

# Brief Alcohol Interventions in Social Service and Criminal Justice Settings: A Critical Commentary

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## Abstract

Screening and brief interventions (BI) have been shown to be effective in the management of alcohol consumption for non-treatment-seeking heavy drinkers, who are at physical and social risk, but not yet dependent. The robust evidence base for the effectiveness of BI in primary health care suggests an implementation in other settings could be beneficial. Given the association between alcohol and social problems, social work has a long history of working with persons with alcohol-use disorders, and social workers are often the first service provider to come into contact with heavy-drinking individuals. This critical commentary summarises the existing literature on BI effectiveness in social services and criminal justice settings, and discusses to which extent the social work field might be a promising area for BI delivery.

**Keywords:** screening and brief interventions, alcohol use disorders, social services, criminal justice

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## Introduction

Alcohol impacts significantly upon individuals, families and communities. In addition to the well-documented health harms ([Lim \*et al.\*, 2012](#)), heavy drinkers may experience social harms such as family disruption, interpersonal violence ([Anderson \*et al.\*, 2009](#)), involvement in crime, problems within the workplace and financial problems ([Rehm, 2011](#)). Moreover, it is estimated that 30 per cent of children aged under sixteen years in the UK (3.3–3.5 million) live with at least one parent with an AUD ([Manning \*et al.\*, 2009](#)). Parental alcohol misuse has been found to be associated with adverse childhood experiences ([Dube \*et al.\*, 2001](#); [Laslett \*et al.\*, 2010](#)) and poor outcomes for children ([Newbury-Birch \*et al.\*, 2009](#); [Kendler \*et al.\*, 2013](#)). The impact upon the community ranges from minor noise disturbances and property damage ([Laslett \*et al.\*, 2010](#)) to severe violence and alcohol-related assault ([Hughes \*et al.\*, 2008](#)) and can also lead to wider social harms, including dependence, social stigma and social exclusion ([Anderson \*et al.\*, 2009](#)). Indeed, a multi-criteria decision analysis that combined risk of harm to self and others found alcohol to be most harmful drug, ranked above heroin and crack cocaine ([Nutt \*et al.\*, 2010](#)). Given the extensive array of social harms relating to heavy drinking, intervening in order to reduce the risk of harm is a priority. Brief interventions (BI) for alcohol have been shown to be effective in the management of alcohol consumption for non-treatment-seeking heavy drinkers, who are at physical and social risk, but not yet dependent ([Kaner \*et al.\*, 2009](#); [Saitz, 2010](#); [Lim \*et al.\*, 2012](#)).

## Brief interventions

Brief intervention is a secondary preventive activity, aimed at individuals who are drinking excessively or in a drinking pattern that is likely to be harmful to their health or well-being ([Kaner \*et al.\*, 2009](#)). The concept of brief intervention comprises a range of interventions that differ in length (mostly five to forty minutes), intensity and delivery frequency (typically one to four sessions). Brief interventions can consist of very short personalised feedback on alcohol intake in relation to recommended limits, discussion of associated health risks or may comprise of a set of personal targets, up to forms of psychological counselling and motivational interviewing, as, for example, summarised in the FRAMES approach (Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy; see [Miller \*et al.\*, 1991](#)). Typically they are applied to opportunistic, to individuals whose drinking places them at risk of harm, delivered by practitioners other than addiction specialists.

There is a large amount of high-quality evidence of the effectiveness of BI with adults who have an alcohol-use disorder ([Kaner \*et al.\*, 2007](#)). Most of the evidence for brief alcohol intervention in non-treatment-seeking groups is

within primary health care (Ockene *et al.*, 1999; Ballesteros *et al.*, 2004; Whitlock *et al.*, 2004; Bertholet *et al.*, 2005; Littlejohn, 2006; Kaner *et al.*, 2007; Ockene *et al.*, 2009; Saitz, 2010), but other settings have learned from these studies and examined the benefits for their service users and patients. Recent reviews of interventions in educational settings to reduce the harm associated with adolescent substance use outlined the positive potential of brief alcohol intervention with young people (Toumbourou *et al.*, 2007; Carney and Myers, 2012; Mitchell *et al.*, 2013). Individual studies also show effect in emergency departments and general hospital wards (Nilsen *et al.*, 2008; McQueen *et al.*, 2011) and with pregnant women within antenatal care (O'Connor and Whaley, 2007; Marais *et al.*, 2011).

Social services in their various forms potentially represent an important field for brief intervention delivery. Social workers practice across a wide range of areas with the primary goal of intervening with individuals in need. Given the association between alcohol and social problems, social work has a long history of working with persons with alcohol or substance use disorders (Bliss, 2009) and, as such, are well placed to conduct secondary preventative intervention. In a US survey on a large and representative sample of social workers, 71 per cent of respondents reported having taken some action related to substance abuse diagnosis and treatment in the preceding twelve months with clients, whereas only 2 per cent stated substance use disorders being their primary practice area (Smith *et al.*, 2006). Delivering brief intervention within a social service setting may enable the capitalisation upon the 'teachable moment' wherein individuals are able to consider their alcohol use within the context of their contact with the helping professional, as has been shown to be beneficial within primary health care (Babor *et al.*, 1986). Thus, these settings may be another valuable point of contact to populations and target groups who are not necessarily reached within health care settings.

## Evidence for brief interventions within social services settings

There are few studies which measure effectiveness of brief alcohol interventions within a social service setting and those that have vary widely in terms of setting and service user populations. In a systematic search for literature on the effectiveness of brief alcohol interventions in social service settings (published in the English language between 2002 and 2013, controlled study design, measurements of effectiveness, an intervention duration up to forty minutes), we found a small number of only six studies (seven publications) that met our inclusion criteria. Three studies examine BI within homeless populations, two of which include homeless adolescents (Peterson *et al.*, 2006; Baer *et al.*, 2007) and one study with homeless war veterans

([Wain et al., 2011](#)). One study has been conducted in a community-based drug and alcohol counselling centre ([Shakeshaft et al., 2002](#)). A further three studies have been conducted in the criminal justice setting, either in the context of participants arrested for driving while intoxicated (DWI) offences ([Wells-Parker and Williams, 2002](#); [Brown et al., 2010](#)) or violent offences while intoxicated with alcohol ([Watt et al., 2008](#)). These studies show mixed results for the effectiveness of BI.

[Peterson et al. \(2006\)](#) examined the effect of brief intervention with homeless substance using adolescents aged fourteen to nineteen years. They recruited 285 homeless adolescents from street intercepts and drop-in centres and randomised them to brief motivational enhancement or one of two control groups (assessment only or assessment at follow-up). This study did not find any changes in alcohol measures, but adolescents who received brief motivational enhancement reduced drug use (other than marijuana) significantly more than those within the control groups at one-month follow-up. This effect was not detected at three-month follow-up. Given the multiple social, psychological and health problems often experienced by homeless adolescents, one may conclude that a brief intervention of around thirty minutes is simply not sufficient to intervene with such needs. However, instability and transience characterise the lives of homeless youth, resulting in intensive and sustained intervention being hard to achieve. As such, [Peterson et al. \(2006\)](#) report that BI provide an opportunity to intervene with those not seeking treatment.

Endeavouring to build upon what they considered to be promising results, the research group repeated this study extending the clinical protocol to include a multiple-session brief intervention ([Baer et al., 2007](#)). They found overall reductions in alcohol use at three-month follow-up and also reductions in other drug use, but no effect of intervention condition. However, service utilisation was significantly greater in adolescents in receipt of the brief intervention at one-month follow-up although this effect was not present at three-month follow-up.

A study by [Wain et al. \(2011\)](#) measured the effectiveness of a single session of motivational interviewing upon treatment entry and completion among homeless veterans with alcohol dependency. Programme entry was significantly higher in the brief intervention group (95 per cent versus 71 per cent;  $p = 0.017$ ) and also length of stay, treatment completion and graduation were higher, although these findings failed to reach significance ([Wain et al., 2011](#)). This study supports the novel use of brief intervention with dependent treatment seekers in order to enhance treatment entry and support engagement with more intensive interventions.

One study, comparing brief intervention with cognitive behavioural therapy (CBT) within a community drug and alcohol service, demonstrated non-inferiority of brief intervention. Within this study, there was no significant difference in alcohol outcomes with both groups showing comparable decreases in alcohol-related problems, as measured by the Alcohol Problem Questionnaire (APQ; [Williams and Drummond, 1994](#)). Client satisfaction between

the group receiving brief intervention and the group receiving CBT were also found to be comparable at six-month follow-up. However, brief intervention was found to have better cost-effectiveness (Shakeshaft *et al.*, 2002).

Watt *et al.* (2008) conducted a study examining intervention with violent offenders comparing brief intervention against assessment only and found comparable reductions in both conditions for weekly units, number of drinking days, AUDIT scores and heavy episodic drinking. Furthermore, no difference in recidivism rates could be determined during the twelve-month follow-up period. They consider the higher proportion of individuals with AUDIT scores >20 in the brief intervention group as a possible explanation for non-effectiveness of brief intervention. However, it should be noted that significantly lower rates of injury (unintentional and self-harm) were reported in the brief intervention group (27.4 per cent versus 39.6 per cent) (Watt *et al.*, 2008).

Results of the two remaining criminal justice studies showed positive between-group findings favouring BI which approached significance. A study with DWI recidivists found drinking reductions between six and twelve months' follow-up of marginal relevance (Brown *et al.*, 2010). It should be noted, however, that nearly half of their sample fulfilled current alcohol dependence criteria, which could have reduced the intervention effect. Service utilisation was assessed also with no effect on the sum of days of inpatient or outpatient treatment was found during the twelve-month follow-up period. Wells-Parker and Williams (2002) investigated differential effects on individuals with high versus low depression scores (as measured by the sadness/depression subscale of the Mortimer-Filkins questionnaire). Although they failed to determine an overall superiority of adding two brief intervention sessions and a follow-up to standard treatment, rates of DWI recidivism were significantly lower among highly depressed participants receiving the extended brief intervention (16.7 per cent extended brief intervention versus 25.6 per cent standard treatment). In this study, the highly depressed group had, at baseline, more motivation to change, but self-efficacy was lower. The authors discuss this being a reason why additional, individual BI sessions had significant effects only in this subgroup, insofar as the enhancement of self-efficacy might be an active ingredient of BI in individuals who are willing to change but who lack the confidence to be able to.

## Comment

Social workers are often the first service provider to come into contact with individuals with alcohol-use disorders (Smith *et al.*, 2006). The high proportion of alcohol users on social work caseloads, and the social harms associated, result in social workers viewing alcohol intervention as a legitimate social work role (Loughran *et al.*, 2010). The motivational work inherent within some forms of brief intervention may offer an opportunity to work

with the seemingly ubiquitous resistance found within child and families social work (Forrester *et al.*, 2012). However, as the vast majority of social work contacts occur in non-substance specialist services, social workers often report difficulties in this role (Galvani *et al.*, 2013) and a lack of knowledge on how to intervene to promote change (Galvani and Hughes, 2010). Brief interventions are designed to be delivered opportunistically, at the point of contact with non-substance specialists. Training social workers to deliver brief alcohol interventions is likely to improve social workers' confidence and competence to work with risky drinkers, as has been found to be the case in other settings (Babor *et al.*, 2004).

This critical commentary has considered the evidence for brief alcohol intervention in social service settings. We have found that BI in this setting show promise, although the findings should be interpreted with some caution. The social service setting and the service user populations varied widely, making it difficult to generalise the findings beyond very small sub-groups. Moreover, there are crucial gaps within the literature, with important settings and populations not yet considered.

The majority of the studies of BI in the social service setting have been conducted in the USA, raising questions over their generalisability to other countries. To date, there has been no research of brief intervention within statutory social work settings. Given the often involuntary nature of statutory social work involvement, there are likely to be contextual issues which may influence the effectiveness of the intervention or the feasibility of its delivery (Medical Research Council, 2008). Moreover, social work is at the forefront of protecting vulnerable adults and children from harm, within which alcohol is often a significant factor (Forrester and Harwin, 2006; Smith *et al.*, 2006). However, there has been no research into BI within the context of adult or child welfare. The absence of brief intervention studies within the social work and social service settings represents a missed opportunity.

Nonetheless, the research conducted in social service settings has demonstrated the potential for BI to have a positive impact on a range of outcomes. These settings offer valuable 'teachable moments', such as getting arrested or experiencing significant social problems, as well as others yet to be researched. To successfully reach target groups of risky drinkers, therefore, research should not seek to solve the question of whether BI for alcohol generally 'work' (National Institute for Health and Clinical Excellence, 2010), but rather explore which target groups could be best reached in which settings, alongside the question of whether the barriers or constraints demonstrated in some settings would prevent their successful implementation (Medical Research Council, 2008). One might also raise the question whether a focus on drinking reductions is a realistic and achievable first-line goal for all target groups that social service professionals might come into contact with. The studies with homeless people (who generally have more needs and numerous impairments other than alcohol abuse) suggest that brief approaches may be unlikely to reduce drinking levels in certain patient populations

(Peterson *et al.*, 2006; Wain *et al.*, 2011; Baer *et al.*, 2007), but that other factors might be successfully addressed, such as rates of entry in addiction treatment (Wain *et al.*, 2011) and service utilisation (Baer *et al.*, 2007). For certain client groups, BI approaches might thus more serve as a ‘door-opener’, in the sense of enabling referral to other services, and should not be seen as a tool which directly influences the amount of drinking. Given the large evidence base in health care settings which has taken years to accrue, social work would gain from this experience, accelerate the evaluative process (also see Kaner (2010)) and achieve the potential benefits for clients in a shorter time frame.

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