

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

ABSTRACT

Aims: There is evidence that alcohol is strongly correlated with offending. This qualitative study explored the views of staff on the efficacy of alcohol brief interventions within a prison setting. The perceptions of prisoners in relation to non-dependent drinking were also examined.

Methods: Nine prisons in one English region took part in this research. Five focus groups with 25 prisoners were undertaken with prisoners alongside focus group discussions with 30 professionals. Discussions were recorded using shorthand notation and the main themes were thematically mapped using visual mapping techniques.

Findings: The use of the Alcohol Use Disorder Identification Test (AUDIT) was perceived as problematic. Prisoner drinking norms differed widely from community consumption patterns. There were also operational issues that reduced the salience of a brief intervention for prisoners.

Conclusions: The delivery of screening and brief interventions within a prison setting is highly nuanced and fraught with inconsistencies. Despite these challenges, there are opportunities to develop coherent and tailored brief interventions for a custodial environment that should focus on developing three key areas around: (a) interventions for the point of release; (b) enhanced content around family impact and offending; and (c) forward-looking goal-setting as motivational tools to facilitate change.

Keywords:

Alcohol – Screening and Brief Intervention – Prison

Word count: 197

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INTRODUCTION

There is evidence that alcohol use is strongly correlated with offending, with alcohol cited as a factor in nearly half (47%) of all violent crimes in England and Wales (Walker et al, 2009). The relationship between the two however, is complex when it comes to looking at drinking patterns, linking the amount of alcohol consumed alongside individual and contextual factors. Alcohol is also implicated in criminal damage, domestic violence, sexual assaults, burglary, theft, robbery and murder. Offenders have been identified as having a higher prevalence of alcohol problems compared to the general population (Newbury-Birch et al, 2009). In a recent survey, 70% of prisoners admitted drinking when committing the offence for which they were imprisoned (Alcohol & Crime Commission, 2014). National UK prison-based surveys (across Scotland, England and Wales) emphasize this higher prevalence (Carnie et al, 2014; Light et al, 2013; Stewart, 2008). In a survey of 1,435 adult prisoners nearly one-third (32%) of all respondents who admitted drinking, did so on a daily basis (Light et al, 2013). In this survey, prisoners drank a mean of 14 days per month consuming an average (mean) of around 16 units in the four weeks prior to custody (ibid). The prevalence rate of alcohol consumption has been shown to be even higher among young offenders in custody aged between 18 and 20 years, with nearly half (49%) of all offenders in one survey determined as binge drinkers (Williams, 2015).

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

A key segment of potentially problematic drinkers include a mid-range of non-dependent users of alcohol who may only periodically drink to excess. These drinkers may not perceive the need for formal “treatment” and may be resistant to health promotion messages.

Prison-based services for AUDs have been viewed as limited, pointing toward considerable unmet need for on-going treatment and support (HM Inspectorate of Prisons, 2010). In England and Wales, the prison system comprises different categories. Categories A through to C are “closed” prisons based on the seriousness of the offence. Category A houses high-security prisoners on long-term sentences. Category B includes prisoners held on remand pre-trial and post-conviction, and this type of prison is also known as “local” prisons as they tend to service the local court system. Category C prisons manage longer-term prisoners who can access employment support and behavioural change interventions aimed at addressing offending. Category D or “open” prisons house prisoners where the risk of absconding is considered to be low, or who may have committed low-tariff offences. This category may also include offenders near to the point of release who may have worked their way through the categories. Young offender institutions are aimed at 15 to 21 year olds (sometimes separated by 15-17 and 18-21 year olds).

The England and Wales prison system has identified that prisoners with primary alcohol problems have been overlooked in favour of treating those with addiction to illicit drugs (HM Inspectorate of Prisons, 2010). Prison services (formerly known as CARATS – Counselling, Assessment, Referral, Advice and Throughcare service) had been designed for illicit drug misusers although commissioning changes since 2010 have allowed for alcohol-only misusers to also access services (Ministry of Justice, Public Service Order 3630). Yet despite this, one study in Wales and South West England found that of pre-trial prisoners, 81% reported drinking at levels requiring an intervention, and of these, only those identified as dependent were likely to access an in-house service (Kissell et al, 2014).

Alcohol Brief Interventions

In England, Screening and Brief Interventions (SBIs) form part of NICE Quality Standards (NICE, 2011), with health and social care staff identified as those who can opportunistically deliver SBIs for adults who have been identified via screening as drinking at increasing- or higher-risk levels. In Scotland, the Scottish Government set the delivery of SBIs as a national HEAT (Health Improvement, Efficiency, Access and Treatment) target in three priority settings within Emergency Departments, Primary Care and Antenatal care (NHS Scotland, 2011). The policy envisages around 20 per cent of all SBIs to be delivered in other settings including prisons (Scottish Government, 2015). An alcohol brief intervention (ABI) encompasses a range of approaches and goals ranging from simple advice to brief lifestyle counselling that can suggest ways to reduce levels of drinking, to a series of bespoke

interventions delivered within a more structured treatment setting. Given the nature and sensitivity of the topic, an ABI can also encompass more Extended Brief Interventions (EBI) that incorporate more detailed discussions of an individual's drinking (Heather et al, 2013).

For a brief intervention to be effective, it requires an initial assessment of drinking patterns and associated problems resulting from alcohol consumption. 'Lower-'; "increasing-", "higher-risk" and 'possible dependence' are all categories that follow from an initial screening of an individual's drinking, using validated tools including the Alcohol Use Disorder Identification Test (AUDIT). Due to the nature of the intervention that allows the delivery to be undertaken by non-specialist professionals, an ABI has been defined as an "opportunistic intervention" (Raistrick et al, 2006).

UK policy guidance advocates a stepped model that provides for ABI for individuals drinking to excess but not requiring treatment for dependence, alongside a separate suite of interventions for those with moderate or severe levels of dependence (NTA, 2006). The opportunistic nature of an ABI allows for prisoners to receive an intervention even if they fall outwith the threshold traditionally held for "treatment". This allows for prisons to potentially offer a service to large numbers of prisoners who otherwise may not have received any support for their alcohol problems (including a key segment of prisoner on short-term sentences). Despite the potential to see large numbers of individuals, studies have shown the intrinsic challenges of criminal justice settings to deliver an ABI (Thom et al,

2014) and in a prison context issues include enforced abstinences and literacy or language barriers (Coulton et al, 2011).

Alcohol Brief Interventions in Prison

The prison population in the UK has risen by 66% since 1995, with current numbers just over 90,000 and of these 95% are male (National Statistics, 2015). Those who have offended or are at risk of offending frequently suffer from multiple and complex health needs, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality.

Prisons in England and Wales include an initial screen for AUDs on entry into an establishment largely reliant on use of AUDIT (Public Health England, personal communication). This screening tool includes a three-question initial screen and a more detailed ten-item schedule designed to calculate severity of alcohol use. A review of the literature found few studies examining ABIs in prison and of these a number were hampered by methodological constraints including differences in outcome measurements (Newbury-Birch et al, 2015; 2016). Of the reviewed studies, the picture is one of mixed effectiveness with either; no change in drinking behaviours noted between prisoners receiving a brief intervention and a control group (Davis et al, 2003; Clarke et al, 2011); or where change was noted this effect lasted in the short-term only and not beyond six

months (Stein et al, 2010). These studies only examined the extent of post-intervention behaviour change as opposed to staff or prisoner perceptions.

This study was commissioned to explore the views of prison staff (mainly healthcare and substance misuse teams) on the efficacy of ABI within a custodial setting. Prisoners' perceptions of drinking at non-dependent levels were also explored. The study examined the content of a brief intervention; the process by which an ABI was delivered (why and when); and prisoner/staff perceptions of what elements an effective brief intervention may comprise.

Methods

The research was conducted in nine prisons in one English region between 2014 and 2015 (out of ten possible establishments) as part of the government's Transforming Rehabilitation agenda (Ministry of Justice, 2013). The prisons included two male Category D or "open" prisons; two male Category C Training Prisons; one male Category A (high security) and Category B 'local' prison (combined); two separate male Category B 'local'; and one female Category B 'local' prison that incorporated young female offenders (aged under 21 years). One Category C Training prison did not participate in the research project due to resource constraints. As recording devices are routinely prohibited from use within a prison setting (under Ministry of Justice Prison Service Instruction 10/2012), detailed notes were taken from the focus group discussions using short-hand notation.

Focus group methodology was used to collect as much information within a short-time frame that was allowed for this study within each prison, that allowed for a structured, but informal discussion among group of key participants (Barbour, 2007). Focus groups also are a pragmatic mean to access numbers of prisoners, as prison regimes limited access to prisoners at any one time. Interactions between participants were also encouraged to develop themes across prisoner and professional groups (Kitzinger, 1994). The focus groups were undertaken by two of the research team in conjunction with representatives from Public Health England who acted as facilitators and note takers to the project. The main themes were thematically mapped and coded using visual mapping techniques (Langfield-Smith, 1992; Huff & Schwent, 1990) in response to resource constraints imposed on the study. Governance and project oversight for the study was provided through the local Transforming Rehabilitation Project Board managed by NHS England who ensured appropriate governance and ethical oversight. All prisoners interviewed completed informed consent forms to ensure confidentiality.

Prisoners

Focus groups with prisoners were conducted in five prisons. The prisons were selected to include all category of prisoner (with the exception of the Category A prison which housed long-term prisoners). Two male Category B and two male Category C prisoners were recruited alongside the female prison. From these prisons, 26 prisoners were identified using the AUDIT tool (with scores of less than 20) as drinking at increasing- or higher-risk levels. Prisoners were purposively selected using the AUDIT score criteria by each

establishment's substance misuse teams as being current service users for either drugs and/or alcohol and were interviewed in five focus groups. All prisoners were given the choice to participate in the study.

Twenty-one male and five female prisoners with an average (mean) age of 36.1 years accessed five focus groups lasting for one hour using a semi-structured interview schedule that probed prisoners' history of alcohol use and perceptions of services offered in relation to alcohol. An initial ice-breaker component was added to the focus groups aimed at testing participants' knowledge of units across a range of alcoholic products. A section of the interview schedule also included assessing views of existing brief intervention health promotion information (e.g. pamphlets) and experiences of AUDIT screening tools.

Staff

Thirty staff members across healthcare (n=5), prison officers (n=3) and substance misuse services (n=22) were recruited across nine convenience groups lasting between one and two hours in each prison using a semi-structured interview schedule. The professional sample reflected the availability of staff on the day of the interview and therefore is not representative of the professional population. Although responses across professional groups were examined, differences in professional perceptions were negligible, although this may be due to the small numbers of healthcare and prison officers interviewed. The schedule was designed to probe what current practice was including pathways into alcohol

treatment; a description of what a brief intervention comprised of and suggestions for improving delivery.

RESULTS

Three main themes emerged from the research:

Issues in the use of the AUDIT screening tool in a custodial setting

For all prisons, prisoners are screened at the initial point of entry into the prison system by healthcare staff. At the time of the study, prisons used either the shorter three-question AUDIT-C or full ten questions AUDIT-10 schedule. The derived AUDIT “score” following an initial screen was used by healthcare staff to refer prisoners to specialist drug and alcohol services. Prisons using AUDIT-C would refer any prisoner scoring five or more; establishments using the full AUDIT referred prisoners scoring eight or more.

Following referral, most prisons undertook a secondary screen using the full AUDIT tool. For most staff, this was seen as “paperwork” and “administration” rather than a means to create a tailored intervention and for some staff interviewed, use of AUDIT was a legacy requirement from previous providers who had been decommissioned. Staff highlighted that although AUDIT would be used as part of an initial assessment, it was not used to initiate a brief intervention (although focus group discussions with staff suggested that this had been the original intent). In most cases, AUDIT scores were held on casefiles and not used as an

indicator of need as prisoners were automatically placed into existing group or one-to-one interventions largely due to resource implications:

“We might use it [AUDIT] to guide our key-work sessions but they [AUDIT scores] tend to stay in the files. Prisoners on the caseload will be able to access all the interventions we have here. I’m not sure how we would change what we give prisoners because the caseloads are so high.”

[Prison Staff Interview, Category C Prison]

For prisoners and prison staff, use of AUDIT at reception was perceived not to elicit a truthful response, confirming previous research on the topic (Maggia et al, 2004). For prisoners, the point at which an AUDIT was administered was sub-optimal with little face validity. When prisoners in the focus groups were shown AUDIT-C and the full AUDIT, few were able to recall it specifically, and for those that did, it was not perceived as relevant:

“When you first get in jail, they ask all these questions...hundreds...you can’t take it all in and I don’t know what they want from me. It’s only a stats exercise and I’m not sure what I have gained from all of this.”

[Prisoner Focus Group #1, Category B, Remand Prison]

Moreover, there was cognisance that questions about alcohol consumption were highly personal with value-laden connotations. For some prisoners interviewed, there was a concern about being “judged” by health professionals:

“I don’t like the questions they ask. They are no one’s business. Go down the list [refers to the AUDIT scoring system] and then tell you what a bad person you are. Some of the nurses just look at you when you give an answer they don’t like, like you are something else. They judge you on the answers they [referring to AUDIT] give. I don’t like that and they shouldn’t do it.”

[Female Prisoner Focus Group #5, Category C Prison]

For staff, an initial AUDIT screen at reception was deemed unreliable as prisoners were known to “blag” (lie about alcohol consumption) to gain access to medication or other services. In addition, the AUDIT was shown not to identify alcohol-related offending. There were examples of very low AUDIT scores for offenders imprisoned for alcohol-related violence, as the schedule does not include questions specifically related to offending.

Issues with Delivering ABIs within a Prison Setting

In many prisons, there was conflation of health promotion, the use of alcohol within the context of other substances (including medication) and offending behaviours that all of which formed discussion points. This approach pragmatically fused a number of key messages around alcohol consumption in the community, with the limited time available to deliver a coherent message a key factor:

“There’s a lot to get in and try to make some of it stick. You may only have a short window before they leave here so I try and focus in on the key messages. I tend to focus on stopping them reoffending so health-type stuff may not always get a look in, but I try.”

[Prison Staff Interview, Category B, Remand Prison]

Staff discussions probed how far a brief intervention conformed to the FRAMES (e.g. Miller and Sanchez, 1994) motivational interviewing approach that aims to enhance an individual’s motivation to change harmful or risk-taking behaviours. Only two prison staff recalled that they had received alcohol-specific brief intervention training although staff expressed confidence in their ability to deliver a coherent message. Most interventions that staff delivered did not include any feedback on existing levels of drinking, rather a specific focus on imparting information pertaining to excessive consumption. There were few specific examples of encouraging prisoner self-efficacy and other attributes in relation to their drinking. One example where this did occur was in relation to providing a brief intervention for prisoners on short-term release or ROTL. Staff highlighted how prisoners on long-term sentences would be confused by changes in drinking habits and products once released and back into the community. Interventions were provided to prisoners released with the specific aim of dealing with these new triggers.

“There’s a lot of changes in pubs now and drinking [is not] the same. They say to us they get bamboozled by it all.”

[Prison Staff Interview, Category C, Male Training Prison]

All the prisoners interviewed were poly-drug users, using alcohol in conjunction with other substances (often also at non-dependent levels). All were in receipt of interventions largely geared towards their drug use and some specifically for their alcohol use. Focus group discussions with prison staff suggested that unless a prisoner engaged with Drug and Alcohol services following a referral then an alcohol brief intervention would not be delivered to them. For those that did engage, alcohol-specific interventions tended to be group work (e.g. Alcohol Awareness or externally provided groups such as Alcoholics Anonymous) or one-to-one key-work. Staff interviewed suggested that an ABI was considered best delivered at the point of release from prison including for home visits such as Release on Temporary Licence (ROTL).

Acceptance of Drinking Norms in a Prison Context

For most prisoners, pre-existing brief intervention literature had little relevance. Prisons often combined their own agency-specific promotional literature which tended to focus on extreme images of violence, death and poor physical health resulting from excessive alcohol consumption, with generic health promotion information downloaded from the internet. According to prisoner interviewees, graphic images were seen to have an initial shock value with wider health promotion information being “lost”.

The reported levels of drinking in the community amongst the prisoners interviewed was far higher than the general population and standard health promotion messages had little salience with prisoners. For all prisoners, drinking large amounts of alcohol was the “norm” inherited from the drinking habits of their immediate family, and whilst a few interviewed considered abstinence as a means to “start afresh”, none of the prisoners interviewed stated that they had a goal of reducing their alcohol consumption (rather the converse was true). For all prisoners interviewed regardless of prison setting, the ABI tended to be a retrospective review of behaviour, which tended to be often emotionally charged as it related to the offence committed and its aftermath. Rather, there was a preference for an intervention that was geared towards future-planning that emphasized a positive future:

“It’s all about how rubbish you’ve been, and how it’s all going to [go wrong] for you if [you] have a drink or whatever.....better for me to think about this [alcohol consumption] if they [health professionals] made me feel more better [sic] about changing.”

[Male Prisoner Focus Group #4, Category C Prison]

Moreover, drinking was perceived as one of the few pleasures still available to this group:

“I’m off the gear and have detoxed off methadone and reducing my other meds. I’m in much better nick [physical health] than I was when I got here. A pint is the last thing I have left. ”

[Male Prisoner Focus Group #4, Category C Prison]

The health promotion literature tended to focus on either short-term effects such as a lack of sleep or longer-term physical health issues such as hypertension, diabetes and cancer that did not resonate with prisoners' own perceptions. The concept of units has little relevance for prisoners, although for female prisoners, there was some relevance in terms of emphasising the calorific nature of alcohol consumption.

"Why not just say a beer is a beer. What's all this [units] meant to be about?"

[Male Prisoner Focus Group #3, Category C Male Training Prison]

Among the prisoners interviewed, their alcohol consumption was calibrated by the amount of money spent, time spent drinking or by how inebriated they felt. None of the respondents stated that units were or would be used to moderate their drinking. For all prisoners, the immediacy of returning to the community from prison life, particularly in the context of other substance use was considered paramount:

"This is my first time in jail and I'm telling you never again, but I've got all these things I need to get done when I leave jail....Stopping using [drugs] being one and others like....seeing my daughter again."

[Male Prisoner Focus Group #1, Category B Remand Prison]

The focus group discussions with prisoners probed what type of messages would have more salience in reducing excessive alcohol consumption. As highlighted above, motivational discussions focusing on offending and the family impact of excessive drinking was seen as

more relevant. Discussions also focused on the exact point where a BI should be delivered. For most prison staff and prisoners, the point of release (including release on temporary license or ROTL) was seen as the optimal point to engage prisoners. Many prisoners (especially prisoners held on remand) stated the point of release was a trigger point for excessive drinking (e.g. being “gate-happy”), although this was seen as short-term consequence of being in prison:

“There’s nothing wrong...celebrating getting out from this place than having a few beers, you know, a few tinnies [cans of beer] on the way home, you haven’t got much money in your pocket anyway. Chance to get on with your life then.”

[Male Prisoner Focus Group #4, Category C Male Training Prison]

DISCUSSION

The study identified three main themes that affected the delivery of an ABI within a custodial setting. Use of AUDIT was largely used pragmatically as a referral mechanism at reception to initiate contact with specialist substance misuse services. For prisoners, the implementation of the AUDIT screen at reception was perceived suspiciously as it coincided with a large number of additional health-related questions that were routinely asked as part of healthcare induction. Prisoners highlighted the difficulty in understanding the nature of the questions asked as part of AUDIT at this stage and stated a concern that they may be “judged” by healthcare professionals. Although subsequent AUDIT scores were routinely collected by substance misuse teams, this information was not used to inform the nature of

the ABI (although this had been the original intent). The integration of screening for use as a motivational tool can easily be rectified and would provide the necessary feedback to enhance prisoner self-efficacy. AUDIT screening scores could be shared with community-based teams at the point of release to maintain continuity of contact.

Further opportunities exist to develop ABI in a prison setting that is cognisant of prisoner perceptions of alcohol and takes into account prevailing norms and drinking patterns.

Although screening did not routinely provide feedback on a prisoner's drinking level, ABIs fused pragmatic messages around health promotion, drug use and offending concerns. This may also be an opportunity to develop bespoke ABIs for a prison environment that would reinforce natural synergies between non-dependent drinking, substance misuse and offending reflecting the complexities of prisoner lives whereby family and offending concerns have greater primacy. Placing alcohol consumption within a wider family and offending context may also help address the lack of desire to curtail their drinking in the immediate post-release period (although some expressed a desire for abstinence as part of a desire to "start afresh").

Many prisoners also reported a sense of being "gate happy" and primed for drinking at the point of release. This may offer an opportunity to deliver a series of revised and bespoke short interventions at the point of release and at subsequent follow-up in the community. The role of an immediate aftercare component to enforce a health promotion message has been identified as effective in acute settings (Crawford et al, 2004) and for recently released

prisoners (Thomas et al, 2014). A role for probation services and the privatised Community Rehabilitation Companies may offer a conduit for the delivery of ABIs in the community. Prisoners highlighted the importance motivational, forward-looking interventions as opposed to retrospective reviews of past behaviour, and this raises the possibility of integrating goal-setting theory (Webb et al, 2010) within a suite of possible interventions aimed at affecting behaviour change post release. The development of prison-based cognitive tools across England and Wales (Day et al, 2010) could provide a vehicle for such an approach. Few staff members interviewed had specific ABI training although most were aware of motivational interviewing techniques, and this suggests the wider need to develop and enhance the competencies of the workforce.

Study Limitations

The study selected small samples of prisoners and staff across nine establishments and although the perceptions recorded in this study may be seen as indicative, they cannot be viewed as representative. No alcohol-only users were interviewed who may have a differing perception to alcohol consumption compared to poly-drug users. The study is likely to have some resonance with other English regions through use of standardised screening tools and provide similar prison-based interventions. However, differing local commissioning will limit the generalisability to other prisons.

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