Delivering Alcohol Brief Interventions in the Community Justice Setting:
Evaluation of a Pilot Project

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Executive Summary

Background
This report presents the findings of an independent evaluation of the feasibility and potential effectiveness of using Alcohol Brief Interventions (ABIs) in the community justice setting. It describes the set up and operation of a pilot of ABIs introduced into three Local Authority areas in Scotland, which was operational between January 2010 and April 2011.

The pilot was set in the context of an increasing policy and research focus on the relationship between alcohol, offending and health inequalities in Scotland and the UK. It arose from a commitment set out in the Scottish Government’s framework for tackling Scotland’s alcohol misuse problems, ‘Changing Scotland’s Relationship with Alcohol: A Framework for Action’, to fund research on the delivery of ABIs in settings outwith the NHS, such as in criminal justice. This report is the third of three projects that were funded as part of the Alcohol and Offenders Criminal Justice Research programme (2009-2011) led by NHS Health Scotland on behalf of the Scottish Government1.

Although ABIs have been widely researched in primary health care settings, there is little evidence to date of their effectiveness in the community justice setting. The purpose of the study, therefore, was to contribute to the evidence base for ABIs through assessing the feasibility, barriers and potential implications of using the ABI model in day-to-day practice in community justice for recently convicted offenders.

The Pilot
The pilot was designed to be delivered as part of routine practice for staff working in community justice services, and was to be delivered to clients in receipt of Probation Orders (POs) or Community Service Orders (CSOs). The pilot adopted a randomised control design in which staff were randomly allocated to either a control group (screening and issue of an alcohol information/behaviour change booklet) or an intervention group (screening and delivery of ABI), where appropriate.

A baseline questionnaire was developed to assess clients for eligibility and to act as a consent form. For screening purposes, the Alcohol Use Disorders Identification Test (AUDIT) questionnaire was selected as this represents the ‘gold standard’ test for identifying hazardous, harmful and dependent drinkers and has also previously been shown to work effectively in offender populations. Those scoring in the range of 8 to 19 (hazardous or harmful drinkers), and who were in the intervention group went on to receive an ABI.

1 http://www.healthscotland.com/topics/health/alcohol/offenders.aspx
From the outset, although the main aim of the pilot was to test feasibility of the screening and ABI model in this context, it was hoped that a primary outcome for the pilot might be a reduction in alcohol consumption among those who took part. Follow up screening using the AUDIT at 3 and 6 month intervals was intended to be used to provide this outcome data.

**Evaluation Approach**

The evaluation took place over a 14-month period from February 2010 to April 2011, and ran concurrently with the pilot itself. A mixed methods approach was used which included: an online survey of staff who delivered the pilot in the three participating areas; analysis of training feedback; analysis of screening and follow-up data and depth interviews with strategic, policy and operational staff. Views from a participating client were also obtained.

**Research Findings**

The pilot was effective at identifying alcohol problems within the community justice setting and, as a screening exercise, provided valuable evidence of the levels of problem drinking in the community justice population which was otherwise not known.

Willingness to take part in alcohol screening among the community justice population was around 70%, and this is encouraging as an indicator for uptake within this setting. It is important to note, however, that there was a higher refusal to consent rate among community service clients. Only just over half (51%) of community service clients who were eligible to take part provided verbal consent, compared to 93% of probation clients.

Among those who were not eligible to take part, around two thirds were already receiving alcohol advice and support from another source and so the prevalence figures presented are likely to be an underestimate of the true level of need among this group.

The screening showed that:

- Around 59% of offenders in receipt of CSO or POs in the pilot area, and who fulfilled the eligibility criteria, were categorised as having an Alcohol Use Disorder (AUD).
- Of these, 42% fell into the hazardous/harmful category and could potentially have benefited from receipt of an ABI.
- Almost 1 in 5 offenders screened demonstrated high risk drinking behaviour that might indicate possible dependence. This may be an underestimate of the true prevalence of high risk drinking in this population, however, since a substantial proportion of clients were excluded from the pilot as they were already in contact with specialist alcohol services.
- Those falling into the high risk/possibly dependent group were more likely to be in receipt of a PO than a CSO.
• Although client numbers were small, men were almost two times more likely to fall into the intervention range than women, with almost two thirds of women falling below the cut-off for AUDs.
• Those in the 18-24 age band were more likely than those in older age bands to have an AUD.

Accepting that the sample was small, and that there may therefore have been some inherent bias, these findings nonetheless indicate that screening for AUDs in this population could potentially be used to effectively identify and intervene with a large number of people with alcohol problems who might otherwise not be identified as being in need.

The evaluation was not able to say anything conclusive about the impact of ABIs on those who took part due to a lack of primary or secondary outcome data. This occurred largely as a result of the inability to collect sufficient follow-up data, and a lack of engagement from offenders with the qualitative evaluation.

Although the AUDIT tool and the ABI seem to have been easy to administer, and were seen as useful tools in themselves, some negative perceptions of the appropriateness and likely success of screening and ABIs in this environment were expressed by staff. This may have resulted in reluctance to deliver the pilot, and the limited follow-up data, although it is recognised that data collection problems may also have occurred due to other factors outwith staff control. In particular, staff expressed views that alcohol problems were of less immediate concern in light of their other issues for clients and this is perhaps one of the strongest themes emergent from the qualitative analysis.

Comments were also raised in the evaluation about the timing of screening and ABIs for this group, and there was a strong view that they may capture more people and be of greater use in determining sentencing outcomes if undertaken at an earlier stage in the community justice process.

Despite this, some valuable learning points arose from the pilot, including a need for greater involvement of operational staff during the planning and implementation of local screening and ABI practices to ensure that models of working take into account current workloads and client-staff protocols.

The research showed that there may be a need for targeted, designation-specific training and regular refresher training among community justice staff.

The research suggests that screening and ABIs in this context would perhaps work better with the presence of a local manager/champion who takes overall responsibility for ABIs and ‘manages managers’ across split sites, if appropriate, so that a consistent approach is adopted to allow for comparable data within and between areas. This is the main workforce development requirement to ensure more engagement with front-line staff to provide education and evidence for the effectiveness of ABIs.
The pilot has shown that, on an administrative and resource level, there should be few barriers to introducing screening and ABIs into community justice settings, although there is clearly some scope for reducing the time taken by staff to deliver the ABI so that it does not impact too greatly on workloads. This could be achieved with better training and it is assumed that, as familiarity with ABIs increased, staff would become more efficient at their delivery.

The process of establishing eligibility, screening and delivering an ABI has been estimated, using data from the pilot, to take around 25 minutes with an estimated cost of around £67 per person (including overheads). Further uptake could potentially offer economies of scale, in terms of coordinated central costs and training and therefore possibly reduce this figure.

It is estimated that the indicative total cost of alcohol misuse to Scottish society in 2007 was around £3.56 billion (Scottish Government, 2010). Of this figure, it is estimated that £727 million (approximately 20% of the total) is related to crime. There is evidence to suggest that ABIs are a cost effective method of tackling alcohol misuse in particular settings and they have similar potential within community justice. However, to determine overall value for money, further analysis would be needed to understand the full benefits to society and to the individual of such interventions.

**Conclusions**

Considering the challenges inherent in applying the ABI model to this setting, the pilot has successfully highlighted that the community justice setting does afford an opportunity to reach some of those most at risk of alcohol related harm. The screening results show a high level of need in this population. It addresses a previous gap in evidence on alcohol problems in offenders in the community, whilst adding to the growing evidence base on the prevalence of AUDs in offenders more generally.

The pilot has, therefore, shown that it is possible to deliver ABIs in the community justice setting, providing valuable learning and guidance on how best this might be taken forward.
1. Introduction

1.1 Background
This report presents the findings of an independent evaluation of the feasibility and potential implications of using Alcohol Brief Interventions (ABIs) in the community justice setting. It describes the set up and operation of a pilot of ABIs introduced into three Local Authority areas in Scotland, and which was operational between January 2010 and April 2011.

This report is the third of three studies that were funded as part of the Alcohol and Offenders Criminal Justice Research programme (2009-2011) led by NHS Health Scotland on behalf of the Scottish Government². Collectively, the three studies sought to add to the evidence base on the extent and nature of alcohol problems in offenders and which interventions can address them effectively, recognising that the criminal justice setting is an opportunity to detect and intervene with an often hard-to-reach population.

1.2 Research Rationale
The pilot was set in the context of an increasing policy and research focus on the relationship between alcohol, offending and health inequalities in Scotland and the UK.

Data from the Scottish Prison Service Prisoner Survey 2009 show that 50% of those in receipt of a custodial sentence or on remand in a Scottish Prison reported being drunk at the time of their offence (Scottish Prison Service, 2009). Statistics also show that 46% of prisoners may have harmful alcohol use or potential dependency (ISD, 2011) compared to 14% of the adult male general population (Corbett et al, 2009). Recent research from a Scottish prison has also shown that around three quarters (73%) of prisoners reported hazardous/harmful or possibly dependent drinking patterns (Parkes et al, 2011).

Research has also shown that there may be a direct association between alcohol misuse and increased risks of violent offending among young people in particular (Fergusson et al, 1996; McKinlay et al, 2009). Indeed, more than three quarters of young offenders (77%) reported being drunk at the time of their offence (Scottish Prison Service, 2010).

Alcohol consumption has also been shown to be linked to risk of victimization (WHO, 2010). Data from the Scottish Crime and Justice Survey (SCJS) 2009/2010 showed that around two thirds (62%) of victims of violent crime perceived the offender to be under the influence of alcohol at the time of the offence (Scottish Government, 2010). Again, evidence shows that young people in particular may be at risk of alcohol related victimization (Galloway et al 2007)

and women have also been found to be at risk of alcohol related partner abuse (Hamlyn and Brown, 2007).

The National Strategy for the Management of Offenders (Scottish Government, 2006) recognized this link between alcohol and offending and has as one of its nine core offender outcomes the need for ‘reduced or stabilised substance misuse’. It determined that local services should be designed around priority offender groups, one of which was those with substance misuse problems, in order to reduce re-offending. It contained a commitment to tackle alcohol related offending at the local level. Indeed, there is evidence to show that agencies who work with offenders often seek to tackle alcohol misuse as part of their intervention programmes for reducing re-offending (McMurran, 2001). However, there is less evidence of proactive screening of offenders for alcohol misuse, especially in the community justice setting.

As well as being a direct risk factor for offending and victimisation, alcohol misuse has also been shown to be linked to poor social and health indicators. These include, for example, unemployment (Crawford, et al, 1987), deprivation (ISD, 2011), physical and mental health problems (SIGN, 2003) and accident/injury risk (ScHARR, 2008). In December 2007, the Scottish Government published an ‘Action Plan for Better Health, Better Care’ which suggested a need to concentrate efforts on tackling alcohol and drug misuse and improve mental health and wellbeing across Scotland (Scottish Government, 2007a). The report specifically 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. This was followed, in 2008, by the ministerial task force report on health inequalities *Equally Well* which set out a series of recommendations, including more effective local delivery of joined up services for problem drug and alcohol users with a longer-term aspirational outcome to reverse the inequalities in harm to health from alcohol. It identified offenders as one of a number of particular groups in need of targeted interventions to address alcohol misuse. This reflects that those most at risk of offending and victimization are often young males, who are most likely to drink to excess (Corbett et al, 2009), with binge drinkers also being those most likely to offend (Richardson et al, 2003). The personal risks for this group therefore compound the risks of offending and victimization.

Recognising that a population-wide approach to tackling alcohol misuse was needed, in March 2008, the Scottish Government published its framework for tackling Scotland’s alcohol misuse problems, ‘Changing Scotland’s Relationship with Alcohol: A Framework for Action’. The Framework set out a series of long term outcomes for cross-Government action to tackle alcohol problems and help change the drinking culture in Scotland. It also contained a commitment to expand access to treatment and support for those with alcohol problems which was supported by additional investment of £85.3 million over three years.
The Framework sets out strategies to tackle alcohol misuse including actions to address the affordability and availability of alcohol, action to improve substance misuse education and public health messaging, controlling promotion and advertising of alcohol and encouraging delivery of evidence based ABIs. In particular, recognising the effectiveness of screening and ABIs in primary health care settings (SIGN, 2004), the national strategy document contained a commitment to fund research on the delivery of ABIs in settings outwith the NHS such as in criminal justice.

1.3 Aims and Objectives
Although ABIs have been widely tested in primary health settings, there is little evidence to date of their effectiveness in the community justice setting. The purpose of the study, therefore, was to contribute to the evidence base for ABIs through assessing the feasibility, barriers and potential effectiveness of using the ABI model in day-to-day practice in community justice for recently convicted offenders. The research also sought to inform consideration of the potential for further uptake of the model across Scotland should ABIs be effective with this population group.

The specific research objectives were:

- To identify alcohol problems among offenders within community justice and the impact of screening and delivery of an ABI on alcohol consumption for those drinking at hazardous and harmful levels through analysis of data collected through the pilot by existing community justice staff.
- To analyse impact on a range of secondary outcome data, such as re-offending.
- To explore the experiences of staff and clients directly involved in the delivery of screening and ABIs in community justice for recently convicted offenders.
- To determine the feasibility of the process implementation model adopted for delivering screening and ABIs in community justice in day-to-day practice.
- To identify any differences in feasibility of implementing screening and ABIs which exist between probation and community service.
- To identify barriers to implantation of the screening and ABI both strategically and operationally.
- To identify and report on the perceived workforce development requirements from key informants.
- To explore and report on the resource and cost implications of implementing screening and ABI within existing practice in community justice.
- To assess potential impact of criminal justice services should further uptake of the pilot be undertaken.
1.4 Evaluation Overview

The evaluation took place over a 14-month period from February 2010 to April 2011, and ran concurrently with the pilot itself. It was envisaged that the evaluation would adopt both a process and impact approach, so as to explore process, operational and feasibility questions alongside ascertaining the impact of the scheme on those who took part. That said, it became clear early on that it would not be possible to address all of the outcome and impact questions since there were time constraints on staff collecting additional primary impact data and access to secondary data held by criminal justice partners was not feasible. This meant that follow-up data collected by the pilot staff would act as the main outcome measure. As a result, the evaluation became largely process focussed and this is reflected in the data presented here.

A mixed methods approach was used which included: an online survey of staff who delivered the pilot in the three participating areas; analysis of training feedback; analysis of screening and follow-up data collected during the pilot and depth interviews with strategic, policy and operational staff and clients.

Although the evaluation was independent, and the researchers played no part in the pilot model development or delivery, the work was formative in some respects, insofar as ongoing feedback was provided during the research which could be used by the pilot teams to improve or change data collection practice as the pilot progressed. For example, operational data relating to the pilot were not collected by the researchers but were collected locally by project staff. Feedback on early inaccuracies with form-filling was fed back to the participating staff to allow improvements in subsequent data collection.

The following section provides a summary of the research evidence against which the evaluation took place, and the remainder of the report describes the evaluation approach and the research findings.
2. The Research in Context

2.1 Alcohol Screening

A variety of screening tools exist which seek to quantify alcohol problems and consequences and classify respondents in terms of their likely risk of harm. Raistrick et al (2006) describe three main screening methods, these being self-report screening questionnaires, biological markers of recent alcohol consumption and clinical indicators identified by clinicians using clinical history or signs at physical examination. The most commonly applied method both within and outwith primary health care settings is the self-report measure.

The most frequently cited tools that measure alcohol problems include the Fast Alcohol Screening Test (FAST); Paddington Alcohol Test (PAT); Michigan Alcoholism Screening Tool (MAST); Cut down Annoyed Guilty Eye-opener (CAGE) and CAGE Plus; T-ACE (Tolerance/annoyed/cut down/eye opener) and TWEAK (Tolerance/Worried/Eye-opener/Amnesia/Cut down). The suitability of these tools varies depending on the client group and delivery context, as well as on the precise level or nature of alcohol problems that they seek to identify.

Across the literature, the Alcohol Use Disorders Identification test (AUDIT) is the tool which represents the ‘gold standard’ test specifically for identifying hazardous and harmful drinking (Babor, Higgins-Biddle, Saunders et al., 2001). Developed by the World Health Organization (WHO) the AUDIT is a self-report measure that comprises 10 pre-coded questions which produce a score in the range of 0 to 40.

AUDIT scores can be clustered to four levels. Those scoring 8 or below are considered low risk, and those scoring 8 or above can be classified as having an Alcohol Use Disorder (AUD). The four clusters, as described in the National Institute for Health and Clinical Excellence Public Health Guidance 24 (NICE, 2004) are:

- 1 to 7: low-risk drinking.
- 8 to 15: hazardous drinking.
- 16 to 19: harmful drinking.
- 20+: possible dependence.

The AUDIT has been internationally validated, is quick and simple to deliver and has been proven to integrate well into standard practice in numerous applied health and social care settings and across a range of drinking cultures (Reinert and Allen 2007).
2.2 Alcohol Brief Interventions (ABIs)
Where screening has been used to identify hazardous/harmful drinkers, one of the most appropriate evidence based follow-up interventions that is used is the ABI.

In Scotland, ABIs have been defined as “a short, evidence based, structured conversation about alcohol consumption with a patient/service user that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm” (Scottish Government, 2008).

The principles of ABIs are to develop and maintain rapport and empathy with clients to enable them to discuss their alcohol use in an open and honest way, and to adopt a non-confrontational approach to motivating and supporting the person to think about how they might change their behaviour and reduce their alcohol consumption. Personal responsibility for decision making is integral to this process and this should be emphasised with the individual throughout the intervention. The ABI works best when personal responsibility for consumption can be established and is also an opportunity to help drinkers feel more confident about being able to change as well as suggesting strategies to change.

The evidence base for the effectiveness of ABIs when delivered in the primary health care setting is considerable (SIGN, 2004; Raistrick et al, 2006; Kaner, et al, 2007; WHO, 2005).

2.3 Screening and Interventions in the Criminal Justice Setting
Despite there being numerous screening studies and considerable evidence of the effectiveness of ABIs in tackling alcohol misuse in multiple applied settings, there remains little evidence of the application or effectiveness of these tools in the criminal justice setting (McCord et al, 2011; Parkes et al, 2011; Roberts et al, 2007; Raistrick et al, 2006). To date, there are no alcohol problem screening tools that have been designed explicitly for the criminal justice population, and although many screening tools have been tested rigorously in other applied settings, there is little in the research evidence that evaluates their effectiveness with offenders (Lapham, 2004/05). Of the studies that have been conducted, most have focussed either on the police custody setting or the prison and probation settings, and these are summarised here.

2.3.1 Police Custody Studies
Drawing heavily on the Arrest Referral (AR) model used primarily in the past for those with drug problems, an alcohol arrest referral scheme was set up in Nottingham in 2006 specifically for alcohol, using an intervention approach to advise and refer detainees arrested for alcohol related/specific incidents and held in police cells (Hopkins and Sparrow, 2006). The project ran from April 2001 to 2002 and employed nurses working alongside the police in a busy custody suite, with the police undertaking initial screening and nurses interviewing arrestees
and providing either an ABI or onward referral to appropriate services. The evaluation showed that, during the 12 months that the scheme operated, referral workers came into contact with over 2000 arrestees, although outcome records were only kept for 1181. Of these, an AUDIT score was available in 805 cases, and, on a scale range of 0-40, the mean score was 12. Of the 1181 arrestees who were interviewed, 67% received information or an intervention, and 12% were referred to an agency for treatment. In 20% of cases, nurses were either not allowed access to the arrestee, the person refused to take part or the interview was terminated. Although the evaluation attempted to collect follow-up impact and outcome data, only 66 arrestees completed follow-up interviews. Of these, most provided positive feedback about the initiative in terms of alerting them to the risk associated with their drinking, and its interaction on other problematic areas of their lives (contact with the law, family relationships, etc). Some said that their contact with the nurses had prompted them to begin to contemplate changing their behaviour. Importantly, 67% (n=18) reported that their drinking level fell after their arrest, although it was not possible to say if this linked directly to the AR scheme. The researchers note the response bias that was likely to be inherent in the follow-up data given that the majority of participants did not take part in follow-up.

The research concludes that evaluating projects such as these can prove difficult due to access issues (ensuring that appropriately trained staff are reaching eligible people even during busy and chaotic times in custody settings) as well as data issues (records were poorly kept using the monitoring spreadsheets). There was a high percentage of ‘zero’ scores and it was noted that nurses felt that arrestees were not always truthful about their drinking lifestyles.

In 2008, researchers in Plymouth worked with Devon and Cornwall police to carry out a study of screening and ABIs with detainees held in police custody for a number of specified offence types, including violent crimes, domestic assault, public order offences, criminal damage, driving related offences, acquisitive crimes, sexual and other crimes (Barton and Squire, 2008). The custody suite housed specialist alcohol workers working alongside fifteen trained police officers who together carried out the screening and delivery of an ABI. The screening tool used was the AUDIT questionnaire and, depending on AUDIT scores, detainees were provided either with information regarding alcohol consumption for low risk drinkers, more detailed information and counselling for those classified as hazardous and harmful drinkers, or further assessment and treatment for those classified as having moderate to high levels of dependence. Participation in the screening was voluntary.

In the 13-month period during which the screening took place - March 2007 to March 2008 - a total of 4721 detainees were contacted, and 3900 (83%) agreed to take part. The majority of participants were aged below the age of 35 (75%), most were male (85%), and almost all were White European (96%). Most were held in connection with a violence related offence (75%). The proportions of
those screened who scored in each of the three AUDIT ranges were 36% low risk, 33% hazardous/harmful, and 21% dependent respectively. The data showed that older drinkers (those over 41) were more likely to be in the dependent range and to be long term chronic drinkers, while those aged 17-24 were more likely to exhibit binge drinking behaviours. Reflecting the AUDIT scores, most of those who took part in the research were provided with multiple interventions which included advice, leaflet and/or referral (40%), with a further 44% given advice only and 14% given only a leaflet. Interestingly, CCTV data captured as part of the research showed that those given the leaflets did read them whilst in police cells.

The study sought to measure impacts of the screening and intervention, but, as with other similar projects, data were limited and it was not possible to evidence direct causal associations between the initiative and reduced offending or other personal change. What the researchers did find was that a number of detainees opted to access a more detailed alcohol screening service after the initial screening undertaken in custody, which may be seen as an indication of their willingness to take action to address their drinking behaviour as a consequence of participation. A large proportion of those screened also admitted that they were not really aware of the amount they were drinking, or how to access services, and so participation had been educational on that level. Indeed, qualitative data collected from interviews with staff and clients who participated in the research suggested that failing to see their drinking behaviour as a problem was a common theme among participants. This aside, perhaps the main outcome of the project was that it provided local intelligence of the scope and scale of alcohol related problems within the detainee population in the area, to help inform the development and delivery related support.

More recently, in 2010, researchers from Robert Gordon University worked alongside Grampian Police in Aberdeen to collect and analyse alcohol screening data from people in police custody (Gibbons-Wood et al, 2010). Adapting the model used in the Plymouth study, the AUDIT tool was again used alongside questions to determine whether or not alcohol has been a contributing factor to the person’s arrest. The project took place over a nine month period, and made contact with 207 detainees with all data collected by the police. Most participants had been arrested for Public Order or violence related offences, and most were males aged 18-34. Of those taking part, 16% scored in the low risk category, compared to 39% hazardous/harmful and 45% dependent. In total, this meant that almost 85% had a score over 8 indicating a possible AUD. The overall proportions of those in the hazardous/harmful and possibly dependent clusters were greater than the Barton and Squire (2008) research and the researchers conclude that the data indicates high levels of problematic consumption in the Scottish context which, if anything, was likely to be under-represented in the research given the small sample who took part in the screening.
In the north of England, a feasibility study for the delivery of screening and ABI has also been carried out with arrestees detained for offences linked to drinking behaviour (Brown et al, 2010). Delivered by a team of trained detention officers over a three month period, participants were asked to complete an AUDIT questionnaire, and staff who participated in the scheme were later interviewed to explore issues around feasibility of delivery screening and ABI in the police setting. From 704 people arrested for the target offences, 229 (33%) were screened, most of whom were male, white British and aged for the most part in the 18-30 age band. The screening data showed similar patterns to other studies, with a mean score of 15.3 and 76% scoring 8 or more. Within this group, 50% were hazardous drinkers, 15% were harmful and 35% showed signs of dependence.

Qualitative feedback from the officers involved in the screening and ABI was quite divided. Although administratively the screening and ABI was considered non-problematic, half of the staff felt that delivery of such work was not suited to their role, and that the policing environment was not conducive to the ‘helping’ role that characterises delivery of ABIs. Staff questioned the value of the screening and ABIs and were reluctant to deliver them. These staff commented that arrestees were likely to distort the truth about their drinking behaviour, that there was limited time to deliver the screening and ABI and that some arrestees were hostile to the approach. Conversely, half of the staff interviewed offered directly contrasting views, suggesting that they had welcomed the training and that the screening and ABIs had worked well. Importantly, the difference in opinion between staff in the study seemed to link directly to the arrestees reactions to the scheme. Staff who were reluctant and expressed apathy were likely to report resistance and hostility from arrestees towards screening and ABIs and were also least likely to express a positive beliefs about clients potential to change as a consequence of the intervention.

2.3.2 Prison and Probation Studies
Whilst the above studies all focussed on arrestees held in policy custody, research has also been carried out with offenders in prisons and those on probation.

Unpublished research by Graham et al (2008) showed approximately 30% of remand and short-term prisoners to be drinking at hazardous and harmful levels, and just under 50% at possibly dependent levels following a small scale study using AUDIT in a Scottish prison. Most recently, as part of a *Prison Health Needs Assessment for Alcohol Problems* (Parkes et al, 2011) the AUDIT tool was tested in a Scottish prison with a sample of all new prisoners entering a male prison over a 12 week period in late 2009 and early 2010. From a total of 259 screening questionnaires, the data showed that 73% of prisoners had scores in the hazardous/harmful range (8+ AUDIT score), including 36% possibly dependent (20+ AUDIT score). Those in the highest risk range were at opposite ends of the age spectrum (18-24 and 40-64 age groups), and higher AUDIT
scores were present among those with shorter sentences (less than 6 months). The research also showed that there is currently no formal alcohol screening using a validated instrument in the Scottish prison estate and, as a result, many prisoners with alcohol problems often go undetected. Further, there was limited accessibility to alcohol specific interventions with most prisoners instead accessing more general substance misuse interventions.

A prevalence study of alcohol use in four prisons and three probation offices in the north of England showed that AUDs are similarly prevalent among these populations (Newbury-Birch et al, 2009). A mixed sex sample of 715 people who voluntarily completed the AUDIT in these settings showed that 66% scored 8 or more and were classified as having an AUD. Among all those tested, 27% were in the hazardous/harmful range, and 35% were in the dependent range. A secondary purpose for this research was to compare the performance of the AUDIT with the Offender Assessment System (OASys) used to assess health and risk needs of offenders in England and which asks five questions specifically on alcohol consumption. It showed that 41% of those who scored above 8 on the AUDIT were not identified by the OASys tool as being in need of alcohol intervention, whereas 10% of those with a score below 8 were identified as having alcohol related need on the OASys. While the research confirms that there is a high prevalence of alcohol related problems in the probation and prison settings, as with the arrestee population, it also shows that there is great variability in different screening tools in terms of identifying those classified as ‘in need’. The researchers conclude that the OASys tool may fail to identify a significant number of people in these settings who would benefit from ABI, and suggest that current methods of screening and/or assessment in such settings under-estimate a much large alcohol problem in that population.

Finally, in England and Wales, a national Screening and Intervention Programme for Sensible Drinking (SIPS) is currently underway to provide evidence on the delivery, effectiveness and cost effectiveness of a range of screening and ABI approaches across settings and regions in England (Cochrane, 2010). Set up as part of the National Alcohol Harm Reduction Strategy for England, the programme comprises three linked trials: one in the primary health setting, one in the accident and emergency setting and one in the criminal justice setting. The SIPS programme is the largest screening and ABI randomised control trial so far conducted in the UK and is scheduled to report its findings in autumn 2011.

The criminal justice arm of the trial is operating in probation offices in three geographical areas of England, with trained offender managers testing two screening tools (FAST and M-SASQ) and three forms of intervention to explore the effectiveness of each for screening and brief intervention for AUDs in probation. It is also exploring staff and client views about the appropriateness and acceptability of screening and intervention, and is examining staffing and organisational factors associated with successful implementation. Essentially a cluster randomised controlled trial, the study provides offenders with either a
leaflet, brief advice or brief lifestyle counselling depending on their need. At the time of writing, the study is showing high eligibility, screening, consent and follow-up rates, with the main reasons for non-eligibility being that the offender was already seeking help for alcohol problems elsewhere. Despite some differences between the two tools, around 20% of all those screened, to date, have received brief advice and around 10% brief lifestyle counselling. Factors that have facilitated the project so far have included support from managers in delivering the scheme, client motivation and willingness and the ease of use of the screening materials. That said, the project has also reported problems with clients being disengaged, concerns about confidentiality, and resistance to questions about drinking as well as concerns about the length of screening and intervention being too long. In addition, offender managers reported feeling overworked by the scheme. Training was also a barrier with one-to-one training having to take place due to lack of group availability. Staff also challenged the appropriateness of the scheme given their work was primarily with heavy drinkers (Cochrane, 2010).

2.4 Learning from the Previous Research
The evidence shows that there is a high prevalence of AUDs in the offender population and also that the criminal justice setting is one which affords a potential opportunity to engage with clients, who wouldn’t necessarily engage elsewhere, to address their alcohol problems. There are numerous alcohol screening tools and interventions available, many of which have been tested rigorously and shown to work in applied settings, predominantly health. That said, there is little evidence of tools designed specifically for criminal justice populations and only a few studies which test standard tools in this setting. Indeed, an independent review of procedures adopted by the National Probation Service (NPS) for identifying and intervening with offenders who have alcohol problems has shown that there is currently limited scope for developing empirically informed guidance to instruct staff about the effective targeting of interventions within a criminal justice context, or to identify which ones are likely to be most effective for whom (McSweeney et al, 2009).

It is noted that most screening tools that have been used in the criminal justice setting rely on self-report and researchers have noted that offenders are likely to under-report their alcohol-related problems, because they do not wish to be labelled as having alcohol problems (Lapham, 2004/05). It is also well evidenced that alcohol problems among offenders often exist alongside other problems such as drugs misuse and mental-health issues which means that screening for alcohol in this group can be problematic since self-report estimates may be confounded (Lapham et al, 2001).

Evaluation of screening and interventions is also difficult with this population and the limited evidence that is available suggests that this is mainly due to lack of follow-up and outcome data and being able to track clients, as well as issues with staff training and workloads which make it difficult to collect reliable and
representative data. The research shows some interaction between staff willingness to administer screening and ABIs in this context and their likely effectiveness, as well as AUDIT scores and likely impact, with higher scoring persons more likely to seek further help, treatment or advice. Sample sizes are often too small, however, to say anything conclusive about actual impacts or outcomes and this seems the primary issue in terms of previous research. The SIPS study in England and Wales will hopefully address this gap.

In summary, although evidence on validated alcohol screening and effective alcohol interventions work with criminal justice populations is still very much in its infancy, there is already, it seems, a growing evidence base to suggest that the criminal justice setting can be used to effectively identify and target at risk drinkers, and to provide them with information, advice, support and onward referral (where appropriate) to allow them to reduce their alcohol consumption and related harm. It is against this backdrop that the current pilot was developed.
3. The Pilot Model and Evaluation Methodology

3.1 Design

3.1.1 The Pilot Model
The pilot was designed and developed primarily by a team of staff from NHS Health Scotland, the ISD of NHS National Services Scotland and the Scottish Government. This group met with other stakeholder representatives from the Scottish Prison Service (SPS) and acted as a project advisory group during the planning and implementation stages, as well as throughout the lifetime of the pilot to monitor progress.

Plans were for the pilot to be based initially in one area. At the time that the pilot was being developed, one Local Authority area was identified by the project advisory group as already planning to roll out screening and ABIs in their Criminal Justice Social Work department. Thus, they invited the pilot to ‘piggy back’ onto their plans. A representative from that Local Authority joined the project advisory group at this point to advise on local issues which might affect implementation of the scheme.

During the planning stages, it became clear that the area which had agreed to house the pilot may not receive a sufficiently large volume of clients who met the pilot inclusion criteria to allow sufficient power to measure impact of outcomes. In particular, a potential risk was identified by the project advisory group that many of the potential participants may have to be excluded due to receiving an ABI elsewhere, since this was a national priority target for the NHS in Scotland at that time. Indeed, this resulted in the use of an exclusion criteria option on the baseline questionnaire for those who had already received screening or an ABI elsewhere in the previous 12 months. As a result, it was decided to invite two other areas to take part in the pilot, principally to boost the sample size for the evaluation analysis.

In routine practice, initial screening for alcohol problems usually occurs at the Criminal Justice Social Work Report (CJSWR) wherein criminal justice staff carry out a full assessment of an individual’s substance misuse problems. Information collected regarding client’s offending and personal history at this time would usually be used as an indicator of potential substance misuse (including alcohol problems) and staff can also interview family members and other professionals at this time to try and ascertain if alcohol is a problem. If alcohol problems are identified, suitable onward routes are identified including to relevant Criminal Justice Programmes and appropriate referrals to community based addiction services provided by the NHS, Social Work Services and voluntary sector. There are also occasions when staff will work with the client directly to address their drinking behaviour.
The pilot was designed to be delivered as part of routine practice for probation and community service staff, after Orders had been issued and as part of the initial appointment with the designated social worker/community service officer. This stage of the community justice process was chosen for the study instead of at an earlier stage so as not to interfere with the sentencing process. It was also felt that if screening and ABIs were carried out at an earlier stage there would be higher levels of attrition among participants as not all those who were recruited would go on to be sentenced (and therefore have onward contact with staff). Carrying out the screening and ABI at the initial appointment stage also meant that the same staff member would be engaged with the client over time and so they could carry out both baseline and follow-up data collection, thus limiting any potential bias in the sample.

Inclusion criteria were only for those where alcohol treatment or education was not a condition of the Order, and where screening and an ABI had not been carried out elsewhere in the preceding 12 months. This was because it was assumed that such individuals were already likely to be engaged with alcohol treatment or support providers or to have done so recently, and so would be unlikely to benefit further from engagement with the ABI pilot. Other exclusion criteria were based on demographic and health factors, including age (the pilot was only open to those aged over 18) and physical/mental fitness to take part.

The pilot adopted a randomised control design in which staff were randomly allocated to either a control group (screening and delivery of a booklet) or an intervention group (screening and delivery of ABI if appropriate) using a statistical software package (SPSS). This approach was taken, instead of randomising clients themselves, so that there was less chance of the sample being contaminated by staff bias which might have occurred if decisions were made on a client-by-client basis. It was also an approach that seemed most practical in terms of staff training and delivery. The researchers were blinded to this randomisation for the duration of the fieldwork, and data were only allocated to the two groups at the start of the data analysis. Data were intended to be collected at three stages – at initial appointments and at three and six month follow-ups as appropriate, to explore change in AUDIT scores over time. Probation clients already had an existing review structure every three months which the pilot model mapped onto. For community service clients, the pilot required that staff would undertake a three month face-to-face ‘mini review’ and a six month review over the telephone or face-to-face, as appropriate.

Data were collected from three separate pilot sites, but were merged for analysis purposes. The three separate pilot sites are identified here as pilot areas A, B and C to retain anonymity.

Pilot Area A was a medium sized Local Authority in the central belt, comprising a large urban centre with disparate surrounding rural communities and relatively low population concentration. In Area A, a total of 21 staff were trained to take
part and all staff were co-located in the same office. For this area, a designated project co-ordinator was appointed to oversee the work, learning from experience in the SIPS study in England (Cochrane, 2010) which suggested that an on site presence was required to keep staff motivated to take part, and encourage the completion and return of administrative data. The project co-ordinator’s role involved collating data from staff and providing overall supervision of the pilot, including ongoing support to staff. Recruitment of the co-ordinator took longer than was anticipated due to the recruitment procedures within the participating authority. Following internal delays, an advert was published in October 2009 with interviews carried out in January 2010 and the co-ordinator came into post on 1st March 2010. The local Research and Information Officer agreed to oversee and monitor the pilot in the area until the project co-ordinator commenced employment.

Although the official start date of the pilot in Area A was September 2009, staff time and resources were thinly spread at that time and so no data were returned in the period September to December 2009. Given this delay, many of the staff in the area requested refresher training. As a consequence of the late appointment of the co-ordinator and the refresher training that was requested, the main data collection activity in this area did not start until April 2010. Given the slow start in the area, the evaluation considered the true start date of the pilot to be January 2010.

Area B was a relatively large Local Authority based in the central belt, with a smaller urban centre than Area A, but more urban surrounds and a significantly higher population. A total of 53 staff took part, and were spread across multiple different offices within the authority area. The pilot in this area was managed by a Senior Officer (Justice) who undertook to oversee the co-ordination within their existing job role and acted as a conduit between NHS Health Scotland and the local area managers/team leaders overseeing operational staff for the duration of the project. Ongoing support and feedback was conveyed to the co-ordinator via a series of regular meetings held with NHS Health Scotland as the pilot progressed.

Area C was located close to Area B in the central belt of Scotland, and was of a similar size, but with a greater population density. A total of 47 staff were trained to take part in the pilot in this area, and staff were again dispersed across multiple sites within the authority. Again, a local co-ordinator volunteered to oversee the pilot in the area within their existing job role as Operations Manager, and oversaw the administrative running of the pilot in the area for its duration. Regular contact was maintained by all areas with NHS Health Scotland for the duration of the project to share feedback on progress.

As well as acting as a direct liaison between the project advisory group and the operational staff in each of the sites, co-ordinators were asked to ensure that key messages were communicated about the way in which the pilot should be run.
They also provided feedback to the group on any problems encountered as the pilot progressed and were responsible for collating and returning screening data to the researchers.

3.1.2 The Evaluation Model
The research employed a mixed-methods, mixed measures approach combining analysis of screening and follow-up data collected by operational staff participating in the pilot and collection of primary quantitative and qualitative data collected directly by the researchers.

The screening and follow-up data were collected by operational staff at the time of the appointments with community justice clients, and were forwarded to the researchers on a regular basis as the pilot progressed. All data entry, cleaning and analysis was undertaken by the researchers.

Primary data were collected from an online survey of staff and one-to-one face-to-face interviews with staff and clients. Feedback data generated by the trainers who undertook the training of staff was also undertaken to inform the evaluation, and analysis of secondary cost data was undertaken as part of a parallel cost exercise.

3.2 Measures

3.2.1 Materials for the Pilot
The pilot involved the use of three key tools – the participant baseline questionnaire (Appendix A), the Alcohol User Disorders Identification Test (AUDIT) (Appendix B) and a ‘Making a Change’ booklet.

The baseline questionnaire was developed specifically for the pilot by the project advisory group, in collaboration with staff in each of the three pilot sites. The form was designed to collect basic administrative data from staff such as their staff ID number, designation (job role), the setting in which they operated (community service or probation), the date of the appointment and whether the assessment was taking place as part of an initial or follow-up meeting with the client. The baseline questionnaire was short and was designed specifically with brevity in mind so as to minimise disruption to the initial appointments being attended by clients.

The baseline questionnaire was also used to assess for eligibility and as a consent form. If clients met all of the specified eligibility criteria (see Appendix A), staff were asked to obtain verbal consent to collect demographic information and for entry to the study. Permission was recorded on the form. Demographic data collected from clients included their unique local identifier, their Scottish Criminal Records Office (SCRO) number, date of birth, gender, post-code and ethnicity.
For screening purposes, the AUDIT questionnaire was selected as this represents the ‘gold standard’ test for identifying those with AUDs (as discussed above). It has also previously been shown to work effectively in offender populations.

The ‘Making a Change’ booklet was a public-facing ‘off-the-shelf’ publication that was produced by NHS Health Scotland and distributed as part of the wider HEAT target for delivery of ABIs in Scotland, but not developed specifically for the criminal justice population. Its original design and content were targeted toward primary care clients. The booklet offers practical advice to help readers change their drinking habits. It includes advice on the recommended daily alcohol unit levels for men and women, contains a drinks calculator to help people understand how many units are contained in various types of drinks, it sets out the benefits of reducing alcohol consumption, and offers practical advice on reducing consumption, as well as offering a template drinks diary. This booklet was made available to all staff working on the pilot, with a requirement that those in the control group give it to clients to take away after their screening, while the experimental group could use it alongside the ABI, as appropriate.

From the outset, although the main aim of the pilot was to test feasibility of the screening and ABI model in this context, it was hoped that a primary outcome for the pilot might be a reduction in alcohol consumption among those who took part.

During the planning for the pilot, discussions were also held as to whether it would be possible to ask staff to collect additional secondary outcome data, for example, on offending, health and other social outcomes. Due to time constraints during initial appointments with clients, these were ruled out early on.

Linkage to a number of data sources in relation to possible secondary outcomes were also considered as the pilot progressed, however, the project advisory group decided that access to such data would not be feasible for this pilot given the necessary permissions required. Thus, no secondary outcome data were collected.

3.2.2 Materials for the Evaluation
The first stage of data collection for the evaluation involved the development and distribution of an online, pre-coded quantitative survey to all staff who were taking part in the pilot. The survey was developed following a number of scoping and contextualisation interviews with key personnel involved in setting up the scheme which took place before the primary data collection began. It sought to ascertain information on practices regarding the giving of alcohol advice/information before the pilot, views of the ABI pilot training, views on the ease or difficulty of administering the pilot, perceived barriers and facilitators to implementation, and perceptions of clients’ engagement with the scheme. A copy of the questionnaire is attached as Appendix C.
The second stage of the evaluation was analysis of pre and post-training course forms that had been designed and distributed by NHS Health Scotland. The questionnaires contained largely closed, pre-coded response options and sought to ascertain such aspects as previous training undertaken around alcohol, confidence in knowledge and skills ahead of the training, expectations of the training and the pilot, and confidence, post-training, in delivering the pilot. Copies of the training questionnaires are attached as Appendix D.

Qualitative interviews followed on from the survey and training form analysis and were targeted at policy, strategic and operational staff who were involved in the pilot, as well as clients participating in the scheme. Bespoke topic guides were developed for each of the individuals who were targeted, as well as information sheets and consent forms. Staff interviews were to be followed by client interviews and similar, shorter discussion guides were developed along with an information sheet and consent form. The client discussion guides focussed more on perceived impact of the pilot and engagement with the screening and ABI whereas the staff questions also had an operational focus. The discussion guides are attached as Appendix E.

To facilitate the collection of cost data, a spreadsheet was prepared which local pilot co-ordinators were asked to populate with local numeric cost data.

3.3 Access Procedures

Policy and strategic staff who took part in the pilot were identified by the project advisory group members. All had played a part in either the planning, set up or operation of the pilot. This was used to make onward contact with co-ordinators in each of the areas to carry out further scoping and contextualisation work.

Access to operational staff in all of the three areas was through the local co-ordinators appointed to overseeing the pilot. The online survey was administered via the co-ordinators so that names of individual staff were not released.

Staff were invited to take part in an interview by the co-ordinators, and copies of the research questions were issued in advance, along with the information sheet and consent form. Interviews lasted approximately one hour and were carried out confidentially, on a one-to-one basis.

The approach to client recruitment was via pilot staff. Again, an information sheet was provided along with a copy of the questions and consent form, and the names and contact details of clients who wished to take part were then passed to the researchers to allow interviews to be scheduled. No information about clients’ personal circumstances or offending history was sought. Issues that affected the later recruitment of clients are discussed below.
3.4 Pilot Participants
A total of 121 operational staff were allocated to take part in the pilot, which included two staff who acted as co-ordinators but who also had operational contact with clients. An additional one staff member took part in a non-operational role, acting more as an administrative co-ordinator in one of the pilot sites.

It is not possible to say conclusively how many staff actually participated in the pilot in terms of undertaking initial assessments with clients, since many of the forms that were returned during the research contained missing or incorrect staff identifiers, meaning that it was not possible to tally the origins of all forms. For reporting purposes, it was assumed that all of the 121 staff who were allocated to either a control or intervention group took part at some stage.

3.4.1 Online Survey
A total of 46 staff took part in the online survey, representing 38% of all staff involved in the pilot at the time, and who were invited to take part (121). This was spread evenly between the three areas (14, 16 and 16). The majority of those who responded described themselves as Social Workers or Senior Social Workers (n=31; 67%) or Community Justice Assistants/Officers (n=11; 24%). The remaining 9% referred to themselves as 'Other'. Of those who took part, 91% had direct client contact. Of those, 39% said that they were in the control group, 52% in the intervention group and 9% did not know. Although participation rates for the survey were low, respondents did represent all areas and designations and views were received from those in both control and intervention groups.

3.4.2 Training Questionnaires
Prior to attending the course, all attendees were asked to complete a pre-training course questionnaire. All those who attended were also asked, on completion of the course, to complete a post-training questionnaire. Pre-course training questionnaires were completed online and on paper, while post-course questionnaires were completed after the training event took place.

A total of 34 staff completed the pre-course training questionnaire and there were 89 post-course completions. This difference probably reflects the collection methods, with post forms being collected on the day of the training in person, whereas pre-training forms were returned to the local co-ordinators and then returned to NHS Health Scotland.

3.4.3 Qualitative Interviews
A total of eight strategic and policy staff were interviewed, along with the three local co-ordinators and one interim co-ordinator in one of the areas (i.e. twelve interviews in total).
Among operational staff, there was some difference in the uptake of invitations to take part in the qualitative interviews between the three pilot areas. In Area A, eight operational staff took part in a one-to-one interview, whilst in Area B, no volunteers were identified. A group interview was conducted with eight staff in Area C.

There was also limited uptake of clients to take part in the interviews, and only two clients agreed to speak with the researchers. Of these, only one went on to take part, as the other client failed to respond to calls or to be available at the planned interview time. There were suggestions from staff that some ABI clients were either incarcerated or engaged in a drug treatment or other substance misuse programmes, which meant that they would not be accessible.

### 3.5 Data Coding, Manipulation and Analysis

All survey and pilot data were entered and analysed using the statistical software package SPSS. Given the small numbers in the pilot, analysis was largely descriptive. Thus, the main analysis of pilot data was the generation of frequencies for exclusion criteria, demographic characteristics of participants, summary level statistics for AUDIT scores and some cross-tabulation to explore interactions between designation (Probation or Community Justice), research group (control or experimental) and area.

All of the qualitative interviews were digitally recorded (with consent) and transcribed for analysis purposes. A thematic analysis approach was used for the qualitative data wherein all of the responses were reviewed and the core messages highlighted and extrapolated. These then underwent an assimilation process so that similar responses were clustered together which could be analysed to provide summary findings. This approach meant that the findings were grounded in the data instead of the data being assigned to arbitrary pre-codes or reduced to numerical data. In the reporting that follows, an indication of the prevalence of the feelings expressed is provided to indicate the frequency with which similar sentiments were raised by respondents, recognising that in all cases the numbers are small. Some of the data are reported verbatim to evidence key emerging themes.

The following three chapters present the findings from the research, combining data from all sources.
4. Research Findings 1: Implementation of the Pilot

4.1 Feedback on Implementation Approach
When the pilot was given the go-ahead after agreement with local managers, an internal memo was sent to all frontline staff explaining what was involved and informing them of what their role would be in the study.

Data from the qualitative interviews with staff suggests that, despite this information being shared, some staff were not entirely sure about what was being asked of them at the start of the pilot:

‘Unfortunately [frontline] staff weren’t consulted about it at all really, and we just got told that we were doing it, and that it was compulsory and that we were getting the training. That was a bit poor from the [frontline] staff point of view. It felt like something that was being imposed on us, whether or not we had time in our schedules or workloads to add this extra thing on’.

‘It was just something that was thrust upon us, we weren’t part of any of the negotiations at all.’

Indeed, there was suggestion from some staff in Area A that they had initially been invited to volunteer to take part in the pilot via email, with an option to ‘opt out’, but that this had later been reneged and staff were instructed to take part. From this outset, this seems to have set the pilot off on a fragile footing with some staff reluctant to deliver something that they had not consented to do. The enthusiasm for the pilot during set up was, it seems, only at the management level.

4.2 Staff and Accommodation in the Pilot Sites
During interviews, no real issues with staffing capacity or management arose, except, perhaps a perception that team leaders for pilot staff were not engaging with the pilot, and not passing on update and progress information, as required. Team leaders were briefed by co-ordinators throughout the pilot, but it seems that different messages were reaching operational staff, and not all team leaders had attended the ABI training with their staff which made them unable to answer staff queries at times:

‘The problem was that managers had different interpretations and there was no consistency office to office.’

There were suggestions that someone needed to ‘manage the managers’ directly in order for the pilot to run more smoothly and that it was essential that all team leaders attended the same ABI training as staff, so that they shared a common understanding of what was required.
Importantly, comments were also made in Area A that one of the main facilitators to the pilot there once it was up and running was the presence of a ‘dedicated’ co-ordinator. The role of the co-ordinator in that area was slightly different from the other areas insofar as it was their only responsibility. Thus, the co-ordinator was able to dedicate more time to ensuring data was returned, answering queries and providing ongoing, informal coaching, if required.

Staff in this area said that they felt supported during the time that the co-ordinator was in place, which contrasted with some of their earlier initial doubts about the pilot. Queries could be raised face-to-face or via email, and there were never any delays in gaining a response:

‘Access to the co-ordinator is easy, they are just through the office, very approachable… we get reminders about filling in forms, and further training if that’s necessary, help and advice too, so quite well supported.’

Thus, despite some initial reluctance towards the pilot in Area A, levels of enthusiasm increased once a dedicated co-ordinator was on hand to facilitate its operation.

4.3 Training the ABI Pilot Staff

Training was delivered by external trainers from NHS Tayside and covered background to the pilot; the relationship between alcohol and criminality; ABIs in the health care setting; how to use the AUDIT screening tool; and key skills involved in delivering ABIs, including enhancing motivation and building confidence. The group also carried out some practical sessions using case studies and the AUDIT tool using a role play format, and an NHS Health Scotland DVD was used to demonstrate how ABIs might work in the applied setting.

Depending on whether participants were part of the control or intervention group, they attended either a half day or one day course respectively. Those who attended full day training were also asked to complete a NHS Health Scotland ABI e-learning package prior to the one-day training. The intervention group training also included practical exercises and role play involving delivery of an ABI.

Training in Area A was spread across two training sessions in September/October 2009. This comprised initial training for Probation and Community Service staff and follow-up training for Community Service staff who were less familiar with the motivational interviewing techniques that had been introduced during training, and had therefore asked for more training to be provided.
Training in Area B took place in January 2010 with separate days for the intervention and control staff. There was no refresher training in this area, and all staff began collecting data in March 2010.

Training in Area C again took place over separate dates for control and intervention staff, with all training completed in December 2009. The pilot was operational in that area from January 2010. Although no refresher training was offered in this area, some staff who were unable to attend the training in December were invited to attend sessions in Area B at the start of 2010. This will have meant that some staff from Area C did not start assessing clients for the pilot until that date.

Data collected from the staff by means of pre and post-training course questionnaires was made available for analysis. Feedback from the pre-course questionnaires was also made available to the trainers to allow them to adapt the training as necessary in line with the feedback gained.

By comparing responses from pre and post-course questionnaires, it was possible to identify some differences in attitudes expressed with regard to alcohol screening and ABIs which may have been as a result of the training received. It should be noted, however, that due to 34 people completing a pre-course questionnaire compared to 89 who completed a post-course questionnaire, it is difficult to compare like-for-like. Further, it was not possible to match the pre and post-course data, and so it is not certain that any differences in attitudes expressed occurred at the individual level. That said, there are some normative differences in scores pre and post-training, which are summarised below and which might be taken as indicative of collective attitude change in the group.

4.3.1 Previous Training
Respondents were asked what previous training they had received on alcohol related issues. Of the 33 respondents who gave at least one answer, almost all of them (91%, n=30) stated that they had received some form of training on alcohol related issues. Many of the respondents also indicated that they had received training on motivational interviewing techniques (64%, n=21), most of whom were social workers. Only a small number of the respondents stated that they had completed a formal training course (>1 day in duration), had a qualification related to alcohol (21%, n=7), or had training on how to support health behaviour change (15%, n=5).

A key emerging characteristic of the previous training that was cited was that much of it took place a long time ago and, therefore, some of the learning previously received was not current.

4.3.2 Helping People with Alcohol Problems
Of the respondents who provided an answer, over two thirds pre-course (69%,
n=22) thought it was quite or very relevant for them to be able to offer ABIs in their job. Post-course, almost all of the respondents (91%, n=80) who provided an answer thought it was quite or very relevant for them to be able to offer ABIs in their job. This shows considerable post-course differences in staff attitudes towards the relevance of delivering ABIs in community justice (although, again, this does not necessarily reflect a change at the individual level). The proportions of respondents who said that using an ABI was either useful or very useful in all of the scenarios outlined in the questionnaire were higher post-course compared to pre-course.

Pre-training, some of the concerns that respondents raised in relation to discussing alcohol use with clients and using an ABI approach included the amount of training they had personally received on the subject and the likely effectiveness of ABIs:

‘I do not feel that I have the detailed, specialist knowledge or skills to undertake such work.’

Concerns were, therefore, mostly linked to lack of understanding or training about alcohol issues and ABIs. Indeed, when asked specifically how confident they felt about helping clients address their drinking behaviour, three quarters (75%, n=22) of those who provided a response pre-course said that they felt either quite or very confident.

Respondents were asked if certain factors would be likely to affect their ability to deliver ABIs to their clients. The responses they gave to each of the factors are detailed in Table 4.1

Table 4.1 Factors Likely to Affect Ability to Deliver ABI Post-training

<table>
<thead>
<tr>
<th>Factor</th>
<th>Critical</th>
<th>Useful</th>
<th>Not Needed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longer client appointment times</td>
<td>21</td>
<td>43</td>
<td>23</td>
<td>87</td>
</tr>
<tr>
<td>Administrative support to record ABIs</td>
<td>27</td>
<td>36</td>
<td>23</td>
<td>86</td>
</tr>
<tr>
<td>Support from other colleagues to deliver ABI</td>
<td>14</td>
<td>48</td>
<td>25</td>
<td>87</td>
</tr>
<tr>
<td>Support from senior staff/managers to deliver ABI</td>
<td>36</td>
<td>35</td>
<td>16</td>
<td>87</td>
</tr>
<tr>
<td>Appropriate consulting area in which to deliver ABI</td>
<td>40</td>
<td>33</td>
<td>15</td>
<td>88</td>
</tr>
</tbody>
</table>
The data show that the factors which were most likely to be considered as critical by respondents in affecting their ability to deliver an ABI were the ability to allocate time, given competing priorities (53%, n=47) and an appropriate consulting area in which to deliver an ABI (45%, n=40). A large proportion of the respondents also considered it useful to have support from other colleagues to deliver an ABI and greater knowledge and skills with regard to delivery of an ABI.

### 4.3.3 Confidence and Responsibilities

Prior to the training, a notable proportion of respondents either disagreed or strongly disagreed (18%, n=6) or neither disagreed nor agreed (21%, n=7) that they had a clear idea of their responsibilities in helping clients who are considered to be risky drinkers. However, after completing the training only 5% (n=5) of respondents disagreed/strongly disagreed with this statement, while only 9% (n=8) neither disagreed nor agreed with this statement. This showed a difference at the group level in agreement with this statement from 61% (n=19) who agreed or strongly agreed with this statement prior to the training to 86% (n=76) after completing the training. Whilst it is not possible to say that the training directly influenced this it does show that, at the start of the pilot, there was general clarity among staff on their responsibilities with this client group.

Encouragingly, another statement which showed a normative difference post course was the proportion of those that agreed or strongly agreed that 'I feel that I am as able to work with clients who are considered to be risky drinkers as with people who are not'. This rose from 67% (n=22) pre-course to 79% (n=70) post-course.

### 4.3.4 Clients Likelihood of Change

Change was also evident regarding the statement 'clients can make good progress towards achieving sensible drinking levels with the right support'. Pre-course results show that while 76% (n=25) either agreed or strongly agreed with this statement. However, post-training results show that a larger proportion of respondents (87%, n=77) either agreed or strongly agreed with this statement.

On a less positive note, prior to the training, 85% (n=28) of respondents either agreed or strongly agreed that they had the right to ask clients with whom they come into contact with, questions about their drinking. After the training, 75% (n=67) of respondents either agreed or strongly agreed with this statement.

### 4.3.5 Impact of Training

Before the training, respondents who completed a pre-course questionnaire
generally viewed the forthcoming training in a positive light and placed high importance on all of the learning outcomes.

While post-course results show that respondents considered the training to have had neither a great deal of impact nor very little impact on their knowledge and skills, this is contradictory to how confident they now felt about their knowledge and skill.

Prior to the training, three quarters of respondents (75%, n=22) described themselves as quite or very confident about helping clients address their drinking behaviour, while post-course results show that 91% (n=81) of respondents now considered themselves to be quite or very confident about helping clients address their drinking behaviour.

Analysis of the training questionnaires suggests, therefore, that the training was necessary since most previous training received had been delivered a long time ago, or was not appropriately focused. The main reservations were around practical aspects of delivery including time and resources required, although pre-course confidence in knowledge and skills was high. Staff seemed to feel even more confident after attending the course.

4.4 Feedback on the Training

Whilst the training questionnaires primarily generated data to demonstrate the impact of the training on staff practice, and change in their attitudes and confidence levels regarding ABI pre and post-course, feedback on the training itself was also generated from the questionnaires which was further explored through depth interviews with staff, and which is summarised below.

The evaluation identified some mixed feedback regarding the training that staff received. The pre-course questionnaires suggested that staff were generally receptive to the training and the opportunity to further their skills and help their clients. Post-course, the questionnaire data suggested that respondents generally felt that the delivery of the training course was very good and that they found many aspects of the content useful. Most said that they felt sufficiently confident and equipped to take forward the pilot work. This was congruent with informal feedback to the project advisory group at the time the training was carried out which indicated that it had been well received, and that staff had found the ABI training DVD especially useful. At that time, it was noted that the probation staff had much more confidence going into the training than the community service staff due to their existing experience and training in motivational interviewing techniques, but that generally, there had been no negative feedback from the training.

Several comments were given in interviews that strongly contradicted this positive message. Indeed, several respondents explained that the training had perhaps been a little condescending and below the professional skills level of
some of those who took part (this view came mainly from probation staff rather than community service). Staff described it as being long winded and targeted at a less knowledgeable group of people:

‘Very dry. I mean, alcohol interventions are kind of our bread and butter, you know, we do this a lot so it was pitched at the wrong level for us, definitely.’

‘It was pitched a bit low, it felt a bit condescending.’

‘I came out the training feeling as if I hadn’t learnt anything about what I was supposed to be doing, and feeling a bit confused…I don’t think I learnt anything new at the training.’

Several respondents suggested that in-house training of a couple of hours would have sufficed. They suggested that the training could have been shorter and more to the point. In particular, comments were made that it would have been useful if the trainers had understood that most of the social workers were already quite experienced in discussing alcohol problems with clients.

The refresher training that was offered by the co-ordinator in Area A was greatly appreciated, and seemed to have been perceived as more tailored to staff:

‘The refresher training was much more relaxed, I felt as if I’d been given more information than in the previous training. It was a lot less formal, there were less people, and maybe because we’d had a look at the forms previously, this was upping the ante again.’

Comments also revealed that, whilst most staff were keen to embrace the training and saw it as an opportunity to develop their own skills and experience, there were also some early doubts about whether the training would be used in practice, given constraints on time:

‘Would need time and space to deliver brief intervention work, which I just cannot see happening with current workload.

‘To date nothing about 'brief interventions' has been brief!’
5. Research Findings 2: The Pilot in Operation

5.1 Introduction
The pilot was originally intended to start in September 2009, but was delayed, largely as a consequence of the need to identify suitable dates for training and availability of staff to attend. As a result, the pilot was not fully operational in all areas until April 2010. The evaluation began in February 2010 and the first forms received from the three areas were dated January 2010. New clients were accepted onto the pilot up to and including January 2011 and follow-up data were collected to the end of April 2011. In essence, this meant that the pilot was operational for a 16-month period from January 2010 to April 2011, and this is the period that has been used for analysis and reporting purposes.

5.2 Eligibility and Participation
Figure 5.1 below shows the total number of clients who participated in the ABI pilot across all three pilot areas.

The data show that a total of 419 clients were assessed for eligibility. Of the 419 baseline questionnaires received, 12 were not marked as initial or follow-up forms. However, the dates included on the forms suggested that they were initial appointments. On this basis, they were included in the analysis.

Participation across the three areas is shown in Table 5.1 below. It shows that twice as many clients were assessed for eligibility in Areas A and C compared to Area B. Of those assessed, fewer were eligible in Area A (62%) compared to Area B (87%) and C (71%) respectively.

The proportion of clients providing verbal consent to take part was also much lower in Area A (47%) compared to Area B (80%) and Area C (86%). In all areas, data returns were high with 100% of data received for eligible consenting clients in Area A, 91% in Area B and 93% in Area C.

<table>
<thead>
<tr>
<th>Table 5.1 Assessment Activity and Participation by Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area</strong></td>
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<tr>
<td>----------------------------------------</td>
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<tr>
<td><strong>Assessed for Eligibility</strong></td>
</tr>
<tr>
<td><strong>Eligible</strong></td>
</tr>
<tr>
<td><strong>Consented</strong></td>
</tr>
<tr>
<td><strong>Data Received</strong></td>
</tr>
</tbody>
</table>
Figure 5.1 Numbers Participating in the ABI Pilot

Assessed for eligibility:
Baseline Questionnaires (n = 419)

Eligibility
Met inclusion criteria (n = 295; 70%)
Did not meet inclusion criteria (n = 120; 29%)
Not specified (n = 4; 1%)

Consent
Provided consent (n = 207; 70%)
Declined to give consent (n = 88; 30%)

Participation
AUDIT Form Received (n = 195; 94%)
Missing AUDIT form (n = 12; 6%)

Education only (AUDIT Score 0-7) (n = 79; 41%)

Allocated to ABI (AUDIT Score 8-19) (n = 82; 42%)
Control Group = 28 (34%)
Intervention Group = 43 (52%)
Not Known = 11 (14%)

Referred to a specialist service (AUDIT Score >19) (n = 34; 17%)

Followed Up
(from n = 82 with AUDIT Score 8-19)
3 months = 11 (13.5%)
6 months = 7 (6%)
Other Known Outcome = 34 (41.5%)
Lost to Follow Up = 32* (39%)

* two people were followed up at both 3 and 6 months so the 18 follow-up forms relate to 16 individual clients
5.2.1 Reasons for Ineligibility
Of the 419 clients who were screened, 120 people (29%) did not meet the specified eligibility criteria, and in 1% of cases, eligibility data were not recorded. Table 5.2 below shows the breakdown of all clients who did not meet the inclusion criteria, by reason.

Table 5.2 Number and Percentage of Clients who did not meet Eligibility Criteria

<table>
<thead>
<tr>
<th>Reason for Ineligibility</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol treatment/education included as a condition of Order</td>
<td>47</td>
<td>39%</td>
</tr>
<tr>
<td>Currently in treatment for alcohol problems</td>
<td>35</td>
<td>29%</td>
</tr>
<tr>
<td>Under 18</td>
<td>15</td>
<td>13%</td>
</tr>
<tr>
<td>Received screening and/or ABI elsewhere in previous 12 months</td>
<td>7</td>
<td>6%</td>
</tr>
<tr>
<td>Intoxicated at time of interview/not alert and orientated</td>
<td>6</td>
<td>5%</td>
</tr>
<tr>
<td>Suffering serious mental health problem</td>
<td>6</td>
<td>5%</td>
</tr>
<tr>
<td>Cannot read and write English sufficiently well to take part</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100%</td>
</tr>
</tbody>
</table>

Data show that most did not meet the criteria on the basis that they were already subject to alcohol treatment/education as a condition of their Order. This was the case for 47 clients. A total of 35 clients were already in treatment for their alcohol problems (outwith an Order), and so were not included in the pilot on that basis. Seven clients had already received screening or an ABI elsewhere in the previous 12 months, and so were not eligible to take part. This means that almost two thirds of clients who were excluded from the pilot would have already had an opportunity to receive alcohol advice and support from another source.

5.2.2 Declined Consent
Of the 295 clients (70%) who met the eligibility criteria, 207 (70%) consented to take part. Participation in the pilot was entirely voluntary and, at 70%, was lower than other similar studies. This total population percentage was affected, however, by the low consent rate in Area A (47%), as in Areas B and C it was over 80%. There was also a higher refusal to consent rate among community service clients. Only just over half (51%) of community service clients who were eligible to take part provided verbal consent, compared to 93% of probation clients.
5.2.3 Missing Forms
Although a total of 207 clients consented to take part, in 6% of cases (13 clients) the screening and consent form were returned to the researchers without a completed AUDIT form. Essentially, this resulted in 195 cases (94%) where a full set of data were received (baseline questionnaire, consent and AUDIT). Only cases where a completed baseline questionnaire and paired AUDIT form had been received by the researchers were included in the final analysis.

5.2.4 Participation Over Time
Figure 5.2 shows the numbers of eligible clients who consented to participate each month for the duration of the pilot, and those that declined.

Figure 5.2 Participation over time

Following a slow start in the first two months of the pilot, the data show that there was considerable activity in the six month period between March and August 2010, before numbers started to drop again in the latter part of 2010. The number of participating clients ranged from 1 in January 2010 to a high of 43 in March 2010.

Consent to participate also appeared to fluctuate across the duration of the pilot. Around 20-25% of clients declined in most months, although there were higher refusals in June and September 2010 (57% and 50% respectively).
5.3 Participant Demographics

Of the 195 clients from whom a full set of data were returned, and where gender data were recorded, 85% were male and 15% were female. This gender split was exactly the same as the proportionate split for all those who completed the baseline questionnaire.

These figures compare closely with the gender split for Community Service CSOs and POs for the selected case study areas combined which, in 2009/10 were 89% male, 11% female and 83% male, 17% female respectively. Essentially, therefore, the gender data show that the participating population was not different from those who were assessed for eligibility, or from the wider CSO/PO population.

The average (mean) age of participating clients was 31, ranging from 18 to 65. The average age of participants was the same as the average for all those assessed for eligibility. Although the average (mean) age of those receiving CSOs and POs nationally and locally is not known, national statistics do show that those aged 31-40 make up around 21% of all those in receipt of Orders. While this age band has the greatest prevalence among PO recipients, it is second to 21-25 year olds for CSOs.

In 97% of cases, clients were classified as being ‘White’ and in 2% of cases their ethnicity was described as ‘Other’. Ethnicity data was missing in 1% of cases. Again, this did not differ from the total population assessed for eligibility or the national data for POs and CSOs.

5.4 Community Justice Designations

Of the 419 people assessed for inclusion in the pilot, there was a fairly even split between those in receipt of a PO (51%) and those in receipt of CSOs (45%). In a further 2% of cases, the recipient was marked as being seen in both the probation and community service setting. Designation data were missing in the remaining 2% of cases.

Of the 195 people from whom a full set of data were returned, 57% fell into the probation setting and 38% were community service clients. Again, some clients were marked as both (4%) and data were missing in 1% of cases.

The higher participation rate among probation clients was not due to a higher proportion of these clients meeting the eligibility criteria. Indeed, 62% of probation clients met the inclusion criteria compared to 78% of community service clients. The main difference in participation rates for the full pilot seems to have been a higher refusal to consent rate among community service clients. Only just over half (51%) of community service clients who were eligible to take part provided verbal consent, compared to 93% of probation clients. Much of this difference in the sample overall, however, is accounted for by a very high proportion of community service clients in Area A declining to consent.
5.5 AUDIT Scores

Table 5.3 shows the number and percentage of clients who fell into each of the three AUDIT clusters. Scores fell in the full range of 0 to 40 with a mean score of 11.7.

Table 5.3 AUDIT Scores for Participating Clients

<table>
<thead>
<tr>
<th>AUDIT Classification</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score 0-7: low risk drinking or abstinence and eligible for education only</td>
<td>79</td>
<td>41</td>
</tr>
<tr>
<td>Score 8-19: strong likelihood of hazardous and harmful consumption and eligible for alcohol brief intervention</td>
<td>82</td>
<td>42</td>
</tr>
<tr>
<td>Score &gt;19: possible alcohol dependence and referred to alcohol specialist service</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>100%</td>
</tr>
</tbody>
</table>

Just over 40% of those who completed the AUDIT form scored between 8 and 19 and were, therefore, eligible to receive the ABI. Table 5.4 shows how this compares to previous studies in the criminal justice field. It shows that the proportion of clients falling into the hazardous and harmful category were broadly in line with other studies, although there were slightly more in the low risk category compared to other research, and fewer in the high risk cluster. This was perhaps to be expected given that this pilot excluded those who were already in treatment for alcohol related problems, or who had alcohol education/treatment as part of their condition. Thus, the low proportion of dependent drinkers in this sample is artificially low if used as an indicator of likely prevalence in the wider community justice population.

Table 5.4 ABI Pilot Scores and Other Studies (%)

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Score 0-7</td>
<td>41</td>
<td>36</td>
<td>16</td>
<td>38</td>
</tr>
<tr>
<td>Score 8-19</td>
<td>42</td>
<td>43</td>
<td>39</td>
<td>27</td>
</tr>
<tr>
<td>Score &gt;19</td>
<td>17</td>
<td>21</td>
<td>45</td>
<td>35</td>
</tr>
</tbody>
</table>

5.5.1 Variation in AUDIT Scores by Designation

There was some variation between probation and community service clients in terms of the overall distribution of scores, with 38% and 45% respectively scoring in the 0-7 range, 40% and 46% respectively scoring in the 8-19 range and 22% and 9% respectively scoring in the >19 range. This shows that, although the proportion of clients from each designation who were eligible for an ABI was
broadly similar, a higher proportion of community service clients fell in the low risk category compared to those in receipt of POs. Conversely, a higher proportion of probation clients were in the possibly dependent category compared to community service clients.

5.5.2 Variation in AUDIT Scores by Demographics
For males, the mean AUDIT score was 12.25 compared to 9.31 for women. There were also differences in the distribution of scores among males and females, with 46% of males compared to 24% of females falling in the intervention AUDIT range (8-19). Far fewer males fell in the low risk score range (36% of males compared to 59% of females). The proportion of males and females in the high risk category was 17% in each case, showing that the difference between the genders was all located in the lower two categories.

Interestingly, the gender ratio in the different settings showed that there was a slightly higher presence of females in the probation setting (80% male compared to 20% female) than the community service setting (89% male compared to 11% female). Thus, although both gender and designation seem to interact with AUDIT scores, the lower scores in the community service designation and among females should not be considered as confounding.

Table 5.5 shows AUDIT scores by age. It shows that those aged 18-24 were more likely to have an AUDIT score in the hazardous/harmful range (55%) compared to those aged 25-29 (38%) or 30-39 (40%) or older (21%). Indeed, 18-24 year olds accounted for just over half (51%) of all those falling into the ABI range despite only accounting for 40% of the sample overall.

<table>
<thead>
<tr>
<th></th>
<th>18-24 (n=76)</th>
<th>25-29 (n=40)</th>
<th>30-39 (n=40)</th>
<th>40+ (n=34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score 0-7</td>
<td>30%</td>
<td>42%</td>
<td>42%</td>
<td>59%</td>
</tr>
<tr>
<td>Score 8-19</td>
<td>55%</td>
<td>38%</td>
<td>40%</td>
<td>21%</td>
</tr>
<tr>
<td>Score &gt;19</td>
<td>15%</td>
<td>20%</td>
<td>18%</td>
<td>20%</td>
</tr>
</tbody>
</table>

5.5.3 Allocation to Experimental Groups
Of the 82 people who fell into the hazardous and harmful category, just over a third (n=28; 34%) were in the control group and received a booklet only. Just over half (n=43; 52%) were in the experimental group and were offered both the AUDIT screening and follow on ABI. It is important to note that, for those in the control group, where hazardous and harmful drinking was identified, staff were instructed to follow their routine practice, and so onward referral for specialist assessment would still have occurred for any client where it was considered appropriate by staff.
In just over 1 in 8 cases (n=11; 13%) it was not possible to allocate cases to the control or intervention group since the identification information that had been returned on the baseline questionnaires that accompanied the AUDIT forms was incorrect or missing.

The relatively high proportion of forms that could not be matched is disappointing, however, perhaps not surprising in light of comments raised during the qualitative interviews about lack of understanding of which group people belonged to. It also reflects the finding from the online survey of staff which showed that 9% of respondents were not clear to which group they belonged. Given that the survey response rate was so low, this early finding seems to have been indicative of a wider problem among those who failed to respond to the survey, and which was not evidenced until all AUDIT forms were analysed and the blinding was lifted from the researchers for analysis of the data.

5.6 Staff Views on the Pilot in Operation
Data from the online survey and staff interviews were analysed to explore how the pilot was operating on a day-to-day basis and data showed that there were mixed responses to the pilot in terms of its purpose, ease of administration and perceived impact. Here comments are presented relating to the purpose and process of delivering the pilot, and section six explores perceptions of impact.

5.6.1 The Baseline Questionnaire
Administration of the baseline tool was considered to be easy. The staff survey showed that 81% of respondents found the baseline questionnaire very/fairly easy to use, and interviews confirmed this was the case.

Although the baseline questionnaire was described as being easy to use, some comments were made during interview about the restrictive nature of the eligibility criteria and a suggestion was made that this had a significant impact on numbers of potential participants:

‘Appropriate training provided made it easy enough to deliver the ABI pilot in the area. There have been issues, however, as to when it is most appropriate to use this, and to find people who are suitable to use the information with’.

Feedback from some staff during early scoping interviews also suggested that when a client had an Order with a condition of alcohol treatment/education, staff often would not begin the pilot process, including the baseline questionnaire. This suggests that the numbers of people assessed for eligibility was lower than should have been and does not present an entirely accurate view of the numbers of people accessing community justice services who may have an alcohol use disorder.
5.6.2 The Target Group
A common view from staff seems to have been that they did not feel that the pilot was suited to their client groups. This was largely because they felt that their clients had more ‘serious’ issues impacting on their lifestyles and that addressing their alcohol problems was not a high priority:

'It's, kind of, targeted at more middle of the road clients, and I don't have that, I work with the extremes...they are either alcoholics or they are drug users'.

'The aim of ABI is to identify if there are any alcohol issues, however, given my clientele, this is irrelevant as they are either already in services, it was a condition as part of their offence, or alcohol definitely wasn't an issue.'

'...if you're meeting a client for the first time and you're hitting them with a whole load of other things plus this and really drink is not perceived to be an issue then...it might have to take a backseat.'

Even as early as the training, comments on the day suggested that staff might be reluctant to administer the screening and ABI if they felt that the client had other more important issues affecting them than their alcohol consumption. Staff said that they often have to focus on ‘immediate’ problems such as money and housing and that, if time was against them, they would postpone the AUDIT to the second appointment. Staff also said that they felt that it might be more helpful if the AUDIT were done at the second appointment rather than the first as, by this point, the client will already have engaged with the worker and would be more likely to provide more reliable data.

Several staff felt that ABIs would be better targeted at younger and less established drinkers, as they felt they were less likely to be already entrenched in a cycle of drugs, alcohol and offending:

'My own professional opinion is that this may have been more successful if aimed at younger age group as most of our adult clients already have significant alcohol histories and associated difficulties.'

This does perhaps also imply a lack of understanding of the role of screening and ABIs.

5.6.3 The AUDIT Tool
Data from the online survey showed that 66% of those who responded found the AUDIT tool very easy/fairly easy to administer. Interestingly, staff in the control group were more likely say that they found both the baseline questionnaire and the AUDIT ‘very easy’ to complete than staff in the intervention group.
Of those who responded to the survey, 69% said that they completed the AUDIT in less than 10 minutes. In interviews, staff confirmed that the AUDIT was not time consuming.

This said, some staff did comment in interview that, although the time taken to complete the AUDIT was not problematic, they did resent any time being dedicated to the pilot if they felt that it was not suitable for their client:

'It is not the time to do a piece of paper exercise in the timescale that you were given …it’s that I knew it was irrelevant, and they [the client] were sitting looking at me as if “What is this?” So I was doing it because I had to do it, and I was asking them if they wanted to do it but it was quite clearly inappropriate.'

This was not a unanimous view and other staff commented that the AUDIT was a welcome addition to their toolkit when working with the clients who might not otherwise have wanted to talk about their drinking behaviour:

'It's a reminder and a useful tool to start a discussion about alcohol issues, particularly where the person has initially said there are no alcohol problems, especially where the client has said there are not problems but then you go through the tool and suddenly things do come out so it does act as a help and has improved practice slightly.'

5.6.4 Delivering the ABI
Again, staff commented that delivery of the ABI was non-problematic. Responses to the staff survey showed that 54% of respondents found the ABI easy/fairly easy to deliver and 46% complete ABI in under 10 minutes. Staff described the ABI as being useful insofar as it provided a structure for conversations with clients.

5.6.5 Making a Change Booklet
Staff were asked how often they used the ‘Making a Change’ booklet when working with clients with an appropriate AUDIT score. Survey responses showed that 51% (n=23) used it with every appropriate client, a further 15% (n=7) used it ‘with most’ but over a quarter (27%, n=12) said that they never used the leaflet.

Although three quarters of staff said that they used the booklet with suitable clients, there was a general scepticism about how many clients would read or use the booklet after leaving the interview with staff. Some staff commented that clients were likely to ‘bin it’ on the way out.

One staff member described giving a booklet and talking it through, but said that the client had a ‘blank expression on their face’ – the worker explained that the client ‘then folded it up and put it under his cup’. Based on that experience, this member of staff did not use the booklet again. The worker explained that they
had previously used an alternative stimulus when working with this client group, which they felt was more effective:

‘Measuring cups are a good idea…and it’s far more powerful because the clients go away with them and its visual, and the two people I’ve given them to, I’ve said, “Just use that for your drinking”, and that works, and they have come back to me…and that’s far more powerful.’

Staff explained that they go through the leaflet with clients and point out important and relevant sections, but how much clients took on board was unclear.

5.6.6 Timing of Delivery
A decision was made that the screening and ABI for the study would take place at the initial appointment with the probation or community service workers. As said, this stage of the community justice process was chosen instead of an earlier stage so as not to interfere with the sentencing process, to minimise likely attrition among offenders, to ensure client-staff relationship continuity and thus to maximise consistency and comparability of the initial and follow-up data collected.

A key emerging theme from the staff interviews at both the management and operational level was that staff considered the timing of the screening and ABI to be misplaced. There was a strong view, evidenced as early as the training, and present even at the end of the pilot, that a better place for delivery of the screening and ABI would be at the Social Enquiry Report (SER) stage:

‘This is done at too late a stage as most service users have an alcohol problem. This refers to the local area and alcohol team at the SER stage, by social workers. Then the court usually imposes alcohol counselling as it would have been better to moderate ABI at SER stage.’

Staff felt that, if delivered at SER stage, the pilot would have captured more eligible candidates and suggested that the AUDIT tool would actually be useful to argue the case for Structured Deferred Sentences instead of an Order. Thus, although the tools themselves were not problematic, and it was recognised that they could be useful in building profiles for clients, the timing at the initial appointment was seen as not right:

‘It would have made more sense, at the report stage even, and you can then use it in court to say that this has identified that they would benefit from a brief intervention’.

5.6.7 Impact on Workload
In line with comments about feeling that the pilot had been ‘imposed’ on them without consultation at the start, interviews with some of the staff toward the end
of the pilot suggested that this may have been a reason for some failure to generate more data among staff. There was, perhaps, a view that the pilot was 'one of many' demands being placed on staff which have resulted in some resistance:

'We're in a constantly changing environment anyway and it always feels as if we're getting stuff put on us to do...and that's it, you get the trainers coming along and tell us we've got to do this but there's a whole raft of other things we have to do and pressures put on us.'

5.6.8 Understanding the Pilot and Research Requirements

It became clear as the research progressed that understanding of the aims and objectives of the research was limited in some areas, especially in relation to the allocation of staff to control and intervention groups:

'I didn't know, am I a control, am I a screener. I really didn't understand it at all. I got that it was research, but I didn't know what my role was.'

Further, there was evidence that some people were not happy being allocated to their group, and this may have caused some resistance to the pilot:

'People were just grouped, and I think that's when people were asking me loads of questions... People were asking "Why am I in the control group? Why am I not?"...and that's where people felt, "How come I can't deliver what I want to deliver?"'

There was also considerable evidence from the interviews that staff either were not aware of the need to carry out follow-up screening at the three and six month stages or, where this was known, they often forgot to complete the AUDIT.

'Because the way the groups were separated, I think it led to confusion as to how this followed through. I mean, I was only doing the briefing, but then you don't know "What's the follow-up?" What's the purpose?"

Staff seemed to suggest that they had not been fully alerted to the need for follow-ups from the start:

'From the very initial training sessions provided in [Area], at that point, there was no mention of follow-up forms... The expectations were not made very clear about what was needed to be collected at each stage...The clarity wasn't there from the beginning.'

As a result, many people in the control group thought that they were not meant to be doing follow-ups:

'I thought my role was, I do the initial screening, and that's it.'
The area where follow-ups seemed to work best was Area A, where the dedicated co-ordinator took an active role in reminding staff that a follow-up was due:

‘Reminders for follow ups are really helpful because when there are months between doing one and doing the next one you do forget about it…you do lose track and something like ABI can get lost if you don’t get a reminder’

Reasons for low response rates at follow-up stage may also have been linked to staff doubts about the reliability of the data that would be generated and how it could reliably inform the evaluation:

‘There was an uncertainty about the methodology of it, because in the control group, you were asked to do the screening, and if they met the criteria you were only asked to give a leaflet. But what a lot of the workers were saying is “Well, if this persons got has got substance misuse problems, over the course of their PO, I would have given them substance misuse counselling anyway.” So how are you gonna be able to tell the difference between if this changes because of the substance misuse counselling or the brief intervention?’

Staff suggested that a better rapport between themselves and clients that would build up naturally over time would probably result in more honest reporting at follow up stage which might increase their AUDIT score compared to initial screening. There was also a view that those in the control group would have contributed to support and assist clients with identified drinking problems regardless of whether they were in the control or intervention group, and so this independent advice or information may have had the same (or better) impact on follow-up scores as those in the intervention group. These feelings of doubt with regards to the model may have made a significant contribution to an apparent reluctance to collect follow-up data.

‘I have done a follow up but there was not that much change…I don’t know if that’s because clients were lying, not be honest about their alcohol use. They are more likely to be honest three months down the line because the fear of court has been removed from them.’

‘This is all self-reported, and we know that clients self-report different things at different times so at the initial stage they might not be that willing to be honest, but this time they might be more honest and there might be a real change in what it’s telling me. I’ll have also had the experience of asking the client about his drinking over the last three months when I’ve been meeting with him, so I could also take issue with some of his answers. Not sure I’m supposed to do that though because I think we’re supposed to deliver it in a very non-judgemental, non challenging way where they give us the answers.’
Doubts about the ABI model *per se* were evident in all areas from the start of the evaluation to the end. As one person commented in their online questionnaire:

‘Not sure how a five minute conversation can motivate someone to change their drinking behaviour.’

Staff doubts about whether the model works and a lack of robust evidence presented to staff about whether it would work based on learning from elsewhere seem to have resulted in some views about whether the investment of their time would be worthwhile.

The main problems seem to have been reluctance among staff because, as one of them summarised:

‘Wrong place, wrong environment, wrong client group.’
6. Research Findings 3: Perceived Impact and Effectiveness

6.1 Introduction
The pilot was designed to test both the feasibility and potential impact of using ABIs in the community justice setting, although it was always recognised that the available evidence to support that latter would be more restricted. This was borne out as the research progressed, with no access to secondary outcome data, low levels of follow-up data collected and negligible client engagement with the evaluation.

The limited impact data that was collected is presented in this section, although much of this is anecdotal and should be considered as indicative of the impact and relative effectiveness of the ABI pilot, rather than conclusive.

6.2 Follow Up Data
Data were collected up to the end of April 2011, meaning that follow-up data for all clients who had been screened up to the end of January 2011 could potentially be captured (at three months only in some cases). From the 82 clients who scored between 8 and 19 in the initial AUDIT assessment, 18 follow up forms were returned. This included 11 clients followed up at the three month stage, and seven clients followed up at the six month stage. Of these, only two clients had both three and six month follow up data and so the 18 forms received represented 16 individual clients. It also means that in four cases, initial and six-month data were available, but there was no accompanying three month data. For one person for whom a six month form was returned, there was nothing to enable the data to be matched to an initial or three month form, and so this person was excluded from the follow-up data analysis.

The low volume of follow-up data was disappointing but does mirror findings from the interviews with staff that revealed that there was a generally poor understanding of the requirement to carry out screening at 3 and 6 months, with many reporting that they did not recall this message being conveyed as part of their training. It should be stressed that the need to collect the three and six month follow up data was emphasised throughout the project, via the co-ordinators, and so the absence of this being covered in the training (if so), should not have been a determining factor. Visits to the local areas were also made by the project advisory group staff, and were used as an opportunity to stress the need for this data, and so it is not clear why this did not transpire in more follow-up data being collected. A number of factors could have contributed to the low volume of follow up data including clients’ failure to attend meetings, administrative errors, timing problems or other work conflicts.

6.3 Breached and Revoked Orders
In 21 cases, Orders were described as ‘successfully completed’ and so contact with the client had been terminated before it was possible to carry out a three
month follow-up. In 10 cases the Order had been breached or a breach had been submitted. In one case an ABI had been done in another setting which the worker felt made it unnecessary to do again during the three-month follow-up appointment. At six months, one person who was due to be followed up had been referred to a specialist agency. A further participant was described as being ‘currently suspended’ at the time that follow-up data would have been captured. Information relating to all other clients who were not followed up was not available from the pilot areas. Table 6.1 below summarises the follow up and outcome data for each of the three pilot areas, and also shows the number of cases that were lost to follow-up.

**Table 6.1 Follow up and Outcome Data by Area**

<table>
<thead>
<tr>
<th></th>
<th>Area A</th>
<th>Area B</th>
<th>Area C</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Participants (scoring 8-19 at initial assessment)</td>
<td>20</td>
<td>22</td>
<td>40</td>
<td>82</td>
</tr>
<tr>
<td>Total Followed up (3 months)</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Total Followed up (6 months)</td>
<td>5</td>
<td>-</td>
<td>2</td>
<td>7*</td>
</tr>
<tr>
<td>Total where other outcome was known (of which:)</td>
<td>8</td>
<td>5</td>
<td>21</td>
<td>34</td>
</tr>
<tr>
<td>Order Completed</td>
<td>3</td>
<td>3</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Order Breached</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Order still active – breach submitted</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Already had ABI screening in another context</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Referred to specialist service at 3 months</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Currently suspended</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Lost to Follow Up</td>
<td>2</td>
<td>13</td>
<td>15</td>
<td>32</td>
</tr>
</tbody>
</table>

* two people were followed up at both 3 and 6 months so the 18 follow-up forms relate to 16 individual clients

### 6.4 Feedback from Staff

During interviews, staff were asked how clients generally responded to receiving the ABI. Responses suggested that clients were generally accepting of the screening and ABI but were not noticeably enthusiastic or engaged. The reasons for this was that clients perhaps felt it was just a form filling exercise, especially if they did not consider alcohol to be a problem in their lives:
‘People just didn’t think drinking was a problem.’

Staff were keen to highlight that many of their clients led chaotic lifestyles and it was naïve to consider that tackling alcohol problems would significantly change their lifestyle. Indeed, staff suggested that excessive alcohol consumption among their client group was often linked to wider social and personal pressures, and was not the cause of these issues. The suggestion was, therefore, that drinking was symptomatic of these pressures. As such, an idea was posited that staff should be trying to tackle the wider issues before tackling alcohol misuse, since to do so would likely have a greater impact:

‘It’s about looking at all these other things that lead to alcohol use…if alcohol has become a problem because of other things then it’s looking at these other things and dealing with them and that normally reduces the alcohol consumption.’

On several occasions, staff stressed that change would only occur if clients were willing, and they felt that many of their clients were not at that stage of contemplation which would maximise the likely usefulness of an ABI:

‘There has been no noticeable change in client’s drinking behaviour…you do get the odd light bulb moment where clients are like ‘oh’…but you don’t know whether that will have a lasting impact or if it is just a light bulb moment.’

Interestingly, where follow-ups had been performed, there was suggestion that worsening of scores may have been de-motivating for clients:

‘I did reviews a couple of times and the review always went up, because they were maybe being more honest. I think they felt quite disappointed that their scores had went up.’

As part of the survey, respondents were also asked how well they thought clients were engaging with ABIs. Table 6.2 shows the responses, by area. Of the 24 respondents who answered the questions, 63% (n=15) stated that they thought engagement varied considerably between clients and so general statements about client engagement could not be made.
Table 6.2: Perceptions of client engagement

<table>
<thead>
<tr>
<th>Perceptions</th>
<th>All Areas (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>They engage well, better than I expected</td>
<td>8 (n=2)</td>
</tr>
<tr>
<td>Engagement varies considerably between clients</td>
<td>63 (n=15)</td>
</tr>
<tr>
<td>They do not engage at all</td>
<td>13 (n=3)</td>
</tr>
<tr>
<td>I have not delivered an ABI yet</td>
<td>4 (n=1)</td>
</tr>
<tr>
<td>Don't Know/Unsure</td>
<td>13 (n=3)</td>
</tr>
<tr>
<td><strong>Total (N)</strong></td>
<td><strong>N = 24</strong></td>
</tr>
</tbody>
</table>

Interestingly, one staff member also commented that she felt that clients’ failure to engage may have been linked to her own uncertainties about the pilot and its purpose:

‘The ABI, I think they found it difficult to engage, but again that’s maybe cause I was confused with it as well.’

6.5 Client Feedback

Despite repeated efforts, the researchers were not able to reach clients to engage with them. For ethical reasons, it was not possible for client contact details to be shared with the researchers, and so all recruitment had to take place via their workers. Information sheets and consent forms were passed to staff who had expressed a willingness during interviews to invite their clients to take part. Following this exercise, only two clients’ names were forwarded and only one of these ultimately agreed to take part in a telephone interview.

It is not possible to say how many clients were actually invited, and, therefore, to say what the actual response rate was. It may be that clients were asked and declined or it could be that they were not asked by staff in the first place. Given that the recruitment of clients was attempted towards the end of the evaluation, when numbers of clients being screened were starting to fall, it may simply have been that there were fewer people to invite. The limited follow-up data and the numbers of clients who breached or revoked Orders before follow-ups were due also suggest that clients were not necessarily engaged over time with staff. Indeed, some staff replied to requests by advising that their pilot clients had been returned to prison or were receiving addictions treatment elsewhere. Had they been invited to take part in the evaluation during the initial appointment, participation may have been greater and this is noted as a learning point for the future.
Whilst client feedback is not available, therefore, a ‘view from a client’ is presented below which summarises the views expressed by the one male client (age not known) who was interviewed.

**A View from a Client**

The client had been engaging with his worker for almost 12 months. He explained that he could not remember the first time that the ABI pilot was mentioned to him, although he said that he had always been happy to take part in anything offered to him. He did remember being asked about his drinking during his initial appointment, and again at all subsequent meetings. He could not remember specific questions, or any specific advice that he had been offered.

The client explained that he used to be a 'strong drinker', drinking every weekend, and often during the week. He had a history of violence, and contemplated that this may be linked to his drinking behaviour. He explained that he had been involved in several incidents when out with friends and family members who were also drinking. He explained that he was under peer pressure to drink and often 'got into hassle' as a result.

The client had previously spoken with the police about his drinking behaviour, but had paid little attention to their advice on the need for him to stop drinking.

The client reported a significant reduction in his drinking since he had been in touch with his worker – he said that he had recently been 'on a night out' – the first in several months where he had had a drink.

He had no objection to being asked questions about his drinking over the last year, and had always found it easy to discuss with his worker. His worker was 'pleased', he said, with his progress.

The information provided as part of the ABI pilot was described as 'helpful', and the client explained that, while he didn't understand everything he was being told at first, he had started to gain a greater appreciation of the risks of hazardous/harmful consumption as a result of talking it through with his worker.

Information that had been given to the client had been shared by him with his brother, who he said also seemed to benefit – 'some of it really worked'.
7. Cost Analysis

7.1 Introduction
As part of the evaluation, a cost analysis was undertaken to explore and report on the resource and cost implications of implementing screening and ABI within existing practice in community justice.

The cost exercise draws on primary data collected from the surveys and interviews described above in relation to staff time required to deliver ABIs in the community justice setting, as well as to provide an estimate of the material costs that were incurred. Together, these have been used to produce estimates of what the likely resource and cost implications would be if there was further uptake of the pilot model elsewhere, based on anticipated numbers of clients who would be eligible for screening and ABI in all areas across Scotland.

7.2 Key Literature
In order to set this review of the cost-effectiveness of ABIs in context, it is important to consider the wider cost of alcohol misuse in Scotland. The latest available figures from the Scottish Government estimate that the indicative total cost of alcohol misuse to Scottish society in 2007 was around £3.56 billion (Scottish Government, 2010). The constituent elements of this cost are shown in Table 7.1 below:

<table>
<thead>
<tr>
<th>Resource Category</th>
<th>Cost Range (£ Million)</th>
<th>Midpoint (£ Million)</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service</td>
<td>143.6 – 392.8</td>
<td>267.8</td>
<td>7.5%</td>
</tr>
<tr>
<td>Social Care</td>
<td>114.2 – 346.8</td>
<td>230.5</td>
<td>6.5%</td>
</tr>
<tr>
<td>Crime</td>
<td>462.5 – 991.7</td>
<td>727.1</td>
<td>20.4%</td>
</tr>
<tr>
<td>Productive Capacity of the Scottish Economy</td>
<td>725.2 – 1,006.1</td>
<td>865.7</td>
<td>24.3%</td>
</tr>
<tr>
<td>Wider Social Costs</td>
<td>1,031.1 – 1,898.0</td>
<td>1,464.6</td>
<td>41.2%</td>
</tr>
<tr>
<td>Total</td>
<td>2,476.6 – 4,635.4</td>
<td>3,555.7</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table clearly demonstrates the substantial cost of alcohol to Scotland. In particular, 20.4% of the costs are absorbed by the Criminal Justice System, with additional impacts in terms of productive capacity and wider human and social costs. To this end, cost effective interventions that reduce the level of alcohol
misuse have the potential to also make significant positive social and economic impacts in Scotland. This is an important point as there is evidence to suggest that ABIs offer a cost effective means to tackling several aspects of alcohol misuse. This section briefly summarises some of the key literature.

In 2006, the NHS published *A summary of the Review of the Effectiveness of Treatment for Alcohol Problems* (Heather, et al 2006). They discovered that providing effective treatment for alcohol misuse per se is likely to reduce significantly the social costs relating to alcohol, as well as offering an increase in social welfare. However, the report does explain that costs may increase in the short-term as drinkers who have not accessed healthcare services prior to alcohol treatment come forward. In addition, the evidence does infer that there would be a longer-term downward trend in the costs of treatment. The Review also noted that savings to the public sector from alcohol treatment are comparable to savings from the treatment for problem drug users.

Roberts et al (2007) noted that ABIs were shown to be a cost effective means of reducing alcohol consumption amongst men in community settings, although the evidence in offender settings was more mixed.

Another study by Latimer et al (2008) added weight to the argument that screening plus ABI is cost effective in primary health care settings, supporting the earlier analysis of Anderson and Baumberg (2006); Ludbrook et al (2001) and Ludbrook (2004). However, it also concluded that further evidence and research were required to address the perceived uncertainties surrounding the cost effectiveness of specific types of ABI. An interesting point to arise from this study is that very brief interventions are likely to be more cost effective than extended brief interventions. However, it is noted that the existing literature does not allow conclusions to be drawn on the relative cost effectiveness of intervening in different population groups. Roberts et al (2007) also raised concerns over the lack of hard evidence in this field.

In summary, the literature concludes that there is some evidence that ABIs in the community justice setting could be cost effective. However, there are sufficient gaps in the evidence and it is difficult to draw definitive conclusions at this point.

The remainder of this section presents the cost analysis relevant to this study.

### 7.3 Planned Spend

In order to implement the pilot, each of the three pilot sites was given a sum of £5,000 to cover some of the expenditure that would be associated with its delivery. From the start, it was recognised that this money would not cover all of the costs incurred, and the three sites hosted the pilot, for the most part, in kind. Additional funding was made available in Area A to pay for the part-time dedicated co-ordinator’s post.
At the beginning of the pilot, staff proposed that this money would be spent on contributing towards the cost of staff training. Some of it was also used for clerical assistance in printing materials, photocopying, storage of materials, travel to pilot update meetings and other ‘communications’ costs.

For the purpose of this analysis, £5,000 has been assumed to be the overhead costs for running the pilot in each area.

### 7.4 Actual Spend

None of the pilot areas felt able to provide a breakdown of actual spend, since no formal records had been kept. The only cost that can be reliably quantified is the cost of funding the part time co-ordinator’s post in Pilot Area A, since this was paid directly by NHS Health Scotland for the period of 12 months for which the co-ordinator was in post.

The cost of the dedicated co-ordinator post was £1,250 a month for 12 months between January and December 2010, which covered a 0.5 WTE salary of 17.5hrs a week. The salary covered all training and administration associated with the post, but travel costs for attendance at national meetings were additional. The monthly expenditure on travel was considered to be negligible and related largely to participation in meetings associated with the evaluation of the pilot, rather than being as a consequence of the pilot itself. The other pilot areas did not have a dedicated co-ordinator and largely accommodated the pilot within existing resources. While there is an opportunity cost associated with these staff resources, there is no increase in the absolute costs for these areas. As a result, the analysis assumes that the cost of co-ordinator support in these areas is zero.

The findings from the pilot suggest that the part-time co-ordinator role had a positive impact in terms of ensuring the return of monitoring data, and ensuring that follow-ups were undertaken, however it impacted little on likely participation rates among clients. The expectation is, therefore, that the co-ordination of ABIs would be undertaken by current staff within Local Authorities, thus meaning that further uptake would have a zero cost in absolute terms (although it should be borne in mind that there is an opportunity cost).

In the absence of any other cost data, hourly rates for staff employed on the pilot were requested. This was provided for one area, and has been proxied to the other areas and used for illustrative purposes to show likely staff costs resulting from the pilot.

The only other fixed costs that are available are the cost of printing and distributing the ‘Making a Change’ booklet, which were £0.80 each (around £100 in total) and the cost of paying trainers. The trainer’s fee was £400 per day and with payment not only for training but also for preparatory work for the sessions. The total training cost was £10,470 which included catering at £5 per head and
accommodation in two of the areas. This cost was fixed and was not linked to numbers of staff trained. A total cost of £10,550 for training and materials has been assumed.

Given that pilot materials were printed externally and provided to the teams at no cost, the only real cost to the sites was time spent in a) training the staff and b) administering the pilot (the baseline questionnaire, AUDIT and ABI and any follow up activity).

7.4.1 Training
The training costs provided by one area have been used for illustrative purposes to show likely staff training costs resulting in a single area.

Thirty five staff in the Intervention Group attended full-day training sessions. Staff were from different grades and thus had different hourly rates, as follows:

- Grade 1 - 9 at £18.93 per hour x 7.5 hour day
- Grade 2 - 15 at £16.48 per hour x 7.5 hour day
- Grade 3 - 11 at £14.03 per hour x 7.5 hour day.

In addition, fifteen staff in the control group attended a half day training, with staff again at different grades and rates, as follows:

- Grade 2 - 5 at £16.48 per hour x 3.5 hour day
- Grade 3 - 5 at £14.03 per hour x 3.5 hour day
- Grade 4 - 5 at £11.20 per hour x 3.5 hour day.

In addition, a number of staff completed online training which was estimated to take approximately 1 hour to complete. It is not possible to say how many of the staff undertook this training, as it was completed at their own convenience. Assuming that all staff participated, this would be:

- Grade 1 - 9 at £18.93 per hour
- Grade 2 - 20 at £16.48 per hour
- Grade 3 - 16 at £14.03 per hour
- Grade 4 - 5 at £11.20 per hour.

ABI interventions were undertaken by staff across all four grades. Without more definitive information on the responsibilities of each grade, it has been assumed that the cost of one hour of intervention work is equal to the weighted average of the hourly rates of all grades. This rate is equal to £15.61 per hour of intervention.

7.4.2 Delivering the Baseline Questionnaire
Data from the staff online survey suggests that the baseline questionnaire took approximately 1 minute to complete. This was validated during interviews with
staff who were unanimous that the time taken to complete the baseline questionnaire was minimal, and non-intrusive.

7.4.3 Delivering the AUDIT
Just over two thirds (69%) of staff said that the AUDIT screening took less than 10 minutes to administer, and this was again confirmed in interviews. Estimates ranged from 5-10 minutes, with an assumed average of 8 minutes.

7.4.4 Delivering the ABI
ABIs generally were considered to be non-time intensive, however, ranges for time taken to complete the ABI were 8 to 20 minutes. Data from the questionnaire and interviews suggest that an average of 15 minutes might be realistic.

7.4.5 Follow Up Appointments
Staff who carried out three and six month follow ups were required to administer the AUDIT screening tool again, to assess any changes in scores between appointments. Given that few follow-ups emerged from the pilot, and in the absence of any evidence to suggest otherwise, it can only be assumed that the follow up screening and AUDIT took the same amount of time as the initial screening and AUDIT (ie around 9 minutes in total).

7.4.6 Per Person Cost of ABI Pilot
Table 7.1 below summarises the length of staff time taken at each stage of the ABI process and the weighted average hourly rate.

<table>
<thead>
<tr>
<th>Table 7.1: Time taken to administer the pilot at key stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Average hourly rate</td>
</tr>
<tr>
<td>Average time taken to administer Baseline</td>
</tr>
<tr>
<td>Average time taken to administer AUDIT</td>
</tr>
<tr>
<td>Average time taken to administer ABI</td>
</tr>
</tbody>
</table>

Table 7.2 below sets out the cost of each stage of the ABI process for the 419 clients who were assessed.

<table>
<thead>
<tr>
<th>Table 7.2: Costs associated with administering the pilot at various stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of ABI Process</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Baseline</td>
</tr>
<tr>
<td>AUDIT</td>
</tr>
<tr>
<td>ABI</td>
</tr>
<tr>
<td>Total Cost</td>
</tr>
</tbody>
</table>

The table clearly shows that the cost of delivering the screening and ABI process is relatively modest – the total staff cost for the three pilot areas was £835. This equates to an average variable cost of £1.99 per client for the pilot areas (ie £835
divided by the 419 clients who were engaged in the screening and ABI process). As would perhaps be expected, the cost of delivering the ABI itself is the most costly aspect of the process in absolute terms. However, at an average cost of only £3.90 per person, the cost is still relatively low.

While the operational cost of the ABI process is low, it is important to consider the overhead costs of the pilot. The central costs of the project have been estimated at £5,000 in each of the Pilot Areas, amounting to a combined £15,000 for the Pilot overall. In addition, training and material costs for the pilot areas accounted for a further £10,550. It should again be remembered that the £5,000 for each area is likely a slight underestimate of the real costs. However, using this figure, with only 419 eligible clients the overhead cost per client amounts to £60.98 per person. The share of overheads is larger than the average variable cost (£1.99) by a factor of 30. The total cost per person is equivalent to £60.98 (overhead/fixed costs) plus £1.99 (variable costs) i.e. £62.97.

The cost for one person to progress through the full ABI is £67.22, comprising of:

- Baseline Assessment (£0.26)
- AUDIT (£2.08)
- ABI (£3.90)
- Share of overheads (£60.98).

This raises an important point. The key to ensuring the ABI process is cost effective is by promoting a high level of engagement. The marginal cost of engaging one extra person is relatively low, with the more people that are engaged, the lower the share of total overheads for each person. By engaging double the number of people within the pilot areas (838 in total), the share of overheads absorbed by each person would be only £30.49. The costs of any further uptake are presented in more detail below.

7.5 Predicting Future Costs
There are several assumptions underlying the estimated costs that are presented here:

- Firstly, it is not possible to reliably predict numbers of clients who will be eligible: client estimates presented here are based on an average from the three pilot sites.
- Secondly, the time taken to administer the screening and the AUDIT itself can vary enormously depending on the client and staff responsible for administering it: again time estimates presented here are based on average from three pilot sites.
- Third, different grades of staff are employed by probation and social work services, and so hourly costs will vary considerably: staff time estimates presented here are based on the ‘average’ salary weighted across the four bands provided by Pilot Site B.
These factors aside, the analysis includes an estimate of the client numbers that further ABI uptake in this setting might engage. This in turn is used to predict future costs.

Table 7.3 shows the number of CSOs and POs awarded at the national level in the five year period from 2005 to 2010, taken from the national published Criminal Justice Social Work Statistics (Scottish Government, 2010).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>5,927</td>
<td>5,937</td>
<td>6,202</td>
<td>6,437</td>
<td>6,429</td>
</tr>
<tr>
<td>CSOs</td>
<td>8,402</td>
<td>8,404</td>
<td>8,706</td>
<td>9,179</td>
<td>8,838</td>
</tr>
</tbody>
</table>

The Criminal Justice Social Work statistics show that the three pilot areas had a combined 2,485 POs and CSOs during 2009/10. In the absence of published data for 2010/11 it is assumed that the number of POs and CSOs would be the same as that in 2009/10, which was not an untypical year. Based on this assumption, a total of 419 people were assessed for eligibility for an ABI, equating to 16.85% of the total number of people in receipt of Orders in the Pilot Areas.

In the absence of other data, it is reasonable to assume that the national engagement rate in the ABI process is similar to that in the pilot areas, circa 16.85%. There were a total 15,267 CSOs and POs issued in Scotland in 2009/10. It is therefore assumed that 2,574 of these offenders would be assessed for eligibility for the ABI scheme. Using the same ratios found in the analysis of the pilot schemes, of these offenders:

- 1,210 would undergo the AUDIT
- 515 would be offered an ABI.

It is not understood what the fixed costs that would be required in each of the non-pilot areas. Therefore, for the purpose of this assessment, it is reasonable to assume if the scheme is delivered by additional Local Authorities on the same basis as the pilot, the average cost of processing a client would be equal to that of the pilot areas – i.e. £62.97 per eligible person. In reality however, economies of scale arising from any further uptake out of the pilot would likely reduce the marginal cost of each intervention, whilst also spreading the fixed costs over a larger number of clients.

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3 It should be noted that the pilot was run over a 16 month period, while the CSO / PO data relate to a twelve month period. However, the first months of the ABI Pilot witnessed very little activity and so it is reasonable to take these two time periods as broadly comparable.
larger number of clients. At present, there is no evidence on the potential extent of these economies of scale, but it is worth bearing this point in mind.

Using an average cost figure of £62.97 this would lead to a nominal national uptake cost of around £162,084 although in reality, the cost would possibly be lower. Indeed, once the one-off training costs had been absorbed in the first year of the pilot, the overhead cost would be reduced for subsequent years as the training component would be removed or greatly reduced.

7.6 Caveats
Importantly, assessments of alcohol use are already made by social work staff and probation officers during their initial and onward contact with clients. There was no suggestion, as part of the pilot, that the ABIs should replace these current practices, rather, they were administered alongside routine practice.

If there was further uptake of ABIs in this setting, along with the use of the AUDIT tool for screening, decisions would need to be made as to how it would be phased in to replace existing alcohol screening measures and following information/advice. This is not something that has been explored as part of this evaluation.

From a process perspective, it has not been possible from the evaluation to identify any areas where real savings occur as a result of delivery of AUDIT screening or ABIs, and so costs are presented as being additional to existing costs incurred by community justice teams. Should the AUDIT screening and ABI replace existing practice, this would clearly change.

It is also important to note that the cost estimates are based on previous numbers of clients receiving POs and CSOs which have now been replaced with Community Payback Orders (CPOs). Since it is not yet known what the likely number of CPOs will be each year, this affects the ability to say what the likely client numbers eligible for screening and ABI would be.

It is also likely that if there was further uptake of ABIs in this setting, then overhead costs may be nationally or at least regionally centralised. It therefore follows that it may not cost an additional £5,000 start-up fee for every area, while ongoing staff costs may also be shared, thus allowing for efficiencies. This in turn implies that wider promotion of ABI could reduce the cost per client.

7.7 Understanding the Benefits
This section focuses principally on the costs of the ABI Pilot and the resource implications of further uptake of the scheme across Scotland. However, in understanding the value for money of the ABI initiative, it is important to consider the potential benefits of the scheme. While ABI may give rise to up-front costs, intuitively, the scheme offers potential long-term cost savings, in terms of:
• reduced alcohol problems to the individual
• reduced harm to others
• reduced levels of alcohol related crime
• improved road and fire safety
• reduced costs to the NHS of treating excessive alcohol consumption / addiction
• enhanced economic productivity.

The analysis presented in this section suggests that ABIs in the community justice setting could be a relatively inexpensive means of reducing alcohol problems in offenders. However, there is insufficient evidence at present to make a definitive judgement on the overall value for money of the intervention. Nevertheless, the analysis suggests that, if an ABI can reduce alcohol related costs by £63 for each eligible client, there would likely be a net benefit to society. That is, it costs just under £63 to deliver the screening and ABI, so a reduction in the costs of alcohol related crime to society of £63 would represent a net societal benefit.
8. Discussion

8.1 Summary of Screening Findings

The pilot has been effective at identifying alcohol problems within the community justice setting and, as a screening exercise, has provided valuable evidence of the levels of problem drinking in this population which was otherwise not known.

Willingness to take part in alcohol screening among the community justice population was around 70%, and this is encouraging as an indicator for future uptake within this setting. It is important to note, however, that there was a significantly higher refusal to consent rate among community service clients. Only just over half (51%) of community service clients who were eligible to take part provided verbal consent, compared to 93% of probation clients.

Among those who were not eligible to take part, around two thirds were already receiving alcohol advice and support from another source and so the prevalence figures presented are likely to be an underestimate of the true level of need among this group.

The screening showed that:

- Around 59% of offenders in receipt of CSOs or POs in the pilot area, and who fulfilled the eligibility criteria, were categorised as having an AUD.
- Of these, 42% fell into the hazardous/harmful category and could potentially have benefited from receipt of an ABI.
- Almost 1 in 5 offenders screened demonstrated high risk drinking behaviour that might indicate possible dependence, and who wouldn’t necessarily have been picked up through routine practice. This may be an underestimate of the true prevalence of high risk drinking in this population, however, since a substantial proportion of clients were excluded from the pilot as they were already in contact with specialist alcohol services.
- Those falling into the high risk/possibly dependent group were more likely to be in receipt of a PO than a CSO.
- Although client numbers were small, men were almost two times more likely to fall into the intervention range than women, with almost two thirds of women falling below the cut-off for AUDs.
- Those in the 18-24 age band were more likely than those in older age bands to have an AUD.

Accepting that the sample was relatively small, and that there may therefore have been inherent bias in the sample, these findings nonetheless indicate that screening for AUDs in this population could potentially be used to identify and tailor interventions for a large number of people with alcohol problems who might otherwise not be identified as being in need.
8.2 Summary of Feasibility Findings

As a feasibility pilot, the evaluation has uncovered considerable evidence of what works, as well as the barriers that might affect attempts to increase uptake.

8.2.1 Eligibility Criteria

Perhaps counter-intuitively, some staff suggested that the eligibility criteria for the study were too strict, and that there may be others who could have benefited from the pilot, but who were excluded. This was particularly true in relation to younger offenders (those aged under 18), who staff considered would be less entrenched in drinking cultures and who would be more likely to change their behaviour as a consequence of screening and ABI. This observation was based on staff experience rather than being based on robust evidence and it does, perhaps, again highlight some of the doubts and misunderstandings around the use of AUDIT and ABI which have both been robustly tested in other settings and reported as such in the research literature.

It is important to note that, although some staff felt that the pilot was perhaps targeted at the wrong type of client, the pilot delivery model as a whole (including the exclusion criteria that were set out in the baseline questionnaire) specifically took cognisance of previous research evidence around ‘what works’ for screening and ABIs so as not to include those who were not likely to benefit, such as young people under the age of 18 and those who are alcohol dependent. That said, the lack of research evidence around usefulness of ABIs specifically in community justice means it is difficult to say whether staff observations may hold true.

8.2.2 Consent to Participate

The proportion of clients providing consent was perhaps lower than expected at the outset of the pilot and while this may have been due to clients feeling uncomfortable discussing alcohol use with their worker, it might also reflect that clients themselves did not feel that alcohol was a significant issue that they wanted to give up time to speak about, especially in the context of their wider criminal and social circumstances. There was also some fluctuation in consent rates over time, and it is difficult to explain why this occurred, since there were no significant staffing or other external influences on the pilots at this time. It can only be assumed that this variance is accounted for by client predisposition to take part. It does seem that refusals to provide verbal consent dropped slightly towards the end of the pilot. This perhaps suggests that, as staff became more comfortable with the pilot, they were able to better advise clients of the requirements of participation, thus increasingly likely willingness to take part.

The proportion of clients providing verbal consent to take part was also much lower in Area A (47%) compared to Area B (80%) and Area C (86%). Although there is no obvious explanation for this, it should again be noted that the start up of the pilot in this area coincided with an usually heavy period of work for the
community justice staff and did not really pick up momentum until the dedicated co-ordinator came into post.

The lower participation rate among eligible community service clients compared to probation is also interesting. When examining all those who completed the baseline questionnaire, fewer of those in the community service group were excluded because they were already accessing alcohol treatment/education elsewhere, or to have it as a condition of their order, compared to probation clients. This could be interpreted that, as a group, community service clients are less likely to be already receiving alcohol education, support, advice or intervention ‘in the round’ and so might perhaps have benefited most from the opportunity presented by the pilot. Their decision to decline participation may, however, also indicate that they were less likely to consider themselves to be in need of alcohol education, support, advice or intervention.

Another possible explanation for the lower participation rate among community service clients may have been staff influence over decisions to take part. The training analysis and subsequent interviews with staff showed that community service staff felt less comfortable with the skills required to administer the AUDIT screening and ABI, possibly because of lack of previous motivational interviewing training, and this may have led to them inadvertently discouraging clients to take part.

8.2.3 Staff Confidence and Skills
Interestingly, staff in the control group were more likely say that they found both the baseline questionnaire and the AUDIT ‘very easy’ to complete – possibly because this was the extent of their involvement in the project, and they did not then have to go on to administer the ABI. Perceived challenges with the ABI may have affected intervention group perceptions of the ease or difficulty with the earlier stages of the screening and ABI.

Perceived failure to consult frontline staff properly and to inform them of the potentially positive impact of what they were tasked to do seems to have resulted in a negative impact on working practice for some staff. The evidence around reluctance to engage, and lack of perceived evidence for effectiveness of ABIs, emphasises the importance of briefing all staff (Including frontline and strategic) on the evidence and application of interventions in advance of implementation into practice. There may be scope for qualitative work with staff in different areas of the country to gauge wider support for ABIs in the community justice setting before further uptake is considered. This might also provide insight into modifications which could be made to the existing model which would ensure a smoother integration elsewhere than was experienced here. This is not to say, however, that even with full consultation staff buy-in can be guaranteed.

8.2.4 Staff Attitudes
Although the AUDIT tool and ABI seem to have been easy to administer, and
were seen as useful tools in themselves, some negative perceptions of the appropriateness and likely success of screening and ABIs in this environment were expressed by staff. This may have resulted in reluctance to deliver the pilot, and the limited follow up data, although it is recognised that data problems may also have occurred due to other factors outwith staff control. As with other research (Brown et al, 2010) the evaluation has shown that staff attitudes and feelings of whether it was appropriate for them to deliver screening and ABIs has perhaps impacted directly on how the initiative was delivered.

Indeed, low motivation linked to perception of alcohol problems as being of less immediate concern in light of their other issues for clients is perhaps one of the strongest themes emergent from this qualitative analysis. Again, this is not unique to this research and the large scale SIPS trial in England and Wales has also reported reluctance from staff engaged in delivering screening and ABIs where they considered their clients to be ‘heavy drinkers’ and thus beyond the reach of such initiatives as ABI (Cochrane, 2010). From a process view, this maybe suggests a need to adapt training materials for this client group, although it is possible that this still would not overcome some staff reluctance to deliver ABIs if they perceive that they are not appropriate for their client group. A cultural shift in attitudes would be needed, it seems, to fully overcome this problem.

8.2.5 Joined Up Approach
Similarly, it seems that there is considerable scope for educating both staff and clients about the importance of viewing alcohol as something which should not be sidelined or ignored in light of other seemingly larger or more urgent issues. This is crucial, it seems, as otherwise there is a risk of such problems remaining unaddressed. The emphasis needs to be on tackling alcohol problems as part of the client’s wider personal and social needs, rather than in isolation, and perhaps using the opportunity to engage around alcohol issues as a first step towards tackling other issues.

Previous research looking at substance misuse in a female offender population has shown that these women often saw alcohol problems as being of secondary importance in the light of serious substance use with some women viewing alcohol use as an acceptable ‘healthier’ alternative to drugs (Williams & Duncan, 2008). Staff, therefore, need to challenge such views where possible and in order to achieve this, staff views need to be challenged first.

8.2.6 Administration and Costs
The pilot has shown that, on an administrative and resource level, there should be no real barriers to introducing screening and ABIs into community justice settings, although there is clearly some scope for reducing the time taken by staff to deliver the ABI so that it does not impact too greatly on workloads. This could be achieved with better training and it is assumed that, as familiarity with ABIs increased, staff would become more efficient at their delivery.
The process of establishing eligibility, screening and delivering an ABI has been estimated to take around 25 minutes with an estimated cost of just over £67 per person (including overheads). It is recognised, however, that economies of scale could be achieved in a wider uptake of the scheme. This figure needs to be considered against the estimated annual cost of £727m as a result of alcohol-related crime.

8.2.7 Timing of Delivery
Comments were also raised in the evaluation about the timing of screening and ABIs for this group, and there was a strong view that they may capture more people and be of greater use in determining sentencing outcomes if undertaken at the SER stage. There was a feeling that initial appointments with social workers/community service workers did not present the requisite 'teachable moment' (Havighurst, 1952) that ABIs require to have a real impact, since clients are often distracted by their sentencing experience, or have more pressing social issues that need to be addressed. Positioning screening and ABIs at this point in the community justice process would also not be without its problems. For the pilot, it was not selected since it precluded a single point of contact to allow initial and follow-up data to be generated, as well as ensuring client-staff relationship continuity. Further, the later timing meant that the screening and ABI would not interfere with the sentencing process, as well as minimising likely attrition among offenders. It may, however, be worth exploring this option through further testing, since this seems to have received more favour among staff who saw client engagement at this point as being potentially more useful for their client group.

Of course, a counter view may be that screening and ABIs could work better if located later in the community justice process i.e. after the initial appointment with clients. This would remove some of the stresses (and associated concentration/priority issues) mentioned by staff, and could also benefit from an established relationship between staff and clients. Qualitative data from staff interviews suggests that an improvement in staff-client relationships over time may produce more reliable reporting of alcohol use, although this could not be shown from the available screening data. If this were true, however, it could be argued that screening tools such as AUDIT would be of greater reliability and use if employed at a later stage in client’s community justice journey.

8.2.8 Training
A different approach to training may also be required if there was further uptake in this setting. It seems that different levels of training were required for community service and probation staff, with the latter requiring a less intensive training package. The qualitative data from the evaluation also implies that in-house training delivered by staff 'within' the criminal justice context might have been more effective than training delivered by those from a health services background. Trainers with a better knowledge of the criminal justice system may have had a greater appreciation of some of the complexities facing this client
group, and likely issues affecting willingness to take part, and responses to the screening and ABI materials.

The refresher training delivered by the ABI co-ordinator in Area A was well received, particularly the shorter more focussed nature of that training. This may have been because staff had already had an opportunity to work with the tools and so could ask more informed questions, and get more from the day. The co-ordinator was also on site to offer post-training support which may have artificially augmented positive feedback about this training.

8.2.9 Commitment, Motivation and Understanding
The biggest overall process issue, however, seems to have been a lack of commitment from some of the operational staff to deliver the screening and ABIs, linked, it seems, to a lack of understanding around the purpose and likely effectiveness of the pilot, the research model itself, and a perceived lack of engagement with frontline staff during the planning and implementation stages. Messages also appeared to have been lost between co-ordinators and the team-leaders who had line management responsibility for staff since feedback provided by co-ordinators at their meetings with the project advisory group seemed to indicate that the pilot was running smoothly, which was not evidenced in the data returned. Qualitative interviews also suggested that there was inconsistent practice and reluctance to deliver the pilot in some cases, regardless of whether messages were being conveyed from co-ordinators, to team-leaders and then on to staff. Overall, this probably explained the lower than anticipated number of returns, especially at the follow-up stage, and some of the data quality issues that were noted.

Thus, although there have been few practical issues around administering the pilot, a number of attitudinal challenges have been evidenced among some community justice staff which might act as a barrier to implementation of screening and ABI in other operational areas.

8.3 Summary of Impact Findings
The evaluation has not been able to reach any firm conclusions regarding the impact of the pilot due to a lack of data. During the pilot, it was hoped that impact would be measured by analysis of follow-up data from AUDIT proforma, as well as from independent research interviews with clients. In practice, both of these data sources were unable to provide sufficient data to measure impact. Research of this kind benefits greatly from a ‘client view’ and failure to capture their views means that a crucial viewpoint is missed. This is not unique to the current study and has been evidenced in similar work to screen offender populations (Hopkins and Sparrow, 2006).

Although impacting negatively on the pilot, this does offer valuable learning about research which is reliant on data from secondary sources (ie not generated by
the researchers themselves). Future research in this area should, perhaps, adopt a different design with researchers employed directly and proactively to oversee the collection of data and to work closely with staff to ease concerns about recruitment protocols and access to clients. This would not, of course, provide learning about feasibility in ‘real life’ community justice practice, since this level of research support is not sustainable in the long term.

8.4 Other Issues Affecting the Pilot

It has already been noted that staff availability was limited in pilot area A at the same time as the pilot was being implemented (in late 2009). This was unfortunate, and undoubtedly impacted directly on the pilot insofar as it reduced the amount of time that staff were able to give to the pilot in the early stages. Importantly, this resulted in a delay between the training being received (September/October 2009) and the time at which staff felt that they had the time to start the pilot proper (early 2010). A valuable lesson must be learned from this with the need for training to be delivered as close as possible to the time that the ABIs can start. This undoubtedly had a negative impact on the pilot finding its feet, which seemed to resonate for many months into the pilot thereafter.

The internal recruitment protocols which had to be followed delayed the recruitment of a project co-ordinator. It was thought by staff in Area A that if the Project Co-ordinator had been in place from the beginning of the pilot, early operations would have been smoother. It was hoped that when the Project Co-ordinator took up post, some of these problems would be rectified as the pilot would then be more closely supervised, and evidence suggests that this appointment had a positive effect.

8.5 Issues Affecting the Evaluation

Research has shown that evaluation of screening and intervention studies with criminal justice populations can be subject to a number of problems including small samples (Edmunds et al, 1998), obtaining adequate and accurate monitoring and evaluation data (Lapham, 2004/05) and difficulties in establishing causal links between interventions and ‘change’ in drinking behaviours (Hopkins and Sparrow, 2006). In line with the experiences of other similar projects, the community justice ABI pilot evaluation was impacted on negatively by the quality of some (but not all) of the monitoring data that was collected.

Although staff reported that the baseline and screening tools were easy to administer, quality checks on the incoming forms revealed early on that some staff were failing to complete the forms correctly. A small number of baseline questionnaires were returned which did not list valid staff identity or client identity numbers, meaning that it was not possible to ascertain if the questionnaires related to clients in the control or intervention groups. Again, however, this
affected only a small proportion of all forms returned and was something that was less evident in Area A once the dedicated co-ordinator was in post.

Secondly, there seems to have been an element of ‘staff selection bias’ in terms of who was screened. Although all those who met the eligibility criteria should have been screened, some staff seemed to have omitted to do so if they felt that it was not appropriate for their client. This was evidenced in staff interviews where it was reported that conflicting priorities would be used as a reason for not completing the AUDIT (i.e. money, housing or drug issues). The rationale may have had a firm basis in that it may not have been suitable for some clients, and this perhaps indicates a need for a flexible approach where discretion can be used. For the evaluation, however, it did impact on numbers and acted as a barrier.

There was also some evidence that a small number of non-trained staff took part in the process, as indicated by the presence of untrained staff identifiers on returned questionnaires. This will have affected the quality of data collected and purity of the research if only to a small degree.

Although the focus of the evaluation was primarily on processes and feasibility, the limited amount follow up data and the lack of interviews with clients meant that it was difficult to reach any firm conclusions around impact of the pilot. It is recognised that follow-up rates were impacted on by issues around breaches and revoked orders, client consent and attendance at appointments, etc. For the client interviews, staff may have confused these as part of the pilot, and not as part of the research, which was voluntary and required a separate recruitment approach. This should have been clear from the materials that were distributed, however some staff may have felt that if clients had not consented to the research interview as part of their initial assessment, that they should not be invited to take part.

It is also possible that the poor client uptake was a reflection of staff apathy in these areas and the qualitative evidence certainly points towards a reluctance from staff to deliver the pilot to those for whom they felt alcohol was not a ‘key priority’. This impact of staff on client willingness to take part has also been evidenced in other UK criminal justice studies (Brown et al, 2010; Cochrane, 2010), and so is not unique to this pilot. It is also important to stress that some of the staff did engage wholeheartedly with the pilot, and so such assumptions cannot be applied broad brush. It is possible that they existed instead among staff for whom the training had failed to offer the clarity required, and for whom update information from the pilot as it progressed was not made available. There is no attribution of fault in such observations, instead, they are presented here as a learning point for the future.
8.6 Summary of Lessons for the Future

The research has been valuable in highlighting lessons that can be used to inform the application of similar models in the future. The main lessons for the future, and things that would be needed in order to ensure that further uptake of such a scheme could be achieved to maximum effect, seem to be:

- A need for greater involvement of operational staff during the planning and implementation of local screening and ABI practices to ensure that models of working take into account current workloads and client-staff protocols. Service users themselves should also be consulted to ensure that this translates into better engagement with clients.
- A need for targeted, designation-specific training and regular refresher training where needed, to ensure that staff remain motivated and committed to the intervention. Such training must include more education around the potential for better outcomes.
- Adaptation of training materials, as far as possible, specifically for a criminal justice context which may be more convincing for training staff in this context than the standard primary health materials that were used here (including the ABI training DVD and the Making a Change leaflet).
- The presence of a local manager/champion who takes overall responsibility for screening and ABIs and ‘manages managers’ across split sites, if appropriate, so that a consistent approach is adopted to allow for comparable data within and between areas. This is the main workforce development requirement.
- More engagement with front-line staff to provide education and evidence for the effectiveness of ABIs.
- Possible reconsideration of the timing at which screening and ABIs are delivered in the context.

In the event of any further uptake of this pilot model, it is also worth noting that close working with another area with previous experience may greatly assist in smoother implementation and running (i.e. sharing best practice). Potential attitudinal barriers could be overcome from learning from the positive experiences of others, either in community justice, or other settings, to see that ABIs can and do work. It is also important to stress again that many of the staff concerns which may impede the implementation of such a scheme could be reduced or removed over time once staff become more familiar and more confident with delivering screening and ABIs, such that it takes less time to complete, impacts less on workloads and becomes truly embedded into routine practice. The principles of ABIs do, after all, fit well with the overall objective of community and wider criminal justice practitioners to improve health and reduce offending behaviours among their core client group.

Indeed, although the pilot encountered some challenges along the way, it is essential that these are considered against the backdrop of the complex arena in which the pilot was delivered i.e. community justice setting. The complexities of
the client group are notable, in particular the likely prevalence of co-existing personal, social and practical problems for many of those in receipt or POs or COs. Many in this client group may also have ongoing and future links with the criminal justice system more widely, which may make engagement with a pilot of this kind a challenge over time (including, for example, future custodial sentences). The essential thing is that the mandatory engagement with a dedicated worker as part of these orders provides an opportunity to identify and support people whose lifestyles may indeed be chaotic and less suited to more formal or systematic alcohol education approaches.

8.7 Conclusions

The purpose of the study was to support alcohol policy and contribute to the evidence base for ABIs through assessing the feasibility/barriers and potential implications of using this model in day-to-day practice in probation/community service for recently convicted offenders.

Considering the challenges inherent in applying the ABI model to this setting, the pilot has successfully highlighted that the community justice setting does afford an opportunity to reach some of those most at risk of alcohol related harm. The screening results show a high level of need in this population. It addresses a previous gap in evidence on alcohol problems in offenders in the community, whilst adding to the growing evidence base on the prevalence of AUDs in offenders more generally.

The pilot has, therefore, shown that it is possible to deliver ABIs in the community justice setting, providing valuable learning and guidance on how best this might be taken forward.
9. References


University of Sheffield School of Health and Related Research (2006). Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People, University of Sheffield, UK.


Appendix A. Baseline Questionnaire
Screening & Alcohol Brief Interventions in the Community Justice Setting:
Participant Baseline Questionnaire

Staff SWIFT ID: __________  Designation: __________
Setting: Probation □  CS □  Date: __/__/_____
Is this a follow-up appt: Y □  N □ … if yes 3-month □ 6-month □
TO BE COMPLETED BY PROBATION / COMMUNITY SERVICE STAFF

Does the client fulfil all of these criteria? (If not please circle)

- Is aged 18 or over
- Is alert and orientated
- Can read and write English sufficiently well to take part in the study
- Is not severely injured
- Is not suffering with a serious mental health problem
- Is not grossly intoxicated
- Does not have alcohol treatment/education included as a condition of their order
- Is not currently in treatment for alcohol problems
- Has not received screening and/or ABI elsewhere in the past 12 months
- Is not involved in any alcohol research study
- Has provided verbal consent to be screened

If the client meets all the inclusion criteria remember, before continuing, to obtain verbal consent to collect demographic information (below) and to be screened.

Has provided verbal consent to be screened ------------------------------ □  □

REMEMBER - IF THE ANSWER TO ANY QUESTION ABOVE IS 'NO', THE CLIENT DOES NOT MEET THE ELIGIBILITY CRITERIA. PLEASE TERMINATE THIS SURVEY AND STORE THE QUESTIONNAIRE FOR THE RESEARCHER TO COLLECT.

CLIENT DEMOGRAPHIC INFORMATION TO BE COLLECTED BY STAFF

Client SWIFT ID: ___________    Client SCRO No: ___________
DOB: __/__/_____    Male □    Female □    Postcode: ___________
Ethnicity:    White □    Other □…please detail ________________

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Appendix B. Alcohol Use Disorders Identification Test (AUDIT)
Alcohol Use Disorders Identification Test (AUDIT)

AUDIT is for the detection of hazardous or harmful drinking and identifying mild dependence, and is designed to be used as a brief structured interview or self-report questionnaire.

How to complete
These questions will help you ask your patient about the amount of alcohol they have consumed in the last six months. The questions ask about how many standard drinks they have consumed. See below for the number of units of alcohol in some typical drinks.

1 unit of alcohol = 1 standard drink

- Half pint of normal strength beer, lager or cider (4% abv)
- Half a 175ml glass of average-strength wine (12.5% abv)
- One single (25ml) measure of spirits (40% abv)

The following drinks contain more than one unit of alcohol

![Icons and units of alcohol](image)

AUDIT questions

Record the scores in the boxes on the right.

1. How often do you have a drink containing alcohol?
   - Never 0
   - Monthly or less 1
   - 2-4 times a month 2
   - 2-3 times a week 3
   - 4 or more times a week 4

2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?
   - 1 or 2 0
   - 3 or 4 1
   - 5 or 6 2
   - 7-9 3
   - 10 or more 4

3. How often do you have six or more standard drinks on one occasion?
   - Never 0
   - Less than monthly 1
   - Monthly 2
   - Weekly 3
   - Daily or almost daily 4

Score
Alcohol Use Disorders Identification Test (AUDIT)

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   - Never 0
   - Less than monthly 1
   - Monthly 2
   - Weekly 3
   - Daily or almost daily 4

5. How often during the last year have you failed to do what was normally expected from you because of your drinking?
   - Never 0
   - Less than monthly 1
   - Monthly 2
   - Weekly 3
   - Daily or almost daily 4

6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?
   - Never 0
   - Less than monthly 1
   - Monthly 2
   - Weekly 3
   - Daily or almost daily 4

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - Never 0
   - Less than monthly 1
   - Monthly 2
   - Weekly 3
   - Daily or almost daily 4

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - Never 0
   - Less than monthly 1
   - Monthly 2
   - Weekly 3
   - Daily or almost daily 4

9. Have you or someone else been injured as a result of your drinking?
   - No 0
   - Yes, but not in the last year 2
   - Yes, during the last year 4

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
    - No 0
    - Yes, but not in the last year 2
    - Yes, during the last year 4

Add up the scores to the above questions and record here. The minimum score (for non-drinkers) is 0 and the maximum score is 40. **Total score:**

A score of 0–7 indicates low-risk drinking or abstinence therefore eligible for education only.
A score of 8–19 indicates a strong likelihood of hazardous or harmful consumption therefore eligible for a brief intervention.
A score of >19 indicates possible alcohol dependence and these clients should be referred to a specialist service for diagnostic evaluation and possible treatment.
Appendix C. Staff Survey
**Evaluation of Alcohol Brief Interventions (ABIs) – Staff Survey Intervention Group**

### Your Role

**Q1.** Which local authority area do you work in?

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area A</td>
<td>1</td>
</tr>
<tr>
<td>Area B</td>
<td>2</td>
</tr>
<tr>
<td>Area C</td>
<td>3</td>
</tr>
</tbody>
</table>

**Q2.** What is your job title?

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Leader</td>
<td>1</td>
</tr>
<tr>
<td>Community Justice Assistant</td>
<td>5</td>
</tr>
<tr>
<td>Senior Social Worker</td>
<td>2</td>
</tr>
<tr>
<td>Social Work Trainee</td>
<td>6</td>
</tr>
<tr>
<td>Social Worker</td>
<td>3</td>
</tr>
<tr>
<td>Other (please specify in box)</td>
<td>7</td>
</tr>
<tr>
<td>Social Work Assistant</td>
<td>4</td>
</tr>
</tbody>
</table>

**Q3.** What is your role in the operation and delivery of the ABI pilot?

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic manager with no client contact</td>
<td>1</td>
</tr>
<tr>
<td>Operational staff with client contact</td>
<td>2</td>
</tr>
<tr>
<td>Other (please specify below)</td>
<td>3</td>
</tr>
</tbody>
</table>

### Practice before the ABI pilot

**Q4.** Before the ABI pilot, did you provide any information or advice to clients about hazardous and harmful drinking? (please tick all that apply)

- Yes, every client | □ 1
- No, not part of common practice | □ 4
- Only clients who seemed to have an alcohol problem | □ 2
- I have never offered information or advice to clients about alcohol problems before | □ 5
- Only if there was time to do so | □ 3

If yes, please describe the approach that you used
**Training in practice**

Q5. How helpful did you find the ABI training that you received in developing your understanding of hazardous and harmful drinking and how it can be addressed?

<table>
<thead>
<tr>
<th>Very Helpful</th>
<th>Fairly Helpful</th>
<th>Neither Helpful nor Unhelpful</th>
<th>Fairly Unhelpful</th>
<th>Very Unhelpful</th>
<th>Don't Know/Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
</tbody>
</table>

Q6. How helpful was the training to your everyday practice in delivering the ABI pilot?

<table>
<thead>
<tr>
<th>Very Helpful</th>
<th>Fairly Helpful</th>
<th>Neither Helpful nor Unhelpful</th>
<th>Fairly Unhelpful</th>
<th>Very Unhelpful</th>
<th>Don't Know/Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
<td>□ 6</td>
</tr>
</tbody>
</table>

Q7. Have you received any follow-up training since the initial training session?

Yes □ 1  No □ 2

If so, what, how much and by whom?

Q8. Do you feel that you need more training on screening and the delivery of ABIs?

Yes □ 1  No □ 2  Don't Know/Unsure □ 3

If yes, what would you like to see the training cover?
The ABI pilot in practice

Q9. How easy do you find it to fill in the Baseline Questionnaire to determine if your client is eligible for the ABI pilot?

Neither Easy

Very Easy Fairly Easy Neither Easy nor Difficult Fairly Difficult Very Difficult Don't Know/Unsure

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6

Q10. How easy do you find it to administer the AUDIT screening tool to clients?

Neither Easy

Very Easy Fairly Easy Neither Easy nor Difficult Fairly Difficult Very Difficult Don't Know/Unsure

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6

Q11. On average, how long does it take you to fill in the AUDIT screening tool?

Less than 2 minutes □ 1 More than 10 minutes □ 4

3 - 5 minutes □ 2 Don't Know/Unsure □ 5

6 - 10 minutes □ 3

Q12. How often do you use the 'Making a Change' leaflet when working with a client with an appropriate AUDIT score?

I offer it to every client with an appropriate AUDIT score □ 1

I rarely use the leaflet when working with a client □ 4

I offer it to most clients with an appropriate AUDIT score □ 2

I never use the leaflet □ 5

I use it only when I remember □ 3

Q13. Do you think clients seem interested in the 'Making a Change' leaflet?

Yes □ 1 No □ 2 Don't Know/Unsure □ 3

Day-to-day management

Q14. How easy do you find it to deliver an ABI?

Neither Easy

Very Easy Fairly Easy Neither Easy nor Difficult Fairly Difficult Very Difficult Don't Know/Unsure

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6
Q15. On average, how long does it take you to deliver an ABI?

Less than 5 minutes □ 1  More than 15 minutes □ 4
More than 5 minutes but less than 10 minutes □ 2  Don’t Know/Unsure □ 5
More than 10 minutes but less than 15 minutes □ 3

Q16. How much has the delivery of ABIs impacted on your workload?

It has increased my workload a lot □ 1  It has not impacted on my workload at all □ 4
It has increased my workload slightly □ 2  Don’t Know/Unsure □ 5
Sometimes it increases my workload, but not all the time □ 3

Q17. How relevant do you think being able to offer ABIs is to your job?

Neither Relevant nor Irrelevant □ 3
Very Relevant □ 1  Fairly Relevant □ 2  Fairly Irrelevant □ 4  Very Irrelevant □ 5
Irrelevant □ 3  Don’t Know/Unsure □ 6

18a. Who would you contact if you had a query regarding the ABI pilot?

Senior Social Worker □ 1  The trainers from NHS Tayside □ 4
Local CJ ABI Pilot Lead □ 2  I am unsure who to contact □ 5
My colleagues □ 3  Other (please specify below) □ 6

Offender engagement

Q19. How well do you think clients are engaging with ABIs?

They engage well, better than I expected □ 1  I have not delivered an ABI yet □ 4
Engagement varies considerably between clients □ 2  Don’t Know/Unsure □ 5
They do not engage at all □ 3
Q20. What are the main factors that have facilitated the delivery of the ABI pilot in your area?

Other Comments

If you have any other comments, please write them in the box below.

Thank you for completing this questionnaire. Please put your completed questionnaire in the reply paid envelop provided and return.
Appendix D. Pre- and Post-Course Training Questionnaires
Alcohol Screening and Brief Interventions Training in Community Justice setting: pre-course evaluation questionnaire form (A)

Please complete this pre-course questionnaire to help us identify your learning needs and also to provide us with a way of assessing how useful the training course has been.

At the end of training you will be asked to complete a similar questionnaire. So that we can match your pre and post course questionnaire please use your date of birth as a unique number. Information provided on this form will be used to help us identify your learning needs in order to design appropriate training; the post course questionnaire will be used to assess the effectiveness of the training. Information provided will be anonymised.

Day (DD)  Month (MM)  Year (YY)

1. Please circle or write down your job title:

Social worker
Criminal Justice Assistant
Other – please specify:

2. How long have you been in your current post? Please circle one option

A year or less  1
More than 1 year but less than 3 years  2
More than 3 years but less than 5 years  3
More than 5 years but less than 10 years  4
More than 10 years  5

3. Please circle your gender: Female Male
**ALCOHOL AND YOUR WORK**

4. Have you had previous training on alcohol-related issues? *Please circle all of the options that apply to you*

<table>
<thead>
<tr>
<th>I have received training on alcohol related issues.</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have received training on how to support health behaviour change (e.g. smoking, physical exercise, diet).</td>
<td>B</td>
</tr>
<tr>
<td>I have received training on motivational interviewing techniques.</td>
<td>C</td>
</tr>
<tr>
<td>I have completed a formal training course (&gt; 1 day in duration) or have a qualification related to alcohol (please provide details)</td>
<td>D</td>
</tr>
</tbody>
</table>

**Please indicate any previous training on alcohol-related issues or motivational interviewing /health behaviour change you have received.**

Please provide details of training (indicated above) that you have received, year, title of course, length and whether accredited.
5. Your views about alcohol and your work

Please indicate how much you agree or disagree with each of the following statements, on a scale of 1 (strongly disagree) to 5 (strongly agree). Please consider each statement in relation to helping people who are risky or harmful drinkers*, with whom you may come into contact via your work, to reduce or modify their alcohol consumption.

*A risky or harmful drinker is someone who is regularly drinking more than the recommended sensible drinking limits, but who is not dependent on alcohol or considered to be an ‘alcoholic.’

<table>
<thead>
<tr>
<th>Please circle one number for each statement</th>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel that the best I can personally offer risky* drinkers is referral to someone else.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. I feel that I have a clear idea of my responsibilities in helping clients who are considered to be risky drinkers.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. I should not be expected to work with clients who have problems relating to their alcohol consumption.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. I feel that I have the right to ask clients with whom I come into contact, at work, questions about their drinking.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Clients can make good progress towards achieving sensible drinking levels with the right support.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. In general, I feel that the clients with whom I work would be uncomfortable if I asked them about their alcohol consumption.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. In general I feel less sympathy for people who are risky drinkers than for most other clients with whom I work. I feel they make their own problems worse.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. I feel that I am as able to work with clients who are considered to be risky drinkers as with people who are not.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
6. How important do you think it is for you to be able to address the drinking behaviour of clients in your current role? Please circle one option

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
<td>1</td>
</tr>
<tr>
<td>Quite important</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Not very important</td>
<td>4</td>
</tr>
<tr>
<td>Not at all important</td>
<td>5</td>
</tr>
</tbody>
</table>

USING BRIEF INTERVENTIONS ON ALCOHOL

An alcohol brief intervention is a short, evidence-based, structured conversation about alcohol consumption with a client that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.

7. Using brief interventions on alcohol in your work
As this training forms part of a research study, we are seeking the views of all practitioners, though you may only be required to undertake alcohol screening. Please indicate how useful you think you would find using brief interventions in the following scenarios in your work. Please score the usefulness of brief interventions for each situation on a scale of 1 (not at all useful) to 5 (very useful). Circle ‘NA’ if you think that the scenario is not applicable to your work.

Please circle one number for each scenario

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Not at all useful</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You are working with a client whose sentence is related to alcohol.</td>
<td>NA</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2. You are involved in health/lifestyle screening which includes standard questions on alcohol consumption.</td>
<td>NA</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3. You provide support to clients who you suspect has a drinking problem.</td>
<td>NA</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. You suspect your client’s drinking affects their relationships at home.</td>
<td>NA</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5. You provide support for people to help them to cope with stressful times/situations.</td>
<td>NA</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>6. A service user reports having engaged in unsafe sex while drinking.</td>
<td>NA</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7. Clients with whom you work talk about their drinking behaviour from time to time.</td>
<td>NA</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
8. A client asks for advice on how to talk to their child about drugs and alcohol.  

<table>
<thead>
<tr>
<th>Not at all useful</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA 1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

9. Clients with whom you work frequently refer to ‘getting lifted’ or ‘getting into fights’ when they are drinking.  

<table>
<thead>
<tr>
<th>Not at all useful</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA 1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

10. A client asks you where he/she can get advice on how to help their partner to stop drinking so much.  

<table>
<thead>
<tr>
<th>Not at all useful</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA 1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

8. Overall, how relevant do you think being able to offer brief interventions on alcohol is to your job? Please circle one option

<table>
<thead>
<tr>
<th>Very relevant</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quite relevant</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Not very relevant</td>
<td>4</td>
</tr>
<tr>
<td>Not at all relevant</td>
<td>5</td>
</tr>
</tbody>
</table>

9. Please outline any concerns that you have in relation to discussing alcohol with clients and using a brief interventions approach.
10. Please rate how confident you would feel about your knowledge or skills in doing each of the following tasks, on a scale of 1 (not at all confident) to 5 (very confident). Not all of these are tasks you will have to do in your everyday work.

**Please circle one number for each task**

<table>
<thead>
<tr>
<th>Task</th>
<th>Not at all confident</th>
<th>Very confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understand what is meant by the term ‘brief intervention’ in relation to alcohol.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Aware of the evidence base underpinning the delivery of brief interventions on alcohol.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Aware of my own and others’ common attitudes to alcohol and how they can affect practice.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Discussing personal, social, cultural and environmental influences on individuals’ alcohol consumption.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Describe the impact of excessive alcohol consumption on individuals and society in terms of physical and mental health, crime, health inequalities and the economy.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. Understand common concerns about and barriers to raising issues of drinking with clients.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. Able to recognise the indications of alcohol misuse.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. Able to provide information on how to reduce harm caused by alcohol consumption including keeping safe, avoiding unprotected sex etc</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9. Understand unit measures of alcohol and be able to accurately estimate the number of units in a range of common drinks.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10. Understand and explain recommended alcohol limits for different individuals and circumstances (e.g. those on medication, older people or drivers)</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11. Recognise and define common terms used to describe different levels of alcohol consumption, including hazardous drinking, harmful drinking, binge drinking and alcohol dependence.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12. That you have adequate information on the range of services available and how individuals can access them.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all confident</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---------------------</td>
</tr>
<tr>
<td>13.</td>
<td>Able to raise awareness about alcohol its effects proactively or when raised by the client.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>14.</td>
<td>Able to carry out screening and referral assessment for those misusing alcohol, including the provision of feedback and brief advice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>15.</td>
<td>Recognise and then respond appropriately to (including making referrals as necessary) clients who may be alcohol dependent or have other problems that might indicate a need for additional support and help.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>16.</td>
<td>Able to access up to date information and advice on alcohol and its effects on health and social well being.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>17.</td>
<td>Able to establish, sustain and disengage from discussions on alcohol with individuals.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>18.</td>
<td>Able to encourage clients to take personal responsibility for their drinking behaviour and changing their behaviour.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>19.</td>
<td>Able to promote individuals rights and acknowledge their views without being judgemental.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>20.</td>
<td>Give advice on how to cut down drinking and enable individuals to adopt safe practices associated with drinking.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>21.</td>
<td>Use motivational interviewing styles to enhance clients’ motivation to change.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>22.</td>
<td>Provide a range of options for individuals who wish to cut down their drinking, and set goals and monitor progress.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>23.</td>
<td>Build the confidence of clients in their ability to make changes (self-efficacy).</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>24.</td>
<td>Support individuals in developing coping strategies to help to prevent a return to their former drinking levels.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>25.</td>
<td>Able to provide resource materials and personal advice on alcohol misuse and its impact on health and well being.</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
11. Overall, in your work, how confident or not are you in helping clients address their drinking behaviour? 
*Please circle one option*

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>1</td>
</tr>
<tr>
<td>Quite confident</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Not very confident</td>
<td>4</td>
</tr>
<tr>
<td>Not at all confident</td>
<td>5</td>
</tr>
</tbody>
</table>

**EXPECTATIONS**

12. We would like to know how important the learning outcomes are to you in terms of helping you in your work. Please rate the following list of learning outcomes on a scale of 1 (not at all important) to 5 (very important). *Please circle one number for each learning outcome*

<table>
<thead>
<tr>
<th>Learning Outcome</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of problems due to alcohol-related harm, and their impact on individuals, families and communities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Understanding of the impact that personal and cultural attitudes to alcohol consumption have on working in this area.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of alcohol units and daily and weekly drinking limits.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ability to recognise the signs and symptoms of alcohol misuse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ability to use appropriate guidance, screening and intervention tools.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Communication skills in raising the issue of alcohol with clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Communication skills in using alcohol screening tools.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Communication skills in using collaborative motivational approaches as part of a brief intervention.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of resources and locally based referral pathways.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

NHS Health Scotland Alcohol screening and Brief Interventions: pre-course evaluation questionnaire form (A).
13. Please outline your views on undertaking the training and alcohol misuse both positive and negative.

Thank you for completing this form.

Please return the form to ....... by.........
Alcohol Screening and Brief Interventions Training in Community justice Setting: post-course evaluation questionnaire form (B)

Please complete this post course evaluation form this will be used to assess the impact of training on your perception of knowledge and skills gained during the training and will help us identify areas where the training needs strengthened.

All of your comments will be made anonymous.

Please write your date of birth, which serves as your reference number and allows us to link this form with the pre course questionnaire you completed before the course (ddmmyy):

[ ] [ ] [ ] [ ] [ ]

We use your reference number (date of birth) so that we don’t have to ask you for background/monitoring information again. Please write this number clearly, as it is very important for our evaluation.
1. Your views about alcohol and your work

Please indicate how much you agree or disagree with each of the following statements, on a scale of 1 (strongly disagree) to 5 (strongly agree). Please consider each statement in relation to helping people who are risky or harmful drinkers*, with whom you may come into contact via your work, to reduce or modify their alcohol consumption.

*A risky or harmful drinker is someone who is regularly drinking more than the recommended sensible drinking limits, but who is not dependent on alcohol or considered to be an 'alcoholic.'

<table>
<thead>
<tr>
<th>Please circle one number for each statement</th>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel that the best I can personally offer risky* drinkers is referral to someone else.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. I feel that I have a clear idea of my responsibilities in helping clients who are considered to be risky drinkers.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. I should not be expected to work with clients who have problems relating to their alcohol consumption.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. I feel that I have the right to ask clients with whom I come into contact, at work, questions about their drinking.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Clients can make good progress towards achieving sensible drinking levels with the right support.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. In general, I feel that the clients with whom I work would be uncomfortable if I asked them about their alcohol consumption.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. In general I feel less sympathy for people who are risky drinkers than for most other clients with whom I work. I feel they make their own problems worse.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. I feel that I am as able to work with clients who are considered to be risky drinkers as with people who are not.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

2. How important do you think it is for you to be able to address the drinking behaviour of clients in your current role? Please circle one option

<table>
<thead>
<tr>
<th></th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
<td>1</td>
</tr>
<tr>
<td>Quite important</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Not very important</td>
<td>4</td>
</tr>
<tr>
<td>Not at all important</td>
<td>5</td>
</tr>
</tbody>
</table>

USING BRIEF INTERVENTIONS ON ALCOHOL

An alcohol brief intervention is a short, evidence-based, structured conversation about alcohol consumption with a client that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.
3. Using brief interventions on alcohol in your work

As this training forms part of a research study, we are seeking the views of all practitioners, though you may only be required to undertake alcohol screening. Please indicate how useful you think you would find using brief interventions in the following scenarios in your work. Please score the usefulness of brief interventions for each situation on a scale of 1 (not at all useful) to 5 (very useful). Circle ‘NA’ if you think that the scenario is not applicable to your work.

<table>
<thead>
<tr>
<th>Please circle one number for each scenario</th>
<th>Not at all useful</th>
<th></th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You are working with a client whose sentence is related to alcohol.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. You are involved in health/lifestyle screening which includes standard questions on alcohol consumption.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. You provide support to clients who you suspect has a drinking problem.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. You suspect your client’s drinking affects their relationships at home.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. You provide support for people to help them to cope with stressful times/situations.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. A service user reports having engaged in unsafe sex while drinking.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Clients with whom you work talk about their drinking behaviour from time to time.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. A client asks for advice on how to talk to their child about drugs and alcohol.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Clients with whom you work frequently refer to ‘getting lifted’ or ‘getting into fights’ when they are drinking.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. A client asks you where he/she can get advice on how to help their partner to stop drinking so much.</td>
<td>NA 1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Overall, how relevant do you think being able to offer brief interventions on alcohol is to your job? Please circle one option

<table>
<thead>
<tr>
<th></th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very relevant</td>
<td>1</td>
</tr>
<tr>
<td>Quite relevant</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Not very relevant</td>
<td>4</td>
</tr>
<tr>
<td>Not at all relevant</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Please rate how confident you NOW feel about your knowledge or skills in doing each of the following tasks, on a scale of 1 (not at all confident) to 5 (very confident). Not all of these are tasks you will have to do in your everyday work.

<table>
<thead>
<tr>
<th>Please circle one number for each task</th>
<th>Not at all confident</th>
<th>Very confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understand what is meant by the term ‘brief intervention’ in relation to alcohol.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not at all confident</td>
<td>Very confident</td>
</tr>
<tr>
<td>---</td>
<td>---------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>2.</td>
<td>Aware of the evidence base underpinning the delivery of brief interventions on alcohol.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3.</td>
<td>Aware of my own and others' common attitudes to alcohol and how they can affect practice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.</td>
<td>Discussing personal, social, cultural and environmental influences on individuals’ alcohol consumption.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5.</td>
<td>Describe the impact of excessive alcohol consumption on individuals and society in terms of physical and mental health, crime, health inequalities and the economy.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>6.</td>
<td>Understand common concerns about and barriers to raising issues of drinking with clients.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.</td>
<td>Able to recognise the indications of alcohol misuse.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>8.</td>
<td>Able to provide information on how to reduce harm caused by alcohol consumption including keeping safe, avoiding unprotected sex etc</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>9.</td>
<td>Understand unit measures of alcohol and be able to accurately estimate the number of units in a range of common drinks.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>10.</td>
<td>Understand and explain recommended alcohol limits for different individuals and circumstances (e.g. those on medication, older people or drivers)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>11.</td>
<td>Recognise and define common terms used to describe different levels of alcohol consumption, including hazardous drinking, harmful drinking, binge drinking and alcohol dependence.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>12.</td>
<td>That you have adequate information on the range of services available and how individuals can access them.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>13.</td>
<td>Able to raise awareness about alcohol its effects proactively or when raised by the client.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>14.</td>
<td>Able to carry out screening and referral assessment for those misusing alcohol, including the provision of feedback and brief advice.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>15.</td>
<td>Recognise and then respond appropriately to (including making referrals as necessary) clients who may be alcohol dependent or have other problems that might indicate a need for additional support and help.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>16.</td>
<td>Able to access up to date information and advice on alcohol and its effects on health and social well being.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>17.</td>
<td>Able to establish, sustain and disengage from discussions on alcohol with individuals.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>18.</td>
<td>Able to encourage clients to take personal responsibility for their drinking behaviour and changing their behaviour.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>19. Able to promote individuals rights and acknowledge their views without being judgmental.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>20. Give advice on how to cut down drinking and enable individuals to adopt safe practices associated with drinking.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>21. Use motivational interviewing styles to enhance clients' motivation to change.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>22. Provide a range of options for individuals who wish to cut down their drinking, and set goals and monitor progress.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>23. Build the confidence of clients in their ability to make changes (self-efficacy).</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>24. Support individuals in developing coping strategies to help to prevent a return to their former drinking levels.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>25. Able to provide resource materials and personal advice on alcohol misuse and its impact on health and well being.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

6. How much of an impact would you say the training course has had on your knowledge and skills in relation to the following learning outcomes, on a scale of 1 (very little) to 5 (a great deal)?

**Please circle one number for each learning outcome**

| Knowledge of problems due to alcohol-related harm, and their impact on individuals, families and communities. | 1 2 3 4 5 |
| Understanding of the impact that personal and cultural attitudes to alcohol consumption have on working in this area. | 1 2 3 4 5 |
| Knowledge of alcohol units and sensible drinking guidelines. | 1 2 3 4 5 |
| Ability to recognise the signs and symptoms of alcohol misuse. | 1 2 3 4 5 |
| Ability to use appropriate guidance, screening and intervention tools. | 1 2 3 4 5 |
| Communication skills in raising the issue of alcohol with clients, using screening tools and collaborative motivational approaches as part of a brief intervention. | 1 2 3 4 5 |
| Knowledge of resources and locally based referral pathways. | 1 2 3 4 5 |
7. Overall, in your work, how confident or not are you NOW in helping clients to address their drinking behaviour?  
*Please circle one option*

<table>
<thead>
<tr>
<th>Confidence Level</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>1</td>
</tr>
<tr>
<td>Quite confident</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Not very confident</td>
<td>4</td>
</tr>
<tr>
<td>Not at all confident</td>
<td>5</td>
</tr>
</tbody>
</table>

8. How helpful or not do you think the course has been to you in your work?  
*Please circle one option*

<table>
<thead>
<tr>
<th>Helpfulness Level</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very helpful</td>
<td>1</td>
</tr>
<tr>
<td>Quite helpful</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Not very helpful</td>
<td>4</td>
</tr>
<tr>
<td>Not at all helpful</td>
<td>5</td>
</tr>
</tbody>
</table>

**NEXT STEPS**

9. How likely are you to take the following actions as a result of this training?  
*Please circle option 1, 2 or 3 for each action, and write down any additional ones*

<table>
<thead>
<tr>
<th>Action</th>
<th>Probably</th>
<th>Possibly</th>
<th>Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do more reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Do more training</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Encourage colleagues to attend training</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Find out about other agencies to which to refer patients/service users</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other – please specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Which, if any, of the following factors are likely to affect your ability to deliver alcohol-related brief interventions (ABI) to your clients?  
*Please circle option 1, 2 or 3 for each factor, and write down any additional ones*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Critical</th>
<th>Useful</th>
<th>Not needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longer client appointment times</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Administrative support to record brief interventions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Support from other colleagues to deliver ABI</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Support from senior staff/managers to deliver ABI</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Critical</td>
<td>Useful</td>
<td>Not needed</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>Appropriate consulting area in which to deliver ABI</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Ability to allocate time, given competing priorities</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Greater knowledge and skills with regard to delivery of ABI</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other – please specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. What element(s) of the training did you find most useful, and why?

12. How might the training be improved? Please write down any suggestions or comments:

13. Please add any other comments you wish to make about the course or its delivery:

Thank you for taking the time to complete this evaluation. Please hand in your form before you leave.
Appendix E. Discussion Guides
MVA Consultancy has been commissioned by NHS Scotland to undertake a process and impact evaluation of a pilot study for the delivery of Alcohol Brief Interventions (ABIs) to offenders with hazardous or harmful drinking in the Community Justice Setting.

The evaluation seeks to contribute to the evidence base for ABIs by assessing the feasibility/barriers for implementation (and potential effectiveness) of using this intervention in day-to-day practice in probation/community service for recently convicted offenders.

The evaluation involves a mixed method approach, including:

- desk-based documentary and secondary data analysis;
- an online survey for operational staff;
- depth interviews with a sample of professional stakeholders and operational staff;
- client case studies; and
- a resource and cost analysis exercise.

We are inviting you to participate in the work as you have been identified as one of the main stakeholders for the pilot.

We appreciate your participation in the research, and remind you that your participation is voluntary, and that you can withdraw at any time or can decline to answer any individual questions or sections you do not feel comfortable answering. We also undertake to treat your personal details in confidence and will not pass your details to any third party. Please be assured that this research is being conducted in accordance with the Code of Conduct of the Market Research Society and the Data Protection Act.

Your responses will form part of the final report, due in March 2011 and any reporting of the data collected as part of this research will be done in such a way that it is not possible to identify individual respondents. Any direct quoting of responses will not be attributed to you individually and quotes will only be used to support findings presented at the thematic level.

We anticipate that the interview should last around one hour and we thank you again in advance for your time and co-operation.

**Target groups for interview are local co-ordinators (or equivalent) in all three pilot sites.**

Please sign below to indicate that you are aware of the requirements of the research and that you have provided informed consent:

NAME: ____________________________________________

DATE: ___________________________________________
Opening Questions

1 - Please can you begin by describing your job role to me? **Prompt:** How long have you held this position? What did you do before taking up your current post?

2 - Please explain your understanding of the Community Justice ABI pilot in Scotland? **Prompt:** What are the aims and objectives of the scheme, and how did it come about?

3 - What is your role in the ABI pilot? **Prompt:** How did you become involved with the ABI pilot?

4 - Can you explain what you expect the main outcomes of the pilot to be? **Prompt:** For example, feasibility of implementing ABIs in this setting; reduced alcohol consumption and so improved health and wellbeing for offenders and their families, potential reduction in re-offending (safer communities), signpost into treatment those with alcohol dependency?

Planning, Set Up and Management

5 - How was the project initially designed/set-up in this area? **Prompt:** Who was involved in the planning and set up of the scheme? How were decisions made about how it would run?

6a – What were the positive learning outcomes when setting up and implementing the project? Can you provide details? **Prompt:** Increased knowledge of the problem, better team working, etc?

6b - Did you experience any challenges with the set up and implementation of this project? **Prompt:** How were these overcome? Can you provide details?

7 - To date, how do you think the pilot is running? **Prompt:** Do you think that the pilot is running as it was originally intended? If not, why not? If so, what factors have facilitated this?

8 - To what extent has including ABIs impacted on:

- your own workload?
- the workload of staff?

9 - Have you had any feedback from staff regarding the delivery of the ABI pilot? **Prompt:** If so, what?

10 - Did you attend the training course? **Prompt:** If so did you find this useful? Which aspects did you find particularly useful/not useful?

11 - Did you receive feedback from your staff about the training course? **Prompt:** If so, what did they say? Why do you think they said this/did they provide any reasons for this?

12 - Could the training course be improved in any way? If so, how?

13 - In routine practice, is this stage the best place to deliver an ABI for offenders? If not, can you suggest an alternative? Please explain.

14 – Are there any local strategic approaches to dealing with offenders with alcohol problem in the local area? **Prompt:** Please describe.

15 - Please can you describe if/how the ABI pilot links in with the local strategic approach to dealing with offenders with alcohol problem in the local area?

16 - Are there any local steering or management groups to which progress on the ABI pilot is reported to?
Prompt: If so, please explain the reporting arrangements/accountability.

17 - Who would you discuss with if you had a concern/question about the ABI pilot? Prompt: This may be operational questions/concerns or strategic concerns.

18 - Do you feel supported in delivering the CJ ABI Pilot? Prompt: What kind of support and input do you receive from more senior managers?

19 – How would you describe the commitment within the organisation to the pilot? Prompt: Has the pilot been embraced at a higher level? Do you have a feel for whether it would receive longer term support, beyond the life of the pilot?

**Resource issues**

20 - What resources have been provided for implementing this pilot? Prompt: Where have these resources come from?

21 - Are these resources sufficient? Prompt: accommodation, staff time, etc.

22 - Have you needed to overcome any finance/resource difficulties? If so how did you achieve this?

23 – Do you foresee any resource issues if integrating screening and ABIs into routine practice for community justice services across Scotland? Prompt: Please explain.

**Learning for the Future**

24 - What do you think have been the main successes and challenges of delivering screening and ABIs within community justice services in this area?

25 - What are the main factors that have facilitated the delivery of the ABI pilot in your area?

26 - What do you perceive to be the longer term benefits of ABIs?

27 - Have there been any barriers to the running of the ABI pilot in your area? Prompt: Is so, please specify.

28 - What is your view about the potential roll out of the scheme across Scotland? Prompt: what do you think would be the main problems/advantages associated with roll out? Is there anything that could be learned from this pilot to assist in the roll out of the scheme elsewhere?

**Thank and close**

Thank you for your time. Do you have any questions that you would like to ask me, or is there anything that I have not already covered that you would like to mention?

As explained, we will be bringing together the findings from these interviews along with interviews with policy, strategic and operational staff, to prepare a draft report for the Evaluation of Alcohol Brief Interventions in the community justice setting, due in March 2011.

Can I just ask, are you happy for us to re-contact you if we need to seek clarification on any of the issues discussed today, when we are preparing our report?

Many thanks again.
MVA Consultancy has been commissioned by NHS Health Scotland to undertake a process and impact evaluation of a pilot study for the delivery of Alcohol Brief Interventions (ABIs) to offenders with hazardous or harmful drinking, in the Community Justice setting.

The evaluation seeks to contribute to the evidence base for ABIs by assessing the feasibility/barriers for implementation and the potential effectiveness of using this intervention in day-to-day practice in criminal justice, for recently convicted offenders.

The evaluation involves a mixed method approach, including:

- desk-based documentary and secondary data analysis;
- an online survey for operational staff;
- depth interviews with a sample of professional stakeholders and operational staff;
- client case studies; and
- a resource and cost analysis exercise.

We are inviting you to participate in the work as you have been identified as a member of the operational staff team involved in the delivery of the pilot.

We appreciate your participation in the research, and remind you that your participation is voluntary. If you do choose to take part, you can withdraw at any time and/or can decline to answer any questions you do not feel comfortable answering. We also undertake to treat your personal details in confidence and will not pass your details to any third party. Please be assured that this research is being conducted in accordance with the Code of Conduct of the Market Research Society and the Data Protection Act.

Your responses will contribute to the final evaluation report, due in 2011. We would stress that any reporting of the data collected as part of this research will be done in such a way that it is not possible to identify individual respondents. **Any direct quoting of responses will not be attributed to you individually and quotes will only be used to support findings presented at the thematic level.**

We anticipate that the interview should last no longer than one hour and we thank you again in advance for your time and co-operation.

Please sign below to indicate that you are happy to take part in the research and that you have provided informed consent to be interviewed:

NAME: ______________________________________________________________________________

DATE: ______________________________________________________________________________

Thank you
Opening Questions

1 - Please can you begin by describing your job role to me? **Prompt:** How long have you held this position? What did you do before taking up your current post?

2 - What is your role in the ABI pilot? **Prompt:** What are you required to do on a day-to-day basis as part of the pilot?

3 – What do you think are the main aims of the pilot? **Prompt:** What do you think the pilot hopes to achieve?

Set Up, Training and Support

4 – How do you feel about the way that the pilot was introduced in your area? **Prompt:** Were you consulted/involved in the development/implementation of the pilot in your area? How did you first learn about the pilot?

5 - Who would you discuss with if you had a concern/question about the ABI pilot? **Prompt:** Do you feel supported in delivering the CJ ABI Pilot? What kind of support do you receive?

6 – Can you confirm, did you attend the pilot training course before you started working on the pilot? **Prompt:** If so, did you find this useful? Which aspects did you find particularly useful/not useful? Could the training course be improved in any way? If so, how?

7 - Did you feel prepared for the pilot starting?

Pilot in Practice

8 - How easy do you find it to complete the Baseline Questionnaire to determine if your client is eligible for the ABI pilot?

9 - How easy do you find it to administer the AUDIT screening tool to clients? How long does this generally take you?

10 - Has the AUDIT screening tool improved your practice? **Prompt:** Has it improved the appropriateness of your referrals to other services?

11 - To what extent has asking questions from the Baseline Questionnaire and AUDIT Screening Tool impacted on your day-to-day workload? **Prompt:** Is it easily accommodated?

12 - Can you describe what happens when a client does not consent to participate? **Prompt:** Can you provide an insight into the characteristics of those who refuse, any reasons offered for refusal, etc. What you think could be done to improve uptake?

13 - How often do you use the 'Making a Change' leaflet when working with a client with an appropriate AUDIT score? Do you know if clients find this leaflet helpful/useful?

14 - In routine practice, in your opinion, is this stage of the community sentence process the best place to deliver an ABI for offenders? If not, can you suggest an alternative? Please explain why you think this.

**CONTROL GROUP GO TO QUESTION 19. INTERVENTION GROUP, PLEASE CONTINUE.**
Delivering an ABI (Intervention Group only)

15 - How easy do you find it to deliver an ABI? Are there any problems you frequently encounter when delivering an ABI?

16 - On average, how long does it take you to deliver an ABI? Does this impact on your workload, and if so, how do you deal with this? **Prompt:** Is it easily accommodated?

17 - How do clients generally respond to receiving an ABI? **Prompt:** How well do you think clients are engaging with ABIs? I.e. positively/negatively, interested/disinterested.

18 - Has the ABI improved your practice? If so, in what ways?

Learning for the Future

19 - Do you think the pilot has ‘worked’ from a process/delivery point of view?

20 - What are the:

- main strengths/positive aspects of the pilot? **Prompt:** For example, is it providing an additional tool to educate clients about alcohol problems, increasing staff knowledge and skills?
- main weaknesses/negative aspects of the pilot? **Prompt:** For example, encouraging clients to take part, fitting it into current workload, length of time it takes to complete Baseline Questionnaire/AUDIT/ABI.

21 – What, if anything, would you yourself do differently if you were starting this pilot again?

22 - What would you like to see as the main outcomes of this pilot?

23 – Finally, do you have any questions that you would like to ask me, or is there anything that I have not already covered that you would like to mention?

Thank and close

Thank you for your time.

We will use the feedback that you have given to us today to help inform the final evaluation report, along with data from interviews that we have already completed with policy, strategic and managerial staff.

Can I just ask, are you happy for us to re-contact you if we need to seek clarification on any of the issues discussed today, when we are preparing our report?

Please feel free to contact us again at any time, if there is anything else you wish to add, or if you have any further questions about the research. A copy of the report will be published by NHS Health Scotland and a copy will also be made available to local staff on completion.

Many thanks again.
ABI Pilot Client Consent Form

MVA is a research company that has been asked to collect your views of the Alcohol Brief Interventions (ABIs) pilot running being run in your area by Criminal Justice Social Work, so that those responsible for running the scheme get to hear what you think about it.

Your worker will have had a brief conversation with you at the start of your Probation/Community Service Order about how much alcohol you drink, the impact of alcohol on your health and wellbeing, and ways of reducing your alcohol consumption. They may have also given you a leaflet to take away and read about ways of changing your drinking behaviour.

We would like to meet with you to ask you about your experience of being involved in the pilot. We are interested in hearing your ideas about whether the scheme was helpful to you, and the things that you like or dislike about the scheme. No names will be passed on, so your feedback is anonymous. Meeting with us is completely voluntary – you do not have to take part.

If you are prepared to take part, we will arrange a time and place that suits you to meet with us. We have just a few short questions to ask, and the meeting should take no more than 30 minutes. You can see the questions before you decide if you want to take part. Just ask the person who gave you this form and they will show you the questions.

Please be assured that this research is being conducted in accordance with the Code of Conduct of the Market Research Society and the Data Protection Act. Taking part in this research will not affect the way in which you are treated by the criminal justice social work staff or by the Court. Your feedback will be used to inform those responsible for running the pilot so that they are aware of your experience and views. Again, we can assure you that no names or other identifying features will be passed on, so your feedback is anonymous. We would like you to be as honest as possible in giving your views.

Please sign below to indicate that you are happy to take part in the research and that you have provided informed consent to be interviewed:

NAME:

________________________________________________________________________

DATE:

________________________________________________________________________

The person who gave you this form will now arrange a time and date for you to meet with us.

Thank you
1 - Have you ever had the Alcohol Brief Intervention pilot explained to you? If so, by whom, and what did they say?

2 – In just a few words, please can you explain what you understand an Alcohol Brief Intervention to be?  
*After response, follow up with brief explanation/reminder of what the ABI entails again.*

3 - Why did you agree to take part in the pilot?  
*Prompt:* What were you hoping to get out of being involved in the pilot? Did you consider not taking part? If so, why?

4 – Was the information and advice that you were given (verbally) during the ABI interaction easy to understand? Why do you say that?

5 – Did you receive a ‘Making a Change’ leaflet? Did you read it/use it? If so, did you find this leaflet helpful/useful? Why do you say that?

6 – Do you think the conversation that you had (including the advice and information that you were given) has impacted on your drinking behaviour? If so, how?  
*Prompt:* Physical, psychological, social and financial impacts? Other changed behaviour?

7 – Have you taken part in an Alcohol Brief Intervention/had a conversation about your drinking anywhere else? If so, where, when and with whom?  
*Prompt:* Police station, court, was previously in treatment, etc.

8 – Do you think that talking to someone about your alcohol consumption in the criminal justice setting is a good idea? Why do you say that?

9 - Is there anything about the Alcohol Brief Intervention which you think could be improved?  
*Prompt:* Any other information you would have liked? A different way of approaching the conversation?

10 - Is there anything else you would like to add, or any questions that you would like to ask us?

Thank you for your time.

We will use the feedback that you have given to us today to help inform the final evaluation report, along with data from interviews that we have already completed with operational staff and managerial staff involved in the pilot.

Please feel free to contact us again at any time, if there is anything else you wish to add, or if you have any further questions about the research.

*Many thanks again.*