

Containment and care? A qualitative interview study exploring police custody staff views about delivering brief alcohol interventions to heavy drinking arrestees.

McGovern, R.¹ Crowe, L.¹ Addison, M.² Hickman, M.³ Kidger, J.³ McColl, E. PhD ¹Newbury-Birch, D.⁴, Kaner, E.¹

¹ Institute of Health & Society, Newcastle University, Newcastle upon Tyne, UK

² Department of Social Sciences, Northumbria University, Newcastle upon Tyne, UK

³School of Social and Community Medicine, University of Bristol, Bristol, UK

⁴School of Health and Social Care, Teesside University, Middlesbrough, UK

Corresponding author: Ruth McGovern, Institute of Health & Society, Newcastle University, Newcastle upon Tyne, UK; tel: +44 191 2087045 Fax: +44 191 2086043; email: r.mcgovern@ncl.ac.uk

Abstract

Heavy alcohol use and associated needs are prevalent amongst arrestees. The custody suite offers an opportunity to identify and intervene with this population. However, it is unclear whether functions of care can be effectively delivered within an environment of containment. This study aimed to examine custody staff experiences of screening and delivering brief alcohol interventions to heavy drinking arrestees. Qualitative interviews were conducted with 25 custody staff (detention officers and assessment, intervention and referral staff), involved in a pilot feasibility trial of alcohol screening and brief interventions in the police custody suite. We examined the tension between containment and care using concepts of role security and therapeutic commitment to guide our analysis. Our findings show that custody staff considered brief interventions to be legitimate in the custody suite setting, although there were differing views relating to which staff are best placed to deliver them. Detention officers reported vacillating therapeutic commitment to intervening with heavy drinking arrestees, compounded by some arrestees being perceived to be 'undeserving' of care. Tensions inherent in the need for 'containment' as well as 'care' must be addressed if brief alcohol interventions are to be implemented within the custody suite.

Introduction

Heavy alcohol use is a major public health and criminal justice issue. Epidemiological research shows that heavy drinking causes mortality, morbidity and social problems (World Health Organisation, 2014). Arrestees in police custody have been found to have high rates of heavy drinking (Orr, McAuley, Graham, & McCoard, 2015). Between 64% and 84% of arrestees in UK police custody are heavy drinkers (Newbury-Birch et al., 2016) compared to 24% of the general population (Drummond et al., 2005). Specific rates for alcohol dependence range from 21% to 38% (Newbury-Birch et al., 2016) compared to around 4% in the general population (Drummond et al., 2005). In France almost 60% of arrestees in police custody are heavy drinkers (Chariot, Beaufrere, et al., 2014; Gerardin et al., 2017) and 14% are daily drinkers (Gilard-Pioc, Dang-Hauter, Denis, Boraud, & Chariot, 2013).

Heavy drinking arrestees have significant health needs and vulnerabilities, and have been found to be at increased risk of death following their contact with the criminal justice system (Independent Office for Police Conduct, 2018). In a Dutch sample, almost 50% of arrestees in the custody suite receiving a health intervention were diagnosed with mental health problems, with substance abuse as the main reason for consultation (Dorn et al., 2014). Further to the high prevalence rates and health implications of heavy alcohol use within the arrestee population, there is a substantial international evidence demonstrating an association between alcohol use and crime. In half of all violent crimes in England and Wales either the victim or perpetrator had been drinking alcohol within the 4 hours before the incident (Flatley, Kershaw, Smith, Chaplin, & Moon, 2010), with further studies demonstrating a causal link between alcohol consumption and violence (Felson & Staff, 2010; O'Meara, Witherspoon, Hapangama, & Hyam, 2012) and crimes such as burglary and robbery (Felson & Staff, 2010). It has been estimated that a quarter of all police time is spent dealing with alcohol-related incidents (G. Palk, Davey, & Freeman, 2007); the combined cost of which to the UK economy is £11 billion per annum (Home Office, 2013) whilst alcohol-related crime costs the US economy \$73.3 billion per annum (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011).

A number of environmental strategies have been implemented to tackle alcohol-related crime, including national and local policies to reduce alcohol consumption by manipulation trading hours and outlet density as well as policing interventions and the enforcement of licensing regulations (Jones, Hughes, Atkinson, & Bellis, 2011; Liu, Ferris, Higginson, & Lynham, 2016; G. Palk, Freeman, & Davey, 2010). Further, alcohol treatment systems have been developed to interface within the criminal justice pathway in order to address the clinical needs of heavy drinking offenders. Alcohol arrest referral schemes have been piloted in the UK (A. Birch, Dobbie, Barnsdale, McIvor, & Yates, 2006; Kennedy et al., 2012; McCracken, McMurrin, Winlow, Sassi, & McCarthy, 2012). These schemes are typically provided by third sector organisations and employ alcohol identification and referral workers (AIRS) to provide in-reach into the custody suite. Whilst positive effects have been reported, it is not possible to attribute this reduction to the alcohol intervention due to the absence of a control group (Kennedy et al., 2012; McCracken et al., 2012) and wide variability in how services were delivered, as well as by whom (A. Brown et al., 2013). Similarly, mental health liaison and diversion services have been introduced in a number of police custody suites (Scott, McGilloway, M., Browne, & Donnelly, 2013; Srivastava, Forrester, Davies, & Nadkarni, 2013). Within the UK system, external partners such as health and voluntary sector organisations with close alignment to priorities of care, also work within the custody suite; responding to a range of health and social care needs.

Amidst the evolving alcohol treatment system and wider health care within the custody suite, there has been an increasing emphasis in recent years placed upon the role of police custody staff to respond to the wider health and social care needs of arrestees (Chariot & Heide, 2018; Her Majesty's Inspectorate of Constabulary (HMIC), 2015; HM Government., 2009). There has been a call for accurate health screening, followed by appropriate interventions within the custody suite (McKinnon, Thomas, Noga, & Senior, 2016), fuelled by a persistently high number of deaths (2009-2018) during or following police contact, many of which are self-inflicted (Independent Office for Police Conduct, 2018; Kinner et al., 2015). At the same time there has been a philosophical shift towards diversionary approaches which aim to reduce future reoffending throughout the criminal justice system (HM Government., 2009). Large numbers of arrestees receive health interventions, either

through referral to emergency departments (Dorn et al., 2018) or from a health practitioner within the custody suite (Lepresle, Taprest, & Chariot, 2018). The focus upon arrestee welfare occurs against a backdrop of a continued need to enforce the law, introducing a continuum between care and containment. The tension between these two functions presents difficulty; police personnel are more likely to perceive victims and witnesses as being vulnerable compared to those suspected of committing an offence (Her Majesty's Inspectorate of Constabulary (HMIC), 2015) and detention officers (DOs) often experience difficulty in identifying arrestees who require additional care (Home Office, 2017). The variety of staffing contributes to a lack of consensus within the custody suite as to what makes an arrestee vulnerable as well as reinforcing a separation between functions of care and functions of containment. Nonetheless, police custody has been highlighted as the best opportunity to affect change in offenders, emphasising the importance of early intervention to address the vulnerabilities and health care needs, which are frequently linked to offending behaviour (Lord Bradley, 2009).

Brief alcohol intervention is a secondary preventative intervention, which aims to reduce alcohol consumption and related harm in heavy drinkers who are not seeking treatment. Intervention usually follows a positive alcohol screening test. There are broadly two approaches intervention: brief advice which seeks to raise awareness of alcohol-related risks and extended brief intervention which is a brief counselling intervention based upon motivational interviewing techniques (National Institute for Health and Clinical Excellence, 2010). A large and robust evidence for screening and brief interventions shows efficacy in primary health care settings, wherein a statistically significant reduction in alcohol consumption in heavy drinking patients and improved health outcomes have been shown (Kaner, 2012; Kaner et al., 2007). This evidence has resulted in a recommendation to implement alcohol screening and brief interventions in a wide range of UK settings, including the criminal justice system (National Institute for Health and Clinical Excellence, 2010), highlighting the potential to capitalise on the teachable moment within novel settings (Babor, Ritson, & Hodgson, 1986). However, evidence relating to alcohol screening and brief interventions in the criminal justice setting is limited (Newbury-Birch et al., 2016). A large randomised controlled trial of alcohol screening and brief intervention delivered to

adults subject to community disposals found that neither brief advice nor brief counselling to be more effective than minimal intervention at reducing alcohol use. However, a statistically significant effect was found for brief counselling compared to minimal intervention and a reduction in offending behaviour (Newbury-Birch et al., 2014).

A small number of studies have examined the feasibility of health and social care providers screening and delivering brief alcohol intervention in the custody suite (Chariot, Lepresle, et al., 2014; Lefevre et al., 2018) and other non-health settings (Giles et al., 2016; McGovern et al., 2018; Newbury-Birch et al., 2014; Webb, Shakeshaft, Sanson-Fisher, & Havard, 2009). At present, it is unclear whether screening and brief interventions can be delivered by custody staff within a pressurised context of containment. Further, little is understood about whether the role of the delivery agent is a persuasive feature. This paper examines the acceptability of screening and brief intervention in a police custody setting. Custody staff's experiences of identifying and intervening with heavy drinking arrestees are considered; exploring the interaction of contextual and attitudinal factors as they are experienced by DOs (a role with a tradition relating to containment) and assessment, intervention and referral staff (AIRS; a role with a tradition relating to care). Our objectives are to examine custody staff's perceptions of:

- the legitimacy of alcohol screening and brief interventions in the custody suite
- their sense of skilfulness in delivering opportunistic alcohol intervention with arrestees
- their motivation to fulfil a caring role to heavy drinking arrestees

Methods

Sample

We conducted a pilot feasibility trial of screening and brief alcohol interventions within a police custody suite setting. The study was based in six custody suites across four police forces in the North East (Tyne and Wear, Durham, Cleveland) and South West of England (Bristol). Within the trial, custody staff were randomised into one of three arms: Screening only

(control group); 10 minutes of manualised brief structured advice delivered by the custody staff who carried out screening; and 10 minutes of manualised brief structured advice as stated above followed by 20 minutes of manualised brief counselling delivered by trained alcohol counsellors. Custody staff were asked to screen arrestees and deliver the randomised intervention (where applicable) at any stage in the processing of the arrestees they considered feasible, based upon their understanding of their specific context. Furthermore, this allowed custody staff the opportunity to consider the most appropriate time and place to administer the tools, as the geography of police custody has been found to impact upon arrestee emotions (Wooff & Skinns, 2017). Typically, DOs approached arrestees during fingerprinting and discharge or whilst they were being held in the cells. Due to restricted access within the custody suite, AIRS workers approached arrestees whilst they were in the cells only. Staff participating in the trial were mostly DOs (n=95), with AIRS (n=17) recruiting arrestees in a small number of sites. DOs are civilian staff with a 24 hour presence in all police custody suites. They support the Custody Sergeant with responsibility for the management and care of arrestees whilst they are in police custody (Her Majesty's Inspectorate of Constabulary (HMIC), 2015). DOs are required to complete a six-week Home Office approved Initial Training Course (ITC) which covers skills such as communication, security, first aid, control and restraint. This training includes basic training on the management of users of alcohol and other substances within the custody suite. AIRS are alcohol counsellors who are employed by third sector organisations to deliver the aims and objectives of arrest referral schemes. Their roles are discrete from that of the police and civilian roles in that they have only a caring function. Their responsibilities focus on identifying heavy drinking and drug-using arrestees within the custody suite and signposting into alcohol and drug treatment within the community. The involvement of arrestees with AIRS workers is voluntary and not formally part of the criminal justice system. AIRS work exclusively with substance misusers within the custody suite setting and typically work restricted hours. There is no standardised training required for this role, although AIRS workers typically have health and social care experience and/or qualifications. Further details of the trial are reported in the published protocol (J. Birch et al., 2015) and within a linked paper reporting upon the findings of the feasibility trial (****, 2018).

Two post-doctoral experienced interviewers (LC, JK) conducted qualitative interviews with a purposive sample of 25 custody staff who participated in the trial. The interviewers had no prior interaction with the custody staff, having not been directly involved in the feasibility trial. To achieve maximum variation, interview participants were sampled according to their role (DO or AIRS), trial arm, the custody suite in which they were employed, gender and their engagement with the trial, operationalised in terms of the number of arrestees they screened. Within the trial, custody staff were expected to screen all eligible arrestees over a 60 week recruitment phase. The number of arrestees screened by the participating custody staff members ranged from 0-325. With a large arrestee population throughout the recruitment period, the variation in screening rates was indicative of the custody staffs' engagement with the activity. Custody staff who screened up to 20 arrestees were categorised as low performers, between 21-99 as medium performers and 100+ as high performers.

The final interview sample consisted of 20 DOs and 5 AIRS, which is reflective of the greater proportion of DOs participating in the trial. Sixteen participants were male (14 DOs; 2 AIRS). Similar numbers of custody staff were sampled from each intervention group (9 control, 7 brief advice, 9 extended brief intervention) and according to their level of engagement with the trial (7 low performers, 13 medium performers, 5 high performers), with no clear difference in performance observed by intervention group.

Data collection and analysis

Custody staff who provided informed consent to participate were interviewed within the custody suite, during working hours. All interviews were audio recorded and transcribed verbatim. A semi-structured interview approach was adopted, enabling the interviewer to gather the information necessary to respond to the aims of the feasibility study, whilst also allowing new themes to emerge. Participants were asked about their experiences of administering alcohol screening and delivering alcohol interventions to arrestees. Contextual and attitudinal factors were explored, with specific reference to the interaction between care and containment within the custody suite setting. Participants were encouraged to speak freely about their experiences.

Data was subject to framework analysis, which is appropriate for qualitative health research with objectives linked to quantitative investigation (Pope, Ziebland, & Mays, 2000). We took a deductive approach to this analytic strategy, in which our analysis was structured around given themes so that our findings had detailed relevance to our applied research questions (Ritchie & Lewis, 2003; Ritchie & Spencer, 1993). Specifically, we developed a framework of a-priori headings based on concepts from SAAPPQ (P. Anderson & Clement, 1987); a well-used instrument that measures practitioner attitudes towards working with people with alcohol problems. The instrument has 10 items and 5 domains which can be further coalesced into two super-ordinate concepts: role security and therapeutic commitment. Role security refers to the practitioner's sense of role adequacy as it relates to skills and knowledge as well as ownership of an intervention role with heavy drinkers. Therapeutic commitment is concerned with the practitioner's motivation to intervene with this population, the satisfaction they derive from the activity and task-specific self-esteem. A hierarchal structure was used to organise the codes of role adequacy, role legitimacy, motivation, satisfaction and self-esteem under the super-ordinate concepts, providing a framework for analysis. All interview transcripts were repeatedly read and coded by two researchers using this framework. This framework approach enables in-depth analysis of key themes, whilst maintaining their connection to the interviewee. This prevents meaning from being separated from context, enabling comparison between and within interviews therefore maintaining participant subjective frames (Gale, Heath, Cameron, Rashid, & Redwood, 2013). Similarities and differences in participants' views were examined. To enhance validity, research team members jointly discussed the themes within analysis meetings, and refined codes to ensure a working analytical framework. The semantic meanings had value in structuring our exploration of attitudes within a context wherein varying levels of both care and containment maybe present, as well as allowing the findings to be related to wider work in the field.

Ethical approval was granted by Newcastle University Ethics Committee (reference number 00754/2014).

Results

Role security in screening and brief intervention

Legitimacy of care within a containment role

Custody staff reported that it was routine practice within the custody suite to ask arrestees about a range of health and social care needs, including alcohol use. This activity was an expectation of the custody staff role and one they were confident in. It was also perceived to be legitimate to provide brief alcohol intervention to heavy drinking arrestees within the custody suite. This legitimacy related to both care and containment functions. For some the potential to address a factor in the arrestees' offending behaviour was typically highlighted to be a core function of the custody suite. Others discussed the arrestee's health needs as the primary motivation, unrelated to criminal diversion, embracing care *whilst* in containment (to bring about health and social care benefits to a vulnerable population) rather than care *within* the function of containment (to reduce reoffending).

At the end of the day we're here to care and it's their welfare...you can help change somebody's life by changing the support outside through other agencies then that's benefitting them and us (DO 10, male, high performing, randomised to extended brief intervention).

DOs made regular reference to the busy custody suite environment impacting upon the ability to screen and intervene with heavy drinking arrestees. Whilst generally legitimate, screening and intervening for alcohol use are additional, secondary tasks, rather than the function of containment. Staff shortages, competing demands and the high prevalence of alcohol issues within this setting were highlighted as factors affecting legitimacy comparative to other tasks. AIRS did not raise the issue of workload during interviews. Nonetheless, the pressured environment did impact upon their ability to intervene with arrestees; alcohol screening and intervention by AIRS was perceived to be something that could be completed only if it did not interrupt processes relating to containment. It is of

note, however, that many of the custody staff found administering a screening tool and delivering brief advice to be manageable within their daily work. Within the busy custody suite environment, it was the added research tasks of gathering consent and completing a baseline questionnaire that were typically the activities considered to be a less worthwhile use of their time.

Asking them about their alcohol use isn't really a problem. The problem came later on with some of the replies from them or feedback afterwards. And also it came with the fact that the, the whole thing took longer than I felt was necessary ... And, and they [senior custody staff] wonder why you're missing for 20 minutes, or whatever because you're not doing your checks or whatever (DO 01, male, medium performing, randomised to brief alcohol intervention).

Adequacy in providing care

A prevailing issue discussed was the day-to-day challenges staff face within the context of the custody suite. In particular, the custody staff reported interaction with arrestees was often difficult with high levels of hostility to be common. DOs reported that the role was 'not for everybody', and staff require specific expertise and abilities enabling them to manage such encounters with arrestees and tolerate the pressures within this environment. DOs in particular were considered possess the necessary skills and training. These skills, which were reported to be beyond the usual capability of staff working in other settings, were highlighted as essential for delivering alcohol screening and intervention in the custody suite.

I would never advocate that you actually came and delivered it because I think, with all respect, we know the detainees better than you do... 'Cause some of them can be quite, well some can be obstructive, some can be downright foul and not pleasant at all. So I wouldn't want to put somebody in that position that wasn't trained (DO: 01, male, medium performing, randomised to brief advice).

Advising heavy drinking arrestees about alcohol was, however, perceived to be a specialist activity for which DOs felt they lacked sufficient training and knowledge. AIRS were identified as possessing high levels of skill in providing brief alcohol intervention. Intervention skill was further contrasted with intervention reach. Whilst DOs have a 24 hour presence in the custody suite, AIRS work restricted hours. Moreover, participants reported that financial cuts have resulted in some custody suites seeing a reduction in or elimination of dedicated AIRS. As such, many arrestees who may have alcohol-related need do not come into contact with AIRS and therefore do not receive an intervention in response to their alcohol needs.

Therapeutic commitment to screen and provide brief advice: the deserving and undeserving arrestee

Motivation and satisfaction within a caring role

The custody staff's perception of the individual arrestee impacted upon their motivation to provide alcohol advice. First time or frequent offenders of lesser gravity offences were highlighted by DOs and AIRS as increasing the pertinence of providing a caring intervention around alcohol. Many of the custody staff discussed the intrinsic reward that they experience when responding to the needs of such arrestees. Here the custody suite was perceived to be an opportunity to help people by evoking motivation through the 'teachable moment' present within the reality of their containment. Custody staff who were motivated to intervene with the arrestee in a caring capacity tended to demonstrate an appreciation for the prevalence of health and social care needs within this population. These custody staff made a link between the arrestee's needs and their behaviour and perceived a value in intervening in order to divert arrestees away from future offending.

I find that quite disheartening, knowing that it's just the same people, in and out. And most of it is alcohol and drug-related. They seem to have these factors that have just put them on our card. The same lifestyles over and over again, and what a waste of

money it is, because it's - and if something like this could even enlighten a few onto different paths to help a small sector of that, then it's of benefit (DO 21, male, medium performing, randomised to control).

The severity of the offence was highlighted as a prominent factor, wherein some offence types were considered to have a gravitas which proscribed a caring role in favour of one of containment. The custody staff's judgement of these arrestees resulted in a view that they did not deserve care or that they could not be helped. Such a view greatly reduced the custody staff's commitment to intervene.

The real heavy stuff you know, sort of children stuff, anything with children and rapes and murders and stuff like that I wouldn't even entertain them, because it was pointless, because they weren't fit to be spoken to really (DO 22, male, medium performing, randomised to control).

Care-specific self-esteem

Task-specific self-esteem was low amongst the custody staff. They were pessimistic about intervening with heavy drinking arrestees in the custody suite, with some DOs and AIRS stating that arrestees were rarely honest about their drinking. They expressed doubt that the arrestees 'admitted' their heavy drinking even to themselves. This caused custody staff to question the value of care for alcohol within the containment of the custody suite. DOs often perceived intervening to address arrestee alcohol use to be 'someone else's job', typically, highlighting the AIRS to be better suited to fulfilling a caring role. A further common theme discussed was the arrestee's lack of motivation to change. High prevalence of heavy drinking within the arrestee population created a sense within the population that their alcohol use was normal. Arrestees were often considered to be apathetic about change and actively 'choosing to be the way they are'. The DOs reported that arrestees were often reluctant to listen to advice or engage in interventions offered. There was a sense that motivational domains such as health and wellbeing were not a concern to the

arrestees. Rather, external factors, typically those linked to sanctions for offending behaviour were perceived as necessary to enhance motivation. Whilst AIRS tended to accept ambivalence to change within the arrestee population, a perceived lack of arrestee motivation negatively impacted upon the DO motivation to intervene.

If I thought, oh this is going to really help these people, then I probably would've pushed it more (DO 04, female, medium performing alcohol screening, randomised extended brief alcohol intervention).

The alcohol advice intervention was broadly considered to be overly simplistic, with arrestees reportedly requiring more intensive and structured intervention in response to their complex levels of need. The custody suite was perceived to provide an opportunity to arrange an appointment for alcohol intervention to be delivered *after* the arrestee has been released from custody. In contradiction of this view however, DOs acknowledged that arrestees rarely attended these appointments, recognising that containment offered an opportunity to intervene with arrestees who, due to often chaotic lifestyles, may not access care within community settings.

You're probably not going to find a better venue...There is probably nowhere else you can do it, you've got them here, they're stuck in here, so you've kind of got them cornered a little bit. (DO 08, male, medium performing, randomised to extended brief alcohol intervention).

Discussion

Arrestees have a high prevalence of heavy drinking and other health and social vulnerability (Orr et al., 2015). As such, this is an important population for targeted care and intervention. Public health and criminal justice are often perceived as alternative perspectives on related issues, with the strict boundaries between traditional organisations

no longer being present (van Dijk et al., 2019). Moreover, collaboration between public health and law enforcement is recognised as being essential to a successful response to complex societal issues (Punch & James, 2017). The UK Modern Crime Prevention Strategy sets out a series of interventions to address alcohol-related crime, including the implementation of alcohol brief interventions within the criminal justice system (Home Office, 2016), and public health has been placed at the heart of the Policing Vision 2025 (NPCC, 2016). However, this novel setting for public health intervention has many challenges, with multiple practical and cultural barriers that have been found to impact collaboration (E. Anderson & Burris, 2017). Further, differing objectives which drive the behaviour of each sector and the way in which organisational performance is measured can undermine collaborative action (van Dijk et al., 2019).

Within the custody suite setting, there is a clear hierarchal structure both in terms of personnel and of process, enshrined by the need to ensure safe and lawful containment of the arrestee. Care within this context often has an urgency to it, wherein it is in reaction to presenting issues that threaten the immediate welfare of the arrestee. Preventative interventions which may bring about abstract behaviour change in the future were often viewed to be of lesser contiguity to their containment, resulting in other activities taking priority. Whilst workload pressure and competing demands have been highlighted as an issue in other settings (P. Anderson, 2009; Bendtsen et al., 2015; N. Brown, Newbury-Birch, McGovern, Phinn, & Kaner, 2010) and have been associated with poor implementation of alcohol screening and brief intervention (Wilson et al., 2011), these settings have a primary function of providing care. Within the custody suite, care other than that with immediate and urgent consequence, is at times viewed as being in conflict with the core function of containment, with research finding an inverse relationship between the levels of busyness within different custody suites and how 'good' policing is for the arrestee (Skinns, Rice, Sprawson, & Wooff, 2016).

The findings from this qualitative study show that opportunistically delivered alcohol screening and brief intervention within the custody suite are broadly viewed as legitimate,

with the provision of care to arrestees being seen to be appropriate activity *whilst* arrestees are contained and *within* the containment function. However, it is unclear who is best placed to provide this care. Higher levels of practitioner role security and therapeutic commitment (P. Anderson & Clement, 1987), have been shown to be associated with the management of alcohol problems in primary care patients (P. Anderson et al., 2014). Our study found the DOs with whom the arrestees have the most frequent contact are adept in interpersonal interactions within this context of containment; providing credibility and skills that are considered necessary to navigate this setting. This has been found in other research into police custody detention officers, who have been found to be skilful in the use of 'soft power', wherein detention officers were able to build rapport with arrestees by distinguishing themselves from the arresting officer, communicating respect and the use of humour (Skinns et al., 2016). However DOs were found to lack confidence and task-specific self-esteem in providing a caring intervention in response to the identified need. There was much evidence that the therapeutic commitment of DOs to provide caring interventions vacillates, and attitudinal and contextual factors impact negatively upon the provision of brief alcohol interventions. Other research has reported that the quality of health-care heavy drinkers receive is negatively impacted by the perception that they are 'undeserving patients' (Skinner, Feather, Freeman, & Roche, 2007) due to their difficulties being 'self-inflicted' (Gramenzi et al., 2011), with high likelihood of persistence (Kotlyar, Burke, Campbell, & Weinrieb, 2008). Within our study the severity and frequency of offending were important factors influencing the perceived level of arrestee deservingness for care.

AIRS possess the skills to provide care but may lack interactional skills necessary for the specific environment. In a recent UK study of the implementation of a DO administered health screening tool, forensic nurses were found to lack context specific skills (McKinnon & Finch, 2018). Further the efforts of AIRS in our study were often thwarted by reduced presence or authority within a context with functions primarily concerned with containment. Whilst brief alcohol interventions are often delivered in busy team environments, such as primary care, the custody suite culture added further challenge. A number of studies have examined the feasibility of physicians delivering alcohol brief interventions. A study in France found that physician-delivered brief alcohol interventions

were mostly feasible (Chariot, Lepresle, et al., 2014), although similar concerns were raised regarding role legitimacy by physicians, many of whom considered themselves to have a judicial role only with no caregiving (Best, Noble, Stark, & Marshall, 2002). It maybe that for alcohol screening and brief intervention to be implemented effectively, the delivering agent would need to be able to have role legitimacy bore equally out of both containment and care functions.

Both the DOs and AIRS expressed a pessimistic view of arrestee willingness to accurately report upon their alcohol use, which impacted upon the perceived value of providing care for heavy drinkers. Perceptions of offender inaccurate reporting have been highlighted as a barrier in other intervention research in the criminal justice system (Maggia et al., 2004; Sondhi, Birch, Lynch, Holloway, & Newbury-Birch, 2016), including in a study of alcohol and brief interventions delivered by physicians within a custody suite (Chariot, Lepresle, et al., 2014). This suggests that interactional and interpersonal barriers are a characteristic of the context rather than the specific care and containment roles within it.

Whilst it is evident that the custody suite is a complex and busy environment (Wooff & Skinnis, 2017), the findings of the linked feasibility trial demonstrate that arrestees rarely attend alcohol interventions that are offered on a subsequent occasion. This suggests that for intervention to occur, it must be provided opportunistically whilst the arrestee is in the custody suite (****, 2018). This has been found in other studies of alcohol intervention within primary care (Kaner et al., 2013), emergency care (Drummond et al., 2014) and elsewhere in the criminal justice system (Newbury-Birch et al., 2014). The findings of this study have important implications for public health within custodial settings. The custody suite provides an opportune point to address public health issues with arrestees. It is clear that alcohol is a prevalent and significant issue to both public health and law enforcement, however this is not enough to ensure collaborative practice (van Dijk et al., 2019). Similar to other studies examining the integration of health processes within a custody setting (McKinnon & Finch, 2018), the public health agenda is not considered a priority. Public health interventions within police custody require synergy wherein a reciprocal

understanding of the potential of intervention is shared by both sectors (van Dijk et al., 2019). For screening and brief intervention to be implemented within the custody suite setting, care as a means of addressing the drivers of crime, must be fully integrated. Such conceptual interface between the fields is necessary (E. Anderson & Burris, 2017; van Dijk et al., 2019) and requires considerable support from national and local policy-makers. Further, practical integration of police and health systems are required to enable containment and care to be complementary and consistent (van Dijk et al., 2019). For integrated practices to be effective, the role of the practitioners is fundamental (van Dijk et al., 2019; Wood, Taylor, Groff, & Ratcliffe, 2015). Incentivisation and appropriate reimbursement for the delivery of brief interventions may also be beneficial, as has been recommended in other settings (McCormick et al., 2010). Training of staff responsible for containment of arrestees should seek to address attitudinal factors and focus upon the enhancement of therapeutic commitment to the task.

This study has a number of limitations. Our sample was taken from a pilot feasibility trial which was conducted in North East England and Bristol. Whilst it is appropriate that feasibility trials are conducted in a restricted geographical area, the findings from our linked qualitative study may not be representative of custody suites within other Police forces. The DOs and AIRS were required to undertake a number of research processes that increased the burden of the overall task. These tasks were linked to the research, and not the identification and intervention activity, yet may have negatively affected the role security and therapeutic commitment of the custody staff. We did not gather information about the length of service of the custody staff we interviewed. Recent research has found more experienced staff are more likely to engage in public health strategies (Rouhani et al., 2019). It is possible that role security and therapeutic commitment may have differed depending upon the level of experience of the custody staff, as well as between their role-type. Further, our exploration of role security and therapeutic commitment was restricted to DOs and AIRS. It is possible that other healthcare practitioners within the custody suite setting such as physicians, nurses and attending paramedics maybe better suited to alcohol screening and brief intervention within the custody suite. Finally, these findings do not include the views of arrestees who may provide further insight into the scope for integration

of care within the context of the containment of the custody suite. In particular, arrestee view, which we plan to report in detail elsewhere, may help further unpack issues of socially desirable reporting, custody staff role security and therapeutic commitment.

Acknowledgements

We thank all custody suites for their participation in this study, and all arrestees for giving their time to participate in the linked trial. We would also like to acknowledge Professor Simon Coulton, Frauke Becker; Alan Brennan; Colin Angus, Colin Muirhead and Muhammad Waqas for their valuable contribution to the pilot feasibility trial.

Declaration of Completing Interests:

This research was funded by the National Institute of Health Research, School for Public Health Research (**SPHR-SWP-ALC-WP2**). The funders had no role in the conduct of the study or in the decision to publish. The NIHR School for Public Health Research is a partnership between the Universities of Sheffield, Bristol, Exeter, Cambridge, UCL; The London School for Hygiene and Tropical Medicine; the LiLaC collaboration between the Universities of Liverpool and Lancaster and Fuse; The Centre for Translational Research in Public Health, a collaboration between Newcastle, Durham, Northumbria, Sunderland and Teesside Universities.

Clinical Trial Registration: This qualitative study is linked to the ACCEPT Trial; ISRCTN Number: 89291046

References

- ****. (2018). Alcohol screening and brief intervention in police Custody suites: Pilot randomized controlled Trial (AcCePT). *Alcohol and Alcoholism*. doi:doi.org/10.1093/alcalc/agy039
- Anderson, E., & Burris, S. (2017). Policing and public health: Not quite the right analogy. *Policing and Society*, 27(3), 300-313. doi:10.1080/10439463.2016.1231188
- Anderson, P. (2009). Overview of interventions to enhance primary care provider management of patients with substance-use disorders. *Drug and Alcohol Review*, 28, 567-574.
- Anderson, P., & Clement, S. (1987). The AAPPQ revisited: The measurement of general practitioners attitudes to alcohol problems. *British Journal of Addiction*, 82, 753-759.

- Anderson, P., Wojnar, M., Jakubczyk, A., Gual, A., Reynolds, J., Segura, L., . . . Kolsek, M. (2014). Managing alcohol problems in general practice in Europe: results from the European ODHIN survey in general practitioners. *Alcohol and Alcoholism*, 49(5), 531-539.
- Babor, T. F., Ritson, E. B., & Hodgson, R. J. (1986). Alcohol-related problems in the primary health care setting: A review of early intervention strategies. *British Journal of Addictions*, 81, 23-46.
- Bendtsen, P., Anderson, P., Wojnar, M., Newbury-Birch, D., Mussener, U., Colom, J., . . . Gual, A. (2015). Professional's attitudes do not influence screening and brief intervention rates for hazardous and harmful drinkers: results from ODHIN study *Alcohol and Alcoholism*, 50(4), 430-437.
- Best, D., Noble, A., Stark, M. M., & Marshall, E. J. (2002). The role of forensic medical examiners and their attitudes on delivering brief alcohol interventions in police custody. *Criminal Behaviour and Mental Health*, 12(230-235).
- Birch, A., Dobbie, F., Barnsdale, L., McIvor, G., & Yates, R. (2006). *Evaluation of the arrest referral pilot schemes*. Retrieved from Edinburgh:
- Birch, J., Scott, S., Newbury-Birch, D., Brennan, A., Brown, H., Coulton, S., . . . Kaner, E. (2015). A pilot feasibility trial of alcohol screening and brief intervention in the police custody setting (ACCEPT): study protocol for a cluster randomised controlled trial. *Pilot and Feasibility Studies*, 1(6). doi:DOI 10.1186/s40814-015-0001-7
- Bouchery, E., Harwood, H., Sacks, J., Simon, C., & Brewer, R. (2011). Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Preventive Medicine*, 41(5), 516-524.
- Brown, A., Gaynor, J., Grimm, C., Harris, L., Keaney, F., Leach, J., . . . Richardson, P. (2013). *The case for better access to alcohol treatment for alcohol dependence in England*. Retrieved from
- Brown, N., Newbury-Birch, D., McGovern, R., Phinn, E., & Kaner, E. (2010). Alcohol Screening and Brief Intervention in a Policing Context: A mixed methods feasibility study. *Drug & Alcohol Review*, 29, 647-654.
- Chariot, P., Beaufre, A., Denis, C., Dang, C., Vincent, R., & Boraud, C. (2014). Detainees in police custody in the Paris, France area: medical data and high-risk situations (a prospective study over 1 year). *International Journal of Legal Medicine*, 128, 853-860.
- Chariot, P., & Heide, S. (2018). Custody Medicine. *Journal of Forensic and Legal Medicine*, 57, 55-57.
- Chariot, P., Lepresle, A., Lefevre, T., Boraud, C., Barthes, A., & Tedlaoui, M. (2014). Alcohol and substance screening and brief intervention for detainees kept in police custody. A feasibility study. *Drug and Alcohol Dependence*, 134, 235-241.
- Dorn, T., Ceelen, M., Buster, M., Stirbu, I., Donker, G., & Das, K. (2014). Mental health and health-care use of detainees in police custody. *Journal of Forensic and Legal Medicine*, 26, 24-28.
- Dorn, T., Janssen, A., de Keijzer, J. C., van Rijk-Zwikker, G. L., Reijnders, U. J. L., Luitse, J. S. K., . . . Das, C. (2018). Hospital referral of detainees during police custody in Amsterdam, the Netherlands. *Journal of Forensic and Legal Medicine*, 57, 82-85.
- Drummond, C., Deluca, P., Coulton, S., Bland, M., Cassidy, P., Crawford, M., . . . Kaner, E. (2014). The effectiveness of alcohol screening and brief intervention in emergency departments: a multicentre pragmatic cluster randomized controlled trial. *PLoS ONE*, 9(6). doi:10.1371/journal.pone.0099463
- Drummond, C., Oyefeso, A., Phillips, T., Cheeta, S., Deluca, P., Perryman, K., . . . Christopoulos, A. (2005). *Alcohol needs assessment research project (ANARP). The 2004 national needs assessment for England*. Retrieved from London:
- Felson, R., & Staff, J. (2010). The effects of alcohol intoxication on violent versus other offending. *Criminal Justice and Behaviour*, 37(12), 1343-1360.
- Flatley, J., Kershaw, C., Smith, K., Chaplin, R., & Moon, D. (2010). *Crime in England and Wales 2009/10*. Retrieved from London:
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, 13, 117-117. doi:10.1186/1471-2288-13-117
- Gerardin, M., Guigand, G., Wainstein, L., Joliet, P., CVictorri-Vigneau, C., & Clement, R. (2017). Evaluation of problematic psychoactive substances use in people placed in police custody. *Journal of Forensic and Legal Medicine*, 49, 24-32.
- Gilard-Pioc, S., Dang-Hauter, C., Denis, C., Boraud, C., & Chariot, P. (2013). Detainees in police custody in seine-Saint Denis (France): medical data and high-risk situations, a descriptive study. *Presse Medicines*, 42, e293-299.
- Giles, E., Coulton, S., Deluca, P., Drummond, C., Howel, D., Kaner, E., . . . Newbury-Birch, D. (2016). Multicentre individual randomised controlled trial of screening and brief alcohol intervention to prevent risky drinking in young people aged 14-15 years in a high school setting (SIPS JR-HIGH): srudy protocol *BMJ Open*, 6. doi:10.1136/bmjopen-2016-012474
- Gramenzi, A., Gitto, S., Caputo, F., Biselli, M., Lorenzini, S., Bernardi, M., & Andreone, P. (2011). Liver transplantation for patients with alcoholic liver disease: an open question. *Digestive and Liver Disease*, 43, 843-849.
- Her Majesty's Inspectorate of Constabulary (HMIC). (2015). *The welfare of vulnerable people in police custody*. Retrieved from London:
- HM Government. (2009). *Improving Health, Supporting Justice*. Retrieved from London:
- Home Office. (2013). *Next steps following consultation n delivering the Government alcohol strategy*. Retrieved from London:

- Home Office. (2016). *Modern Crime Prevention Strategy*. Retrieved from London:
- Home Office. (2017). *Code C revised: code of practice for the detention, treatment and questioning of persons by police officers*. London: HMSO.
- Independent Office for Police Conduct. (2018). *Deaths during or following police contact: Statistics for England and Wales 2017/18*. Retrieved from London:
- Jones, L., Hughes, K., Atkinson, A. M., & Bellis, M. A. (2011). Reducing harm in drinking environments: A systematic review of effective approaches. *Health & Place, 17*, 508-518.
- Kaner, E. (2012). Health Sector Responses. In P. M. Anderson, L. Galea, G. (Ed.), *Alcohol in the European Union. Consumption, harm and policy approaches* (pp. 40-48). Copenhagen: World Health Organization.
- Kaner, E., Beyer, F., Dickinson, H., Pienaar, E., Campbell, F., Schlesinger, C., . . . Burnand, B. (2007). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews, Issue 2*, CD004148.DOI:004110.001002/14651858.CD14654148.pub14651853.
- Kaner, E., Bland, M., Cassidy, P., Coulton, S., Dale, V., Deluca, P., . . . Drummond, C. (2013). Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. *BMJ, 346*:e8501.
- Kennedy, A., Dunbar, I., Boath, M., Beynon, C., Duffy, P., Stafford, J., & Pettersson, G. (2012). *Evaluation of alcohol arrest referral pilot schemes (Phase 1)*. Retrieved from London:
- Kinner, S. A., Degenhardt, L., Coffey, C., Hearps, S., Spittal, M., Sawyer, S. M., & Patton, G. C. (2015). Substance use and risk of death in young offenders: A prospective data linkage study. *Drug & Alcohol Review, 34*(1), 46-50.
- Kotlyar, D. S., Burke, A., Campbell, M. S., & Weinrieb, R. M. (2008). A critical review of candidacy of orthotopic liver transplantation in alcoholic liver disease. *American Journal of Gastroenterology, 103*, 734-743.
- Lefevre, T., Denis, C., Marchand, C., Vidal, C., Gagnayre, R., & Chariot, P. (2018). Multiple brief interventions in police custody: The MuBIC randomized controlled study for primary prevention in police custody. Protocol and preliminary results of a feasibility study in Paris metropolitan area, France. *Journal of Forensic and Legal Medicine, 57*, 101-108.
- Lepresle, A., Taprest, V., & Chariot, P. (2018). Doctors attendance with arrestees in police custody: physicians' representations. *Journal of Forensic and Legal Medicine, 57*, 73-81.
- Liu, T., Ferris, J., Higginson, A., & Lynham, A. (2016). Systematic review of Australian policing interventions to reduce alcohol-related violence – A maxillofacial perspective. *Addictive Behaviours Reports, 4*. doi:10.1016/j.abrep.2016.05.002
- Lord Bradley. (2009). *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. Retrieved from London:
- Maggia, B., Martin, S., Crouzet, C., Richard, P., Wagner, P., Balmes, J. L., & Nalpas, B. (2004). Variation in audit (alcohol use disorder identification test) scores within the first weeks of imprisonment. *Alcohol & Alcoholism, 39*, 247-250.
- McCormick, R., Docherty, B., Segura, L., Colom, J., Gual, A., Cassidy, P., . . . Heather, N. (2010). The research translation problem: Alcohol screening and brief intervention in primary care - real world evidence supports theory *Drugs: education, prevention and policy, 17*(6), 732-748s.
- McCracken, K., McMurrin, M., Winlow, S., Sassi, F., & McCarthy, K. (2012). *Evaluation of Alcohol Arrest Referral Pilot Schemes (Phase 2)* Retrieved from London:
- McGovern, R., Stamp, E., Javanbakht, M., McColl, E., Hickman, M., & Kaner, E. (2018). Promoting Alcohol Reduction in Non-Treatment Seeking parents (PARENTS): a protocol for a pilot feasibility cluster randomised control trial of alcohol screening and brief interventions to reduce parental alcohol use disorders in vulnerable families. *Pilot and Feasibility Studies, In press*.
- McKinnon, I., & Finch, T. (2018). Contextualising health screening risk assessment in police custody suites - qualitative evaluation from HELP-PC study, in London UK. *BMC Public Health, 18*(393). doi:doi.org/10.1186/s12889-018-5271-6
- McKinnon, I., Thomas, S., Noga, H., & Senior, J. (2016). Police custody health care: a review of health morbidity, models of care and innovations within police custody in the UK, with international comparisons. *Risk Management and Health Care Policy, 9*, 213-226.
- National Institute for Health and Clinical Excellence. (2010). Alcohol-use disorders - preventing the development of hazardous and harmful drinking. <http://guidance.nice.org.uk/PH24>.
- Newbury-Birch, D., Coulton, S., Bland, M., Cassidy, P., Dale, V., Deluca, P., . . . Drummond, C. (2014). Alcohol screening and brief interventions for offenders in the probation setting (SIPS Trial): a pragmatic multi-centre cluster randomized controlled trial. *Alcohol and Alcoholism, 49*(5), 540-548.
- Newbury-Birch, D., McGovern, R., Birch, J., O'Neill, G., Kaner, H., Sondhi, A., & Lynch, K. (2016). A rapid review of what we know about alcohol use disorders and brief interventions in the criminal justice system. *International Journal of Prisoner Health, 12*(1), 57-70.
- NPCC. (2016). *Policing Vision 2025*. Retrieved from London:
- O'Meara, C., Witherspoon, R., Hapangama, N., & Hyam, D. M. (2012). Alcohol and interpersonal violence may increase the severity of facial fracture. *British Journal of Oral and Maxillofacial Surgery, 50*(1), 36-40.

- Orr, K. S., McAuley, A., Graham, L., & McCoard, S. (2015). Applying an alcohol brief intervention (ABI) model to the community justice setting: learning from a pilot project. *Criminology and Criminal Justice*, 15(1), 83-101.
- Palk, G., Davey, J., & Freeman, J. (2007). Policing alcohol-related incidents: a study of time and prevalence. *Policing: International Journal of Police Strategy Management*, 30, 82-92.
- Palk, G., Freeman, J., & Davey, J. (2010). The impact of a lockout policy on levels of alcohol-related incidents in and around licensed premises. *Police Practice and Research*, 11, 5-15.
- Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *BMJ*, 320(7227), 114-116. doi:10.1136/bmj.320.7227.114
- Punch, M., & James, S. (2017). Researching law enforcement and public health. *Policing and Society*, 27(3), 251-260. doi:10.1080/10439463.2016.1205066
- Ritchie, J., & Lewis, J. (2003). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*: Sage.
- Ritchie, J., & Spencer, L. (1993). Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analysing qualitative data*. London: Routledge, 1993:17394. London: Routledge.
- Rouhani, S., Gudlavalleti, R., Atzmon, D., Park, J. N., Olson, S. P., & Sherman, S. G. (2019). Police attitudes towards pre-booking diversion in Baltimore, Maryland. *Int J Drug Policy*, 65, 78-85. doi:10.1016/j.drugpo.2018.11.012
- Scott, D., McGilloway, S., M., D., Browne, F., & Donnelly, M. (2013). Effectiveness of criminal justice liaison and diversion services for offenders with mental disorders: a review. *Psychiatric Services*, 64(9), 843-849.
- Skinner, N., Feather, N. T., Freeman, T., & Roche, A. (2007). Stigma and discrimination in health-care provision to drug users: the role of values, affect, and deservingness judgments. *Journal of Applied Social Psychology*, 37(1), 163-186.
- Skinns, L., Rice, L., Sprawson, A., & Wooff, A. (2016). Police legitimacy in context: An exploration of 'soft' power in police custody in England. *Policing: an International Journal of Police Strategies & Management*, 40. doi:10.1108/PIJPSM-06-2016-0077
- Sondhi, A., Birch, J., Lynch, K., Holloway, A., & Newbury-Birch, D. (2016). Exploration of delivering brief interventions in a prison setting: A qualitative study in one English region. *Drugs: education, prevention and policy*, 23.
- Srivastava, S., Forrester, A., Davies, S., & Nadkarni, R. (2013). Developing criminal justice liaison and diversion services: Research priorities and international learning. *Criminal Behaviour and Mental Health*, 23(5), 315-320.
- van Dijk, A. J., Herrington, V., Crofts, N., Breunig, R., Burris, S., Sullivan, H., . . . Thomson, N. (2019). Law enforcement and public health: recognition and enhancement of joined-up solutions. *Lancet*, 393(10168), 287-294. doi:10.1016/s0140-6736(18)32839-3
- Webb, G., Shakeshaft, A., Sanson-Fisher, R., & Havard, A. (2009). A systematic review of work-place interventions for alcohol-related problems. *Addiction*, 104(3), 365-377. doi:doi:10.1111/j.1360-0443.2008.02472.x
- Wilson, G., Lock, C., Heather, N., Cassidy, P., Christie, M., & Kaner, E. (2011). Intervention against excessive alcohol consumption in primary health care: a survey of GPs' attitudes and practices in England ten years on. *Alcohol & Alcoholism*, 46(45): 570-577.
- Wood, J. D., Taylor, C. J., Groff, E. R., & Ratcliffe, J. H. (2015). Aligning policing and public health promotion: Insights from the world of foot patrol. *Police practice & research : an international journal*, 16(3), 211-223. doi:10.1080/15614263.2013.846982
- Wooff, A., & Skinns, L. (2017). The role of emotion, space and place in police custody in England: Towards a geography of police custody. *Punishment & Society*, 20(5), 562-579. doi:10.1177/1462474517722176
- World Health Organisation. (2014). *Global status report on alcohol and health 2014*. World Health Organization.