DRUG & ALCOHOL FINDINGS Matrix cell

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# Alcohol Treatment Matrix cell A5: Interventions; Safeguarding the community

S No use ordering 'chronic drunks' to AA or treatment (1967). Identified by reviews (1; below) as one of just three randomised trials of self-help groups. It found that a court order to attend an alcohol clinic or AA meetings did not reduce arrests compared to no treatment – if anything, the reverse. The authors', originally optimistic about the interventions, ended by concluding that their findings "offer no support for a general policy of forced referrals to brief treatment." Related review below. Discussion in bite's *Issues* section.

S Disulfiram backed by sanctions helps reform repeat alcohol-related offenders (1966). In the early '60s in Atlanta in the USA, a pioneering trial tested whether faced with another spell in jail, 'skid-row' repeat drunkenness offenders would instead take a drug which generates deterrent physical reactions to alcohol. Most did, belying their supposedly hopeless condition. The Effectiveness Bank commentary describes an early trial (1983) in London which tested a similar programme with similar results. Discussion in bite's *Issues* section.

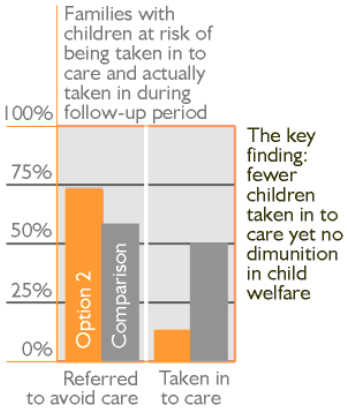
K No significant benefits from court-ordered treatment in England (2011). In the English Midlands introduction of court-ordered treatment for problem-drinking offenders on probation could not be shown to have reduced re-offending more (though the reductions were substantial) than previous probation arrangements. Similar evaluations in Lancashire (2010), West Yorkshire (2011) and nationally ([UK] Ministry of Justice, 2009) also found considerable improvements but did not benchmark these against any, or any adequate, comparison groups. Discussion in bite's *Issues* section.

K ASRO programme did not cut crime (2011). No impact on reconviction from main group therapy programme for UK problem substance users on probation. See also similar UK findings (2012) from the same cognitive-behavioural family of interventions applied to drink-driving. Discussion in bite's *Issues* section.

K No crime-reduction dividend from offering brief counselling to drunk arrestees ([UK] Home Office, 2012). UK government-funded pilot schemes found no crime-reduction benefits from brief alcohol counselling for arrestees under the influence of drink, confounding hopes that these 'arrest referral" schemes would help quell late-night alcohol-related disorder. The schemes did however uncover many dependent drinkers. Discussion in bite's *Issues* section.

K Minimal 'drinking too much' warning works as well as brief interventions in UK probation services (2014). Largest alcohol screening and brief intervention evaluation yet conducted in Britain found risky drinking rates fell as much after the most minimal intervention as after more sophisticated and longer alternatives, but these might have impacted more on recidivism. A similar Scottish study did not directly test effectiveness. Discussion in bite's *Highlighted study* and *Issues* sections.

K Intensive support for problem drinking parents enabled children to stay at home (Welsh Assembly Government, 2008). Found that a service which worked intensively over a few weeks with substance using parents (their problems mainly involved alcohol) whose children faced imminent care proceedings forestalled their removal from the home. Later evaluation (2012) of the same service confirmed this was not at the expense of the children's welfare ▶ chart. Similar schemes were implemented across Wales and have been evaluated (2014). Related guidance below. Discussion in bite's *Issues* section.

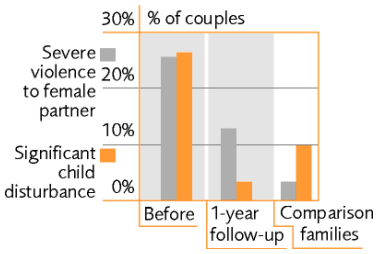



K Intensive support for 'troubled families' yielded no demonstrable benefits for children or parents ([UK] Department for Education, 2011). Evaluation of national payment-by-results scheme to 'turn round' troubled families in England found substantial remission in substance use problems, but could not attribute these to the interventions. Final evaluation report (2016) found that relative to comparison families, there were no significant impacts on drinking or outcomes related to employment, job-seeking, school attendance, or anti-social behaviour. Related guidance below. Related discussion in bite's *Issues* section.

K Therapeutic orientation improves outcomes of child care proceedings in London (2016). First UK family drug and alcohol court achieved lastingly better parental and child outcomes at lower cost ([UK] Home Office, 2012). The authors said "there was a sound basis for comparing outcomes" but the families allocated to the family drug and alcohol court versus usual care proceedings derived from different boroughs and were not randomly assigned. Related guidance below. Discussion in bite's *Issues* section.

K Support the relatives in their own right (2011). Brief primary care counselling seemed to help relatives in England cope with living with a problem drinker, but without a control group against whom to benchmark the outcomes the study could not be sure the outcomes were due to the interventions.

K Patient-focused treatment aids wives and children too (2003 and 2006). Even when treatment is focused on the individual problem drinker, families benefit from reduced violence and improved child welfare ▶ chart. Discussion in bite's *Issues* section.




K Most impact from (when feasible) couples therapy (2009). Anti-violence benefits for partners greatest when they join with the dependent drinker in couples-based therapy which addresses relationships as well as drinking. See also other couples-therapy reports focused on male (2004) or female (2009) drinkers and British advice (2007) on how to avoid the risk that couples therapies might provoke partner abuse. Related review below.

R Routine alcohol treatment can reduce domestic violence (2009). When successful, alcohol treatment in general results in reduced violence between sexual partners; couples therapy has yet greater impacts, but is not always (2007) safe or feasible. Related studies above. Discussion in bite's *Issues* sections (1 2).

R Family programmes can improve prospects of children of problem substance users (2012) Of the reviewed programmes, most

effective were those which involved both parents and children, particularly the Strengthening Families Programme (2004). Related guidance below. Discussion in bite's *Issues* section.

R Alcohol treatment prevents injuries (2004) ... and also causes of injury such as violence and accidents; same lead author was responsible for an earlier review (1999) analysed for the Effectiveness Bank. Similar message tentatively emerged from another review analysed (2000) for the Effectiveness Bank. Discussion in bite's *Issues* section.

R Is therapy undermined by a punishment context? (2005). Asks whether in criminal justice settings, the contradictions of helping and punishing at the same time ('motivational arm-twisting') undermine interventions which might work elsewhere – in particular, the supposedly client-centred motivational interviewing style of counselling.

R How to stop drink-drivers reoffending (2006). Includes the "encouraging" results from rehabilitation programmes. Related guidance below.

R Encourage but don't coerce AA attendance (1999) Synthesis of studies concludes that people forced to attend AA do worse than when coerced instead into professionally run treatments or left to their own devices, but when AA is chosen it records statistically significant advantages over alternatives. Related seminal study above.

G Offender management guidance for England and Wales ([UK] National Offender Management Service, 2010); Treating prisoners in Scotland (Scottish Prison Service, 2011). Official guidance on the commissioning, management and delivery of interventions for alcohol misusing offenders, dating from before the transfer of responsibility for treatment in prison to the NHS. Discussion in bite's *Highlighted study* section.

G Managing alcohol problems in prisoners (World Health Organization, 2012). Based on UK experience, offers an integrated model of best practice in care for problem-drinking prisoners, including a consideration of specific types of treatments. Discussion in bite's *Where should I start?* section.

G Developing and providing effective services for the children of problem drinkers (accessed 2017). Funded by the UK charity Comic Relief, a web resource to help managers, commissioners and practitioners develop and provide effective services for children whose parents misuse alcohol.

G Treating the drink-driver (Health Canada, 2004). Authors reviewed evidence and consulted experts to arrive at recommended education and treatment and rehabilitation approaches to alcohol/drug impaired driving. Related review above.

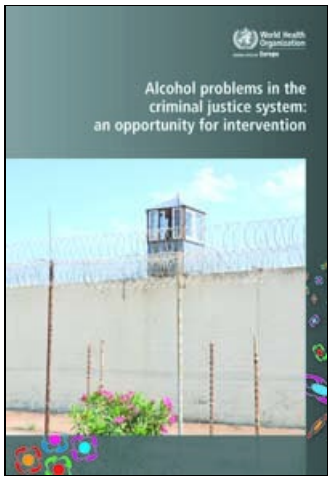
MORE This search retrieves all relevant analyses.
For subtopics go to the subject search page or hot topics on supporting families, testing and sanctions and protecting children.

## Close Matrix Bite

**Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text**

**What is this cell about?** About treatment funded or ordered to safeguard the wider community, or studies of whether treatment in general has a safeguarding impact. Treatment focuses on the welfare of the individual patient, but it may be funded and organised by authorities whose primary motivation is to safeguard the wider community. In these cases, treatment is offered or imposed not because the substance user has sought it, but because it is thought that treating their substance use could result in benefits to the community. Typically these take the form of reductions in crime including drink-driving and violence, but also reductions in non-criminal behaviour which the community finds offensive and/or which degrades the local social or physical environment. Treatment not organised primarily for these purposes may nevertheless have these benefits; studies and reviews documenting these effects are also included in this cell. Also here are interventions which focus on the welfare of the children and families of problem drinkers in their own rights, rather than primarily as a means to promote the welfare of the drinker.

**Where should I start?** A thought-provoking starting point is guidance from the World Health Organization (WHO) on treating problem-drinking prisoners. Though international, it was drafted by a team from Scotland and drew extensively on UK experience, so doubles as a good-practice guide for the UK.




The publication's cover (▸ illustration right) poses the key dilemmas. On it we find side by side an optimistic subtitle ("An opportunity for intervention") seemingly belied by a forbidding concrete wall topped with barbed wire. How could such an environment offer "opportunity" for productive intervention, and even if it did, would the benefits persist beyond the highly controlled and atypical environment created by the walls and the wire? And yet of course, the same walls should create the alcohol-free (and less successfully, drug-free) 'dry space' within which productive intervention seems feasible. To a degree the same contradiction is found across the criminal justice system ▸ below.

In recognising that prison "can be both a help and a hindrance", the guidance acknowledges the dilemma. Though prison "enforces an environment of abstinence", this is "however, artificial and does not ... enable prisoners to practise their newly acquired knowledge about drinking in moderation or coping skills for preventing relapse".

In your opinion, how well does WHO's guidance address this core issue? You might also test its suitably tentative recommendations against the evidence presented in this cell. For example, considered promising (but mainly on the basis of non-prison work) are the brief interventions dealt with in row 1 of the matrix. Results from the sole randomised evaluation in a prison setting cited in the guidelines were not entirely negative, but overall unconvincing; the same can be said of related non-prison studies from England (more in Highlighted study section) and Scotland.

**Highlighted study** WHO's guidance on dealing with alcohol problems in prison (discussed above) is not

alone in considering brief interventions promising for problem-drinking offenders. Drawing on guidance from outside the criminal justice sector, Britain's National Offender Management Service also considers these suitable for non-dependent problem drinkers.

Neither sets of guidance authors would have had available to them the final published results of the government-funded SIPS alcohol brief interventions trials in England discussed in cell A1. One of the three sub-studies was set in 20 probation offices, by far the largest UK randomised trial of alcohol advice or counselling for offenders. Results from these offices were similar to those from GPs' surgeries and emergency departments: there were no great differences between how well the screening methods identified risky drinkers, nor in drinking reductions after three interventions of varying intensity. These ranged from a straightforward and very terse warning not intended to be a brief intervention at all, to a five-minute brief intervention and most extensively, an additional 20 minutes of counselling at (in the probation arm) a further appointment with a specialist alcohol worker. In probation as in other settings, these two brief intervention formats recommended by Britain's National Offender Management Service (NOMS) were no more effective at reducing drinking than a straightforward warning.

However, the probation arm of the SIPS study did throw up a partial exception to the overall non-superiority of the brief interventions. Police records revealed that over the next 12 months, offenders offered either of the more extended interventions were significantly less likely to be reconvicted (36% and 38% v. 50%) than offenders given only the straightforward warning. With so many outcomes tested, this could have been a chance finding due to a relatively high reconviction rate among the brief-warning offenders. Given no greater impacts on drinking, the authors themselves queried whether the findings reflected a real effect. Assuming a real effect, it seems possible that more intense drink problems among offenders than among patients in the other arms of the study afforded scope for them to respond better to the brief interventions, which (unlike the straightforward warning) both addressed the risks of offending while under the influence of drink. Remember though, that without a no-intervention comparator, there is no way of knowing whether *any* of the three interventions were better than doing nothing at all.

> *Are the SIPS results enough to overturn NOMS's recommendations on brief interventions?*

Are the results of the SIPS study – intended after all to inform UK government policy – enough for you to overturn NOMS's recommendations on brief interventions for offenders and to revert to a simple, no-training-needed, 'Don't drink; it's bad for you' warning? To be precise, SIPS was unable to reject the possibility that such a warning worked as well (or as badly) as research- and theory-informed brief interventions. That is not the same as saying it proved they were equivalent. Would abandoning brief interventions for offenders on this basis risk throwing the baby out as well as the bathwater?

## Issues to consider and discuss

▸ **Why is the record so poor?** Look through the studies in this cell and you might spot an unfortunate trend in the criminal justice studies. It starts with the seminal US study from the 1960s. Assuming arrests reflect crime, this found (read the researchers' conclusions) court referral of "chronic drunk arrestees" to 12-step mutual aid or to treatment was in crime-reduction terms at best ineffective and possibly counterproductive. Then we go through the British record, accumulating little or no evidence for court-ordered treatment, the popular cognitive-behavioural family of interventions, for brief counselling of arrestees under the influence of drink, or for brief counselling as opposed to merely giving a health warning to heavy-drinking offenders on probation. There is a relatively bright spot from trials of the alcohol-deterrent drug disulfiram. Allied with legal pressure to take, disulfiram seemed to help regular alcohol-related offenders become abstinent in the USA and England, but in both cases there was no control group against whom to benchmark the results. When this is missing from a study, we cannot know whether the findings were due to the intervention, or would have happened anyway.

Regardless of whether it produces positive or negative findings, rigorous research of any kind is in short supply. When in 2014 the UK Ministry of Justice looked at the evidence they found that "Overall, there is currently insufficient evidence to determine the impact on reoffending of alcohol treatment for offenders." A review for the Scottish health service came to similar conclusions: "... in the criminal justice setting ... there is limited evidence that explores the suitability or effectiveness of alcohol interventions or treatment of any kind".

Perhaps absence of evidence reflects the relative absence of research which could produce this evidence, rather than the ineffectiveness of the interventions – certainly possible, for example in respect of court-ordered treatment in the British context. Or is it that the contradictions of helping and punishing at the same time ('motivational arm-twisting' as we termed it) undermine interventions which might work in other settings? Conceivably, adding a coercive element to treatment makes it seem to the 'patient' less like treatment, and they respond less like a patient, reducing effectiveness. That was the clear but not entirely certain implication of a review of evaluations of interventions for offenders, which graded them on the dimension of voluntariness versus coercion. It discovered that the impact of treatment increased in line with the degree to which the offender was free to choose the treatment. Could this be why the record seems stronger for the impact of voluntarily-entered

> *The contradictions of helping and punishing at the same time might undermine treatment*

generic treatment programmes than for treatment aimed at offenders (1 2 3)? Instead of extending the net of legally coerced treatment, should we seek to maximise the attractiveness and availability of treatment in general so that a higher proportion of offenders *choose* this rather than being coerced in to it? Or is this an unrealistic ideal which would miss the unmotivated and could never reach enough offenders whose drinking is affecting not just them, but their families and the rest of society?

**Research is *motivated*** The sudden death (see panel in the linked analysis) of a researcher after accusations that he had covered up the falsification of his research data offers a tragic and extreme illustration of the fact that like every other action we make, research is a motivated endeavour. Nothing entailing this deliberation and effort is undertaken and completed without emotion and motivation to move it. A dispassionate, unconcerned observer, with nothing to lose or gain, simply would not be bothered.

The deceased was a leading researcher on behavioural couples therapy, the approach which seems to have the most solid evidence base in respect of curbing crime in the home and improving the lives of the drinker's family. There is no specific reason to doubt that record, but it is a concern that most of the studies have been led by the developers of the programmes being evaluated, and that when they have not, though still positive, results have been less convincing. In general we can have more faith in findings when the researcher has no interest in validating versus invalidating the intervention being tested – in particular, when it is not 'their' intervention – than when their reputation, self-esteem, and/or career and income, could hinge on the results.

We can perhaps have even more faith when the results *go against* their desires and/or expectations, as in the seminal US study, which its creators expected to confirm their earlier observations that court-ordered treatment helped cut crime amongst regular heavy drinkers, and the British SIPS trials (discussed above), which against expectations generally found an abrupt health warning as effective as scientific, theory-based counselling. In both the shock was delivered by the 'randomised controlled trial' format. It reminds us that done well, this entails the researcher engineering a level playing field and ensuring they can have no hand in which option rises to the top, meaning it can deliver results which force them to think again.

**Can it ever be safe to leave children with dependent drinkers?** In England in 2014/15 roughly 120,000 alcohol-dependent adults had perhaps 200,000 children living with them in the household. In Scotland in 2008–10 between 36,000 and 51,000 children were estimated to be living with alcohol-dependent parents or guardians.

Is it simply too risky to leave their children with the most severely affected of these parents, even if the parents are in treatment, and even if they appear to have successfully completed it? If substance dependence at least *behaves* like a chronic relapsing condition, and even if that is only broadly valid for treatment populations, relapse is to be expected after treatment, and with it, renewed risk to the child. In recent years in England, about a third of the treatment caseload have been returning to treatment, presumably having relapsed after their previous treatments.

But what if, as well as treatment of dependence, intensive resources were targeted at strengthening the family and improving parenting – an expert family therapist available 24 hours a day, seven days a week, even if only over four to six weeks? This kind of specialist 'family preservation' service has been tried and evaluated in Wales and in Middlesbrough. Independent researchers found the services prevented the need to permanently place children in care, and reduced time spent in temporary placements. Crucially, over a follow-up period averaging five to six years, one of the Welsh studies was able directly to confirm that reduced resort to care had not been at the expense of the children's welfare; there was no indication that the service had inadvertently harmed children by helping keep them with their families.

> *Is the risk of relapse and with it the risk to the children simply too great?*

The results were convincing enough for the Welsh government to roll out similar services across Wales, initially concentrating on families where there is parental substance misuse and concern over child welfare. Regulations stipulate that teams providing the services must consist of at least five professionals including a social worker, nurse and health visitor, perhaps an attempt to address the need to maintain quality highlighted by researchers. An evaluation concluded that at three first-phase sites, the new schemes "appeared to improve short-term outcomes for a good number of families", though, staff felt, less so for a few with "very chaotic lives and serious multiple issues". There was evidence directly from the families that their lives and those of the children had improved, but with no comparison group, it is unclear whether the interventions were the cause of the improvements.

Do you find the results to date convincing? Remember that the parents in the initial trials were not dabblers in drink or drugs, but had problems serious enough to take them to the brink of losing care of their children. Is the risk of relapse to dependent substance use and with it the risk to the children simply too great? Or is the greater risk to unnecessarily blight children's lives by taking them in to care? Of course, these decisions must be made case-by-case, but still on the basis of an understanding of the general and likely balance of risk and benefit. To help you work through the issues and for more background, read our hot topic on protecting the children of problem substance users.

An alternative is to get the family courts involved (what the family preservation services try to make unnecessary, saving costs), but to use the court's powers to collaboratively arrange intensive treatment and support from a specialist team allied with the court, and to judicially monitor parents' progress while the

children are under the care of court-appointed guardians. Like drug courts generally, these ‘family drug and alcohol courts’ back the treatment process with the leverage available to the court. They also provide immediate, legally-backed safeguards for the children. On the evidence from the UK, they seem to have greater success than usual care proceedings in achieving long-term family stability whilst keeping more children with their parents.

It is worth finishing this section with a reminder that *in itself*, successfully treating substance use problems is likely to improve child welfare because it reduces conflict and violence (1 2) in the family and makes competent parenting more possible. Treatment services can and have gone further, offering specific parenting and family support, potentially forestalling the need for the more intensive services discussed above. There seems a case for making parenting and child welfare support available to all problem substance using parents in treatment. Because not predicated on the parent admitting to shortcomings in their child’s upbringing and welfare (which many will be reluctant to do) or this being discovered, these programmes can reach families in need of help who would otherwise be missed or feel stigmatised. Examples are given in our hot topic on protecting children, and researchers based in the UK who specialise in substance misuse in families have offered recommendations for addiction treatment services based on a review of the international literature.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