# Brief interventions for alcohol related problems

**Ana Cecília Petta Roselli Marques[a] e Erikson Felipe Furtado[b]**

[a]Unidade de Dependência de Drogas da Universidade Federal de São Paulo (UDED/UNIFESP)
[b]Programa de Ações Integradas para Prevenção e Atenção ao Uso de Álcool e Drogas na Comunidade da Faculdade de Medicina de Ribeirão Preto da Universidade de São Paulo (PAI-PAD/FMRP-USP)

## Abstract

*This article presents the concepts and basic premises that are necessary for a better understanding of the Brief Interventions (BIs), with a literature review of its effectiveness and a discussion about BIs in Brazil. The theoretical premises are discussed, as well the concepts represented by the acronym FRAMES: Feedback; Responsibility; Advice; Menu; Empathic and Self-efficacy. Results of systematic reviews and metanalysis about BIs effectiveness are discussed and a summary box with the main studies is presented. Finally, the recent developments about the introduction of BIs in Brazil are commented. The importance of health professionals training and the adoption of BIs within different settings are emphasized considering its demonstrated effectiveness and economic feasibility.*

***Keywords****: Substance abuse. Therapy. Methods. Intervention studies. Harm reduction. Prevention & control. Risk reduction behavior. Counseling.*

**Introduction**
The use of concise and short-term therapeutical techniques, classified as brief interventions and therapies, has become an increasingly important part in the spectrum of available care for the treatment of substance-use related problems *(SURP)*.
Currently, Brazilian society is becoming increasingly aware for the dimension of medical and social problems stemming from the consumption of substances. At the same time the existence of an extraordinary abyss between the rising demand for assistance and the existent resources becomes clear. Therefore, the focus and the priority of assistance policies should be the highest reach and effectiveness possible using the limited resources. Not only in the public area, but also in health services subjected to the rules of private practices (health insurances and HMOs), the rational use of resources and the choice of economically viable techniques are emphasized.
In this context, it is increasingly relevant the professional mastering of brief intervention and therapy techniques, as well as the adequate investigation of their cultural adaptation to the Brazilian conditions and the verification of their effectiveness.
This article aims to present an update on the issue of brief interventions for SURP.

**Basic concepts**
Brief interventions should not be confounded with brief therapies, but both forms of short-term techniques must be understood as part of a continuum of care, rather of being applied out of the indicated context or for all SURP.z
The main differences between brief interventions and brief therapies

are related to the width of their treatment goals. Brief interventions (BIs) aim primarily to detect the problem and motivate patients to reach determined actions, such as starting a treatment or improving the level of information about the risks associated with the use of substances, increasing their sense of risk and self-care.[1]

Brief psychotherapies have more comprehensive goals, such as obtaining more profound and persistent patterns of emotional or behavioral reaction, the maintenance or the capability of developing strategies to deal with stress and intrinsic and extrinsic risk situations.[1]

Bis are interventions which may also complement habitual assistencial activities and are inserted in the usual attention routine, taking a minimal time, using didactic resources to allow patients to rapidly obtain a higher level of information about their current problems, assessing and eliciting the motivation for change, preparing them for making decisions. Therefore, for example, a physician of the family health program (FHP) could incorporate in the routine consultation a brief moment dedicated to the screening in order to identify patients with SURP, including in their usual scheme of follow-ups and monitorings part of the consultation to apply the BI.

Brief Psychotherapies (BPs), on the other hand, are more intensive, exclusive therapeutical moments, that is, longer and less structured therapeutical sessions, applied according to the therapist's experience and characteristics.

BIs do not demand much time and are easily incorporated into the usual consultation of family physicians, nurses and community health agents. BPs imply a longer programming of sessions. BIs may last from five up to thirty minutes, at least, and are composed by a short sequence of steps including the identification and dimensioning of problems or risks (generally by means of a standardized screening instrument, such as AUDIT) and the offering of counseling, orientation and, in some situations, periodical monitoring of success to reach goals voluntarily adopted by patients.[2]

There is a great variety of definitions for brief interventions. In the most recent literature, they are mentioned as simple advice, minimal interventions, or brief counseling. They may be simple recommendations to reduce the consumption, provided by a professional (social worker, nurse or nurse attendant, etc.), and may also include a series of resources provided by a structured treatment program. Therefore, Bis should not be seen as a homogenous technique, but as a set of strategies or procedures which vary in their duration, structure, goals, people in charge, modes of communication, settings and also regarding their different theoretical foundations and philosophical presuppositions.[3]

**Theoretical presuppositions**

The first theoretical referentials used as the foundations for the creation of this type of intervention originated in behavioral and cognitive theories.

In 1972, Sanchez-Craig et al., in Canada, proposed brief intervention as a psychotherapeutical approach for alcohol-dependent subjects. With the application of four focalized and simple sessions, its authors aimed at an immediate reduction of the consumption of alcohol on severely-dependent subjects and, consequently, an improvement on their health when compared to non-treated patients.[4] The technique could be applied by professionals with several backgrounds, if well trained for a short period of time. Using a simple strategy to reduce the number of doses consumed by episode, previously detected and monitored, this result strengthened the original idea that learned and dysfunctional behaviors might be modified and the subject's autonomy reestablished.

In the initial interview, the communication, sympathetic and aimed at the subject's readiness to change, was considered as a step as important as the diagnosis. Due to this aspect and the shortness of the technique, motivational approaches have been introduced in the brief intervention's structure. The motivational stage of the patient was then studied and considered as a predictive factor for the treatment's effectiveness.[5]

Summing up, the theoretical presuppositions of BIs are:

-the dysfunctional behavior can be changed;

-the motivation must be assessed and adapted for the action, and

-the patients' perception regarding their responsibility in the equilibrium process should be developed.

There are many other strategies which may be applied to reach the objectives of BI: the behavioral and cognitive exercise in order to perceive the reality, detecting risk situations and problems stemming from their confrontation; the application of questionnaires, surveys and/or scales corroborating the existence of problems; counseling, based on a 'menu of actions', in order to decrease or interrupt the consumption and its execution through tasks; the positive and responsible cooperation of the user in order to elaborate a plan for intervention, follow-up and monitoring of results.

This intervention model may be synthesized as 'self-regulating model', triggered by the evidence of problems and the loss of equilibrium, whose goal is the rescue of autonomy.[6]

Studies showed that nearly 80%of the subjects who seek assistance are not prepared to perform this process alone, as they are in pre-contemplation or contemplation stages of their problem.[7] The same occurs with professionals, who think they are hardly prepared to solve these problems.[8]

**Brief Interventions' goals**

The main goal of any brief intervention is to reduce the risk of harm as a result of the continuous use of psychoactive substances or, more precisely, to reduce the chances and conditions which favor the development of substance-use related problems (SURP). The goals are individually established for each patient based on the clear identification of his/her current consumption pattern and associated risks.

The six elements that compose a brief intervention are essential and must be present to characterize such intervention. They are identified by the acronym FRAMES, originated in the composition of the first letter of the English words: - ***F***_eedback;_ - ***R***_esponsibility;_ - ***A***_dvice;_ - ***M***_enu;_ - **E**mpathic and, **S**elf-efficacy.

The term feedback is employed to define the patients' feedback by means of communicating the results of their assessment, more commonly performed by means of the devolutive of the results obtained in the application of a screening instrument (e.g.,: the professional informs the AUDIT score and explains it in terms of which part of the general population shows the same risk level, as well as informs which is the risk load associated with the score obtained by patients).

'Responsibility' is related to the emphasis in the patients' autonomy and responsibility in the decisions, which imply the necessary attitudes of self-protection and care and commitment with change.

'Advice' corresponds to the orientations and recommendations given by professionals to their patients, grounded on the current empirical knowledge, being they clear, direct and without moral or social judgment and preserving the patients' autonomy of decision.

'Menu' is a catalog of alternative actions which patients may implement, aimed to their self-help or to the available treatment options.

'Empathic' is related to the sympathetic, solidarious and understanding attitude, which should be adopted by professionals before their patients.

'Self-efficacy' is the word employed for the focus that the professional should have in order to promote and facilitate the patients' confidence in their resources and success, corresponding to a reinforcement of the patients' optimism and self-confidence, aimed at a higher perception of personal efficacy, of consecution of the tasks assumed.

Bandura (*apud* Barry, 1999), a cognitivist theoricist, has proposed that 'self-efficacy' represents an important influence on the behavior which manifests in a joint response of the cognitive, motivational and emotional systems. If a person has a perception of low self-efficacy due to the lack of coping skills, he/she probably will have distorted and negative beliefs about him/herself and about his/her condition and will have less motivation, even to try to face up to the problems.[1]

**Application fields**

The first contact of these subjects occurs generally with the general physician, but they are not investigated and diagnosed as frequently and precisely as for other chronic diseases.[9] The difficulties found in the interview of patients at the primary care network, related to the screening of dependent patients by a general clinician were: lack of specific knowledge (18%); lack of confidence on and knowledge about brief techniques (90%) and the fact that 50% of professionals wanted to be trained to be able to use the technique.[10]

Basic health units are the settings with the lowest stigma and consequently the lowest resistance of subjects to the approach and orientation about the problem. In a few minutes, the professionals in these units may apply BI, investigating the problematic use and counseling the decrease of consumption. The positive impact of this action has been studied and was deemed effective.[11,12]

Table 1 displays schematically the different contexts and settings in which brief interventions for alcohol-related problems may be applied from a screening, or active search, performed as part of the routine attention through the application of AUDIT.[13]

**Table 1 – Teams, places and groups considered as appropriate for the implementation of the Screening Program, using AUDIT for Brief Interventions**

| SETTING | TARGET GROUP | TEAM |
|---|---|---|
| Primary care services | Patients | Nurses, social workers |
| Emergency care | Victims of accidents, patients with intoxication, victims of trauma | Physicians, nurses and team |
| Medical office | Patients | General physician, family doctor and team |
| General hospitals Ambulatories | Patients with hypertension, cardiac and gastrointestinal diseases and neurological disorders | Residents and team |
| Psychiatric hospitals | Psychiatric patients, especially those with suicide risk | Psychiatrist and team |
| Court, jail, prison | Traffic offenders, violent criminals | Employees, lawyers and technical staff |
| Other risk situations | People who have had social or occupational harm (e.g., marital problems, child negligence,...) | Health professionals and social workers |
| Military facilities | Enrolled people and officers | Physicians |
| Working settings Employee assistance programs | Employees, especially those with productivity, absenteeism and accident problems | Employee's assistance team |

**Studies of Brief Interventions**

Some studies have suggested that, when applied on risk users with medium or high consumption, the potential of BIs to reduce individual problems and harm and the treatment costs can overcome significantly the effectiveness of BIs applied on subjects with substance dependence.[14] That is, the best use of BIs occurs when directed to risk users or to patients with diagnosis of harmful use, not being necessarily ideal for patients which already have dependence syndrome.

Some systematic reviews and meta-analyses have been performed aiming to verify and add evidence about the effectiveness of BIs. Kahan et al.[15] identified 43 studies indexed on MEDLINE between 1966 and 1985 and other 112 indexed on EMBASE and published between 1972 and 1994. Wilk et al.[16] using more specific criteria, found 99 studies, based on 6000 indexed articles on MEDLINE and PsychLIT between 1966 and 1995. Of the bibliographic samples obtained, 11 reviews by Kahan et al. and 12 other reviews by Wilk et al. had an adequate methodology with control groups, adequate sample sizes and specified criteria for BIs.[15,16] Evidence has pointed to the confirmation of effectiveness of BIs.[1] Table 2 presents a summary of the main studies.[2]

**Studies on Brief Interventions in Brazil**

In 1988, Masur et al., at the Department of Psychobiology of the Paulista Medical School, started a project in collaboration with Sanchez-Craig and Wilkinson, aiming to study the effectiveness of this technique in the attention of substance-use dependent subjects in Brazil.[17] It was then performed a controlled clinical trial in which the effectiveness of brief intervention was assessed, compared to a control group of patients under psychodynamic group psychotherapy, the most used model at that period. After two follow-up assessments, accomplished 10 and 20 months after admission of patients in the program, it was concluded that both modalities had similar results, with a little advantage over group therapy, regarding compliance of patients dependent on other drugs.[17] Due to the cultural differences and the higher dependence severity of Brazilian patients in that study, changes in the technique were introduced, among them the increase in the number of sessions.

As a continuation of that study, it was performed, in the same service, a comparison between the effectiveness of individual and group therapy applied to subjects dependent on alcohol and other drugs. The results showed that both formats had the same effectiveness, and group therapy could be used, having the advantage of treating a higher number of patients.[18,19]

Some studies were dedicated to assess the motivational techniques for the treatment of alcoholic patients[20,21] and have some conceptual proximity with Bis' topic.

**WHO's project in Brazil**

Alcoholism is among the ten most important health problems selected to compose the list of priorities of the National Family Health Program which has become the center of an ambitious reform of the entire public health sector. The family health team is the most frontal unit in this community-based health system. Basically, one physician, one nurse, two nurse attendants and six community health agents compose this unit. Specialists may be requested to act as consultants of the family health teams.

The WHO's project in Brazil aims to identify the implementation and development of training strategies for non-specialized health professionals, as well as the monitoring of the implementation and execution of BIs in the assistencial services, especially in the Family Health Program. In the region of Ribeirão Preto (PAI-PAD/FMRP-USP) this program has the participation of the State of São Paulo Health Department, through its Regional Board. We know that the National Secretary of Health follows attentively this experience and is interested in disseminating BIs in the country.

The proven effectiveness of BIs justifies their implementation on assistance services, as an integrating part of the routine of attention provided. One important challenge to be overcome is the training of health professionals and the establishment of an efficient integrated network of specialized services to provide support for the demand of community secondary and tertiary care which, inevitably, will unfold. Psychiatrists will be increasingly called to contribute with the training, supervision and counseling of non-specialized professionals, both on primary care environments (Family Health Programs, outpatient settings and medical offices), both on emergency care services or in general hospitals. As specialists they will be able to introduce BIs in the routine attention of psychiatric outpatients. The adequate management of alcohol screening scales, diagnostic interviews, motivational assessment and the use of brief psychotherapeutical techniques should be part of the basic arsenal of psychiatrists and of their regular or complementary formation. Professional associations responsible for the defense of the specialty's interests should strive to assure psychiatrists the role of reference specialist professionals.

**Conclusions**

Brief interventions for problems related to the use of psychoactive substances have been developed and investigated regarding their effectiveness. A solid body of evidence provides support to recommend their adoption in different treatment contexts, especially in those aimed at patients with risk consumption pattern or diagnosis of harmful use, not necessarily dependent. It is expected that specialized and non-specialized health planers and managers adopt BIs as a basic, effective and economically viable resource, for the attention of the thousands of patients with problems related to the use of psychoactive substances in Brazil.

**Table 2**
**Evidence for Brief Interventions**

In the last 20 years, there have been several standardized clinical experiences of brief interventions in several health care settings. There were studies in Australia, Bulgaria, Mexico, United Kingdom, Norway, Switzerland, US and other countries. The evidence of the effectiveness of brief interventions has been summed up in several review articles, including the following:

In one of the first review articles, Bien et al[9]. considered 32 controlled studies which involved more than 6000 patients and found that brief interventions are as much effective as more protracted treatments. "There is encouraging evidence that the course of harmful use of alcohol may be effectively altered with well-designed intervention strategies, which are possible in environments where there is relatively brief contact, such as primary care settings and employeeís assistance programs".

Kahan et al.[10] reviewed 11 experiences of brief interventions and concluded that, even though more researches are needed to seek specific results, the impact of brief interventions in public health has a huge potential. "Physicians are advised to implement brief interventions in their practice, given the evidence of effectiveness of these strategies and the low amount of time and effort they require".

Twelve controlled and standardized experiences were reviewed by Wilk et al.,[11] being concluded that alcohol users who had received brief interventions had twice as much chances of decreasing their use pattern after six to twelve months as those who had had no intervention. "Brief interventions have low cost and are effective preventive measures for heavy alcohol users in outpatient settings".

Moyer et al.[12] reviewed studies in which there were comparisons between brief interventions in control groups not under treatment with others in which patients were under long treatment. They found "more positive evidence" for the effectiveness of brief interventions, especially among patients with less severe problems. They warn that brief interventions should not replace a specialized treatment, but suggest that they may be used as an initial treatment for severely dependent users who are seeking for a longer treatment.

***References***

*1. Barry KL. Brief interventions and brief therapies for substance abuse. Rockville, MD: Center for Substance Abuse Treatment; 1999.*

*2. Babor TF, Higgins-Biddle JC. Brief intervention for hazardous and harmful drinking: a manual for use in primary care. Geneva: World Health Organization; 2001.*

*3. Heather N. Treatment approaches to alcohol problems. Copenhagen: World Health Organization, Regional Office for Europe; 1995.*

*4. Sanchez-Craig M, Wilkinson DA. Brief treatments for alcohol and drug problems: Practical and methodological issues. In: Loberg T, Miller WR, Nathan PE, Marlatt GA, editors. Addictive Behaviors: Prevention and Early Intervention. Amsterdam/Lasse, Netherlands: Swets and Zeitlinger B.V.; 1989. p. 233-52.*

*5. Diclemente CC, Prochaska JO. Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors. In: Miller WR, Heather N, editors. Treating Addictive Behaviors. New York, NY: Plenum Press; 1998. p. 3-24.*

*6. Miller WR, Brown JM. Self-regulation as a conceptual basis for the prevention and treatment of addictive behaviours. In: Heather N, Miller WR, Greeley J, editors. Self-control and the addictive behaviours. Sydney, Australia: Maxwell Macmillan Publishing; 1991. p. 3-79.*

*7. Prochaska JO. How do people change, and how can we change to help many more people? In: Hubble MA, Duncan BL, editors. The heart and soul of change: What works in therapy. Washington, DC, US: American Psychological Association; 1999. p. 227-55.*

*8. Kaariainen J, Sillanaukee P, Poutanen P, Seppa K. Opinions on alcohol-related issues among professionals in primary, occupational, and specialized health care. Alcohol Alcohol 2001;36(2):141-6.*

*9. Walsh RA. Medical education about alcohol: review of its role and effectiveness. Alcohol Alcohol 1995;30(6):689-702.*
*10. Aalto M, Sillanaukee P. Compliance rate and associated factors for entering an alcohol brief intervention treatment programme. Alcohol Alcohol 2000;35(4):372-6.*
*11. Saunders JB, Aasland OG, Amundsen A, Grant M. Alcohol consumption and related problems among primary health care patients: WHO collaborative project on early detection of persons with harmful alcohol consumption–I. Addiction 1993;88(3):349-62.*
*12. Babor TF, Longabaugh R, Zweben A, Fuller RK, Stout RL, Anton RF, et al. Issues in the definition and measurement of drinking outcomes in alcoholism treatment research. J Stud Alcohol Suppl 1994;12:101-11.*
*13. Babor TF, Higgins-Biddle JC, Saunders JB, Monti PM, Monteiro MG. AUDIT The alcohol use disorders identification test: guidelines for use in primary care. Geneva: World Health Organization; 2001.*
*14. Higgins-Biddle JC, Babor TF, Mullahy J, Daniels J, McRee B. Alcohol screening and brief intervention: where research meets practice. Conn Med 1997;61(9):565-75.*
*15. Kahan M, Wilson L, Becker L. Effectiveness of physician-based interventions with problem drinkers: a review. CMAJ 1995;152(6):851-9.*
*16. Wilk AI, Jensen NM, Havighurst TC. Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers. J Gen Intern Med 1997;12(5):274-83.*
*17. Formigoni MLOS. A intervenção breve na dependência de drogas: a experiência brasileira. São Paulo, SP, Brasil: Contexto; 1992.*
*18. Marques ACPR. Comparação da efetividade da terapia comportamental-cognitiva breve individual e em grupo no tratamento de dependentes de álcool ou outras drogas [Thesis]. Universidade Federal de São Paulo; 1997.*
*19. Marques AC, Formigoni ML. Comparison of individual and group cognitive-behavioral therapy for alcohol and/or drug-dependent patients. Addiction 2001;96(6):835-46.*
*20. Oliveira MS. Eficácia da intervenção motivacional em dependentes do álcool / The efficacy of motivational intervention in alcohol dependents [Thesis]. Universidade Federal de São Paulo; 2000.*
*21. Figlie NB. Motivação em alcoolistas tratados em ambulatório específico para alcoolismo e em ambulatório de gastroenterologia [Dissertation]. Universidade Federal de São Paulo; 1999.*

**Correspondence**
PAI-PAD – FMRP/USP
Av. dos Bandeirantes 3900 – Campus da USP
Hospital das Clínicas – 3º andar, sala 333
14.049-900 Ribeirão Preto, SP, Brasil
E-mail: efurtado@fmrp.usp.br
14.049-900 Ribeirão Preto, SP, Brazil
Note: WHO, AUDIT and BIs manual are available at PAI-PAD (www.fmrp.usp.br/paipad)