have been drunk at the time of their offence (66% compared to 35%)
- have thought relationships were being affected by drinking (42% compared to 28%)
- have thought drinking to be affecting their health (35% compared to 24%), and
- be worried that alcohol would be a problem after release (25% compared to 17%).

The SPS surveys do not report on further sub-groups within the prison population. No evidence is provided, for example, on differences between socio-economic or ethnic groups. One reason for this is that the prison system in Scotland is overwhelmingly white and drawn from the most marginalised sections of society (Graham, 2007). Other groups are so small in number that providing meaningful breakdowns would require specific methods.

3.4.3 Prevalence of alcohol problems amongst Scottish prisoners – a comparative analysis

This section examines alcohol problems amongst the prison population in comparison to the general population. It uses the SPS Prisoner Survey (referred to as SPS survey for the remainder of this section) for 2008 which enables a comparison with the 2008 SHeS conducted in the same year.

The SPS survey includes a range of questions including socio-demographic indicators (age and gender) and various questions relating to alcohol use. Of particular interest to this report are the four CAGE questions. These have been slightly modified to make them applicable to a prison population, specifically relating the questions to life prior to incarceration. The questions, as asked in the SPS survey, were:

1. *On the OUTSIDE did you ever think you ought to CUT DOWN your drinking?*
2. *Has anyone ever ANNOYED you by criticising your drinking?*
3. *Have you ever felt GUILTY about your drinking?*
4. *Have you ever had an EYEOPENER a drink first thing in the morning?*

At time of analysis the 2008 SHeS data had not been released so the tabulations used here were produced by the Scottish Government's Health Analytical Services Division (2010b). A range of questions were included on socio-demographic and health topics. Data presented in Section 3.4.3 have all been weighted to produce nationally representative figures. Percentages shown are thus a proportion of the Scottish population for each age group.

Various questions were asked in the 2008 SHeS relating to alcohol including the CAGE questions providing an opportunity for comparison to the SPS survey. As

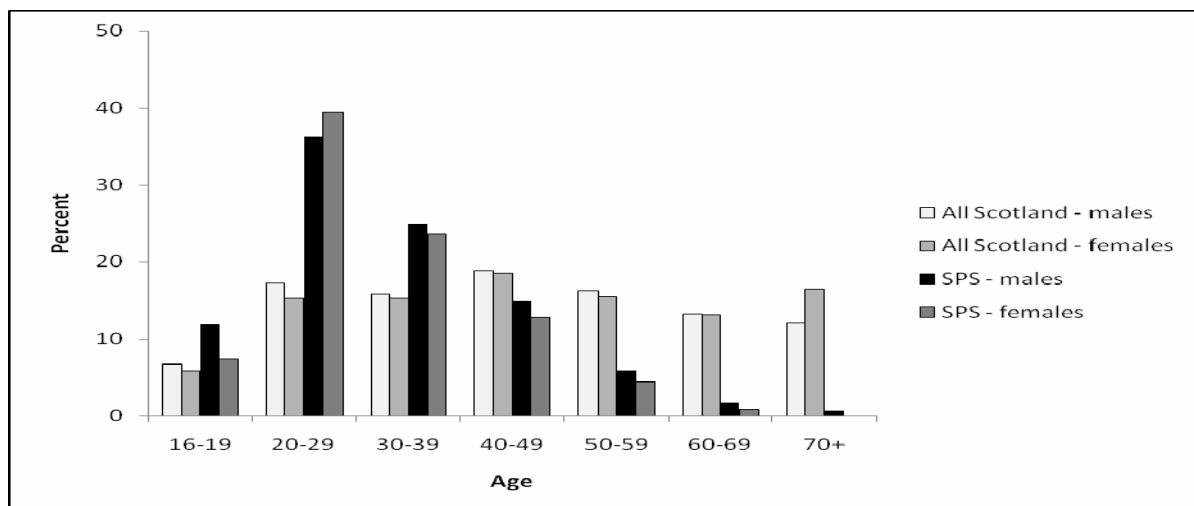
indicated above, wording is not exactly as was included in the SPS survey, given the different context in which people were answering questions²².

Data from estimates derived by the General Register Office for Scotland (GROS) for 2008 is also used to provide indication of how the demographic profile of the prison population compares to the general population.

Figure 3.1 provides an overview of the age composition of participants in the 2008 SPS survey alongside comparative figures for those aged 16 years or over across Scotland (as estimated by General Register Office for Scotland, 2009a), and by gender. This clearly shows the prison population to be younger than the general population and to contain a greater proportion of males. Nearly half (48%) of all male prisoners who participated in the SPS survey were aged between 16 and 29 years; this compares to 24% across the general population. The same is true of female prison survey participants for whom 46% were aged between 16 and 29 years in comparison to just 21% in the general population.

A very small proportion of prisoners were over 60, whether male or female. For the general population aged over 16 years (in other words those old enough to be imprisoned), the GROS estimates more than 25% to be 60 years or older in 2008. This figure compares to just 3% of males and 1% of females amongst prison survey participants. The Scottish prison population was also predominantly male; 94% of those participating in the SPS survey were male. This figure compares to Scotland as a whole where for those aged 16 years or older males were very slightly in the minority, making up 48% of the population.

Figure 3.1 Age composition of the population of Scotland projected 2008 mid-year estimates¹ compared to participants in the 2008 SPS survey



Figures from General Register Office for Scotland (2009a)

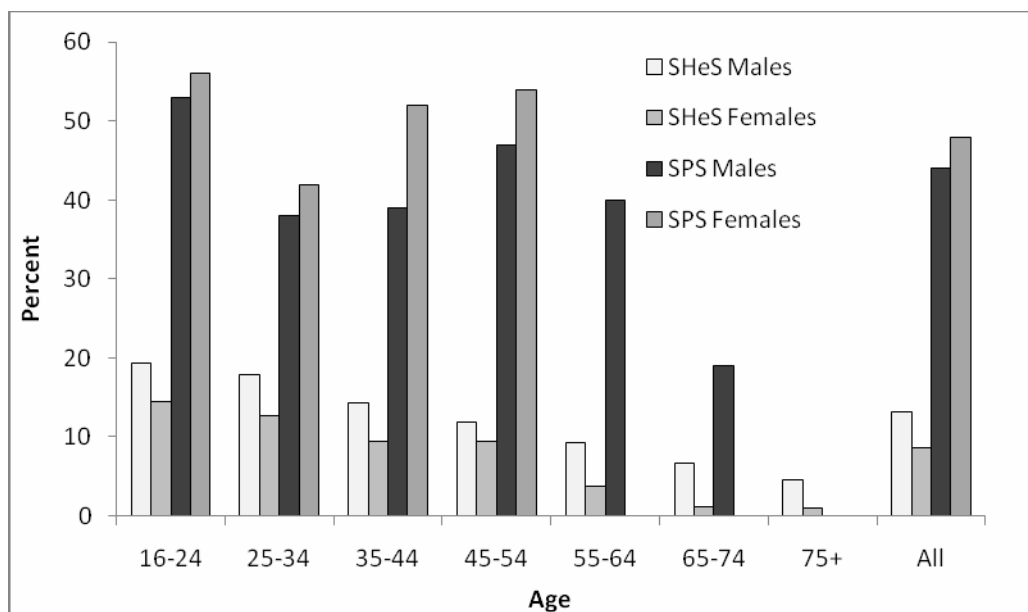
²² The specific wording of the SHeS questions was as follows:

1. *I have felt that I ought to cut down on my drinking*
2. *People have annoyed me by criticising my drinking*
3. *I have felt ashamed or guilty about my drinking*
4. *I have had a drink first thing in the morning to steady my nerves or get rid of a hangover.*

Figure 3.2 shows a comparison of percentages answering two or more CAGE questions positively in the 2008 SPS survey compared to equivalent figures for the 2008 SHeS (figures are also shown in Appendices 2 and 3) and clearly shows the high percentage of alcohol problems found in the prison population, especially those in younger age groups.

At all ages, and comparing males to females, the prevalence of alcohol problems is higher in the prison population compared to the general population. Over 50% of prison survey participants aged 16-24 years had CAGE scores indicating an alcohol problem, both males and females. This figure compares to slightly fewer than 19% of male and 14% of female SHeS participants. The prevalence was thus more than two-and-a-half times greater amongst men in prison, and three-and-a-half times greater amongst women in prison, in this age group. Other age groups similarly demonstrated far higher prevalence amongst prisoners. Indeed, amongst women in prison aged 45-54 years, 54% were indicated as having an alcohol problem, a prevalence more than five times greater than indicated by the SHeS for the general female population.

Figure 3.2 Percentage answering two or more CAGE questions positively in the 2008 SPS and SHeS surveys^{1 2}



¹ Figures for the 2008 SHeS provided by the Scottish Government Health Analytical Services Division (2010b).

² Figures for the 2008 SHeS have been weighted to make them more representative of the Scottish population.

Figure 3.2 also demonstrates a clear decreasing prevalence of alcohol problems as people get older amongst SHeS participants. In the general population, older people, men or women, were less likely to have an alcohol problem compared to younger age groups. This association is also apparent amongst the prison population although not to the same extent. Amongst men in prison, the highest prevalence was clearly found in the youngest age group, those aged 16-24 years, with 53% answering two or more CAGE questions positively. Prevalence was considerably lower amongst those aged over 25 years, although was never lower than 38% for

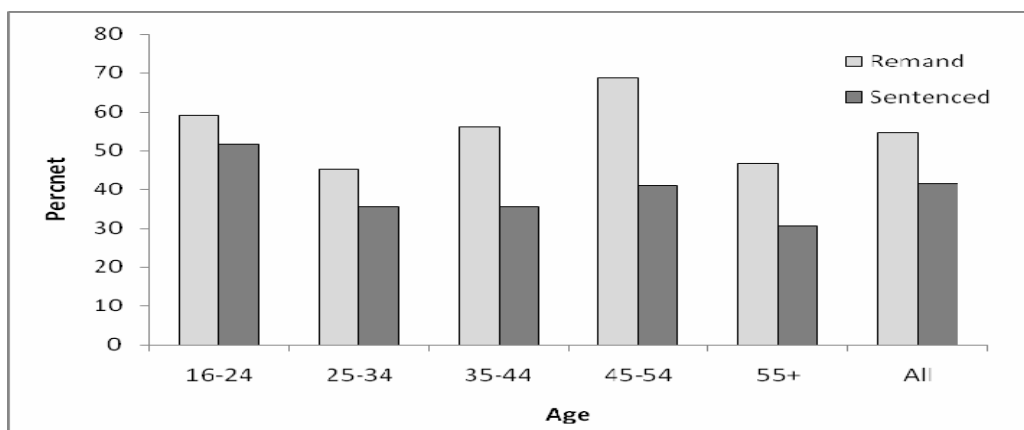
any group under 65 years of age. The 45-54 year-old age group had a particularly high prevalence for both men and women, with 47% male prisoners indicated as having an alcohol problem. Prevalence was lowest amongst those aged 65-74 years, though still markedly higher than found in the general population. Prevalence is not shown for male prisoners aged over 75 years as a very small number answered all four CAGE questions.

A similar association between age and prevalence is seen for women prisoners, although numbers participating and answering CAGE questions in the SPS survey were insufficient for analysis above 54 years of age. More than half of women prisoners aged 16-24 years were indicated as having an alcohol problem. A lower percentage is evident amongst those aged 25-34 years (42%). Prevalence rises again amongst women prisoners aged 35-44 years (52%) and 45-54 years (54%) (see Appendix 3).

The 2008 SHeS figures clearly show higher prevalence of alcohol problems amongst men compared to women, a difference found in every age group (Appendix 4). The same was *not* true amongst 2008 SPS survey participants for whom women had a greater prevalence in every age group (keeping in mind that there were insufficient responses from women over the age of 54 years for analysis and only 13 women aged 45-54 years).

The 2008 SPS survey figures show a greater prevalence of alcohol problems amongst prisoners on remand compared to those sentenced (see Figure 3.3). The difference is least marked amongst those aged 16-24 years amongst whom 59% of those on remand answered two or more CAGE questions positively against 52% of sentenced prisoners. The difference was much greater amongst older age groups. The difference was particularly marked amongst those aged over 35 years for whom each group of remand prisoners had prevalence at least 50% greater than amongst sentenced prisoners. The high prevalence amongst those aged 45-54 years noted earlier was again evident in both sentenced and remand prisoners but was particularly so amongst the latter. Indeed, the highest prevalence amongst remand prisoners was found in this age group (69%), higher even than those in the 16-24 age group (59%).

Figure 3.3 Percentage of 2008 SPS survey respondents answering two or more CAGE questions positively by whether on remand or sentenced



3.4.4 Discussion of comparative analysis findings

The results above highlight the considerable scale of alcohol problems found in the Scottish prison population. While the higher prevalence of alcohol problems in prisons partly reflects the demographics of the prison population (being young and male), higher prevalence rates were found across age groups, and for women as well as men, compared to the general population.

While the 2008 SPS survey showed that, as in the general population, younger age groups had a greater prevalence of alcohol problems, two additional findings are worth noting. Firstly, contrary to the general population, there appears to be a particularly high rate of alcohol problems within a group in later middle age, those aged 45-54 years. Secondly, the relationship between alcohol problems and gender is different in the prison population: women being more likely than men to have an alcohol problem.

The analysis reported above has several limitations. The CAGE question was modified to make it applicable to a prison population and thus differed slightly from the CAGE questions used in the SHeS. The SPS survey questions also relied to a certain extent on recollection of events prior to imprisonment. These recollections are likely to have been clearer for those recently imprisoned, perhaps especially so for those on remand, and reporting bias might have therefore impacted some results. Both these factors may have reduced comparability.

More generally, administrative data sources run the risk of missing many people with alcohol problems. Research in England has suggested that only a proportion of those with alcohol problems are identified within the prison system (Mason, Birmingham and Grubin, 1997). In the Scottish prison system Graham (2007) found a disparity between self-reported rates of alcohol problems and recording of clinical diagnosis that 'suggest that alcohol problems are under-detected, under-recorded and under-treated in SPS' (Graham, 2007: 18). Newbury-Birch, Harrison, Brown *et al.* (2009a) also found discrepancy between AUDIT screening prevalence of AUDs and those identified by the current OASys (Offender Assessment System) process. Research relying on routine data sources is therefore likely to underestimate prevalence.

In terms of developing the comparability of alcohol problems in the prisoner versus the general population, there are electronic databases that may hold some potential for research in this area in the future. A development of note in the SPS is use of the GPASS system, an electronic database for recording health information commonly used in primary care. However, this system has not yet been fully implemented across the SPS estate. The prison service's own electronic database (PR2) may also have potential as a data source, but is not currently designed to incorporate clinical information.

Lastly, of relevance to this section and to the rest of this report, is the issue of prisoner motivation to address alcohol problems. In Table 3.3, the answers to five questions on both willingness to take up help for alcohol problems and the receiving

of assessment and treatment for alcohol problems are reported from the 2009 SPS survey (using the same methods as for 2008). This data indicates that many prisoners are open to being provided with opportunities to address alcohol-related problems.

Table 3.3 Prisoners answering 'yes' to questions on assistance with alcohol problems in the 2009 Scottish Prison Service prisoner survey

<i>Base: n=4431</i>	Number	% of all surveyed prisoners
If I was offered help IN PRISON for alcohol problems I would take it	1735	39
If I was offered help ON THE OUTSIDE for alcohol problems I would take it	1577	36
I was assessed for alcohol use on my admission to prison	1368	31
I have been given the chance to receive treatment for alcohol problems during my sentence	1389	31
I have received help/treatment for alcohol problems during my sentence	860	19

3.5 Key findings

This section outlined trends in alcohol consumption and harm in the Scottish population and highlighted:

- a rise in alcohol consumption over the past decades with a consequent rise in alcohol related harm
- the high proportions of the population drinking excessively across all ages and socioeconomic groups
- that young males are the highest alcohol consumers
- that Scotland has the highest prevalence of alcohol related health problems in the UK and are among the highest in Western Europe
- that specific alcohol related harms appear to be stabilising.

The section also provides an epidemiology of alcohol problems in offenders from the UK published literature and included a comparative analysis of the 2008 Scottish Prison Survey with the general population 2008 Scottish Health Survey in relation to alcohol problems, highlighting:

- that the prisoner population in Scotland is younger than the general population and predominantly male
- the high prevalence of alcohol problems in prisoner population for both men and women
- a higher prevalence of alcohol problems in remand prisoners than in sentenced prisoners
- evidence that the problem is getting worse

- a willingness amongst some prisoners to receive help with their alcohol problems.

4. Rapid review of the relevant literature on effective interventions for identifying and treating offenders with alcohol problems

4.1 Introduction

This section of the report addresses the following objective:

- to conduct a rapid-review of the relevant literature on effective interventions for identifying and treating offenders with alcohol problems in prison²³ (objective 1).

The aim of this review was to collate all the relevant evidence in this area. Many systematic reviews of effectiveness (e.g. Cochrane reviews) focus on evaluating only the highest quality evidence (generally from randomised controlled trials (RCTs)). However, for this review, all types of evaluation studies were considered (e.g. RCTs, controlled non-randomised studies, before and after studies, qualitative studies and case study evaluations) in order to understand why and how interventions are ineffective or effective.

RCTs and other studies of outcomes can provide estimates of the effectiveness of interventions. Qualitative studies and case study evaluations (e.g. in-depth process and outcome evaluations of smaller single programmes) can contribute to the understanding of effectiveness by providing explanations as to 'how' and 'why' interventions may be effective or ineffective (e.g. barriers and enablers). In addition, UK policy documents which outline both the development and application of policy and practice on the management of alcohol misuse are briefly detailed. Appendix 5 provides further methodological details of the rapid review including the inclusion criteria.

4.2 Results

A total of 1031 references were retrieved from searching the electronic databases. A further 33 references were obtained from searching the grey literature, the Internet and other sources (e.g. from personal sources). After applying the inclusion criteria 89 studies and documents were assessed in more detail. During this stage further references were excluded leaving a total of 64 included references. Table 4.1 details the types of literature that were included in the review.

²³ Originally the intention was to review the literature for all offenders. However, an initial literature search identified a considerable volume of evidence (much in the community setting) which would have been impossible to review in the time available. As the focus of the project was on the prison service a decision was made, in consultation with the project commissioners, to limit the review to offenders in the prison setting.

Table 4.1 Breakdown of the types of literature included in the review

Type of literature	No. of documents /studies
Policy or discussion documents	9
Literature reviews (systematic and non-systematic)	15
Literature on identification of offenders with alcohol problems (screening studies)	11
Literature on interventions including case studies and qualitative studies (total):	29
Randomised controlled trials	9 (2 reports of the same study were included)
Non-randomised controlled trials (quasi-experimental)	7
Evaluations	5
Case studies/pilot studies	4
Qualitative studies	3

Whilst every attempt was made to identify all the relevant literature, it is acknowledged that a proportion may have been missed. The search focused on terms related to alcohol but some studies used the terms ‘substance abuse’ or ‘drug abuse’ to include alcohol. Searching for all of these terms may have identified more studies but would have been too time consuming. Although some searching of the Internet for UK based evaluations was undertaken, it was limited due to the number of other studies identified. However, some of the local evaluations were reported in one or more of the studies or reviews.

4.2.1 Grey literature

Nine highly relevant policy documents were identified in the search that took place at the start of the study (August-early September 2009) on alcohol and offenders²⁴. These are summarised in Appendix 6. A number of these policy documents were used to construct the gap analysis and model of care presented in Section 8. 4. In addition, three reports were collected through the course of the review, after this initial search (late September 2009-June 2010), and have been drawn upon in this report but have not been added retrospectively to Appendix 6: HM Inspectorate of Prisons (2010), National Offender Management Service (NOMS, u.d) and McSweeney, Webster, Turnbull *et al.* (2009).

4.2.2 Literature on identification of offenders with alcohol problems

As mentioned in the review’s methodology (Appendix 4), only studies which have assessed the *reliability and validity* of one or more alcohol screening tools for use in the prison population were included in the review. A number of screening tools are available for detecting alcohol problems. The preference for a tool depends on the

²⁴ Policy documents with some relevance to alcohol and offending were used in the background to the report rather than reported in this table. Only documents that were of central relevance to the research aims were included in the grey literature summary.

population of interest, settings and the purpose of the assessment (Peters, Greenbaum, Steinberg *et al.*, 2000). Other factors include cost and availability of the instrument, time to administer and, most importantly, the sensitivity of the tool to detect alcohol problems (Watt, Shepherd and Newcombe, 2008). Alcohol or drinking problem is a term that usually covers a range of problematic drinking behaviours often grouped as hazardous, harmful, and dependent drinking (see definitions given at the beginning of Section 3). There are different screening tools available to detect different kinds of drinking problems. In this review, eleven studies were identified that used diverse screening tools (see Table 4.2 for types of main screening tools) to evaluate alcohol or substance abuse or dependence in varying populations of offenders. See Appendix 7 for a summary of the studies. Some screening tools are designed to detect only alcohol problems (e.g. AUDIT, CAGE) others are multipurpose (e.g. SASSI, TCUDS, MMPI) for detecting both alcohol and drug problems.

Table 4.2 Description of main screening tools identified

Tool Acronym	Meaning/Description
AUDIT	Alcohol Use Disorder Identification Test
CAGE	C - Cut down, A - Annoyed, G - Guilty, E - Eye opener
MAST	Michigan Alcohol Screening Test
SASSI	Substance Abuse Subtle Screening Inventory
TCUDS	Texas Christian University Drug Screen
MMPI	Minnesota Multiphasic Personality Inventory
UNCOPE	U—Have you continued to use alcohol or drugs longer than you intended? N—Have you ever neglected some of your usual responsibilities because of alcohol or drug use? C—Have you ever wanted to stop using alcohol or drugs but couldn't? O—Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use? P—Have you ever found yourself preoccupied with wanting to use alcohol or drugs? E—Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?

The population subgroups were juvenile, female, male and mixed adult offenders. Three studies (Rogers, Cashel, Johansen *et al.*, 1997; Toyer and Weed, 1998; Stein and Graham, 2001) evaluated screening tools in juvenile offenders. Only one study (Caviness, Hatgis, Anderson *et al.*, 2009) was undertaken with female offenders. Four studies (Peters, Greenbaum, Steinberg *et al.*, 2000; Michaud, Pessione, Lavault *et al.*, 2000; White, Ackerman and Caraveo, 2001; Maggia, Martin, Crouzet *et al.*, 2004) evaluated tools in male offenders and finally, three studies (Johnston, 1999; Campbell, Hoffmann, Hoffmann *et al.*, 2005; Welsh and McGrain, 2008) with a mixed adult incarcerated population. None of the studies were undertaken in the UK (nine in the USA, two in France).

Screening of alcohol use in juvenile offenders

As stated above, three of the identified studies evaluated screening tools in juvenile offenders: the adolescent versions of SASSI (SASSI-A) and MMPI (MMPI-A). One study (Rogers, Cashel, Johansen *et al.*, 1997) validated the SASSI-A on the ability to identify juvenile offenders who acknowledged using substances (including alcohol) and those who denied use. It is worth stating that the scale was originally developed to detect unacknowledged substance misuse (Miller, 1990). The findings indicated that SASSI-A identified a high number of false positives (68.4%) although it was able to identify non-admitting (denied using substance even though they were users) alcohol and drug users (75.6%). The authors concluded that due to its unconvincing sensitivity, SASSI-A should not be employed to identify adolescents as substance dependent.

Another study (Toyer and Weed, 1998) compared the validity of MMPI-A with counsellor rating in identifying adolescent offenders with behaviour problems (including alcohol problems). Several scales on MMPI-A were employed to assess behaviour problems in adolescents. Overall, the results showed the effectiveness of MMPI-A in identifying conduct disordered behaviour in adolescents. The Scales, Alcohol/Drug Problem Acknowledgment scale (ACK), Adolescent School Problems (A-Sch), Adolescent Anger Problems (A-Ang), Hypomania (Ma), and Alcohol/Drug Problem Proneness (PRO) were highly predictive of adolescent behaviour problems. Although the authors noted that the scale has been extensively validated in incarcerated juvenile population, the present study was based on a small sample size (42 adolescent offenders) and may not have had adequate statistical power to sufficiently support its findings.

The third study (Stein and Graham, 2001) also evaluated the effectiveness of MMPI-A to identify substance abuse problems in a USA juvenile correctional setting. Specifically, they assessed the ability of the MacAndrew Alcoholism Scale-Revised (MAC-R), Alcohol/Drug Problem Acknowledgment scale (ACK), and the Alcohol/Drug Problem Proneness scale (PRO) of the MMPI-A to detect alcohol and other substance use problems in comparison to interviewer rating. Due to anticipated reading difficulty among the study population, a taped version of the scale was administered individually to each participant. Two of the Scales (ACK and PRO) of the MMPI-A were found to prove more successful in predicting substance abuse in juvenile offenders. However, ACK produced more accurate classification rates than PRO. The findings support the use of MMPI-A to identify alcohol and other substance abuse in juvenile correctional settings.

Screening for alcohol problems in incarcerated women

Only one study (Caviness, Hatgis, Anderson *et al.*, 2009) evaluated screening tests in incarcerated women. The women were being screened to participate in a randomised controlled trial. The study assessed the two screening tools: AUDIT and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) tool. The AUDIT is a ten-item screening instrument recommended by the World Health Organization for detecting hazardous or harmful levels of drinking, and alcohol dependence (Babor, Higgins-Biddle, Saunders, *et al.*, 2001). Although it has been validated extensively with different population groups, its reliability and validity in an incarcerated

population has been less extensively evaluated. The utility of the AUDIT sub scales, AUDIT-consumption (AUDIT-C) and AUDIT-3 (an item on AUDIT used to assess frequency of six or more drinks on one occasion) and the NIAAA (criterion for heavy episodic drinking) to detect hazardous drinking were compared with the full AUDIT. The findings showed that the three item AUDIT-C showed reliability for detecting hazardous drinking in female inmates. 'The AUDIT-C with a cut off score of 3 or higher yielded a classification most consistent with the 10-item AUDIT; its sensitivity and specificity both exceeded 0.9 and 91.5% of cases were correctly classified' (Caviness, Hatgis, Anderson *et al.*, 2009: 51). The findings of the study are encouraging considering the fact that AUDIT-C provided a brief and easy to administer questionnaire and the study was based on a large sample size (1751) of female offenders.

Screening for alcohol problems in incarcerated males

Three studies evaluated screening tools in incarcerated males and these tools included the SASSI-2, TCUDS, CAGE and MAST. One study (Peters, Greenbaum, Steinberg *et al.*, 2000) compared the effectiveness of eight substance abuse scales with the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders-IV (SCID-IV) in an attempt to identify the most appropriate tools for detecting substance use disorder (*sic.*) among male prisoners. The tools were Alcohol dependence scale (ADS), Addiction severity index-drug use (ASI), Alcohol use subscales, Drug abuse screening test (DAST-20), Michigan alcohol screening test-short version (SMAST), Substance abuse subtle screening inventory-2 (SASSI-2), Simple screening instrument (SSI) and the Texas Christian University Drug Screen (TCUDS).

The authors found that each of the screening and diagnostic instruments examined were of high reliability in detecting substance dependence disorders. However, considering the most desirable psychometric properties (predictive value, sensitivity, and accuracy), the TCUDS, the SSI and a combined instrument – Alcohol Dependence Scale/Addiction Severity Index-Drug Use section – were found to be the most effective in identifying alcohol and other substance misuse and dependence disorders.

Another study (Michaud, Pessione, Lavault *et al.*, 2000) compared the utility of CAGE to screen for alcohol-related diseases (ARDs) and alcohol-related problems (ARPs) in French male inmates in comparison to the ability of a physician to detect these problems. The CAGE questionnaire was originally designed to identify alcohol dependence. For ARDs among inmates, CAGE correctly identified 88.4%. For ARPs, CAGE was less efficient (sensitivity 58.7%, note however that CAGE is not designed for ARPs). As the reliability of CAGE was questionable in this population, the authors concluded that a screening test in prisons should include two more questions on the number of incidents of drunkenness and the reasons for incarceration.

In a USA based study (White, Ackerman and Caraveo, 2001), the authors assessed the ability of MAST in identifying male alcohol abusers in a low-security prison and how this predicts antisocial personality patterns, anxiety disorders, domestic violence histories and other substance misuse. The majority of inmates screened positive for

alcohol problems on the MAST (61%). The findings showed that a positive screen for alcohol problems correlated highly with all the other factors listed above.

A French study (Maggia, Martin, Crouzet *et al.*, 2004) evaluated AUDIT in the male incarcerated population. It examined the re-test reliability of the scale in detecting alcohol problems. The AUDIT was administered for the first time on the day of entry to prison and again after about 15 days. The findings indicated that at entry prisoners significantly scored low on the AUDIT for a probable alcohol problem compared to what they scored at the later time point. This posits that AUDIT results are more reliable when offenders are more settled in the prison environment. It is likely that the guilt and shock of imprisonment at entry may bias responses given to the various items on the AUDIT. This finding should be interpreted with caution in that only a small sample size of 47 prisoners was involved in the study. Additionally, authors did not compare participant AUDIT results with other objective or diagnostic measures for detecting alcohol problems.

Screening for alcohol problems in mixed inmate population

Three USA studies used MMPI, UNCOPE and TCUDS to evaluate alcohol or substance misuse and dependence in the general (male and female) offender population. One of these studies, a thesis (Johnston, 1999), determined the accuracy of the substance abuse scale MMPI-2 in prison inmates. Specific components of the MMPI-2 scale assessed were MacAndrews Alcoholism Scale Revised (MAC-R), the Addiction Potential Scale (APS) and the Addiction Acknowledgement Scale (AAS). The AAS and APS showed more accuracy for identification of alcohol and other chemically dependent inmates than the MAC-R. However, the study was based on a small sample size of 71 and the usual cut-off score for each scale was altered to enhance identification.

Another study (Campbell, Hoffmann, Hoffmann *et al.*, 2005) used the UNCOPE, a six-item screen developed on clinical and correctional populations, to evaluate substance dependence (alcohol and drugs) in a State inmate population. Items on the screen concentrate on the consequences of alcohol or other substance use rather than on issues of frequency and quantity of use. The utility of UNCOPE was assessed against the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders-IV (SCID-IV). A total of 2097 male and female inmates were tested with UNCOPE. The overall sensitivity of the UNCOPE was found to be 0.91. On the basis of gender, ethnic and educational background, the accuracy of UNCOPE was also found to be high.

Finally, one study (Welsh and McGrain, 2008) used the TCUDS II to predict therapeutic engagement among prison inmates. Participants were already involved in a therapeutic community (TC) drug treatment programme. Assessment of all predictors in the study was based on TCUDS II, the Resident Evaluation of Self and Treatment (REST), Counsellor Rating of Client (CRC) form and the correctional database. The TCUDS II is a screening tool administered at intake to determine the overall level of drug or alcohol dependency of an individual prior to treatment placement and admission. The study demonstrated that the level of inmate's motivation and relevant dimensions of the treatment experience (e.g. peer support,

counsellor rapport) predicted therapeutic engagement. Both offenders with alcohol and drug dependency participated in this study but authors did not make any alcohol-specific points in their findings.

Summary of screening literature

Eleven studies evaluated a wide range of screening tests to identify alcohol misuse in incarcerated populations. Some screening tools proved effective whilst others did not. The screening tools that were identified to be effective were MMPI, TCUDS and AUDIT. MMPI was examined by three studies in this review and in all it was found to produce reliable findings. MMPI-A had good validity for use in juvenile offender settings and two USA studies that applied it with offenders consistently recorded good results. TCUDS II was reported to have good validity and reliability in correctional populations in one study.

AUDIT was also identified to be effective, especially the brief, easy to use AUDIT-C which has been shown to be a reliable tool to detect hazardous drinking in women. However, its reliability with men and young offenders has yet to be fully established. Only one small study evaluated its reliability in males, and no studies have evaluated its reliability and validity in young offenders.

Since this current rapid review was undertaken, two recently published studies have also been identified that examined the potential of AUDIT. The first is a UK based study (Newbury-Birch, Harrison, Brown *et al.*, 2009a) which compared the ability of AUDIT with the Offender Assessment System (OASys) to identify alcohol-related need in probation clients. Forty per cent of probation cases who were classified as either hazardous, harmful or possibly dependant drinkers with AUDIT were not identified by OASys. The authors concluded that 'current methods of identifying offenders with alcohol-related need in probation are flawed and as such many people go undetected' (Newbury-Birch, Harrison, Brown *et al.*, 2009a: 201). The second, Almarri, Oei and Amir (2009) aimed to validate an Arabic translation of AUDIT in Muslim male prisoners in Dubai. Good internal reliability ($\alpha=.91$) and predictive validity were observed in the sample of 107 inmates.

In contrast to the effectiveness of AUDIT, SASSI was found to be ineffective in successfully identifying alcohol misusing offenders. The tendency of SASSI-A to misclassify high number of substance nonusers makes it undesirable for use in incarcerated juveniles. In male inmates (Peters, Greenbaum, Steinberg *et al.*, 2000; Welsh and McGrain, 2008) the performance of SASSI could be deemed as average as compared to the other tools tested.

The UNCOPE, although not extensively used in correctional settings as compared to other screening tools, looks promising in that it is brief and had high predictive values. The ability of UNCOPE to produce high predictive values in different population subgroups makes it potentially attractive to use with a multicultural incarcerated population. Yet more evidence is required in order to make a definitive statement about its effectiveness.

There are a number of factors that impact on the ability to make generalisations from these studies. Firstly, the lack of studies that address alcohol on its own, rather than subsuming alcohol within substance use more generally needs to be noted. The heterogeneous nature of the studies with many different subpopulations and many different tools is also worth noting. This is not particularly unusual within studies on alcohol screening within certain subpopulations (see Parkes, Poole, Salmon *et al.*, 2008, as a comparison) but this complexity makes it difficult, alongside a lack of UK studies, to be comfortable in making definitive statements on the basis of studies reported here.

4.2.3 Literature on interventions

Reviews of alcohol screening or interventions for prisoners with alcohol problems

Fifteen reviews were identified which evaluated interventions (see Appendix 8 for a summary of the reviews). The majority (n=13) were traditional non-systematic literature reviews, with no inclusion or exclusion criteria, or search strategy. Their findings and conclusions should be interpreted with caution. The 15 reviews of interventions either focused on all interventions (n=3), specific interventions such as alcohol brief interventions (ABIs), therapeutic communities and juvenile drug courts, or issues such as the economic benefits, or coercion (see Table 4.3 for further descriptions of interventions). The three reviews which covered all alcohol interventions in the prison section are discussed below and the reviews on specific interventions are discussed in more detail in the relevant sections.

Of the three reviews, only one was systematic and of high quality (Roberts, Hayes, Carlisle *et al.*, 2007). It was an unpublished review, commissioned and funded by Offender Health in the Department of Health, via the Offender Health Research Network. Within the field of substance misuse, alcohol is not often considered separately, so the authors conducted a new systematic review of alcohol treatments in offender populations (which included studies of interventions with people with alcohol and drug problems). They included 24 studies which either had a comparison group or a no-intervention control group, and focused on interventions specifically targeting problem drinkers (as opposed to drug and alcohol interventions) targeted at alcohol problems to reduce.

The authors concluded that, due to the poor methodological quality and heterogeneity of the studies, there was no consistently conclusive evidence for the effectiveness of a single intervention. They did, however, report that there was an evidence base for therapeutic communities. It is important to note that the population in their review was slightly different to this review, in that they included the whole offender population (which included a number of studies focusing on drink-driver offenders), whilst the review being presented here was restricted to the prison population.

The second review (non-systematic) reached similar conclusions to Roberts, Hayes, Carlisle *et al.* (2007) about the quality of studies and evidence of effectiveness, and also commented that there is very limited evidence of effectiveness of alcohol treatment for offenders within prisons in the UK context (Alcohol Concern, 2007).

The third review (non-systematic) of all interventions reported that the evidence is strongest for the effectiveness of therapeutic communities and cognitive-behavioural therapies (McMurrin, 2007). The author also suggested that arrest-referral schemes, court-mandated drug rehabilitation and drug courts can be effective, but improvements in multi-agency working are also necessary.

Another review focused on economic issues for both drug and alcohol misuse interventions (McCollister and French, 2003). The primary finding of this review was that 'avoided' criminal activity was the greatest economic benefit of addiction interventions and contributed more, as a separate outcome domain, to the total economic benefit of addiction interventions than any other outcome domain.

Primary studies evaluating interventions

The search identified 29 relevant reports (of 28 studies) which included a wide range of interventions, study designs, populations and settings (see Appendix 9). In brief, 17 studies were undertaken in North America (Canada or USA), six in the UK, and three in Australasia (Australia or New Zealand). Studies included nine RCTs, seven non-randomised controlled trials (quasi-experimental), five evaluations of projects with no control group, four reports of case studies/pilot studies and three qualitative studies.

The population groups in the reports included young offenders, male and female offenders, offenders with substance use problems (including alcohol), offenders with alcohol abuse problems, and offenders with both mental health and substance use problems. Whilst most of the interventions took place in the prison setting (which was the remit of this review) some studies of offenders in police custody were included if it was thought that they would inform the evidence base (for example around brief interventions).

The interventions in the studies ranged from brief interventions to complex intensive interventions such as therapeutic communities. As could be expected, the intensity of the intervention was usually related to the needs of the population group (e.g. brief interventions were aimed at offenders with hazardous drinking rather than dependence; more intensive interventions were used for inmates with both substance use and mental health problems). For this review, the interventions reported in the studies were grouped into similar categories to those used in the Roberts, Hayes, Carlisle *et al.* (2007) review: *Therapeutic Communities, Psycho-Social-Behavioural interventions, Victim Impact Panels (VIP) and Other interventions*. This enabled comparisons to be made, where appropriate, with their findings. Table 4.3 provides details of how the interventions were grouped.

Table 4.3 Description of categories used to group the interventions²⁵

Category	Types of intervention	Description of intervention
Therapeutic communities interventions	Therapeutic communities	Therapeutic communities are drug-free residential settings where treatment stages reflect increased levels of personal and social responsibility (Smith, Gates & Foxcroft, 2006)
	Modified therapeutic communities (MTC)	MTC model alters the traditional therapeutic community approach by applying three fundamental modifications—increased flexibility, decreased intensity and more individualisation (Sullivan and McKendrick, 2007)
Psycho-Social-Behavioural interventions	Alcohol brief interventions (ABI)	Brief interventions are generally restricted to four or fewer sessions. Each session lasts from a few minutes to 1 hour, and is designed to be conducted by health professionals who do not specialize in addictions treatment. They are most often used with patients who are not alcohol dependent, and the goal may be to promote moderate drinking rather than abstinence. For the purpose of this review, brief interventions include motivational interviewing which is delivered only once or twice to individuals
	Cognitive behavioural counselling or psychological interventions	Interventions that include some aspect of cognitive behavioural therapy, counselling or psychological therapy
	Spiritual interventions	Included meditation and sweat lodges
	Family interventions	Family members receive an intervention, in the form of a family meeting with a facilitator, for example, to improve family interactions
Victim Impact Panels		The panels consist of three or four victims and may also include emergency services personnel (police officer, paramedic, nurse, etc.). Panellists speak briefly about the drunk driving crashes in which they tended to the dead or injured, were injured, or in which a loved one was killed, and what it has meant to them (Wheeler, 2004)
Other interventions	Jail diversion	Diversion from the criminal justice system to community treatment
	Educational interventions	Alcohol education course
	Health promotion interventions	Included exercise classes and health education lectures
	Multi component complex interventions	Which may include a combination of the interventions described above

Therapeutic communities interventions

A Cochrane systematic review evaluated the effectiveness of therapeutic communities for substance related disorder (Smith, Gates and Foxcroft, 2006). The

²⁵ These are the interventions that were identified in the review. Other interventions may be used in the prison setting such as medical interventions but no evidence was identified for these using the review inclusion criteria.

review did not separate out alcohol-related interventions from other substance abuse. The review authors concluded that there is little evidence to show that therapeutic communities offer significant benefits in comparison with other residential treatment, or that one type of therapeutic community is better than another in terms of drug use related outcomes and retention in treatment. Prison therapeutic community may be better than prison on its own or mental health treatment programmes to prevent re-offending post-release for male in-mates. However, the authors state that firm conclusions cannot be drawn due to limitations of the existing evidence.

The search identified two studies (Smiley-McDonald and Leukefeld, 2005; Sullivan and McKendrick, 2007) which were published subsequent to the searches which were undertaken in both the Cochrane review and the Roberts, Hayes, Carlisle *et al.*, (2007) review. Sullivan and McKendrick (2007) undertook a high quality RCT in the USA whereby they randomly assigned male inmates with mental illness and chemical abuse (MICA) disorders (including alcohol) (n=139) to either a modified therapeutic community (MTC) or a comparison group (mental health (MH) treatment programme). An intent-to-treat analysis found better outcomes on all substance use variables for MTC subjects compared to the control group subjects at 12-months post-prison release. The MTC group had a significantly lower likelihood of alcohol or drug use 12-months post-prison release, as compared to a control group. Another article on the same study (Sacks, Sacks, McKendrick *et al.*, 2004) reported on criminal outcomes and found that inmates randomized into the MTC group had significantly lower rates of re-incarceration compared with those in the MH group.

The study by Smiley-McDonald and Leukefeld (2005) was a longitudinal qualitative case study (over 4 years) of offenders with substance misuse issues, involving a process of transformation from a residential treatment setting to a therapeutic community. The findings of the study suggested that an increased sense of community played an integral role in how the therapeutic community evolved without significant resistance. Treatment was perceived differently by the clients as the residential treatment programme evolved into a therapeutic milieu and finally into a therapeutic community. Residents were committed to their treatment when they completed their treatment requirements and demonstrated their community engagement. Rather than resist additional responsibilities and expectations, clients believed that additional structure was a programmatic step in the right direction. The evolution of individual roles within the community was a substantial part of transitioning to a therapeutic community.

The systematic review by Roberts, Hayes, Carlisle *et al.* (2007) included two further studies (Farrell, 2000; Jainchill, Hawke, De Leon *et al.*, 2000) neither of which was identified by the search for this review, nor by the Cochrane review (possibly due to the lack of an alcohol focus although alcohol consumption was reported as an outcome). The study by Jainchill, Hawke, De Leon *et al.* (2000) evaluated the effectiveness of therapeutic communities in reducing substance abuse (including alcohol) and criminal activity in 485 young offenders. Results showed significant reductions in alcohol use to intoxication, regardless of whether the participants fully completed the therapeutic community programme. Roberts and colleagues comment that:

‘Although the authors suggest the results highlight important evidence for the effectiveness of Therapeutic Communities, the lack of any direct comparisons with a control group prevent any conclusions being drawn as to the effectiveness of the therapeutic community.’ (Roberts, Hayes, Carlisle *et al.*, 2007: 93)

Roberts and colleagues’ assessment of the Farrell paper was as follows:

‘Farrell (2000) randomly allocated 36 female participants to either a prison-based therapeutic community (CREST) or a work release control group. No baseline differences were detected between the two groups and there was no loss to follow up. The effectiveness of the therapeutic community was assessed after 18 months on both measures of alcohol use and recidivism. Results showed that participants in the CREST therapeutic community programme were significantly more likely to remain abstinent than those in the control group. However, the CREST therapeutic community programme was not effective at reducing recidivism as there were no significant differences between the two groups. Although this is a high quality study the findings can only be generalised to females.’ (Roberts, Hayes, Carlisle *et al.*, 2007: 94)

Two reviews considered coercion issues for treatments such as therapeutic communities and drug treatments. Whilst both discuss legal and ethical concerns, the review by Hall (1997) concluded that the evidence (primarily from the USA) gives qualified support for some forms of legally coerced drug treatment, provided that these programmes are well resourced, carefully implemented, and their performance is monitored to ensure that they provide a humane and effective alternative to imprisonment.

In summary, there is some evidence to suggest that therapeutic communities may have a positive long-term effect on alcohol-related outcomes for drug offenders, but none of the studies were carried out in the UK so relevance may be limited. In addition, it is not clear whether this type of intervention would be effective or relevant to offenders who only misuse alcohol and not drugs.

Psycho-social-behavioural interventions

The majority of studies identified (n=20) evaluated interventions based on either psychological or behaviour models. These are described in more detail below.

a) Brief alcohol interventions

Ten studies²⁶ evaluated brief interventions of which five were RCTs (Begun, Rose, Lebel *et al.*, 2009; Davis, Baer, Saxon *et al.*, 2003; Ginsburg, 2001; Stein, Colby,

²⁶ Since the review was conducted, one further USA study (Stein, Caviness, Anderson *et al.*, 2010) was identified which evaluated an alcohol brief intervention in women prisoners. The intervention increased abstinent days at 3 months, but this effect was no longer evident at 6 months and participants continued to drink heavily after return to the community.

Barnett *et al.*, 2006; Watt, Shepherd and Newcombe, 2008), three were non-randomised or evaluations (Harper and Hardy, 2000; Hopkins and Sparrow, 2006; Porporino, Robinson, Millson *et al.*, 2002), and two were qualitative studies (Best, Noble, Stark *et al.*, 2002; Deehan, Stark, Marshall *et al.*, 1998). Of all the groups of intervention studies, these were of the highest quality, perhaps due to the brief nature of the intervention which is easier to evaluate than other more complex interventions. It is worth noting that, to determine eligibility for the intervention, the AUDIT screening tool was used in at least two studies (Begun, Rose, Lebel *et al.*, 2009; Watt, Shepherd and Newcombe, 2008). For example, Begun, Rose, Lebel *et al.* (2009) are using AUDIT to screen women and then referring them either to an ABI or to more intensive treatment.

As mentioned previously, the offender population in several of these studies were detainees rather than people in prison. For detainees these interventions were often delivered in police custody. The two qualitative studies both explored the possibility of British forensic medical officers (FMEs) delivering brief alcohol interventions in custody suites and had contrasting results. In the study by Begun, Rose, Lebel *et al.* (2002), 25 FMEs and 15 police officers were interviewed, using semi-structured interviews. The main concerns expressed by FMEs regarding brief alcohol interventions were around role legitimacy, the suitability of the location and the state of the detainee. Several FMEs suggested that all drinkers would benefit from some intervention, especially young binge drinkers, drink drivers and those detained for domestic violence. The earlier study by Deehan, Stark, Marshall *et al.* (1998) surveyed FMEs (n=76) about extending their role to include the routine detection of problem drinking by detainees in police custody. The authors found that the FMEs were not averse to the detection of alcohol misuse; most felt trained to offer advice and to care for the drunken detainee, despite their awareness of the difficulty in getting such detainees to take advice seriously.

Results from one RCT, however, suggest that these interventions, delivered to detainees are not effective. The highest quality study in this review (Watt, Shepherd and Newcombe, 2008) found that no significant between-group differences were observed in any of the alcohol measures or in re-offending after participants received an ABI. However, injury was significantly less likely in offenders who had received the intervention (27.4%) than those who had not (39.6%). In addition, at 3-month follow-up, significantly more participants in the intervention group (31%; n=37) than control group (16%; n=18) demonstrated an increase in their readiness to change drinking behaviour, but this did not persist at 12-month follow-up, similar to findings from ABI's in other settings (Scottish Intercollegiate Guidelines Network, 2003).

Hopkins and Sparrow (2006) described both a process and outcome evaluation of an arrest referral and brief intervention scheme in the UK (Nottingham alcohol arrest referral scheme). The scheme included both assessment and brief intervention. After the needs of the offender had been assessed there were three possible courses of action that could be taken. First, the offender could be given a brief intervention that simply included advice and information as to the health risks of drinking and how to alter their patterns of drinking. Second, the offender may be given a more extended brief intervention where they were referred to see the arrest referral worker on four occasions for counselling and advice. Finally, drinkers with more serious problems

could be referred to another agency such as a hospital, a day unit or other counselling services.

The process evaluation identified four key problems that persisted throughout the project: officers not screening arrestee; staffing problems; refused access to patient; and arrestees denying they had a problem. Evaluation data from the scheme suggested that the number of arrests fell within a sample of 200 detainees after the intervention. A small postal survey with respondents also indicated that the scheme had some impact upon reducing their level of drinking.

Another report evaluated six Arrest Referral Pilot Schemes in the Scottish setting (Birch, Dobbie, Chalmers *et al.*, 2006). In summary, the researchers found that the larger pilots were more able to reach targets in terms of numbers of arrestees seeing an arrest referral worker (ARW). The evidence suggested that the pilots were generating appropriate referrals and also, for the most part, reaching their target groups. However, it proved impossible for the researchers to assess the impact of the pilots on substance misuse and offending.

Four studies evaluated brief interventions (using motivational techniques) in the prison setting. Begun, Rose, Lebel *et al.* (2009) is undertaking an RCT of a brief motivational intervention with women who are in jail. However at the time of writing this review, no further results are available. The researchers are currently beginning a new data collection phase (personal communication, April 2010). Another study evaluated a brief Motivational Interviewing (MI) intervention to reduce alcohol - and marijuana-related driving events among incarcerated adolescents (Stein, Colby, Barnett *et al.*, 2006). Adolescents were randomly assigned to receive MI or Relaxation Training (RT). The MI interventions were about 90 minutes at baseline and about 60 minutes at booster. Follow-up assessment showed that, as compared to RT, adolescents who received MI had lower rates of drinking and driving, and being a passenger in a car with someone who had been drinking. Following further analysis of adolescents with and without depressive symptoms, the authors suggested that it appears that adolescents who score low in depressive symptoms may be responsive to interventions increasing motivation to alter harmful drinking.

Ginsburg (2001), reports a PhD thesis where the information obtained was incomplete. However, it was an RCT of MI intervention aimed at inmates with symptoms of alcohol dependence (duration and intensity of the intervention was not reported) and results suggested that the MI group participants who were in the pre-contemplation stage of change at pretest (i.e. in changing their alcohol behaviour) had significantly greater post-test contemplation scale scores than their control group counterparts.

The only other RCT evaluating brief interventions in the prison setting (Davis, Baer, Saxon *et al.*, 2003), focused on the outcomes of post-incarceration substance use disorders (SUD) treatment contact, rather than alcohol use. Although participants were more likely to have contact with treatment services within 60 days of release, the findings were not statistically significant.

One quasi-experimental study evaluated MI in the probation setting (Harper and Hardy, 2000). The study project undertaken within Middlesex Probation Service

(England) aimed to evaluate the introduction of MI as a technique to aid probation officers in their assessment and supervision of offenders who misuse alcohol and drugs. Results suggest that, irrespective of stratification, all offenders indicated an improvement in their questionnaire scores during their contact with the probation service. However, there were more statistically significant improvements in the attitudinal scales amongst offenders whose officers were trained in the technique.

A pilot cluster randomised controlled trial of alcohol brief interventions is currently underway in England (Newbury-Birch, Bland, Cassidy *et al.*, 2009b) as part of the Screening and Intervention Programme for Sensible drinking (SIPS). Offender Managers are randomly assigned to screen for alcohol use disorders using either FAST or M-SASQ and also randomly assigned to deliver one of three interventions: a client information leaflet control condition; 5 minute simple structured advice; or 20 minute brief lifestyle counselling delivered by an Alcohol Health Worker.

In summary, although this is the area where most studies have been undertaken, there is still not enough evidence, at this time, to determine the effectiveness of ABIs, either delivered to people in police custody or to people who are in the prison setting.

b) Cognitive behavioural, counselling or psychological interventions

Six studies evaluated interventions with a cognitive behavioural, counselling or psychological component, most of which were relatively intensive (Bond, 1998; Calhoun, Stefurak and Johnson, 2005; Huriwai, 2002; Keiley, 2007; Letters and Stathis, 2004; Turley, Thornton, Johnson *et al.*, 2004) . None of the studies were of high quality, and three only describe the intervention rather than provide any evaluation data. Several of the studies target young offenders rather than adults.

Huriwai (2002) describes an intervention in New Zealand which uses an intensive, explicitly cognitive-behavioural, insight and skill development approach. Although the authors say that there is evidence to suggest that the approach taken should lead to a reduction in recidivism, they also say that it is still too early to demonstrate this. Letters and Stathis (2004) describe a programme in Australia which aims to provide young people in detention with the same quality of mental health and substance dependency services that would normally be available to them in the community, including both health promotion and psycho-educational training regarding drugs and alcohol problems. No evaluation of this initiative is reported.

Calhoun, Stefurak and Johnson (2005) describe a relational group therapy model as an example of an approach in treating juvenile, female, substance abuse offenders. This model aims to improve the relational abilities and confidence of young women by equipping them with knowledge, skills and experiences to make more positive choices for their futures. The report continues with details of a gender specific treatment intervention programme - Gaining Insight into Relationships for Lifelong Success (GIRLS) - that has utilised this model, but does not provide evaluation data on alcohol-related outcomes.

Turley, Thornton, Johnson *et al.* (2002) report on a longitudinal (5 year) study of an intensive intervention for adult inmates. Features of the programme are daily

counselling sessions, assigned counsellors and follow-up treatment after release. Follow-up data demonstrate that for up to 1 year after receiving the treatment, three different cohorts (1995, 1998 and 2000) were found to be substantially less likely to be recidivists (people with repeated relapse). Alcohol use was not reported.

Bond (1998) describes the philosophy and development of the Substance Abuse Treatment Programme (SATP) in several UK prisons which is a 12-week treatment programme which includes one-to-one counselling, goal setting, assignments and peer evaluation. Positive drug and alcohol tests dropped from 98% to 8% and disciplinary incidents fell in proportion. Following a 6-month study, Home Office researchers reported a 50% plus successful completion over the first year with more than 50% of those followed-up in the community still abstinent and had not re-offended.

The evidence from these studies does not allow any conclusions to be made as to the effectiveness of counselling and psychological interventions on alcohol-related outcomes.

c) Spiritual interventions

One non-systematic review (Sheehan, 2004) discussed the Twelve Step Facilitation (TSF) which is based in part on spirituality as a motivational basis for change. It identified a number of interventions in the prison setting which appeared to have some evidence of effectiveness (although it was difficult to distinguish between studies that evaluated its effectiveness in drug dependency and those for alcohol dependency). The authors concluded that it is an effective method of treating alcohol and drug dependency. Yet, controversy remains regarding its use with offenders (because of its focus on spirituality). The authors also discussed the importance of post-treatment continuity of care (e.g. once the offenders have left prison). The results of studies suggested extending the benefits of treatment through additional continuing care delivered by professionals and participation in twelve-step self-help/mutual aid groups was associated with better outcomes.

Three studies identified evaluated interventions with some 'spiritual' component (this component was explicitly stated by the authors) and all were delivered in the prison setting (Bowen, Witkiewitz, Dillworth *et al.*, 2006; Gossage, Barton, Foster *et al.*, 2003; Marlatt, Witkiewitz, Dillworth *et al.*, 2004). These included Vipassana meditation (2 studies) and sweat lodges. None of the studies were RCTs so their results should be interpreted with caution. The study using Sweat Lodge Ceremonies (SLC) (traditional/spiritual cleansing ceremonies) (Gossage, Barton, Foster *et al.*, 2003) was implemented in a prison population with a high number of Native American Indians which makes it of little relevance to the UK setting.

The two meditation studies found a positive impact for Vipassana meditation (VM) (Bowen, Witkiewitz, Dillworth *et al.*, 2006; Marlatt, Witkiewitz, Dillworth *et al.*, 2004). Results from Bowen, Witkiewitz, Dillworth *et al.* (2006) indicate that after release from jail, participants in the VM course, as compared with those in a treatment-as-usual control condition group, showed significant reductions in alcohol, marijuana and crack cocaine use. VM participants showed decreases in alcohol-related problems and psychiatric symptoms, as well as increases in positive psychosocial

outcomes. Marlatt, Witkiewitz, Dillworth *et al.* (2004) suggested that Vipassana meditation could play an important role in the reduction of temptations and craving responses.

The results from the three studies should be interpreted with caution due to potential bias in study design. The relevance of the interventions to the UK setting should also be considered.

d) Family interventions

Two USA based studies evaluated family interventions for juvenile offenders or incarcerated adolescents (Dembo, Wothke, Livingston *et al.*, 2002; Keiley, 2007). Dembo, Wothke, Livingston *et al.* (2002) randomly assigned juvenile offenders (who were recruited from a juvenile assessment centre) to either receive a family empowerment intervention (FEI) or an extended service intervention (ESI). FEI families received three one-hour, home based meetings per week for approximately 10 weeks. The aim was to improve family functioning by empowering parents. Follow-up was at 36 months and the authors reported that, although the difference between the FEI and ESI was not significant, the reported frequency of getting high or drunk on alcohol declined more over time for FEI completers than FEI non-completers.

Keiley (2007) describes a non-controlled pilot study of The Multiple-Family Group Intervention (MFGI). In brief, adolescents who were due to be released in two months, were entered into the intervention whereby they and their family members (usually one or more caregivers) met with the facilitators of the intervention for an hour and a half every week to learn a six-step method for altering interactional patterns from an affect regulation and attachment perspective. The 6-month follow-up assessment indicated a recidivism rate of only 44% compared to the national norm of 65-85%.

These interventions show some promise but need further evaluation and to be assessed for relevance in the UK setting.

e) Victim impact panels

There have been several studies assessing the effectiveness of Victim Impact Panels (VIPs), particularly for drink driving offenders. The review by Roberts, Hayes, Carlisle *et al.* (2007) identified six such studies which had mixed evidence of effectiveness on reducing recidivism (i.e. some reported an effect whilst others did not). Most of the studies included were carried out on non-incarcerated populations so fell outside the remit for this current review.

The review identified one good quality USA based RCT which evaluated a 28-day VIP for inmates convicted of drink driving offences (Wheeler, 2004). The author found that there were no significant differences between the two groups on alcohol consumption, drinking and driving behaviour, or recidivism within 2 years.

These findings support the findings of other studies, that VIPs do not produce a differential benefit with regards to recidivism of those convicted as first-time driving under the influence (DUI) alcohol offenders.

f) Other interventions

Five studies look at other interventions which do not fit into any of the categories. These included intensive, multi component interventions (Morehouse and Tobler, 2000; Woodall, Delaney, Kunitz *et al.*, 2007); an education intervention (Crundall and Deacon, 1997) a health promotion intervention (Peterson and Johnstone, 1995); and a drug court intervention (Broner, Mayrl and Landsberg, 2005).

Woodall, Delaney, Kunitz *et al.* (2007) evaluated an intervention designed primarily for Native American Indians (including sweat lodges) so is not useful to discuss it in detail in this report. Morehouse and Tobler (2000) described an evaluation of a Residential Student Assistance Program, serving high-risk, multi-problem, inner-city, primarily African-American and Latino youth. Outcomes included its ability to prevent and decrease alcohol and other drug use. Participants were drawn from several adolescent residential facilities including a non-secure facility for adjudicated juvenile offenders, and a locked county correctional facility. In addition, comparison groups were employed. A 5th-year outcome evaluation documented the programme's effectiveness in both preventing and reducing substance use among participants, with impact related to programme dosage. Qualitative process data clarified and strengthened confidence in the quantitative outcomes.

Crundall and Deacon (1997) used quasi-experimental methods to assess the impact of a prison-based alcohol educational programme. The prisoners that attended the course showed significant improvements on all outcomes (including a reduction in alcohol consumption) when compared with the control group.

Peterson and Johnstone (1995) used a before and after design to evaluate a health-promotion programme, focusing on exercise and health education lectures, integrated with drug rehabilitation in prison. Although alcohol outcomes were not assessed, pre-test and post-test comparisons on a variety of physiological parameters indicated that significant improvements had occurred in the physical fitness of the group. Thematic analysis of qualitative self-reports by inmates exiting the programme suggested that participants had also experienced significant enhancements in a number of areas.

Finally, Broner, Mayrl and Landsberg (2005) examined the effect of jail diversion and treatment for detainees with co-occurring mental illness and drug or alcohol problem. Jail cases that met the inclusion criteria were identified, entitlement application made, and the treatment programme drawn. Cases were then transferred to any of the four non-profit community agencies for post diversion follow-up.

The duties of community agencies included records attainment, treatment planning, medication continuity between jail and the treatment linkage and case management follow-up for two years post detention. The diversion process was referred to as mandated when an agency negotiates diversion and management of offender

directly with the court, and offenders are sanctioned when they do not abide by the conditions of their diversion. When an agency was not involved in any negotiations with the court and offenders were not sanctioned for non-compliance, the process was deemed as non-mandated diversion. Participants in mandated diversion showed greater improvement in days using drugs at 12-months than did those in the comparison group.

These interventions lack a high quality evidence base, and some such as sweat lodges are of limited relevance to the UK setting.

4.3 Discussion

4.3.1 General comments

Several issues need to be considered when interpreting the findings from both the rapid review of screening tools and the rapid review of interventions. Firstly, alcohol problems include a range of drinking behaviours from binge and hazardous drinking to alcohol dependency. Few of the studies, particularly around identifying alcohol problems, evaluated the validity and reliability of a screening tool in its ability to identify (and differentiate) between hazardous and harmful drinking and alcohol dependency, with the exception of AUDIT. Therefore, it is not possible to determine whether there is any single tool which can reliably identify these types of drinking behaviour in offending populations specifically. Therefore, more than one screening tool may be needed.

The lack of clear definition around problem drinking in the studies meant that it was not always possible to determine whether the interventions were aimed at hazardous, harmful or dependent drinking. However, the nature of the intervention usually suggested which type of drinking behaviour was being targeted. For example, brief interventions focused on hazardous drinking and would not be appropriate for alcohol dependency. Other studies which evaluated more intensive interventions such as counselling did not mention the type of drinking patterns of the target population. The most intensive interventions (therapeutic communities) were aimed at alcohol dependent offenders.

A further issue is that alcohol misuse can often coincide with drug use and mental health problems. Alcohol problems were often included under the umbrella of 'substance misuse' in the intervention studies. Therefore, several studies evaluated interventions for people with 'substance abuse' (and sometimes mental health problems) which included alcohol, but the intervention was not specifically targeted to reduce alcohol use. Whilst this is a holistic approach, for the purpose of this review it was difficult to distinguish how such interventions impacted on alcohol specific outcomes. The alcohol brief interventions were the main category of interventions which clearly focused on alcohol-related outcomes.

Overall, there was a lack of studies that included the views of prisoners themselves on the effectiveness of alcohol/substance misuse interventions. This is an important omission particularly in relation to attempting to gain a better understanding of how interventions are experienced, from a user perspective, given the importance now

placed on this dimension within other health settings including within the new recovery agenda.

4.3.2 Screening studies

The review identified 11 studies which evaluated the reliability and/or validity of a range of screening tests in a prison population. Three tests that appear to have good reliability were MMPI, TCUDS and AUDIT. For the juvenile population, the adolescent version of MMPI (MMPI-A) seems to be the most appropriate test to use at this current time, as the other two tests have not been assessed in this population group. However, its reliability and validity in the UK population is not known.

AUDIT is currently being used in the UK for several schemes relating to offenders. For example it is used to screen offenders for inclusion in Alcohol Arrest Referral Schemes (AARS).²⁷ In addition it is the screening tool of choice in a current pilot Scottish study exploring the feasibility and potential effectiveness of alcohol brief interventions (ABI) in the community justice setting²⁸. It is also recommended as a screening tool for probation officers (NOMS Interventions and Substance Abuse Unit, 2008) and in the piloting of a training intervention for Offender Health Trainers (OHTs).²⁹ The Screening and Intervention Programme for Sensible drinking (SIPS)³⁰, commissioned by the Department of Health, has recently validated the Modified Single Alcohol Screening Question (M-SASQ) and Fast Alcohol Screening Test (FAST) (the first four items on AUDIT) in a pilot study with offenders in the Criminal Justice System. The two screening tools were found to be effective and had high predictive values, although FAST was more sensitive than M-SASQ. All of these projects are using the screening tools to identify offenders who might benefit from the delivery of an ABI. The TCUDS II screening test is not currently used in the UK and its reliability and validity in the UK has not been established.

4.3.3 Intervention studies

The review identified 28 studies (29 reports) that used a range of methods to assess the feasibility or effectiveness of interventions to reduce alcohol consumption or other outcomes. However, the evidence base was poor for most of the interventions, which is likely to be a result of the complex nature of the interventions and the diversity of both the setting and the population group. In addition, the review found a lack of UK research, a finding that mirrors the conclusions of McSweeney, Webster, Turnbull *et al.* (2009). Alcohol brief interventions (ABIs) are the interventions which have the highest quality evidence base. However, their effectiveness still remains to be established in this population, although one study found reduction in injuries and increase in readiness to change. One ongoing study which may prove to be useful (Begun, Rose, Lebel *et al.*, 2009) is a large scale USA based RCT (n=1091) of an intervention which includes a brief motivational intervention for female inmates. The researchers use AUDIT to screen the women and then refer them either to an ABI or

²⁷ For example, see Gloucester AARS <http://www.hubcapp.org.uk/B2VC>

²⁸ See <http://www.healthscotland.com/topics/health/alcohol/offendersABIpilot.aspx>

²⁹ Offender Health Trainers Pilot, see <http://www.alcohollearningcentre.org.uk/Topics/Browse/OffenderHealth/Pilot/>

³⁰ <http://www.sips.iop.kcl.ac.uk/index.php>

to more intensive treatment. In addition, the current Scottish ABI Pilot and the SIPS study (Newbury-Birch, Bland, Cassidy *et al.*, 2009b), both set in UK community justice settings and described previously, will provide useful findings when they are completed.

4.4 Key findings

- While no single screening tool was identified as superior with offending populations, three were identified as having good reliability.
- AUDIT looks most promising and is being used in several UK schemes related to offenders but findings from these studies are not yet available.
- More than one screening tool may be required for a diverse population.
- There is some suggestion that timing of screening may be an issue (early screening not as effective).
- The evidence is limited for most interventions: they are complex in nature and settings and populations are diverse.
- There is a lack of published UK studies although there are a number of relevant studies currently in progress which were therefore not able to be reported on here.
- Conflating alcohol and drugs makes it difficult to identify alcohol-related outcomes.
- Therapeutic communities may be effective but only evidence for alcohol use in drug misusers and they are costly and time intensive.
- Alcohol brief interventions (ABIs) are the interventions with highest quality evidence base but effectiveness in this setting is still to be established. New studies are currently underway and are likely to shed more light on this.
- There is some evidence that addiction interventions have an economic benefit for reducing reoffending.

4.5 Key messages

There is a need for more research into

- screening tools that appear most promising in this population e.g. AUDIT
- effective interventions
- the optimum timing for both screening and interventions
- the economic benefits of screening and interventions with prisoners.

5. Assessment of alcohol problems among offenders in an individual prison

This section reports results from a screening exercise undertaken in the case study setting to meet the following objective:

- to undertake an assessment of alcohol problems among offenders within an individual prison using appropriate screening tools to tease out potential sub-groups with differing problems and needs.

5.1 Introduction

As described in Section 2, a male prison was identified which had a high turnover of admitted prisoners, including some young offenders as well as adults, and incorporated short term and long term prisoners as well as remand.

A questionnaire was developed (see Appendix 10) which incorporated the WHO AUDIT standardised screening tool (Babor, Higgins-Biddle, Saunders *et al.*, 2001) and supplementary contextual questions. The AUDIT screening tool has ten questions addressing the following four areas: alcohol intake; abnormal drinking behaviour and alcohol dependence; the link between alcohol consumption and the detection of psychological effect; and alcohol-related problems (see Appendix 2 and other studies using AUDIT reported in Section 4.2.2). In terms of measurement for Question 2, a standard 'drink' was considered to be 8 grammes of pure alcohol; an amount in line with current UK standards and equating 1 unit. In administering the AUDIT, a visual Ready Reckoner was designed to help respondents calculate the units of alcohol consumed, in order to enhance accuracy, and improve the reliability and validity of the information gathered. This provided a list of culturally sensitive drink types, including pictures and units per glass, can and bottle as appropriate.

The research team also added a set of eight supplementary questions to the screen in order to contextualise better the screening results, developed in consultation with the Project Advisory Group and study advisers. The questions were asked after the AUDIT screen was administered to avoid influencing screening results. They enquired into: sentence status, impact of alcohol and substances on the crime, treatment experience, employment, education, marital/family status and age. Showcards were used to enable response choices where these were too detailed for the administered questionnaire (see Appendix 10).

This Screening Questionnaire was administered at the same time as the Scottish Prison Service (SPS) Core Screen/Induction interview. This initial interview is conducted by Links Centre officers who are responsible for the safe and seamless integration of new prisoners into the establishment. The cooperation of prison staff was essential to the smooth running of this aspect of the study and their supportive participation was much appreciated. A 2 hour training session was held with the Links Centre staff together with relevant management and administrative staff. After this training session the officers stated that they were confident in their ability to participate in the study and to screen prisoners for alcohol use/problems.

Screening took place over a period of approximately 12 weeks and included all new prisoners entering the establishment over that period. Prisoners were informed about the aims of the screening, and the study it was part of, and given the choice to participate or not. All respondents were given a leaflet, 'What's in a Drink?'³¹, with prison service information added regarding where prisoners could get help with their drinking, if desired. The prison officers administering the questionnaire were aware of AUDIT score levels indicating moderate/hazardous/harmful and dependent drinking and could highlight current alcohol-related services in the prison for respondents with elevated scores.

Data collation and input was the responsibility of the research team: data was sent to researchers every week by the administrator at the prison site and checked for errors and consistency. Data was then imported into PASW³² and analysis undertaken. In terms of completed screens: 259 screening questionnaires collected between November 2009 and January 2010 were eligible for inclusion in the final analysis.

In this section, socio-demographic details and information regarding sentence status and offence are presented, followed by overall AUDIT scores. Further analysis by key demographics and other factors is then provided. To help maintain confidentiality low values have been suppressed due to the potential risk of disclosure and are indicated with '*' in the tables. Percentages are not calculated where the base is less than 25 respondents.

5.2 Demographic and custody-related information

As shown in Table 5.1 this is a relatively youthful sample, with the majority of respondents under 30 years of age (62%) including 36% less than 25 years old. Mean and median ages were 29 and 27 years respectively.

Table 5.1 Age of respondents

<i>Base: All respondents (259)</i>	%	(no)
18-24 years	36	(94)
25-29 years	26	(67)
30-39 years	25	(64)
40-60 years	13	(34)

Mean (SD) = 29 (8.666); median (IQR) = 27 (11); minimum = 18; maximum = 63

Examination of employment status and education prior to entering prison show strong indicators of deprivation and exclusion (Table 5.2). The vast majority (75%) had been unemployed, although 14% described themselves to be in full-time employment. In addition, a sizeable minority (41%) reported having no educational qualifications when asked to choose from the list provided. A further 42% identified basic qualifications of Standard Grades or NVQs at Foundation or Intermediate levels or equivalents. Only 17% reported having further qualifications such as

³¹ See leaflet at <http://www.alcohol-focus-scotland.org.uk/pdfs/Whats%20in%20a%20Drink.pdf>

³² Predictive Analytics SoftWare Statistics 18 (formerly SPSS)

Highers, Advanced NVQs or equivalents, including 3% with further academic or professional qualifications.

Table 5.2 Socio-economic indicators

<i>Base: All respondents</i>		
¹ <i>Base: 257</i>	%	(no)
² <i>Base: 258</i>		
Employment status before prison¹		
Unemployed / benefits	75	(193)
Full-time employment	14	(35)
Part-time employment	3	(7)
Casual employment	4	(9)
FT education / training	2	(5)
Other	3	(8)
Educational qualifications²		
None of these qualifications	41	(106)
Standard Grade or equivalent	22	(58)
GNVQ / GSVQ Foundation or Intermediate or equivalent	20	(51)
Higher Grade or equivalent	4	(11)
GNVQ / GSVQ Advanced or equivalent	6	(16)
HNC, HND, SVQ Level 4, RSA Advanced Diploma or equivalent	3	(9)
First Degree, Higher Degree, SVQ Level 5 or equivalent / professional qualifications	3	(7)

In reviewing family status, Table 5.3 shows that nearly two-thirds (61%) of this adult male sample described themselves as single, while just over a third were in a cohabiting relationship with the majority of these living with a partner (29%), compared with 3% who were married. In the context of children³³, almost two-thirds (60%) of those who answered described themselves as having children, markedly higher than the proportion currently reporting a co-habiting relationship. In combination, these findings could be taken to further contribute to a picture of men tending to live outside a range of social support mechanisms such as living with partners and parenting. This has implications for successful resettlement, in addition to the poor employment and educational experiences already noted.

³³ The question asked 'number of children?' without defining a maximum age, so answers could have included adult children.

Table 5.3 Relationship and family status

<i>Base: All respondents</i>		
¹ <i>Base: 258</i>	%	(no)
² <i>Base: 247</i>		
³ <i>Base: 191</i>		
Relationships¹		
Single	61	(158)
Living with partner	29	(75)
Married	3	(7)
Divorced	3	(7)
Other	4	(11)
Number of children²		
No children	40	(99)
1 child	28	(70)
2 children	16	(40)
3 children	10	(24)
4+ children	6	(14)
Children expected³		
Expecting a child	15	(28)
None expected	85	(163)

Turning to prison-related information, just over half (53%) of the sample was on remand (Table 5.4). This would mean their length of stay in the prison was uncertain, with some going to court fairly quickly while others might be in the system for several months. Table 5.5 shows that among the 117 sentenced prisoners who provided information, almost a third of sentences (29%) were for less than 6 months, with a further half having sentences of 6 months to two years (51%). There were no marked differences between age and sentence length. As highlighted in Section 6 on mapping prison activities, remand prisoners and those on short sentences have limited access to interventions in prisons.

Table 5.4 Sentence status

<i>Base: All respondents (259)</i>	%	(no)
Sentenced	47	(122)
Remand	53	(137)

Table 5.5 Length of sentence

<i>Base: All sentenced (117)</i>	%	(no)
31 days or under	[-]	(*)
Less than 3 months	5	(6)
3 months - less than 6 months	24	(29)
6 months - less than 2 years	51	(62)
2 years - less than 4 years	11	(13)
4 years or over / Life	[-]	(*)

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

Respondents were also asked, 'What is your current offence?' Responses were then allocated to the classification of crimes and offences in Prison Statistics Scotland (Scottish Government, 2009b; see also Appendix 11). Table 5.6 gives an indication of the types of crimes reported, with crimes of dishonesty (31%), violence (27%) and other crimes (24%) being most prominent amongst total respondents. These figures should be viewed with caution, however, as they are based on verbal reporting noted by the interviewing officers, rather than response to a pre-coded list. A greater proportion of remand prisoners compared with sentenced prisoners reported crimes of violence and a greater proportion of sentenced prisoners compared with remand prisoners reported crimes of dishonesty.

Table 5.6 Respondent 'current offence' categories (only/main category¹)

Categories ²	Total (n=259)		Sentenced (n=122)		Remand (n=137)	
	%	(no)	%	(no)	%	(no)
3. Dishonesty	31	(79)	35	(43)	26	(36)
1. Violence	27	(70)	22	(27)	31	(43)
5. Other crimes	24	(62)	21	(26)	26	(36)
6. Miscellaneous offences	9	(23)	11	(13)	7	(10)
7. Motor vehicle offences	3	(9)	[-]	(*)	[-]	(*)
2. Indecency	[-]	(*)	[-]	(*)	[-]	(*)
4. Fireraising	[-]	(*)	[-]	(*)	0	(0)
No information / no category	5	(12)	[-]	(*)	[-]	(*)

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

¹ Takes the 'highest' category where more than one given; 55 (21%) reported more than 1 category, including 4 who reported more than 2 categories.

² Categories based on the classification of crimes and offences used in Prison Statistics Scotland (Scottish Government 2009b)

Implications for tailoring interventions to address the high turnover of prisoners are brought into focus by 88% of respondents answering 'Yes' to the question 'Have you been in prison before?' (Table 5.7), although the question was not defined in terms of whether their previous prison experience was on remand or sentenced.

Table 5.7 Previous prison experience

Base: All respondents (259)	%	(no)
Yes	88	(228)
No	12	(31)

5.2.1 Comparison with Scottish Prison population as a whole

This sample is younger than the Scottish Prison male population as a whole as sourced from the most recent Statistical Bulletin 2008-09 (Scottish Government, 2009b; see Appendix 12). For example 36% were under 25 years old compared with 28% of males in custody on 30th June, 2008. In addition, sentence length was shorter than for the male population as a whole; for example 32% less than 6 months compared with 8% across the prison population. The majority of remand prisoners

(53%) is comparable to the 57% remand male prisoners among receptions to penal establishments 2008-2009. However, in part comparisons with the overall prison population need to take into account the varied function of different establishments and the clustering of prisoner categories across the estate. Arguably this study sample incorporates important target groups of youthful drinkers, which is of concern in the general population as well.

In addition, the high proportion of those with prior prison experience (88%) resonates with the *Scotland's Choice* report which highlights that:

‘In 2006/07, nearly 7,000 offenders who received a custodial sentence had already accumulated between them 47,500 prior spells in prison. Nearly one in six of these offenders had already been to prison on more than ten previous occasions’ (Scottish Prisons Commission, 2008: 57)

5.3 Links between drinking and crime

Respondents were asked whether they believed alcohol was a factor in the offence for which they were in the prison. Two-fifths of respondents reported that alcohol was a factor (40%) with a further 5% acknowledging they had been drinking at the time (Table 5.8). This is most marked among the 40-64 year olds (56% alcohol a factor) followed by 18-24 year olds (41% alcohol a factor and 5% drinking at the time respectively). Conversely, 30-39 year olds and 25-29 year olds were less likely to feel alcohol was a factor in the crime.

In addition, among those reporting violent crimes (n=70, see Table 5.6) further analysis shows the proportion linking their drinking and the offence was higher than for the total sample: 50% of those reporting violent crime said alcohol was a factor in their offence (compared to 40% in the total sample) together with a further 9% who said they had been drinking at the time (compared to 5% in the total sample).

Table 5.8 Alcohol reported as a factor in offence by age

<i>Base: All respondents</i>	18-24 years (n=94)		25-29 years (n=67)		30-39 years (n=64)		40-64 years (n=34)		Total (n=259)	
	%	(no)	%	(no)	%	(no)	%	(no)	%	(no)
Yes	44	(41)	37	(25)	28	(18)	56	(19)	40	(103)
No, was sober	51	(48)	[-]	(*)	[-]	(*)	[-]	(*)	55	(143)
No, but had been drinking	5	(5)	[-]	(*)	[-]	(*)	[-]	(*)	5	(13)

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

Among those who reported that alcohol was a factor in the offence for which they were in prison, nearly half (49%) of those who responded to a supplementary question (n=90) agreed that drugs were also involved in the offence (Table 5.9). An additional eight respondents who reported drinking at the time, but did not think

alcohol was a factor in the offence, volunteered that they had also taken drugs. This indicates a relatively prevalent influence of mixed substance use.

Table 5.9 Drugs also involved in offence

<i>Base: All who said alcohol was a factor and responded to supplementary question (90)</i>	%	(no)
Yes	49	(44)
No	51	(46)

5.4 Overview of AUDIT scores

Scores from the 10 individual AUDIT questions are summed to give overall scores ranging from 0-40. In interpreting the implications of the scores, it is suggested that 'total scores of 8 or more are recommended as indicators of hazardous and harmful alcohol use, as well as possible alcohol dependence' (Babor, Higgins-Biddle, Saunders *et al.*, 2001). This is refined to give the following guidance:

- Zone I 0-7 represents low risk drinking or abstinence
- Zone II 8-15 represents a medium level of alcohol problem: ('hazardous' drinking)
- Zone III 16-19 represents a high level of alcohol problem: ('harmful' drinking)
- Zone IV 20-40 clearly warrants further diagnostic evaluation for alcohol dependence: ('possibly dependent')

Table 5.10 gives the overall AUDIT score across all respondents. This shows that nearly three quarters of respondents had scores indicating a degree of alcohol problems (73%), with over a third of respondents (36%) having scores in Zone IV indicating possible dependence. The AUDIT scores obtained are broadly similar to others in criminal justice settings (see Section 3.4.1).

Table 5.10 AUDIT score category

<i>Base: All respondents (259)</i>	%	(no)
0-7 Zone I	27	(70)
8-15 Zone II	27	(71)
16-19 Zone III	9	(24)
20-40 Zone IV	36	(94)

Table 5.11 shows that 25 respondents (10%) reported that they were 'currently in treatment'³⁴ in relation to their drinking'. This is equivalent to 27% of those with AUDIT scores of 20+ (possibly dependent) who would be expected to be in treatment. However, if also considering those with AUDIT scores of 16+ (indicating high level of harmful alcohol problems as well as possibly dependent and so also likely to benefit from treatment or support); this would be equivalent to around one fifth (21%) currently in treatment. In addition, responses from those 'in treatment' suggest that for eight respondents the 'treatment' they reported was instigated as a result of this current detention, rather than a sustained community based support.

³⁴ The nature of 'treatment' was not defined in the question.

Seven respondents reported 'prison based detox support' and another respondent mentioned 'Phoenix in Prison'. The remaining 17 respondents (7% of the overall sample) reported attending a range of local alcohol-related agencies, including seven who mentioned local access points for the relevant Area Alcohol Problems Service and one mention of Alcoholics Anonymous.

Table 5.11 Currently in treatment for alcohol problems

<i>Base: All respondents (259)</i>	%	(no)
Yes	10	(25)
No	90	(234)

Overall comparison of AUDIT scores by age groups (Table 5.12) shows notable differences. The proportion of those with Zone IV scores of 20-40 is high among 18-24 year olds (40%) and 40-64 year olds (56%) although it should be noted the latter age band incorporates a smaller number of prisoners. The age band of 30-39 year olds shows a smaller proportion of Zone IV scores (25%) and a high proportion of Zone I drinkers (45% including 18 non-drinkers). It is not possible to infer why; however, these differences may reflect lifestyle changes, for example parenting and partner responsibilities acting as a moderating factor, or a cohort effect of variations in substance misuse behaviour, e.g. greater use of opiates, or they may be more likely to have been previously alcohol dependent.

Table 5.12 AUDIT score by age category

<i>Base: All respondents</i>	18-24 years <i>(n=94)</i>		25-29 years <i>(n=67)</i>		30-39 years <i>(n=64)</i>		40-64 years <i>(n=34)</i>		Total <i>(n=259)</i>	
	%	(no)	%	(no)	%	(no)	%	(no)	%	(no)
0-7 Zone I	17	(16)	27	(18)	45	(29)	21	(7)	27	(70)
8-15 Zone II	32	(30)	[-]	(*)	[-]	(*)	24	(8)	27	(71)
16-19 Zone III	11	(10)	[-]	(*)	[-]	(*)	0	(0)	9	(24)
20-40 Zone IV	40	(38)	31	(21)	25	(16)	56	(19)	36	(94)

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

Examining AUDIT scores by sentence status (Table 5.13) shows that a slightly higher proportion of sentenced prisoners had Zone IV scores than remand prisoners (39% vs. 34%) and a smaller proportion had Zone I scores (21% vs. 32%). Focusing on sentence length (Table 5.14), AUDIT scores tended to be higher among those whose sentences were shorter. Further analysis shows that of the nine respondents with sentences of less than 3 months, five had Zone IV scores. Again, this emphasises the need for alcohol-related interventions to be provided for those with shorter sentences as well as longer term.

Table 5.13 AUDIT score by sentence status

<i>Base: All respondents (259)</i>	Sentenced (n=122)		Remand (n=137)	
	%	(no)	%	(no)
0-7 Zone I	21	(26)	32	(44)
8-15 Zone II	31	(38)	24	(33)
16-19 Zone III	9	(11)	10	(13)
20-40 Zone IV	39	(47)	34	(47)

Table 5.14 Audit score by sentence length

<i>Base: All sentenced (117)</i>	<6 months (n=38)		6 months to <2 years (n=62)		2+ years & Life (n=17)	
	%	(no)	%	(no)	(no)	
0-7 Zone I	13	(5)	23	(14)	(5)	
8-15 Zone II	29	(11)	31	(19)	(7)	
16-19 Zone III	13	(5)	[-]	(*)	(*)	
20-40 Zone IV	45	(17)	[-]	(*)	(*)	

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

Additional analysis shows that over two thirds of the 103 respondents reporting alcohol as a factor in their offence (see Table 5.8 above) had a high AUDIT score (69% Zone IV). Conversely, almost half of the 143 respondents saying they were sober at the time had low AUDIT scores (48% Zone I) with a further third (34%) having scores indicating hazardous rather than harmful/possibly dependent drinking (34% Zone II). Eight of the additional 13 respondents who had been drinking at the time but did not feel it was a factor in the offence had Zone IV AUDIT scores.

Further differences of interest in AUDIT scores by other measures include the following:

- A smaller proportion of those living with a partner had a Zone IV score (24% of 75 respondents, compared with the overall proportion of 36% in Zone IV).
- Of those reporting violent crime offences (n=70), 51% had a Zone IV AUDIT score compared with 36% of the overall sample.

There were no clear differences in AUDIT scores by the following criteria:

- Previous prison experience (however 88% of the overall sample reported being in prison before, making comparison across experiences difficult)
- Employment (however 75% of the overall sample were unemployed, again making comparison across employment limited)
- Educational qualifications.

5.5 Examination of individual AUDIT questions

The AUDIT scores were further examined by the individual questions (Table 5.15) with details of age breakdown given in Appendix 13. Responses to Question 1

shows that 15% of respondents said they never drank. In contrast, for a considerable proportion, drinking was a regular part of their lives, with 21% saying they drank four or more times a week and 21% drank two to three times a week. The proportion of non-drinkers is higher than among Scottish men in the general population; for example in the 2008 Scottish Health Survey (SHeS), 10% said they never drank, with higher proportions of never drinkers in the 65+ age bands which are barely represented in our prison sample (Reid, 2009: 83).

Examination of the 38 non-drinkers' responses to other questions shows that nearly all (n=37) said they had been in prison before. Further examination by age shows that nearly half (n=18) were in the 30-39 year old group (see Table 5.16 and Appendix 13), with a similar number under 30 years old (detail suppressed in table). It is difficult to attribute the reasons for this distribution, although it might be that 30-39 year olds had developed problematic drinking behaviours and decided abstinence was the best approach, as perhaps reflected in their previous prison records.

Table 5.15 AUDIT score by questions (%)

Question	Score (%)					Base*
	0	1	2	3	4	
Q1 – How often drink	15	29	14	21	21	259
Q2 – How many drinks typical day drinking	2	5	5	6	83	221
Q3 – How often 6 units +	10	22	18	30	21	221
Q4 – How often can't stop	49	11	10	13	17	221
Q5 – How often failed expectations	54	16	12	8	10	221
Q6 – How often need drink in morning	69	9	4	5	12	221
Q7 – How often feel guilt or remorse	48	16	15	12	8	221
Q8 – How often can't remember	32	27	16	15	9	221
Q9 – How often injured self or other person	26	-	31	-	43	259
Q10 – How often suggested you cut down	54	-	12	-	33	259
*For Q2-8, base=221 as 38 prisoners were not asked these questions as they reported that they never drink alcohol						
AUDIT SCORES						
Q1	0 = Never 1 = Monthly or less 2 = 2-4 times a month 3 = 2-3 times a week 4 = 4 or more times a week	Q3, 4, 5, 6, 7, 8	0 = Never 1 = Less than monthly 2 = Monthly 3 = Weekly 4 = Daily or almost daily			
Q2	0 = 1 or 2 1 = 3 or 4 2 = 5 or 6 3 = 7, 8 or 9 4 = 10 or more Drink = 1 unit of alcohol (8 grammes)	Q9, 10	0 = No 2 = Yes but not in the last year 4 = Yes, during the last year			

Further examination of drinking behaviour shows that in response to Question 2, drinking a high number of units of alcohol in a session is common among this sample, with 83% saying they would drink 10 or more drinks (units) on a 'typical' day (the current recommendations are that men should not regularly drink more than 3-4 units a day (Department of Health, 1995)). Additional information about 'typical' drink types was gathered following response to Question 2 although not a formal part of the data collection exercise (Appendix 14). Prisoner consumption levels appear much higher than in the male general population. Although not directly comparable,

2008 SHeS figures suggest that 27% of men (16 years and over) in the general population drink over 8 units on their heaviest drinking day of the week (Reid, 2009: 89).

However, in a small study with representation from a variety of social groups, among men 84% (n=38) reported drinking double or over the recommended limits, i.e. 8 units or over, suggesting this sample might not be unusually high (MacAskill, Heim, Eadie *et al.*, 2007). Focusing on how often the sample tended to drink 6 or more units (Question 3), patterns were less polarised, but over half (51%) reported drinking at least weekly, including 21% reporting drinking that amount daily or almost daily.

Positive responses to Questions 4, 5 and 6 imply the presence or incipience of alcohol dependence. Overall, around half the total sample identified with two of the questions (Questions 4 and 5). For example, 51% said they felt they could not stop drinking once started (with around 30% saying this was weekly-daily), and 46% said that they had failed to do what was normally expected from them because of drinking (with 18% saying this was weekly-daily). Around one third reported indications of likely dependency through needing a first drink in the morning to get themselves going after a heavy drinking session (Question 6: 31% with 17% saying this happened weekly-daily).

The remaining Questions (7 to 10) relate to harm from drinking. Reported feelings of guilt or remorse after drinking during the last year were relatively low, with 48% saying they had never felt such feelings, in spite of the high drinking levels reported. However, there were some who acknowledged feelings of guilt or remorse, albeit intermittently (for example, 16% less than monthly and 15% monthly). This has implications in devising interventions to encourage motivation to change behaviour. Around two-thirds (67%) reported being unable to remember what happened the night before because they had been drinking, although again this tended to be intermittent, with 27% saying this was less than monthly and 9% saying it was on a daily or almost daily level.

Interestingly, in this context, 43% said they or someone else had been injured as a result of their drinking during the last year, although the nature of the injury is not defined in the question nor any relationship to violence. A further 31% said that injuries related to their drinking had been experienced in previous years. Finally, nearly half of respondents (54%) said that a relative or friend or a doctor or another health professional had been concerned about their drinking or suggested they cut down, with 33% saying this had happened during the last year and a further 12% saying it had happened in previous years.

Detailed breakdown of response to individual questions by age groups is provided in Appendix 13. Notably in relation to Q1, frequency of having a drink containing alcohol, 18-24 year olds tended to report drinking 2-3 times a week (32%), whilst 40-64 year olds tended to report drinking more frequently than the other three main age groups (43% drinking 4 or more times a week Table 5.16). In contrast, 30-39 year olds tended to report never drinking (28%) or drinking monthly or less (28%).

Table 5.16 Response to AUDIT Q1¹: analysis by age group

<i>Base: All respondents</i>	18-24 years (n=94)		25-29 years (n=67)		30-39 years (n=64)		40-64 years (n=34)		Total (n=259)	
	%	(no)	%	(no)	%	(no)	%	(no)	%	(no)
<u>Q1 Drink frequency</u>										
Never	10	(9)	[-]	(*)	28	(18)	[-]	(*)	15	(38)
Monthly or less	29	(27)	[-]	(*)	28	(18)	[-]	(*)	29	(75)
2-4 times a month	14	(13)	15	(10)	13	(8)	18	(6)	14	(37)
2-3 times a week	32	(30)	13	(9)	13	(8)	24	(8)	21	(55)
4 or more times a week	16	(15)	19	(13)	19	(12)	41	(14)	21	(54)

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

¹Analysis of responses to the other AUDIT questions by age groups is shown in Appendix 13.

5.6 Examination of those with AUDIT Zone IV scores

This section further explores attributes among the 36% of the sample (n=94) who had Zone IV AUDIT scores of 20-40 (see Table 5.10). The mean score of those in the Zone IV category is 29, considerably higher than the cut-off point of 20. As with the overall analysis, notable differences are apparent by age. For example, the mean AUDIT Zone IV score for the youngest respondents (18-24 year olds) is 27 with scores gradually increasing with age to 31 for those in the 40-49 years age band and 34 for those in the 50+ years age band.

Table 5.17 examines individual question responses among the Zone IV drinkers in a similar way to the total sample portrayed above in Table 5.15. Unsurprisingly this shows higher levels of potentially problematic drinking, for example 98% drinking 10 or more units on a typical drinking day, and 91% were drinking 2-3 times a week or more. Importantly, 85% said that they or others had been injured as a result of their drinking in the last year. Interestingly, 83% of those with Zone IV AUDIT scores indicated that it had been suggested by a relative or friend or doctor or another health professional in the last year that they cut down, but 20% said they never felt guilt or remorse.

Table 5.17 AUDIT score by questions: those with Zone IV scores (%)

Question	Score (%)					Base
	0	1	2	3	4	
Q1 – How often drink	0	*	*	36	55	94
Q2 – How many drinks typical day drinking	0	*	*	0	98	94
Q3 – How often 6 units +	0	*	*	44	47	94
Q4 – How often can't stop	12	6	16	26	40	94
Q5 – How often failed expectations	25	16	19	18	22	94
Q6 – How often need drink in morning	40	11	9	13	28	94
Q7 – How often feel guilt or remorse	20	11	22	29	18	94
Q8 – How often can't remember	12	7	28	32	21	94
Q9 – How often injured self or other person	*	-	*	-	85	94
Q10 – How often suggested you cut down	7	-	10	-	83	94
AUDIT SCORES						
Q1	0 = Never	Q3, 4, 5, 6, 7, 8		0 = Never		
	1 = Monthly or less			1 = Less than monthly		
	2 = 2-4 times a month			2 = Monthly		
	3 = 2-3 times a week			3 = Weekly		
	4 = 4 or more times a week			4 = Daily or almost daily		
Q2	0 = 1 or 2	Q9, 10		0 = No		
	1 = 3 or 4			2 = Yes but not in the last year		
	2 = 5 or 6			4 = Yes, during the last year		
	3 = 7, 8 or 9					
	4 = 10 or more					

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

Furthermore, whilst the AUDIT guide suggests that a Zone IV score of 20-40 indicates likelihood of dependent drinking, examination of age breakdown reveals differing patterns of drinking (although there are fairly low numbers in each age band) (Table 5.19). Taking as a start point that nearly all with Zone IV scores (98%) drink heavily on a typical drinking day (10 or more drinks Question 2), older drinkers with Zone IV scores, especially 40-64 year olds, tended to be frequent and dependent drinkers, whereas 18-24 year olds showed less signs of dependency and drank on fewer days in a week (see also Appendix 14). More specifically:

- In the youngest age band (18-24 year olds) the greatest proportion drinks 2-3 times a week (21 of 38 respondents), whereas older respondents were more likely to drink 4 or more times a week, increasing with age to 14 of the 19 40-64 year olds reporting drinking in this way (Question 1).
- Younger respondents were more likely to drink 6+ units on a weekly basis (23 of 38 respondents) compared with respondents 25 years and older, who were more likely to be daily or almost daily drinkers at this level (Question 3).
- Finally, focusing on a key indicator of dependence, the youngest respondents tended not to report needing a drink in the morning after a heavy drinking session, with 22 of 38 respondents saying this never happened, compared with over half of 40-64 year olds (10 of 19 respondents) who experienced this on a daily or almost daily basis (Question 6).

Table 5.19 Zone IV key breakdown: key questions by age

<i>Base: All with Zone IV score (94)</i>	18-24 years <i>(n=38)</i>	25-29 years <i>(n=21)</i>	30-39 years <i>(n=16)</i>	40-64 years <i>(n=19)</i>	Total <i>(n=94)</i>
Q1 Drink frequency					
Monthly or less	*	*	*	0	*
2-4 times a month	*	*	0	*	*
2-3 times a week	21	6	*	*	34
4 or more times a week	14	13	11	14	52
Q3 Drink 6 or more					
Less than monthly	0	*	*	0	*
Monthly	*	*	*	*	*
Weekly	23	*	*	*	41
Daily or almost daily	*	12	*	11	44
Q6 Drink morning					
Never	22	8	*	*	38
Less than monthly	*	*	*	*	10
Monthly	*	*	*	*	8
Weekly	*	*	*	*	12
Daily or almost daily	5	6	5	10	26

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

These findings further inform the need for varied intervention approaches among those who drink heavily to respond to these differing behaviour patterns.

5.7 Discussion

The case study sample is younger and has experienced shorter sentences than the Scottish Prison population as a whole, reflecting the varied functions of different establishments across the estate. Nevertheless, the sample incorporates important target groups of youthful drinkers, also of concern in the wider population, identifying issues for their drinking patterns as well as for older addicted drinkers. In addition, those having repeated and shorter stay 'revolving door' prison experiences are well represented, as well as longer term and older prisoners.

These findings add to current understandings about the value and feasibility of using the AUDIT tool in criminal justice settings (see also Sections 3.4.1 and 4.2.2). The sample showed similarities to the study conducted in HMP Edinburgh (Graham, personal communication 2010); for example, the mean age was 30 years compared to 29 years for this sample. Similar indications of high levels of drinking and possible dependency were shown (AUDIT scores of 20-40 39% for Graham vs. 36% for this study).

Administration of the AUDIT Questionnaire by trained prison officers in the Links Centre was successful, supported by a Drinks Units Ready Reckoner, including collection of additional demographic data.

The screening exercise has highlighted a marked prevalence of high consumption and harmful/hazardous/dependent drinking behaviours amongst men prior to entry into the prison. Importantly it has also highlighted differing drinking patterns among those with high levels of consumption. Notably, differences between younger drinkers who are more likely to drink on a few days a week, and older drinkers who are likely to drink nearly every day were identified, indicating more habitual and addictive behaviours among the latter group (18-24 and 40-64 years respectively).

Drinking alcohol was associated with the index crime, with two-fifths (40%) of respondents believing alcohol was a factor and a further 5% reporting drinking at the time, in particular older and younger prisoners (40-64 and 18-24 year olds). A higher proportion of those reporting violent crimes recognised alcohol as a factor (50%). Whilst it would be simplistic to identify alcohol as the only factor in these crimes, the data add to the argument for addressing alcohol issues in the criminal justice setting.

The data provide indications of disparity between the high levels of harmful/hazardous/dependent drinking identified and low levels of engagement with 'treatment' in this study population. Just over a quarter of those with AUDIT scores of 20+ (possibly dependent: 25 respondents) reported being 'in treatment for their drinking'. However, interpretation of 'treatment' varies, for example seven of those respondents appeared to be responding in relation to immediate detox treatment rather than ongoing work with alcohol issues. In addition, those with AUDIT scores below 20, but indicating high levels of alcohol problems, would arguably also benefit from treatment or support. This is further explored in the following mapping section (Section 6) and is evident across the prison estate.

The challenging gap between prevalence and the present levels of service provision and access to alcohol interventions within prisons is reflected in data from the annual SPS survey data (see Section 3 Table 3.3: 2009 data³⁵). In the context of high prevalence of reported alcohol problems, over one third of prisoners said they would take help for alcohol problems in prison (39%) and outside prison (36%), if offered. Almost one third (31%) of prisoners said they had been assessed for alcohol use on admission to prison, and a similar proportion (31%) said they had been given a chance to receive treatment during their sentence, although only one fifth (19%) said they *had* received help/treatment for alcohol problems during their sentence.

The screening exercise has also highlighted indicators of disadvantage and social exclusion, with a high proportion of men without employment, with limited educational achievements and living alone. For example, lack of social support has major implications on successful resettlement and desistance from offending (Loucks, 2004), although it may be difficult to know whether less problematic drinkers are more likely to attract and retain a partner, or whether they drink less because they have a partner or children. In addition high levels of literacy problems can have an impact on access to services (see Section 7).

³⁵ Scottish Prison Service 2009 annual Prison Survey data provided by SES in 2010. See also: <http://www.sps.gov.uk/default.aspx?documentid=21190703-e7b4-4abc-bc83-44b5d0f06f69>

5.8 Key findings

- This was a predominantly young population with a high prevalence of exclusion factors, in particular: unemployment, low education achievement and not being in a relationship.
- Many were on remand or short sentences.
- Over 1 in 4 reported their current offence to be a violent crime and four fifths had been in prison before.
- Alcohol was self-reported to be a factor in the offence in 40% of cases (50% for violent crime) and, of these, nearly half of those giving further information said drugs were involved as well.
- 73% of prisoners had AUDIT scores of 8+ indicating a degree of alcohol problems, with 36% of these possibly dependent (20+ AUDIT score).
- The highest proportion of 20+ AUDIT scores were in 18-24 and 40-64 age groups, but those in middle age drank more often and were more likely to score higher in dependency focussed questions, such as needing a first drink in the morning to get going after a heavy drinking session.
- Higher AUDIT scores were notable among those with shorter sentences (less than 6 months).
- In addition to those who demonstrated AUDIT scores indicating possible dependence (20+), a further 37% showed scores above the threshold for concern (8-19).

5.9 Key messages

- Need for a range of alcohol interventions and to tailor alcohol interventions to address the needs related to differing drinking behaviours and levels of dependency, which are also largely correlated to age groups.
- Need to respond to different sentence lengths, the short turnaround for many prisoners and high numbers of repeat offenders.
- Younger drinkers tend to show less signs of dependency, in spite of high consumption, and so may be less likely to identify that their drinking as a problem and may be more likely to be missed.
- Need to consider the interaction between drinking and drug use in interventions designed to modify substance use-related behaviour and prevent reoffending and specifically links with violent crime.
- High levels of disadvantage and social exclusion have implications on successful desistance and holistic approaches and interventions that address such broader social and contextual issues are required.

6. Mapping

6.1 Introduction

This section presents the findings of a mapping of the current range of alcohol interventions across the Scottish prison estate and the community interface. Further, an overview of key issues relating to treatment continuity and best practice is given. The objectives for this stage of the study were threefold:

- to map current models of care in the Scottish prison estate and how they interface with community care models e.g. scoping of existing care pathway(s)
- to assess aspects of treatment continuity with that previously received in the community prior to admission, that received in prison and that planned for the community on release
- to identify examples of best practice through the mapping fieldwork.

The findings presented in this section are based on interviews undertaken with key informant stakeholders and staff members involved in alcohol service delivery in each of the 16 prisons in the Scottish prison estate, as detailed below. The interviews followed the same schedule in public and private sector prisons. The findings are supplemented by data provided by SPS and by individual prisons.

6.1.1 Key informant scoping interviews

Eleven key informant stakeholders were identified who were able to speak to current issues across the whole prison estate from a national perspective, the community interface aspect, or who had key insights into particular aspects of the research questions. Four face-to-face interviews (seven respondents) and four telephone interviews were held to inform the service mapping and case study work. These were undertaken using a semi-structured format and following an interview schedule devised with input from the Project Advisory Group. These interviews were designed to inform the whole research study and centrally informed both the approaches used and analyses throughout. They were audio recorded and transcribed in full.

6.1.2 Detailed estate mapping

Fifteen³⁶ structured interviews were undertaken with relevant staff member(s) in each prison across the Scottish prison estate concerning the alcohol-related activity in each site: 14 were telephone interviews and one was face-to-face (see Appendix 16 for the mapping interview topic guide). Some interviews involved more than one person, making a total of 18 respondents. These were on average 45 minutes in length and were transcribed in full. Staff members interviewed were those who had been identified by the Scottish Prison Service (SPS) as best able to provide accurate and relevant information on the provision of alcohol interventions, such as Addictions Co-ordinators, Health Centre Managers, Enhanced Addiction Casework Service

³⁶ 15 interviews were conducted (rather than 16) since one respondent had responsibility for service provision for both open estate prisons.

(EACS) staff³⁷, Clinical Managers, Addictions and Practitioner Nurses. Interviews aimed to assess aspects of treatment continuity across prisoner ‘journeys’ before, during and after sentence, and the prison/community interface. Prison staff were also asked for any supporting documentation relevant to the research brief (e.g. uptake of alcohol interventions, settings and service providers, relevant policies).

Interview respondents from each prison also reviewed and verified the information about the key alcohol interventions in their establishment (as outlined in the matrix provided in Appendix 17). It should be noted that variations in service provision across the prison estate are, in part, a reflection of differing prison populations and their associated needs. The average daily population in individual prisons, for example, ranged from less than 151 to 1555 in 2008-09 (Scottish Government 2009b). Moreover, the population characteristics within each prison vary according to which combination of remand, short term, long term, sex offenders, female or young offenders it accommodates. Within the prison estate, there are also two open prisons and two private prisons.

Whilst this study focuses on alcohol misuse, it should be mentioned that prisoners may misuse other substances outside and inside prison. Similarly, interventions and services may take account of wider substance misuse rather than focus on alcohol alone.

6.2 Responsibility for delivering alcohol interventions

A range of alcohol interventions exists across the prison estate, namely clinical support in relation to detoxification and relapse prevention, one-to-one support and group work to help offenders address their alcohol use, pre-release support and through care. The key personnel responsible for delivering alcohol interventions and through care are prison healthcare staff (e.g. Doctors, Addictions Nurses), SPS Programmes Officers, Psychologists, Enhanced Addiction Casework Service (EACS) staff, community-based agencies (e.g. Alcoholics Anonymous), and through care Addictions Service (TAS) staff. Offender Outcomes Managers, Addiction Coordinators, Interventions Managers or in some prisons more senior managers, oversee delivery of interventions, although this varies from prison to prison as there is no blanket approach. Strategic planning is carried out by senior management teams in conjunction with central input from SPS Headquarters Prisons Directorate although it is noteworthy that there is no individual staff member with the sole remit to undertake the strategic management of alcohol interventions.

6.3 Alcohol interventions in prisons

An overview of key elements of provision across Scotland is given in Appendix 17. Further detail about these aspects of provision is given below, following an overview of assessment and referral processes.

³⁷ Phoenix Futures are contracted by the SPS to provide an Enhanced Addictions Casework Service (EACS) for prisoners with drug and alcohol problems in public sector prisons.

6.3.1 Assessment and referral processes

On admission to prison there are two key assessment processes whereby prisoner alcohol problems may be detected: healthcare assessment and Core Screening. As part of the reception process on the day of admission to prison, all prisoners are given an initial healthcare assessment by a Practitioner Nurse and are seen by a doctor within 24-hours of admission. This assessment process is required by SPS Health Care Standard 1 (*Health Assessment on Admission into Prison from Community*, SPS, 2010c). During initial healthcare assessment, prisoners are asked briefly about their alcohol use and whether they consider themselves to have an alcohol problem. If an alcohol problem is identified, prisoners can be referred to an Addictions Nurse for a more detailed assessment. There is no unified assessment screening tool for alcohol problems used by Addictions Nurses across the prison estate; assessment procedures are limited and have typically been developed in-house by addictions staff.

Within 72 hours of being admitted to prison, a Core Screening is carried out by Prison Officers with every prisoner. The Core Screen forms the basis of a broad needs assessment, which covers a wide range of issues (e.g. finance, employment) and as such, it also includes a question about whether prisoners have an alcohol problem. The Core Screen forms part of the Integrated Case Management process (ICM), which integrates all aspects of sentence management for individual prisoners, from initial admission through to liberation.

If a prisoner is identified as having an alcohol problem and consents to be referred for help to address this during the Core Screening process, a referral can be made via the PR2 electronic prison information system to the EACS, provided that they meet EACS criteria as detailed below. If a prisoner is referred to EACS regarding an alcohol problem, a more specialised ICM Substance Misuse Assessment will be carried out within 5 days as part of the Integrated Case Management process. Prisoners can also self-refer to the EACS or they can be referred by healthcare or prison staff, if they are fully committed or convicted and serving a sentence over 31 days. Prisoners can also be referred to the TAS although this service is not available to prisoners who are serving a sentence of 31 days or under unless they are a female prisoner, a young offender (under 21 years), or considered to be vulnerable. For prisoners serving a sentence of 31 days or less, a voluntary throughcare referral can be made to social work.

Referrals to SPS programmes or other interventions (e.g. EACS) are made in a variety of ways, in particular through the ICM process, although prisoners can also self-refer to a programme or be referred via healthcare staff or Prison Officers following completion of the Core Screen. Prior to being admitted to a prisons programme, prisoners would be assessed by Programmes Officers and other staff to ensure that their participation in a particular programme was appropriate. For an overview of the SPS integrated addictions assessment and referral process, see Appendix 18.

Reflecting upon the effectiveness of assessment processes, the identification of alcohol problems amongst prisoners and subsequent referral to appropriate alcohol interventions was also considered to be hampered by prisoners' own lack of

recognition or admission that they have an alcohol problem. Even in cases where a prisoner may have identified that he/she had an alcohol problem prior to admission to prison, or where alcohol was involved in their offence, they may not consider themselves to have an alcohol problem, partly because they may perceive their behaviour as non-problematic and they are unlikely to be drinking when asked (alcohol is prohibited in prisons).

It may also be the case that the prisoner does not regard their drinking as a priority issue at the point of admission to prison, although it may emerge as an issue at a later date. Younger prisoners in particular were reported to be less likely to see their alcohol use as problematic, although some disclosed high levels of alcohol consumption. Some respondents reflected that the normalised culture of drinking within society at a broader level contributes to the lack of recognition amongst younger prisoners that they may be drinking in a problematic way.

The prison induction process includes an EACS Overdose Awareness Session (previously termed the National Harm Reduction Session) which briefly highlights interventions available so that prisoners who attend the induction have the opportunity to be introduced to programmes and services interventions, without having identified that they have a specific problem. Further, this session is also a first contact opportunity between prisoners and EACS staff. The overdose awareness session is primarily focused on opiate overdose and risks. As such, alcohol is only mentioned in terms of contributing to drug-related overdose in polydrug use.

Finally, although the main needs assessments are undertaken when a prisoner is initially admitted to a prison, prisoners can also refer themselves, or be referred, to alcohol interventions further into their sentence. This could include reviews undertaken as part of the Enhanced ICM process for longer-term prisoners serving sentences of four years or more.

6.3.2 Health care and clinical support interventions

On admission, prisoners experiencing alcohol withdrawal can access detoxification support in all prison Health Centres. Clinical detoxification support will be prescribed by the medical officer (doctor), although need for a prescription may have been identified by nursing staff. Detoxification support is provided through the prescription of Diazepam (Valium) and Chlordiazepoxide (Librium), on a reducing schedule. The timescales reported for the detoxification process ranged from 6 to 18 days across different prisons. Thiamine (Vitamin B1) may be prescribed alongside to prevent the consequences of malnutrition. Guidance on prescribing for clinical management of drug and alcohol dependence is outlined in SPS Health Care Standard 10 (SPS, 2010d).

In preparation for release, prisoners can be prescribed Disulfiram (Antabuse) or Acamprosate (Campral) to help them abstain from drinking following liberation. However, two prisons commented that Antabuse was less suitable for younger prisoners since they were more likely to continue drinking on top of this medication. For this group of prisoners, reducing alcohol consumption was considered to be more realistic goal than abstinence.

Table 6.1 reports the alcohol-related prescribing across the Scottish Prison estate between 2007-2009. It should be noted that prescribing data for Diazepam has been excluded from Table 6.1 since it was not possible to separate prescribing for alcohol detoxification from prescribing for other substance dependency.

Table 6.1 Alcohol-related prescribing across Scottish Prisons 2007-09

Medication	2007-08	2008-09
Acamprosate tablets	4,399	1,931
Antabuse / Disulfiram tablets	1034	1262
Benerva / Thiamine HCl tablets	125,239	134,673
Thiamine compound tablets	21	
Campral EC tablets		666
Chlordiazepoxide / Librium capsules	36,858	300
Chlordiazepoxide HCl tablets	100	600
Chlordiazepoxide tablets	13,053	44,665

Source: SPS

As detailed in Table 6.1 there is a notable variation in prescribing levels between 2007-08 and 2008-09. The reasons for this variation are not entirely clear, although it may be partially explained by changes in prescribing practices. There is no national prescribing formulary in Scotland as NHS Boards each have their own. However SPS have adopted one formulary to ensure a consistent approach to prescribing. Chlordiazepoxide tablets are generally prescribed rather than capsules due to misuse issues.

Addictions Nurses play an important role in service delivery from assessment of alcohol problems, delivery of clinical support, and referral to other appropriate interventions (e.g. EACS). Where resources and time allowed, Addictions Nurses provided one-to-one support for prisoners, particularly those who were not eligible for EACS, due to being a remand prisoner or serving a sentence of 31 days or less. However, the capacity of Addictions Nurses to provide this type of support varied across different establishments. Data supplied by SPS for the mapping study identified 30.5 Addictions Nurses in post (excluding the private prisons). Apart from two prisons reported to have no Addictions Nurses in post, numbers varied from one to eight post-holders, in part reflecting variations in size and prisoner needs in different prison populations in individual establishments. Overall numbers are slightly lower than reported in the earlier health care needs assessment in Scottish Prisons (34.4 Addictions Nurses) and at that time one prison did not have an Addictions Nurse (Graham, 2007).

In considering capacity, it should be noted that Addictions Nurses, as multi-skilled Practitioner Nurses within Primary Care, may also be called upon to assist with prisoner health care in a general capacity and address other wide and varied needs. The extent of prior experience in addictions issues may also vary among Addictions Nurses, although all will meet required competencies for Practitioner Nurses (NHS Education for Scotland, 2005).

6.3.3 SPS programmes

The SPS delivers a range of programmes to address offending behaviour and life skills.

The Alcohol Awareness (AA) Programme and the Substance Related Offending Behaviour Programme (SROBP) were the key interventions relating to alcohol, as reported by interview respondents. They differ markedly in targeting and intensity. However, it is acknowledged that alcohol issues may feature indirectly in the broader range of programmes which are designed to allow participants to address individual areas of need, recognising that prisoners have complex and multi-faceted needs. A full breakdown of SPS substance-related programmes is detailed in Appendix 19.

SPS Alcohol Awareness Programme

SPS Programmes Officers deliver an eight session (22 hour) Alcohol Awareness groupwork programme. The main aims of this programme are to look at the harmful physical and social effects of alcohol use and allow participants to explore their own alcohol use including problematic drinking patterns and related behaviour. Participants are also introduced to the throughcare process and sources of further support.

This programme was initially developed in HMP Edinburgh, although it has now been given approved status by SPS and is currently provided in 11 establishments. There is some variation in the way that this programme is delivered. Most prisons, for example, deliver these groupwork sessions over an eight week period although two prisons reported delivering it as a more condensed programme, over the course of two to three weeks. While it was not possible to evaluate the impact of delivering the programme in a condensed format, doing so could make the programme more accessible to prisoners serving short sentences. Up to 12 prisoners will attend this group at any one time, and the development of peer support was recognised as a positive aspect of this groupwork.

Substance Related Offending Behaviour Programme (SROBP)

The SROBP programme is currently going through the SPS accreditation process and runs in nine³⁸ of the larger prisons within the SPS estate. This programme is delivered by SPS-employed psychologists and Programme Officers using a Cognitive Behavioural approach. SROBP is designed for medium, high and very high risk offenders to address their drug- or alcohol-related offending. A broad range of issues are addressed, including self-esteem, motivation, relationships, victim empathy and lifestyle modification. The rolling programme of 70 to 140 hours comprises essential and optional modules. Programme participants must complete essential modules (Life History, Behaviour Analysis, Moving to the Future and

³⁸ One prison introduced this programme in August 2009 and another introduced it in March 2010 after the collation of the 2008/09 SPS programme delivery figures for 1st April 2008 – 31st March 2009 detailed in Appendix 17.

Managing the Future), while further optional modules are undertaken by individual prisoners as determined by their treatment plan within the ICM process.

This modular approach was described by interview respondents as beneficial in terms of meeting the needs of individual prisoners. Since the SROBP operates on a rolling basis throughout the year, there is scope for flexibility in the way that prisoners access this programme. That said, individual prisons estimated that the programme took between 3 and 6 months to complete depending on how many modules are undertaken, making it more appropriate for prisoners serving at least a 6 month sentence. There was a perception amongst some prison staff that this programme was mainly accessed by prisoners who had drug misuse problems rather than alcohol issues alone, although it is acknowledged that some prisoners have both drug and alcohol issues, as well as other issues. Substantiating this level of detail about the uptake of this programme was not possible.

Anecdotally, prison staff respondents described the completion rates for alcohol-related programmes to be good, in part reflecting the rigorous screening process. Nonetheless, the numbers of prisoners completing programmes is low given that the number of receptions into prison³⁹ reached over 39,000 in 2008/09 (Scottish Government, 2009b). Over the same period, 269 prisoners completed the SPS AA Programme and 78 prisoners completed the SROBP, as indicated in Table 6.2. It should be noted that although alcohol problems are prevalent within the prison population, not all prisoners would have the need to attend such programmes and some groups of prisoner would not be eligible to attend these programmes (e.g. remand prisoners or those with very short sentences).

The figures for SROBP are much increased in 2008-09 because this is a relatively new programme with only two prisons offering it the previous year. No accounts were given in either the mapping or strategic interviews for the drop-off in numbers of prisoners accessing/completing the SPS AA Programme. One possibility is that because the SROBP is resource-intensive (noted in conversations with prison staff) this impacts on the ability of prisons to run both programmes successfully.

³⁹ Prison receptions provide an indication of flows through the prison service but they are not equivalent to persons received, since persons could be counted more than once (e.g. if they received custodial sentences at different times in the year).

Table 6.2 SPS alcohol-related programme data 1st April 2007 - 31st March 2009

Prison	SPS Alcohol Awareness (AA) Programme		Substance Related Offending Behaviour Programme (SROBP)	
	2007-08	2008-09	2007-08	2008-09
Aberdeen	35	45	8	15
Barlinnie	25	25*		16
Cornton Vale	18	16		8
Dumfries				
Edinburgh	47	18		8
Glenochil	19	18		8
Greenock	52	44		
Inverness	11	34		
Kilmarnock	59	63		
Open Estate				
Perth	49	36		
Peterhead	39	30		
Polmont	60	28		8
Shotts	47		8	15
TOTAL	461	357	16	78

Main source: The Scottish Prison Service (SPS)

* Data provided by prison.

6.3.4 Enhanced Addictions Casework Service (EACS)

Phoenix Futures are contracted by the SPS to provide an Enhanced Addictions Casework Service for prisoners with drug and alcohol problems in public sector prisons. This service is provided across all 14 SPS establishments⁴⁰. Phoenix Futures are not contracted to work in private prisons, although both private prisons are contracted to provide equivalent services to those provided by Phoenix. The EACS forms part of the ICM process, and EACS staff liaise and work in partnership with other services provided in prisons, including the provision of case reports for relevant prisoners (e.g. for case management and parole or pre-release meetings).

In addition to conducting ICM Substance Misuse Specialist Assessments, harm reduction advice, alcohol awareness group sessions (not to be confused with the SPS Alcohol Awareness Programme), one-to-one motivational interviewing support and pre-release groupwork is provided through EACS. The aim of these interventions is to inform prisoners of the health and social effects of drinking, including the links between alcohol and offending behaviour. Relapse prevention and associated coping strategies are also addressed. A two hour Alcohol Awareness session is offered, which addresses issues such as the physical and behavioural effects of alcohol and includes an interactive element prompting prisoners to calculate their own alcohol unit intake. This session is regarded as a precursor to the more in-depth programmes provided by SPS Programmes Officers.

⁴⁰ This includes both facilities in the Open Estate.

The focus of the structured one-to-one motivational interviewing sessions provided by EACS is to explore how drinking is affecting their lives and to try to motivate prisoners to address their alcohol use. The one-to-one support provided by EACS was described as being open-ended rather than time limited, and based on prisoner need. Variation in the frequency of support sessions was reported, according to the individual needs of prisoners, and varied from weekly to monthly support. This flexible approach was described as being best suited to the fluctuating needs of prisoners. In preparation for prisoner release, EACS provide an input into pre-release groups. Referrals can also be made from EACS to other relevant services in the prison or the community.

As with other prison-based interventions, the majority of the work undertaken by EACS relates to drug rather than alcohol issues, although the number of alcohol-focused interventions provided increased between 2007-08 and 2008-09, as indicated in Table 6.3. Further, alcohol issues may emerge over time, including when prisoners may be working on other substance-related problems. The number of ICM specialist assessments completed specifically for alcohol increased by 12% over this period, while the number of prisoners attending an initial one-to-one session and alcohol awareness groupwork increased by 15% and 23% respectively. The number of motivational interview sessions provided increased by 34%, although it should be noted that it is not possible to ascertain whether this reflects an increase in the number of prisoners attending these sessions.

Table 6.3 EACS alcohol intervention data 1st April 2007- 31st March 2009

Prison	ICM specialist Assessment completed for alcohol		No. of prisoners attending initial alcohol contact (one-to-one session)		No. of prisoners attending alcohol groupwork (EACS Alcohol Awareness session)		Motivational interviewing for alcohol (Number of sessions)	
	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09
Aberdeen	39	33	8	16	3	22	17	53
Barlinnie	241	275	49	14	101	157	200	245
Cornton Vale	60	76	19	59	58	68	94	139
Dumfries	69	76	44	20	104	104	157	229
Edinburgh	81	132	9	46	46	112	78	134
Glenochil	59	68	4	2	167	90	56	53
Greenock	110	116	13	0	27	65	428	271
Inverness	81	103	29	21	42	78	173	183
Low Moss*	3	-	0	-	0	-	7	-
Open Estate	44	84	29	67	33	92	166	299
Perth	70	82	4	19	58	59	94	108
Peterhead**	44	58	41	88	17	93	44	236
Polmont	332	288	138	97	306	251	620	922
Shotts	9	4	4	2	9	10	9	1
Total	1242	1395	391	451	971	1201	2143	2873

*HMP Low Moss closed in May 2007

**HMP Peterhead commenced EACS in December 2007

Note: Equivalent services are provided in the two 2 Scottish private prisons, although data for these establishments was not available.

Source: SPS

Setting the alcohol specific work carried out by EACS in the context of their broader substance misuse work, in 2008-09, 4596 ICM Substance Misuse Assessments were undertaken, of which 30% (1395) are identified as relating to alcohol (Table 6.4). Over the same period, 10,424 one-to-one motivational support sessions were delivered, of which 28% (2873) focused on alcohol. As a proportion of all substance misuse assessments and sessions, this represents an increase of 3% and 10% respectively from the previous year, as highlighted in Table 6.4.

Table 6.4 EACS intervention data 1st April 2007 - 31st March 2009

	ICM assessment completed for all substances	ICM Assessment completed for alcohol		Motivational interviewing for all substances (Number of sessions)	Motivational interviewing for alcohol (Number of sessions)	
	No	No	(%)	No	No	(%)
2007-2008	4523	1242	(27)	12040	2143	(18)
2008-2009	4596	1395	(30)	10424	2873	(28)

Source: SPS

6.3.5 Interventions provided by community-based agencies

Alcoholics Anonymous (AA)⁴¹ runs a weekly, or in some instances a twice-weekly, group work session in all but two establishments⁴². This service operates on a voluntary basis and prisoners can self-refer to this service, although they may be signposted to the group by prison staff. The numbers attending this group across different prisons were reported to be between 6 and 15 per prison. Attendance at the group is voluntary and any prisoner can access the group. The provision of a service where prisoners could speak to their peers and non-prison staff about alcohol-related issues was considered by prison staff respondents to be a key benefit of the groups run by AA. However, these groups were thought to have less appeal to younger prisoners, who were described by staff as being less likely to associate their own drinking patterns with 'alcoholism'.

Other than group work provided by AA, relatively few external agencies provide a regular alcohol-focused service within prisons, although events such as health promotion days and alcohol awareness week act as a stimulus for workers in community-based agencies to come into prisons to raise awareness of alcohol-related issues and the availability of services within the community. Having more external support services coming into prisons to work with prisoners prior to release was identified as an area which could be developed. This would allow prisoners to establish a relationship with a community service prior to release and increase the likelihood that prisoners might engage with that service on release from prison.

6.4 Treatment continuity

In this context, treatment continuity refers to three key processes: admission to prison, transfer between prisons and liberation from prison.

6.4.1 Admission to prison

Following admission to prison, staff are largely dependent upon prisoners informing them of any external services they were accessing prior to admission to prison. The main links described with community services related to external prescribers for alcohol as well as drugs. Beyond communication with external prescribers, links with other community-based services were variable, although good practice was described by prison staff in this regard (e.g. prisons notifying external agencies, with the prisoner's prior permission, that an individual was in their custody, so that they did not lose future access to the services available due to not taking up appointments).

6.4.2 Transfer between prisons

SPS Health Care Standard 5 requires the health care of prisoners to be maintained throughout the transfer to other prisons and on liberation (SPS, 2010e). Continuity of

⁴¹ AA cannot be truly anonymous in prison.

⁴² In one prison where AA groupwork was not available, prisoners were able to access one-to-one support from AA if they had prior support in the community. In the other prison, there was capacity to restart AA sessions if required by demand.

treatment and service provision is incorporated in the decision making process about transferring prisoners to another SPS establishment. For example, if a prisoner was attending a programme then allowing the prisoner to complete this programme would be prioritised within the transfer process. Ensuring continuity of care is assisted by the maintenance of electronic prisoner records on the PR2 information system detailing the programmes and support being accessed by individual prisoners, including EACS. Paper-based healthcare records are also transferred between prisons to assist continuity of clinical treatment.

6.4.3 Liberation from prison

Continuity of support for alcohol problems when a prisoner is released from prison was recognised as particularly important given that this is a period when the risk of relapse is heightened. The ICM process was described as important in facilitating continuity of care upon release via Community Integration Plans (CIPs) prepared for each prisoner accessing TAS prior to release.

Key community agencies providing support for offenders with alcohol problems include social work, NHS addictions services, GP practices, substance misuse teams and voluntary agencies. Some prisons described having good relationships with external agencies and prescribers, although the links with and availability of community services varied in accordance with geographical areas. One prison, for example, described having constant communication with external prescribers to ensure continuity of service. Others described difficulties in terms of having to liaise with so many different external medical staff, or being able to secure support for prisoners with alcohol problems beyond prescriptions for treatment such as Antabuse. Some respondents noted that it was difficult to determine how effective links with community services were, since they receive little feedback about whether referrals to external services are taken up.

The availability of services for liberated prisoners with alcohol-related problems in the community was perceived by some prison staff respondents to be lower than those available for drug problems and while some voluntary sector projects were highly regarded, it was understood that projects may lack stability due to funding constraints. The local remit of some of these projects may prevent pre-release work being carried out with prisoners who are serving their sentence in a prison which is not within the catchment area of a particular project, or will be liberated to a more distant community. This has implications for prisoner engagement with services following liberation. There was also some acknowledgement by respondents that prisons could do more to develop relationships with community agencies. However, particular challenges were described for prisons which operate as a national resource (e.g. HMPs Polmont, Cornton Vale, Shotts and the Open Estate), due to potentially having to work with agencies across Scotland's 32 Local Authorities, eight Community Justice Authorities, 14 NHS Boards and 30 Alcohol and Drug Partnerships.

Throughcare Addiction Service (TAS)

The Throughcare Addictions Service, delivered via Criminal Justice Social Work, provides an interface between SPS prisons and external services. This service was

introduced in 2005, offering support to prisoners 6 weeks prior to, and after release from, prison with a view to engaging prisoners with community-based services for longer-term support if required. Prisoners can be referred to TAS through the ICM process, although TAS can only be accessed by prisoners serving sentences of over 31 days unless they are young offenders, female offenders or considered to be vulnerable. For prisoners serving 31 days or less, a Voluntary Throughcare Service is available through Criminal Justice Social Work services. This service is available for up to one year after release, providing offenders with access to the prison social work unit, or community Criminal Justice Service, if they wish to seek further support and guidance.

In 2006-07, 1427 referrals were made to TAS from SPS and 1353 individuals were offered a TAS service (Scottish Government, 2008d). This culminated in 1086 prisoners accessing TAS. Of the 1086 prisoners who accessed TAS, 72% had a CIP attended by the TAS worker. However, 59% missed their first appointment in the community and 85% did not complete all six sessions. It should be noted that data regarding the referrals and services accessed specifically for alcohol is not currently available.

6.5 Challenges in delivering effective alcohol interventions

An initial factor which inhibits the development and delivery of alcohol interventions in prisons is a formal identification of alcohol problems in the first instance. As discussed, unless a prisoner presents with symptoms of alcohol withdrawal on admission to prison, staff are largely dependent on prisoners themselves identifying that they have an alcohol problem. Limited self-reporting and self-referrals can mean limited organisational perception of service provision needs.

The relative lack of prioritisation of alcohol issues by prisoners and prison staff was also identified as an inhibitor to providing effective interventions. Alcohol issues were commonly described as being overshadowed by drug issues. This was partly due to the limited availability of illegal drugs within prison compared to the much lower availability of alcohol. Prisoners with drug misuse problems were described as being more forthcoming in terms of identifying and seeking support than prisoners with alcohol problems. This suggests that a more proactive approach is required to address prisoners' alcohol problems.

Further, there are numerous strands to the alcohol interventions provided in prisons, and consequently many different staff members involved in the delivery of interventions. However, during the mapping interviews it was apparent that few members of staff had full knowledge of the range of alcohol interventions in their prison. While this is understandable given the demands on frontline staff, this may have implications for effective referral routes and signposting prisoners to appropriate interventions. Moreover, delivery of alcohol interventions within individual prisons is dispersed across healthcare and prison programme staff, EACS and TAS.

Particular barriers to accessing interventions were highlighted for short-term and remand prisoners. Due to serving a short sentence, some prisoners are unable to access SPS programmes. Difficulty in accessing interventions is particularly acute

for adult male prisoners who are untried or serving a sentence of 31 days or less, since they do not meet the criteria for referral to the EACS or TAS (however female and young offenders do have access to these services irrespective of sentence length). Where resources allowed, Addictions Nurses typically provide some support for these prisoners. However, Addictions Nurses may not always have the capacity to do this, and efforts to work with this group of prisoners can be hampered by the prioritisation of other pressing issues (e.g. housing), according to the needs of individual prisoners.

In the case of prisoners serving very short sentences, providing support beyond attending to their immediate or clinical needs was recognised as very challenging. This is particularly the case for remand prisoners when staff are unable to predict whether a prisoner may be released immediately following a court appearance, thus hindering further engagement with prison services. Provision of through care for remand and short term prisoners was also recognised as particularly challenging due to the relatively short period of time available for engaging with services. It is noteworthy that the alcohol interventions available to offenders are largely determined by their sentence status and sentence length rather than by the outcome of a needs assessment.

6.6 Best practice

It was widely acknowledged by prison staff respondents that alcohol is a common factor in offending behaviour, and prison was recognised as an environment which could be conducive to working effectively with prisoners on their alcohol issues. Since they are not drinking at this point in time, they may be more likely to engage with services, including primary care, while in prison rather than in the community:

‘I would like to think that we apply or respond to individual needs’
(prison staff interview)

Meeting the varying needs of individual prisoners, as determined by factors such as their age, drinking patterns, sentence status and sentence length, was recognised to be a key factor in facilitating the delivery of effective alcohol interventions. For young offenders, brief interventions and one-to-one work were reported anecdotally to be particularly effective. Brief interventions of 5 to 10 minutes were described as preferable to longer interventions which may cause young offenders to disengage. One-to-one work was also considered to be more effective with young offenders than group work due to the effects of group dynamics whereby individuals may not want to speak up in front of peers, or lack the maturity and confidence to speak in a group setting.

The availability of both one-to-one and group work support was identified as an important aspect of providing a package of support options to meet individual needs. One-to-one support was also considered to be particularly effective in addressing personal issues which may underlie alcohol use, providing the capacity to respond to the individual needs and behaviours of prisoners (e.g. identifying triggers for drinking, developing alternative coping mechanisms to support abstinence from alcohol). An additional benefit of one-to-one support is the flexibility attached to this

type of support. Unlike group work, there is no need to wait for a group to start, and it may be easier for remand or short term prisoners to access. Group work was described by some respondents as a particularly effective means of challenging offending behaviour due to the opportunity for participants to challenge one another. There were mixed views, however, about how groups should be structured (i.e. whether to combine younger and older prisoners or short and long term prisoners).

With regard to women offenders, there was a perception amongst staff that they were more likely to present with complex issues and have combined alcohol and drug misuse problems. In terms of interventions, women prisoners were thought particularly to benefit from, and appreciate, counselling services although such interventions were not available in all prisons accommodating women offenders⁴³. While some female-specific programmes are available (e.g. Female Offending Behaviour Programme, Relationships – Connections for Women, and Parenting for Mothers with Substance Abuse Problems), there are currently no female-specific alcohol programmes. This was identified by respondents as something which would be valuable, although EACS support and interventions are adapted to meet the needs of female and young offenders). No mapping or strategic respondent chose to focus on the specific needs of black and minority ethnic groups in relation to alcohol, beyond the need for interpreters.

A key factor thought to facilitate the identification of alcohol problems, assessment and referral to appropriate services, and continuity of care, was fostering good working relationships between the staff within different strands of services in prisons (e.g. healthcare, Prison Officers, EACS, TAS) and community-based agencies:

‘Getting involved in the community planning partnership process and again it’s about identifying gaps in services, supporting alcohol and drug partnerships and developing services or improving services for users on liberation’ (prison staff interview)

Integration of prison and community-based agencies was considered to be an important factor in ensuring continuity of care upon admission and liberation from prison, particularly for short term and remand prisoners who may move rapidly between community and prison settings. Examples of innovative practice, designed to meet the challenges associated with providing continuity of care for short term and remand prisoners, are outlined in the text boxes below.

⁴³ HMP & YOI Cornton Vale is Scotland’s only prison for women, though three other prisons now accommodate small numbers of women.

Highland Criminal Justice Alcohol Project

An innovative intervention providing a throughcare and after-care service with 'revolving door' prisoners, who by virtue of their short sentence length or remand status are not eligible to access other services, is currently being piloted centred on HMP Inverness. This pilot is funded for 3 years by the local Community Justice Authority. A key distinguishing feature of the service is that it follows prisoners from prison to community, and back to prison, as necessary. This service is provided by Criminal Justice Addictions Workers who work within and outside prison. A key aim of this intervention is to reduce reoffending by addressing alcohol-related offending behaviour.

Support is primarily provided on a one-to-one basis, with a focus on issues which underlie alcohol use. This intervention is designed to complement EACS and TAS, although unlike TAS, these workers can work indefinitely with offenders in the community rather than just for 6 weeks. The Criminal Justice Alcohol Workers also co-facilitate groups in the prison in partnership with Prison Officers. The SPS Alcohol Awareness Programme will soon be provided in the community by these workers, allowing prisoners who are in prison for short periods of time to start this programme within the prison and then continue the programme on liberation from prison.

Referrals to this intervention can be made via a wide range of channels, including EACS, Addictions Nurses, TAS, Mental Health Nurses, Addictions Social Workers and self-referral. The main referral route is via the prison Addictions Nurse, although referrals from EACS and self-referral are also common routes.

This pilot was launched in 2009, so it has not yet been possible to evaluate its efficacy, although it would appear to be a promising model for working with short term and remand prisoners with alcohol problems.

Tayside Inter-agency Protocol: Prison and community interface for working with substance using offenders

HMP Perth has recently worked with community-based services to develop an inter-agency substance misuse protocol with the intention of consolidating joint working between prison and community-based services for short term and remand prisoners. The main aim of the protocol is to provide a 'seamless' transition between community- and prison-based services for substance misusing offenders who are not eligible to access the interventions available via the ICM system (e.g. EACS or SPS programmes). Continuity of support from community to prison and from prison to community, without interruption, is the aim (Tayside Police, Perth and Kinross Council, Scottish Prison Service *et al.* u.d.).

The protocol focuses on ensuring that there are clear lines of communication between agencies, including confidentiality and information sharing agreements. Common terminology has been adopted in order to avoid misunderstanding and promote joint working. It aims to ensure that there is an agreed process and system which all partners adhere to and that services provided are consistent

across Tayside. Consistency and continuity of practice is promoted between prison based and community-based services. An important feature of the protocol is that it recognises the need for consistency in service provision across the Local Authorities within the Community Justice Authority it applies to.

Using a client-centred and individualised approach, partnership working is considered key to ensuring continuity of practice. In practice, this entails identification of offenders who are in contact with community-based services at the point of admission and who require support in relation to substance misuse upon release.

A Community Integration Plan is required prior to release and forwarded to relevant agencies identified within the plan (with the offender's knowledge that this information will be shared). There is signposting to appropriate agencies which are able to support the client on release and recording of these services offered and whether the client refuses services on release.

A post-liberation pack is provided to clients with harm reduction information and information on services available in their local authority area upon entry to prison. There is also recognition of the need for carers/spouses/parents/families support, and referrals are made where this is deemed appropriate.

6.7 Discussion

'We've all got different parts to play and the challenge for us is integrating all of our parts and making it as seamless as possible for the individual going through that pathway.' (prison staff interview)

It is apparent that a range of alcohol-related interventions and links with the community interface exist within Scottish prisons. However, responsibility for delivering these interventions is dispersed across a number of staff groups and community-based agencies, presenting challenges to the provision of integrated interventions, especially in the case of remand and short term prisoners. At the level of individual prisons, Offender Outcomes Managers, Addiction Coordinators, Interventions Managers or in some prisons more senior managers, oversee delivery of interventions, although this varies from prison to prison as there is no blanket approach. Strategic planning is carried out by senior management teams in conjunction with central input from SPS Headquarters Prisons Directorate although it is noteworthy that there is no individual staff member with the sole remit to undertake the strategic management of alcohol interventions.

Particular challenges exist in terms of the identification and prioritisation of alcohol issues both at an individual and prison wide level. While there is the desire to be both needs focused and to develop integrated services and pathways in the SPS, the ability to put these into action can be frustrated from a number of directions, most specifically due to the main role of prisons being custody. Also, the inevitable

pressures of the volume and swift turnover of prisoners in the SPS estate are impediments.

Both the mapping and strategic interviews highlighted the danger that, within current arrangements, many prisoners who could potentially benefit from an alcohol-related intervention are being missed. Further, access to alcohol interventions is largely determined by their sentence status and sentence length, rather than by the outcome of a needs assessment. This is particularly problematic in the cases of remand and short term prisoners. Primarily custodial data relating to the uptake of alcohol interventions in prisons points to a significant disparity between the number of prisoners accessing interventions and number of prisoners with alcohol problems, given the size of the prison population and the prevalence of alcohol problems as discussed in other report sections.

6.8 Key findings

- Recognition that prison is an opportunity to detect and intervene with alcohol problems.
- No formal alcohol screening using a validated instrument.
- Prisoners may not admit to an alcohol problem on admission – other priorities.
- A range of interventions to address alcohol problems in the context of offending but not a full model of care, and limited CBT.
- Not all alcohol interventions available within the prison to those on short sentences/remand.
- Lack of accessibility to alcohol interventions: while there are far greater numbers accessing substance use interventions more generally, the numbers of prisoners accessing specific alcohol-related interventions are low.
- One to one interventions thought to be effective for younger offenders.
- Timing of asking about alcohol problems can be important.
- Variation in capacity for Addiction Nurses to deliver interventions.
- Limited in-reach although developing.
- Problems establishing continuity of care if prisoner released to a different geographic area.
- Interventions being delivered by different providers within the prison, limited awareness of 'big picture' by staff.
- Lack of outcome information to inform planning and service improvement.

6.9 Key messages

- Introduce formal screening, not only at admission, that is sensitive to both the timing and quality of enquiry.
- Provide a full range of interventions as part of a model of care/care pathway tailoring interventions to prisoner need.
- Care pathway should be open to all at all times, whether provided in prison or community setting.
- Prioritise alcohol issues.
- Local champions needed to provide leadership and direction for planning and delivery.

- Increase capacity to provide interventions, most specifically for those who are short stay and remand who are currently most underserved.
- Enhance continuity of care, through care and more accessible services in the community, particularly important for those on short stay or remand.
- Better monitoring and evaluation, including of the pilot initiatives.

7. Case study

This section reports findings from a case study of an individual prison undertaken to meet the following objective:

- to explore and report on the attitudes towards the delivery and effectiveness of current alcohol interventions through interviews with prison staff, prisoners and internal/external service providers (objective 8).

7.1 Introduction

An in-depth case study in one of Scotland's prisons was carried out to examine the processes involved in the identification and treatment of prisoners with alcohol problems, attitudes towards the delivery and effectiveness of current alcohol interventions, and the referral procedures and care pathways that exist between the prison setting and community services.

Four focus group interviews were undertaken with male prisoners from different custodial profiles to ensure a range of perspectives and experiences. Overall, 26 prisoners participated in separate groups: respectively long term (5), short term (7), remand (5) and young offender (9). It should be noted that prisoners generally had previous experience of being in prison, here and elsewhere, including those on remand. Prisoners fitting the relevant categories were recruited by prison staff, following discussion with the study team. Prisoners were informed that there was going to be a group discussion about alcohol and prison officers identified participants who were best suited to take part in a group session from those who volunteered⁴⁴. There was no screening process relating to drinking behaviour outside prison although all had been drinkers. Recruitment was supported by an information sheet and consent form. At the close of the focus groups, all were asked to privately self-complete the same instrument that was used in the screening exercise to obtain data on drinking behaviours and other demographic details (see Appendix 20 for this data).

The prisoner focus groups were run by two researchers. A semi-structured topic guide was used to allow free discussion as well as gather specific material on the research questions (see Appendix 21 for the focus groups topic guide). Researchers reviewed key issues about participation at the start of each session, highlighting details from the information sheet, stressing the voluntary element and providing an opportunity to leave. Ground rules were put into place at the start to ensure the smooth running of each group and sensitive personal information was not sought. The focus groups had obvious limits to confidentiality by the nature of being a group activity. These limits to confidentiality were stressed at all junctures prior to undertaking the groups. The information sheet also contained details of limits to confidentiality should the detail of harms or current/potential crimes be spoken about in the groups. Prison officers ensured the movement of prisoners to and from the

⁴⁴ This was suggested as necessary when planning the data gathering with prison management. It is impossible to tell whether this biased the results in any way.

interview rooms. They were not present in the room, allowing more open discussion, but were available outside if needed⁴⁵.

Twelve face-to-face interviews were conducted with staff working in the prison: some with a specific substance use or alcohol focus to their work and some without. One telephone interview was conducted with an external service provider. Prison and external staff were recruited to profile as wide a range of perspectives as possible using purposive sampling to ensure different areas of prison and interface/community activity was included. As with other interviews, a semi-structured topic guide supported the discussion (available on request). It should be noted that the prison site was extremely supportive of this study and prison staff facilitated many of the contacts required for these interviews.

The interviews and focus group discussions were digitally-recorded, transcribed and analysed thematically. The analysis was guided by the research questions and objectives, but also allowed for open coding in order that new themes could emerge throughout the study. Constant comparison (checking experiences against those of others in the sample) ensured that the thematic analysis represented all perspectives.

In this section, an initial overview of perceptions of alcohol needs and interventions in the prison is provided. Perceptions at differing stages of the custody experience are then explored, from the perspectives of both prisoners and staff. Consideration has been given to the use of illustrative quotes to provide richness but in the context of anonymity issues. Prisoner quotes without attributes are included in appropriate sections but staff quotes have been used sparsely as being more closely linked to an aspect of their work and hence to individual respondents.

7.2 Overall perceptions of alcohol needs and interventions in prisons

Prisoners and staff recognised that alcohol was an important issue to be addressed within prisons, and had broadly convergent understandings, with staff perceptive of prisoners' concerns.

7.2.1 Overview: prisoners

Prisoners felt that alcohol was often part of the reason for imprisonment and re-imprisonment, with drinking a prevalent element of Scottish society. Alcohol use was also believed to be commonly interwoven with drug taking:

'A couple of bottles and then I will be like ... I am going to get some coke, I will go and get some f***ing amphetamines or bubbles [Mephedrone] or anything like that. That's where you start.'

They often made spontaneous links between use of alcohol and drugs, both as part of the problem and in the context of interventions: 'drink is a drug'. However, it was widely felt that fewer resources were allocated to support with alcohol issues,

⁴⁵ Again, this was required by prison management.

attributing this to drug taking being more widespread outside and within the prison, and drugs being more closely linked to crime:

'80% of their efforts go on drugs which is little or none; you can imagine what 20% is left for alcohol then.'

'Energy and money ploughed into drug addiction whereas ... alcoholism is getting left behind.'

Reflecting these links, some older prisoners identified a negative effect from imprisonment, with drinkers, especially young people, perceived to turn to drugs while in prison as they are more readily available. In addition, older prisoners felt that there should be particular efforts to encourage younger people to address their drinking in prison, as they might not see their binge drinking behaviours to be a problem.

While prisoner respondents felt that there was a need for alcohol interventions in the prison, it was recognised that not all would want to address their drinking issues or take part in interventions. A few reflected that alcohol was used to mask other problems that could be extremely challenging to face up to: 'it cuts to the bone when you are sober'. Opinions tended to vary on the extent of possible stigma from accessing services, but overall it was felt not to be an issue.

7.2.2 Overview: staff

There was widespread recognition among staff that alcohol had an influence in many crimes and on the lifestyle of prisoners when 'outside'. It was felt that in the past an overwhelming focus of attention had been on drug misuse with a parallel focus of allocation of resources. However, increasingly alcohol was seen to be emerging as one of many substances that might be taken, often in combination with other drugs. It was felt to be unusual for individuals to take either hard drugs or alcohol alone, a dichotomy that had been more common in the past. This means that alcohol-related intervention provision may have to address use of differing substances in parallel.

Influences on changing patterns identified included 'fashions' in substance use, with possible cohort effects in habits, and the current low cost and availability of alcohol in the community. Perceptions of the relative salience of drugs versus alcohol varied among respondents, but it was recognised that there might be differences relating to age, with alcohol 'problems' more associated with older prisoners for whom drinking had become habitual or addictive. That said, there was recognition that younger prisoners would also drink extremely heavily but with different patterns. Staff also connected alcohol with violence in an offence, and commonly with shorter term sentences and 'revolving door' prisoners.

Further comparisons were commented on in the prison setting. Staff consistently commented that alcohol was markedly less readily available than drugs in the prison. It was difficult to bring in and the making of 'Hooch', while undertaken, was difficult to keep secret. Linked with this, drugs represented a much greater discipline issue on a day-to-day level in the prison, although if a prisoner had consumed Hooch their behaviour was described as being very difficult to deal with.

It was also felt that the lower prominence of alcohol as opposed to drugs may lead to staff and prisoners 'forgetting' it as an issue, and for prisoners to have unrealistic expectations about staying abstinent or drinking safely on liberation.

Staff pointed out that in the early days especially, and also on liberation, substance-related activity had to incorporate the priority of 'keeping people alive', for example through tailored detoxification, identification of suicide risks and advice about altered tolerance levels. Again, this might be seen to be a more common issue for drug users than for those with alcohol problems. Finally, it is important to stress that addressing alcohol problems in a prison setting was not considered to be easy for prisoners to do, with the additional challenge of coping with a custodial environment:

'Prison's a coercive environment. No one really wants to be here ... if someone comes from a hall environment where it's all about control and order and structure, and just being kept in your place, really, and you come into a position where you're expecting someone to be more relaxed and feeling motivated and energised, it doesn't always work that way.'

7. 3 First few days

7.3.1 First few days: prisoners

Most prisoners seemed to remember being asked whether they had a drug or alcohol problem as part of assessments on admission or on transfer in from other prisons. As described in Section 6 on mapping, this is a key point for identifying need and triggering further intervention. However most recalled this as an 'aye or no' question, and generally did not feel there had been referrals made or later follow-up as a result, although one respondent reported being referred to Phoenix at this point when he was in a Young Offenders Institution (YOI):

'They just ask you if you have got a drink problem - aye or no? I just said, "Aye", and they never said to me about any services.'

'I have been transferred from another prison but it's just exactly the same there, "Have you got a drink or alcohol problem?"'

In addition, it was felt that the main motivation for 'asking the question' was to identify needs in relation to withdrawal and suicide risk, rather than addressing behaviour change:

'They just ask you if have you got a drink problem or a drug problem? ... Here are some pills and that's it!'

'When you first come in you get assessed with the doctor and they ask you if you have got any problems with drugs or alcohol, only because they have got to give you medication for it but that's it. It's as far as it goes. It's not about any help.'

Prisoners also commented that young people in particular might not see their drinking as a problem, and would answer 'no':

'That young 17/18 year old that comes in, if he is asked have you got an alcohol problem he doesn't see himself as an alcoholic, he sees himself as a normal teenager that goes out for a bevy two or three times a week.'

'... His dad is maybe in the pub every night having a couple of pints and he thinks his dad has got more of an alcohol problem.'

'See the likes of a young person like me I only drank at the weekend, and you come in and they say, "Have you got a problem with alcohol?" "No". I only drank at the weekend, but really I do, but I am saying to them, "No".'

Prisoners were aware that medication may be offered to help control delirium tremens (DTs), where identified, but felt that broader personal support was limited or counterproductive. To illustrate this, some past practices were still prominent in the minds of participants. In one group discussion one respondent (with the agreement of fellow group members) highlighted the perceived approach of putting sufferers in 'suicide cells' and thus in isolation. Another prisoner (also with the agreement of other group members) disapprovingly reported incidents of prisoners being weaned off medication they had been taking in the community to help them control their drinking, such as Librium or Valium, again seen as unsupportive (rather than recognising that clinically medication in support of abstinence should only be short-term).

Prisoners also commented on the induction process, which would include the EACS Overdose Awareness Session (more likely to be described as a 'talk'). They felt there was a lot of information to assimilate at a difficult time, often when coping with withdrawal or hangovers and other stresses, although they recognised it had some value. However, as with the question about alcohol problems, some felt the induction session was undertaken primarily to ensure staff could be said to have made prisoners aware of overdose and other substance-related risks, rather than initiating support: 'covering their arses'. Some participants in one group perceived the session to cover suicide risk, although this is not part of the current programme.

'... You come in the day before right, the first thing, the very first thing the next day, your first day in you get taken down to this induction. A lot of people are like that, they can't be bothered ... Especially somebody that is coming and they are withdrawing off of alcohol, withdrawing off of drugs, they just want to be [left alone].'

One prisoner felt his experiences in English prisons had been more productive, with the induction period lasting several days on a separate wing, and a plan of inputs developed from an identification of needs at that stage. In addition, he reported being given a comprehensive folder incorporating information about a range of interventions, which was not provided in his experience of Scottish prisons.

7.3.2 First few days: staff

The first few days in prison were seen to offer key opportunities for identifying alcohol issues among new arrivals. This included identifying drinking as an issue, responding to any immediate clinical and support needs, providing information and referral for further planning of care and support, for example to EACS, and harnessing links with community services as appropriate (discussed in more detail below).

As described in Section 6 on mapping, prisoners are asked directly whether they have a drink problem at three points, involving staff from different organisational structures: firstly by the Practitioner Nurse as part of the Reception process on the day of arrival, secondly by the GP as part of the medical assessment, and thirdly as part of the Core Screening undertaken by Links Centre Officers. Staff acknowledged that these could be very limited enquiries, utilising forms requiring 'yes/no' answers, and being part of a wider interview covering many issues. Most specifically, the Reception Nurse Interview is conducted in an extremely pressured environment, with arrivals worried and possibly 'under the influence', and prison staff keen to move prisoners through the Reception process which incorporates a range of clinical issues, including risk of suicide. Alcohol issues/problems may also emerge in the first days in response to the Overdose Awareness Session undertaken by EACS, and during discussion with the Addictions Nurse if the prisoner has been referred.

Staff also acknowledged a dependence on the prisoner being 'up-front' that they had an alcohol problem. They recognised many reasons why prisoners might answer 'no', reflecting an understanding of prisoners' perspectives. For example, they felt prisoners may view their drinking as normal rather than a problem or that other concerns may be more salient at the time. There were also felt to be some indications of prisoners denying having alcohol problems, or alcohol problems being seen as 'taboo', although more so for older and more dependent drinkers. In addition, there is no screening or physical testing carried out that would reveal alcohol to be a problem, in the way that testing for drug use can enable detection. This means relying on observing appearance and behaviour, in addition to the prisoner's own admission, although the introduction of breathalysers is being considered.

Approaches to enhance identification were reported in relation to the Reception Nurse and Core Screen Interviews. In an ongoing pilot within Health Care in this prison, those conducting the Reception Nurse Interview are encouraged to expand questioning of prisoners and more proactive referral to the Addictions Nurse of *anyone* with alcohol or drugs issues. This is seen as a positive development from previous practice of referring only those overtly asking for help. This was still in the data collection stage and figures were not available for this study. The pilot is considering staff training to give greater confidence in questioning, and a review of the wording on the interview form.

More proactive referral to the Addictions Nurse is seen to have created positive changes. For example, many more prisoners are being seen with a range of alcohol issues, rather than just those requiring clinical support on liberation to aid abstinence (e.g. Antabuse). Seeing more prisoners was felt to have facilitated Addictions

Nurses making recommendations to the GP for more tailored and timely detoxification regimes, use of vitamin supplements, and earlier and more appropriate onward referrals. There was also scope for the Addictions Nurses in this prison to offer some additional support for those not eligible for EACS, such as very short stay or remand prisoners, facilitated by having had counselling experience in previous posts.

Similarly, there had been discussion and some training regarding alcohol and drugs questioning in the Core Screen process, with additional supplementary questions being considered. Perceived improvements in the general administration of the Core Screen Interview were reported, such as using Links Centre Officers, rather than having many Personal Officers undertaking the interview along with their many other duties. In considering addressing alcohol in more depth at the Core Screen Interview, it is worth noting that during the AUDIT screening process for this study (see Section 5) there were very few refusals. Links Centre Officers had found the process practicable and felt that having a structured questioning approach had enhanced the process of raising the issue with prisoners.

Recognition of varying needs due to differing drinking behaviours was also seen as important. However staff respondents recognised this required careful questioning and discussion which might not be fully achieved at this early stage. Consumption of additional substances and their impact also had to be taken into account. Additional support could also be accessed, for example via the Links Centre, or from Alcoholics Anonymous (AA), the Chaplaincy or Listeners⁴⁶.

Similarly, the first days provided opportunities for information giving, both about alcohol issues and service options. As described in Section 6, the EACS Overdose Awareness Session during Induction includes information about alcohol risks and services, albeit in the context of a main focus on drugs. More personalised one-to-one information could come from all the contacts outlined above, but this was mostly seen as signposting rather than fully addressing issues at that time. Brief information about services was also left in cells in the First Night Centre.

Finally, a prisoner's entry to the prison was an opportunity to liaise with relevant community services and agencies. This could be to obtain information about a prisoner's history, for example, any current medication regimes, and any services attended which could provide details to inform care. The process was challenging, with many agencies to contact, but was felt to be enhanced by the ongoing development and implementation of protocols, such as a local multi-agency multi-authority protocol developed in this area, and information from criminal justice social workers.

In addition, staff could, with prisoners' permission, inform agencies that an individual was in prison and thus give reasons for not attending appointments to avoid losing ongoing contact. Staff could therefore help in relation to broader issues that would

⁴⁶ The Listener Scheme is a peer support scheme whereby selected prisoners are trained and supported by Samaritans, to listen in complete confidence to their fellow prisoners who may be experiencing feelings of distress or despair.

http://www.samaritans.org/your_emotional_health/our_work_in_prisons.aspx

impact on an individual's wellbeing and release opportunities, such as housing and benefits provision. In addition, a Links Centre staff member mentioned the introduction of Family Packs, which included information on visit times and travel, key contact telephone numbers in the prison, and information provided by substance misuse services. The prisoner could ask for these to be sent to family members identified as relevant and this was felt to be positively received.

Overall whilst the first days might be seen as a key time to identify needs and offer treatment and support, particularly essential in relation to clinical issues, some staff respondents reflected that it was a lot for prisoners to take in at that point, when so many other issues were in play. It was felt that prisoners were likely to be emotionally and physically stressed, reflecting similar comments made by prisoners: 'perhaps it's not the best timing'.

7.4 Mid sentence

7.4.1 Mid sentence: prisoners

Prisoners felt there was scope for staff to proactively raise alcohol issues further into the sentence, which might elicit a more positive response than in the first days. However, this rarely happened:

'I mean when I came in I just said, "I have no drug or alcohol problems", but that's the last I heard about it, not one screw, or nurse, or anything.'
'Nobody comes back to you and says ... "Do you really not have a problem?"'

'Once you settle into the hall you get to hear people talking, and come out of your shell a bit more, maybe if they came back to you, you would communicate you know.'

'I have been here from July [5 months] and I have not been asked about anything, I don't know what courses they have got and how to ... as you say nothing. Basically they leave you to your own devices'

The initial response when respondents were asked if there were opportunities for them to raise personal concerns about alcohol was that this would be unusual. Whether or not they raised issues with Hall/Residential Staff, for example, would tend to reflect concerns around trust and the perceived qualities of individual staff and any relationships they may have developed. There was considerable distrust of the prison officers' responses, and prisoners were concerned about how such information would be shared across the prison. However, some did feel they could talk to some staff about such issues. In addition, it was felt there would be a considerable time lag before there was any action taken and prisoners also drew parallels with delays in requests for healthcare appointments and access to doctors:

'You have got to approach them for help, and even then it takes them long enough to get their finger out, ken what I mean?'

'It depends what staff you ask as well.'

'Exactly!'

'You have got one or two staff here that just don't care'

'You can speak to them [prison officers] about your problems and they will listen but that's as far as it goes.'

'It's hard enough getting them to f***ing help you fill out a form never mind helping you with an alcohol problem, ken what I mean? I am not joking.'

There was some acknowledgement that Hall/Residential staff were very busy, which made it more difficult for them to take action for an individual:

'You can go to them saying look I need to see ... They go "no bother" ... lock you up, and they are getting a hundred people going "I need this, I need that, I need that", and they have forgotten all about you, ken what I mean?'

These comments reflected others that drew attention to the pressures prison staff were under:

'An important area in prison just now is...for prison management is time management. Everything is surrounded by time and'

'Pressure?' [Interviewer]

'Plus overcrowding and whatnot.'

'They don't have the time or the manpower to set time aside for certain things that need addressing which is ridiculous.'

'So if you decided I want ... not you necessarily, but if anyone decided they wanted help?' [Interviewer]

'I was put on a waiting list to see Phoenix House and Addictions - that covers a multitude of sins. It's like a sweeping broad spectrum of stuff it covers but ... they have not got the time basically.'

'Everything is tied up with referrals.'

'Aye.'

'And waiting lists.'

'And budgets.'

'We have got all the time!'

'They don't sympathise with that, they just think, 'right', because they are in a rush or whatever'

'A lot of things as well is application forms in here right, if you have got a lot of people that come in that can't read or write, they don't want to admit ... grown men don't like to admit that they can't read or write.'

'They need help filling in forms.'

7.4.2 Mid sentence: staff

As noted, staff recognised a considerable challenge to introduce effective interventions for remand and very short stay prisoners. However, for those whose prison stay continued, there are felt to be ongoing opportunities for offenders to find out about and engage with services. This might be part of the process of 'settling down' and taking time for alcohol to come to the surface as an issue to be

addressed. Physical or mental health issues may also emerge that can be linked with alcohol consumption. As with the first few days, referrals could come from many routes including Integrated Case Management and opportunities for prisoners to self-refer, although completing the paper forms was thought to be a potential deterrent where there are literacy difficulties.

In addition to those specialists providing EACS interventions and SPS Programmes, there is considerable scope for a range of staff to encourage engagement with the issue of drinking at a personal level. For example, Hall/Residential staff in general and Personal Officers⁴⁷ were noted to have important opportunities to notice changes in mental or physical states which might indicate an alcohol influenced change, and to 'have a chat' to explore any emerging concerns. Similarly their support is needed to escort prisoners to a service or course and thus a positive attitude among these staff was seen to encourage and reward ongoing engagement. However, as at all stages, time pressures and competing demands within a wider role may mean this potential cannot be maximised and might, in effect, involve largely sign-posting to others rather than giving individual support.

Many staff noted that since prisoners have minimal exposure to alcohol in the prison, they are less likely to be 'tempted' as their stay progresses. Thus motivation to address alcohol can fade or a prisoner may have unrealistic expectations of how easily they will resist reverting to old habits on liberation. As described earlier, it was felt that there is greater exposure to drugs in prison and hence greater opportunity to practice resistance. Some respondents noted that more generalist staff may not recognise alcohol as a priority issue, in part because it did not impinge much on everyday life in the prison, and was not a discipline issue to the same extent as drugs. This was commented on in relation to Hall/Residential staff and also to generalist healthcare staff indicating scope for awareness raising and/or training initiatives in these groups.

Record keeping and sharing information about prisoners was seen as an important issue to address. For example, healthcare professionals reported limiting what they wrote in the PR2 computerised records, to ensure non-health personnel did not see information they regarded as confidential, or they would give enough detail to flag up the issue (e.g. 'attended xxx clinic') but without giving details of medication which might indicate the severity of the condition. Parallel paper based records include the GP and the addictions / healthcare records. Although there was minimal use of GPASS reported this did not include substance-related records. Record keeping approaches were reported to vary in other prisons, which might have implications when prisoners were transferred in: for example, if records were sparse, staff may need to rely on prisoners' own reports, with the possibility of contacting the relevant prison if further information was needed.

⁴⁷ Prison staff that support prisoner programmes and work as part of multi-disciplinary teams to deliver these programmes.

7.5 Courses and interventions

7.5.1 Courses and interventions: prisoners

When initially asked about support in relation to alcohol, prisoners tended to respond negatively, saying there was 'nothing' available. However, when asked specifically about alcohol-related courses and interventions, prisoners tended to be able to identify the EACS Alcohol Awareness one-off group session and the SPS eight session Alcohol Awareness Programme. The common name made it difficult for them to be sure who ran which one. Awareness was greater among long term prisoners and young offenders who were near to liberation. Respondents were also aware of other courses and programmes but did not focus on them in this context as they were not seen as alcohol focused.

No respondents had attended the relatively recently introduced Substance Related Offending Behaviour Programme (SROBP) course. There was also awareness of one-to-one interventions through EACS, but again they did not come into focus much in the discussions, perhaps reflecting a perceived emphasis on drugs rather than alcohol. AA was also mentioned, but few had a clear idea about provision or interest in attending. However, one long term respondent and a young offender had been regular attendees and were strongly in favour.

Prisoners were aware of a number of routes for referral, for example from interviews in the Links Centre and contact with prison officers. There was also some awareness that self-referral was possible to alcohol-related and other services. However, this usually involved completing a form, adding to the barriers for those with literacy problems. In addition, an individual prisoner, with the agreement of his peers, commented it was usual to be called to a first appointment at short notice following a referral, for example to EACS⁴⁸, perceived as at random, which could reduce motivation to follow-through. On the other hand, longer waits for a course to start could be off-putting and there could be loss of momentum, leading to failure to participate:

'It's usually a few days or something, ... it comes back within a couple of days and then they just randomly come and get you from your cell and say you have got an appointment ken?'

'Right. So you don't know when it's going to be?' [Interviewer]

'No. It could be at any time.'

'It's a piece of paper you fill out, a self-referral form, and you can wait months depending how many people are coming in and if it's quiet then maybe six months, if it's not, it's months and months and months.'

'Here you have to wait for everything and it takes months and some people just get disheartened and say, "Sod it I am not going to bother". It takes too long which isn't right.'

⁴⁸ EACS operate a scheduled appointment system.

Recall of course content tended to highlight information relating to drinking, in particular information about units, rather than addressing complex behaviour changes. Many were dismissive, feeling an informational approach was not helpful:

'It was just two weeks; there wasn't much in it like.'

'It doesn't help at all. I did it in [named YOI] as well. It's just a two week course.'

'It was nothing that I didn't know already.'

'All they did is tell you how many units you drank and how many units you should be taking.'

'And what it's doing to your liver and that, just all ... your insides.'

'Just the facts aye, just the wee facts about it.'

However, among young offenders, opinions were more mixed. Some appreciated learning information that was new to them and allowed them to make more informed choices, for example when driving, 'it's better to know':

'I didn't understand about units and that until I got to jail and did the programme.'

Others felt they would not pay attention to 'units' when they were outside. Prisoners who indicated that they had long term alcohol problems and longer experience of prisons were particularly dismissive of such programmes. In particular, they were seen to lack meaningful support and did not address the 'nitty-gritty' of the problem. This extended to comments about the perceived commitment and skill levels of staff delivering programmes and these perspectives appeared to add to negative perceptions of the value of the programme:

'There is no support, there is no this or that, it's interventions ... [it does not] get down to the nitty-gritty what's happening and what's needed.'

Approaches designed to standardise delivery could be seen as weaknesses among those with experience of SPS Programmes. For example, staff referring to the course manual during a session, and visits from a psychologist seen as 'checking' and videoing 'the officers to make sure they are doing their job right':

'The staff only follow that [manual], that's what the staff do, they follow that, they don't ken half the [stuff].'

'Two days later you are going back and going over what you have done ... to see if anybody remembered what we had done two days before and he [Programme Officer] couldn't remember half the stuff himself without looking [at the manual].'

'They [Programmes Officers] go to college for a couple of days a week. They get put to college for a couple of days [indicating perceived limitations in training].'

There were also some concerns expressed in relation to having prison officers leading programmes, rather than someone from outside, for example 'psychologists'. Concerns regarding confidentiality and the perceived qualities of the officer leading the programme were raised, as were concerns about talking to officers in general about alcohol issues. Again, long term prisoners held the strongest views:

'... it limits their kind of real interest I think [being an Officer].'
'Aye. At the end of the day they are a screw.'
'The less we tell them about us the better.'
'Whatever you tell them it goes down in your Intel.'⁴⁹
'Sometimes for instance if you are in any of these interventions and you are asked to question ... maybe you disagree, you are debating that topic. If you were in any other type of situation you would be able to feel comfortable with that. But at the end of the day in here every person that's taking the group is an officer; it's difficult to argue with them'

Young offenders, many of whom had also been in a YOI, had fewer concerns, in part because the courses were conducted away from their Residential Hall, and also because they reflected that the qualities of the officer were more important. One commented that the differing titles on the name badges made the distinction clear:

'No. The officers are different from the ones in the Halls and that. That's a separate bit altogether.'
'They are still officers.'
'But ... on their badge it says programme facilitator and the other ones it says residential officer. They are different.'
'It depends who it is.'
'If you don't get on with them you are not going to sit and talk to them are you?'

Following from this, many expressed a preference for 'experts' with lived experience of addiction and recovery to be involved in delivery, which was felt to make sessions more credible:

'There is no point in paying somebody good money twenty or thirty grand a year to come in and preach to people because that's what it seems like when somebody comes in and goes, "Right, I am here to tell you about how to behave yourself and drink, and what drink is all about".'

'That's the only value in Alcoholics Anonymous because you ken that person has been ... I am not saying there is not a place for people like yourselves [from universities] but at the end of the day that's ... if you really want somebody to pay attention in here it's got to be somebody that's been through this, that can say, "Well I have been where you are and here is where I am now", and that gives them encouragement. "I have lost my wife", or "I have been in prison", or ... whatever.'

⁴⁹ Ongoing Intelligence report on prisoner.

Motivations to participate in an intervention were perceived to vary. Prisoners commented that many might be motivated to aid progression through their sentence and moving towards release, and some might see it as a relief from the boredom of the cells. To varying extents, participation could be seen as 'mandatory' or a condition for liberation, for example for early release on a 'tag' (Home Detention Curfew) among young offender respondents. Overall, participation is 'voluntary' but the inherent conditionality might modify motivation. While it was admitted most would take part because it was a condition of progress, it was recognised some might engage fully and obtain benefits. Remand prisoners also felt that participation might help their court case if it was noted that they had attended for support:

'We were told that it's ... again it's the carrot and the stick thing, there are the rewards at the end of it, ken like there is going to be either time off your sentence, or it will hold good for you at court, because at the end of the day it's pretty basic ken?'

'It's to keep it simple.'

'It might sound like well ken they [prisoners] are doing it for the wrong reasons. Well if ten people do it for the wrong reasons but two people get'

'For the right reasons.'

'Get any benefit out of it then what's ... is it worth letting the other people [join] giving them another chance even though they don't deserve it if two people have ... ken?'

'It's a mandatory thing. That way they can dot all the I's and cross all the T's for themselves basically. When you do come back in then they say well we gave him the course and he still made a mistake, we will have to do something else with him, that's basically it.'

Prisoners also commented on the perceived relative benefits of group and one-to-one approaches (the former provided by SPS Programmes and the latter by EACS). It was recognised that some might find it difficult to participate in a group session. Group based programmes were seen to have the benefit of certified progression in a sentence, as well as a more in-depth approach, but some might exclude themselves because of personal inhibitions in this context:

'Some people find it awkward in groups and some of them get that embarrassed that they get violent ... If they need this kind of treatment why can't they get it while they are in prison rather than have to wait until the end of their sentence and then go and do it then when they are outside when they might feel ashamed of having to do it in front of family and things like that'

'Phoenix is limited what they can do [can do one-to-one].'

'You don't get the courses that say, "I have done this" and you have got a certificate to verify it, you don't get any of that with Phoenix. What you do is you get referrals to other place, passed on to somebody else. But there is not individual ... like people that find it hard to work in groups,

because there are a few in here that do find it hard to work in groups and it's a shame for them because it's like they are disabled because they can't get to do it.'

'Peer pressure.'

'It's about confidence.'

'Some of them just don't have any of these things and it's not their fault, it's just the way it is but they are being punished again.'

The issue of timing of interventions also emerged. Among long term prisoners, delaying these courses until later in the sentence could be seen as de-prioritising the issue, although it was also recognised it was possible to forget what had been learned as the sentence progressed. On the other hand, only addressing issues relating to life on the outside close to liberation could be seen as 'all that time that you have been in wasted'. For short term prisoners, it was recognised that they may not find alcohol an important issue or there might not be time to fit in an intervention before liberation:

'The young man here was saying you are not getting that approach in the groups in the times that you get to do that here. It's different for longer term ... but for short term prisoners it's no good to them because it's going in one ear and out the other.'

'It's no benefit is it? It's no benefit it's just a waste of time for them, they feel it's a waste of time.'

'See the bottom line is most of the people in here are only in for a wee sentence, they have not got time ... a revolving door.'

Finally, when considering finding out about courses and interventions, interpersonal approaches were seen as most effective from fellow prisoners as well as staff:

'Nothing is promoted do you know what I mean?'

'So it's just word of mouth that you heard about that?' [Interviewer]

'Aye. Word of mouth.'

'You have got to chase it, got to chase it! If you want something you have got to chase it.'

'People like me [first time in prison] rely on people like [Name] because he has been here before so if I have got a problem I won't go to a screw, I will go to him and ask him.'

'[Name] kens more than the screws!'

'I know he is going to tell me the truth. You go to a screw a few times and they just palm you off with bullshit.'

Whilst published information could be found as posters (on the Halls and Links Centre) and leaflets (noted mostly at the Health Centre and Links Centre) distribution was not felt to be widespread and racks and notice boards might not be kept stocked or up-to-date. This contributed to a sense that alcohol was not seen as an important issue. However, prisoners tended to agree that leaflets on this topic might not be picked up, even by those who had alcohol problems.

Literacy issues were seen to have an important impact on leaflet pick-up, with many people not wishing to admit they could not read. A preference for interpersonal information was expressed which could incorporate personalised information and a sense of caring. However, young offenders in the sample who had recently been given leaflets had retained and looked at them, and remembered elements of content such as avoiding fights and hangover cures, in spite of concluding that the advice was unrealistic and simplistic:

‘There is no point to it [leaflets].’

‘I would rather somebody sat down and talked about it instead of Do you know what I mean? It shows that they care a little bit ... Aye.

They just go, “Right we need to give you this”.’

‘... They just give you that and hope you look through them.’

7.5.2 Courses and interventions: staff

Courses and interventions available through EACS and SPS Programmes have been outlined previously (see Section 6). Most staff interviewed were aware of these interventions but were not usually aware of detailed provision unless directly involved. Several staff commented that the sessions offered were largely informational, including EACS Alcohol Awareness and other group sessions and the SPS Alcohol Awareness programmes.

While these were not without value, some staff respondents felt there was a gap in available opportunities for support of prisoners that might address more deep-rooted issues. The comment, ‘it’s minimal’, summarises their concerns and reflects prisoner comments on the quality of provision. For example, lack of counselling approaches was mentioned by more than one respondent, although counselling support had been ‘bought in’ for a few prisoners with long term addiction issues as a pilot intervention. There was also support for wider models of recovery and abstinence focused approaches, such as AA and other 12 Steps programmes, reflecting a feeling that achieving sensible drinking was too challenging a goal for some offenders.

The content of interventions was recognised to be clearly structured for consistency, in particular the ‘manualisation’ of SPS programmes (delivered according to a central manual) and the types of work EACS were contracted to undertake. Modifying the content where a need was identified, for example modifying the input for an EACS Alcohol Awareness Session, was felt to be a slow process requiring much negotiation.

Staff commented that prisoners had a choice whether to participate in programmes and interventions but, like prisoners, recognised that motivation to participate may vary. While some might seriously wish to address their drinking issues, others may be also motivated by the need to be seen to participate in identified interventions to demonstrate intent to change and bring them closer to liberation. However, screening processes were reported to be in place to explore motivation and suitability, in particular for the more in-depth ‘treatment’ programmes.

The 'voluntary' nature of participation was also an issue in relation to attendance at clinics, or EACS individual appointments, and residential staff play an important part in encouraging and ensuring attendance. Like prisoners, Hall/Residential Staff commented that prisoners were often given little prior warning of appointments, and they could just be 'called' on the day for morning or afternoon movement times. It may then clash with work plans or the prisoner may be taken by surprise by the call and perhaps feel less motivated on that occasion. This had ongoing impact on provision through missed appointments.

Staff were aware of a variety of routes and referral mechanisms for prisoners to find out and engage with the intervention support and courses. As described in Section 6, this was largely through Core Screening and ongoing Integrated Case Management (ICM) and through Addictions Nurses, as well as onward referrals, for example from EACS to SPS programmes. This recognises the importance of interpersonal promotion rather than written notification. Many reported that if prisoners did not wish to engage at a structured point of contact they were always encouraged to consider applying at a later stage. The option to self-refer at any point was felt to be important, with Residential Staff and Personal Officers playing an important role in support and encouragement. The EACS lead reported regularly checking that the leaflet racks contained referral forms although it was recognised literacy may be a barrier.

7.6 Liberation

7.6.1 Liberation: prisoners

It was widely recognised by prisoners that liberation was a major challenge in relation to alcohol. Whilst in prison, they were largely abstinent, and freedom made it easy to relapse, for many as soon as they left the gates. This was felt to be enhanced by: the ready availability of alcohol, the many outlets for purchasing or stealing from, the low cost, and alcohol being seen as 'safer' to obtain than drugs.

'I said to myself the last time I went out, that's me off the drink and I lasted six days.'

'Day one starts when you leave this place, that's day one, you have not been at it for five months or whatever, day one is when you have left.'

'They left you out of here at nine o'clock and your bus isn't due until half ten, there is an off-licence across the road so'

'They have started selling from about nine o'clock.'

'Get arrested by twelve!'

'It's too readily available.'

'That's the main problem, too readily available hey?'

'And even if you are an alcoholic and you are not going to buy it, you will just go to the shop and steal it. It's as simple as that'

'You are always going to get it, if you haven't got any money you go to your mates, they will have money to get drink, or with your dole money hey?'

In addition, there was recognition of the need to address the problems that might have influenced the initial imprisonment. In one group lack of employment opportunities were mentioned as being a reason to turn to drink from boredom, and it was felt that being in prison ('in storage') could make unemployment more likely:

'That goes back to what I said as well, short term/long term, especially short term have got to want ... have the willingness as well ... Everybody has got problems and they still sort of address the problems, even though they have come out of prison the problem is still there. If it's an alcohol problem it's still there, if it's drink, a drug problem it's still there. If it's a family problem, it's still there. They have got to go to these places to address these things and understand them, and maybe get treatments if they need them.'

'Whereas people that have not got a job and they have nothing to do through the week they are constantly doing it [drinking]. Boredom! Something to do. Give them something ... give them a trade, learn something, you don't get f*** all here ... You go out and show somebody that [certificate from trade work], they go "Ha-ha you have been in jail for f***'s sake, away you go".'

One prisoner reported previous experiences of having been given Antabuse. He felt he had managed to control his drinking for some time with its help, but felt a strong urge to be a social weekend drinker, and so tried to modify the doses, but eventually stopped using it:

'... knowing that I was going to be sick ... I came off it on the Tuesday because I wanted to go out on the Saturday night and it still affected me on the Saturday.'

'You are like, "Oh shit, I shouldn't have taken it. I want a drink".'

'I want to drink socially; I want to go back to social drinking just at the weekends again ... For six months I was drinking every day.'

Most respondents were aware that services were available to help those with difficulties related to their drinking and were able to name local agencies 'there are loads', although some highlighted the difficulty in getting places on intensive rehabilitation facilities. Mechanisms to help linking with local services were also known to prisoners, notably through the Links Centre, social workers and EACS:

'When it's coming to get released you go down there [Links Centre] and they ask you if you need anything for when ... And they will ask if you need any help on the outside with your drug or alcohol when you are going out, your social worker.'

'They don't pick everybody up but you have got that Throughcare and Addiction Service [that] make appointments for you with the people that you need to see or you tell them you need to see but that's at the end of your sentence.'

‘And does that happen for every prisoner?’ [Interviewer]

‘No. No. No. Not at all.’

‘I think ... they will come and approach you but again they focus on drug addiction, the focus is on ... people that are in for drug-related offences. In fact, I am sure you have got to be in for a drug-related offence ... for them to even come and see you.’

‘You could ask to still work with Phoenix when you get out and they would set it up for the nearest Phoenix outside for you and that.’

However, some prisoners acknowledged the importance of personal motivation to make any liberation support structures work, especially if attendance was not a condition of their release. Where attendance was required, for example attending a probation officer, this was not always seen as a positive experience:

‘Like basically they could set you up with an appointment to see an outside agency, but’

‘If you don’t want to turn up then they are not going to pursue it.’

Some respondents also mentioned the option of pre-liberation advisory sessions, but these were seen to be quite narrow, being more drugs focused and highlighting the frequently repeated messages regarding risks from reduced tolerance. It appeared for some that this information could be seen as encouraging drug use, albeit more safely. Young offender respondents, imminently due for liberation, reported being given a brown envelope containing a range of substance misuse-related leaflets, including ‘How to go out drinking without getting the tripe beaten out of you’⁵⁰, but without any accompanying interpersonal advice at that point⁵¹:

‘You get taken up to the Links Centre and that a week before you go out or something and they tell you about all the ... they tell you all about it when you first come in the jail.’

‘It’s mostly about drugs is it ken?’

‘Telling you about your immune system, once you have been here ... and your immune system is obviously run down so you are.’

‘Not drink as much.’

7.6.2 Liberation: staff

As with prisoners, staff were also very conscious of the challenges of liberation. Immediate temptations to go to the ‘boozer’ or local off-licenses were widely recognised with arrests and rapid return to custody, even within the same day, being seen as not uncommon.

While challenging for all prisoners, many short stay prisoners were reported as being less likely to have a robust care plan set up and rarely had statutory throughcare

⁵⁰ Lifeline ‘How to go out drinking without getting the tripe beaten out of you.’

<http://lifelinepublications.org/catalogue/how-to-go-out-drinking>

⁵¹ SPS reported however that normal practice would be to give out a pack in the course of a one-to-one session.

requirements. In addition, they might be released at short notice making planning difficult, especially if they had been on remand prior to sentence. As well as the immediate temptations to get drunk, many staff recognised the likelihood of a downward spiral on release, with a tendency to return to former friends and habits, which may rapidly lead to behaviours linked to repeat arrests.

Thus, several staff interviewed highlighted the importance of developing service support in the community, not only addressing alcohol use, but also a need for more holistic approaches which would support the prisoner in making positive changes, for example with housing support, benefits advice and employment. However, it was recognised that even with arrangements established, for example with accommodation, prisoners may not turn up for appointments on release or might arrive 'under the influence' at a very late hour. Non-attendance might lead to exclusion from a needed service.

Overall it was felt by staff that links with community services were improving, enhanced by area protocols but that there was considerable scope for improvement in prison-to-community links, and vice versa. Positive developments were identified with community services increasingly coming into the prison, for example 'surgeries' at the Links Centre for employment, housing and benefits advice, as well as the Throughcare Addiction Service (TAS) workers, enabling meetings with community service providers and services being 'set-up' before release. Another example would be community based social workers coming into ICM case conferences to build up relationships with prisoners and develop an appreciation of needs rather than 'starting again' on liberation. Prisoner participation in this case conference or other service links is 'voluntary' but they are advised that it will be helpful. Again prisoner type and sentence will result in differing liberation support, in particular the extent of engagement with TAS.

Staff reported that EACS offer a 'pre-liberation' group session, seen as particularly useful for those who have not engaged with EACS during their stay, but as prisoners commented, this was a measure aimed at reducing drug related deaths after release rather than addressing alcohol issues.

Finally, clinical support of abstinence on liberation, for example with Antabuse, was reported by staff to be relatively infrequent, with concerns expressed about its effectiveness, especially if given without interpersonal support. In addition, concern was expressed about those being released on methadone who might also start to drink with resulting risks of respiratory depression and death. The GP aimed to meet all those being released on methadone to impress awareness of the risks, and it was mentioned that methadone dispensers in the community could be asked to breathalyse before giving methadone.

7.7 Discussion and implications

This case study describes the key issues from the prisoner and staff perspectives on the ground. Interestingly, prisoners and staff had broadly convergent understandings regarding many aspects of alcohol issues in the prison and the wider community, recognising it as an important element in everyday lifestyles as well as in offending

and re-offending. Rich insights are gained into many of the points identified in the mapping exercise (Section 6). Prisoner comments show considerable awareness of the problems in delivering and accessing alcohol interventions in the prison setting. These insights from prisoners can help identify what works for them and addresses the current gap in the literature noted in the rapid review discussion above. There is potential scope to further harness their input to inform planning and delivery of interventions, in addition to current SPS activities aimed at gathering prisoner views.

The case study has indicated that alcohol is viewed by staff and prisoners as closely linked with other substance misuse: less of a dichotomy than in the past, apart from those most heavily addicted. Arguably then, alcohol-related interventions may have to take into account work on other co-occurring substance use. However, all respondents felt that drug problems continue to have a greater focus of activity and resources than alcohol within the prison estate.

Staff and prisoners agreed that the majority of current initiatives and interventions take an informational approach rather than addressing fundamental behavioural issues and tend to be too limited to address the range of needs. It was also recognised that some prisoners may not be ready to address the issue because of 'deeper issues' such as the emotional, social or family problems that the alcohol was 'numbing', for example, or would need considerable support in doing so, not possible for the many with shorter sentences. Thus concerns were raised about the content, depth and value of existing alcohol interventions. Some prisoners felt it was more credible if interventions were delivered by non-prison staff, particularly from those who had 'walked in their shoes' and then made advances with their recovery. Prisoners also expressed preferences for a humanised and practical approach rather than a clinical or manual one.

A variety of providers are potentially involved in alcohol-related interventions across the prison, both among those formally delivering interventions and more generalist staff. Whilst staff may be aware of gaps and needs, and there is notable goodwill on this issue, they are working in separate areas and under considerable time pressures. Communication is often limited to formal referrals rather than expanded communications or a strategic overview of approaches. In addition, for many staff, alcohol would only be one part of their role, with many other demands.

Both staff and prisoners recognised the temptations presented by release. Linked with this, developing service support on release in relation to substance misuse, and wider issues such as housing and financial support, was recognised as an important trend, including services coming into the prison. Whilst Family Information Packs had been introduced, it was notable that the issue of families was not on the radar of prisoner or staff respondents in this context, despite the role that families and other social networks often play in desistance from offending and recovery from addictions (Loucks, 2004). In addition, limited literacy skills were identified as a barrier to accessing services that required written application in prison, and to using health promotion materials, in addition to wider lifestyle impacts. *Scotland's Choice* (Scottish Prisons Commission, 2008) also highlights this issue and whilst literacy may not be markedly worse than in the communities from which prisoners are largely

drawn (Clark and Dugdale, 2008), nevertheless such difficulties will have an effect on social inclusion.

In principle, prison presents a valuable opportunity to address alcohol issues; with enforced abstinence, healthier behaviours such as regular meals, time to think, and access to services and support. However, from the perspective of prisoners, there are long periods where they report being 'left to your own devices'. An inherent distrust of staff, both those providing programmes as well as general officers, alongside the wider prison environment, also makes fundamental life review and subsequent changes considerably challenging.

7.8 Key findings

- Broadly convergent understanding of many alcohol aspects among prisoners and staff was apparent.
- Recognition that alcohol is linked to offending, including violent offending, and drug use.
- Perception that alcohol issues are not as well resourced or as prominent as drug interventions.
- Recognition that not all prisoners will acknowledge alcohol problems or want to deal with them.
- Recognition that differing patterns of alcohol misuse exist across age groups.
- Prisoners view the alcohol problem assessment on admission as an 'aye or no' question, asked at a time of competing concerns and when taking in new information can be difficult.
- Initial support is limited and related to dependency and physical health needs.
- Form filling can be a problem for those with literacy difficulties.
- Challenge to deliver effective interventions for remand/short term prisoners.
- Few interventions address behaviour change and wider issues.
- Prisoners doubt competencies of some prison staff to deliver alcohol interventions effectively - key aspects are an empathetic approach and some separateness from the discipline regime.
- Prisoners want more involvement of 'outsiders' and peers/ex-prisoners/those with experiences of alcohol problems in the delivery of interventions.

7.9 Key messages

- Prisoners' insights into the complexity of delivering and accessing alcohol interventions in prisons can be harnessed.
- Build on awareness among staff and involve them in taking this work forward.
- Tailored interventions addressing individual need continue to be required and expanded, including addressing co-occurring drug and alcohol problems and violence.
- Wider social problems such as social exclusion and unemployment needs to be addressed in alcohol initiatives.
- Structured screening/identification processes are needed followed by proactive referrals.

- Activities need to be mindful of literacy issues including referral processes and information packs.
- Need for a central operational overview on alcohol issues with more direct responsibility than currently.
- Importance of care pathways incorporating community services, and addressing relapse risks, especially for remand or short term prisoners, incorporating improved information sharing on admission and liberation.
- Need for awareness raising / training in alcohol issues for generalist staff as well as extended training needs for specialist staff groups.
- In-reach and buddy services with peers taking lead roles would be worth exploring further.

8. Gap analysis, model of care and care pathway

8.1 Introduction

This section of the report uses the information gathered as part of all other aspects of the study to address the following objectives:

- to conduct a gap analysis between current service provision, best practice, effective interventions and national care standards for substance misuse
- to identify and report on organisational barriers to the delivery of current/proposed models of care
- to identify and report on the perceived workforce development requirements from the evidence and key informants
- to provide recommendations for service development including a model of care⁵².

Best practice on alcohol interventions and standards of care is outlined using current UK policy guidance, and research on effectiveness, in order to clarify what should be provided and how in a prison-based treatment system for alcohol interventions. Most specifically, the integrated treatment systems approach as outlined in *Models of Care for Alcohol Misusers* (abbreviated to *MoCAM*, National Treatment Agency for Substance Misuse/Department of Health (NTASM/DH), 2006) has been used to understand better what gaps exist in current services in the Scottish Prison Service. This has also been the approach of the National Offender Management Service (NOMS, u.d). The main gaps have been identified by categorising what was found in the needs assessment into two main areas: the current situation and potential solutions to address gaps. A model of care and care pathway is then proposed.

8.2 Best practice on effective interventions and standards

8.2.1 Best practices in alcohol interventions

As described in Section 4, ascertaining the effectiveness of alcohol interventions in prison settings is difficult because the evidence base in criminal justice settings is still early in its development. The wider evidence base on effective interventions for general community-based populations (for example, Raistrick, Heather and Godfrey, 2006) is therefore necessary to draw on. The following section should not be taken as comprehensive but more illustrative of the principles that would be important to consider when developing local alcohol care pathways (ACPs) and models of care. While this section will be presenting ideal scenarios there is a recognition that what is best practice for a local context will need to be determined by a range of stakeholders in each context.

- *Levels of screening and assessment* – According to *MoCAM* (NTASM/DH, 2006), three levels of assessment should be used to support alcohol-related

⁵² These have been worked into the text as considerations rather than being listed at the end of the document.

work: screening assessment, triage assessment and comprehensive assessment, all of which support the tiered framework described above.

Screening assessment is a brief assessment that aims to establish whether a person has an alcohol problem (hazardous, harmful or dependent use), the presence of related or co-existent problems including drug misuse and immediate risks for the individual. Screening can also incorporate, or be followed by, a brief intervention.

Triage assessment is a fuller assessment of alcohol problems and aims to determine the seriousness and urgency of a person's problems, including risk factors, and the most appropriate type of intervention. It also aims to assess a person's motivation to engage in treatment.

Comprehensive assessment is targeted at those with more complex needs and those who may require structured alcohol treatment interventions determining the exact nature of the problem, other substance use problems, co-existing mental and physical health problems, social functioning, offending and legal problems and a full risk assessment. Comprehensive assessment may need to be undertaken by different members of a multi-disciplinary team and is best viewed as an ongoing process rather than a single event (NTASM/DH, 2006). The development of a care plan would usually result from this assessment but initial care plans can also be put in place after triage assessment. Assessing risk is an integral part of screening, triage and comprehensive assessment.

- *Drinking goals* – Acceptance of an individual's preference regarding the drinking goal (e.g. abstinence or moderation) is likely to result in a more successful outcome. Raistrick, Heather and Godfrey (2006) suggest that the moderation goal should be reserved for service users with less severe problems i.e. those identified as hazardous and harmful drinkers. One advantage of recommending a moderation goal is to attract people to access alcohol interventions who may be deterred by a focus on abstinence. Generally, unless moderation is contraindicated due to medical problems which relate to alcohol dependence, or because of circumstances such as pregnancy, specific drinking targets should be negotiated with each individual.
- *Goals of treatment* – This provides a reminder that alcohol interventions must be connected to areas of life alongside a person's drinking when planning and evaluating treatment. According to Raistrick, Heather and Godfrey (2006), the targeting of physical health, vocational ambitions, social networks and friendships, living arrangements, offending behaviour and other substance use, for example, should be included in treatment plans in an integrated way.
- *Service user participation and choice* – Service users should be involved in choosing the form of treatment or interventions they receive for a range of reasons including improving the prospects of successful outcomes (Booth, Jones, Taylor *et al.*, 1998). Therefore they need to be provided with accurate, objective descriptions of the available options in a form that they can

understand. This has implications for prisoner populations who have greater literacy issues than the general population (Prison Reform Trust, 2008). Individuals, including those in prisons, can be involved in a range of decisions regarding taking action to address alcohol-related problems such as one-to-one versus group interventions, alcohol-focused versus non-alcohol-focused, low versus high intensity treatment and motivationally- versus socially-based treatment. While local circumstances will almost always vary the likely options available, the principle of self-matching and individual choice should still be carried through a model of care to inform treatment planning and delivery.

- *Involvement of families and carers in care and treatment* – Family members and close friends of people with drinking problems can be helpful in engaging the person in interventions and treatment and bringing about more favourable outcomes of treatment (Epstein and McCrady, 1998). The social environment, including social networks and families, needs to be considered central rather than purely focusing on the individual. Interventions that centrally include families can be important in their own right. This is closely connected to the point above on paying greater attention to a broader set of positive outcomes from treatment, in addition to reductions in alcohol use, including effects on families and the wider social context. Natural recovery is a term used to describe recovery that is not dependent on formal treatment input and which is often mediated through mutual aid groups, peer support, family and friendships. While these issues have been considered to be important aspects of treatment it is recognised that in the context of people in prison the potential for including such approaches may be limited or not feasible.
- *Recovery* – Recovery has been defined as: ‘voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society’ (UKDCP, 2008: 6). According to Malloch and Yates (2010), while recovery has ‘always been implicated, either centrally or on the periphery, of interventions in the drug and alcohol field, it has only recently been embraced by government as a key policy focus and placed at the forefront of policy documents’ (Malloch and Yates, 2010: 9).

In relation to recovery and recent policy, the *Essential Care* report (SACDM Integrated Care Project Group, 2008) identified support services that would maximise opportunity for recovery for those with substance misuse problems and incorporated the principles set out in the national drug strategy, *The Road to Recovery: A new approach to tackling Scotland’s drug problem* (Scottish Government, 2008e). This strategy suggested that moving to an approach based on recovery would mean a significant change in both the pattern of services that are commissioned and in the way that practitioners engage with individuals. While this strategy placed drugs at the forefront of analysis, the stronger emphasis on outcomes and recovery, rather than treatment as the end goal, is also centrally relevant to discussions on the goals of alcohol-specific interventions. In terms of alcohol, the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) has commissioned the Essential Services group to detail what range of alcohol treatment and support services

is essential for local areas, what principles should underlie them and make recommendations for future development.

- *Increasing accessibility and responsiveness of treatment* – Only a small proportion of people in Scotland who might benefit from treatment actually receive it (see Drummond, Deluca, Oyefeso *et al.*, 2009 which states a figure of one in twelve in Scotland). Raistrick, Heather and Godfrey (2006) emphasise the importance of increasing both accessibility and responsiveness to try to address the range of problems, resources, preferences, goals and motivations of those that may benefit from treatment. Extending treatment over time (extensivity) is one way to do this by, for example, providing less intensive interventions over longer periods of time through extended case monitoring. For example, initiatives could be facilitated by enhanced linkages with mutual aid organisations, the voluntary sector, friends and families, more active outreach (or in prison settings ‘in-reach’), fewer requirements being put in place to access services (e.g. less form filling), and making services more rapid and ‘on demand’ to take advantage of peaks in motivation.
- *People with needs in addition to alcohol* – Raistrick, Heather and Godfrey (2006) describe this issue as drinkers with complicated needs and include people with mental health problems, co-occurring other substance use, and groups that may need social consideration based on gender, age, disability and homelessness. Given that co-morbidity of problem drinking and mental health problems is common, the authors suggest that mental health and addictions teams need to be competent in delivering integrated treatment (Raistrick, Heather and Godfrey, 2006: 152). That said, two reports, *Mind the Gaps* (SACDM and SACAM, 2003) and *Closing the Gaps* (Scottish Government, 2007b), have drawn attention to evidence that those with complex needs could be better served by existing mental health or substance misuse services.

Given the known co-morbidity between mental health and substance use problems more broadly in prisoners (see Singleton, Meltzer, Gatward *et al.* 1998), attention should be paid to ensuring that the chosen model of care provides for prisoners with intersecting health problems. There is insufficient evidence in Raistrick, Heather and Godfrey’s (2006) review to support any particular model of integrated treatment for co-morbidity: however, there is theoretical and anecdotal evidence to favour an integrated or shared care approach (Raistrick, Heather and Godfrey, 2006: 158). What is clear is the need to ensure that people with co-occurring health problems are not excluded from treatment.

- *Relapse prevention* – Relapse prevention can mean a variety of different things but usually refers to the work done with an individual post-detoxification or treatment aimed at preventing a return to harmful drinking; a treatment goal rather than a modality (although this does include interventions such as coping strategies and prescribing drugs such as acamprosate). Raistrick, Heather and Godfrey (2006) note that relapse prevention principles should be

incorporated into all specialist treatments for alcohol problems in a variety of treatment settings and that it can improve psychosocial functioning as well as help with alcohol-specific goals.

- *The Stages of Change model* – The Stages of Change model is also discussed in Raistrick and colleagues' review as having 'strong face validity' as a rational approach to intervention (Raistrick, Heather and Godfrey, 2006: 16). The Stages of Change model proposes that there are four main stages that a person will go through in relation to health-related behaviour change: pre-contemplation (including relapse), contemplation (including determination), action and maintenance (Prochaska and DiClemente, 1984). Two Readiness to Change Questionnaires have been developed from the Stages of Change model which can assist in assigning service users to the appropriate stages of change and both are widely used (Raistrick, Heather and Godfrey, 2006). Readiness to change was one of the strongest predictors of outcomes in Project Match (Babor and Del Boca, 2003).

8.2.2 Creating treatment systems, care pathways and models of care

MoCAM (NTASM/DH, 2006) is considered to be a significant milestone towards achieving the second aim of the *Alcohol Harm Reduction Strategy for England* (Prime Minister's Strategy Unit, 2004), 'to better identify and treat alcohol misuse' and suggests the following main categories for consideration in the planning and implementation of alcohol-related interventions:

- (a) integrated treatment 'systems'
- (b) stepped care/tiered interventions
- (c) Integrated Care Pathways/Alcohol Pathways
- (d) integration with other community and social interventions
- (e) services for different alcohol needs based on validated screening and assessment tools
- (f) evidence-based interventions
- (g) quality, competency and workforce issues.

These categories will be discussed to inform the gap analysis and model of care.

(a) Integrated treatment 'systems'

MoCAM is based on the premise that the introduction and development of planned, comprehensive, effective and integrated local alcohol treatment systems can have a beneficial impact on many areas of health and social care:

'There is good evidence that any increased expenditure of resources involved in such an extension of services will be cost-beneficial to society in the long run' (Raistrick, Heather and Godfrey, 2006: 19).

The premise of Raistrick, Heather and Godfrey's (2006) work is to broaden the base of treatment and interventions for alcohol problems, extending the focus to individuals whose problems are less serious than those with severe dependence on alcohol; including those with hazardous and harmful drinking behaviours. This approach aims to reduce alcohol-related harm from a public health perspective, as

well as be in the best interests of the individual. It is this approach which informs this current prison health needs assessment for alcohol study: the broadening of the focus to include those who are not dependent but whose drinking is currently or potentially harmful, as well as to those who are dependent. According to Raistrick, Heather and Godfrey (2006), stepped care is a rational approach to developing an integrated service model that makes best use of finite resources. Raistrick and colleagues' review is designed to be used alongside the *MoCAM* guidance in supporting service commissioners and providers, service users and carers and other interested stakeholders in this development work.

(b) Stepped care/tiered interventions

The tiers of treatment described in *MoCAM* (NTASM/DH, 2006) indicate what kinds of services deliver the kinds of intensities and specialisations of treatment and are designed to work alongside the categories of alcohol problems/use such as that provided by the WHO (World Health Organization, 1992) on hazardous, harmful and dependent drinking. A key idea is that services are offered at the lowest form of intensity to meet the client's needs with the view to these being 'stepped up', if needed. A summary version of this tiered approach is included in Figure 8.1.

Figure 8.1 The four tiers of intervention (adapted⁵³ from *MoCAM* (NTASM/DH), 2006: 20-23)

Tier 1 Interventions: alcohol-related information and advice; screening; simple brief interventions; and referral

Definition: Identification of hazardous, harmful and dependent drinkers, provision of information on sensible drinking, simple brief interventions to reduce alcohol-related harm, and referral of those with alcohol dependence or harm for more intensive interventions.

Interventions: Commissioners need to ensure that a range of generic services provide as a minimum:

- Alcohol advice and information.
- Targeted screening and assessment for those drinking in excess of guidelines on sensible drinking and for those who may need alcohol treatment.
- Provision of simple brief interventions for hazardous and harmful drinkers.
- Referral of those requiring more than simple brief interventions for specialised alcohol treatment.
- Partnership or 'shared care' with specialised alcohol treatment services.

Competency: At least minimal skills in alcohol misuse identification, assessment and interventions including those indicated by Drugs and Alcohol National Occupational Standards (DANOS⁵⁴).

⁵³ For example, the settings category has been excluded because of the need for brevity and the focus of this review on creating a model of care in the SPS where most services will be provided within prisons, though not exclusively because of the need for continuity of care between prison and communities.

⁵⁴ DANOS is not applicable in Scotland so the specific competencies are not detailed here. A new publication by NHS Health Scotland (2010), *Training needs analysis guide: Tackling the alcohol and drug problem in Scotland*, details the competencies required for the alcohol and drugs workforce in Scotland. It specifically deals with criminal justice, as well as a range of other health and social care settings.

Tier 2 Interventions: open access, non-care-planned, alcohol-specific interventions

Definition: Provision of open access facilities and outreach that offer: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.

Interventions: Open access facilities and outreach targeting alcohol misusers which provide:

- Alcohol-specific information, advice and support.
- Extended brief interventions and brief treatment to reduce alcohol-related harm.
- Alcohol-specific assessment and referral of those requiring more structured alcohol treatment.
- Partnership or 'shared care' with staff from Tier 3 and Tier 4 provision.
- Mutual aid groups e.g. Alcoholics Anonymous (AA).
- Triage assessment.

Competency: includes those required for Tier 1.

Tier 3 Interventions: community-based, structured, care-planned alcohol treatment

Definition: Provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

Interventions: Include:

- Comprehensive substance misuse assessment.
- Care planning and review for all those in structured treatment often with regular keyworking.
- Community care assessment and case management.
- A range of evidence-based prescribing interventions, in the context of a package of care including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse.
- A range of structured evidence-based psychological therapies and support within a care plan to address alcohol and co-existing conditions when appropriate.
- Structured day programmes and care-planned day care (e.g. interventions targeting specific groups).
- Liaison services e.g. for acute medical and psychiatric health services and social care services.

Competency: Tier 3 services require competent drug and alcohol specialised practitioners who should have competencies in line with national standards depending on the type of alcohol treatment provided. Medical staff will require different levels of competency depending on their role in alcohol treatment systems and the needs of the service user.

Tier 4 Interventions: alcohol specialist inpatient treatment and residential rehabilitation

Definitions: Provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

Interventions: Include:

- Comprehensive substance misuse assessment, including complex cases

where appropriate.

- Care planning and review for all inpatient and residential structured treatment.
- A range of evidence-based prescribing interventions in the context of a package of care including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse.
- A range of structured evidence-based psychological therapies and support within a care plan to address alcohol misuse.
- Provision of information, advice, training and 'shared care' to others delivering Tiers 1, 2 and support for Tier 3 services as appropriate.

Differences between Tiers 3 and 4 are most specifically the settings interventions are delivered in: Tier 3 incorporates community settings whereas Tier 4 incorporates residential/inpatient settings.

Competency: Tier 4 interventions normally require medical staff with specialist competence in substance misuse and a wide range of competencies as per national standards, as per Tier 3.

It is also important to highlight that the tiers are expected to be viewed as a conceptual framework rather than a rigid blueprint for provision. Tiers refer to the level of the interventions provided rather than the providers themselves. Commissioners need to ensure that all tiers of interventions are commissioned to form a local alcohol treatment system to meet local population needs, in this case prisoners in Scotland. Patterns of local need and provider competencies are key to delivery in such a system.

In terms of types of alcohol misuse and links to the interventions suggested by *MoCAM*, there is no single concise way of categorising individuals in need of alcohol treatment:

'The extent to which individuals would benefit from interventions depends on a number of factors. Key factors include:

- the level of consumption
- the context in which alcohol is used
- the seriousness of the alcohol-related problems
- the severity of the dependence on alcohol.' (NTASM/DH, 2006: 12)

MoCAM identifies four main categories of alcohol misusers who may benefit from some kind of intervention or treatment: hazardous drinkers; harmful drinkers; moderately dependent drinkers; and severely dependent drinkers. There is a reminder that individual drinkers may move in and out of different categories over the course of a lifetime. It is also acknowledged that there is no precise mapping of categories of drinkers to the level and tier of provision required. This is because a number of other factors are taken into account in determining such decisions for each individual. However, the use of these categories enables broad mapping across levels of need and against the range of provision required for any area.

(c) *Integrated Care Pathways/Alcohol Pathways*

Alcohol treatment or care pathways (referred to as alcohol care pathways (ACPs) in the rest of this section) are locally agreed templates for best practice that map out the local help available at various stages of a treatment journey for alcohol (Department of Health, 2009). ACPs are commonly made up of a flow diagram showing the pathway and decision points for particular needs and groups in order to allow a representation, at a glance, of the pathway of care for an individual. The vision of ACPs is to support optimal evidence-based treatment, equitable service provision and efficient and effective service utilisation by service users and providers. The *Local Routes: Guidance for developing alcohol treatment pathways* document (Department of Health, 2009) highlights the need for pathways to be developed that recognise issues such as the cultural appropriateness for the client group, communication needs and physical access to services. The information in the ACP will normally include the local configuration and availability of services. As described above, SMACAP has commissioned the Essential Services group to detail what range of alcohol treatment and support services are essential for local areas, what principles should underlie them and make recommendations for future development.

(d) Integration with other community and social interventions

Research indicates that there are substantial risks that alcohol treatment and support can be disrupted when offenders move from one criminal justice setting to another or back into the community (see Podmore, 2008), and can be particularly problematic for some sub-groups of prisoners, such as women who may be in prisons far away from their home communities. Collaborative, 'joined-up' working, and information sharing between different parts of the system to develop integrated care pathways for offenders with alcohol problems, can be essential in reducing such risks. Increased priority therefore needs to be placed on community linkages as this is a particularly vulnerable point in the system for prisoners.

Best practice guidance (NTASM/DH, 2006; Raistrick, Heather and Godfrey, 2006) suggests that full consideration should be paid to a wide range of outcomes, beyond the reduction of alcohol consumption, as part of alcohol models of care and proposed interventions. As in any piece of complex health behaviour change in the population, notwithstanding the additional challenges when engaging in interventions with a particularly challenged sub-population such as prisoners, there is a need to have a broad focus for the intervention that attempts to include a wide range of potential benefits, in addition to the specific behaviour change of interest. Given that men and women's alcohol use can be closely connected to other issues in their lives such as violence, trauma history, isolation, mental health status and other substance use (Motz, Leslie, Pepler *et al.*, 2006; Parkes, Poole, Salmon *et al.*, 2008; Singleton, Meltzer, Gatward *et al.*, 1998), interventions relating to substance use and offending behaviour require an acknowledgement of the broader context of individual's lived experiences (Malloch and Loucks, 2007).

(e) Services for different alcohol needs based on validated screening and assessment tools

Closely linked to the issues outlined above on wider social needs, the tailoring of interventions is recommended to better meet the needs of individual prisoners as determined by key factors such as their drinking patterns, age, gender, sentence

status and sentence length. There is a need for different services for different needs and prisoner groups/profiles: groups, one-to-one, brief interventions, intensive interventions, and the need to use evidence-based supports where possible. Ideally, there should be a choice of effective interventions to suit the variety of potential individuals that need them.

The screening and case study data presented in earlier sections of this report (Sections 5 and 7, respectively) speak to the intersections between alcohol and other substance use and to the links between alcohol use and multiple layers of social deprivation such as long-term unemployment. Holistic interventions that attempt to see a prisoner as an individual with a range of social- and health-related problems, and to act on improving social as well as health outcomes while trying to create health-related behaviour change regarding alcohol, are essential. Alcohol-related interventions in the SPS, and elsewhere in the criminal justice system, are therefore best viewed as part of a wider framework and vision for intervening at a number of different levels to try to help prisoners ‘turn their lives around’. Integrated case management is the mechanism currently used in the SPS to try to ensure a holistic service model for prisoners.

(f) Evidence-based interventions

‘Treatment effectiveness may be as much about how treatment is delivered as it is about what is delivered. With regard to the “what”, the research evidence indicates that cognitive behavioural approaches to specialist treatment offer the best chances of success’ (Raistrick, Heather and Godfrey, 2006: 9).

Despite there being a lack of evidence on the effectiveness of alcohol interventions in prison populations, there is a considerable evidence base for the effectiveness of alcohol interventions more generally. As Raistrick, Health and Godfrey (2006) suggest, interventions are only effective if delivered in accordance with current descriptions of best practice and by a competent practitioner. This can include how the practitioner is perceived as well as their objective competence to deliver a programme. In terms of assessing evidence-based treatments, mutual aid approaches can be considered to be a treatment alongside more conventional professional-led services.

(g) Quality of care

There are various ways in which the quality of health care is assured in healthcare settings most generally, and substance misuse and criminal justice settings most specifically. *The Healthcare Quality Strategy for NHS Scotland* (Scottish Government, 2010d), a development of *Better Health, Better Care: Action Plan* (Scottish Government, 2007a), produced by the Scottish Government in May 2010 is built around the following priorities:

- Caring and compassionate staff and services
- Clear communication and explanation about conditions and treatment
- Effective collaboration between clinicians, patients and others
- A clean and safe care environment
- Continuity of care
- Clinical excellence.

There are also three 'quality ambitions' which are worth describing in full because of their relevance to this project on the alcohol-related needs of prisoners:

1. 'mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
2. there will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times
3. the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.' (Scottish Government, 2010d: 7).

In terms of staff competencies in healthcare settings, these are clearly described in statutory systems of clinical governance and in the NHS Knowledge and Skills Framework (NHS KSF) (Department of Health, 2004b). The NHS KSF defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver good quality services. It aims to provide a single, consistent, comprehensive and explicit framework on which to base review and development for NHS staff. Specific professional registration criteria and qualifications/accreditation are in existence for groups such as addiction psychiatrists, nurses and general practitioners involved in substance misuse treatment.

In addition, there are also quality safeguarding mechanisms through risk management arrangements, Managed Clinical Networks, SIGN guidelines, clinical audit and the national Patient Safety Programme. The model of care presented below will be drawing on many of these healthcare priorities, of renewed relevance in the context of NHS integration with the SPS due in 2011.

The *MoCAM* document (NTASM/DH, 2006) details the quality standards, including workforce competencies, put in place by DANOS (Skills for Health, 2002 as cited by NTASM/DH, 2006) and the Quality in Alcohol and Drug Services (QuADS) (Alcohol Concern/Drugscope, 1999 as cited by NTASM/DH, 2006) initiatives, however, neither of these frameworks apply in Scotland. The document *National Quality Standards for Substance Misuse Services* (Scottish Executive, 2006b) is the closest reference point for quality standards in this area of practice in Scotland. In addition, a new forthcoming publication will also have a direct relevance to decision-making in relation to workforce competencies in the area of criminal justice and substance misuse: *Training Needs Analysis Guide: Tackling the alcohol and drug problem in Scotland* (NHS Health Scotland, due to be published later in 2010).

MoCAM (NTASM/DH, 2006) sets out further criteria for key quality requirements and while these requirements are too extensive to reproduce here, there are a number of key principles that will be listed next and returned to later in Section 8.4 as part of the proposed model of care:

- The need for a range of interventions and providers of care.
- The development of a treatment system based on assessment of need.

- Health care which reflects the views and health needs of the population served and based on nationally agreed evidence or best practice.
- A system that maximises patient choice.
- Ensuring access (including equality of access) to services through a range of providers and routes.
- Use of locally agreed guidance, guidelines or protocols for admission, referral and discharge which accord with the latest national expectations on access to services.
- Identification of key indicators and monitoring systems to monitor provision and review progress. (NTASM/DH, 2006: 44)

Finally, in terms of criminal justice settings, there are Health Care Standards applicable to healthcare staff working in the SPS⁵⁵. As 'quality' includes the quality of interventions being delivered as well as the competency of the staff delivering them, the SPS interventions are categorised as either accredited or approved, each having a set of processes in place to ensure quality of provision. Longer SPS programmes, for example, have complex quality control mechanisms such as psychologists sitting in on sessions or joint delivery with prison/programme officers, or having the programme sessions video-recorded.

8.3 Gap analysis – where we are now and where we want to be

8.3.1 What is a gap analysis?

A gap analysis is a technique for determining the steps to be taken in moving from a current state to a desired future state. It begins with (1) listing of characteristic factors (such as competencies) of the present situation ('what is'), then (2) cross-listing factors required to achieve the future objectives ('what should be'), and (3) highlighting the gaps that exist and need to be 'filled'. (Sections 3, 5, 6 and 7 have documented the present state, step (1).) Essentially, it is an attempt to map both 'where we are' as well as 'where we want to be'. For the purpose of this analysis, 'need' is defined as the number of individuals in the prison population with an alcohol problem (in the sense of experiencing hazardous, harmful or dependent drinking behaviours) who, if an alcohol intervention was available, could potentially benefit from this (Department of Health, 2005).

In terms of step (2), the rapid review was unable to address fully the question of 'where we want to be' or 'what should be' because of the lack of a suitable evidence base on effective interventions with this specific population. In terms of ascertaining 'what works' in relation to alcohol interventions, prison settings are complex with both diversity in settings and populations making it less than straightforward to undertake high quality studies. There are, however, a number of studies currently being undertaken in Scotland that aim to add to knowledge in this area⁵⁶. In addition to this, the conflation of alcohol and drugs makes it hard to identify specific alcohol-related outcomes in studies that have been undertaken in this area. That said, all the

⁵⁵ There are also assurances built into the EACS contract in terms of minimum training requirements for staff to ensure competency.

⁵⁶ See <http://www.healthscotland.com/topics/health/alcohol/offenders.aspx>

evidence presented in this report (literature, research and primary data), will be drawn upon to suggest potential solutions and implications, while also proposing areas where further research and evidence gathering is needed.

8.3.2 Current situation and solutions to issues arising

From the mapping exercise undertaken as part of this study (Section 6), with the aim to make visible the services and interventions that are being currently offered in the SPS, it is apparent that a range of alcohol-related interventions, and links with the community interface, exist within Scottish prisons. However, a number of important issues have arisen as part of this mapping process that must be emphasised when appraising the gaps in this sector. These are presented in Table 8.1 below.

Table 8.1 Current situation and potential solutions

Current situation	Potential solution(s)
High levels of alcohol problems	<ul style="list-style-type: none"> • Timely access to effective and appropriate interventions based on identified need from screening, triage and comprehensive assessments. • A strategy and good practice model of care document put in place to guide the development of an alcohol care pathway and the development of new services to respond to need. • Existing good practice is supported, maintained and expanded as per agreed model of care. • Enhance capacity in SPS to meet need.
Limited identification	<ul style="list-style-type: none"> • More effective identification e.g. use of a validated screening instrument for all prisoners such as AUDIT. • All staff should have enhanced access to training on alcohol problems, alcohol and links to offending and reoffending behaviour, other substance use and social and health problems in line with identified workforce competencies.
Strong connections between alcohol and other substance use and with mental health problems	<ul style="list-style-type: none"> • Build on existing services that offer interventions for prisoners with co-occurring alcohol, other drug use, mental health problems and experiences of abuse. • Offer interventions that ‘dig deeper’ into the contextual and foundational issues, for those that want this, exploring in more depth the reasons why alcohol is used e.g. access to counselling. • In addition to attending to mental health issues, ensure alcohol interventions are accessible to prisoners with learning disabilities/difficulties.
Strong connections between alcohol and offending	<ul style="list-style-type: none"> • Build on existing services that address alcohol and offending behaviour and alcohol and violence.
High levels of concurrent deprivation/social	<ul style="list-style-type: none"> • Offer interventions that address the complexity and hardship of the majority of prisoners’ lives. • Viewing alcohol problems as connected to social

exclusion indicators in population	inequality, disadvantage and exclusion makes 'joined up' solutions more likely.
Varying needs of sub-populations	<ul style="list-style-type: none"> • Offer tailored interventions based on identified needs. • Explicitly work to address the current significant gaps in service delivery to remand and short term prisoners.
Alcohol has low level of priority in prison system	<ul style="list-style-type: none"> • Continue to raise priority of alcohol amongst all staff. • Continue to ensure alcohol has a specific emphasis separate from drugs, in addition to interventions that address alcohol and drugs. • More information provided to staff in each prison on what is available for alcohol problems. • Create alcohol champions in each prison responsible for raising awareness and priority within establishments. • Working on alcohol-related problems becomes 'everyone's business', with institutional leads accountable for performance and quality standards. • Identified leads should have advanced training and support for such leadership roles.
Limited access to interventions – range of reasons including infrequency of more intensive SPS alcohol interventions	<ul style="list-style-type: none"> • Additional capacity for structured evidence-based psychological therapies. • Provide a range of interventions that will meet the high level of need and/or demand e.g. one-to-one and group interventions, and provide some level of choice. • As well as services needing to exist they need to be accessible. • Increased interventions drawing on peer support or provided by peer approaches. • Examine the implications of overcrowding on the ability of prisons to offer accessible alcohol interventions.
Prisoners are insightful as to the issues facing them and can have high motivation to address alcohol problems	<ul style="list-style-type: none"> • Interventions offered that are meaningful to prisoners, are person-centred, meet their needs and are credible. • Continue to build on the work of ascertaining prisoner views and find new ways for these views to contribute to policy and practice change. • Regular dialogue with prisoners on 'what works' in relation to alcohol use, building their views more explicitly into alcohol interventions including evaluating their effectiveness. • Those with experience of the criminal justice system as prisoners ('peers') are more involved in delivering interventions. • The development of greater opportunities for the collective user voice to be heard nationally and locally⁵⁷.

⁵⁷ See User Voice (2010) The Power Inside: The role of prison councils.

Delays in responding to alcohol needs	<ul style="list-style-type: none"> • Consider appropriate waiting times as part of the development of the model of care (including as part of HEAT target on waiting times). • Good communication and trust make it easier for prisoners to talk to officers about alcohol problems.
Fragmentation of 'the task', divergence of providers and gaps in leadership	<ul style="list-style-type: none"> • Ensure all staff know about the work others in the prison are doing related to alcohol. • Roles and responsibilities are clear regarding alcohol problem assessment and interventions. • Proactive leadership and oversight in each prison. • Continue to develop and enhance networks, e.g. Communities of Practice, amongst those involved in alcohol-related work in each prison, between prisons and community agencies, and between prisons themselves. These can be a way to keep informed of current developments and share innovations, best practice and ideas for new developments.
Varying levels of integration with community supports and services	<ul style="list-style-type: none"> • Build on existing good practice in terms of linkages with the community e.g. surgeries in the Links Centres on housing and benefits. • Local agencies provide services in prison and to prisoners whatever a prisoners 'home' location is. • Cross-referrals both within and outside of the SPS. • Support for Alcohol Drug Partnerships, community planning and proactive development of new community resources. • Staff involved in good practice developments could be encouraged to provide training and assistance to other prisons to help them get new initiatives off the ground. • Prison staff to continue to notify external agencies involved with prisoners when that person is in custody (with prisoner's permission) to try to prevent breakdown of relationships with community agencies that may be essential on liberation. • Community agencies to notify SPS staff as to whether substance use prevention referrals are taken up once prisoners are liberated back into the community. • Need for support for families for effective resettlement of prisoners with alcohol problems.
Lack of peers and 'outsiders' involved in delivering interventions	<ul style="list-style-type: none"> • As per the Substance Related Offending Behaviour programme, peers and mutual aid organisations become more involved in the planning, delivery and evaluation of alcohol interventions • Explore the potential of health trainer models for alcohol-related interventions using evaluated pilot projects.
Potential for development of	<ul style="list-style-type: none"> • Enhanced assessments will enable better information about prisoner needs to be collected and used for

administrative data for service development	<p>service planning and improvement.</p> <ul style="list-style-type: none"> • The potential for administrative data to be used to inform service development in this area is expanded. • Research and evaluation play an important part in evidencing interventions and initiatives that appear to be addressing needs and responding to gaps. • Create further opportunities for the piloting of new methods in line with the emerging evidence base.
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8.4 Proposed model of care

8.4.1 What should be provided?

A model of care, or treatment framework, outlines the provision necessary to have a meaningful impact on prisoners with a range of alcohol-related needs. It is important that the model of care for the SPS is a full model of care i.e. representing treatment pathways that address all four tiers, as per *MoCAM* (NTASM/DH, 2006), in order to offer equitable provision as compared to that accessed in the community. This is informed by the principle of equivalence which means that standards of health care for people in custody should be the same as for those in the wider community. Figure 8.2 addresses what is currently delivered in the SPS and where the gaps are/what is needed to fill gaps, according to the *MoCAM* tiered model outlined in Figure 8.1 above. This model is designed to be read in conjunction with the section above on gaps which informed the *how* as well as the *what*, in terms of delivery.

Figure 8.2 Tiered delivery – current and proposed delivery for Model of Care

Tier 1	
Currently delivered	
<ul style="list-style-type: none"> • Limited screening (yes or no question) • Alcohol advice and information (Enhanced Addiction Casework Service (EACS)) • Overdose Awareness Session (has alcohol component) • Referral of those requiring more than above for specialised alcohol treatment (to EACS) 	
What is needed in addition to above	
<ul style="list-style-type: none"> • Universal screening with validated tool for increased detection of alcohol problems • Verbal self-referrals due to literacy issues • Piloting and evaluation of simple brief interventions for hazardous and harmful drinkers accessible to all who need them including short term (under 31 days) and remand prisoners⁵⁸ • Interventions offered that are meaningful to prisoners, are person-centred, meet their needs and are credible. 	

⁵⁸ Based on emerging evidence on the effectiveness of such interventions, see Section 4.

Tier 2
Currently delivered
<ul style="list-style-type: none"> • Alcohol-specific information, advice and support (EACS Alcohol Awareness session, SPS approved activity Alcohol Awareness) • Alcohol-specific assessment (health assessments) and referral of those requiring structured or more intensive support and interventions (EACS) or treatment (prison health care) • Triage assessment (Addictions Nurse) • Mutual aid groups (Alcoholics Anonymous)
What is needed in addition to above
<ul style="list-style-type: none"> • Universal screening with validated tool for increased detection of alcohol problems • Extended brief interventions and brief treatment to reduce alcohol-related harm among hazardous/harmful drinkers and possibly mildly dependent drinkers • The provision of personalised feedback, often part of brief interventions, could be used to enhance motivation for action • Provide a range of interventions that will meet the high level of need and/or demand e.g. one-to-one and group interventions, and some level of choice • Increased interventions drawing on peer support or provided by peer approaches • Interventions offered that are meaningful to prisoners, are person-centred, meet their needs and are credible.

Tiers 3 and 4⁵⁹
Currently delivered
<ul style="list-style-type: none"> • Comprehensive substance misuse assessment (but effective detection is missing) • Care planning and review for those in structured treatment • Case management • Evidence-based prescribing interventions (alcohol withdrawal/detox) and prescribing interventions to reduce risk of relapse • Structured evidence-based psychological therapies (e.g. SPS prisoner programmes) that address alcohol and co-existing conditions (i.e. alcohol and offending behaviour - SROBP, alcohol and other substance use) • Liaison services for acute medical and psychiatric health services • Pre- and post-release work including community integration
What is needed in addition to above
<ul style="list-style-type: none"> • Enhanced detection using a standardised tool, prior to comprehensive assessment • Enhanced capacity for additional structured evidence-based psychological therapies including counselling approaches – provide access to meet need • Better access to all interventions for short term prisoners whether in community or prison • Interventions offered that are meaningful to prisoners, are person-centred, meet

⁵⁹ Tiers 3 and 4 have been collapsed because the major difference is residential versus community settings which is not a useful distinction in prison services.

their needs and are credible.

- Increased interventions drawing on peer support or provided by peer approaches
- Interventions/therapies/treatment targeting specific groups (i.e. levels of dependency) and diversity issues – i.e. women, co-existing mental health problems/dual diagnosis, learning disabilities, and social problems such as homelessness and literacy
- Enhanced work on community and external provider linkages for communication and service access including in-reach
- Emphasis on throughcare for all prisoners with identified alcohol problems.

8.4.2 Workforce development considerations

There is a need for a SPS workforce strategy to ensure that those providing the ACP are appropriately knowledgeable, skilled and confident in delivering the screening and intervention activities. This is likely to involve building on the range of existing skills, knowledge and competencies and will need to be based on current roles and responsibilities and the tiers of intervention that staff will be involved in. Training in the provision of screening and brief interventions will be needed as a minimum but this will be dependent to a large extent on what detailed care pathways each local areas choose to develop. Workforce competencies for different staff members involved can be developed using existing quality and competency frameworks (e.g. Competency Framework for Nursing Staff in SPS; National Quality Standards for Substance Misuse Services) and the new framework: *Training Needs Analysis Guide: Tackling the alcohol and drug problem in Scotland* (NHS Health Scotland, due to be published 2010).

8.4.3 Resource and cost implications

Clearly development and implementation of a model of care will need to take into account costs and resources. One of the initial objectives of this study had been to: 'explore and report on the resource and cost implications of implementing alcohol interventions in the prison setting addressing both existing provision and alternative models' (objective 11). However, it became clear that a proper cost analysis was beyond the scope of the project for two main reasons: firstly the rest of the project objectives generated so much primary data within the timescale and resources that it was not possible to address this aspect comprehensively, and secondly it also became apparent that individuals interviewed did not have access to data on current alcohol-specific costs. In addition, current interventions relating to alcohol are closely linked with drug-related activities, so costs are hard to disaggregate.

Once the characteristics of the model of care have been agreed it will be important to consider costs and resource implications of the changes suggested, including service redesign/rebalancing, in consultation with appropriate stakeholders and taking into account other policy developments such as the transition to NHS delivered health care in SPS. The study identifies some key requirements which would need to be mapped against provision including: staff contact time, staff

preparation and reporting time, administration support, training and awareness-raising, rooms and IT access, monitoring and audit activities, and prescribing.

Allocating resources for the positive involvement of a wide range of generalist staff may contribute to a more positive climate of recognition of the importance of addressing alcohol issues and taking action. Clearly some elements will come under the integration with NHS Health Care Services⁶⁰ planned for 2011, and will be of relevance to work streams such as ‘throughcare’ and ‘models of care’ and will become cost considerations for Health Boards. While there will be upfront costs there is also likely to be significant “downstream” savings from this work, including in terms of reducing reoffending.

8.5 Alcohol Care Pathway (ACP)

As described above, Alcohol Care Pathways (ACPs) are locally agreed templates for best practice that map out the local help available at various stages of a treatment journey for alcohol (Department of Health, 2009). A flow diagram is now outlined showing the pathway and decision points for prisoners in a high level pathway of care that has been designed to be a subject for dialogue in local areas when planning and commissioning appropriate alcohol services for this population (Figure 8.3). The existing SPS substance misuse flowchart, the Integrated Addictions Process (see Appendix 18⁶¹), covers many of the dimensions needed in an ACP and was used in the development of the one detailed below.

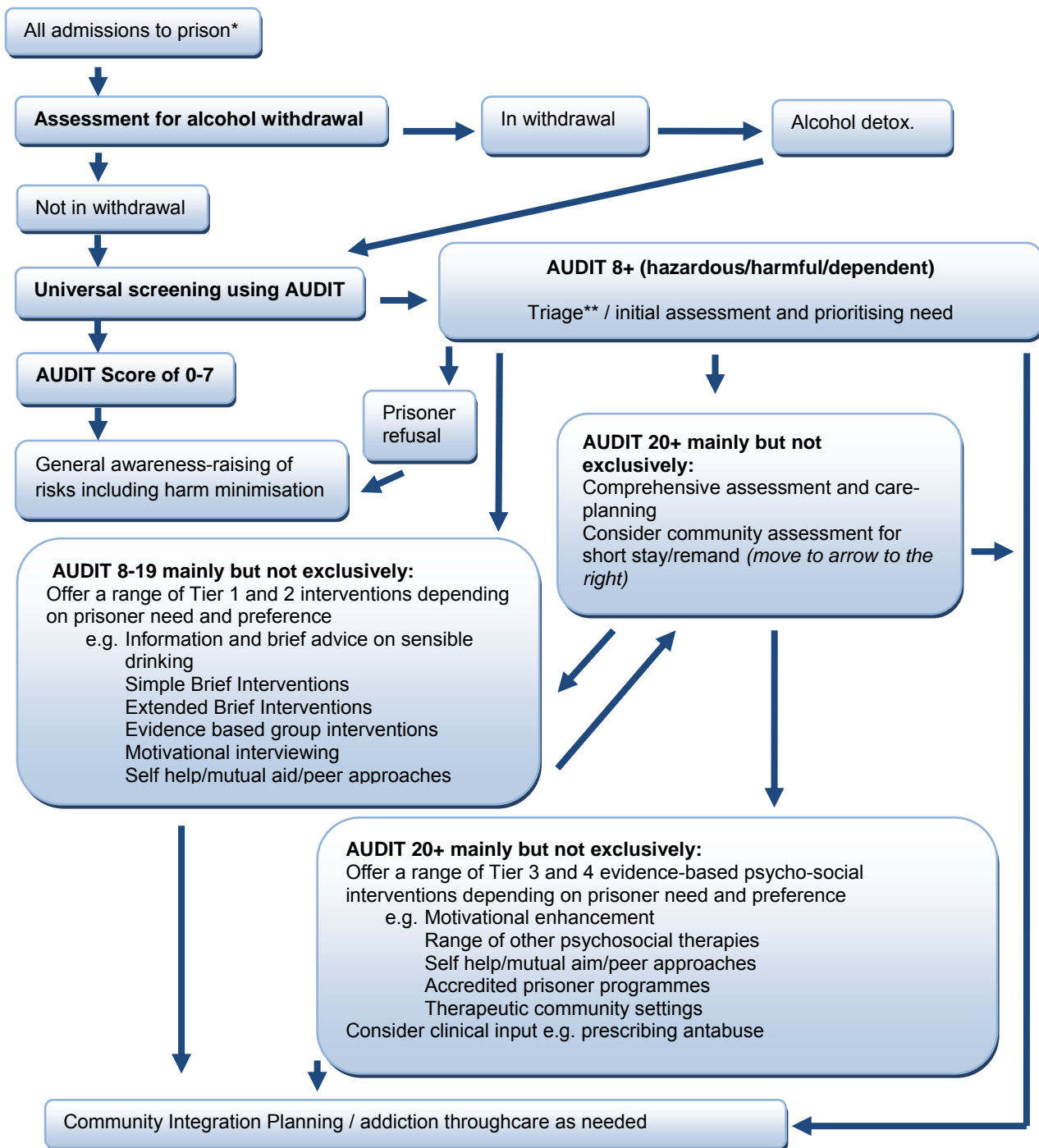
A decision was made to focus on the major decision points and activities only, rather than map the detail of who should be involved, how and detailed timeframes. It is envisaged that, in conjunction with the SPS and the NHS, individual prisons, local Health Boards and other providers will be able to use this ACP to determine what is required to be in place to meet their population’s needs. Sharing of relevant information and joint collaborative working arrangements can be facilitated by the development of an integrated ACP pathway through local consultation and negotiation. Additional pathway routes should be considered for groups with specific needs such as:

- people with co-existing mental health problems
- people with co-existing drug use problems
- people affected by domestic abuse
- homeless people
- women (including pregnant women with/without alcohol dependency).

⁶⁰ See <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/SPSHealth>

⁶¹ The Integrated Addiction Process (IAP) from the SPS Substance Misuse Strategy is available on the SPS Internet: <http://www.sps.gov.uk/Default.aspx?documentid=a6a680de-a162-455b-ac68-438577af40e8>

Figure 8.1 Integrated Alcohol Care Pathway for Scottish Prisoners⁶²



* At any point in a prisoner's stay if they/others think they have an alcohol problem they can enter the start of the process.

** Triage is a critical part of the decision making process and includes determining the presence of other co-occurring social and health problems and the prioritisation of those that most need interventions in the context of high demand.

⁶² Pathway is broadly suggested by AUDIT score but judgement is needed to take into account other issues such as co-morbidity etc. General principle: prisoners on sentences of 31 days and under should have equitable access to alcohol related interventions specific to their needs whether in prison or in the community after release. If in prison for 31 days and under, provision likely to be in the community setting and assessment may be more appropriate in local settings in these cases.

8.6 Key messages

- Limited evidence on the effectiveness of alcohol interventions in prison settings makes it important to use wider literature on the effectiveness of alcohol interventions in community settings to inform a gap analysis and model of care for the SPS.
- A wide range of important principles underpin best practice in alcohol interventions.
- The SPS is best viewed as a "treatment system" when thinking about the development of a model of care and integrated care pathway/s for alcohol.
- Planning and development of tiered interventions is an important mechanism in being able to better target and tailor interventions to prisoner need.
- Good assessment, including use of a validated screening tool, is necessary in order to ensure prisoners with alcohol-related needs are offered relevant needs-led opportunities to address alcohol problems irrespective of length of stay.
- There are a range of mechanisms available in healthcare, substance misuse and criminal justice to inform the development of high quality alcohol-related interventions in the SPS, including those specifically addressing the workforce competencies required.
- Integrated Alcohol Care Pathways in the SPS are likely to be best developed as a result of multilevel discussions amongst a range of local stakeholders who have a shared responsibility for prisoner healthcare and substance misuse interventions, including those representing family and user interests.

9. Conclusion

Prevalence of alcohol problems amongst prisoners is far higher than in the general population in Scotland and evidence suggests the problem is worsening. This study identified, through a multi-method approach, a considerable proportion of individuals in the Scottish Prison Service who could benefit from interventions that address alcohol consumption and alcohol-related harm. Alcohol consumption was shown to be linked with crime, especially violent crime. Findings showed that the nature of alcohol problems vary among prisoners, including drinking patterns and extent of dependency, highlighting the need for tailored provision.

The rapid review identified a range of relevant literature to guide this work but evidence is limited regarding the effectiveness of alcohol interventions conducted in prison settings, and there is a notable lack of published UK studies. While a range of alcohol-related interventions and links with the community interface exist within Scottish prisons, the study has highlighted that within current arrangements, many prisoners who could potentially benefit from such interventions are being missed. Administrative and primary screening data both draw attention to a disparity between the number of Scottish prisoners with alcohol problems and the number of prisoners accessing interventions. This finding is not unique: a range of other UK reports have noted similar disparities (see HM Inspectorate of Prisons, 2010 for example).

Alcohol related activities in prisons take place within the limitations of the custodial regime which is also concerned with security and safety, control and authority. The demands of working with prisoners to meet their health care needs and follow best practice from other health contexts, for example, treating the client/patient as an equal partner in care, should not be underestimated when undertaking work related to improving alcohol interventions in the prison setting (see Walsh, 2007). Prison presents an opportunity to address alcohol issues among a particularly marginalised group of people; with enforced abstinence, healthier behaviours such as regular meals, time to think, and access to services and support. However, from the prisoner perspective, there are long periods where they are 'left to their own devices'. Indeed, factors that can limit the ability of prisoners to access good alcohol interventions may be commonplace. For prisoners, a distrust of staff, those providing programmes as well as general officers, alongside the wider oppressive prison environment, can make fundamental life review, and subsequent changes, considerably challenging. For staff, demanding workloads, administrative boundaries and skills issues can limit their potential to offer effective support and interventions.

The planning and development of tiered interventions, based on detection with a validated screening tool and subsequent comprehensive specialist assessment when appropriate, is an important mechanism in being able to better target and tailor interventions to prisoner need. Integrated Alcohol Care Pathways in the SPS are a vital part of this process and likely to be best developed as a result of multilevel discussions amongst a range of stakeholders. It is hoped that this report will add to current awareness of alcohol-related problems amongst individuals in prison in Scotland and contribute to building on the achievements made thus far. As shown in

this report, addressing the gap between provision and need has the potential to generate significant positive outcomes for prisoners, their families and society.

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Appendices

Appendix 1. Glossary

AA	Alcoholics Anonymous; a voluntary agency of mutual support, organised and operated locally among those with alcohol dependency
AARS	Alcohol Arrest Referral Schemes
ABI	Alcohol Brief Intervention
ACP	Alcohol Care Pathway
ARW	Arrest Referral Worker; provides drug assessments and advice to offenders arrested for key offences or who test positive for Class A drugs. The ARW will refer to the appropriate service and offer the offender encouragement and support to take up the help offered
AUDIT	Alcohol Use Disorder Identification Test; to identify persons with hazardous and harmful patterns of alcohol consumption developed by the World Health Organization
CAGE	A four-item questionnaire used as a quick screening device for alcohol dependence, its title an acronym of the four questions' themes: Cut down, Annoyed, Guilty and Eye opener
CIP	Community Integration Plan
DANOS	Drugs and Alcohol National Occupational Standards; describe all the functions and activities involved in improving the quality of life for individuals and communities by minimising harm associated with substance misuse (in England and Wales)
DTs	<i>Delirium Tremens</i> ; a psychotic condition typical of withdrawal in chronic alcoholics
EACS	Enhanced Addiction Casework Service
FME	Forensic Medical Officer
GPASS	General Practice Administration System for Scotland; clinical and administrative software for Scottish GP practices
Home Detention Curfew	Licence scheme allowing prisoners to live outside of prison monitored by an electronic tag system
ICM	Integrated Case Management; SPS works work closely with other agencies to support prisoners with their social/personal difficulties to reduce reoffending
The Links Centre	Provides a physical setting where prisoners can receive a consistent induction, where the needs of very short term prisoners can be met and where all prisoners can be assisted with their re-integration back into their community. Prisoners are 'linked' to a range of services and partners to assist with reintegration and resettlement
The Listener Scheme	A peer support scheme whereby selected prisoners are trained and supported by Samaritans, to listen in complete confidence to their fellow prisoners who may be experiencing feelings of distress or despair
MI	Motivational Interviewing
MoCAM	Models of Care for Alcohol Misuse; Department of Health best practice guidance for delivering local treatment system for

	adult alcohol misusers
MTC	Modified therapeutic community
NICE	National Institute for Health and Clinical Excellence; provides national guidance on promoting good health and preventing and treating ill health in England and Wales
OASys	Offender Assessment System
Phoenix Futures	A registered charity providing services for people with alcohol and drug problems. Contracted by SPS to provide EACS for prisoners with drug and alcohol problems in public sector prisons
PR2 System	Prisoner recording and management software application with data stored on a central database at the SPS
QuADS	Quality in Alcohol and Drug Services
RCT	Randomised controlled trial
Recidivism	The return to an undesirable behaviour pattern, such as committing another criminal offence after punishment or becoming drug-dependent again after an apparent cure of addiction
SACAM	Scottish Advisory Committee on Alcohol Misuse
SACDM	Scottish Advisory Committee on Drug Misuse
SHeS	Scottish Health Survey; provides a detailed picture of the health of the Scottish population in private households
SIGN	Scottish Intercollegiate Guidelines Network; develops evidence based clinical practice guidelines for the NHS in Scotland
SIPS	Screening and Intervention Programme for Sensible drinking
SMACAP	Scottish Ministerial Advisory Committee on Alcohol Problems
SPS	Scottish Prison Service
SPS Alcohol Awareness (AA) Programme	A groupwork programme aiming to look at the harmful physical and social effects of alcohol use and allow participants to explore their own alcohol use
SPS Core Screen/Induction interview	The Core Screen process is the initial contact for all prisoners who will be involved in the Integrated Case Management system and provides the platform for specialist agencies to engage with the prisoner and plan activities via the Community Integration Plan (CIP)
SROBP	Substance Related Offending Behaviour Programme; SPS programme designed to address substance related offending behaviour in prisoners who are a medium to very high risk of reoffending
TAS	Throughcare Addictions Service; aims to provide continuity of care for those leaving custody who wish to continue receiving treatment in the community
UKATT	UK Alcohol Treatment Trial
WHO	World Health Organization

Appendix 2. Key points in relation to the AUDIT screening tool

Devised in the early part of the 1980s by the World Health Organisation, the AUDIT is a fully validated brief screening tool with high reliability, sensitivity and specificity that measures frequency, consumption, dependence, and harm linked to alcohol usage (Bohn, Babor and Keranzler, 1995; Babor, Higgins-Biddle, Saunders *et al.*, 2001; Daepfen, Yersin, Landry *et al.*, 2000).

The AUDIT Screening Tool

The AUDIT is made up of 10 core questions broken down into sub-sections:

- Qs 1-3 enquire about a person's alcohol intake
- Qs 4-6 examine abnormal drinking behaviour and alcohol dependence
- Qs 7-8 address the link between alcohol consumption and the detection of psychological effect
- Qs 9-10 deal with alcohol-related problems (Saunders, Aasland, Babor *et al.*, 1993).

Questions 1-10 are all scored from 0-4. The WHO advises using a total score of 8 or more as a guide that reflects hazardous/harmful/dependent drinking behaviour:

- Zone I 1-7 represents low risk drinking or abstinence
- Zone II 8-15 represents a medium level of alcohol problem
- Zone III 16-19 represents a high level of alcohol problem
- Zone IV 20+ requires further diagnostic evaluation for alcohol dependence (Babor, Higgins-Biddle, Saunders *et al.*, 2001).

The AUDIT questionnaire (Babor, Higgins-Biddle, Saunders *et al.*, 2001) was chosen for the screening aspect of this study because it enquires about both frequency and level of consumption, and therefore measures people at risk of dependence and risk of hazardous / harmful drinking as well as possible dependency. Another desirable feature of AUDIT, according to Proudfoot and Teeson (2001) and Proudfoot, Teeson and Ashton (2001), is that it is easy to administer and can be administered by staff with no formal training as well as being deemed appropriate for use with prisoners (Babor, Higgins-Biddle, Saunders *et al.*, 2001; Effective Interventions Unit, 2003).

This study required such a tool because it was to be administered by prison officers and incorporated into an existing screening process covering many issues (the Core Screen described further in Section 6 on mapping alcohol interventions across the prison estate). The intention was to minimise risks of under-reporting of alcohol consumption and minimise disruption to the existing Core Screen process (see Appendix 9 for full screening tool).

Appendix 3. CAGE responses in the Scottish Prison Annual Survey 2008

(Data provided by the Scottish Prison Service)

Scottish Prison Service survey	Age (%)							Total
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
Men								
On the outside did you ever think you ought to CUT DOWN your drinking?	49	35	35	45	37	19		41
Has anyone ANNOYED you be criticising your drinking?	40	29	29	35	29	19		33
Have you ever felt GUILTY about your drinking	36	32	32	42	34	10		34
Have you ever had an EYEOPENER a drink first thing in the morning	49	40	38	38	35	19		43
<i>positive on 2 or more of the above indicators</i>	53	38	39	47	40	19		44
Women								
On the outside did you ever think you ought to CUT DOWN your drinking?	42	40	49	54				42
Has anyone ANNOYED you be criticising your drinking?	42	25	30	46				33
Have you ever felt GUILTY about your drinking	44	35	42	62				41
Have you ever had an EYEOPENER a drink first thing in the morning	39	37	46	31				37
<i>positive on 2 or more of the above indicators</i>	56	42	52	54				48
<i>Number of participants answering all 4 CAGE questions</i>								
<i>Males</i>	1061	920	576	288	91	21	<5	2961
<i>Females</i>	52	60	33	13	<5	<5	<5	163

Appendix 4. CAGE responses in the Scottish Health Survey 2008

(Table provided by Scottish Government Health Analytical Services Division (2010))

Scottish Health Survey	Age (%)							Total
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
Men								
Felt the need to cut down on drinking	30	28	35	31	28	21	14	29
Been criticised for drinking	12	13	9	9	6	7	3	9
Felt guilty about drinking	18	15	11	8	7	5	3	11
Had to drink to steady nerves	9	8	5	2	3	2	-	5
<i>positive on 2 or more of the above indicators</i>	19	18	14	12	9	7	5	13
Women								
Felt the need to cut down on drinking	27	26	26	26	19	11	3	22
Been criticised for drinking	13	5	7	4	3	1	1	6
Felt guilty about drinking	12	14	8	8	3	1	1	8
Had to drink to steady nerves	5	2	1	1	2	-	1	2
<i>positive on 2 or more of the above questions</i>	14	13	10	9	4	1	1	9
<i>Bases in SHeS (weighted):</i>								
<i>Men</i>	391	391	447	450	384	237	132	2431
<i>Women</i>	359	355	471	444	359	223	130	2342
<i>Bases in SHeS (unweighted):</i>								
<i>Men</i>	205	257	361	427	415	326	187	2178
<i>Women</i>	265	332	501	473	442	295	154	2462

Appendix 5. Methodology and process for rapid review

Searching for relevant studies and evaluations

Searching exhaustively for studies and evaluations is an extremely time consuming activity. Due to the short time given to undertake a rapid review, the best use of the time is spent evaluating and synthesising the evidence rather than searching for every review or study. Therefore, a pragmatic search was undertaken which aimed to be very specific but may have lacked 100% sensitivity (i.e. may miss a small percentage of the studies or reviews). Due to the time available, this is viewed as a regrettable but acceptable outcome of adopting such an approach. The missed studies are more likely to be published in poor quality journals and are unlikely to substantially change the results of the review. Only English language studies and reviews were included which had been undertaken or updated since 1995. Studies or evaluations published before this date may not reflect current approaches to identification or treatment of alcohol problems. Both electronic databases and the Internet were searched for studies and evaluations. The databases which were searched depended on the type of evidence:

a) Reviews of interventions

The Cochrane Library and the Database of Abstracts of Review of Effectiveness (DARE) were searched for review articles.

b) Primary studies

Databases including ASSIA: Applied Social Sciences Index and Abstracts; EMBASE; Society Today; Cochrane Central Register of Controlled Trials; IBSS: International Bibliography of the Social Sciences; MEDLINE; PsycINFO and Social Services Abstracts were searched.

In addition, we did some broad based searching of the Internet to identify UK evaluations or reviews which may not be published in peer review journals but nonetheless may contribute to the evidence base. We only included those that were readily accessible as reports. The search terms we used are detailed below.

Search terms

a) *alcohol-related terms*

(alcohol adj3 (abuse or misuse or consumption or drinking or harmful or hazardous or dependen\$ or problem\$)).mp. ⁶³

(alcoholic or alcoholism).mp.

((binge or excessive or heavy or problem or harmful or hazardous or dependen\$ or problem\$) adj3 drink\$) mp.

These terms were combined with the Boolean operator 'or'

b) *population-related terms*

⁶³ mp=ti, ab, tx, kw, ct, ot, sh, hw, tc, id, pt, an, tn, dm, mf, nm

Prisoners/ or Crime/ or Juvenile Delinquency/
(prisoner\$ or inmate\$ or offender\$ or delinquen\$ or incarcerate\$).mp.

These terms were combined with the Boolean operator 'or'

c) Study specific terms

intervention.mp. or Intervention Studies/
treatment.mp. or Therapeutics/
screening/ or identif\$.mp. or screen\$.mp.
evaluation studies/
evaluation\$.mp.
randomized controlled trial/
controlled clinical trial/
randomized controlled trials/
random and allocation
random or randomised
interrupted time series.mp.
before and after studies.mp.
qualitative.mp. or interview.mp. or (focus group).m.p.
model of care
health/needs assessment
effective model
best practice

These terms were combined with the Boolean operator 'or'

As The Cochrane Library only includes systematic reviews, reviews or RCTs and these are grouped in separate databases, search terms included in group a) were combined using the Boolean operator 'and' with search terms included in group b) no further search terms are needed to restrict the search. For other databases such as MEDLINE, EMBASE and PsycINFO, search terms included in groups a), b) and c) were combined with the Boolean operator 'and'.

Selection criteria

We only included studies and reports, published in English language since 1995 and easily accessible, which met the following criteria:

- a) *Policy documents*: UK policy documents which outline both the development and application of policy and practice on the management of alcohol misuse in the prison setting.
- b) *Reviews*: literature reviews which have identified and appraised the evidence on interventions to reduce alcohol consumption in the prison population.
- c) *Screening studies*: studies which have assessed the reliability and validity of one or more alcohol screening tools for use in the prison population.
- d) *Evaluation studies*:

Population: offenders in the prison setting (including short-sentences and young offenders) and those on remand.

Interventions: interventions for those identified with alcohol problems.

Study designs: effectiveness studies (RCTs, controlled clinical trials, interrupted time series, before and after studies), other types of evaluations which include data on effectiveness and qualitative studies which focus on barriers or facilitators to treatments in this group.

Outcomes: reduction of alcohol consumption, abstinence, reduction in recidivism or other outcomes as defined in individual studies, e.g. quality of life.

Data extraction

Data were extracted on the following: aims and objectives, content of the intervention, setting, population (including data where appropriate on life transition points), delivery of intervention (and who delivered it), duration, outcomes, results, design and methods, cost and implementation.

Quality appraisal

The design and quality of studies must inform decisions about recommendations. Although studies will not necessarily be excluded on the basis of quality (especially in areas where there is little available evidence), the quality assessment will allow assessment of their internal validity and the robustness of the results and conclusions. Intervention studies were appraised for quality using the criteria set out in the NICE (2009) *Public Health Guidance Methods Manual*⁶⁴ and overall assessment of each piece of evidence were graded using a code '++', '+' or '–', based on the extent to which the potential sources of bias have been minimised.

Study categorisation

Intervention studies were categorised according to study designs described in the table below.

⁶⁴ <http://www.nice.org.uk/media/2FB/53/PHMethodsManual110509.pdf>

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, CBA studies, ITS, 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, CBA studies, ITS, 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, CBA studies, ITS 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, case series)
4	Expert opinion, formal consensus

Assessing applicability

Each paper was scored according to its likely relevance and applicability to the UK setting (see table below).

Score	Description
A (directly relevant)	UK based study
B (probably relevant)	Non-UK study but relevant to UK setting
C (possibly relevant)	Non-UK study that may have some application to UK settings but should be interpreted with caution. There may be strong cultural or institutional differences that would have impact on the effectiveness of the intervention if applied in the UK
D (not relevant)	Non-UK study that is clearly irrelevant to UK settings (e.g. legislation which would be unlikely to be implemented)

Methods for applying the search and inclusion criteria, data extraction and quality appraisal

A systematic search using the terms described above were undertaken by an experienced researcher. All retrieved abstracts were downloaded into Reference Manager (version 11) and de-duplicated.

The electronic abstracts were assessed for eligibility by two reviewers. At this stage we aimed to be over-inclusive rather than missing potentially relevant studies. Full paper copies were obtained for all reviews and primary studies that appeared to meet the inclusion criteria. Reviewers independently applied the inclusion criteria to all potentially relevant research evidence. Once a set of relevant studies had been identified, data were extracted by one reviewer and a percentage (5%) checked by a

second reviewer. Quality assessment was undertaken by one reviewer, and 50% checked by a second reviewer. Any discrepancies encountered during any of these tasks (searching, applying inclusion criteria, data extraction, or quality assessment) were resolved in discussion with a third reviewer.

Appendix 6. List of relevant policy/strategy documents with a brief description of their contents

Organisation/Department Title; Year; URL	Annotated description of policy strategy/practice
<p>Graham (2007)</p> <p><i>Prison Health in Scotland: A Health Care Needs Assessment.</i></p> <p>http://www.sps.gov.uk/MultimediaGallery/363852d6-79d1-464c-9b65-857721c2a628.pdf</p>	<p>The aim of this piece of work was to contribute to the evidence base for the planning and provision of health and health care for Scottish prisoners. Alcohol problems were one of thirteen domains selected to be areas of greatest concern and alcohol problems are included in the epidemiology of prisoner health.</p> <p>One finding to note of relevance to the current review is:</p> <p>3.6 The disparity between self-reported rates and recording of clinical diagnosis does suggest that alcohol problems are under-detected, under-recorded and under-treated in SPS (page18).</p>
<p>HM Prison Service (2004a)</p> <p><i>Addressing Alcohol Misuse: A prison service alcohol strategy for prisoners.</i></p> <p>http://www.hmprisonservice.gov.uk/assets/documents/1000082AAAddressing_Alcohol_Misuse.doc</p>	<p>The launch of the Prison Service Alcohol Strategy for prisoners will align the Prison service with wider Government policy in a way that is complementary to our Drug Strategy. The Strategy provides a framework for addressing prisoners' alcohol problems balancing treatment and support with supply reduction measures. The focus of the Strategy is to improve consistency and build on good practice for the delivery of services within existing resources. As resources allow, the Strategy provides the basis on which to build services. The objectives of the Alcohol Strategy are:</p> <ol style="list-style-type: none"> 1) To reduce the harm associated with the misuse of alcohol, including that related to offending, by offering treatment and support to prisoners; and 2) To prevent the use of alcohol in prisons. <p>Key elements of the strategy include: Education and Communication, Identification, Referral and Treatment</p>
<p>HM Prison Service (2004b)</p> <p><i>Alcohol Treatment / Interventions Good Practice Guide.</i></p> <p>http://www.hmprisonservice.gov.uk/resourcecentre/publicationsdocument/index.asp?cat=88</p>	<p>This good practice guide is designed as a source of reference for prison governors, prison staff, carat/alcohol workers and healthcare staff who have a role in the planning and delivery of alcohol treatment interventions across the prison estate</p> <p>It's objectives are to:</p> <ul style="list-style-type: none"> • Provide a framework on which to improve and develop alcohol treatment interventions • Standardise screening, substance misuse triage and comprehensive assessment instruments • Provide clear guidance on how to plan and deliver a range of interventions to tackle alcohol problems • Set out the outline specifications required to deliver general awareness-raising, one-to-one motivational sessions, structured group work and pre-release intervention sessions to prisoners. <p>With the aim of:</p> <ul style="list-style-type: none"> • Identifying prisoners for whom alcohol causes problems • Providing appropriate treatment interventions where local funding allows • Improving the capacity and quality of the treatment interventions available to prisoners

Organisation/Department Title; Year; URL	Annotated description of policy strategy/practice
	<ul style="list-style-type: none"> Reducing the harm associated with the misuse of alcohol, including that related to offending by offering treatment and support to prisoners Ensuring greater consistency across the prison estate and spreading good practice Improving staff and offender awareness and promoting healthy lifestyles.
<p>HM Prison Service (2004c)</p> <p><i>Alcohol Testing for Prisoners</i> http://www.hmprisonservice.gov.uk/resourcecentre/publicationsdocuments/index.asp?cat=88</p>	<p>Aims and objectives</p> <ul style="list-style-type: none"> To increase significantly the detection of those misusing alcohol and to send a clear message to all prisoners that if they consume alcohol they will have a greater risk of being caught and punished; To help prisoners to resist the peer pressure often placed on them to become involved in supplying, manufacturing and importing of alcohol due to the increased possibility of detection; To help to identify those prisoners who may need assistance to combat their alcohol problems and feed that information into risk assessment and sentence planning processes and treatment interventions (where available); Act as a risk assessment procedure for prisoners who have applied for employment where industrial or heavy equipment will be used.
<p>Ministry of Justice (NOMS) Website (accessed 2009)</p> <p><i>How we manage offenders: drugs and alcohol.</i> http://noms.justice.gov.uk/managing-offenders/reducing_re-offending/reducing_re-offending_pathways/drugs-alcohol/</p> <p>This information has been taken from the website above.</p>	<p>How we aim to tackle offenders' drug and alcohol problems:</p> <ul style="list-style-type: none"> Address the needs of problematic drug users (PDUs) when they first come into contact with NOMS, to reduce the chances of them re-offending and help prevent the harm they cause themselves and others: <ul style="list-style-type: none"> provide end-to-end drug treatment for PDUs before, during and after sentence, co-ordinated with the http://www.drugs.gov.uk/drug-interventions-programme/ (DIP) reduce drug misusing re- reduce drug misusing offenders' re-offending reduce illicit use of drugs by offenders reduce the physical harm caused to drug misusing offenders and others ensure robust links with other agencies, including DIP build on the National Alcohol Harm Reduction Strategy to improve treatment and support for offenders with alcohol misuse problems. <p>Alcohol Strategy The Alcohol Harm Reduction Strategy for England places joint action at the heart of measures to improve treatment and support for people with alcohol problems. An additional £10m will be made available by the Department of Health in 2006-07 to improve alcohol treatment, with a further £15m going to Primary Care Trusts in 2007-08 for this purpose. NOMS is working closely with the Department of Health, the National Treatment Agency and other partners to ensure that the needs of alcohol misusing offenders are addressed in commissioning these improved treatment services. The Prison Service has published an Alcohol Strategy to support this work, and the Probation Service is developing a Delivery Strategy for publication this year.</p> <p>Treatment through sentencing A Community Order (see above) can also include an alcohol treatment requirement (ATR). The ATR is targeted at much the same</p>

Organisation/Department Title; Year; URL	Annotated description of policy strategy/practice
	group of offenders who are currently suitable for a Community Rehabilitation Order (CRO) or Community Punishment and Rehabilitation Order (CPRO) with an alcohol requirement, although for an ATR to be made the offender's dependency does not have to be linked to the offence(s).
<p>National Probation Service/ National Offenders Management Service (NOMS) (2006)</p> <p><i>Working with Alcohol Misusing Offenders: A Strategy for Delivery</i> http://www.alcohollearningcentre.org.uk/library/Working_with_Alcohol_Misusing_Offenders_a_Strategy_for_Delivery.pdf</p>	<p>Once alcohol misuse has been identified as an issue by offender assessment system (OASys), however, the offender should be screened using a specific alcohol screening tool 16 to assess the health aspects of alcohol misuse. Brief interventions should be provided immediately following the screening and those with moderate to severe alcohol problems referred for a more comprehensive alcohol assessment undertaken by specialist staff, in line with the three levels of screening and assessment set out in MoCAM. MoCAM also recommends the development of local systems of screening and assessment involving the use of standardised procedures and tools, development of clear referral criteria and adequate sharing of information between agencies, e.g. prisons, probation and the voluntary sector.</p> <p>NPD will Support areas in implementing the recommendations in MoCAM relating to screening and assessment.</p>
<p>Northern Ireland Prison Service (Magilligan Prison) (2001) (website source address below)</p> <p><i>Drug and Alcohol Strategy</i> http://www.niprisonservice.gov.uk/module.cfm/opt/15/area/A%20to%20Z%20Guide/page/AtoZGuide/azcid/9/azid/80</p>	<p>In response to the growing drugs problem Magilligan Prison devised a three stranded drugs strategy to deal with:</p> <ul style="list-style-type: none"> • Supply reduction • Demand reduction • Harm reduction <p>Strand three - harm reduction</p> <p>Whilst every effort is made to ensure that illicit drugs and alcohol do not get into the prison, there will be those who will present with existing problems. The strategy will provide a range of interventions for this group. These may include; Health care screening, Monitored withdrawal, Support groups i.e. NA/AA, Throughcare.</p> <p>If and when the Northern Ireland Prison Service adopts a formal policy to medical detox and maintenance then Magilligan's strategy will be amended to reflect the changes.</p>
<p>Prime Minister's Strategy Unit (2004)</p> <p><i>Alcohol Harm Reduction Strategy for England</i> http://www.newcastle-staffs.gov.uk/documents/community%20and%20living/community%20safety/caboffice%20alcoholhar%20pdf.pdf</p>	<p>This report sets out the UK Government's strategy for tackling the harms and costs of alcohol misuse in England. The aim of the strategy was to prevent any further increase in alcohol-related harms. Chapter 6 discusses alcohol-related crime and disorder. The summary from this chapter includes the following:</p> <p>Government will reduce the problems caused by drinking in town and city centres by clearly defining the shared responsibilities of individuals, the alcoholic drinks industry and the Government. This will require:</p> <ul style="list-style-type: none"> - making greater use of existing legislation and penalties to combat anti-social behaviour – for example, greater use of Fixed Penalty Notices; - working with the alcohol industry to manage and deal with the consequence of town and city centre drinking, by agreeing a new code of good practice and the joint funding of local initiatives; and - encouraging local authorities more actively to tackle problems where they occur.

Organisation/Department Title; Year; URL	Annotated description of policy strategy/practice
	<p>Government will tackle under-age drinking by:</p> <ul style="list-style-type: none"> - greater enforcement of existing laws not to sell alcohol to under-18s; - improving the information about the dangers of alcohol misuse available to young people; and - encouraging provision of more alternative activities for young people. <p>Government will tackle alcohol-related repeat offending by further piloting of arrest referral schemes and exploring the effectiveness of diversion schemes.</p> <p>Government will seek better identification of alcohol problems and referral to alcohol services as part of existing measures on domestic violence.</p>
<p>Scottish Government (2009a)</p> <p><i>Changing Scotland's Relationship with Alcohol: A Framework for Action</i> http://www.scotland.gov.uk/Publications/2009/03/04144703/0</p>	<p>This document outlines some of the developmental policy around alcohol including for groups such as offenders. Some excerpts have been included below.</p> <p>For example, we will work with partners to encourage the development of integrated care pathways for offenders and information sharing to ensure they receive continuity of alcohol support and treatment both in custody and in the community. The document discusses the particular challenges to engaging with offenders, particularly those who receive custodial sentences which need to be overcome.</p> <p>An offender can travel a path which begins with contact with the police, moves through police custody and possibly to court. It can result in community based sentences, such as a probation order or community service order, or may result in imprisonment and subsequent release back into the community, with or without statutory supervision. Opportunities exist along these various routes to identify that someone has an alcohol problem; assess the nature of that problem and the individual's motivation to change; deliver appropriate interventions or direct them into specialist treatment and support. Conversely there are risks that the treatment and support which people receive can be disrupted as they move from one setting to another.</p> <p>If information about an offender's alcohol use is not shared between services as a matter of course, or in a timely way, opportunities to make a real difference are lost. We want to encourage the development of integrated care pathways for individual offenders and to ensure information sharing protocols between agencies in order that offenders' alcohol issues are identified and appropriate interventions can be provided. Community Justice Authorities (CJAs) have a key role to play here.</p> <p>The Scottish Prison Service (SPS) and those who provide community based services should work together to ensure the identification of needs and continuity of care within and after prison for those in need of specialist support to overcome their problems with alcohol misuse. SPS should formally screen all prisoners for alcohol problems and, where appropriate, deliver brief interventions.</p> <p>We will fund a pilot project to enable them to evaluate the effectiveness of this work. We are also conscious of the need to improve our understanding of 'what works' in terms of alcohol interventions with offenders in a community setting, and will work with CJAs to learn the lessons from Scotland-wide experience.</p>

Appendix 7. Description of the screening studies

Authors, country and title	Name of alcohol screening tool(s)	Target population (Number)	Summary of Author's Findings and Conclusion
Campbell, USA UNCOPE: A Screen for Substance Dependence Among State Prison Inmates	UNCOPE	Substance dependence (alcohol or drugs) state inmate population (2,097)	Results using receiver operating characteristics calculated the overall expected accuracy of the UNCOPE to approach 0.90, with 1.0 being a perfect prediction. The UNCOPE performed comparably on gender and ethnic subgroups as well as subgroups identified by education level. The findings suggest that the UNCOPE could be an effective aid in identifying treatment needs among state prison inmates.
Caviness, USA Three brief alcohol screens for detecting hazardous drinking in incarcerated women	AUDIT-C AUDIT-3 NIAAA	Female detainees drinking at hazardous levels. (1,751)	AUDIT-C: sensitivity and specificity both exceeded 0.9 and 91.5% were correctly classified. The AUDIT-3 and NIAAA are less sensitive measures. There was no evidence of interactions between the screening instruments and age or ethnicity. The three item AUDIT-C has robust test characteristics for detecting hazardous drinking in female inmates.
Johnston, USA Determining cut-off scores for the MMPI-2 substance abuse scales for an inmate population	Minnesota Multiphasic Personality Inventory (MMPI-2) Specifically -MacAndrews Alcoholism Scale Revised (MAC-R) Addiction Potential Scale (APS) Addiction Acknowledgement Scale (AAS)	Inmate population (71)	The data analyses indicated that the AAS and APS are efficient and accurate at discriminating between inmates who do and do not have chemical dependency diagnoses. Furthermore, it was determined that cut-off scores for all three substance abuse scales, AAS, APS and MAC-R, had to be lowered from those of the original standardization sample in order to increase the overall accuracy of the each scale. The AAS and APS showed more promise for identification of chemically dependent inmates than the MAC-R. However, lowered cut-off scores for each scale are necessary to increase the classification accuracy.
Maggia, France Variation in audit (alcohol used disorder identification test) scores within the first weeks of imprisonment	AUDIT	Inmates entering prison and about 15 days later (47)	At the first administration, 19.1% of these 47 men met criteria for a probable alcohol problem but this percentage rose to 59.6% on the second occasion (P = 0.0001). The proportion of subjects with a score 12 or higher (probably dependent) was 10.6% the first time versus 42.6% the second time (P = 0.0001). In the 19 who scored positive at the second administration only, changes in answers to the 10 items were coherent with a total score growing from 3.0 to 18.1 (P = 0.0001). No prisoner had a lower AUDIT score on the second administration. AUDIT, for the purpose of giving a prevalence estimate or to enter appropriate prisoners into more detailed assessment or interventions, should not be conducted immediately at entry, but some weeks later.
Michaud, France Screening of alcohol-related problems in French detainees using the cage questionnaire	CAGE	Male inmates (191)	For Alcohol-Related Disease (ARDs) among inmates, CAGE correctly identified 88.4%. For Alcohol-related Problems (ARPs) CAGE was less efficient (sensitivity, 58.7%). The findings suggest that a screening test in prisons should include two more questions on the number of incidents of drunkenness and the reasons for incarceration.

Authors, country and title	Name of alcohol screening tool(s)	Target population (Number)	Summary of Author's Findings and Conclusion
Peters, USA Effectiveness of screening instruments in detecting substance use disorders among prisoners	Alcohol dependence scale (ADS) Addiction severity index-drug use (ASI) Alcohol use subscales, Drug abuse screening test (DAST-20) Michigan alcohol screening test-short version (SMAST) Substance abuse subtle screening inventory-2 (SASSI-2) Simple screening instrument (SSI) Texas Christian University Drug Screen (TCUDS).	Male inmates (400)	Based on predictive value, sensitivity, and overall accuracy, the TCUDS, the SSI and a combined instrument- Alcohol Dependence Scale/Addiction Severity Index-Drug Use section were found to be the most effective in identifying substance abuse and dependence disorders. They also had desirable psychometric properties in comparison to the other screening instruments. Each of the screening and diagnostic instruments examined in the study were found to be highly reliable over time in detecting substance dependence disorders.
Rogers, USA Evaluation of adolescent offenders with substance abuse: validation of the SASSI with conduct-disordered youth	Adolescent version of SASSI-A (Substance Abuse Subtle Screening Inventory-Adolescent)	Adolescent offenders (317)	SASSI-A had high number of false positives (68.4%). However it was moderately effective at classifying non-admitting alcohol and drug users (75.6%). As evidence of criterion-related validity, elevations on the SASSI-A scales had low to moderate correlations with interview-based data on impairment related to substance abuse. However, it scales appeared to be significantly affected by ethnicity, even when level of impairment was a covariate. It appears, then, that SASSI-A (a) should not be employed to classify adolescents as chemically dependent and (b) has a limited role in screening for suspected substance abuse.
Stein, USA Use of the MMPI-A to detect substance abuse in a juvenile correctional setting	Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) Specifically Alcohol/Drug Problem Acknowledge Scale (ACK) Alcohol/Drug Problem Proneness scale (PRO) MacAndrew Alcoholism Scale-Revised (MAC-R)	Juvenile offenders (123)	ACK and PRO of the MMPI-A were better related to interviewer rating of substance abuse. Results point to the superiority of ACK over PRO in substance abuse identification. The study indicates that the MMPI-A can play an important role in screening for substance use in juvenile correctional settings.
Toyer, USA Concurrent validity of the MMPI-A in a counselling programme for juvenile offenders	MMPI-A Specifically, MAC-R (MacAndrew Alcoholism Scale-Revised) ACK (Alcohol and Drug Acknowledgment Scale) A-Ang (Adolescent Anger Problems) PRO (Alcohol/Drug Problem Proneness)	Adolescent offenders (50)	Scales ACK, A-Sch, A-Ang, Ma, and PRO were highly predictive of adolescent behaviour problems and correlated highly with Counsellor ratings. This pattern of results support the concurrent validity of the MMPI-A for use in this setting.

Authors, country and title	Name of alcohol screening tool(s)	Target population (Number)	Summary of Author's Findings and Conclusion
Welsh, USA Predictors of therapeutic engagement in prison-based drug treatment	Texas Christian University (TCU) Drug Scene II	Inmates admitted to therapeutic community (347).	Three main hypotheses were supported: (1) baseline motivation predicted therapeutic engagement net of other inmate characteristics; (2) critical dimensions of the treatment experience (e.g., peer support, counsellor rapport) also predicted therapeutic engagement; and (3) dynamic predictors and programmatic characteristics became more important over time. Results suggest that policies regarding prison-based drug treatment should focus on strengthening and enhancing therapeutic engagement, but also therapeutic community quality and implementation.
White, USA Self-identified alcohol abusers in a low-security federal prison: Characteristics and treatment implications	MAST, Millon Clinical Multiaxial Inventory Version 3 (MCMI-III), and the Conflict Tactics Scale (CTS).	Male inmates (115)	The majority of inmates screened positive for alcohol problems on the MAST (61%). Self-identified alcohol abusers were more likely to evidence antisocial personality patterns, anxiety disorders, domestic violence histories, and other substance misuse. Roughly 1 in 4 (24%) showed a combination of antisocial personality and low anxiety on the MCMI, suggestive of primary psychopathic disorder. The findings suggest that low-security inmates who screen positive on the MAST often present with other substance use problems, personality pathology, and domestic violence histories that potentially inform treatment efforts by mental health professionals in federal prisons.

Appendix 8. Details of reviews which evaluated alcohol interventions in the prison setting

Citation details	Interventions	Background and findings/conclusions
<p>Alcohol Concern 2007</p> <p>Review Type: non-systematic review</p>	All	<p>Much of the research evidence on the effectiveness of treatment originates in North America and looks at drug and alcohol misuse rather than focusing on alcohol. A Home Office review of research on treatment in prisons showed that good-quality treatment could be effective. Effectiveness was judged in terms of post release relapse to substance misuse and/or re-offending. As a result of the different methodologies employed and shortcomings in the study designs, the review could not show which treatment approach was most effective or to what degree it was effective. However, the review did identify a number of critical elements required for effective treatment of offenders. Treatment needs to be of adequate duration; matched to the individual; followed through by aftercare evaluations of interventions with aftercare components showed distinctly better results for prisoners. There is very limited evidence of effectiveness of alcohol treatment for offenders within prisons in the UK context. Furthermore UK studies of abstinence based interventions for alcohol misuse suggest that they do not result in a reduction in re-offending rates. However there is a growing body of evidence of the effectiveness of interventions for offenders in the community which could be drawn. [Case studies of some prisons are also presented on current strategies in place.]</p>
<p>Baldwin S <i>et al</i> 1995</p> <p>Review Type: non-systematic review</p>	Article reviewed traditional alcohol education courses for court-ordered individuals in Scotland and England.	<p>In law enforcement and criminal justice agencies, an unresolved debate exists about how best to intervene with this challenging client population. Traditional interventions have provided scant assistance. Target-specific Alcohol Education Courses/Programmes provide effective interventions for many drinking offenders.</p> <p>Policy initiatives should focus on investment in effective programmes and withdrawal of funds from ineffective programmes. It also identifies implementation problems with court-ordered interventions.</p>
<p>Belenko S <i>et al</i> 2003</p> <p>Review Type: non-systematic review</p>	Drug Courts	<p>Drug courts provide judicially-monitored treatment, drug testing, and other services to drug-involved offenders within a structured programme featuring sanctions for non-compliance and rewards for compliance. The key goals of drug courts are to reduce drug use and associated criminal behaviour by engaging and retaining drug-involved offenders in treatment and related services within the justice system. The drug court model usually entails: (1) timely identification and referral of defendants in need of substance abuse treatment as soon as possible after arrest; (2) specific substance abuse treatment programme requirements, with compliance monitored by a judicial officer; (3) mandatory periodic drug testing; (4) increased defendant accountability through a series of graduated sanctions and rewards; (5) regular status hearings before the judge to monitor treatment progress and programme compliance; (6) a non-adversarial team approach; and (7) following successful programme completion, case dismissal (in a pre-plea diversion model), or reduced sentence or guilty plea to a lesser charge (in a post-adjudication model). JDC programmes promise many potential benefits over the traditional juvenile court: focused attention on the individual offender, the ability to address multiple issues, providing ongoing supervision and accountability, greater access to services, using better informed judges, and expanded community collaborations. However, many JDC models are based on the adult drug court models and do not account for the substantial differences in adolescents.</p>
<p>Chandler <i>et al</i> 2009</p> <p>Review Type: non-</p>	Mainly pharmacological treatments for drug misuse	<p>Despite increasing evidence that addiction is a treatable disease of the brain, most individuals do not receive treatment. Involvement in the criminal justice system often results from illegal drug-seeking behaviour and participation in illegal activities that reflect, in part, disrupted behaviour ensuing from brain changes triggered by repeated drug use. Treating drug-involved offenders provides a unique opportunity to decrease substance abuse and reduce associated criminal behaviour. Emerging neuroscience</p>

Citation details	Interventions	Background and findings/conclusions
systematic review		has the potential to transform traditional sanction-oriented public safety approaches by providing new therapeutic strategies against addiction that could be used in the criminal justice system. We summarize relevant neuroscientific findings and evidence-based principles of addiction treatment that, if implemented in the criminal justice system, could help improve public health and reduce criminal behaviour.
Egg R <i>et al</i> 2000 Review Type: Review of German studies	Correctionally based treatment	This study presents a review and meta-analyses of research on the recidivism-reducing impact of correctionally based treatment programmes in Germany. The data are part of the Correctional Drug Abuse Treatment Effectiveness (CDATE) project meta-analytic database (covering 1968-1996) of evaluation research studies of correctional interventions. Overall the five studies of educational programmes show no practical impact of these programmes in reducing recidivism. Four programmes to counsel driving under the influence (DUI) offenders fall in the intermediate area (not statistically significant) The eight studies of Social Therapy programmes did show on the average, a statistically significant practical impact in reducing recidivism.
Hall 1997 Review Type: non- systematic review	Coercive techniques	This paper discusses the ethical justification and reviews the American evidence on the effectiveness of treatment for alcohol and heroin dependence that is provided under legal coercion to offenders whose alcohol and drug dependence has contributed to the commission of the offence with which they have been charged or convicted. The paper focuses on legally coerced treatment for drink-driving offenders and heroin dependent property offenders. It outlines the various arguments that have been made for providing such treatment under legal coercion, namely, the over-representation of alcohol and drug dependent persons in prison populations; the contributory causal role of alcohol and other drug problems in the offences that lead to their imprisonment; the high rates of relapse to drug use and criminal involvement after incarceration; the desirability of keeping injecting heroin users out of prisons as a way of reducing the transmission of infectious diseases such as HIV and hepatitis; and the putatively greater cost-effectiveness of treatment than incarceration. The ethical objections to legally coerced drug treatment are briefly discussed before the evidence on the effectiveness of legally coerced treatment for alcohol and other drug dependence is reviewed. The evidence which is primarily from the USA gives qualified support for some forms of legally coerced drug treatment, provided that these programmes are well resourced, carefully implemented, and their performance is monitored to ensure that they provide a humane and effective alternative to imprisonment. Expectations about what these programs can achieve also need to be realistic
Lapham S 2004 Review Type: non- systematic review	Screening and brief interventions	A large proportion of offenders in the criminal justice system have alcohol-related problems. Therefore, it makes sense to implement alcohol screening and brief intervention programmes for people in this setting, particularly for impaired driving offenders, who are likely to be alcohol dependent. Although most States mandate screening for impaired drivers, not much effort has been put forth to determine how the screening process could be improved and expanded to the entire criminal justice population. For example, more research is needed on the potential therapeutic benefit of the screening process and on how brief motivational interventions could be incorporated into this process to improve outcomes. To address this, more emphasis should be placed on developing and implementing national standards for screening programmes in the criminal justice system, evaluating existing programmes, and assuring that these programmes provide adequate treatment services to offenders. [review did not assess reliability or validity of tests used in the prison sector, but did comment that one factor limiting the effectiveness of current screening procedures is that they are not designed to evaluate offenders (or developed in the prison setting)]
McCollister KE <i>et al</i> 2003 Review Type: Economic review	All	The selected addiction interventions address both alcohol use/abuse and illicit drug use/abuse and represent various treatment modalities, including a brief physician intervention and long-term residential programmes. The primary finding of this review was that avoided criminal activity was the greatest economic benefit of addiction interventions and contributed more, as a separate outcome domain, to the total economic benefit of addiction interventions than any other outcome domain. Reduced utilization of health care services was also a noteworthy economic benefit of addiction interventions.

Citation details	Interventions	Background and findings/conclusions
<p>McMurrin M 2007</p> <p>Review Type: Non-systematic review</p>		<p>The prevalence of problematic drinkers and drug users in correctional services of England and Wales is high, with implications not only for the health of prisoners, but also for substance-related crime. For most illicit drug users, the biggest criminological concern is acquisitive offending to fund the habit, whereas with alcohol it is violence and disorder. There is clearly a strong need in correctional services for treatment for both drug and alcohol use. What works in substance misuse treatments for offenders? This review shows that the evidence is strongest for the effectiveness of Therapeutic communities and cognitive-behavioural therapies. Purely behavioural therapies are ineffective, as are boot camps and group counselling. Maintenance prescription for offenders addicted to heroin, especially if combined with psychological treatment, shows promise. Arrest-referral schemes, court-mandated drug rehabilitation and drug courts can be effective, but improvements in multi-agency working are also necessary.</p>
<p>Polcin DL 2001</p> <p>Review Type: non-systematic review</p>	<p>Coercive techniques</p>	<p>Outcome studies on drug and alcohol offenders coerced into treatment by the criminal justice system were reviewed. Positive outcomes were found for therapeutic community, methadone maintenance, and unspecified residential and outpatient programmes. No outcome studies were found for court-mandated clients coerced into social model recovery programmes. When developing studies, researchers should consider how clients perceive legal mandates and whether they are receiving pressures to enter treatment from other sources, such as family members, employers, friends or the welfare system. Use of the Social Model Philosophy Scale (SMPS) is suggested to correlate programme characteristics and processes with outcome.</p> <p>[Discusses issues in coercive treatment of alcohol problems in two population groups, DUI and non-DUI offences such as disorderly conduct, trespassing, assault and theft.]</p>
<p>Raistrick <i>et al</i> 2006</p> <p>Department of Health</p> <p>Review Type: primarily review of reviews of effectiveness</p>	<p>All interventions in all settings</p>	<p><u>Section on the Criminal justice system:</u> Prisons are an important setting. They are usually not a place that people want to be, they contain twice as many hazardous drinkers as in the general population and they are expensive – all of these are reasons to have good alcohol treatment programmes in prisons. The reality is that programmes are not well developed and the evidence base in support of programmes is weak (McMurrin, 2005). There are particular difficulties in delivering treatments in prison:</p> <ol style="list-style-type: none"> 1 Educational achievement is commonly at a low level 2 Mental illness and substance misuse is common 3 Retention in treatment programmes is poor 4 Treatment effect sizes are typically small (less than 0.2) <p>and there is insufficient evidence to recommend particular approaches</p> <p>5 It is not always easy to determine the relationship between offending and drinking.</p> <p>The authors suggest that it would be possible to implement brief interventions in prisons, probation settings and even police stations, as well as establishing special types of intervention for specific groups such as drink-driving offenders. There appear to have been no attempts as yet to evaluate the effectiveness of such possibilities in the UK. However, the Government intends to fund pilot research into the practical implementation of brief interventions in criminal justice settings.</p> <p>6. Drug treatment programmes are much better developed but not always integrated with alcohol programmes.</p>

Citation details	Interventions	Background and findings/conclusions
<p>Roberts <i>et al</i> 2007</p> <p>Review Type: Systematic review</p>	<p>All</p>	<p>Substance misuse is a major problem in the general population as well as in prisons and the wider Criminal Justice System (CJS). Whilst there is a large body of evidence for community-based drug treatments, there has been far less research in criminal justice settings. We outline the recent in-depth reviews of offender-based drug treatments. Within the field of substance misuse, alcohol is not often considered separately. We have therefore conducted a new systematic review of alcohol treatments in offender populations. Studies were included if they had either a comparison group or a no-intervention control group, or if they had used an outcome measure of alcohol use and/or recidivism. Twenty-four articles met the inclusion criteria, and were rated on a scale of methodological quality. Due to the heterogeneity of the studies, meta-analysis was not possible. Therefore a quantitative narrative review was conducted. There is no consistently conclusive evidence for the effectiveness of a single intervention. Opportunities for research with rigorous methodology exist into: whether different treatment interventions work for different types of offenders, by virtue of the type of offence committed, and; which interventions have a sustainable effect to ensure both cost effectiveness and long-term benefits to the individuals and society. The methodological quality of the included studies was low, in part due to poor study design and/or due to structural obstacles within the CJS. In particular, studies lacked random allocation, no-treatment comparison groups, and participation was often mandatory. One area where there is an evidence base for offender populations is therapeutic communities.</p>
<p>Sheehan 2004</p> <p>Review Type: non-systematic review</p>	<p>Twelve Step Facilitation</p>	<p>Twelve Step Facilitation is empirically supported and the most widely used model of alcohol and drug dependency treatment. While other treatment models are also empirically supported, no reliable method of treatment matching has been discerned. As a result, limiting access to this effective treatment is both short-sighted and limits the repertoire of rehabilitative efforts for a serious public health problem and threat to public welfare.</p> <p>2. Twelve Step Facilitation is the only model that proactively prepares, motivates, and trains clients to access the resources of twelve-step self help groups as a relapse prevention strategy. Clients become part of a support network that extends beyond the walls or timeline of the treatment programme. TSF provides a cost free system of life-long support through referral to twelve-step self-help groups. Participation at twelve-step meetings is related to more robust rates of sustained abstinence, a critical factor in reducing criminal behaviour and re-incarceration.</p> <p>3. Criticism of Twelve Step Facilitation as a quasi-religion is over stated. Spirituality, a corner stone of the model, is by nature a self-enhancing and highly personal experience, which may or may not involve theism or ties with religion. Religion is an organized system of prescribed beliefs or doctrines whereas spirituality is a self-defined experience that transcends prescribed beliefs and as an inclusive construct may include agnostic, humanistic, or non-theistic foundations for personal beliefs and values.</p> <p>4. The trans-theoretical nature of the Twelve Step Facilitation model promotes flexibility to address individual variability such as personality traits, criminal thinking patterns, and diverse learning styles in addition to customized approaches for populations with special needs such as women offenders. Built on a bio-psycho-social and spiritual foundation, the model has the capacity to integrate diverse motivational strategies and accommodate innovations as new knowledge is gained.</p>

Citation details	Interventions	Background and findings/conclusions
<p>Smith <i>et al.</i> 2006</p> <p>Review Type: Cochrane systematic review</p>	<p>Therapeutic Communities</p>	<p>Seven studies were included. Differences between studies precluded any pooling of data, results are summarised for each trial individually: therapeutic community versus community residence: no significant differences for treatment completion; Residential versus day therapeutic community: attrition (first two weeks), and abstinence rates at six months significantly lower in the residential treatment group; Standard therapeutic community versus enhanced abbreviated therapeutic community: number of employed higher in standard therapeutic community RR 0.78 (95% CI 0.63, 0.96). Three months versus six months programme within modified therapeutic community, and six months versus 12 months programme within standard therapeutic community: completion rate higher in the three months programme and retention rate (40 days) significantly greater with the 12 months than 6 months programme. Two trials evaluated TCs within a prison setting: one reported significantly fewer re incarcerated 12 months after release from prison in the therapeutic community group compared with no treatment, RR 0.68 (95% CI 0.57, 0.81). In the other, people treated in prison with therapeutic community compared with Mental Health Treatment Programmes showed significantly fewer re incarcerations RR 0.28 (95% CI 0.13, 0.63), criminal activity 0.69 (95% CI 0.52, 0.93) and alcohol and drug offences 0.62 (95% CI 0.43, 0.90) 12 months after release from prison. There is little evidence that TCs offer significant benefits in comparison with other residential treatment, or that one type of therapeutic community is better than another. Prison therapeutic community may be better than prison on its own or Mental Health Treatment Programmes to prevent re-offending post-release for in-mates. However, methodological limitations of the studies may have introduced bias and firm conclusions cannot be drawn due to limitations of the existing evidence.</p>

Appendix 9. Brief descriptions of reports which assess process or outcomes of interventions (grouped by category/intervention type)

Author & Year	Country	Intervention type	Study design	Quality and relevance	Target population	Intervention location	Timing of intervention	Follow-up period	Outcomes
Sacks 2004 <i>Same study as Sullivan</i>	USA	Therapeutic community (modified)	RCT	1+(B)	Male inmates with co-occurring mental illness and chemical abuse (MICA) disorders	Prison	In prison	6- and 12-months post-prison release	Re- incarceration and criminal activity
Smiley-McDonald 2005	USA	Therapeutic community	Qualitative Longitudinal case study	Qualitative study (B)	Male substance use offenders	In prison	Not applicable	n/a	n/a
Sullivan 2007	USA	Therapeutic community	RCT	1+(B)	Male offenders who have co-occurring mental and substance use disorders	Prison	In prison	6- and 12-months post-prison release	Any substance use as well as separate measures for any illegal drug use & alcohol use.
Begun 2009	USA	Brief intervention -motivational interviewing (MI)	RCT	1+ (B)	Female inmates	Prison	As close as possible to release date	1- and 2-month post release follow-up	Substance-related and treatment engagement outcomes <i>these results are not yet available</i>
Best 2002	UK	Brief Intervention	Qualitative	Qualitative (A)	Detainees in police custody	In custody	n/a	n/a	n/a
Deehan 1998	UK	Brief Intervention	Qualitative	Qualitative (A)	Detainees in police custody	In custody	In custody	n/a	n/a
Hopkins 2006	UK	Brief Intervention	Quasi-experiment	3(A)	Detainees	Police custody	Morning after arrest	About three months after their interview	Reduction of alcohol-related crime and alcohol consumption.
Porporino 2002	Canada	Brief Intervention	Evaluation	3(B)	Inmates with substance use (including alcohol) problems	Federal correctional system	Just before release and on conditional release	Follow-up data obtained from a national database	Reduction of substance use and recidivism

Author & Year	Country	Intervention type	Study design	Quality and relevance	Target population	Intervention location	Timing of intervention	Follow-up period	Outcomes
Watt 2007	UK	Brief intervention	RCT	1++(A)	Detainees who were violent offenders (not clear whether they had a custodial sentence)	Judicial (Magistrates' court)	Immediately following sentencing	3 months and 12 months after sentence	Re-offending alcohol use and injury rates
Ginsburg 2001	USA	Brief intervention-MI	RCT	1-(B)	Male federal inmates with symptoms of alcohol dependence.	Correctional settings	In prison	Not stated	Stage of change
Harper 2000	UK	Brief intervention-MI	Quasi-experiment	2-(A)	Offenders and Probation officers	Prison	Start of probational orders	Offenders assessed before and after officers training	Attitudes to alcohol/drugs and their re-offending. Probation officers views of MI
Stein 2006	USA	Brief intervention-MI	RCT	1+(B)	Adolescents	State juvenile correctional facility	In prison	3 months	Risky behaviours related to DUI and PUI were chosen for analyses
Davis 2003	USA	Brief Motivational feedback	RCT		Veterans incarcerated in a county jail system who met SUD diagnostic criteria.	Prison	Between 5 and 30 days prior to their estimated release date	Mean 2.2 months after actual jail release dates	Veterans Administration (VA) appointments. Addiction Severity Index-Follow-up
Huriwai 2002	New Zealand	CBT	Case study	3(B)	Inmates	Prison	Whilst in prison	Not stated	Reduction of recidivism, quality of life and reduced alcohol and drug use
Turley 2004	USA	Counselling	Longitudinal study	3(B)	Male and female inmates	In prison	In prison	5 years	Recidivism
Broner 2005	USA	Dug Courts	Quasi-experimental	2-(B)	Inmates with co-occurring mental illness & drug/alcohol problem.	Jail	Recruited at point of jail admission	3 and 12 months.	Legal outcomes

Author & Year	Country	Intervention type	Study design	Quality and relevance	Target population	Intervention location	Timing of intervention	Follow-up period	Outcomes
Crundall 1997	Australia	Education	Evaluation	2-(C)	Prisoners incarcerated for alcohol-related offences	In the community after prisons were released	Six weeks before release.	Six weeks after release into community	Reduction in alcohol consumption, disruptive behaviour, criminal activity, other non-alcohol-related outcomes
Dembo 2002	USA	Family intervention	RCT	1+(B)	Juvenile offenders	At home.	Youth back with their families at home.	36 months	Reduction in heavy drinking levels
Keiley 2007	USA	Family Intervention	Non-controlled pilot	2-(B)	Incarcerated adolescents	Juvenile correctional institutions.	Two months prior to their release	Six months follow-up assessment.	Reducing recidivism and altering the families' coercive interactional patterns
Calhoun 2005	USA	Group Counselling	Case study	3(B)	Female juvenile offenders with drug and alcohol problems.	Court ordered	Not stated	Not stated	Relationship score
Peterson 1995	USA	Health promotion	Evaluation	2-(B)	Female offenders	Federal correctional institute	Whilst in prison	Immediately after the nine months health promotion programme	Changes in health status and perceived psychological well-being between entry into the programme and exit
Woodall 2007	USA	Multi modal	RCT (factorial design)	1+(B)	First-time DWI offenders	Prison	During 28 days of incarceration	6-, 12-, and 24-month assessment points	Alcohol drinking (Form 90) Drinker Inventory of Consequences Diagnostic Interview Schedule (DIS) Drunk driving recidivism
Morehouse 2000	USA	Multi-modal	Quasi-experiment	2+(B)	Adolescents	County correctional facility	Whilst in correctional facility	5 years	Reduction in alcohol and other drug use

Author & Year	Country	Intervention type	Study design	Quality and relevance	Target population	Intervention location	Timing of intervention	Follow-up period	Outcomes
Letters 2004	Australia	Psychological	Case study	3(B)	Young people in detention with dual mental health and drugs and alcohol problems.	Detention centre	Within 2 or 3 working days	N/a	To address specific mental health and drug and alcohol treatment needs of young people in detention
Bond 1998	UK	Psychological intervention (intensive)	Quasi-experiment	3(A)	Alcoholic and drug-addicted inmates	Prison	In prison	Not clear	Drug/alcohol free Reduction in re-offending
Bowen 2006	USA	Spiritual	Evaluation	2-(D)	Substance use disorder (SUDs) Inmates	Prison	In prison	3 and 6 months post release	Reduction in recidivism and improvements in psychosocial outcomes
Gossage 2003	USA	Spiritual	Quasi-treatment experiment.	2-(D)	Male inmates	Prison	Participant	3 months after release	Reduction substance misuse and recidivism
Marlatt 2004	USA	Spiritual	Quasi experimental design	2+(D)	Offenders	Inmates at a rehabilitation centre	Whilst in prison	3 and 6 months after inmates release.	Alcohol and drug use, alcohol and drug related offences, criminal behaviour, spirituality and psychological functioning
Wheeler 2004	USA	Victim impact panel	RCT	1+(C)	DWI first-time offenders	In prison	During 28 days of incarceration	Post-test and 2 months	Quantity/frequency of alcohol use & DWI

Appendix 10. Screening using AUDIT and supplementary questions

AUDIT Screening Questionnaire

Are you willing to take part in a brief survey about your use of alcohol?

This will be completely anonymous and participation is voluntary.

Yes No (Please record response and signature in separate list)

AUDIT: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying

"Now I am going to ask you some questions about your use of alcoholic drinks during this past year."

For example, cider, vodka, beers, wines, lagers etc (show list)

Code answers in terms of "standard drinks". Place the relevant answer number in the box at the right.

NB. Questions relate to most recent time outside in the community

Thinking about your most recent time in the community....

<p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p> <div style="text-align: right;"><input type="text"/></div>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <p style="text-align: right;"><i>Please write in drinks</i></p> <div style="text-align: right;"><input type="text"/></div>	<p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>
<p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p><i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i></p> <div style="text-align: right;"><input type="text"/></div>	<p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>
<p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <div style="text-align: right;"><input type="text"/></div>
<p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <div style="text-align: right;"><input type="text"/></div>
<p>Record total of specific items here</p> <div style="text-align: right;"><input type="text"/></div>	

And now I would like to ask you some brief questions about yourself – again this will be completely anonymous.

1) What is your sentence status:

– which best describes you?

Sentenced Remand (unconvicted) Remand (convicted awaiting sentence)

What is your current offence (charge / conviction)?

.....

IF SENTENCED, How long is your sentence?

.....

2) Have you ever been in prison before?

Yes No Don't know

3) Do you believe alcohol was a factor in the offence for which you are here?

Yes No, was sober No, but had been drinking Don't know

IF YES, was misuse of illegal or prescription drugs also involved? Yes No

4) Are you currently in treatment in relation to your drinking?

Yes No Don't know

IF YES, can you provide details?

.....

5) What was your working situation before coming into prison?

Showcard 1 – which one best describes you?

Full time employment Part-time employment Casual
Training schemes Unemployed / on benefits, e.g. incapacity etc
Full time education Other

6) Please tell me which, if any, educational qualifications you have, looking at this card.

Showcard 2 – point to any that apply to you.

1 2 3 4 5 6 7 8 9 10 11 12

7) How would you describe your marital/family status?

Showcard 3 – which one best describes you?

Married Living with partner Single Divorced Widowed

Other Number of children Expected

8) Finally, what was your age at last birthday:..... years

Thank respondent and give leaflet.

Officer initial Date of screening.

SHOWCARD 1

Full time employment
Part-time employment
Casual
Training schemes
Unemployed / on benefits, e.g. incapacity etc
Full time education
Other

SHOWCARD 2

12. None of these qualifications
1. School leaving certificate, NQ Unit
 2. Standard Grade, O Grade, GCSE, GCE O Level, CSE, National Qualification, Access 3 Cluster, Intermediate 1 or 2, Senior Certificate or equivalent
 3. GNVQ/GSVQ Foundation or Intermediate, SVQ Level 1 or 2, SCOTVEC/National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent
 4. Higher grade, Advanced Higher, CSYS, A level, AS Level, Advanced Senior Certificate or equivalent
 5. GNVQ/GSVQ Advanced, SVQ Level 3, ONC, OND, SCOTVEC National Diploma, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent
 6. HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent
 7. First Degree, Higher degree, SVQ Level 5 or equivalent
 8. Professional qualifications e.g. teaching, accountancy
 9. Other school examinations not already mentioned
 10. Other post-school but pre Higher Education examinations not already mentioned
 11. Other Higher Education qualifications not already mentioned

SHOWCARD 3

Married
Living with partner
Single
Divorced
Widowed

Appendix 11. Respondent 'current offence' categories

Screening questionnaires: In answer to question, 'What is your current offence?' [Categories reflect interviewing officers' notes from respondents' verbal reports rather than response to a pre-coded list. These were post-coded following the classification of crimes and offences used by the Scottish Government (2009b)].

Categories ¹ (see expanded version below)	Total sample				Sentenced		Remand	
	Only/main Category ² (n=259)		Additional Category ³ (n=259)		(n=122)		(n=137)	
	%	(no)	%	(no)	%	(no)	%	(no)
1. Violence	27	(70)	4	(11)	22	(27)	31	(43)
a. Homicide	[-]	(*)			[-]	(*)	[-]	(*)
b. Serious assault & attempted murder	24	(62)			[-]	(*)	[-]	(*)
c. Robbery	[-]	(*)	[-]	(*)			[-]	(*)
d. Other	[-]	(*)	[-]	(*)			[-]	(*)
2. Indecency	[-]	(*)			[-]	(*)	[-]	(*)
c. Lewd & indecent behaviour	[-]	(*)			[-]	(*)	[-]	(*)
Uncategorised	[-]	(*)					[-]	(*)
3. Dishonesty	31	(79)	4	(9)	35	(43)	26	(36)
a. Housebreaking	7	(17)			8	(10)	5	(7)
b. Theft by opening a lockfast place	11	(28)	[-]	(*)	14	(17)	8	(11)
c. Theft of/from a motor vehicle	[-]	(*)	[-]	(*)			[-]	(*)
d. Shoplifting	11	(28)	[-]	(*)	10	(12)	12	(16)
e. Fraud	[-]	(*)			[-]	(*)	[-]	(*)
f. Other	[-]	(*)	[-]	(*)	[-]	(*)		
4. Fireraising	[-]	(*)	[-]	(*)	[-]	(*)		
a. Fire-raising	[-]	(*)	[-]	(*)	[-]	(*)		
5. Other Crimes	24	(62)	6	(15)	21	(26)	26	(36)
a. Crimes against public justice	13	(33)	3	(9)	[-]	(*)	[-]	(*)
b. Handling an offensive weapon	4	(10)	[-]	(*)	[-]	(*)	[-]	(*)
c. Drugs	7	(19)	[-]	(*)	7	(9)	7	(10)
6. Miscellaneous Offences	9	(23)	5	(14)	11	(13)	7	(10)
a. Common assault	[-]	(*)					[-]	(*)
b. Breach of the peace	8	(21)	[-]	(*)	11	(13)	6	(8)
d. Other	[-]	(*)	[-]	(*)			[-]	(*)
7. Motor Vehicle Offences	3	(9)	[-]	(*)	[-]	(*)	[-]	(*)
a. Dangerous and careless driving	[-]	(*)			[-]	(*)		
b. Drink/drug driving	2	(5)	[-]	(*)	[-]	(*)	[-]	(*)
c. Speeding			[-]	(*)				
d. Unlawful use of vehicle	[-]	(*)			[-]	(*)	[-]	(*)
e. Other	[-]	(*)	[-]	(*)	[-]	(*)		
No information / no category	5	(12)	[-]	(*)	[-]	(*)	[-]	(*)

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality.

¹ Categories based on the classification of crimes and offences used by the Scottish Government (2009b).

² Takes the 'highest' category where more than one given.

³ 55 (21%) reported more than 1 category, including 4 who reported more than 2 (remainder for these not reported here).

Crime categories and codes derived from the 2008-09 Statistical Bulletin, Crime and Justice Series (Scottish Government, 2009b)

1. *NON-SEXUAL CRIMES OF VIOLENCE* (Also referred to as **Violence**)
 - a. **Homicide** Comprises murder and culpable homicide (including the statutory crimes of causing death by dangerous driving or causing death by careless driving while under the influence of drink or drugs).
 - b. **Serious assault and attempted murder** Referred for short in the text as “serious assault”.
 - c. **Robbery** Includes offences involving intent to rob.
 - d. **Other** Includes threats, extortion and cruel and unnatural treatment of children.
2. *CRIMES OF INDECENCY* (Also referred to as **Indecency**).
 - a. **Rape and attempted rape.**
 - b. **Indecent assault.**
 - c. **Lewd & indecent behaviour** Comprises lewd & indecent practices against children, indecent exposure.
 - d. **Other** Includes offences connected with prostitution, incest and sexual intercourse with girls aged under 16.
3. *CRIMES INVOLVING DISHONESTY* (Also referred to as **Dishonesty**)
 - a. **Housebreaking** Includes business as well as domestic premises.
 - b. **Theft by opening a lockfast place.**
 - c. **Theft off/from a motor vehicle.**
 - d. **Shoplifting.**
 - e. **Other theft** Includes theft of pedal cycles.
 - f. **Fraud** Includes statutory fraud, except social security benefit fraud.
 - g. **Other** Includes forgery, reset and embezzlement.
4. *FIRE-RAISING, VANDALISM ETC*
 - a. **Fire-raising**
 - b. **Vandalism** Includes malicious mischief, vandalism and reckless conduct with firearms.
5. *OTHER CRIMES*
 - a. **Crimes against public justice** Includes perjury, contempt of court, bail offences and failing to appear at court.
 - b. **Handling an offensive weapon** Comprises carrying offensive weapons, restriction of offensive weapons legislation.
 - c. **Drugs** Includes importation, possession and supply of controlled drugs.
 - d. **Other** Includes conspiracy and explosives offences.
6. *MISCELLANEOUS OFFENCES*
 - a. **Common assault** Also sometimes termed petty or minor assault.
 - b. **Breach of the peace.**
 - c. **Drunkenness.**
 - d. **Other** Includes offences against local legislation, Revenue and Excise Acts, Licensing Acts, Wireless Telegraphy Acts / Communication Acts.
7. *MOTOR VEHICLE OFFENCES*
 - a. **Dangerous and careless driving** Prior to 1992 this was known as “reckless and careless driving”.
 - b. **Drink/drug driving** Comprises driving or in charge of motor vehicle while unfit through drink or drugs, blood alcohol content above limit and failing to provide breath, blood or urine specimens.
 - c. **Speeding** Includes the small number of motorway and clearway offences, as these are mostly speeding-related.
 - d. **Unlawful use of vehicle** Comprises driving while disqualified, without a licence, insurance, test certificate, vehicle tax and registration and identification offences.
 - e. **Vehicle defect offences** Comprises construction and use and lighting offences.
 - f. **Other** Includes parking, record of work offences, neglect of traffic directions, failing to stop after accident and mobile phone offences.

Appendix 12. Comparison with the SPS population

Age of respondents

<i>Base: All respondents</i>	Study Population ¹		Offenders in custody by age (male) 30 th June 2008 ²	
	%	(no)	%	(no)
18-24 years	36	(94)	28	(2013)
25-29 years	26	(67)	20	(1434)
30-39 years	25	(64)	28	(2009)
40+ years	13	(34)	24	(1703)

¹Base: 259

²Base: 7159 (7349-190 under 18s) Source: Scottish Government (2009b)

Length of sentence

<i>Base: All sentenced</i>	Study Population ¹	Average daily population Men 2008-2009 ²
	%	%
Less than 3 months	8	2
3 months - less than 6 months	24	6
6 months - less than 2 years	51	25
2 years - less than 4 years	11	18
4 years or over	*	27
Life	*	12
Other	-	10

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality

¹Base: 117

²Base: 5,876

Source: Scottish Government (2009b)

Sentence status

<i>Base: All respondents</i>	Study Population ¹		Receptions to penal establishments by type of custody (men) 2008-2009 ²	
	%	(no)	%	(no)
Sentenced	47	(122)	43	(15443)
Remand	53	(137)	57	(20416)

¹Base: 259

²Base: 35973

Source: Scottish Government (2009b)

Appendix 13. AUDIT questions by age⁶⁵ (total sample) % (no)

	18-24 years (n=94)	25-29 years (n=67)	30-39 years (n=64)	40-64 years (n=34)	Total (n=259)
	% (no)	% (no)	% (no)	% (no)	% (no)
Q1 Drink frequency by age					
Never	10 (9)	[-] (*)	28 (18)	[-] (*)	15 (38)
Monthly or less	29 (27)	[-] (*)	28 (18)	[-] (*)	29 (75)
2-4 times a month	14 (13)	15 (10)	13 (8)	18 (6)	14 (37)
2-3 times a week	32 (30)	13 (9)	13 (8)	24 (8)	21 (55)
4 or more times a week	16 (15)	19 (13)	19 (12)	41 (14)	21 (54)
	18-24 years (n=85)	25-29 years (n=58)	30-39 years (n=46)	40-64 years (n=32)	Total (n=221)
	% (no)	% (no)	% (no)	% (no)	% (no)
Q2 How many drinks typical day drinking					
1 or 2	[-] (*)	0 (0)	[-] (*)	[-] (*)	[-] (*)
3 or 4	[-] (*)	[-] (*)	[-] (*)	[-] (*)	5 (11)
5 or 6	[-] (*)	[-] (*)	[-] (*)	[-] (*)	5 (10)
7, 8 or 9	6 (5)	9 (5)	[-] (*)	[-] (*)	6 (13)
10 or more	88 (75)	85 (49)	78 (36)	77 (23)	83 (183)
Q3 Drink 6 or more					
Never	6 (5)	[-] (*)	20 (9)	[-] (*)	10 (21)
Less than monthly	19 (16)	32 (19)	[-] (*)	[-] (*)	22 (48)
Monthly	21 (18)	[-] (*)	[-] (*)	[-] (*)	18 (40)
Weekly	39 (33)	16 (9)	26 (12)	39 (11)	29 (65)
Daily or almost daily	15 (13)	24 (14)	20 (9)	35 (11)	21 (47)
Q4 How often can't stop					
Never	51 (43)	43 (25)	61 (28)	38 (12)	49 (108)
Less than monthly	9 (8)	19 (11)	[-] (*)	[-] (*)	11 (24)
Monthly	11 (9)	12 (7)	[-] (*)	[-] (*)	10 (22)
Weekly	17 (14)	10 (6)	[-] (*)	[-] (*)	13 (28)
Daily or almost daily	12 (10)	16 (9)	20 (9)	31 (10)	17 (38)
Q5 How often failed expectations					
Never	54 (46)	59 (34)	70 (28)	34 (11)	54 (119)
Less than monthly	15 (13)	16 (9)	13 (6)	22 (7)	16 (35)
Monthly	14 (12)	[-] (*)	11 (5)	[-] (*)	12 (26)
Weekly	8 (7)	[-] (*)	[-] (*)	[-] (*)	8 (18)
Daily or almost daily	7 (6)	10 (6)	[-] (*)	19 (6)	10 (21)
Q6 Drink morning					
Never	75 (64)	69 (40)	72 (33)	37 (15)	69 (152)
Less than monthly	9 (8)	10 (6)	[-] (*)	[-] (*)	9 (20)
Monthly	[-] (*)	[-] (*)	[-] (*)	[-] (*)	4 (9)
Weekly	[-] (*)	[-] (*)	[-] (*)	[-] (*)	5 (12)
Daily or almost daily	6 (5)	10 (6)	11 (5)	31 (10)	12 (26)
Q7 How often feel guilt or remorse					
Never	49 (42)	41 (24)	61 (28)	41 (13)	48 (107)
Less than monthly	[-] (*)	22 (13)	11 (5)	[-] (*)	16 (36)
Monthly	14 (12)	17 (10)	11 (5)	16 (5)	15 (32)
Weekly	17 (10)	10 (6)	[-] (*)	[-] (*)	12 (27)
Daily or almost daily	[-] (*)	9 (5)	[-] (*)	22 (7)	8 (17)
Q8 How often can't remember					
Never	28 (24)	31 (18)	41 (19)	31 (10)	32 (71)
Less than monthly	31 (26)	28 (16)	28 (13)	[-] (*)	27 (59)
Monthly	[-] (*)	17 (10)	[-] (*)	[-] (*)	16 (35)
Weekly	18 (15)	16 (9)	11 (5)	16 (5)	16 (34)
Daily or almost daily	[-] (*)	9 (5)	[-] (*)	22 (7)	9 (20)
	18-24 years (n=94)	25-29 years (n=67)	30-39 years (n=64)	40-64 years (n=34)	Total (n=259)
	% (no)	% (no)	% (no)	% (no)	% (no)
Q9 How often injured self or other person					
No	22 (21)	19 (13)	34 (22)	32 (11)	26 (67)
Yes, but not in the last year	30 (28)	36 (24)	33 (21)	24 (8)	31 (81)
Yes, during the last year	48 (45)	45 (30)	33 (21)	44 (15)	43 (111)
Q10 How often suggested you cut down					
No	52 (49)	57 (38)	63 (40)	41 (14)	54 (141)
Yes, but not in the last year	12 (11)	[-] (*)	16 (10)	[-] (*)	12 (32)
Yes, during the last year	36 (34)	30 (20)	22 (14)	53 (18)	33 (86)

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality.

⁶⁵ Q3-Q7 have a smaller base as not answered by those with a low score at Q1 and Q2.

Appendix 14. Drink types on a typical drinking day

Information on drink types was noted by Prison Officers when asking AUDIT Question 2: *How many drinks containing alcohol do you have on a typical day when you are drinking?*

This was additional information and was not part of the formal screening questions. Data are provided for 198 of the 221 prisoners who said they drank, although the level of information detail recorded depended on the Prison Officer administering the screen, rather than a rigorous questioning exercise.

Half of respondents reported typically drinking more than one of these broad drink types in a session: mixing their drinks. This information is summarised below.

Drink types	Percentage reporting drinking type of drink
<i>Base: 198 respondents</i>	%
Lagers/beers	72
Spirits	53
Wines/fortified wines	22
Ciders	19
Others	11
Number of drink types on a typical day	Percentage reporting drinking type of drink
<i>Base: 198 respondents</i>	%
One type	49
Two types	34
Three types	13
Four + types	5

Appendix 15. AUDIT questions by age Zone IV sample: AUDIT scores 20-40

	18-24 Years n=38	25-29 Years n=21	30-39 Years n=16	40-64 Years n=19	Total n=94
Q1 Drink frequency by age					
Never	0	0	0	0	0
Monthly or less	*	*	*	0	*
2-4 times a month	*	*	0	*	*
2-3 times a week	21	6	*	*	34
4 or more times a week	14	13	11	14	52
Q2 How many drinks typical day drinking					
1 or 2	0	0	0	0	0
3 or 4	0	0	0	*	*
5 or 6	0	0	0	*	*
7, 8 or 9	0	0	0	0	0
10 or more	38	21	16	17	92
Q3 Drink 6 or more					
Never	0	0	0	0	0
Less than monthly	0	*	0	0	*
Monthly	*	*	*	*	*
Weekly	23	7	*	*	41
Daily or almost daily	*	12	*	11	44
Q4 How often can't stop					
Never	7	*	*	0	11
Less than monthly	*	*	0	*	6
Monthly	*	*	*	*	15
Weekly	12	6	*	*	24
Daily or almost daily	10	9	9	10	38
Q5 How often failed expectations					
Never	13	6	*	0	23
Less than monthly	5	*	*	5	15
Monthly	8	*	*	*	18
Weekly	6	5	*	*	17
Daily or almost daily	6	6	*	6	21
Q6 Drink morning*					
Never	22	8	*	*	38
Less than monthly	*	*	*	*	10
Monthly	*	*	*	*	8
Weekly	*	*	*	*	12
Daily or almost daily	5	6	5	10	26
Q7 How often feel guilt or remorse					
Never	8	*	5	*	19
Less than monthly	5	*	*	*	10
Monthly	9	6	*	*	21
Weekly	14	6	*	*	27
Daily or almost daily	*	5	*	8	17
Q8 How often can't remember					
Never	7	*	*	0	11
Less than monthly	*	0	*	*	7
Monthly	10	*	*	6	26
Weekly	13	8	*	*	30
Daily or almost daily	*	5	*	7	20
Q9 How often injured self or other person					
No	*	0	0	*	*
Yes, but not in the last year	*	*	*	*	*
Yes, during the last year	32	*	*	15	80
Q10 How often suggested you cut down					
No	*	*	*	*	7
Yes, but not in the last year	*	*	*	*	9
Yes, during the last year	29	18	14	17	18

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain prisoner confidentiality.

Appendix 16. Topic guide prison informant – mapping

The overall aim of this study is to conduct a needs assessment of alcohol problems in prisoners and provide recommendations for service developments and produce a model of care (relevant objectives for mapping are below).

Introduction

- Provide a reminder of the purpose and main focus of the study.
 - Explain that focusing on opinions and experiences (not a test).
 - Introduce the recorder underlining the importance of confidentiality.
 - Provide opportunity for participants to ask ‘any questions’.
1. Please can you tell me about your role overall and in relation to alcohol treatment and support services in particular in this prison? *Note scope includes detection and early intervention (e.g. screening/ABIs etc) and potentially prevention and education.*

The sequence of topics described below is not intended to provide a rigid structure for the interviews but rather to act as a check list of key topic areas to be covered. It is recognised that all aspects covered here may not be relevant to individual respondents or prisons.

2. Please tell me about alcohol-related activities in the prison e.g. treatment and support, detection and early intervention, education etc?
 - what is provided (e.g. nature of contact, frequency, range of interventions, time in each session etc)? e.g. 1 to 1 or group
 - what focus e.g. health or offending cessation based; abstinence or harm reduction
 - any models of care utilised?
 - participant recruitment?
 - who is eligible?
 - how are they identified and recruited?
 - any selection (assessment) procedures? e.g. related to pattern of alcohol use, type of offence, time spent so far during sentence or overall length of sentence
 - refusal rates/reasons.
 - waiting times
 - who provides/leads the service(s)?
 - any outside support e.g. staff coming into the prison?
 - any additional support to participants e.g. leaflets etc?
 - continuity of care on transfer to another prison – any integrated care models?
3. Can you tell me about links with community services?
 - continuity of care arrangements on release?
 - what services are available?
 - what referral routes and mechanisms?
 - likely uptake?
 - prisoners entering the prison who have received prior service input?

4. What treatment and support services and detection / brief interventions are provided for *newly arrived* sentenced or remand prisoners related to alcohol and at what stage?
 - screening?
 - detoxification support if relevant?
 - information leaflets?
 - how are services accessed ? referral from health care/other or self-referral?
 - signposting to services in the prison or the community?
5. Please can you tell me about any broader health promotion activities in relation to alcohol?
 - health awareness days, distribution of information leaflets etc
 - education and prevention with any target groups e.g. women prisoners, young offenders, families, staff?
6. Please can you tell me about any additional issues and variations (e.g. varied provision of interventions, access to services) relevant to particular sentenced or remand prisoner groups in relation to alcohol e.g.:
 - length of stay
 - age
 - gender
 - other substance misuse
 - BME groups
7. Can you give me any indication of costs for providing these services or how costs are met (e.g. what budgets, costed elements of service support).
8. Are there any staff awareness raising / training activities provided in the prison, as far as you know?
 - e.g. screening, identifying / referring potential users, supporting interventions, general promotion of safer drinking, control of alcohol in the prison
9. Can you tell me about any wider organisational issues, such as individual prison policies and structures to support activity on alcohol problems?
Are alcohol interventions prioritised in any way (financial, time, formal, informal, relationship to offence, type of offence etc.) and how does this compare to illegal drugs, smoking etc.
10. Overall, what aspects do you feel help or hinder provision of services and support in the prison? (e.g. prisoners accessing clinics, prisoner movement, transfers, resources and staffing levels, organisational culture, access to alcohol).
11. Finally, what approaches do you feel are or would be most effective in relation to alcohol and the prison service and what developments would you like to see?

Appendix 17. Mapping of alcohol interventions across Scottish prison estate

Prison	Detox support	Relapse prevention medication	SPS Alcohol Awareness Programme (AAP)	SPS Substance Related Offending Behaviour Programme (SROBP)	EACS	AA Groupwork
Prison 1	yes	yes	yes	no	yes	no*
Prison 2	yes	yes	no**	no**	no	yes
Prison 3	yes	yes	yes	yes	yes	yes
Prison 4	yes	yes	yes	yes	yes	yes
Prison 5	yes	yes	yes	yes	yes	yes
Prison 6	yes	yes	yes	yes	yes	yes
Prison 7	yes	yes	yes	no	yes	yes
Prison 8	yes	yes	no	yes	yes	yes
Prison 9	yes	yes	no	no	yes	yes
Prison 10	yes	yes	yes	no	yes	yes
Prison 11	yes	yes	yes	yes	no	Yes
Prison 12	yes	yes	yes	yes	yes	yes
Prison 13	yes	yes	yes	yes	yes	yes
Prison 14	yes	yes	yes	yes	yes	yes
Prison 15	yes	yes	no	no	yes	yes
Prison 16	yes	yes	no	no	yes	no***

* AA support may be accessed on individual basis if prisoner has previously attended community meetings.

** An equivalent programme is delivered.

*** There is capacity to re-start this programme if required by demand.

KEY

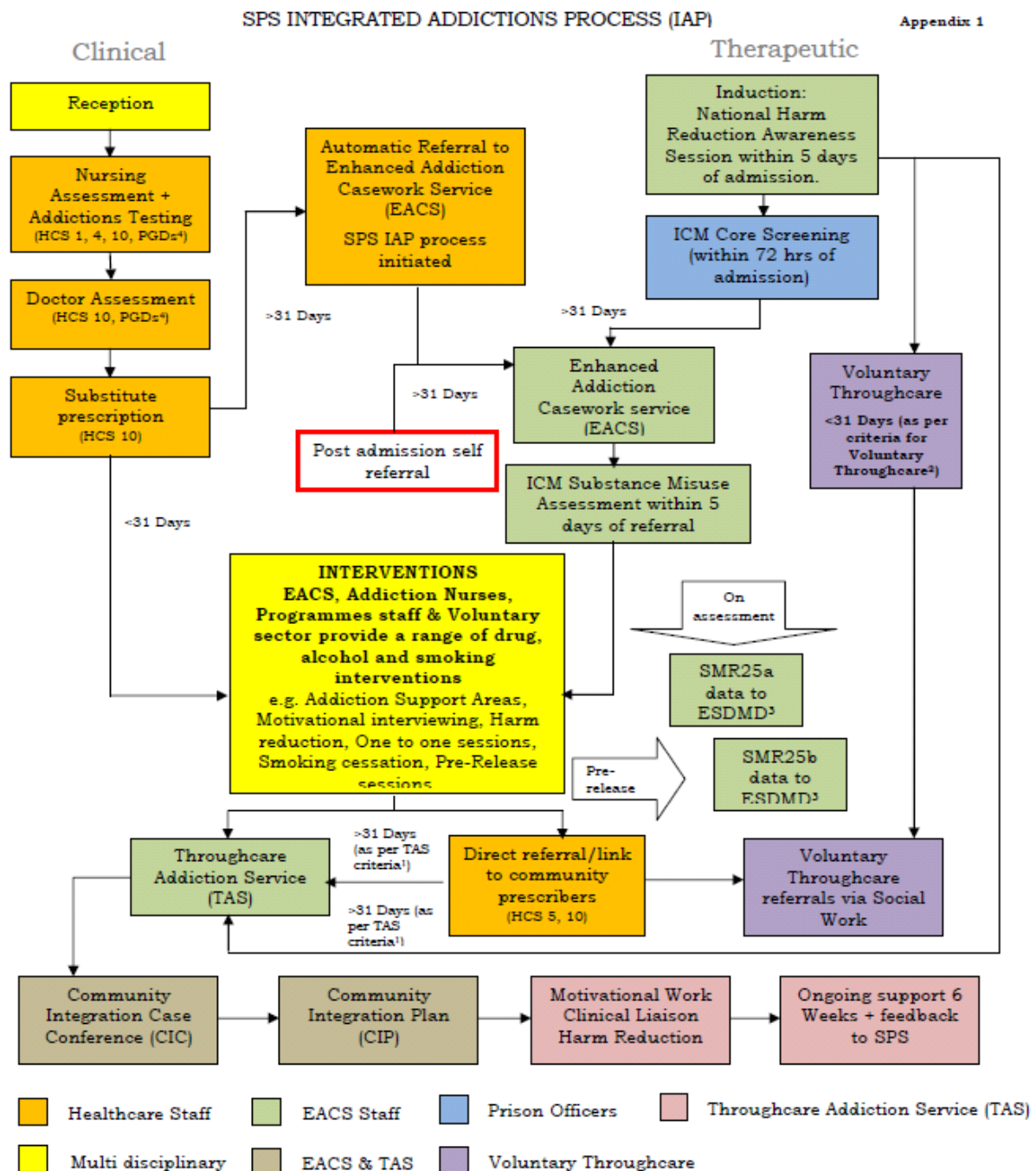
Detox support: Clinical support for alcohol detoxification provided through the prescription of Diazepam (Valium) and Chlordiazepoxide (Librium).

Relapse prevention medication: Prescribing of Disulfiram (Antabuse) or Acamprosate (Campral) to prevent relapse upon liberation.

AAP: SPS Alcohol Awareness Programme consisting of 8 x 2-3hr sessions. Delivered by SPS programmes officers, usually over an 8 week period.

SROBP: SPS Substance Related Offending Behaviour Programme consisting of 70-140 hrs of cognitive behavioural groupwork. Delivered by SPS programmes officers and psychologists on a rolling modular basis Designed for medium to very high risk offenders.

Appendix 18. SPS Integrated Addictions Assessment and Referral Process – July 2010



¹Young Offenders and Females on any sentence length, can access TAS – except those on Remand and Fine Defaulters

²Adult Males and all those on Remand or Fine Defaulters, can access Voluntary Throughcare

³ESDMD – Enhanced Scottish Drug Misuse Database

⁴PGD – Patient Group Direction

All Referrals should be made via PR2 for tracking and monitoring purposes

Appendix 19. Prisoner programmes and approved activities

Substance-Related Interventions: Delivery 2007-08 and 2008-09

Prison	Alcohol Awareness		Substance Related Offending Behaviour		Smart Recovery		First Step		Lifeline		Parenting for Mothers with Substance Misuse		Overcomers		Drug Action for Change		Advanced Drug Awareness	
	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09
Aberdeen	35	45	8	15			19											
Barlinnie	25			16			63	40	14									
Cornton Vale	18	16		8							13	12			64	19		
Dumfries							26	24										
Edinburgh	47	18		8											41	10		
Glenochil	19	18		8			10	8	24									
Greenock	52	44													46	39		
Inverness	11	34			40	37									5	12		
Kilmarnock													41				76	
Open Estate					77	62												
Perth	49	36					18	18										
Peterhead	39	30																
Polmont	60	28		8			33	17										
Shotts	47		8	15	33	45												
TOTAL	402	269	16	78	150	144	169	107	38	0	13	12	41	0	156	80	76	0

Source: SPS

For further information regarding SPS programmes, see SPS (2009b) *Interventions to Address Offending Behaviour and Life Skills*.

Appendix 20. Characteristics of prisoner focus group participants from completion of the AUDIT tool and questionnaire

26 respondents⁶⁶ in total:

- 15 had AUDIT scores of 20-40 indicating possible dependence and all scored above 8 which indicates hazardous / harmful drinking behaviour
- 17 had been in prison before
- 17 reported that alcohol had been a factor in their offence
- 16 reported that they had been unemployed before coming into the prison and 7 had no educational qualifications with a further 8 having only standard grades.

⁶⁶ Some caution needed in comparing with the screening sample as used self-completion rather than interview (e.g. interpretation of 'drinks' might be under-estimates).

Appendix 21. Topic guide: prisoner focus groups

These case study interviews are intended to explore and report on the attitudes within the prison towards the delivery and effectiveness of current alcohol interventions in this setting (objective 8).

Introduction

- Provide a reminder of the purpose and main focus of the study.
- Explain that focusing on opinions and experiences (not a test).
- Introduce the recorder underlining the importance of anonymity.
- Provide opportunity for participants to ask '*any questions*'.
- Highlight need for mutual respect and confidentiality

The sequence of topics described below is not intended to provide a rigid structure for the interviews but rather to act as a check list of key topic areas to be covered [potential prompts on next page]. All aspects covered here may not be relevant to all respondents.

Warm up: Please can you tell us a little about yourselves, for example how long have you been here, and what wings you are in?

1. We are interested in service activities in the prison relating to alcohol. Please could you tell me about any activities that you are aware of in the prison – explore activities and response.
2. [if not already covered] Are people asked about their alcohol use in their first couple of days in the prison? Explore who asks about it, what action taken, how effective is that?
3. [if not already covered] What alcohol programmes and advice and support services in the prison are provided? Explore activities and response as prompts above for key possibilities.
4. [if not already covered] Are there links between alcohol services for those in prison and then on release back in the community? Could this be done better? If so, how?
5. [if not already covered] what happens with transfers to another prison?
6. [if not already covered] what happens with those coming into the prison who are already having treatment? Is there continuity of care?
7. How would you expect to find out about help and advice about alcohol in the prison and when you go out?
8. How important do you feel it is for advice and treatment and support services in relation to alcohol to be available in the prison?
9. Who do you think would accept an alcohol service if it was offered (would you)? Why?
10. Overall, what aspects do you think makes it difficult to get advice or treatment/support services in the prison for alcohol issues?
11. What makes it easier to get advice and treatment/support services in the prison for alcohol issues?
12. How do you think alcohol services should be delivered in prison settings? What would be most helpful/successful? [potentially includes ABI and prevention]
13. And what would make it better for those going back into the community?

14. Is there anything else we have not covered you would like to add before we finish?

Additional question prompts can be made available on request.