ALCOHOL ALERT

Brief Intervention for Alcohol Problems

Nearly one-fifth of patients treated in general medical practices report drinking at levels considered "risky" or "hazardous" (1,2) and may be at risk for developing alcohol-related problems as a result. Brief intervention, which can be conducted in general health care settings, can help patients reduce that risk. Brief intervention is generally restricted to four or fewer sessions, each session lasting from a few minutes to 1 hour, and is designed to be conducted by health professionals who do not specialize in addictions treatment. It is most often used with patients who are not alcohol dependent, and its goal may be moderate drinking[1] rather than abstinence (4-6). The content and approach of brief intervention vary depending on the severity of the patient's alcohol problem. Although the approaches used in brief intervention are similar for alcohol-dependent and non-alcohol-dependent patients, the goal of brief intervention for alcohol-dependent patients is abstinence. Most of the findings in this *Alcohol Alert* relate to the use of brief intervention with non-alcohol-dependent patients treated in general health care settings. However, brief intervention also has been used to motivate alcohol-dependent patients to enter specialized treatment with the goal of abstinence (7) and has been studied as an alternative to long-term treatment in specialized alcohol treatment settings (8,9). This *Alcohol Alert* explains the components of brief intervention and considers the effectiveness of this approach.

Screening for Alcohol Problems

A number of screening tools are available to identify current or potential alcohol problems among patients (see *Alcohol Alert* No. 8, "Screening for Alcoholism" [10]). Medical history questionnaires can pose questions about current and past alcohol use, including quantity and frequency of drinking (6). Questions about a patient's previous accidents and injuries can elicit clues to a potential alcohol problem (11). Several standardized screening questionnaires, such as the Alcohol Use Disorders Identification Test (AUDIT) (12), the CAGE (13), and the Michigan Alcoholism Screening Test (MAST) (14) and its derivatives (e.g., the Brief MAST [15]), can identify alcohol problems among current drinkers (16).[2] Laboratory tests, such as the test for the liver enzyme gamma-glutamyltransferase (GGT), may also reveal the presence of unsuspected alcohol problems (6).

Common Elements of Brief Intervention

Research indicates that brief intervention for alcohol problems is more effective than no intervention (e.g., 1,17-19) and often as effective as more extensive intervention (e.g., 4,8). To identify the key ingredients of brief intervention, Miller and Sanchez (20) proposed six elements summarized by the acronym FRAMES: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy. The importance of these elements in enhancing effectiveness has been supported by further review (4). Goal setting, followup, and timing also have been identified as important to the effectiveness of brief intervention (5).

Feedback of Personal Risk. Most health professionals delivering brief intervention provide patients with feedback on their risks for alcohol problems based on such factors as their current drinking patterns; problem indicators, such as laboratory test results; and any medical consequences of their drinking (1,17,21). For example, a physician may tell a patient that his or her drinking may be contributing to a current medical problem, such as hypertension, or may increase the risk for certain health problems (22).

Responsibility of the Patient. Perceived personal control has been recognized to motivate behavior change (23). Therefore, brief intervention commonly emphasizes the patient's responsibility and choice for reducing drinking (e.g., 8). For example, a doctor or nurse may tell patients that "No one can make you change or make you decide to change. What you do about your drinking is up to you."

Advice To Change. In some types of brief intervention, professionals give patients explicit advice to reduce or stop drinking (8,24). While expressing concern about the patient's current drinking and the related health risks, the physician may discuss guidelines for "low-risk" drinking (22).

Menu of Ways To Reduce Drinking. Health professionals providing brief intervention may offer patients a variety of strategies from which to choose. These may include setting a specific limit on alcohol consumption; learning to recognize the antecedents of drinking and developing skills to avoid drinking in high-risk situations; planning ahead to limit drinking; pacing one's drinking (e.g., sipping, measuring, diluting, and spacing drinks); and learning to cope with the everyday problems that may lead to drinking (e.g., 19,25,26). Health care professionals often give their patients self-help materials to present such strategies and to help them carry these strategies out (e.g., 11,18,27,28). Self-help materials often include drinking diaries to help patients monitor their abstinent days and the number of drinks consumed on drinking days (e.g., 18,21), record instances when they are tempted to drink or experience social pressure to drink, and note the alternatives to drinking that they use (29). When working with alcohol-dependent patients, abstinence, rather than reduced drinking, is the goal of brief intervention.

Empathetic Counseling Style. A warm, reflective, and understanding style of delivering brief intervention is more effective than an aggressive, confrontational, or coercive style (4). Miller and Rollnick (30) found that when they used an empathetic counseling style, patients' drinking was reduced by 77 percent, as opposed to 55 percent when a confrontational approach was used.

Self-Efficacy or Optimism of the Patient. Health professionals delivering brief intervention commonly encourage patients to rely on their own resources to bring about change and to be optimistic about their ability to change their drinking behavior (e.g., 8,9). Brief intervention often includes motivation-enhancing techniques (e.g., eliciting and reinforcing self-motivating statements, such as "I am worried about my drinking and want to cut back," and emphasizing the patient's strengths) to encourage patients to develop, implement, and commit to plans to stop drinking (e.g., 9,31).

Establishing a Drinking Goal. Patients are more likely to change their drinking behavior when they are involved in goal setting (30,32). The drinking goal usually is negotiated between the patient and physician and may be presented in writing as a prescription from the doctor or as a contract signed by the patient (e.g., 1).

Followup. The health care professional continues to follow up on the patient's progress and provide ongoing support. Followup may take the form of telephone calls from office staff, repeat office visits, or repeat physical examinations or laboratory tests (e.g., 1,17,33).

Timing. Much of the research investigating the relationship between an individual's readiness to change and actual behavior change is based on studies of smoking cessation. Research findings have been applied to reducing drinking (5,6). Individuals are most likely to make behavior changes when they perceive that they have a problem (34,35) and when they feel they can change (36). Some patients may not be ready to change when brief intervention begins, but may be ready when they experience an alcohol-related illness or injury (34,35,37). Because a patient's readiness to change appears to be a significant predictor of changes in drinking behavior (38), it is important to assess patients' readiness to change when beginning a brief intervention. Rollnick and colleagues (39) created a 12-question "readiness to change" questionnaire for use in matching intervention techniques with a given patient's stage of readiness to change.

A few studies indicate that matching the type of brief intervention to the patient's readiness to change may be important. Among patients highly motivated to reduce their drinking and confident that they could change on their own, 77 percent decreased their drinking when given a self-help manual with specific instructions, compared with 28 percent who were given materials with only general advice (40). For patients with little motivation to change, Heather and colleagues (38) found that motivational interviewing was more effective than specific instructions.

Effectiveness of Brief Intervention

For non-alcohol-dependent patients. Many studies suggest that brief intervention can help non-alcohol-dependent patients reduce their drinking (e.g., 1,17,18). In a meta-analysis of 32 brief intervention studies, Bien and colleagues (4) reported that the average positive change observed for intervention groups was about 27 percent. Positive changes were often observed for control groups, suggesting that the assessment of drinking behavior and related problems may, in itself, have led motivated patients to alter their drinking behavior.

For Alcohol-Dependent Patients. Other studies have examined the effectiveness of brief intervention for motivating alcohol-dependent patients to enter long-term alcohol treatment. Among alcoholics identified in an emergency

care setting, 65 percent of those receiving brief counseling kept a subsequent appointment for specialized treatment, compared with 5 percent of those who did not receive counseling (7).

Some studies conducted among alcohol-dependent patients have found that brief intervention is as effective as more extensive treatment approaches used in specialized alcohol treatment settings (8,9,41,42). Edwards and colleagues (8) compared the effectiveness of one session giving brief advice to stop drinking with standard alcohol treatment among 100 alcohol-dependent men. The brief advice emphasized personal responsibility to stop drinking and encouraged group members to return to work and improve their marriages. Group members also received a monthly followup telephone call. The group receiving standard alcohol treatment was admitted for an average of 3 weeks' inpatient alcoholism treatment, attended an average of ten 30-minute psychiatric outpatient counseling sessions, and received monthly followup visits. One year later, both groups reported a 40-percent decrease in alcohol-related problems. After 2 years, patients with less severe problems were more likely to report improvement if they received brief intervention than if they received intensive treatment. However, patients with more severe problems were more likely to report improvement if they received intensive treatment (43).

Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity) compared the effects of four 1-hour sessions of motivational enhancement therapy (MET) with 12 sessions of 12-step facilitation therapy and 12 sessions of cognitive-behavioral coping skills therapy in more than 1,500 alcohol-dependent patients (9). (Although MET can be considered a brief intervention because it consisted of only four sessions, it is more intensive than other brief interventions.) Both 1 year and 3 years after the intervention, participants in all three groups reported drinking less often and consuming fewer drinks per drinking day compared with their drinking behavior before treatment (9,42) (see *Alcohol Alert* No. 36, "Patient-Treatment Matching" [44]).

In summary, variations of brief intervention have been found effective for helping non-alcohol-dependent patients reduce or stop drinking, for motivating alcohol-dependent patients to enter long-term alcohol treatment, and for treating some alcohol-dependent patients.

Brief Intervention for Alcohol Problems--A Commentary by NIAAA Director Enoch Gordis, M.D.

The finding that brief intervention can be an effective means of intervening in alcohol problems adds an important tool to the clinician's repertoire of treatment options. It is an especially attractive option, because it can be used in primary care settings with minimum disruption to office routine and patient care. However, the evidence of its effectiveness and low cost may lead to the conclusion--particularly in today's managed-care environment--that it is always possible to substitute brief intervention for more specialized care. This would be a mistake. Brief intervention is not one therapy but several different types of treatment interventions, with differences in the types of patients who can benefit from it, the time required to administer the intervention, and the cost. Thus, requiring brief intervention in lieu of other types of therapy without specifying the

type of intervention or the patients for whom it is best suited might help some, but certainly not all, patients with alcohol problems.

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[1]The U.S. Department of Agriculture and the U.S. Department of Health and Human Services define moderate drinking as no more than two drinks per day for men and no more than one drink per day for women. A standard drink is 12 grams of pure alcohol, which is equal to one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits (3).

[2]These and other instruments are available on NIAAA's World Wide Web site at

http://www.niaaa.nih.gov

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