Brief Intervention Efficacy

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What is Brief Intervention?

- 10-15”, empathic, non-confrontational
- 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).

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

EFFICACY

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RANDOMIZED TRIALS OF SCREENING AND BRIEF INTERVENTION VS. NO SCREENING

NONE

EFFICACY OF ALCOHOL BI VS. NO BI

- Efficacious: 10-15" multi-contact
  - ≥23 original RCTs,* 9 systematic reviews, primary care, non-dep, screen id'd
    - Lower proportion of drinkers self-reporting risky amounts
      - 57% vs. 69% at 1 year (n=2784)**; 11% risk diff (n=5973)*
    - Lower self-reported **consumption** (n=5639)
      - by 15% (38 grams per week)(n=5639)***; 3.6 drinks/wk (n=4332)*
    - Accidents, injuries, liver problems, hospital/ER/primary care use, legal problems, quality of life: insufficient evidence*
      - Decreased hospital utilization (≥2 RCTs)
      - Cost-effective (spend $166, save $546 medical, $7780 society)
      - Decreased mortality (RR 0.47)(4 RCTs (n=1640)
    - Prevention of disorder – no evidence

*Jonas DE et al. Ann Intern Med 2012;157:645-54.
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 (mortality, 3-16 yrs)
Fleming MF et al. Alcohol Clin Exp Res. 2002;26(1):36-43 (cost)
Cuijpers et al. Addiction 2004;99: 839–845 (mortality)

SETTING

- Evidence is mixed for emergency and hospital
- Most people identified by screening in hospitals have a mod/severe disorder
- 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

McQueen J. Cochrane review 2011
D'Onofrio RCTs; Schmidt CS. Et al. Addiction, 2016;111: 783–794
Very small effect (meta-analysis).
Gentilello et al 1999 and subsequent studies

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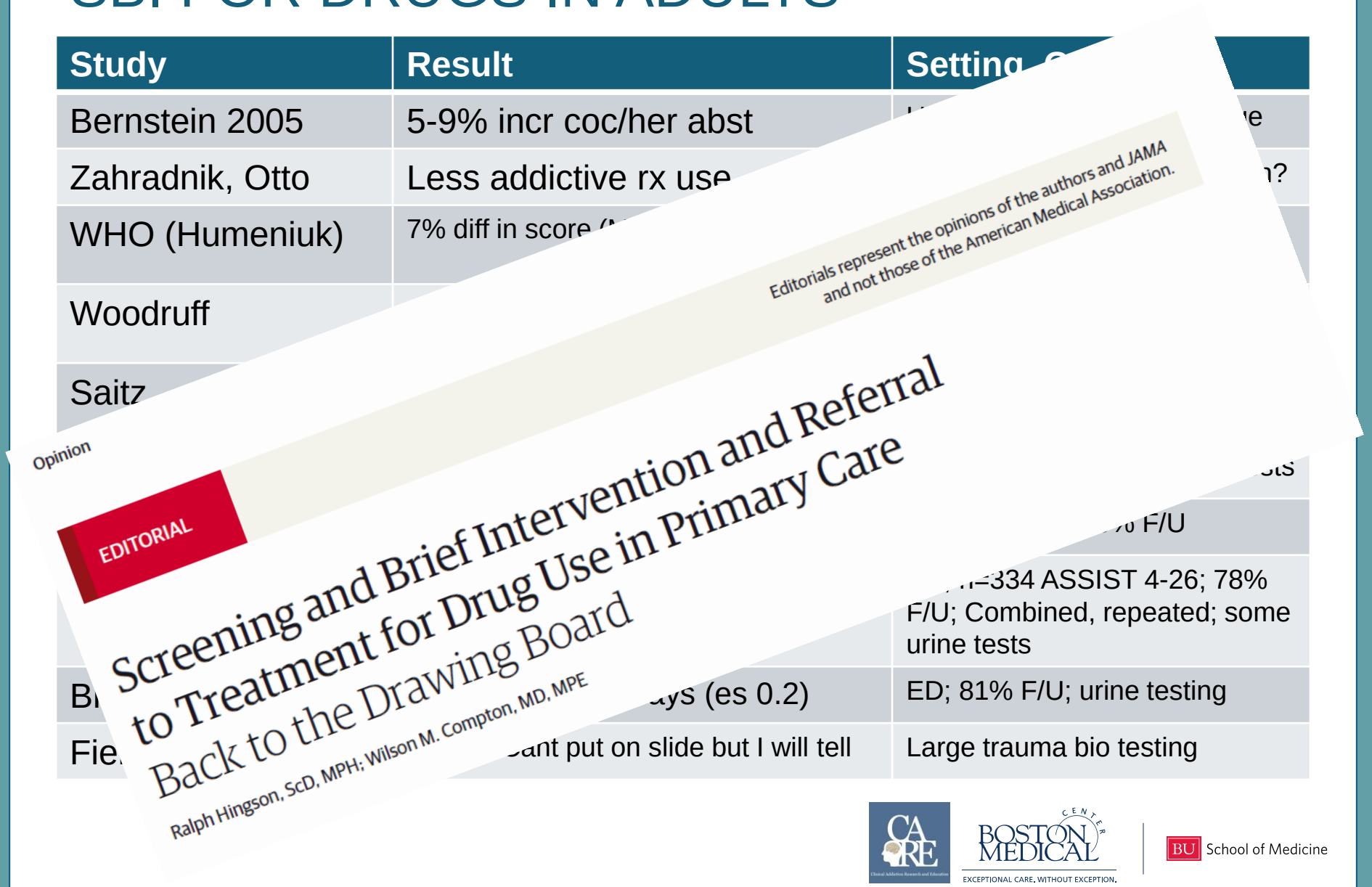
SBI FOR DRUGS IN ADULTS

Study	Result	Setting
Bernstein 2005	5-9% incr coc/her abst	
Zahradnik, Otto	Less addictive rx use	
WHO (Humeniuk)	7% diff in score	
Woodruff		
Saitz		
		% F/U
		=334 ASSIST 4-26; 78% F/U; Combined, repeated; some urine tests
Br	ays (es 0.2)	ED; 81% F/U; urine testing
Fie	ant put on slide but I will tell	Large trauma bio testing



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YOUTH DRUG SBI RCTS: PROMISING

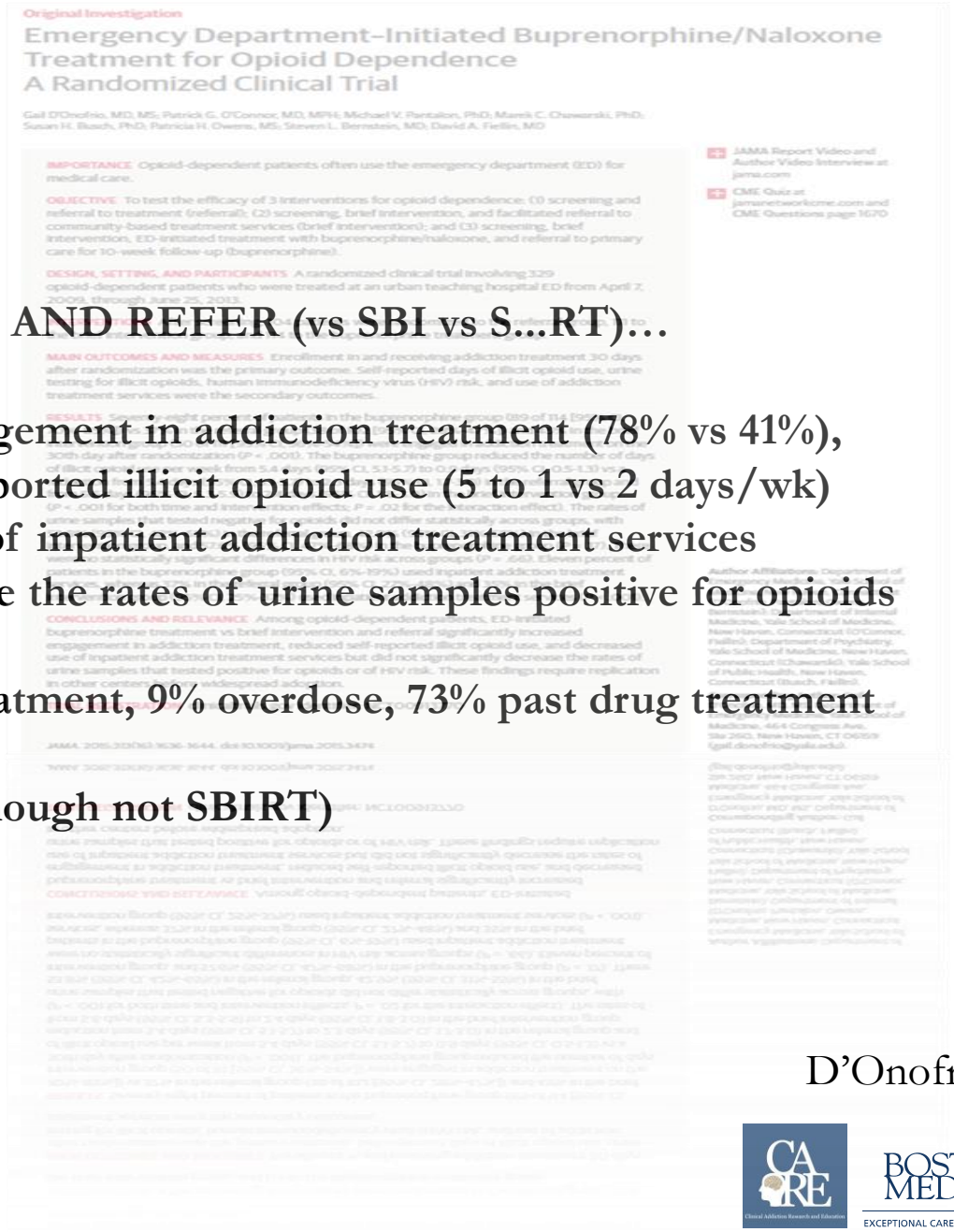
① n=59 **adolescents in primary care** in Brazil-decreased MJ and stimulant use and problems

② Decreased marijuana use by **adolescents in the emergency department** in a pilot study (n=210)

③ Decreased cannabis problems and drug use (computer BI) and cannabis DUI (therapist) by **adolescents in primary care** (n=328)

④ Computer (but not therapist) BI *prevented* cannabis (17% vs 24%, 1 yr) use in adolescents in primary care (n=714)

DeMicheli D et al. Rev Assoc Med Bras 2004; 50(3): 305-13
Bernstein E et al. Acad Emerg Med 2009; 16: 1174-85
Walton MA (Blow) et al. Drug Alcohol Dependence 2013;132;646-53.
Walton MA (Blow) et al. Addiction 2013;109:786-97.


Original Investigation

Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

(screen), TREAT AND REFER (vs SBI vs S...RT)…

✓increased engagement in addiction treatment (78% vs 41%),
✓reduced self-reported illicit opioid use (5 to 1 vs 2 days/wk)
✓decreased use of inpatient addiction treatment services
✓did *not* decrease the rates of urine samples positive for opioids

*34% seeking treatment, 9% overdose, 73% past drug treatment

(*e.g. Terrific! Though not SBIRT)

D'Onofrio et al. JAMA 2015

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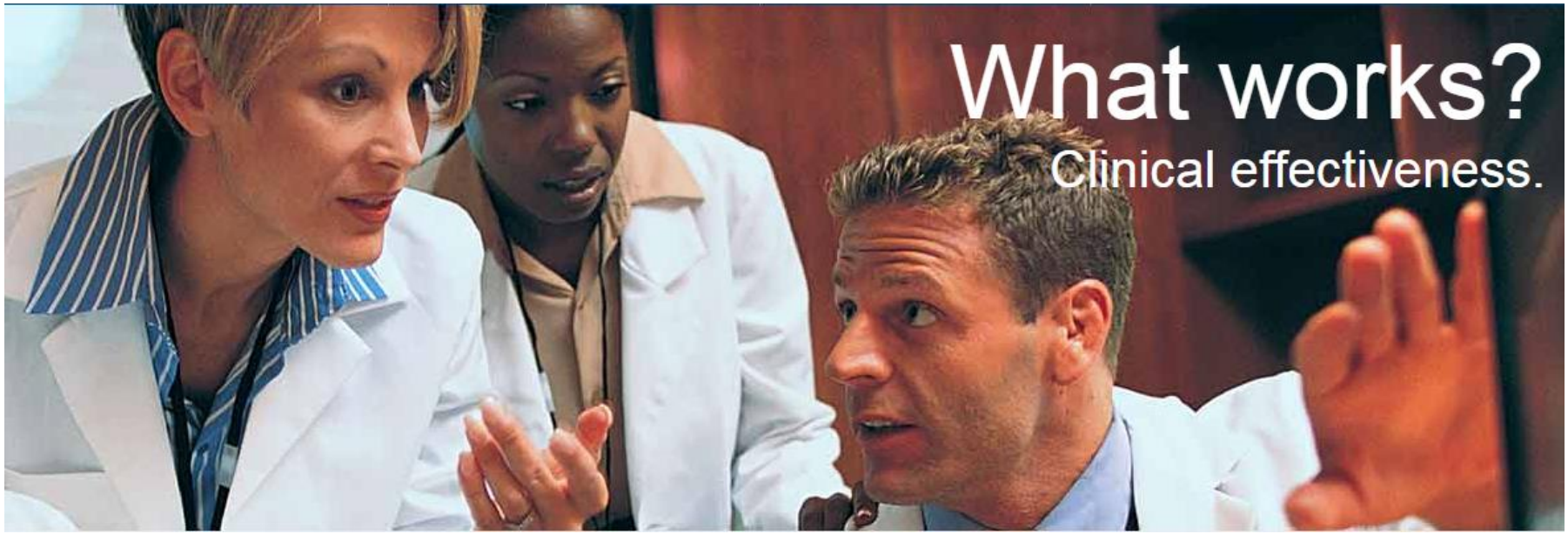
SBI DRUGS

- 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, rx drugs cocaine, MJ, qualitatively different
- Other reasons to ask/intervene
  - interactions/safety, diagnoses, help-seeking/recognized
- Need better ways to address in general medical settings…repeated BI and/or just treat



BMJ

BMJ 2013;346:e8501 doi: 10.1136/bmj.e8501 (Published 9 January 2013)

RESEARCH

Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial

OPEN ACCESS

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Kaner et al. BMJ 2013;346:e8501 doi: 10.1136/bmj.e8501

"I've heard the saying, but I never thought it was something that could actually happen."

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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
- Repeat or just treat

BEST ADVICE

- Abstinence
  - Failed attempts at cutting down
  - Dependence
  - Pregnancy/preconception
  - Contraindicated medical condition or medication
- Cutting down
  - Risky or problem use

“Beyond Screening”

- Determine the patient’s perception of his/her use, both the need and perceived ability to change behavior

  Example: “Do you think your drug use is a problem?”
- Assess the patient’s stage of readiness to change behavior

Samet, JH, Rollnick S, Barnes H. *Arch Intern Med*. 1996;156:2287-2293.

FEEDBACK

Provide personalized feedback and state your concern.

- GGT
- drinking data
- risky behaviors
- consequences

ADVICE

Make explicit recommendation for change in behavior

- Emphasis on personal RESPONSIBILITY for change
  - "…it's up to you to decide…"
- Give them a menu of options
- Use an EMPATHIC counseling style

GOAL SETTING

Discuss patient's reaction and negotiate plan.

- Enhancement of SELF-EFFICACY
- Reinforce it, state your belief they can do it
- Give example of patient's past success

Precontemplation

→Goal is to raise doubt, increase perception/ consciousness of problem

- →express concern
- →state the problem non-judgmentally
- →agree to disagree
- →advise a trial of abstinence or cutting down
- →importance of follow-up (even if using)
- →less intensity is better

Samet, JH, Rollnick S, Barnes H. *Arch Intern Med*. 1996;156:2287-2293.

Contemplation

→Goal is to tip the balance

- →elicit positive and negative aspects of drinking
- →elicit positive and negative aspects of not drinking
- →summarize (patient could write these down)
- →demonstrate discrepancies between values and actions
- →advise a trial of abstinence or cutting down

Determination

- →Goal is to help determine the best course of action
  - →working on motivation is not helpful
  - →supporting self-efficacy is (remind of strengths--i.e. period of sobriety, coming to doctor)
  - →help decide on achievable goals
  - →caution re: difficult road ahead
  - →relapse won't disrupt relationship

Action

→Goal is to help patient take steps to change

- →support and encouragement
- →acknowledge discomfort (losses, withdrawal)
- →reinforce importance of recovery

Maintenance

- →Goal is to help prevent relapse
  - →anticipate difficult situations (triggers)
  - →recognize the ongoing struggle
  - →support the patient's resolve
  - →reiterate that relapse won't disrupt your relationship

Relapse

→Goal is to renew the process of contemplation

- →explore what can be learned from the relapse
- →express concern
- →emphasize the positive aspects of prior abstinence and of current efforts to seek care
- →support self-efficacy

Brief Counseling Interventions: Summary

- Assess to determine best advice
- Assess readiness to change
- Counsel including known effective elements of brief intervention
  - Feedback, advice, goal setting