ALCOHOL BRIEF INTERVENTIONS: AN HISTORICAL AND INTERNATIONAL PERSPECTIVE

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The Malmö Study: the 1st RCT of alcohol brief intervention? (1)

- Kristenson, H. *et al*. (1983). Identification and intervention of heavy drinking in middle-aged men: results and follow-up of 24-60 months of long-term study with randomized controls. *Alcoholism: Clinical and Experimental Research*, 7(2), 203-210.
- All male residents of Malmö 45-50 years invited to a health screening interview
- Problem drinkers identified by raised GGT on 2 occasions 3 weeks apart
- Intervention: detailed physical examination; interview regarding drinking history, problems and dependence; appointments with physician every 3 months; monthly visits to a nurse who gave GGT feedback.
- Control: informed by letter of impaired liver function and advised to cut down
- Research on referral to treatment in Boston in early 1960s by Chafetz and colleagues NOT 1st studies of BI

The Malmö Study: (2)

- At follow-up 2 and 4 years after initial screening, both groups showed significant decrease in GGT levels
- But intervention group showed greater decrease in mean sick days per individual, fewer days of hospitalisation and strikingly fewer days of hospitalisation for alcohol-related conditions
- At 5-year follow-up, control group showed twice as many deaths, both alcohol-related and not, as the intervention group

Centres D'Hygiène Alimentaire

- Babor, TF, Treffardier, M, Weill, J, Feguer, L, & Ferrant, JP. (1983). The early detection and secondary prevention of alcoholism in France. Journal of Studies on Alcohol, 81, 23-46.
- Chick, J. (1984). Secondary prevention of alcoholism and the Centres D'Hygiène Alimentaire. British Journal of Addiction, 79, 221-225
- In 1970, the French government established 3 experimental clinics
- Referrals received from courts, social service agencies, hospitals and various other sources
- Remit: to stress to patients the importance of diseases related to nutrition, to offer help to chronic excessive drinkers without serious psychological or social problems, to help those who rejected psychiatric treatment
- This method of intervention viewed as very promising in view of cheapness, accessibility and widespread contact with problem drinkers
- But no controlled evaluation at that time

Research in UK in 1980s

- Heather, N. *et al*. (1987). Evaluation of a controlled drinking minimal intervention for problem drinkers in general practice (The DRAMS Scheme). *Journal of the Royal College of General Practitioners,* 37, 358-363.
  - Equivocal findings but insufficiently powered to detect an effect of BI
- Chick, J., Lloyd, G., & Crombie, E. (1985). Counselling problem drinkers in medical wards: a controlled study. BMJ, 290, 965-967.
  - No effect on consumption but some evidence of effect on composite outcome measure
- Wallace, P., Cutler, S., & Haines, A. (1988). Randomized controlled trial of general practitioner intervention with excessive alcohol consumption. BMJ, 297, 663-668.
  - 1st good evidence for efficacy of BI

ORIGINS OF BRIEF INTERVENTIONS: Coalescence of several influences

- 1) Abstinence-controlled drinking controversy
- 2) Move to community-based response to alcohol problems
- 3) Research on less intensive forms of treatment in UK and USA
- 4) Research in the smoking cessation field showing that brief advice by general practitioners was effective and highly cost-effective
- 5) Greater attention to non-treatment-seeking population
- 6) More generally, part of shift from disease perspective on alcohol problems to public health perspective

Phases of the WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care

- PHASE I: Development of the AUDIT questionnaire (1984-87)
- PHASE II: A cross-cultural randomised controlled trial (RCT) of screening and brief interventions (SBI) in primary health care (1988-92)
- PHASE III: A cross-cultural study on disseminating and supporting SBI in primary health care (1993-97)
- PHASE IV: Development of country-wide strategies for implementing SBI in primary health care (1998-2003)

PHASE I: Development of the AUDIT questionnaire

- Alcohol Use Disorders Identification Test
- International collaboration – 5 countries
- Developed to detect "risky drinkers" rather than "alcoholics"
- High sensitivity (92%) and specificity (94%)
- Now used as a screening instrument world-wide

PHASE II: Cross-cultural RCT of SBI

- International collaboration – 10 countries, 1,655 heavy drinkers
- Among males, patients randomised to 5 min. simple advice based on 15 min. assessment reduced consumption (mean = 25%) more than non-intervention controls
- Among females, patients in intervention and control groups both showed reductions in consumption
- No advantage of more extended counselling over simple advice

PHASE III: A cross-cultural study on disseminating and supporting SBI in primary health care

- Strand 1: Questionnaire survey of GPs
- Strand 2: Qualitative interviews with GPs and Key Informants
- Strand 3: RCT of methods for uptake and utilisation of SBI by GP's

MAIN BARRIERS TO IMPLEMENTATION OF SBI (from English arm of Phase III study)

- "Doctors are too busy dealing with the problems people present with" (72%)
- "Doctors are not trained in counselling for reducing drinking" (62%)
- "Government health policies do not support doctors who want to practise preventive medicine" (56%)
- "Doctors don't believe that patients would take their advice and change their behaviour" (53%)
- "Doctors don't have suitable counselling materials available" (51%)
- "The Government health scheme doesn't reimburse doctors for time spent on preventive medicine" (51%)

MAIN INCENTIVES FOR IMPLEMENTATION OF SBI (from English arm of Phase III study)

- "(If) support services were readily available to refer patients to" (85%)
- ".. early intervention for alcohol was proven to be successful" (80%)
- ".. patients requested health advice about alcohol consumption" (77%)
- ".. public health education campaigns made society more concerned about alcohol" (65%)
- ".. quick and easy counselling materials were available" (60%)
- ".. salary and working conditions were improved" (60%)

COUNTRIES PARTICIPATING IN PHASE IV

- Australia
- Bulgaria
- Catalonia
- Denmark
- England
- Finland
- Flanders
- France*
- Italy
- Russian Federation
- Slovenia
- Switzerland

- http://apps.who.int/iris/handle/10665/43519

- *Authors: Philippe Michaud,
- Anne-Violaine Dewost, Patrick Fouilland, Sonia Arfaoui & Guillaume Fauvel

COMPONENTS OF PHASE IV

- Phase IV is a flexible study but each participating country pays attention to the following 4 components:
- Customization of materials and services
- Reframing understanding of alcohol issues
- Establishing a Lead Organisation and building a Strategic Alliance among organisations and individuals interested in widespread implementation of SBI
- Carrying out a Demonstration Project(s) (i.e., to demonstrate that widespread implementation of SBI in PHC is feasible and, if possible, has wider public health and economic benefits for the community)

FEATURES OF PHASE IV

- **Evaluation - the extent to which study aims have been achieved, especially the overall impact of study on the country-wide implementation of SBI**
- **Economic evaluation - e.g. cost of implementing SBI per patient, health and other economic benefits for PHC and for wider community, possible cost-offsets**
- **Action research**
  - **Aims to impact real-world of PHC service delivery as well as increase knowledge**
  - **Distinction between "researcher" and "subject" breaks down**
  - **An iterative process**
  - **Especially suited to on gap between research evidence and practice**
- **Qualitative and quantitative methods**

INEBRIA

- International Network on Brief Interventions for Alcohol and Drugs
- Set up in 2004 following conclusion of WHO Phase IV study and other projects
- Aims to provide global leadership in the development, evaluation and implementation of evidence-based practice in the area of early identification and brief intervention for hazardous and harmful substance use
- Currently 589 members. Membership is free.
- Annual conferences around world – next in Lausanne, 22-23 September, 2016
- Current President: Professor Sven Andreasson
- Other activities include google.group
- http://www.inebria.net/Du14/html/en/Du14/index.html

TWO TYPES OF BRIEF INTERVENTION: (i) simple

- Simple brief intervention (simple, structured advice)
- “Minimal” intervention consisting of 5 minutes simple but structured advice is effective in reducing alcohol consumption and improving health status among hazardous and harmful drinkers encountered in health care settings
- Should be offered to all those screening positive for hazardous or harmful alcohol consumption

TWO TYPES OF BRIEF INTERVENTION: (ii) extended

- Extended brief intervention (brief behavioural counselling)
- Based on principles and methods described by Rollnick, Mason & Butler (1999)
- Mixed evidence on whether extended brief intervention in health care settings (20 mins + offer of repeat visits) adds anything to the effects of simple advice
- The offer of extended brief intervention to some hazardous and harmful drinkers can be justified on pragmatic grounds

THE EFFICACY-EFFECTIVENESS DISTINCTION

- Heather, N. (2014). The efficacy-effectiveness distinction in trials of alcohol brief intervention. *Addiction Science & Clinical Practice,* 9, 13. doi:10.1186/1940-0640-9-13
- Efficacy trials provide tests of whether a technology, treatment, procedure, or program does more good than harm when delivered under optimum conditions.
- Effectiveness trials provide tests of whether a technology, treatment, procedure, or program does more good than harm when delivered under real world conditions.
- Several large-scale cluster RCTs in real-world conditions recently have failed to show the effectiveness of brief advice or brief counselling (e.g., SIPS trial)
- Richard Saitz argues that there is very little evidence for the effectiveness of BI
- One should not go straight to effectiveness research without the intervening step of efficacy research and political pressures for premature effectiveness trials should be resisted.

WHAT SETTINGS (HEALTH OR NON-HEAALTH) CAN BI BE IMPLEMENTED IN?

- Evidence of effectiveness good for primary health care, mixed for general hospitals and A&E and thin or non-existent for other health care settings (e.g. sexual health clinics, needle & syringe exchange programs, dentistry
- In non-health care settings, evidence strong in educational settings but weak elsewhere (criminal justice system, workplace, social services, etc.)
- Some people argue that BI should be widely implemented only in settings where there is good evidence of effectiveness
- But two arguments for extending implementation to settings where evidence may be thin or non-existent:
  - BI has been shown to work with problem drinkers in general and the same processes of behaviour change, whatever they are, should apply to people in any setting;
  - The extended precautionary principle: 'Supporting an activity where there is scientific uncertainty of potential benefit from the activity may be justified.'

THE IMPLEMENTATION PROBLEM: how can widespread implementation of BI be achieved?

- Both top-down and bottom-up actions necessary
- Bottom-up – engagement of practitioners (by similar practitioners) essential but not sufficient for widespread implementation
- Top-down – organisation and structural changes (from government, regulatory bodies, professional associations, etc.) also necessary

INCENTIVES ESSENTIAL BUT OF WHAT KIND?

- Measures to prevent adding to GP's workload
  - Screening and/or BI delivered by nurses, 'lifestyle counsellors or other non-medical personnel
  - Electronic BI – various forms of eBI – see ODHIN (Optimizing Delivery of Health Care Intervention) trial http://www.odhinproject.eu/
- Financial incentives
  - In UK, smoking cessation advice part of Quality and Outcomes Framework (QOF) but alcohol BI not
  - ODHIN trial found evidence of benefits of pay-for-performance and interaction between financial incentive and training