

Chapter 4. Brief interventions

4. Brief interventions

This chapter provides a description of brief interventions and their role in addressing risky or harmful patterns of alcohol use. It also explains how to deliver brief interventions, who the appropriate candidates are for brief interventions, and suitable settings for brief interventions.

Brief interventions are clinical interventions that include screening and assessment, and provide information and advice designed to achieve a reduction in risky alcohol consumption and/or alcohol-related problems. They are recognised as an important part of the overall approach to responding to people with risky drinking patterns, who may or may not have experienced alcohol-related harms. Significant reductions of up to 30 per cent in alcohol consumption have been achieved in a variety of health care settings, including hospitals and general practice. Brief interventions in primary care are also cost-effective.

Brief interventions are delivered in a time-limited way, ranging from one to four sessions of between 5 and 30 minutes. They usually involve a combination of motivational interviewing and counselling techniques (see Chapter 6).

Opportunistic brief interventions are offered to people who have not sought treatment or assistance but have been identified through routine screening as drinking at risky levels. Such interventions aim to inform people that they are drinking at levels that increase their risk of developing abuse or dependence disorders, and to encourage them to decrease consumption to reduce that risk. Such interventions have the potential to prevent harm and should be more cost effective than other harm reduction strategies.

Who to target for brief interventions

People who can be considered prime targets for brief interventions are usually those who:

- are drinking beyond recommended limits, often identified through screening procedures or clinical history, such as AUDIT questionnaire – see Chapter 3
- present to services with alcohol-related problems, but do not have a diagnosis of alcohol dependence.

Scientific evidence strongly supports the view that brief interventions effectively reduce levels of alcohol intake in people who drink above recommended levels and are at risk of developing alcohol-related problems, but who do not seek treatment. A number of meta-analyses have examined the effectiveness of brief interventions in these patient populations. Results from all these meta-analyses have been consistent in suggesting that opportunistic brief interventions, compared to no intervention, effectively reduce levels of alcohol consumption.

Brief interventions are not usually effective in people who have developed dependence, or who are experiencing severe alcohol-related harms. For these people, more intensive treatment interventions are recommended.

If a patient returns to the same setting and is still drinking to excess, the clinician should recommend a more intensive treatment program in an effort to reduce alcohol use and related problems. This may involve referral to a specialist alcohol and drug treatment service.

Recommendation	Strength of recommendation	Level of evidence
4.1 Brief interventions are effective in reducing alcohol use in people with risky pattern of alcohol use and in non-dependent drinkers experiencing alcohol-related harms and should be routinely offered to these populations.	A	1a
4.2 Brief interventions are not recommended for people with more severe alcohol-related problems or alcohol dependence.	A	1b

How to deliver brief interventions

As a general rule, brief interventions should include at least the five components which can be summarised in the acronym FLAGS (see Table 4.1), the two most crucial of which are feedback and advice. Alternative acronyms, such as FRAMES (feedback, responsibility, advice, menu, empathy, self-efficacy) and 5As (ask, advise, assess, assist, arrange) with comparable structures for guiding an intervention, can be used.

Table 4.1: FLAGS brief intervention structure

Feedback	<ul style="list-style-type: none"> • Provide individualised feedback about the risks associated with continued drinking, based on current drinking patterns, problem indicators, and health status. • Discuss the potential health problems that can arise from risky alcohol use.
Listen	<ul style="list-style-type: none"> • Listen to the patient's response. • This should spark a discussion of the patient's consumption level and how it relates to general population consumption and any false beliefs held by the patient.
Advice	<ul style="list-style-type: none"> • Give clear advice about the importance of changing current drinking patterns and a recommended level of consumption. • A typical five to 10 minute brief intervention should involve advice on reducing consumption in a persuasive but non-judgemental way. • Advice can be supported by self-help materials, which provide information about the potential harms of risky alcohol consumption and can provide additional motivation to change.
Goals	<ul style="list-style-type: none"> • Discuss the safe drinking limits and assist the patient to set specific goals for changing patterns of consumption. • Instil optimism in the patient that his or her chosen goals can be achieved. • It is in this step, in particular, that motivation-enhancing techniques are used to encourage patients to develop, implement and commit to plans to stop drinking.
Strategies	<ul style="list-style-type: none"> • Ask the patient to suggest some strategies for achieving these goals. • This approach emphasises the individual's choice to reduce drinking patterns and allows them to choose the approach best suited to their own situation. • The individual might consider setting a specific limit on alcohol consumption, learning to recognise the antecedents of drinking, and developing skills to avoid drinking in high-risk situations, pacing one's drinking and learning to cope with everyday problems that lead to drinking.

Brief interventions are usually motivational. Although some patients who are identified as drinking at risky levels do not perceive change as necessary, providing them with advice and information about the potential consequences of continued use may help them recognise that their consumption of alcohol is excessive. Other patients may acknowledge that they are

drinking too much and be aware that risky alcohol use can be harmful. Brief intervention can be particularly successful for this group, as the clinician provides encouragement and support.

However, for people who drink above recommended levels but are not experiencing alcohol-related harm, brief advice may be sufficient.

Recommendation	Strength of recommendation	Level of evidence
4.3 Brief interventions may consist of the five components of the FLAGS acronym: feedback, listening, advice, goals, and strategies (or equivalent).	A	1a
4.4 Brief advice may be sufficient for those drinking above NHMRC recommendations but not experiencing harm.	S	–

Who can deliver brief interventions?

Any health professional or treatment provider with adequate training can deliver brief interventions. Generalist health professionals can be successfully trained to deliver brief interventions within a one-hour training program.

Where should brief interventions be delivered?

Brief interventions can be delivered in a variety of settings, including general practice and other primary care, emergency departments and trauma centres, general hospital wards and outpatient clinics, community counselling and welfare services, and the workplace.

General practice and other primary care settings

Routine screening in general practice can identify excessive drinkers suitable for brief interventions, as about 85 per cent of the population visits their general practitioner at least once each year.

Current data suggest that about 25 per cent of patients who are drinking at risky levels are likely to remain undetected when presenting to general practitioners in Australia. General practitioners have the resources and skills to offer a brief intervention and therefore have the ability and potential to substantially reduce risky levels of drinking.

The level of evidence for effectiveness of brief interventions in this setting is strong, especially for male patients.

Routine screening for excessive alcohol consumption, and brief interventions are recommended for general practice settings.

Recommendation	Strength of recommendation	Level of evidence
4.5 Brief interventions should be implemented in general practice and other primary care settings.	A	1a

Emergency departments and trauma centres

People attending accident and emergency departments exhibit a high rate – 1.5 to 3 times that seen in primary care – of alcohol-related injuries and conditions. Data suggest that recent trauma or a life-threatening experience increases patient receptivity to intervention, thus increasing the likelihood that brief intervention will reduce alcohol consumption in this patient population.

Interventions in emergency departments have proved effective in reducing subsequent alcohol-related injuries, risky levels of alcohol intake, and binge drinking episodes within 6 to 12 months of the intervention. Reduction of heavy alcohol consumption in the subsequent 12 months is less likely, but has been reported in some studies.

A number of studies have shown that the effect of brief intervention in this setting is not significantly different from control groups. Control patients, who do not receive a structured intervention, but are asked about their alcohol intake and/or motivation to reduce drinking, often report reductions in alcohol consumption. It would, however, be too early to disregard the usefulness of brief interventions in the emergency settings based on these findings.

Ways to increase effectiveness of brief interventions in the emergency settings have been successfully tested. For example:

- Highlighting the alcohol/injury connection as part of brief intervention appears to increase the effect of the intervention.
- Computer-aided brief interventions have demonstrated reductions in alcohol use over the subsequent 6 to 12 months, and appear a promising dissemination strategy.

Routine screening and brief interventions to reduce alcohol consumption should be implemented in emergency departments and trauma centres.

Recommendation	Strength of recommendation	Level of evidence
4.6 Brief interventions should be implemented in emergency departments and trauma centres.	A	1a

General hospital wards and outpatient clinics

Clear associations have been found between hospital admissions for traumatic incidents or medical problems and alcohol consumption. Hospital wards accommodate a high population of problem drinkers; they are, therefore, fertile grounds in which to offer brief interventions to risky drinkers who already demonstrate or may be at risk of developing alcohol problems.

Hospital wards can also be a particularly effective setting for advice, as patients are often highly motivated and willing to change their drinking behaviours after being hospitalised. However, the evidence for the effectiveness of brief intervention in this setting is limited. Studies suggest that minimal intervention (or simply participation in a research trial) in these settings can be as successful as a more intensive intervention, or conversely, that all interventions are ineffective and the impact of hospital admittance is sufficient to effect changes in alcohol-related behaviour, including rate of consumption.

However, there seems to be more influences at work than is yet fully explored. Possibilities for negative influences include:

- low sample size
- low AUDIT score cut-off for eligibility
- length of intervention
- lack of booster session
- possible contamination of results
- patient characteristics
- social desirability bias.

It would not, however, be appropriate to dismiss the usefulness of brief intervention in hospital settings. The existence of conflicting results – some positive and some negative – indicates that the most effective combination of intervention elements has not yet been found. Routine screening for excessive alcohol consumption should be implemented in general hospital wards, outpatient clinics, and other specialist settings (see Chapter 3). Brief intervention may be effective in these environments.

Recommendation	Strength of recommendation	Level of evidence
4.7 Brief interventions should be implemented in general hospital settings.	D	IV

Community counselling and welfare services

Patients may present to community counselling services with a variety of complaints that may be related to their alcohol or other drug use, including financial, relationship, employment or parenting problems. Brief interventions may be appropriate for those drinking at risky levels.

Recommendation	Strength of recommendation	Level of evidence
4.8 Brief interventions in community health and welfare settings may be used, but should not be a sole intervention strategy.	D	IV

Workplace settings

Rates of alcohol consumption are particularly high in some workplaces. In particular, hospitality, agriculture and construction industries have been identified as having a large proportion of people drinking at levels leading to both short- and long-term risk of harm, which can lead to increased accident rates and absenteeism.

Web-based feedback, with or without motivational counselling, proved an effective way to reduce risky drinking among young employed people, although another study found challenges in getting people to access and participate in the workplace-assisted website program.

A substance misuse prevention training program designed to change work culture, combined with random workplace testing, was successful in reducing injuries in one study. For more details see Review of the Evidence.

Recommendation	Strength of recommendation	Level of evidence
4.9 Brief interventions in high-risk workplaces may be used, but should not be a sole intervention strategy.	D	IV

Limitations of brief intervention

The outcomes of a brief intervention can be perceived as modest and may discourage clinicians from routinely using this technique. The clinician often does not see beneficial results of the intervention (for example, the number needed to treat can be substantial in order to create a measurable effect). In order to get one drinker to return within recommended limits, brief intervention needs to be delivered to 10 patients (this is the number needed to treat). To identify those people one must screen 100 (the number needed to screen).

It is important to recognise, however, that if someone reduces their alcohol intake from 12 drinks a day to 9, it is still a beneficial change. As well, screening alone can raise the patients' awareness and have a similar effect to a brief intervention. Furthermore, repeated brief interventions may provide greater effect, and follow-up (by consultation, letter, telephone, SMS or email) can serve as reinforcement.

No evidence shows that brief interventions are effective among people with severe alcohol problems and dependence disorders. Typically, interventions offered to treatment-seeking populations or those with severe alcohol problems require more comprehensive treatment approaches that will usually include intensive interventions (such as detoxification) and/or extended follow-up sessions.

Services considering implementing brief interventions should address the potential barriers to effective uptake and implementation in health care settings; such barriers include:

- lack of confidence, knowledge, or skills
- difficulty in identifying risky drinkers
- uncertainty of the justification for initiating discussion about alcohol
- lack of simple guidelines
- lack of financial incentives.