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Brief alcohol interventions – everybody's business

Billy Boland, Colin Drummond & Eileen Kaner

Abstract Heavy drinking poses a significant risk to public health in the UK. Opportunistic screening and brief interventions offer a cost-effective method of reducing the harm related to excessive alcohol consumption at both an individual and a public health level. Given the high prevalence of alcohol misuse among patients attending mental health services and its impact on behaviour and health, professionals need to be skilled in identifying and treating these problems in all areas of mental health. There is also a need for effective joint working between mental health and specialist addiction services. This article describes the principles and evidence base for brief alcohol interventions, and methods of implementation in health settings.

The misuse of alcohol and its associated harm sit centre stage in the national consciousness in the UK at present. The relaxation of licensing laws in 2005 indicated a significant change in the attitudes of both government and society towards the availability and use of Britain's favourite legally consumed psychoactive drug. Substantial media interest has fuelled public debate on the role of alcohol in society, highlighting issues such as binge drinking, excessive drinking among women, and alcohol-related violence and disorder.

The extent of the problems

Heavy drinking is the third greatest risk to public health in high-income countries such as the UK in terms of disability-adjusted life years (DALYs). Furthermore, alcohol is a leading cause of loss of healthy life, contributing 9.2% of DALYs, compared with 12.2% for smoking and 10.9% for hypertension (Ezzati *et al*, 2002). The Alcohol Needs Assessment Research Project (ANARP), commissioned by the Department of Health in 2005, has provided the most detailed understanding of problematic alcohol consumption in the UK so far (Drummond *et al*, 2004). It found that about 23% of the adult population, or 7.1 million people, in England drink alcohol in a hazardous or harmful way. These data have informed the development of policy for delivering alcohol services (Models of Care for Alcohol Misuse, MoCAM; Department of Health & National Treatment Agency for Substance Misuse, 2006) through the Department of Health.

Changing patterns of alcohol use are now highly publicised, with significant column inches devoted to news items regarding binge drinking and alcohol-related violence and the evolution of more 'masculine' drinking patterns among women. But there are gender differences: 38% of men and 16% of women have an alcohol use disorder (26% across both genders). In addition, the prevalence of alcohol dependence in this population is 6% of men and 2% of women (3.6% overall) (Drummond *et al*, 2004).

Why would brief interventions be useful?

Current health policy places health promotion, which aims to prevent ill health caused by lifestyle behaviour, at the heart of the National Health Service (NHS) activity (Department of Health, 2004). Programmes aimed at tackling health inequalities due to smoking behaviour and poor diet have been operating for many years in most Western countries. However, alcohol misuse has been relatively neglected, with wide-scale use of interventions in the alcohol field falling significantly behind.

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In recent years, there have been changes in attitudes towards alcohol in the UK due in part to the first national Alcohol Harm Reduction Strategy for England (Prime Minister's Strategy Unit, 2004) and subsequent work outlining the MoCAM programme (Department of Health & National Treatment Agency for Substance Misuse, 2006). A review of the effectiveness of treatment for alcohol problems (Raistrick *et al*, 2006) provided the evidence base to support MoCAM and reported that brief interventions have strong supporting evidence as psychosocial approaches for alcohol use disorders.

Brief interventions fit within a secondary preventive frame – early identification of risk factors or early signs of disease via screening, followed by intervention to reduce the risks or disease symptoms and improve the individual's health status (Winett, 1995). However, Raistrick *et al*'s effectiveness review also highlighted the fact that the term 'brief intervention' has been used inconsistently to cover both brief 'opportunistic' interventions for people not seeking specialist help for their alcohol problems as well as 'less intensive' treatment for those who are seeking specialist care. Brief interventions are not effective for people seeking treatment for alcohol dependence (Moyer *et al*, 2002) and they should therefore be restricted to the contexts of hazardous and harmful alcohol use.

Screening and brief intervention is probably the most thoroughly researched intervention for alcohol problems and has the strongest evidence base. The Mesa Grande project, which reviewed clinical trials of treatments for alcohol use disorders (Miller & Wilbourne, 2002), looked at over 80 different types of intervention and assessed the quality of their evidence for efficacy from the published literature and beyond. This project rated brief interventions number one in the league table as a result of the large number of studies with positive findings and of high-quality design. However, it did not distinguish between the opportunistic non-specialist interventions and less intensive specialist interventions.

By virtue of their simplicity and ease of use, brief interventions are attractive across a range of health and social care settings. They require significantly less time and expertise than many approaches to alcohol misuse and are therefore appealing to people working directly with those delivering services, as well as to service planners and policy makers. Intuitively, one might expect that these qualities would make brief interventions a cost-effective component of a comprehensive strategy to tackle alcohol problems. However, in many settings they have yet to be fully implemented.

Approaching a definition

Brief alcohol interventions are notoriously hard to define. The term covers a spectrum of interventions aimed at both hazardous and harmful levels of drinking. The main feature of brief interventions is that they are short and of low intensity (Babor & Higgins-Biddle, 2000). They last between 5 and 60 min, consist of no more than five sessions and focus on providing counselling and education. A single contact lasting as little as 5–10 min can reduce an individual's risky drinking (Kaner *et al*, 2007).

How do they work?

Brief interventions for substance misuse are thought to work primarily by enhancing an individual's motivation to address their misuse problem. They appear to promote the generation of the impetus the individual needs to set about making changes in their using behaviour. A review of brief alcohol interventions (Bien *et al*, 1993) found that the most effective styles meet the FRAMES format advocated by Miller & Sanchez (1993) (Box 1).

Crucially, the concepts highlighted by FRAMES do not require the delivery of a formal psychological intervention that would necessitate extensive training. Rather, they focus on a style of engagement with an alcohol misuser and cover areas that might catalyse change. Encouraging responsibility and self-efficacy (or confidence to address the problem) and providing evidence that change is possible can prompt the individual to consider change for themselves. Then offering a choice of options that will help them to make these changes can lend to a sense of acquiring control and suggests achievable alternatives to enable individuals to proceed.

Thus, in their most rudimentary form, brief interventions can amount to the offering of simple structured advice regarding sensible amounts and

Box 1 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 the client's *Self-efficacy* or optimism

(Miller & Sanchez, 1993)

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patterns of alcohol use tailored to the individual, and suggested ways to change. This might be backed up with written information that the individual can review in their own time and contact details for local agencies that may provide further, longer-term assistance.

Who should receive brief interventions?

It has been argued that alcohol use occurs on a continuum that ranges from 'safe' use up to the most severe manifestations of alcohol dependence, with no clear-cut point at which disorder is obviously present. Much work has been done, with varying success, to address the issue of matching the severity of an addiction with the most appropriate treatment. Stepped care has been developed as a pragmatic method of providing the most appropriate intervention. Its guiding principle is that the least intensive and least expensive treatment likely to offer significant benefit to the patient should be offered first. Only when this form of treatment fails should a more intensive and costly treatment be offered.

Brief intervention could form an important first step in the stepped-care approach to problem drinking (Sobell & Sobell, 2000). Typically the first treatment provided in a stepped-care framework is chosen on the basis of judgement informed by research and clinical experience. If the treatment is effective, the patient is simply monitored. If it is ineffective, a more intensive treatment is tried and its impact assessed. The cycle of assessment of outcome and increasing of treatment intensity is repeated until there is a satisfactory outcome or the highest possible treatment intensity is reached.

Stepped care is thus flexible and the starting intervention and any subsequent interventions depend on the context and the availability of services. It is important that the patient (client) receives treatment based on their clinical needs and is not required to pass through unnecessary steps. To this end, appropriate assessment is crucial, and the opinions of patients and their families or carers are sought. Success relies on a collaborative relationship between the patient and the clinician.

Figure 1 outlines a clinical algorithm for stepped-care intervention for alcohol use disorders in primary care settings favourably evaluated by Drummond *et al* (2003). This model follows the principles described above and is an example of how such a framework can be integrated into established treatment services. The algorithm is suitable for the treatment both of hazardous and harmful drinkers, and of people with severe alcohol dependence. It also provides a method of joint clinical working between primary care and specialist services.

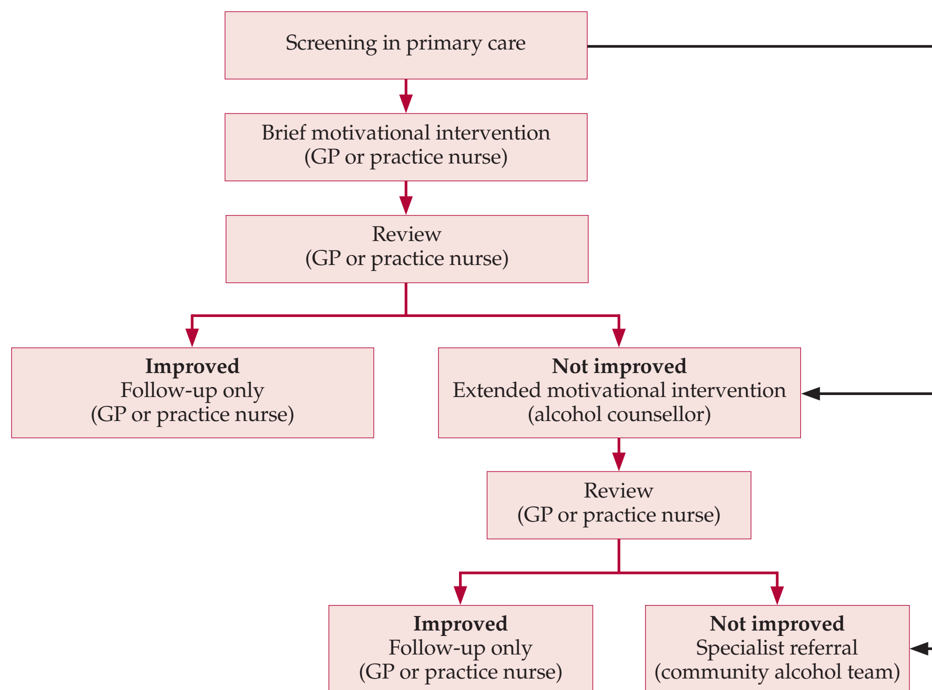

Fig. 1 Stepped care for alcohol use disorders in primary care.

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Screening as a necessary part of brief intervention

Although brief intervention may be appropriate for people with hazardous and harmful drinking patterns, reaching these people in the first place can be a challenge. Treatment of this population has not been a priority for statutory services: specialist addiction services have typically focused on alcohol dependence, and primary and other secondary care providers have not seen alcohol misuse as an appropriate part of their work. Thus, hazardous and harmful drinkers are not well served within established service frameworks, and those in need can fall between the cracks of treatment provision.

The fact that many hazardous and harmful drinkers do not recognise the negative health consequences of excessive drinking compounds the problem of addressing their need. Many do not experience immediate ill-effects of their alcohol consumption. Furthermore, alcohol-related problems that could be identified by health professionals may not be apparent to drinkers themselves. Even if drinkers do understand that there is a connection between their alcohol consumption and their present or future health, they may not appreciate the severity of the relationship or feel that they can alter things. Thus, screening people who are not actively seeking treatment is key to identifying this hidden population and offering appropriate interventions.

Screening for brief interventions is therefore not best situated in specialist addiction services, as those who use these services have typically already had significant substance misuse identified and should be receiving specialist treatment. In addition, owing to the nature and severity of their use they would be less likely to benefit from brief intervention than from more complex specialist treatments. Brief interventions are usually not considered when dependent patterns of use are identified, and they are typically skipped in a stepped-care framework to a more intensive intervention.

It is non-specialist services that could most usefully provide screening and brief intervention. They would be able to approach individuals with hazardous or harmful drinking patterns and invite them for screening and subsequent brief intervention, if indicated. Many different settings would be well placed to provide screening and brief intervention and reach a target population that may benefit but otherwise could not be reached by standard treatment services.

Box 2 Settings assessed for screening and brief intervention

Medical
- Primary healthcare
- General hospital wards
- Accident and emergency departments
- Psychiatric wards
- Out-patient clinics of various kinds

Non-medical
- Educational establishments
- Social services
- The criminal justice system
- The workplace

Settings for screening and brief intervention

As screening and brief intervention are most appropriate for non-treatment-seeking drinkers the range of potential settings for their establishment is wide. Research has recognised this and much work has gone into evaluating this strategy in many different settings (Box 2). Studies have sought to evaluate not only the efficacy of these interventions, but also the practical implications and barriers to implementation within established systems.

Primary healthcare

There is strong evidence in favour of the use of screening and brief intervention in primary healthcare in the UK. Trials in primary care populations (Wallace *et al*, 1988; Anderson & Scott, 1992) have revealed that brief interventions delivered by general practitioners (GPs) are efficacious at reducing drinking that exceeds recommended safe limits, and numerous systematic reviews with meta-analyses have confirmed this finding (Kahan *et al*, 1995; Poikolainen, 1999; Ballesteros *et al*, 2004; Whitlock *et al*, 2004; Bertholet *et al*, 2005; Kaner *et al*, 2007).

Primary care is an appealing setting in which to deliver screening and brief intervention, considering the population it serves. Primary healthcare is typically the first service that patients go to in the UK for health-related advice. With 64% of adults consulting their GP each year (Drummond *et al*, 2004), primary healthcare is well placed to reach out to the wider community and to facilitate treatment if required. It is important to note that it is not just the GP who might usefully practise screening and intervention: practice nurses, physiotherapists, occupational therapists, counsellors, psychologists

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and others in primary care could equally do so. Thus, consideration of local service structure is important when targeting screening and brief intervention.

Accident and emergency departments

Alcohol misuse is frequently involved in presentations to accident and emergency (A&E) departments: up to 30% of all A&E attendances in England are alcohol-related (Prime Minister's Strategy Unit, 2004). Consequently, the A&E department is a promising venue for screening and brief intervention. One UK study that involved alcohol screening in an A&E department and referral to an alcohol health worker showed the intervention to be both practical and effective (Crawford *et al*, 2004). In addition to reducing levels of alcohol consumption, brief intervention can also reduce the frequency of attendance at the A&E department and is cost-effective (Barrett *et al*, 2006). Alcohol health workers are becoming more widespread in A&E departments throughout the UK.

The efficacy studies mentioned here were conducted in large teaching hospitals, and similar work needs to be carried out in A&E department settings more widely.

General hospital wards

A systematic review of the use of screening and brief intervention in general hospital settings found inconclusive evidence of efficacy (Emmen *et al*, 2004) and proposed further research. Logistically, general hospitals are a sensible setting in which to provide screening and brief intervention. They would be well placed to identify people experiencing physical consequences of alcohol misuse at a time when they may be more amenable to considering the impact of their drinking and open to behavioural change. This setting could be particularly useful for helping heavy drinkers who are at high risk of further future consequences.

Non-health-related settings

Although the vast majority of the work on screening and brief intervention has been carried out in healthcare settings, delivery in such settings is not necessarily a requirement. The prospect of introducing screening and brief intervention into other settings is promising. As mentioned above, people who are drinking in hazardous or harmful patterns may not be aware of the risk that they are placing on their health, or even feel that their drinking is a health-related matter. Trying to reach this sector of the population is extremely difficult, particularly if they never access traditional treatment services.

The criminal justice service is one example of an organisation that might lend itself well to successful implementation of screening and brief intervention. There is a well-recognised link between alcohol and crime, and harmful use of alcohol is therefore likely to be overrepresented among criminal offenders. Intervention might benefit not only the individual but also the wider community if alcohol contributes to their offending behaviour. In addition, those who are serving a custodial sentence or have their freedom restricted in other ways are often less able to seek the advice of health professionals and obtain treatment.

Educational establishments may also be well placed to reach alcohol-using groups and they have the potential to reach out to young people. A recent review provides some evidence for screening and brief intervention in this setting (Larimer & Cronce, 2007), but it is inconclusive and further research is needed. Of particular interest is the use of information technology, reaching out to students using emails and the internet. This method has appeal, as the relatively inexpensive medium of IT has the potential to encourage a large cross-section of people at risk to come forward for screening and/or treatment and it can even be used to deliver interventions.

The range of potential venues is extensive and could include social services, youth programmes, sports centres and so on. Transferring such an intervention away from traditional healthcare providers can create its own challenges. Differences in philosophy, culture and training are likely to influence the success of screening and brief intervention in alternative environments.

The psychiatrist's role

The relationship between alcohol use disorders and psychiatric diagnoses is well recognised. A study of psychiatric in-patients revealed that 49% were hazardous or harmful drinkers (McCloud *et al*, 2004). People with a dual diagnosis of mental health and addiction problems are now frequently accessing mental health services, yet many psychiatrists have had little formal addiction training.

Australian research shows that alcohol screening and brief intervention in psychiatric settings are feasible and can improve outcome, but it is likely that many patients will require more extended interventions, given the severity of alcohol problems encountered (Hulse & Tait,

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2002). The experience of the researchers suggested that individuals with psychiatric symptoms in the mid-range of severity responded best to brief intervention. This study showed a superiority of motivational interviewing over an information pack. A subsequent retrospective cohort study by the same authors looked at the effectiveness of brief intervention at 5-year follow-up (Hulse & Tait, 2003). Their analyses suggest that brief intervention had a valuable effect over this period for general and mental health outcomes, with longer time to general hospital episode or mental health in-patient admission, as well as roughly half the number of mental health in-patient episodes. However, the differential effect between motivational interviewing and the information pack was lost. The study had design limitations, as the database used was not entirely robust in recording all encounters and the control group was not randomised.

Although alcohol misuse remains widespread among people with mental health problems, its identification by health professionals may be limited. Previous work has shown that alcohol histories taken by psychiatric staff can be inadequate even for psychiatric in-patients. One study has shown that 49% of a sample of 200 patients recruited from in-patient acute psychiatric wards had hazardous consumption of alcohol, although 73% of the same 200 people had no record of alcohol use in their notes (Barnaby *et al*, 2003). This mismatch of prevalence and identification of harmful and hazardous alcohol use suggests that many of those in need of a targeted alcohol intervention do not get access to this treatment. Screening and brief intervention could be an effective way of uncovering and meeting this need. Further research is required to establish the cost-effectiveness and optimal method of delivery of screening and brief intervention in mental health populations.

Finding the target

It is not yet clear what might be the appropriate method of deciding which sectors of the population using psychiatric services are likely to benefit from an alcohol screening and brief intervention programme. However, the prospect of establishing services in this sector is appealing and they could be a way of addressing much of the comorbidity that alcohol is responsible for among these individuals. Stepped care may be particularly suitable in the mental healthcare settings. These environments present a wide range of alcohol use disorders, including a significant proportion of patients with mental health problems who are alcohol dependent and are likely to require more intensive treatment.

Implementing the programme

As in other settings, a range of staff with differing professional backgrounds could deliver screening and brief intervention. This allows flexibility when considering where and when it might occur in a particular service. Both community and in-patient services could integrate screening and brief intervention into their framework of assessment and review.

To ensure that such operational changes have longevity it would be important to develop an environment where screening and brief intervention are regarded as core business for treatment providers, with strong leadership and appropriate supervision for those that are delivering the programme.

Challenges for the future

Although the evidence base for brief interventions is extensive and generally supports implementation there are some areas of concern. Questions regarding particular aspects of efficacy, including long-term impact and non-alcohol-related outcomes, still remain unanswered. And although support is strong, translation into practice remains a significant challenge.

The active ingredients of brief intervention and the most effective methods of implementation need further research. It is currently unclear whether more extensive brief interventions involving the principles of motivational interviewing are more effective than simple brief advice from a health professional. Further, as most screening and brief intervention studies have been conducted in adults of working age, it is unclear what is the most effective approach for adolescents and older adults.

Randomised controlled trials understandably have focused on the ability of brief interventions to address alcohol use problems over a circumscribed period. However, this strategy of research has led to relative neglect of a wider examination of their impact. Evidence is mixed regarding the effect of brief interventions over extended follow-up periods. Efficacy has been demonstrated at 4 (Fleming *et al*, 2002) and 5 years (Hulse & Tait, 2003), but not at 10 years (Wutzke *et al*, 2002). Furthermore, alcohol consumption outcomes are widely reported in the literature, but other outcomes, such as health, psychological and sociological impact over time, are less widely studied. Work of this type (e.g. Hulse & Tait, 2002, 2003) may be particularly persuasive for policy makers and service providers.

The MoCAM programme advises commissioners of alcohol services that stepped care involving screening and brief interventions is a

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necessary part of alcohol service provision and that it should be used in a variety of settings, including primary care, A&E departments and the criminal justice system (Department of Health & National Treatment Agency for Substance Misuse, 2006). However, issues remain regarding the feasibility of using brief interventions with a British population and health service structure. Much of the research on brief intervention has been done outside of the UK, and there may be special aspects of implementation and process required to make brief interventions relevant in the UK context. Indeed, study of the process of brief interventions is still in its infancy. As a strategy they appear to be effective, but more work needs to be done to separate their critical components from aspects that have little influence over outcome.

Although there is ample research to support the wider implementation of brief interventions, encouraging their provision in appropriate settings has been a significant challenge (McRee *et al*, 2005). Making these interventions attractive to stakeholders and finding the right personnel and settings are factors that need to be considered to ensure a sustainable model of delivery. Numerous barriers to delivery need to be overcome before service users benefit.

Clarification of cost-effectiveness is crucial if these interventions are to be widely adopted. There is some evidence of the cost-effectiveness of screening and brief intervention in primary care and A&E department settings, but this needs to be studied more comprehensively in pragmatic clinical trials in typical UK clinical practice. The cost-effectiveness of stepped-care alcohol intervention also remains to be determined.

Two studies are currently underway in the UK to examine some of these questions. The first of these is a pragmatic randomised controlled trial funded by the Health Technology Assessment programme to study screening and stepped-care intervention for alcohol use disorders in older adults in primary care (Coulton *et al*, 2008). The second, the Screening and Intervention Programme for Sensible Drinking (SIPS; www.sips.iop.kcl.ac.uk), is in support of the Alcohol Harm Reduction Strategy for England (Prime Minister's Strategy Unit, 2004). Commissioned by the Department of Health, this large programme of research into the effectiveness and cost-effectiveness of screening and brief intervention in typical clinical practice involves three cluster randomised controlled trials in primary healthcare, A&E department and criminal justice settings.

Ultimately, the impact of alcohol screening and brief intervention on public health in the UK will depend on political will and funding. There will need to be significant investment in training and support of staff in the healthcare, criminal justice and other implementing professions. This will range from basic and undergraduate training through to postgraduate education. A long-term investment of skill and finance will be required if successful translation into practice is to be achieved.

Declaration of interest

None.

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MCQs

1 Regarding the duration of brief interventions:
a there is no optimal duration
b extended brief interventions are more effective than shorter interventions
c there is a correlation between duration of intervention and subsequent reduction in alcohol consumption
d the minimum duration of face-to-face contact required to deliver a brief intervention is 10 min
e brief interventions must be delivered in the same session as screening.

2 Alcohol screening and brief interventions:
a are most effective when delivered in specialist substance misuse services
b should be given to the patient in primary care if specialist alcohol treatment has failed
c are ineffective in psychiatric settings
d can only be effective when delivered in healthcare settings
e are effective in reducing attendance at A&E departments.

3 Stepped care:
a is delivered primarily by the criminal justice service
b should be employed when specialist addiction treatment has failed
c comprises 12 steps and is based on the Minnesota model
d is a model in which choice of the intervention is guided by the severity of the individual's alcohol problem
e does not require collaboration between the individual and the service provider.

4 In the acronym FRAMES:
a F denotes Facing up to harmful use of alcohol
b R stands for Realising that change needs to occur
c A denotes that clear Advice should be given
d M reminds that Medication should be used if indicated
e E indicates that Extended interventions are more effective.

5 Screening and brief intervention has a strong evidence base:
a yet was not included in the Mesa Grande study
b with most studies being conducted in social care settings
c for delivery in A&E departments but not in primary care settings
d with a recent Cochrane review showing efficacy in clinical practice
e in the UK but not in the USA.

MCQ answers

1	2	3	4	5
a T	a F	a F	a F	a F
b F	b F	b F	b F	b F
c F	c F	c F	c T	c F
d F	d F	d T	d F	d T
e F	e T	e F	e F	e F

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