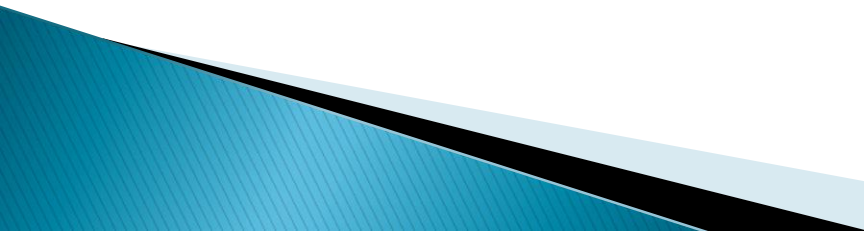


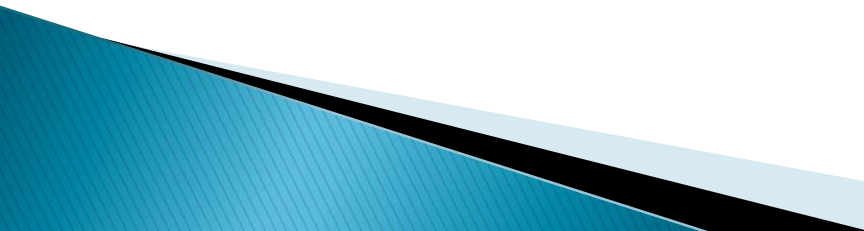
ALCOHOL BRIEF INTERVENTIONS: AN HISTORICAL AND INTERNATIONAL PERSPECTIVE

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Presentation at 'Les Rencontres de Santé Publique France',
8 June, 2016

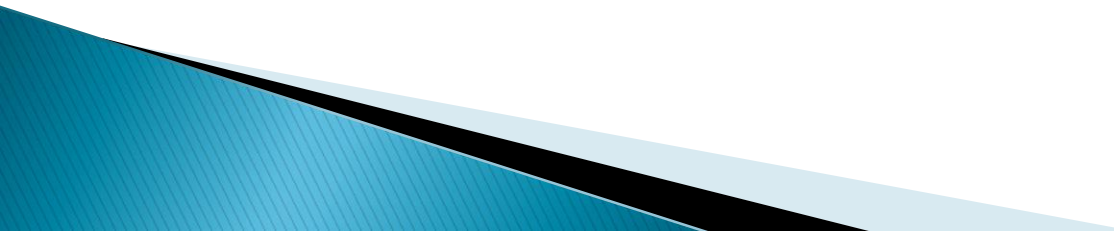
The Malmö Study: the 1st RCT of alcohol brief intervention? (1)

- ▶ 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
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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
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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
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Research in UK in 1980s

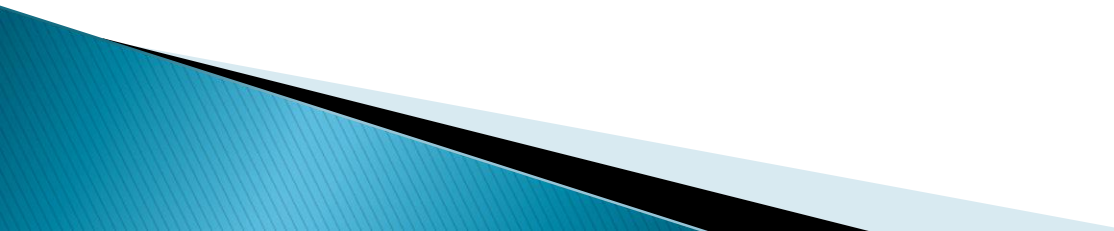
- ▶ Heather, N. *et al.* (1987). Evaluation of a controlled drinking minimal intervention for problem drinkers in general practice (The DRAMS Scheme). *Journal of the Royal College of General Practitioners*, 37, 358–363.
 - Equivocal findings but insufficiently powered to detect an effect of BI
- ▶ Chick, 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:

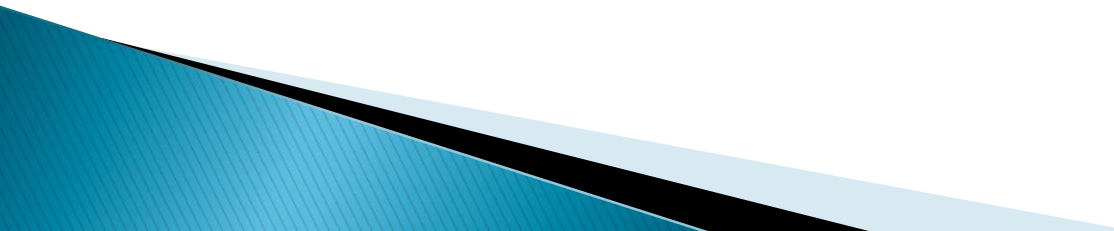
Coalescence of several influences

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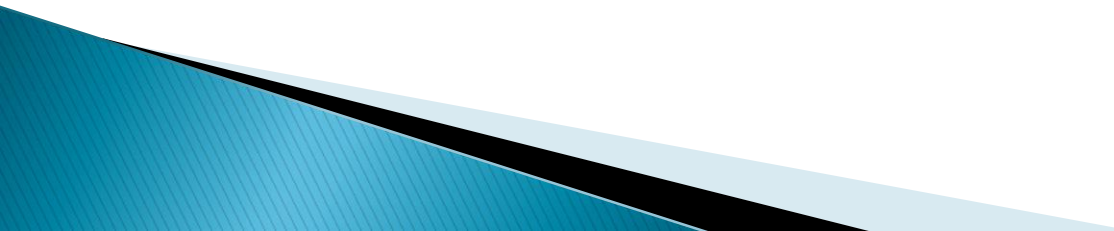
Phases of the WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care

- ▶ 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)
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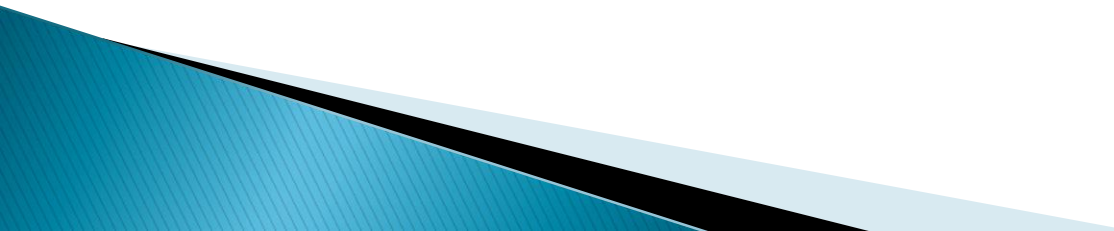
PHASE I: Development of the AUDIT questionnaire

- ▶ 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
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PHASE II: Cross-cultural RCT of SBI

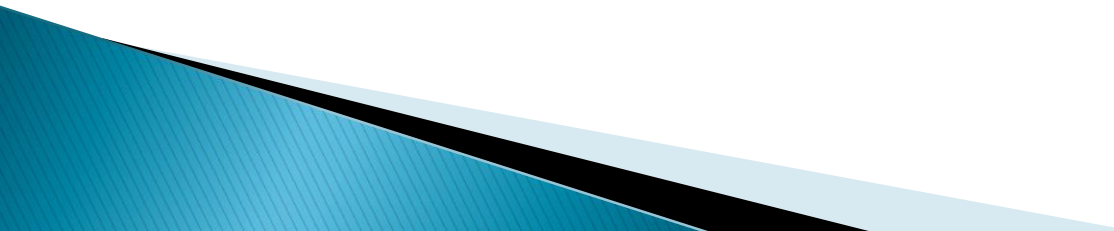
- ▶ International collaboration – 10 countries, 1,655 heavy drinkers
 - ▶ Among males, patients randomised to 5 min. simple advice based on 15 min. assessment reduced consumption (mean = 25%) more than non-intervention controls
 - ▶ Among females, patients in intervention and control groups both showed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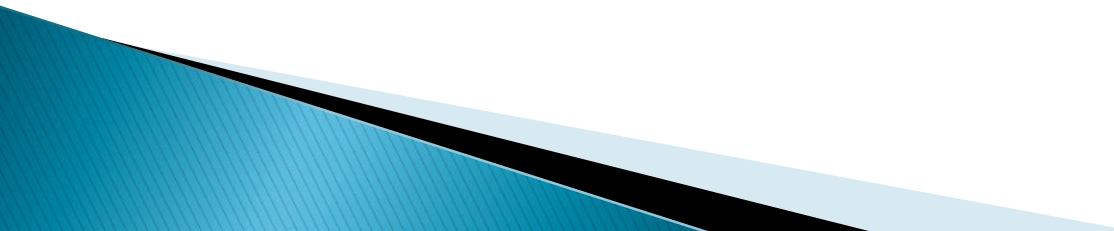
MAIN BARRIERS TO IMPLEMENTATION OF SBI

(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%)
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MAIN INCENTIVES FOR IMPLEMENTATION OF SBI

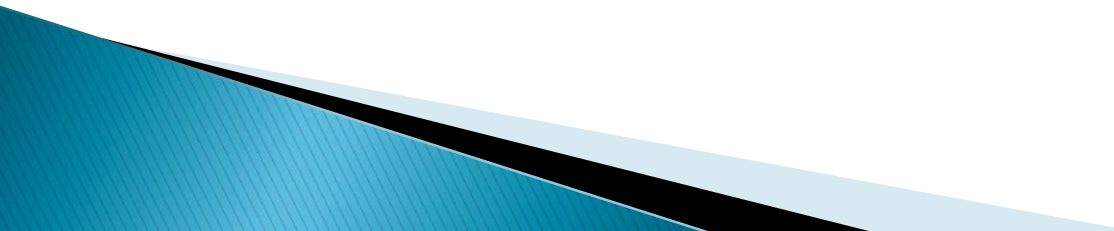
(from English arm of Phase III study)

- ▶ “(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%)
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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)
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FEATURES OF PHASE IV

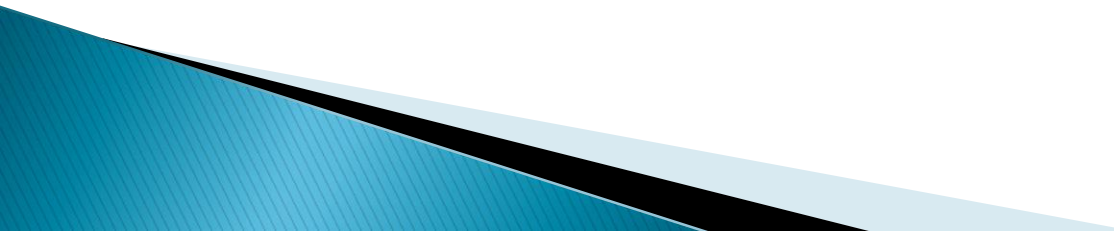
- ▶ **Evaluation** - the extent to which study aims have been achieved, especially the overall impact of study on the country-wide implementation of SBI
- ▶ **Economic evaluation** - e.g. cost of implementing SBI per patient, health and other economic benefits for PHC and for wider community, possible 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

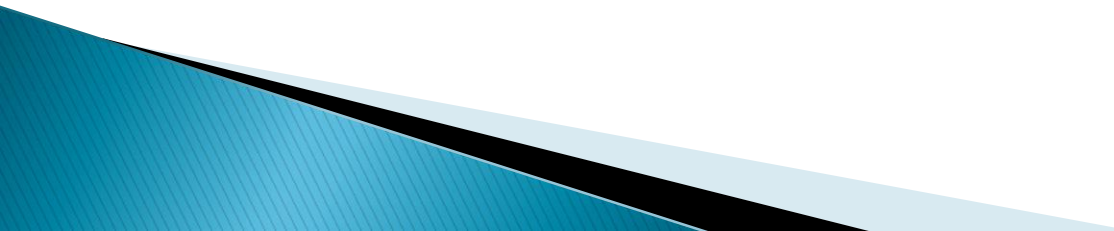
- ▶ International Network on Brief Interventions for Alcohol and Drugs
- ▶ Set up in 2004 following conclusion of WHO Phase IV study and other projects
- ▶ Aims to provide global leadership in the development, evaluation and implementation of evidence-based practice in the area of early identification 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
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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
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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-HEALTH) 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**
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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