Brief Intervention Efficacy

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EXCEPTIONAL CARE. WITHOUT EXCEPTION.

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What is Brief Intervention?

- 10-15”, empathic
- Feedback
  - Ask permission
  - Ask what patient thinks of it
- Advice (clear)
- Goal setting
  - Negotiate
  - Menu of options
  - Support self-efficacy
- Follow-up

“You are drinking more than is safe for your health.”

“My best medical advice is that you cut down or quit.”

“What do you think? Are you willing to consider making changes?”

Table 4. Brief Counseling and Referral.*

How to Advise or Refer Patients	Examples or Explanations
Elicit information about how the patient views the problem.	“What do you think about your drinking? Are you ready to make a change in your alcohol use? How confident are you that you could cut down if you wanted to?”
Express concern and provide clear advice regarding the ideal goal (abstinence or reduced consumption for those with nondependent alcohol use, achieved through brief counseling; abstinence for patients with alcohol dependence).†	“I am concerned about your drinking; my medical advice is that the healthiest choice for you is to cut down or abstain.”
Provide specific feedback about alcohol consumption in comparison with population norms, and link existing problems to alcohol use when appropriate, to make information relevant to the patient.	“Ninety-three percent of adults drink less than the amounts you report drinking. You mentioned your heartburn is worse when you drink. Alcohol is probably causing your heartburn.”
Express empathy, let the patient know you believe that change is possible, and acknowledge that it is the patient’s responsibility to change.	“The fact you were able to quit before for a week tells me you can do it again. But it must be difficult. It is up to you to make these changes.”
When the patient expresses interest or gives permission, provide information, including a menu of options, about how to change.	“Would you like information on how to cut down or abstain? Other people have found a range of options helpful, such as keeping a drinking diary, counseling, and mutual-help groups. What do you think about these?”
Anticipate and discuss situations in which the patient feels at risk for drinking excessively, and talk about strategies to avoid drinking excessively.	“What ways might help you avoid drinking excessively when you go out with friends who drink?” Have the patient keep a drinking diary (including the number of drinks consumed per day).
Schedule a follow-up session to assess drinking and changes in alcohol use.	“Please think about your drinking and the health risks we discussed; contact me if you decide you would like assistance in the future. Let’s schedule a follow-up visit in a month to talk again.” In the follow-up, review the drinking goal, the actual drinking history, and any consequences since the last visit. If the serum levels of γ-glutamyltransferase or carbohydrate-deficient transferrin were initially abnormal, monitor levels.
For patients who are not ready to change their alcohol use, advice about changing their habits or getting help is counterproductive because the patient will enumerate the reasons against change; avoid confrontation and argument.	
Elicit the patient’s own reasons for drinking, reasons for not drinking, and concerns about changing.	“What do you like about drinking? What do you like to drink? What are some problems you have noticed when or after you drink? What would it be like not to drink?”
For patients with alcohol dependence, provide brief counseling with the goal of increasing motivation to change; the recommended change is abstinence and linkage with any or all known effective interventions (mutual-help groups, pharmacotherapy, and counseling).‡	Consider referral to a specialist (a physician who specializes in addiction medicine or an alcoholism-treatment provider) for evaluation and confirmation of the diagnosis, even if the patient is not ready to begin treatment.
Know local referral options, such as health plan referral services, public treatment resources, physicians, other counselors, employee-assistance programs, and national resources (in the United States, http://findtreatment.samhsa.gov); know what patients can expect when they seek assistance.§	Help the patient take the first step (e.g., make an appointment); follow up on treatment entry and engagement.
For patients in recovery, address plans for what to do in the event of relapse.¶	“What would you do if you felt your drinking was out of control?”

* Data are from the Department of Health and Human Services[3] and the U.S. Preventive Services Task Force.[5] This model includes a recommended structure for effective discussions about changing health behavior (elicit–provide–elicit).[23] The elements of brief interventions with proven efficacy include feedback, responsibility, advice, a menu of options, empathy, and support of self-efficacy.

† Patients may need additional assistance if their goal is not achieved. Patients who are pregnant or trying to conceive, who have a medical condition that would be worsened by drinking, or who are taking a medication that interacts with alcohol should be advised to abstain. Discus-

Saitz R. N Engl J Med 2005;352:596-607.

EFFICACY OF ALCOHOL BRIEF INTERVENTION VS. NO BI

- ≥22 original RCTs, 8 systematic reviews
  - Lower proportion of drinkers of risky amounts (n=2784)
    - 57% vs. 69% at 1 year
  - Lower consumption (n=5639)
    - by 15% (38 grams per week)
- Decreased hospital utilization (≥2 RCTs)
- Cost-effective (spend $166, save $546 medical)
- 4 RCTs (n=1640), BI decreased mortality (RR 0.47)
- Some effects 3-16 years later*

RCT=Randomized controlled trial

Kaner et al. Drug and Alcohol Review 2009;28:301–23
Beich et al. BMJ 2003;327:536
Bertholet et al. Arch Intern Med. 2005;165:986
*Kristenson H, et al. Alcohol Clin Exp Res 1983;7:203
*Fleming MF et al. Alcohol Clin Exp Res. 2002;26(1):36-43.
Cuijpers et al. *Addiction* 2004;99: 839–845

Duration and frequency may matter:
Brief and Very Brief (VB) vs. Brief Multi-contact

Brief and very brief

Author(s)	N	Difference	Comment
Richmond et al. (VB)	378	-	Nonrandom
WHO (VB)	1559	+ B & VB	NS for women
Anderson & Scott	154	+	Men
Nilssen	338	+	
Senft et al.	516	Borderline	
Maisto et al.	301	-	Outside clinic
Scott & Anderson	72	-	Women

RED=no diff
GREEN= + study

Example intervention (Fleming)
health booklet +
2 10-15” physician discussions
And follow-up nurse phone call

Brief multi-contact

Author(s)	N	Difference	Comment
Maisto et al.	301	-	Decrease but NS
Curry et al.	307	+	Good quality
Fleming et al.	774	+	Good quality
Fleming et al.	158	+	Good quality; Elderly
Nilssen	338	+	
Ockene	530	+	Good quality
Wallace	909	+	Good quality

Whitlock et al. Ann Intern Med 2004; 140:557-68.

Details of BI literature with relevance to practice

- Key concept: “identified by screening”
- Best evidence: nondependent unhealthy use, primary care
  - Self-report and social desirability a limitation
    - Efficacy results modest
  - Studies find the right ‘zone’
    - More than minimally risky amounts, but not too much
- Almost all studies exclude dependence and even (very) heavy drinking
- Evidence of efficacy for outcomes beyond consumption is limited
  - Little evidence for linkage to specialty care
- Literature regarding ED and hospital mixed

SETTING

- Most people identified by screening in hospitals have *dependence*
- Different expectations and goals
  - Comprehensive care?
  - Preventive care?
  - Longitudinal care? Long-term therapeutic alliance?
  - Teachable vs. learnable moments?

Belen Martinez et al INEBRIA 2007
Saitz et al. Ann Intern Med 2007;146:167-76
Freyer-Adam J et al. Drug Alcohol Depend 2008
Bischoff G et al. Drug Alcohol Depend 2008
Bischof et al. Int J Pub Health 2010
Saitz et al. Int J Pub Health 2010

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SBI for other drugs in adults: not so promising

- RCT in urgent care
  - 9% difference in opioid abstinence (40% vs. 31%)
  - 5% difference in cocaine abstinence (22% vs. 17%)
  - No difference in linkage to treatment
- Multi-site RCT (international) in varied outpatient settings
  - Excluded mild and severe
  - Small (clinically insignificant) decreases in point scales representing marijuana and stimulant use but not opioid use
- 5 RCTs published in 2014, one coming in 2015
  - Woodruff et al-50% loss to follow-up; negative
  - Schwartz et al-computer and person similar; no control
  - Bogenschutz et al-multisite ER study, >80% F/U, hair, NEGATIVE
  - Saitz et al-n=528 primary care, 98% F/U, hair, NEGATIVE
  - Roy-Byrne et al n=868 primary care, 87% FU, urine, NEGATIVE
  - Gelberg et al-positive, small effects, more effect among more severe, no lab outcomes (2015)

SBI DRUGS

- Harder to change a behavior that is not socially sanctioned yet being done or that is not particularly problematic from the patient's perspective
- Injection, heroin, cocaine, MJ, qualitatively different
- Other reasons to ask/intervene: interactions/safety, diagnoses, help-seeking/recognized
- Need better ways to address in general medical settings…

SUMMARY/IMPLICATIONS

- Brief intervention involves feedback, advice and goal setting
- Among those identified by screening, the best evidence for efficacy is for reducing self-reported alcohol consumption in primary care settings
  - Efficacy for disorders, drugs and in acute care settings limited
- Likely effective for health behaviors (e.g. drug use) among those seeking your help
- Feasible in general health settings
- Can be done by generalists