30 YEARS OF EVIDENCE: A SHORT HISTORY OF BRIEF INTERVENTIONS

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DEFINITION OF ALCOHOL BRIEF INTERVENTION (essential features)

- **delivered by non-alcohol specialists in the normal course of their work**
- **offered to drinkers who are not complaining about or seeking help for an alcohol problem**
- **brief in intensity, arbitrarily set at less than or equal to 4 sessions of interaction or 1 hour of total contact**

CHARACTERISTICS OF BRIEF INTERVENTIONS (not essential)

- **usually directed at drinkers with only low levels of alcohol dependence and problems, and therefore a form of secondary prevention**
- **usually aimed at a goal of moderate alcohol consumption rather than total abstinence**
- **normally accompanied by some form of self-help material**
- **usually seen as early intervention**

ORIGINS OF BRIEF INTERVENTIONS

- First developed in Scotland in early 1980s
- Coalescence of several influences:
  - move to community-based response to alcohol problems
  - abstinence-controlled drinking controversy
  - research on less intensive forms of treatment in UK and USA
  - research in the smoking cessation field showing that brief advice by general practitioners was effective and highly cost-effective
  - more generally, part of shift from disease perspective on alcohol problems to public health perspective

THEORETICAL ORIENTATION OF BRIEF INTERVENTIONS

- **Condensed cognitive-behavioural therapy**
- **Brief motivational interviewing**
- **Simple advice**

EFFECTIVE INGREDIENTS (assumed)

- **"It ain't what you do, it's the way that you do it. And that's what gets results"**
- **FRAMES:**
  - **Feedback of personal risk or impairment**
  - **emphasis on personal Responsibility for change**
  - **clear Advice to change**
  - **a Menu of alternative change options**
  - **therapeutic Empathy as a counselling style**
  - **enhancement of Self-efficacy or optimism.**

THEORETICAL MECHANISMS

- **Increase in coping skills (unlikely)**
- **Increase in motivation to change (more likely)**
- **Stages of change (Prochaska & DiClemente)**
- **Cognitive dissonance theory**
- **Self-affirmation theory**

TWO TYPES OF BRIEF INTERVENTION: (i) simple

- **Simple brief intervention (simple, structured advice)**
- **"Minimal" intervention consisting of 5 minutes simple but structured advice is effective in reducing alcohol consumption and improving health status among hazardous and harmful drinkers encountered in health care settings**
- **Should be offered to all those screening positive for hazardous or harmful alcohol consumption**

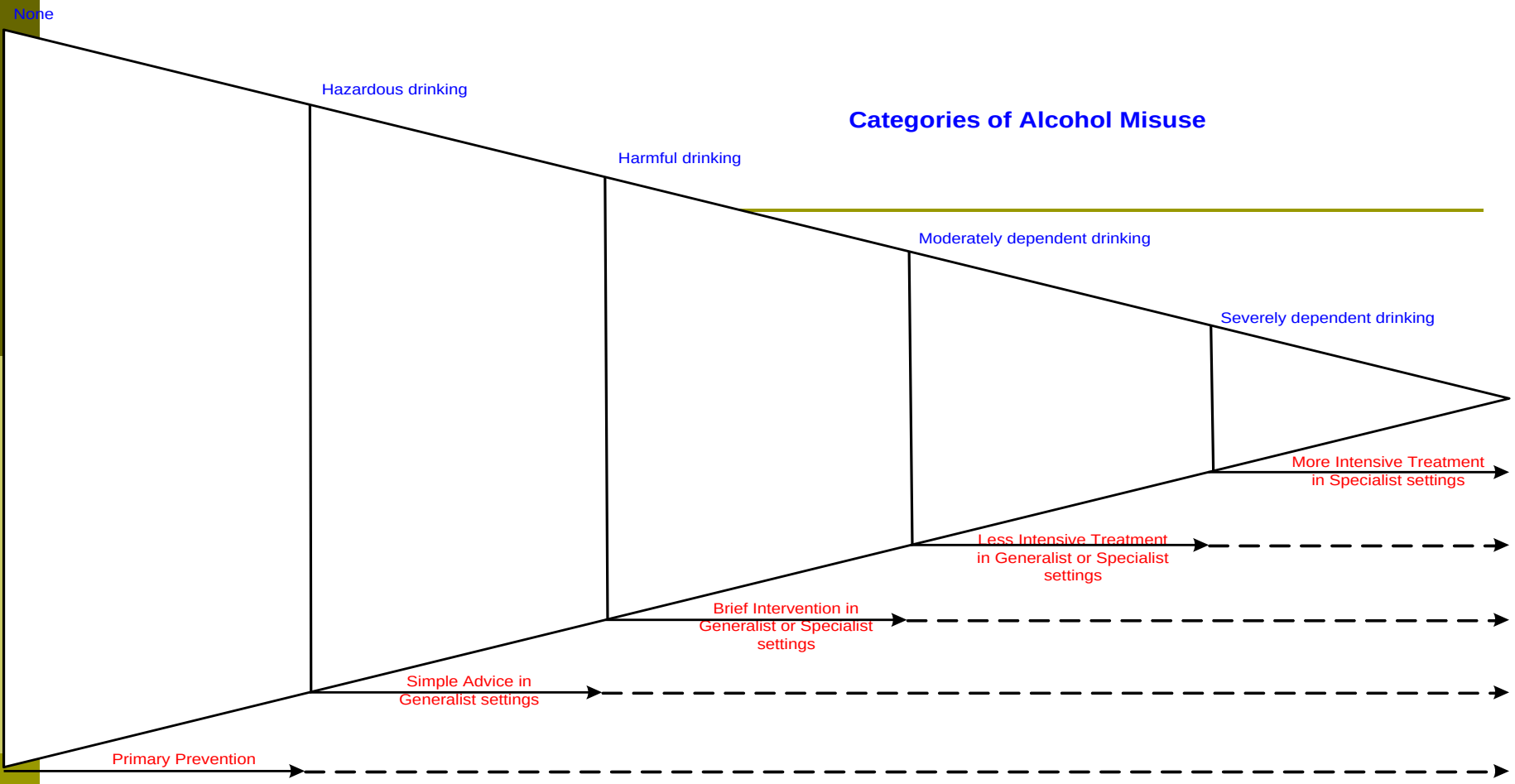
TWO TYPES OF BRIEF INTERVENTION: (ii) extended

- **Extended brief intervention (brief behavioural counselling)**
- **Based on principles and methods described by Rollnick, Mason & Butler (1999)**
- **Mixed evidence on whether extended brief intervention in health care settings (20 mins + offer of repeat visits) adds anything to the effects of simple advice**
- **The offer of extended brief intervention to some hazardous and harmful drinkers can be justified on pragmatic grounds**

APPLICATIONS TO SUBSTANCES OTHER THAN ALCOHOL

- Tobacco
- Benzodiazepines
- Cannabis
- Other substances

FIGURE 2.1 A Spectrum of Responses to Alcohol Misuse



Adapted from Figure 9.1 in the Institute of Medicine [1990] report, p. 212. The triangle shown in Figure 2.1 represents the population of England, with the spectrum alcohol misuse among the population shown along the upper side of the figure. Responses to these problems are shown along the lower side. The dotted lines in Figu 2.1 suggest that primary prevention, minimal intervention, brief intervention and less intensive treatment may have effects beyond their main target area. Although th figure is not drawn to scale, the prevalence in the population of each of the categories of alcohol problem is approximated by the area of the triangle occupied; mos people have no alcohol problems, a very large number show hazardous drinking but no current problems, many show harmful drinking and less serious alcohol problem some have moderate dependence and problems and a few have severe dependence or complicated alcohol problems.

THE ROLE OF BI IN THE OVERALL RESPONSE TO ALCOHOL-RELATED HARM

- **Effective as public health measure only if widely disseminated and routinely implemented**
- **Tension between clinical and public health imperatives**
- **Brief interventions versus alcohol control policies**
  - **In the absence of effective control policies, widespread BI next best thing**
  - **But not alternatives, could be mutually beneficial**

WHAT SETTINGS (MEDICAL OR NON-MEDICAL) CAN BI IMPLEMENTATION IN?

- **Evidence of effectiveness good for primary health care (and educational settings), mixed for general hospitals and A&E and virtually non-existent for other settings**
- **Some people argue that BI should be widely implemented only in settings where there is good evidence of effectiveness**
- **But two arguments for extending implementation to settings where evidence may be thin or non-existent:**
  - **BI has been shown to work with problem drinkers in general and the same processes of behaviour change, whatever they are, should apply to people in any setting;**
  - **The extended precautionary principle: 'Supporting an activity where there is scientific uncertainty of potential benefit from the activity may be justified.'**

HOW CAN WIDESPREAD IMPLEMENTATION OF BI BE ACHIEVED?

- **Both top-down and bottom-up actions necessary**
- **Incentives must be provided but of what kind?**