

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Brief Interventions and Brief Therapies for Substance Abuse

Treatment Improvement Protocol (TIP) Series

34



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed

to facilities and individuals across the country. Published TIPs can be accessed via the Internet at <http://kap.samhsa.gov>.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until

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they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Executive Summary and Recommendations

This Treatment Improvement Protocol (TIP) responds to an increasing body of research literature that documents the effectiveness of brief interventions and therapies in both the mental health and substance abuse treatment fields. The general purpose of this document is to link research to practice by providing counselors and therapists in the substance abuse treatment field with up-to-date information on the usefulness of these innovative and shorter forms of treatment for selected subpopulations of people with substance abuse disorders and those at risk of developing them. The TIP will also be useful for health care workers, social service providers who work outside the substance abuse treatment field, people in the criminal justice system, and anyone else who may be called on to intervene with a person who has substance abuse problems.

Brief interventions and brief therapies have become increasingly important modalities in the treatment of individuals across the substance abuse continuum. The content of the interventions and therapies will vary depending on the substance used, the severity of problem being addressed, and the desired outcome.

Because brief interventions and therapies are less costly yet have proven effective in substance abuse treatment, clinicians, clinical researchers, and policymakers have increasingly focused on them as tools to fill the gap between primary

prevention efforts and more intensive treatment for persons with serious substance abuse disorders. However, studies have shown that brief interventions are effective for a range of problems, and the Consensus Panel believes that their selective use can greatly improve substance abuse treatment by making them available to a greater number of people and by tailoring the level of treatment to the level of client need.

Brief interventions can be used as a method of providing more immediate attention to clients on waiting lists for specialized programs, as an initial treatment for nondependent at-risk and hazardous substance users, and as adjuncts to more extensive treatment for substance-dependent persons.

Brief therapies can be used to effect significant changes in clients' behaviors and their understanding of them. The term "brief therapy" covers several treatment approaches derived from a number of theoretical schools, and this TIP considers many of them. The types of therapy presented in these chapters have been selected for a variety of reasons, but by no means do they represent a comprehensive list of therapeutic approaches currently in practice. Some of these approaches (e.g., cognitive-behavioral therapy) are supported by extensive research; others (e.g., existential therapy) have not been, and perhaps cannot be, tested in as rigorous a manner.

This TIP presents the historical background, outcomes research, rationale for use, and state-of-the-art practical methods and case scenarios for implementation of brief interventions and therapies for a range of problems related to substance abuse. This TIP is based on the body of research conducted on brief interventions and brief therapies for substance abuse as well as on the broad clinical expertise of the Consensus Panel. Because many therapists and other practitioners are eclectically trained, elements from each of the chapters may be of use to a range of professionals.

This discussion of brief therapies is in no way intended to detract from the value of longer term therapies that clinicians have found to be effective in the treatment of substance abuse disorders. However, the Consensus Panel believes it necessary to discuss innovative and/or often-used theories that members have encountered and applied in their clinical practice.

The Consensus Panel's recommendations summarized below are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2). Citations for the former are referenced in the body of this document, where the guidelines are presented in full detail. Many of the recommendations made in the latter chapters of this TIP are relevant only within a particular theoretical framework (e.g., the Panel might recommend how a person practicing strategic therapy should approach a particular situation); because such recommendations are not applicable to all readers, they have not been included in this Executive Summary.

Throughout this TIP, the term "substance abuse" has been used in a general sense to cover both substance abuse disorders and substance dependence disorders (as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition [DSM-IV] [American

Psychiatric Association, 1994]). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, it will be used to denote both substance dependence and substance abuse. The term includes the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine the meaning; in most cases, the term will refer to all varieties of substance abuse disorders as described by DSM-IV.

Summary and Recommendations

Brief Interventions

Brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment.

A brief intervention, however, is only one of many tools available to clinicians. It is not a substitute for care for clients with a high level of dependency. It can, however, be used to engage clients *who need specialized treatment* in specific aspects of treatment programs, such as attending group therapy or Alcoholics Anonymous (AA) meetings.

- The Consensus Panel believes that brief interventions can be an effective addition to substance abuse treatment programs. These approaches can be particularly useful in treatment settings when they are used to address specific targeted client behaviors and issues in the treatment process that can be difficult to change using standard treatment approaches. (2)
- Variations of brief interventions have been found to be effective both for motivating alcohol-dependent individuals to enter

long-term alcohol treatment and for treating some alcohol-dependent persons. (1)

- The Consensus Panel recommends that programs use quality assurance improvement projects to determine whether the use of a brief intervention or therapy in specific treatment situations is enhancing treatment. (2)
- The Consensus Panel recommends that agencies allocate counselor training time and resources to these modalities. It anticipates that brief interventions will help agencies meet the increasing demands of the managed care industry and fill the gaps that have been left in client care. (2)
- Substance abuse treatment personnel should collaborate with other providers (e.g., primary care providers, employee assistance program, wellness clinic staff, etc.) in developing plans that include both brief interventions and more intensive care to help keep clients focused on treatment and recovery. (2)

Goals of brief interventions

The basic goal of any brief intervention is to reduce the risk of harm that could result from continued use of substances. The specific goal for each individual client is determined by his consumption pattern, the consequences of his use, and the setting in which the brief intervention is delivered.

- Focusing on intermediate goals allows for more immediate success in the intervention and treatment process, whatever the long-term goals may be. Intermediate goals might include quitting one substance, decreasing frequency of use, or attending a meeting. Immediate successes are important to keep the client motivated. (2)
- When conducting a brief intervention, the clinician should set aside the final treatment goal (e.g., accepting responsibility for one's own recovery) to focus on a single behavioral

objective. Once this objective is established, a brief intervention can be used to help reach it. (2)

Components of brief interventions

There are six elements that are critical for effective brief interventions. (1) The acronym FRAMES was coined to summarize these six components:

- *Feedback* is given to the individual about personal risk or impairment.
- *Responsibility* for change is placed on the participant.
- *Advice* to change is given by the clinician.
- *Menu* of alternative self-help or treatment options is offered to the participant.
- *Empathic* style is used by the counselor.
- *Self-efficacy* or optimistic empowerment is engendered in the participant.

A brief intervention consists of five basic steps that incorporate FRAMES and remain consistent regardless of the number of sessions or the length of the intervention:

1. Introducing the issues in the context of the client's health.
2. Screening, evaluating, and assessing.
3. Providing feedback.
4. Talking about change and setting goals.
5. Summarizing and reaching closure.

Providers may not have to use all five of these components in any given session with a client. However, before eliminating steps in the brief intervention process there should be a well-defined reason for doing so. (2)

Essential knowledge and skills for brief interventions

Providing effective brief interventions requires the clinician to possess certain knowledge, skills, and abilities. The following are four essential skills (2):

1. An overall attitude of understanding and acceptance

2. Counseling skills such as active listening and helping clients explore and resolve ambivalence
3. A focus on intermediate goals
4. A working knowledge of the stages-of-change through which a client moves when thinking about, beginning, and trying to maintain new behavior

Brief Therapies

Brief therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. The brief therapies presented in this TIP should be seen as separate modalities of treatment, not episodic forms of long-term therapy.

Brief therapies usually feature more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 to 40 sessions, with the typical therapy lasting between 6 and 20 sessions.

Brief therapies also differ from brief interventions in that their goal is to provide clients with tools to change basic attitudes and handle a variety of underlying problems. Brief therapy differs from longer term therapy in that it focuses more on the present, downplays psychic causality, emphasizes the effective use of therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change.

Research concerning relative effectiveness of brief versus longer term therapies for a variety of presenting complaints is mixed. However, there is evidence suggesting that brief therapies are often as effective as lengthier treatments for certain populations.

- The best outcomes for brief therapy may depend on clinician skills, comprehensive assessments, and selective criteria for eligibility. Using selective criteria in prescribing brief therapy is critical, since many clients will not meet its eligibility requirements. (2)

- Brief therapy for substance abuse treatment is a valuable approach, but it should *not* be considered a standard of care for all populations. (1) The Consensus Panel hopes that brief therapy will be adequately investigated in each case before managed care companies and third-party payors decide it is the only modality for which they will pay.
- Brief interventions and brief therapies are well suited for clients who may not be willing or able to expend the significant personal and financial resources necessary to complete more intensive, longer term treatments. (2)
- Both research and clinical expertise indicate that individuals who are functioning in society but have patterns of excessive or abusive substance use are unlikely to respond positively to some forms of traditional treatment, but some of the briefer approaches to intervention and therapy can be extremely useful clinical tools in their treatment. (1)

When to use brief therapy

Determining when to use a particular type of brief therapy is an important consideration for counselors and therapists. The Panel recommends that client needs and the suitability of brief therapy be evaluated on a case-by-case basis. (2) Some criteria for considering the appropriateness of brief therapy for clients include

- Dual diagnosis issues
- The range and severity of presenting problems
- The duration of substance dependence
- Availability of familial and community supports
- The level and type of influence from peers, family, and community
- Previous treatment or attempts at recovery
- The level of client motivation

- The clarity of the client's short- and long-term goals
- The client's belief in the value of brief therapy
- The numbers of clients needing treatment

The following criteria are derived from Panel members' clinical experience:

- Less severe substance dependence, as measured by an instrument like the Addiction Severity Index (ASI)
- Level of past trauma affecting the client's substance abuse
- Insufficient resources available for more prolonged therapy
- Limited amount of time available for treatment
- Presence of coexisting medical or mental health diagnoses
- Large numbers of clients needing treatment leading to waiting lists for specialized treatment

The Consensus Panel also notes that

- Planned brief therapy can be adapted as part of a course of serial or intermittent therapy. When doing this, the therapist conceives of long-term treatment as a number of shorter treatments, which require the client's problems to be addressed serially rather than concurrently. (1)
- Brief therapies will be most effective with clients whose problems are of short duration and who have strong ties to family, work, and community. However, a number of other conditions, such as limited client resources, may also dictate the use of brief therapy. (2)
- It is essential to learn the client's perceived obstacles to engaging in treatment as well as to identify any dysfunctional beliefs that could sabotage the engagement process. The critical factor in determining an individual's response is the client's self-perception and associated emotions. (1)

Components of effective brief therapy

While there are a variety of different schools of brief therapy available to the clinician, all forms of brief therapy share some common characteristics (2):

- They are either problem focused or solution focused – they target the symptom, not its causes.
- They clearly define goals related to a specific change or behavior.
- They should be understandable to both client and clinician.
- They should produce immediate results.
- They can be easily influenced by the personality and counseling style of the therapist.
- They rely on rapid establishment of a strong working relationship between client and therapist.
- The therapeutic style is highly active, empathic, and sometimes directive.
- Responsibility for change is placed clearly on the client.
- Early in the process, the focus is to help the client enhance his self-efficacy and understand that change is possible.
- Termination is discussed from the beginning.
- Outcomes are measurable.

Screening and assessment

Screening and assessment are critical initial steps in brief therapy. Screening is a process in which clients are identified according to characteristics that indicate they are possibly abusing substances. Screening identifies the need for more in-depth assessment but is not an adequate substitute for complete assessment.

Assessment is a more extensive process that involves a broad analysis of the factors contributing to and maintaining a client's substance abuse, the severity of the problem, and the variety of consequences associated with it. Screening and assessment procedures for

brief therapy do not differ significantly from those used for lengthier treatments.

- Clinicians can use a variety of brief assessment instruments, many of which are free. These instruments should be supplemented in the first session by a clinical assessment interview that covers current use patterns, history of substance use, consequences of substance abuse, coexisting psychiatric disorders, major medical problems and health status, education and employment status, support mechanisms, client strengths and situational advantages, and family history. (2)
- The screening and assessment process should determine whether the client's substance abuse problem is suitable for a brief therapy approach. (2)
- Assessment is critical not only before beginning brief therapy but also as an ongoing part of the process. (2)
- Therapists who primarily provide brief therapy should be adept at determining early in the assessment process which client needs or goals are appropriate to address. Related to this, and equally important, the therapist must establish relationships that facilitate the client's referral when her needs or goals cannot be met through brief therapy. (2)

The first session

In the first session, the main goals for the therapist are to gain a broad understanding of the client's presenting problems, begin to establish rapport and an effective working relationship, and implement an initial intervention, however small.

- Counselors should gather as much information as possible about a client before the first counseling session. However, when gathering information about a client from other sources, counselors must be sensitive to confidentiality and client consent issues. (2)

- Therapists should identify and discuss the goals of brief therapy with the client early in treatment, preferably in the first session. (2)
- Although abstinence is an optimal clinical goal, it still must be negotiated with the client (at least in outpatient treatment settings). Abstinence as a goal is not necessarily the sole admission requirement for treatment, and the therapist may have to accept an alternative goal, such as decreased substance use, in order to engage the client effectively. (2)
- The provider of brief therapy must accomplish certain critical tasks during the first session (2), including
 - ◆ Producing rapid engagement
 - ◆ Identifying, focusing, and prioritizing problems
 - ◆ Working with the client to develop a treatment plan and possible solutions for substance abuse problems
 - ◆ Negotiating the approach toward change with the client (which may involve a contract between client and therapist)
 - ◆ Eliciting client concerns about problems and solutions
 - ◆ Understanding client expectations
 - ◆ Explaining the structural framework of brief therapy, including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work)
 - ◆ Making referrals for critical needs that have been identified but cannot be met within the treatment setting

Maintenance strategies, termination of therapy, and followup

Maintenance strategies must be built into the treatment design from the beginning. A practitioner of brief therapy must continue to provide support, feedback, and assistance in setting realistic goals. Also, the therapist should

help the client identify relapse triggers and situations that could endanger continued sobriety. (2)

Strategies to help clients maintain the progress made during brief therapy include the following (2):

- Educating the client about the chronic, relapsing nature of substance abuse
- Considering which circumstances might cause a client to return to treatment and planning how to address them
- Reviewing problems that emerged but were not addressed in treatment and helping the client develop a plan for addressing them in the future
- Developing strategies for identifying and coping with high-risk situations or the reemergence of substance abuse behaviors
- Teaching the client how to capitalize on personal strengths
- Emphasizing client self-sufficiency and teaching self-reinforcement techniques
- Developing a plan for future support, including mutual help groups, family support, and community support

Termination of therapy should always be planned in advance. (2) When the client has made the agreed-upon behavior changes and has resolved some problems, the therapist should prepare to end the brief therapy. If a client progresses more quickly than anticipated, it is not necessary to complete the full number of sessions.

Therapist characteristics

Therapists will benefit from a firm grounding in theory and a broad technical knowledge of the many different approaches to brief therapy that are available. (2) When appropriate, elements of different brief therapies may be combined to provide successful outcomes. However, it is important to remember that the effectiveness of highly defined interventions (e.g., workbook-driven interventions) used in some behavioral

therapies depends on administration of the entire regimen.

- The therapist must use caution in combining and mingling certain techniques and must be sensitive to the cultural context within which therapies are integrated. (2)
- Therapists should be sufficiently trained in the therapies they are using and should not rely solely on a manual such as this to learn those therapies. (2)
- Training for brief therapies, in contrast to the training necessary to conduct brief interventions, requires months to years and usually results in a specialist degree or certification. The Consensus Panel recommends that anyone seeking to practice the therapies outlined here should receive more thorough training appropriate to the type of therapy being delivered. (Appendix B of the TIP provides contact information for some organizations that may be able to provide such training.) (2)
- Providers of brief therapy should be able to focus effectively on identifying and adhering to specific therapeutic goals in treatment. (2)
- Providers who practice brief therapy should be able to distill approaches from longer term therapies and apply them within the parameters of brief therapy. (2)

Cognitive–Behavioral Therapy

CBT represents the integration of principles derived from behavioral theory, cognitive social learning theory, and cognitive therapy, and it provides the basis for a more inclusive and comprehensive approach to treating substance abuse disorders.

CBT can be used by properly licensed and trained mental health practitioners even if they have limited experience with this type of therapy — either as a cost-effective primary approach or in conjunction with other therapies or a 12-Step program. CBT can be also used early in and throughout the treatment process

whenever the therapist feels it is important to examine a client's inaccurate or unproductive thinking that could lead to risky or negative behaviors. (2)

CBT is generally not appropriate for certain clients, namely, those

- Who have psychotic or bipolar disorders and are not stabilized on medication
- Who have no stable living arrangements
- Who are not medically stable (as assessed by a pretreatment physical examination) (2)

Cognitive-behavioral techniques

The cognitive-behavioral model assumes that substance abusers are deficient in coping skills, choose not to use those they have, or are inhibited from doing so. It also assumes that over the course of time, substance abusers develop a particular set of effect expectancies based on their observations of peers and significant others abusing substances to try to cope with difficult situations, as well as through their own experiences of the positive effects of substances.

- CBT is generally effective because it helps clients recognize the situations in which they are likely to use substances, find ways of avoiding those situations, and cope more effectively with the variety of situations, feelings, and behaviors related to their substance abuse. (2) To achieve these therapeutic goals, CBT incorporates three core elements:
 - ◆ *Functional analysis* – This analysis attempts to identify the antecedents and consequences of substance abuse behavior, which serve as triggering and maintaining factors.
 - ◆ *Coping skills training* – A major component in CBT is the development of appropriate coping skills.
 - ◆ *Relapse prevention* – These approaches rely heavily on functional analyses,

identification of high-risk relapse situations, and coping skills training, but also incorporate additional features. These approaches attempt to deal directly with a number of the cognitions involved in the relapse process and focus on helping the individual gain a more positive self-efficacy.

- Overall, behavioral, cognitive, and cognitive-behavioral interventions are effective, can be used with a wide range of substance abusers, and can be conducted within the timeframe of brief therapies. (1)
- A broad range of cognitions will be evaluated in CBT, including attributions, appraisals, self-efficacy expectancies, and substance-related effect expectancies. (2)

Strategic/Interactional Therapies

Strategic/interactional therapies attempt to identify the client's strengths and actively create personal and environmental situations in which success can be achieved. The primary strength of strategic/interactional approaches is that they shift the focus from the client's weaknesses to his strengths.

The strategic/interactional model has been widely used and successfully tested on persons with serious and persistent mental illnesses. (1) Although the research to date on these therapies (using nonexperimental designs) has not focused on substance abuse disorders, the use of these therapies in treating substance abuse disorders is growing.

The Consensus Panel believes that these therapeutic approaches are potentially useful for clients with substance abuse disorders and should be introduced to offer new knowledge and techniques for treatment providers to consider. (2)

Using strategic/interactional therapies

No matter which type of strategic/interactional therapy is used, this approach can help to

- Define the situation that contributes to substance abuse in terms meaningful to the client (2)
- Identify steps needed to control or end substance abuse (2)
- Heal the family system so it can better support change (2)
- Maintain behaviors that will help control substance abuse (2)
- Respond to situations in which the client has returned to substance use after a period of abstinence (2)

Strategic/interactional approaches are most useful in

- Learning how the client's relationships deter or contribute to substance abuse (2)
- Shifting power relationships (2)
- Addressing fears (2)

Most forms of strategic/interactional therapies are brief by the definition used in this TIP. Strategic/interactional therapies normally require 6 to 10 sessions, with 6 being most common.

Humanistic and Existential Therapies

Humanistic and existential psychotherapies use a wide range of approaches to the planning and treatment of substance abuse disorders. They are, however, united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Humanistic and existential approaches share a belief that people have the capacity for self-awareness and choice. However, the two schools come to this belief through different theories.

Humanistic and existential therapeutic approaches may be particularly appropriate for short-term substance abuse treatment because they tend to facilitate therapeutic rapport, increase self-awareness, focus on potential inner

resources, and establish the client as the person responsible for recovery. Thus, clients may be more likely to see beyond the limitations of short-term treatment and envision recovery as a lifelong process of working to reach their full potential. (2)

Using humanistic and existential therapies

Many aspects of humanistic and existential approaches (including empathy, encouragement of affect, reflective listening, and acceptance of the client's subjective experience) can be useful in any type of brief therapy. They help establish rapport and provide grounds for meaningful engagement with all aspects of the treatment process. (2)

Humanistic and existential approaches can be used at all stages of recovery in creating a foundation of respect for clients and mutual acceptance of the significance of their experiences. (2) There are, however, some therapeutic moments that lend themselves more readily to one or more specific approaches.

- *Client-centered* therapy can be used immediately to establish rapport and to clarify issues throughout the session. (2)
- *Existential* therapy may be used most effectively when a client has access to emotional experiences or when obstacles must be overcome to facilitate a client's entry into or continuation of recovery (e.g., to get someone who insists on remaining helpless to accept responsibility for her actions). (2)
- *Narrative* therapy can be used to help the client conceptualize treatment as an opportunity to assume authorship and begin a "new chapter" in life. (2)
- *Gestalt* approaches can be used throughout therapy to facilitate a genuine encounter with the therapist and the client's own experience. (2)

- *Transpersonal* therapy can enhance spiritual development by focusing on the intangible aspects of human experience and awareness of unrealized spiritual capacity. (2)

Using a humanistic or existential therapy framework, the therapist can offer episodic treatment, with a treatment plan that focuses on the client's tasks and experiences between sessions. (2)

For many clients, momentary circumstances and other problems surrounding substance abuse may seem more pressing than notions of integration, spirituality, and existential growth, which may be too remote from their immediate situation to be effective. In such instances, humanistic and existential approaches can help clients focus on the fact that they do indeed make decisions about substance abuse and are responsible for their own recovery. (2)

Psychodynamic Therapies

Psychodynamic therapy focuses on unconscious processes as they are manifested in the client's present behavior. The goals of psychodynamic therapy are client self-awareness and understanding of the past's influence on present behavior. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and/or desire to abuse substances.

Several of the brief forms of psychodynamic therapy are less appropriate for use with persons with substance abuse disorders, partly because their altered perceptions make it difficult to achieve insight and problem resolution. However, many psychodynamic therapists use forms of brief psychodynamic therapy with substance-abusing clients in conjunction with traditional substance abuse treatment programs or as the sole therapy for clients with coexisting disorders. (2)

Although there is some disagreement in the details, psychodynamic brief therapy is generally thought more suitable for (2)

- Those who have coexisting psychopathology with their substance abuse disorder
- Those who do not need or who have completed inpatient hospitalization or detoxification
- Those whose recovery is stable
- Those who do not have organic brain damage or other limitations to their mental capacity

Integrating psychodynamic concepts into substance abuse treatment

Most therapists agree that people with substance abuse disorders comprise a special population, one that often requires more than one approach if treatment is to be successful. Therapists whose orientations are not necessarily psychodynamic may still find these techniques and approaches useful, and therapists whose approaches are psychodynamic may be more effective if they conduct psychotherapy in a way that complements the full range of services for clients with substance abuse disorders. (2)

Family Therapy

For many individuals with substance abuse disorders, interactions with their family of origin, as well as their current family, set the patterns and dynamics for their problems with substances. Furthermore, family member interactions with the substance abuser can either perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is particularly appropriate when the client exhibits signs that his substance abuse is strongly influenced by family members' behaviors or communications with them. (2)

Family involvement is often critical to success in treating many substance abuse

disorders—most obviously in cases where the family is part of the problem. (2)

Family therapy can be used to

- Focus on the expectation of change within the family (which may involve multiple adjustments)
- Test new patterns of behavior
- Teach how a family system works—how the family supports symptoms and maintains needed roles
- Elicit the strengths of every family member
- Explore the meaning of the substance abuse disorder within the family

Appropriateness of brief family therapy

Long-term family therapy is not usually necessary for the treatment of substance abuse disorders. While family therapy may be very helpful in the initial stages of treatment, it is often easier to continue to help an individual work within the family system through subsequent individual therapy. (2)

Short-term family therapy is an option that could be used in the following circumstances (2):

- When resolving a specific problem in the family and working toward a solution
- When the therapeutic goals do not require in-depth, multigenerational family history, but rather a focus on present interactions
- When the family as a whole can benefit from teaching and communication to better understand some aspect of the substance abuse disorder

Definitions of “family”

Family therapy can involve a network that extends beyond the immediate family, involves only a few members of the family system, or even deals with several families at once. (2) The definition of “family” varies in different cultures and situations and should be defined by the client.

Therapists can “create” a family by drawing on the client’s network of significant contacts.

(2) A more important question than whether the client is living with a family is, “Can the client’s problem be seen as having a relational (involving two or more people) component?”

Using brief family therapies

In order to promote change successfully within a family system, the therapist will need the family’s permission to enter the family space and share their closely held confidences. The therapy, however, will work best if it varies according to the cultural background of the family. (1)

Most family therapy is conducted on a short-term basis. Sessions are typically 90 minutes to 2 hours in length. The preferred timeline for family therapy is not more than 2 sessions per week (except in residential settings), to allow time to practice new behaviors and experience change. Therapy may consist of as few as 6 or as many as 10 sessions, depending on the purpose and goals of the intervention.

Group Therapy

Group psychotherapy is one of the most common modalities for treatment of substance abuse disorders. Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It differs from family therapy in that the therapist creates open- and closed-ended groups of people previously unknown to each other.

Appropriateness of group therapy

Group psychotherapy can be extremely beneficial to individuals with substance abuse problems. (2) It gives them the opportunity to see the progression of abuse and dependency in themselves and others; it also provides an opportunity to experience personal success and the success of other group members in an atmosphere of support and hope.

Use of psychodrama techniques in a group setting

Psychodrama has long been effectively used with substance-abusing clients in a group setting. Psychodrama can be used with different models of group therapy. It offers persons with substance abuse disorders an opportunity to better understand past and present experiences — and how past experiences influence their present lives. (2)

Using time-limited group therapy

The focus of time-limited therapeutic groups varies a great deal according to the model chosen by the therapist. Yet some generalizations can be made about several dimensions of the manner in which brief group therapy is implemented.

Client preparation is particularly important in any time-limited group experience. Clients should be thoroughly assessed before their entry into a group for therapy. (2) Group participants should be given a thorough explanation of group expectations.

The preferred timeline for time-limited group therapy is not more than 2 sessions per week (except in the residential settings), with as

few as 6 sessions in all, or as many as 12, depending on the purpose and goals of the group.

Sessions are typically 1½ to 2 hours in length. Residential programs usually have more frequent sessions.

Group process therapy is most effective if participants have had time to find their roles in a group, to “act” these roles, and to learn from them. The group needs time to define its identity, develop cohesion, and become a safe environment in which there is enough trust for participants to reveal themselves. (2)

Conclusion

The brief interventions and therapies described in this TIP are intended to introduce a range of techniques to clinicians. Clinicians will find different portions of this TIP more useful than others depending on their theoretical orientation, but all clinicians who work with substance-abusing clients should find material of value here. Brief interventions will be useful for a wide variety of service providers; brief therapies are intended for properly qualified, educated, and licensed professionals.

1 Introduction to Brief Interventions and Therapies

The use of brief intervention and brief therapy techniques has become an increasingly important part of the continuum of care in the treatment of substance abuse problems. With the health care system changing to a managed model of care and with changes in reimbursement policies for substance abuse treatment, these short, problem-specific approaches can be valuable in the treatment of substance abuse problems. They provide the opportunity for clinicians to increase positive outcomes by using these modalities independently as stand-alone interventions or treatments and as additions to other forms of substance abuse and mental health treatment. They can be used in a variety of settings including opportunistic settings (e.g., primary care, home health care) and specialized substance abuse treatment settings (inpatient and outpatient).

Used for a variety of substance abuse problems from at-risk use to dependence, brief interventions can help clients reduce or stop abuse, act as a first step in the treatment process to determine if clients can stop or reduce on their own, and act as a method to change specific behaviors before or during treatment. For example, there are some issues associated with treatment compliance that benefit from a brief, systematic, well-planned intervention such as attending group sessions or doing homework. In other instances, brief interventions address

specific family problems with a client and/or family members or deal with specific individual problems such as personal finances and work attendance. The basic goal for a client regardless of setting is to reduce the risk of harm that may result from continued use of substances. The reduction of harm, in its broadest sense, pertains to the clients themselves, their families, and the community.

The brief therapies discussed in this TIP are brief cognitive-behavioral therapy, brief strategic and interactional therapies, brief humanistic and existential therapies, brief psychodynamic therapy, short-term family therapy, and time-limited group therapy. The choice to include these therapeutic modalities was based on a combination of relevant research and, in some instances where there is a smaller research base, the clinical knowledge and expertise of the Consensus Panel. All of these approaches are currently being used in the treatment of substance abuse disorders, and all of them can contribute something to the array of treatment techniques available to the eclectic practitioner.

Brief interventions and brief therapies may be thought of as elements on a continuum of care, but they can be distinguished from each other according to differences in outcome goals. Interventions are generally aimed at motivating a client to perform a particular action (e.g., to enter treatment, change a behavior, think

differently about a situation), whereas therapies are used to address larger concerns (such as altering personality, maintaining abstinence, or addressing long-standing problems that exacerbate substance abuse). This TIP presents brief interventions as a way of improving client motivation for treatment. The brief therapies considered here are ways of changing client attitudes and behaviors. Other differences that help distinguish brief interventions from brief therapies include

- Length of the sessions (from 5 minutes for an intervention to more than six 1-hour therapy sessions)
- Extensiveness of assessment (which will be greater for therapies than for interventions)
- Setting (nontraditional treatment settings such as a social service or primary care setting, which will use interventions exclusively, versus traditional substance abuse treatment settings where therapy or counseling will be used in addition to interventions)
- Personnel delivering the treatment (brief interventions can be administered by a wide range of professionals, but therapy requires training in specific therapeutic modalities)
- Materials and media used (certain materials such as written booklets or computer programs may be used in the delivery of interventions but not therapies)

Although the theoretical bases for brief therapy and brief intervention may be different, this distinction is less obvious in practice. These two approaches to substance abuse problems and behavior change reflect a continuum rather than a clear dichotomy. The distinction may be further blurred as the change process associated with the success of brief interventions is better understood or refined and as theories are developed to explain a brief intervention's mechanism of action. Already, some forms of brief intervention overlap with therapy, such as

motivational enhancement therapy, which has a clearly articulated theoretical rationale (for more on this topic, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment*, which was conceived as a companion volume to this TIP [Center for Substance Abuse Treatment (CSAT), 1999c]).

For the purposes of this TIP, brief therapy involves a series of steps taken to treat a substance abuse problem, whereas brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse. Therapy involves movement (or an attempt at movement) toward change. Brief therapy concentrates particularly on investigating a problem in order to develop a solution in consultation with the client; brief interventions generally involve a therapist giving advice to the client.

The increasing emphasis on brief approaches is partly attributable to recent changes in the health care delivery system, in which clinicians are urged to reduce costs while maintaining treatment efficacy. Essentially, clinicians are constrained by time and diminishing resources yet are treating an increasing number of individuals with substance abuse problems.

Fortunately, there is a body of literature on brief approaches in the treatment of substance abuse disorders. Brief interventions and brief therapies have the appeal not only of being brief but also of having research backing that supports their use. Brief interventions have been widely tested with both general clinical and substance-abusing populations and have shown great promise in changing client behavior. Brief therapies, however, have been unevenly researched. As indicated in the discussion of each type, in addition to the empirical results reported in scientific journals, clinical and anecdotal evidence supports the efficacy of brief therapies in the treatment of substance abuse. The brevity and lower

delivery costs of these brief approaches make them ideal mechanisms for use in settings from primary care to substance abuse treatment where cost often plays as much of a role as efficacy in determining what treatments clients receive.

Brief interventions and brief therapies are also well suited for clients who may not be willing or able to expend the significant personal and financial resources necessary to complete more intensive, longer term treatments. Although much research supports the theory that longer time in treatment is associated with better outcomes, research also suggests that for some clients, there is no loss in effectiveness when length and intensity of treatment are reduced.

An Overview of Brief Interventions

Definitions of brief interventions vary. In the recent literature, they have been referred to as “simple advice,” “minimal interventions,” “brief counseling,” or “short-term counseling.” They can be simple suggestions to reduce drinking given by a professional (e.g., social worker, nurse, alcohol and drug counselor, physician, physician assistant) or a series of interventions provided within a treatment program. As one researcher notes,

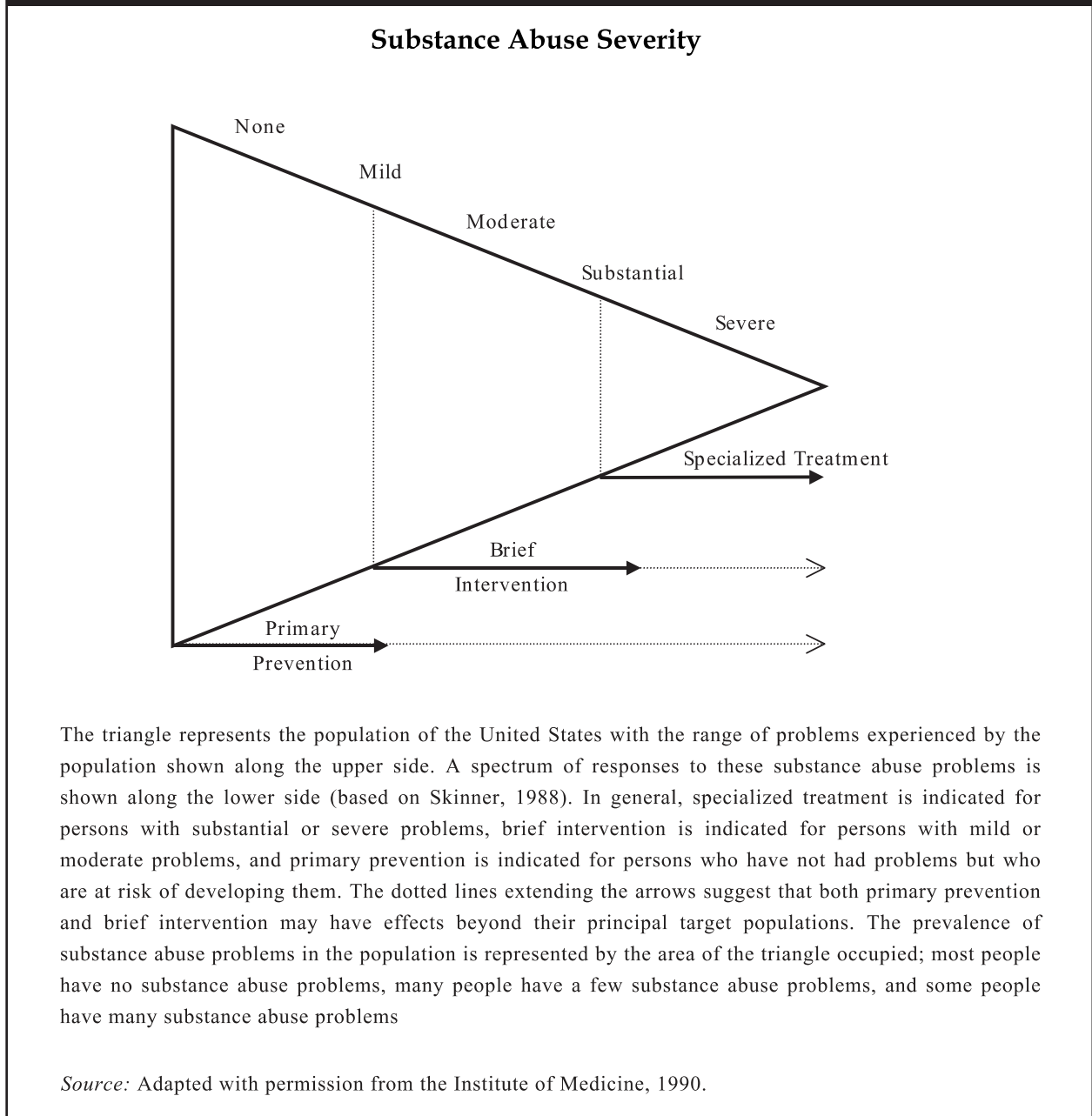
Brief interventions for excessive drinking should not be referred to as an homogenous entity, but as a family of interventions varying in length, structure, targets of intervention, personnel responsible for their delivery, media of communication and several other ways, including their underpinning theory and intervention philosophy (Heather, 1995, p. 287).

Brief interventions, therefore, can be viewed as a set of principles regarding interventions which are different from, but not in conflict with, the principles underlying conventional treatment (Heather, 1994).

Brief interventions for alcohol problems, for example, have employed various approaches to change drinking behaviors. These approaches have ranged from relatively unstructured counseling and feedback to more formal structured therapy and have relied heavily on concepts and techniques from the behavioral self-control training (BSCT) literature (Miller and Hester, 1986b; Miller and Munoz, 1982; Miller and Rollnick, 1991; Miller and Taylor, 1980) (see Chapter 4 for more information on BSCT). Usually, brief treatment interventions have flexible goals, allowing the individual to choose moderation or abstinence. The typical counseling goal is to motivate the client to change her behavior and not to assign self-blame. While much of the research to date has centered on clients with alcohol-related problems, similar approaches can be taken with users of other substances.

Brief interventions are a useful component of a full spectrum of treatment options; they are particularly valuable when more extensive treatments are unavailable or a client is resistant to such treatment. Too few clinicians, however, are educated and skilled in the use of brief interventions and therapies to address the very large group of midrange substance users who have moderate and risky consumption patterns (see Figure 1-1). Although this group may not need or accept traditional substance abuse treatment, these individuals are nonetheless responsible for a disproportionate share of substance-related morbidity, including lowered workforce performance, motor vehicle accidents and other injuries, marital discord, family dysfunction, and medical illness (Wilk et al., 1997). These hazardous substance users are identified in employment assistance programs (EAPs), programs for people cited for driving while intoxicated (DWI), and urine testing programs, as well as in physicians’ offices and other health screening efforts (Miller, 1993). Despite appeals from such distinguished bodies

Figure 1-1
Substance Abuse Severity and Level of Care



as the National Academy of Sciences in the United States and the National Academy of Physicians and Surgeons in the United Kingdom, widespread adoption of brief interventions by medical practitioners or treatment providers has not yet occurred (Drummond, 1997; Institute of Medicine [IOM], 1990).

Brief interventions in traditional settings usually involve a more in-depth assessment of substance abuse patterns and related problems (Institute of Medicine [IOM], 1990). The characterizations of hazardous, harmful, or dependent use as they relate to alcohol consumption patterns (Edwards et al., 1981) were used to distinguish the targets of

brief intervention in a World Health Organization (WHO) study (Babor and Grant, 1991). Hazardous drinking refers to a level of alcohol consumption or pattern of drinking that, should it persist, is likely to result in harm to the drinker. Harmful drinking is defined as alcohol use that has already resulted in adverse mental or physical effects. Dependent use refers to drinking that has resulted in physical, psychological, or social consequences and has been the focus of major diagnostic tools, such as the *Diagnostic and Statistical Manual, 4th Edition* (American Psychiatric Association [APA], 1994) or the *International Classification of Diseases, 9th Revision (ICD-9)* (ICD-9-CM, 1995). Categorizing drinking patterns in this fashion provides both clinicians and researchers with flexible guidelines to identify individuals at risk for alcohol problems who may not meet criteria for alcohol dependence. Similar levels of use for other substances are much more difficult to define, since most of them are illicit and those that are not have often not been widely studied in relation to substance abuse.

Studies of brief interventions have been conducted in a wide range of health care settings, from hospitals and primary health care locations (Babor and Grant, 1991; Chick et al., 1985; Fleming et al., 1997; Wallace et al., 1988) to mental health clinics (Harris and Miller, 1990). (Refer to “Research Findings” in Chapter 2 for more discussion of research on brief interventions.) Individuals recruited from such settings are likely to have had some contact with a health care professional during the study participation and therefore had alcohol-related professional assistance available. Nonetheless, many of these patients would not be identified as having an alcohol problem by their health care providers and would not ordinarily receive any alcohol-specific intervention.

In general, brief interventions are conducted in a variety of opportunistic and substance abuse treatment settings, target different goals;

may be delivered by treatment staff or other professionals, and do not require extensive training. Because of the short duration of brief intervention strategies, they can be considered for use with injured patients in the emergency department who have substance abuse problems. Useful distinctions between the goals of brief interventions as applied in different settings are listed in Figure 1-2.

Brief interventions in traditional settings usually involve a more in-depth assessment of substance use patterns and related problems than interventions administered in nontraditional settings and tend to examine other aspects of participants’ attitudes, such as readiness for or resistance to change. They can be useful for addressing specific behavior change issues in treatment settings. Because they are timely, focused, and client centered, brief interventions can quickly enhance the overall working relationship with clients. However, brief interventions should not be a care substitute for clients who have a high level of abuse.

Some of the assessments conducted for research studies of brief interventions are very extensive and may have been conducted during prior treatment (e.g., in detoxification programs, during treatment intake procedures). Most brief interventions offer the client detailed feedback about assessment findings, with an opportunity for more input. The assessment typically involves obtaining information regarding frequency and quantity of substance abuse, consequences of substance abuse, and related health behaviors and conditions.

The intervention itself is structured and focused on substance abuse. Its primary goals are to raise awareness of problems and then to recommend a specific change or activity (e.g., reduced consumption, accepting a referral, self-monitoring of substance abuse). The participant in a brief intervention is usually offered a menu of options or strategies for accomplishing the

Figure 1-2	
Goal of Brief Interventions According to Setting	
Setting	Purpose
Opportunistic setting	<ul style="list-style-type: none"> ■ Facilitate referrals for additional specialized treatment (e.g., a nurse identifying substance-abusing clients through screening and advising them to seek further assessment or treatment) ■ Affect substance abuse directly by recommending a reduction in hazardous or at-risk consumption patterns (e.g., a primary care physician advising hazardous or at-risk drinkers to cut down, National Alcohol Screening Day) or establishing a plan for abstinence
Neutral environments (e.g., individuals responding to media advertisements)	<ul style="list-style-type: none"> ■ Assess substance abuse behavior and give supportive advice about harm reduction (e.g., a public health initiative to screen people in shopping malls and provide feedback and advice)
Health care setting	<ul style="list-style-type: none"> ■ Facilitate referrals for additional specialized treatment
Substance abuse treatment programs	<ul style="list-style-type: none"> ■ Act as a temporary substitute for more extended treatment for persons seeking assistance but waiting for services to become available (e.g., an outpatient treatment center that offers potential clients assessment and feedback while they are on a waiting list) ■ Act as a motivational prelude to engagement and participation in more intensive treatment (e.g., an intervention to help a client commit to inpatient treatment when the assessment deems it appropriate but the client believes outpatient treatment is adequate) ■ Facilitate behavior change related to substance abuse or associated problems
<i>Source:</i> Adapted from Bien et al., 1993.	

target goal and encouraged to take responsibility for selecting and working on behavioral change in a way that is most comfortable for him. Any followup visits will provide an opportunity to monitor progress and to encourage the client’s motivation and ability to make positive changes. The person delivering the brief intervention is usually trained to be empathic, warm, and encouraging rather than confrontational.

Brief interventions are typically conducted in face-to-face sessions, with or without the addition of written materials such as self-help manuals, workbooks, or self-monitoring diaries. A few have consisted primarily of mailed materials, automated computer screening and advice, or telephone contacts.

Some interventions are aimed at specific health problems that are affected by substance abuse, rather than substance abuse itself.

For example, an intervention may be conducted to help a client reduce her chances of contracting human immunodeficiency syndrome (HIV) by using clean needles; as a result, if the client only has dirty needles, she might avoid using them in order to reduce her risk of HIV and thus reduce her use of heroin. By raising an individual's awareness of her substance abuse, a brief intervention can act as a powerful catalyst for changing a substance abuse pattern.

The distress clients feel about their substance abuse behavior can act as an influence to encourage change as they recognize the negative consequences of that behavior to themselves or others. Positive and negative external forces are also influences. Life events, such as a major illness or the death of significant others, career change, marriage, and divorce, can contribute to the desire to change. Brief interventions can address these events and feelings that accompany them with the underlying goal of changing clients' substance abuse behaviors.

An Overview of Brief Therapies

In contrast to most simple advice or brief interventions, brief therapies are usually delivered to persons who are seeking—or already in—treatment for a substance abuse disorder. That is, the individual usually has some recognition or awareness of the problem, even if he has yet to accept it. The therapy itself is often client driven; the client identifies the problems, and the clinician uses the client's strengths to build solutions. The choice of a brief therapy for a particular individual should be based on a comprehensive assessment rather than a cursory screening to identify potentially hazardous drinking or substance-abusing patterns (IOM, 1990). In some cases, brief

therapy may also be used if resources for more extensive therapy are not available or if standard treatment is inaccessible or unavailable (e.g., remote communities, rural areas). Brief therapies often target a substance-abusing population with more severe problems than those for whom brief interventions are sufficient. Brief therapies can be useful for special populations if the therapist understands that some client issues may be developmental or physiological in nature (see TIP 26, *Substance Abuse Among Older Adults*, and TIP 32, *Treatment of Adolescents With Substance Use Disorders* [CSAT, 1998b, 1999b]).

Although brief therapies are typically shorter than traditional versions of therapy, these therapies generally require at least six sessions and are more intensive and longer than brief interventions. Brief therapy, however, is not simply a shorter version of some form of psychotherapy. Rather, it is the focused application of therapeutic techniques specifically targeted to a symptom or behavior and oriented toward a limited length of treatment.

In addition to the goals of brief interventions, the goals of brief therapy in substance abuse treatment is remediation of some specified psychological, social, or family dysfunction as it pertains to substance abuse; it focuses primarily on present concerns and stressors rather than on historical antecedents. Brief therapy is conducted by therapists who have been specifically trained in one or more psychological or psychosocial models of treatment. Therapist training requires months or years and usually results in a specialist degree or certification. In practice, many therapists who have been trained in specific theoretical models of change borrow techniques from other models when working with their clients. Although the models remain distinct, therapists often become eclectic practitioners.

The Demand for Brief Interventions and Therapies

The impetus for shorter forms of interventions and treatments for a range of substance abuse problems comes from several sources:

- Historical developments in the field that encourage a comprehensive, community-based continuum of care – with treatment and prevention components to serve clients who have a wide range of substance abuse-related problems
- A growing body of evidence that consistently demonstrates the efficacy of brief interventions
- An increasing demand for the most cost-effective types of treatment, especially in this era of health care inflation and cost containment policies in the private and public sectors
- Client interest in shorter term treatments

The increasing demand for treatment of some sort – arising from the identification of more at-risk consumers of substances through EAPs, substance-testing programs, health screening efforts, and drunk driving arrests – coupled with decreased public funding and cost containment policies of managed care leave only two options: provide diluted treatment in traditional models for a few or develop a system in which different levels and types of interventions are provided to clients based on their identified needs and characteristics (Miller, 1993).

Expanding Treatment Options

The development of public substance abuse treatment programs subsidized by Federal, State, and local monies dates to the late 1960s when public drunkenness was decriminalized and detoxification centers were substituted for drunk tanks in jails. At about the same time,

similar efforts were made to curtail heroin use in major cities by establishing methadone maintenance clinics and residential therapeutic communities (IOM, 1990).

By the 1980s, direct Federal financial support for treatment had slowed, and although some States continued to grant subsidies, the most rapid growth in the field switched to the insurance-supported private sector and the development of treatment programs targeted primarily to heavy consumers of alcohol, cocaine, and marijuana (Gerstein and Harwood, 1990). The standardized approach used in most of these private, hospital-based programs incorporated many aspects of the Minnesota model pioneered in the late 1950s, with a strong focus on the 12-Step philosophy developed in Alcoholics Anonymous (AA), a fixed-length, 28-day stay, and insistence on abstinence as the major treatment goal (CSAT, 1995).

Initially, treatment programs in both the public and private sectors tended to serve the most seriously impaired populations; however, providers gradually recognized the need for treatment options for a wider range of clients who had different types of substance abuse disorders. Providers realized that not all clients benefit from a single standardized treatment approach. Rather, treatment should be tailored to individual needs determined by in-depth assessments of the client's problems and antecedents to her substance abuse disorder. Providers were also aware that interventions with less dysfunctional clients often had greater success rates. In the interest of reducing drunk driving, for example, educational efforts were targeted at offenders charged with DWI as an alternative to revoking their driving licenses. In such programs, more attention was given to outcomes and factors in the treatment setting than to the client's history; these seemed to affect success rates whether or not treatment was completed.

As assessments became more comprehensive, treatment also began to address the effects of substance abuse patterns on multiple systems, including physical and mental health, social and personal functioning, legal entanglements, and economic stability. In recent years, this biopsychosocial approach to the treatment of substance abuse disorders has stimulated more cross-disciplinary cooperation. It has also prompted more attempts to match client needs to the most appropriate and expeditious intensity of care and treatment modality. Consideration is now given to differences not only in the severity and types of problems identified but also to the cultural or environmental context in which the problems are encountered, the types of substances abused, and differences in gender, age, education, and social stability. Determining a client's appropriateness for treatment is one of the 46 global criteria for competency of certified alcohol and drug abuse counselors (Herdman, 1997). Indeed, client assessment and treatment matching and referral has become a specialty area in itself that avoids the hazards of random treatment entry.

In order to test the efficacy of current treatment-matching knowledge, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) initiated Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity), which assessed the benefits of matching alcohol-dependent clients (using 10 client characteristics) to three types of treatments: 12-Step facilitation, cognitive-behavioral therapy, and motivational enhancement therapy (Project MATCH Research Group, 1997). Clients from two parallel but independent clinical trials (one in which clients were receiving outpatient treatment, the other in which clients were receiving aftercare therapy following inpatient treatment) were assigned to receive one of the three treatments. Although the results do not

indicate a strong need to consider client characteristics to match clients to treatment, the findings do suggest that the severity of coexisting psychiatric disorders should be considered.

Another study, conducted by McLellan and colleagues, identified specific problems of clients in treatment (e.g., employment, family, psychiatric problems), then matched the clients to services designed to address the problems (McLellan et al., 1993). These clients stayed in treatment longer, were more likely to complete treatment, and had better posttreatment outcomes than unmatched clients in the same treatment programs.

In this context, increasing emphasis has also been given to integrating specialized approaches to substance abuse treatment with the general medical system and the services of other community agencies. A 1990 IOM report called for more community involvement in health care, social services, workplace, educational, and criminal justice systems (IOM, 1990). Because the vast majority of persons who use substances in moderation experience few or minor problems, they are not likely to seek help in the specialized treatment system. Instead, the estimated 20 percent of the adult population who drink or use heavily or in inappropriate ways (Higgins-Biddle et al., 1997) are those most likely to come to the attention of physicians, social workers, family therapists, employers, teachers, lawyers, and police. Because the prevalence of harmful and risky substance use far exceeds the capacity of available services to treat it, briefer and less intensive interventions seem warranted for a broad range of individuals, including those who are unwilling to accept referral for more formal and extensive specialized care (Bien et al., 1993) and those whose substance use is risky but not abusive (Higgins-Biddle et al., 1997).

Cost and Funding Factors

Studies of the cost-effectiveness of different treatment approaches have been particularly appealing to policymakers seeking to reduce costs and better allocate scarce resources. In the managed care environment, however, cost containment has become a byword, and no standard type of care or treatment protocol for all clients is acceptable. In order to receive reimbursement, substance abuse treatment facilities must find the least intensive yet safe modality of care that can be objectively proven to be appropriate and effective for a client's needs. Now that more treatment is delivered in ambulatory care facilities, the usual time in treatment is being shortened, and the credibility of recommended treatment approaches must be increasingly documented through carefully conducted research studies. In this context, some of the most widely used substance abuse treatment approaches, such as the Minnesota model, halfway houses, and 12-Step programs, have only recently been subjected to rigorous tests of effectiveness in controlled clinical trials (Barry, 1997; Holder et al., 1991; Landry, 1996).

In addition to the emphasis on cost containment and careful client-treatment matching, other researchers tout the potentially enormous public health impact that could be derived from conducting mass screenings in existing health care and other community-based systems to identify problem drinkers and then delivering brief interventions aimed at reducing excessive drinking patterns (Kahan et al., 1995). If appropriately selected persons with less severe substance abuse respond successfully to brief interventions with a consequent long-term reduction in substance abuse-related morbidity and associated health care costs, time and energy could be saved for treating those with more severe substance abuse disorders in specialized treatment facilities.

Barriers to Increasing the Use of Brief Treatments

Many clinicians and other care providers in community agencies retain the long-standing notion that clients are generally resistant to change, unmotivated, and in denial of problems associated with their substance abuse disorders. As a result, clinicians are hesitant to work with this population. Some of these attitudes also persist in the specialist treatment community (Miller, 1993). Although this perspective is shifting as clinicians better understand the many aspects of client motivation, there is still a tradition of waiting for a substance user to "hit bottom" and ask for help before attempting to treat him.

Other ideological obstacles present barriers in earlier stages of substance abuse. The focus of brief interventions on harm or risk reduction and moderating consumption patterns as a first and sometimes only goal is not always acceptable to counselors who were trained to insist on total and enduring abstinence. Assumptions underlying brief interventions aimed at harm reduction may seem to challenge ideas that substance abuse disorders are a chronic and progressive disease requiring specialized treatment. However, if substance abuse is placed on a continuum from abstinence to severe abuse, any move toward moderation and lowered risk is a step in the right direction and not incongruous with a goal of abstinence as the ultimate form of risk reduction (Marlatt et al., 1993). Moreover, research indicates that substance-abusing individuals who are employed and generally functioning well in society are unlikely to respond positively to some forms of traditional treatment which may, for example, tell them that they have a primary disease of substance dependency and must abstain from all psychoactive substances for life (Miller, 1993).

In addition to resisting a harm reduction approach, treatment staffs in programs that incorporate pharmacotherapies may be skeptical of behavioral approaches to client change if they believe addiction primarily stems from disordered brain chemistry that should be treated medically. There are many models of pharmacotherapy that suggest that counseling (often in a brief form) coupled with medication provides the most well-rounded and comprehensive treatment regime (McLellan et al., 1993; Volpicelli et al., 1992).

Moreover, research reveals that a longer time in treatment may contribute to a greater likelihood of success (Lamb et al., 1998). Brief interventions challenge this assumption by acknowledging that spontaneous remission and self-directed change in substance abuse behaviors do occur. A new perspective might reconcile these observations by recognizing that limited treatment can be beneficial—especially considering that at least half of all clients drop out of specialized treatment before completion.

Probably the largest impediment to broader application of briefer forms of treatment is the already overwhelming responsibilities of frontline treatment staff members who are overworked and unfamiliar with the latest treatment research findings (Schuster and Silverman, 1993). Not only are these clinicians reluctant to make clinical changes, but their programs may also lack the financial and personnel resources to adopt innovative approaches. Treatment programs limit themselves by such inability and unwillingness to learn new techniques.

Evaluating Brief Interventions and Therapies

Quality improvement has become an important consideration in the contemporary health care

environment. Because of changes in the nature and provision of health care delivery in the United States, health care organizations have been working to develop systematic quality improvement programs to monitor provision of care, client satisfaction, and costs. Brief interventions can be an important part of a treatment program's quality improvement initiative. These approaches can be used to improve treatment outcomes in specific areas. Not only can brief interventions improve client compliance with specific aspects of treatment and therapist morale by focusing on attainable goals, but they can also demonstrate specific clinical outcomes of importance to both clinicians and managed care systems.

Importance of Evaluation

The Consensus Panel recommends that programs use quality assurance improvement projects to determine whether the use of a brief intervention or therapy in specific treatment situations is improving treatment. Examples of outcome measures include

- Aftercare followup rates
- Aftercare compliance rates
- Alumni participation rates
- Discharge against medical advice rates
- Counselors' ratings of client involvement in substance abuse following treatment
- The number of complaints related to the brief intervention or therapy

Mechanisms To Use in Evaluation

The effects of adding brief approaches to standard care should be evaluated as part of continuous quality improvement program testing. Some of these outcomes can be measured by

- Client satisfaction surveys
- Followup phone calls
- Counselor-rating questions added to clinical chart

Programs should monitor client satisfaction over time, and whenever possible counselors should be involved in quality improvement activities. Identifying trends over time can indicate what improvements need to be made. Implementation of substance abuse prevention and brief intervention strategies in clinical practice requires the development of systematized protocols that can provide easier service delivery. The need to implement effective and unified strategies for a variety of

substance abusers who are at risk for more serious health, social, and emotional problems is high, both from a public health and a clinical perspective. As the health care system undergoes changes, programs should take the opportunity to develop and advocate a comprehensive system of substance abuse interventions, combining the skills of clinicians with the knowledge gained from the research community.

2 Brief Interventions in Substance Abuse Treatment

Brief interventions for substance abuse problems have been used for many years by alcohol and drug counselors, social workers, psychologists, physicians, and nurses, and by social service agencies, hospital emergency departments, court-ordered educational groups, and vocational rehabilitation programs. Primary care providers find many brief intervention techniques effective in addressing the substance abuse issues of clients who are unable or unwilling to access specialty care. Examples of brief interventions include asking clients to try nonuse to see if they can stop on their own, encouraging interventions directed toward attending a self-help group (e.g., Alcoholics Anonymous [AA] or Narcotics Anonymous [NA]), and engaging in brief, structured, time-limited efforts to help pregnant clients stop using.

Brief interventions are research-proven procedures for working with individuals with at-risk use and less severe abuse behaviors and can be successful when transported into specialist treatment settings and performed by alcohol and drug counselors. As presented in the literature, brief interventions to change substance abuse behaviors can involve a variety of approaches, ranging from unstructured counseling and feedback to formal structured therapy (Chick et al., 1985; Fleming et al., 1997; Kristenson et al., 1983; Persson and Magnusson, 1989). Brief interventions, as defined and

discussed in this TIP are time limited, structured, and directed toward a specific goal. They follow a specific plan (and in some cases a workbook) and have timelines for the adoption of specific behaviors.

Several studies have attempted to identify factors that result in differential responses to brief intervention by varying client characteristics or by conducting subgroup analyses. Most studies of brief interventions to date are limited by their lack of sufficient subject assessments. Findings from the available research suggest that client characteristics are not good predictors of a person's response to a brief intervention and that brief interventions may be applicable to individuals from a wide range of cultures and backgrounds (Babor, 1994; Babor and Grant, 1991).

This chapter provides theoretical and practical information on brief interventions, both in opportunistic settings and in the substance abuse treatment setting. The stages-of-change model is presented first because of its usefulness in understanding the process of behavioral change. Next, the goals of brief intervention are described and applied to various levels of substance use. FRAMES elements critical to brief intervention are detailed, and five essential steps are listed with scripts to use in various settings. The brief intervention workbook, a practical tool for use during a brief intervention, is explained.

Essential clinician knowledge and skills for conducting a successful brief intervention are then described. Discussions of the use of brief intervention in substance abuse programs and nonspecialized settings follow. The final section presents research findings on brief interventions for both at-risk users and dependent users.

Stages-of-Change Model

The work of Prochaska and DiClemente and their “stages-of-change” model help clinicians tailor brief interventions to clients’ needs (Prochaska and DiClemente, 1984, 1986). Prochaska and DiClemente examined several theories concerning how change occurs and applied their findings to substance abuse behavior modification. They devised a model consisting of five stages of change that seemed to best represent the process people go through when thinking about, beginning, and trying to maintain new behavior (see Figure 2-1). The stages-of-change model is explained more fully in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999c).

These stages have proven useful, for example, in predicting those most likely to quit smoking and in targeting specific kinds of interventions to smokers in different stages (DiClemente et al., 1991; Prochaska, 1999; Prochaska and DiClemente, 1986; Velicer et al., 1992). Stages of change are being examined in brief interventions with hazardous and harmful substance users as well, as a means of tailoring interventions to the individual’s current stage of change (Hodgson and Rollnick, 1992; Mudd et al., 1995).

Clients need motivational support appropriate to their stage of change. If the clinician does not use strategies appropriate to the stage the client is in, treatment resistance or

noncompliance could result. To consider change, clients at the precontemplation stage must have their awareness raised. To resolve their ambivalence, clients in the contemplation stage must be helped to choose positive change over their current circumstances. Clients in the preparation stage need help in identifying potential change strategies and choosing the most appropriate ones. Clients in the action stage need help to carry out and comply with the change strategies.

The clinician can use brief interventions to motivate particular behavioral changes at each stage of this process. For example, in the contemplation stage, a brief intervention could help the client weigh the costs and benefits of change. In the preparation stage, a similar brief intervention could address the costs and benefits of various change strategies (e.g., self-change, brief treatment, intensive treatment, self-help group attendance). In the action stage, brief interventions can help maintain motivation to continue on the course of change by reinforcing personal decisions made at earlier stages.

Understanding these stages helps the clinician to be patient, to accept the client’s current position, to avoid “getting too far ahead” of the client and thereby provoking resistance, and, most important, to apply the correct counseling strategy for each stage of readiness. Effective brief interventionists quickly assess the client’s stage of readiness, plan a corresponding strategy to assist her in progressing to the next stage, and implement that strategy without succumbing to distraction. Indeed, clinician distraction can be a greater obstacle to change in brief intervention than time limitations. Regardless of the stage of readiness, brief interventions can help initiate change, continue it, accelerate it, and prevent the client from regressing to previous behaviors.

Figure 2-1
The Stages of Change

Stage	Example	Treatment Needs
<i>Precontemplation.</i> The user is not considering change, is aware of few negative consequences, and is unlikely to take action soon.	A functional yet alcohol-dependent individual who drinks himself into a stupor every night but who goes to work every day, performs his job, has no substance abuse-related legal problems, has no health problems, and is still married.	This client needs information linking his problems and potential problems with his substance abuse. A brief intervention might be to educate him about the negative consequences of substance abuse. For example, if he is depressed, he might be told how his alcohol abuse may cause or exacerbate the depression.
<i>Contemplation.</i> The user is aware of some pros and cons of substance abuse but feels ambivalent about change. This user has not yet decided to commit to change.	An individual who has received a citation for driving while intoxicated and vows that next time she will not drive when drinking. She is aware of the consequences but makes no commitment to stop drinking, just to not drive after drinking.	This client should explore feelings of ambivalence and the conflicts between her substance abuse and personal values. The brief intervention might seek to increase the client's awareness of the consequences of continued abuse and the benefits of decreasing or stopping use.
<i>Preparation.</i> This stage begins once the user has decided to change and begins to plan steps toward recovery.	An individual who decides to stop abusing substances and plans to attend counseling, AA, NA, or a formal treatment program.	This client needs work on strengthening commitment. A brief intervention might give the client a list of options for treatment (e.g., inpatient treatment, outpatient treatment, 12-Step meetings) from which to choose, then help the client plan how to go about seeking the treatment that is best for him.
<i>Action.</i> The user tries new behaviors, but these are not yet stable. This stage involves the first active steps toward change.	An individual who goes to counseling and attends meetings but often thinks of using again or may even relapse at times.	This client requires help executing an action plan and may have to work on skills to maintain sobriety. The clinician should acknowledge the client's feelings and experiences as a normal part of recovery. Brief interventions could be applied throughout this stage to prevent relapse.
<i>Maintenance.</i> The user establishes new behaviors on a long-term basis.	An individual who attends counseling regularly, is actively involved in AA or NA, has a sponsor, may be taking disulfiram (Antabuse), has made new sober friends, and has found new substance-free recreational activities.	This client needs help with relapse prevention. A brief intervention could reassure, evaluate present actions, and redefine long-term sobriety maintenance plans.

Source: Adapted from Prochaska and DiClemente, 1984.

Goals of Brief Intervention

The basic goal for a client in any substance abuse treatment setting is to reduce the risk of harm from continued use of substances. The greatest degree of harm reduction would obviously result from abstinence, however, the specific goal for each individual client is determined by his consumption pattern, the consequences of his use, and the setting in which the brief intervention is delivered. Focusing on intermediate goals allows for more immediate successes in the intervention and treatment process, whatever the long-term goals are. In specialized treatment, intermediate goals might include quitting one substance, decreasing frequency of use, attending the next meeting, or doing the next homework assignment. Immediate successes are important to keep the client motivated.

Setting goals for clients is particularly useful in centers that specialize in substance abuse treatment. Performing brief interventions in this setting requires the ability to simplify and reduce a client's treatment plan to smaller, measurable outcomes, often expressed as "objectives" in the Joint Commission on the Accreditation of Healthcare Organizations' (JCAHO) language of treatment planning. The clinician must be aware of the many everyday

circumstances in which clients with substance abuse disorders face ambivalence during the course of treatment.

The key to a successful brief intervention is to extract a single, measurable behavioral change from the broad process of recovery that will allow the client to experience a small, incremental success. Clients who succeed at making small changes generally return for more successes.

The clinician should temporarily set aside the final goal (e.g., accepting responsibility for one's own recovery) to focus on a single behavioral objective. Once this objective is established, a brief intervention can be used to reach it. Objectives vary according to the client's stage of recovery and readiness to change, but brief interventions can be useful at any stage of recovery. Figure 2-2 presents several objectives that might be addressed with a brief intervention.

The following are suggested goals for brief interventions according to the client's level of consumption.

Abstainer

Even though abstainers do not require intervention, they can be educated about substance use with the aim of preventing a substance abuse disorder. Such prevention education programs are particularly important for youth.

Figure 2-2

Sample Objectives

- Learning to schedule and prioritize time
- Expanding a sober support system
- Socializing with recovering people or learning to have fun without substance abuse
- Beginning skills exploration or training if unemployed
- Attending an AA or NA meeting
- Giving up resentments or choosing to forgive others and self
- Staying in the "here and now"

Light or Moderate User

The goal of a brief intervention with someone who is a light or moderate user is to educate her about guidelines for low-risk use and potential problems of increased use. Even light or moderate use of some substances can result in health problems or, in the case of illicit substances, legal problems. These users may also engage in binge drinking (i.e., five or more drinks in a single occasion). Clients who drink should be encouraged to stay within empirically established guidelines for low-risk drinking (no more than 14 drinks per week or 4 per occasion for men and no more than 7 drinks per week or 3 per occasion for women [American Society of Addiction Medicine (ASAM), 1994]).

Brief interventions can enhance users' insight into existing or possible consequences or draw attention to the dangers associated with the establishment of an abusive pattern of substance use. For example, a woman who drinks moderately and is pregnant or who is contemplating a pregnancy can be advised to abstain from alcohol in order to prevent fetal alcohol syndrome. Brief interventions can also educate clients about the nature and dangers of substance abuse and possible warning signs of dependency. Older adults who take certain medications and use alcohol, even at this level, may be at risk for problems due to the interaction of medications and alcohol. See TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998b), for guidelines on alcohol use in older adulthood.

At-Risk User

This group includes those whose use is above recommended guidelines for alcohol use (as described above) or whose use puts them at risk for problems related to their consumption or at risk for meeting the criteria for a substance abuse disorder (e.g., people who may be able to report the requisite number of symptoms of a substance abuse disorder may not have three or

more symptoms within a 12-month period). Brief interventions with this group address the level of use, encourage moderation or abstinence, and educate about the consequences of risky behavior and the risks associated with increased use. Brief interventions can help users understand the biological and social consequences of their substance use.

Abuser

These are clients with a substance abuse disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV) (American Psychiatric Association [APA], 1994). The goal of intervention with this population, depending on the clinician's theoretical perspective and the substances used, is to prevent any increase in the use of substances, to facilitate introspection about the consequences of risky behavior, to encourage the client to consider assessment or treatment, and to encourage moderation or abstinence.

There is mixed evidence on whether persons who meet criteria for substance abuse can successfully reduce their use to meet lower-risk guidelines or if abstinence is the only reasonable goal. (See "Research Findings" later in this chapter for a discussion of this issue.) Both research and clinical experience have produced varying results regarding this issue. From a clinical standpoint, however, some clients who meet abuse criteria may not achieve abstinence but might benefit from a positive, nonjudgmental approach to change their behavior over time. For example, after working with a clinician to monitor problems associated with the substance abuse, a client might agree not to drive after using substances or might consider quitting.

Goals of brief interventions with hazardous drinkers who are not alcohol dependent have been flexible, allowing the individual to choose drinking in moderation or abstinence. In such cases, the goal of the intervention is to motivate

the problem drinker to change his behavior, not to assign blame. Helping clients to recognize the need for change is an essential step in this process.

Substance-Dependent User

Intervention at this level of use may focus on encouraging users to consider treatment, to contemplate abstinence, or to return to treatment after a relapse. The goal of intervention for dependent users is to recommend the optimal behavior change and level of care. In reality, however, the clinician may be able to negotiate a change the client is willing to accept and work over time toward abstinence. For example, if a client resists committing to prolonged abstinence, the provider could negotiate a limited period ending with a “checkup,” at which time the client might consider extending abstinence further.

It should be noted that some substance-dependent clients may be in a life-threatening stage in their addiction or risk serious consequences such as losing their jobs, going to jail, or losing their families. For these clients, brief interventions should be linked to a referral strategy in which the goal is a therapeutic alliance between the client and the referral treatment team. Brief intervention in this context is more like “case management,” in which the primary care provider tracks the client’s progress with other service providers

and determines if the client needs any additional services.

ASAM Criteria

Under ASAM criteria (see Figure 2-3), brief interventions are aimed at the nondependent user, at level 0.5 or possibly level I. Individuals at level II may be appropriate for a brief intervention if relapse potential and recovery environment are major problems for those with relatively minor physiological and psychological substance problems and high motivation to change. ASAM criteria have been extremely useful for clinical management of persons with substance abuse disorders who require more care than is needed for at-risk drinkers. Brief interventions, whether directed at reducing at-risk use (often used in primary care settings) or assisting in specific aspects of the treatment process, can be helpful for clients at every ASAM level and in many treatment settings.

Components of Brief Interventions

There is tremendous diversity in the process of recovery from a substance abuse disorder. Clients make changes for different reasons, and an intervention that works well for one client may not work for another. Brief interventions are components of the journey toward recovery and can be integral steps in the process. For some clients, assistance with the decision to

Figure 2-3

American Society of Addiction Medicine (ASAM) Patient Placement Criteria

ASAM has developed client placement criteria for the treatment of substance-related disorders (1996). ASAM delineates the following levels of service:

- Level 0.5, early intervention
- Level I, outpatient services
- Level II, intensive outpatient/partial hospitalization services
- Level III, residential inpatient services
- Level IV, medically-managed intensive inpatient services

make the change will be enough to motivate them to start changing the behavior, whereas others may need more intensive clinical involvement throughout the change process. Brief interventions can be tailored to different populations, and many options are available to augment interventions and treatments, such as AA, NA, and medications. It should be noted, however, that brief interventions are not a substitute for specialized care for clients with a high level of dependency. They can be used to engage clients in specific aspects of treatment programs, such as attending group and AA or NA meetings. Brief interventions can also help potential clients move toward seeking treatment and can serve as a temporary measure for clients on waiting lists for treatment programs. Even clinicians who advocate abstinence as a goal can use brief interventions as tools to help clients reach that goal.

There are six elements critical to a brief intervention to change substance abuse behavior (Miller and Sanchez, 1994). The acronym FRAMES was coined to summarize these active ingredients, which are shown in Figure 2-4. The FRAMES components have been combined in different ways and tested in diverse settings and cultural contexts.

A brief intervention consists of five basic steps that incorporate FRAMES and remain consistent regardless of the number of sessions or the length of the intervention:

1. Introducing the issue in the context of the client's health
2. Screening, evaluating, and assessing
3. Providing feedback
4. Talking about change and setting goals
5. Summarizing and reaching closure

Providers may not have to use all five of these components in every session. It is more important to use the components that reflect the needs of the client and her personal style. Before eliminating steps in the brief intervention process, however, there should be a well-defined reason for doing so. Moreover, a vital part of the intervention process is monitoring to determine how the patient is progressing after the initial intervention has been completed. Monitoring allows the clinician and client to determine gains and challenges and to redirect the longer term plan when necessary.

Following are descriptions of the five basic steps. Sample scenarios are provided where brief interventions might be initiated, with practical information about that particular step. For each step, Figure 2-5 presents scripts for brief interventions that clinicians can use in substance abuse treatment units or other settings where interventions might occur. (For examples focused on at-risk drinkers, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT, 1997]. For detailed descriptions of more techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c]).

Figure 2-4
FRAMES

- Feedback is given to the individual about personal risk or impairment.
- Responsibility for change is placed on the participant.
- Advice to change is given by the provider.
- Menu of alternative self-help or treatment options is offered to the participant.
- Empathic style is used in counseling.
- Self-efficacy or optimistic empowerment is engendered in the participant.

Source: Miller and Sanchez, 1993.

Figure 2-5 Scripts for Brief Intervention		
Component	Script in the emergency department, primary care office, or other setting where consultations will be performed	Script in the substance abuse treatment unit
Introducing the Issue	<p>“I’m from the substance abuse disorder unit. Your doctor asked me to stop by to tell you about what we do on that unit. Would you be willing to talk to me briefly about it? Whatever we talk about will remain confidential.” Or, “This must be tough for you. Would it be OK with you if we take a few minutes to talk about your drinking?”</p>	<p>“Would it be OK with you if we discuss some of the difficulties you’ve had in getting homework done for the group meetings and how we can work together to help you take advantage of the treatment process?”</p>
Screening, Evaluating, and Assessing	<p>“In reviewing the information you’ve given me, using a scale of ‘not ready,’ ‘unsure,’ and ‘ready,’ how prepared do you feel you are to stop drinking?”</p> <p>Client says “unsure.”</p> <p>“One of the factors that might tie together your accident and your problems with your wife is your drinking.”</p> <p>“I think it would be worth talking more to some of the people at the substance abuse disorder unit so that your problems don’t get worse,” or, “I think a 2-week trial when you don’t drink alcohol at all would be helpful in determining whether or not drinking makes things worse and if stopping use works for you. What do you think?”</p>	<p>“Given what you see as the additional stress in your family and your desire to make the treatment work for you this time, on a scale of 1 to 10, how ready do you feel to find a way to put time into your homework?”</p> <p>Client says, “6.”</p> <p>“I am pleased that you are willing to consider trying this, even though it won’t be easy. Let’s come up with some strategies that we can write down to help you accomplish this goal.”</p>
Providing Feedback	<p>“I’d like to get some confidential information about your drinking to give me a better idea of your drinking style. Can you tell me how many days a week you drink? How many drinks a day?”</p>	<p>“I’d like to talk about what was going on when you decided not to do the homework assignment. Can you tell me a little about what you were thinking or feeling at the time? Why do you think it was difficult to get your homework done?”</p>

Figure 2-5 (continued) Scripts for Brief Intervention		
Providing Feedback (continued)	“Have you had any problems with your health, family or personal life, or work in the last 3 months? Were you drinking in the 6 hours before your accident took place?”	“Have there been other parts of treatment that have been hard to follow?”
Talking About Change and Setting Goals	“It looks as if you have been having about 30–35 drinks a week and have been doing some binge drinking on weekends. You’ve said that your accident took place after you’d had some alcohol, and you said you’ve been under a lot of stress with your family and at work. You also indicated that you don’t really think alcohol is making things worse, but you’re willing to think about that. Is that an accurate assessment of how you see it?”	“You’ve said that you completely forgot to do the homework because of arguments with your wife and daughter and that this surprised you because you had really intended to get it done. Is that about right?”
Summarizing and Reaching Closure	“Even though you’re not ready to stop drinking at this time, I’m glad you agreed to write down the pros and cons of not drinking. How about if we meet tomorrow for a followup?”	“You just did a good piece of work. I think you made some progress. I’m glad you’re trying something new. How about if we meet again in a week to see how things went for you?”

Introducing the Issue

In this step, the clinician seeks to build rapport with the client, define the purpose of the session, gain permission from the client to proceed, and help the client understand the reason for the intervention.

Counseling tips: Help the client understand the focus of the interview. State the target topic clearly and stress confidentiality; be nonjudgmental and avoid labels. Do not skip this opening; without it, the success of the next steps could be jeopardized.

Screening, Evaluating, And Assessing

In general, this is a process of gaining information on the targeted problem; it varies in

length from a single question to several hours of assessment on the targeted topic of change. It could involve a structured or nonstructured interview or a combination of both, coupled with questionnaires or standardized instruments, with the extent of the process determined largely by the setting, time, and available resources. A sample screening guideline for alcoholism is provided in Figure 2-6. Additional information about and examples of screening and assessment instruments can be found in the following TIPS: TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*; TIP 10, *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients*; TIP 11, *Simple Screening Instruments for Outreach for Alcohol and*

Figure 2-6 Screening for Brief Interventions for Alcoholism

Screen

At each visit, ask about alcohol use

- How many drinks per week?
- Maximum drinks per occasion in past month?

Use CAGE questions to probe for alcohol problems

- Have you ever tried to **C**ut down on your drinking?
- Do you get **A**nnoyed when people talk about your drinking?
- Do you feel **G**uilty about your drinking?
- Have you ever had an **E**ye-opener? (i.e. a drink first thing in the morning)

Screen is positive if

- Consumption is greater than 14 drinks per week or greater than 4 drinks per occasion (men)
- Consumption is greater than 7 drinks per week or greater than 3 drinks per occasion (women)
- CAGE score is greater than 1

Then assess for

- *Medical problems:* blackouts, depression, hypertension, trauma, abdominal pain, liver dysfunction, sexual problems, sleep disorders
- *Laboratory:* elevated gamma-glutamyl transpeptidase or other liver function tests; elevated mean corpuscular volume; positive blood alcohol concentrations
- *Behavioral problems:* work, family, school, accidents
- *Alcohol dependence:* a score of 3 or higher on CAGE or one or more of the following: compulsion to drink, impaired control, withdrawal symptoms, increased tolerance, relief drinking

Source: ASAM, 1994; reprinted with permission.

Other Drug Abuse and Infectious Diseases; TIP 24, A Guide to Substance Abuse Services for Primary Care Clinicians; and TIP 31, Screening and Assessing Adolescents for Substance Use Disorders (CSAT, 1994b, 1994c, 1994d, 1997, 1999a).

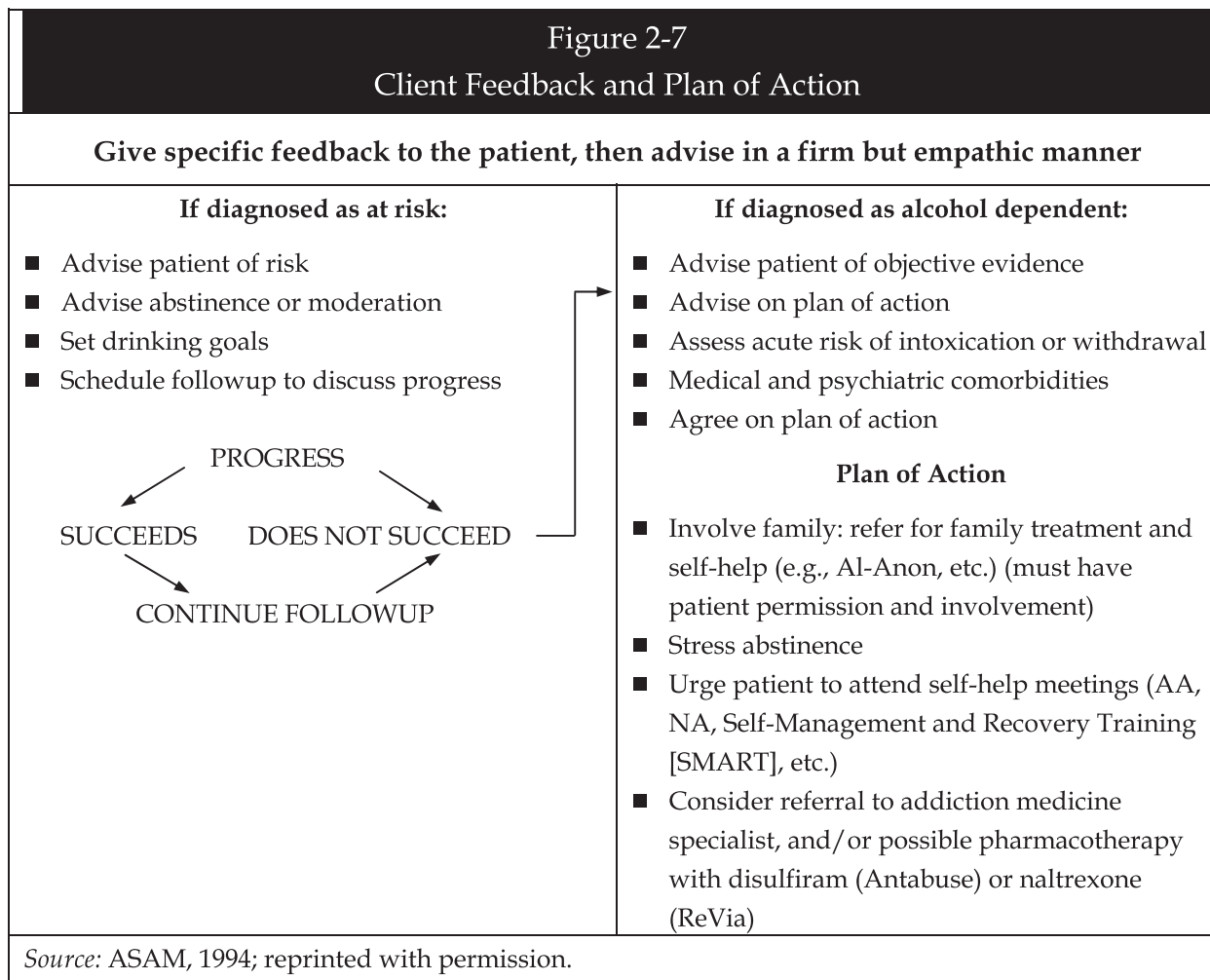
Counseling tips: Before you begin the brief intervention, decide how much information you have time to obtain and whether you want to have the client answer any questionnaires. Watch for defensiveness or other resistance, and avoid pushing too hard.

Providing Feedback

This component highlights certain aspects of the client's behavior using information gathered

during screening. It involves an interactive dialog for discussing the assessment findings; it is not just clinician driven. Feedback should be given in small amounts. First, the clinician gives a specific piece of feedback, then asks for a response from the client. Sometimes the feedback is a brief, single sentence; at other times it could last an hour or more. Figure 2-7 provides an example of giving feedback.

Counseling tips: Use active listening (see "Active listening" later in this chapter). Be aware of cultural, language, and literacy issues. Be nonjudgmental.



Talking About Change And Setting Goals

Talking about change involves talking about the possibility of changing behavior. It is used with clients in all stages of change, but it differs profoundly depending on the stage the client has reached. For example, in precontemplation, clients are helped to recognize and change their view of consequences; in contemplation, they are helped to resolve ambivalence about change. In action, the focus is on planning, removing barriers, and avoiding risky situations; in maintenance, the emphasis is on establishing new long-term behaviors. It is important that the clinician assess the client's readiness to change if it is not already known. (See Figure 2-8 for examples of discussing change with a

client who is trying to stop using cocaine but wants to continue to drink alcohol.)

In talking about change, the clinician often suggests a course of action, then negotiates with the client to determine exactly what he is willing to do. Sometimes, talking about change is premature (i.e., before the assessment and feedback have happened). In that case, it should be postponed until later in the intervention.

Counseling tips: Offer change options that match client's readiness for change. Be realistic: Recommend the ideal change, but accept less if the client is resistant.

Summarizing and Reaching Closure

This step involves a summary of the discussion and a review of the agreed-upon changes.

Figure 2-8

Talking About Change at Different Stages

In this example, a client who has come to treatment to stop using cocaine has her alcohol use brought to her attention. At each stage of readiness, the counselor might use a different strategy. Following are some of the possible scripts that might be used:

- *Precontemplation*: “Some people find it helpful to ask others in a group if any of them tried to quit cocaine but continued drinking. If you were to try that with your group, you might be surprised at what you hear. What do you think?”
- *Contemplation*: “One thing you might try is writing a list of the pros and cons of stopping drinking, as you see them. Just write down all the ideas that come to you, no matter how silly or offbeat they seem. This may help you get a clearer picture of your situation. Is that something you’d be willing to try?”
- *Action*: “You’ve said you want to try quitting alcohol, as well as cocaine. Can we talk about how you might go about making that happen?”
- *Maintenance*: “Things have improved in a lot of ways for you. I’d like to meet with you each month for a while to talk about what things work for you and what things don’t work as well.” (Because relapse can occur at any point in the change process, addressing this issue in a proactive, positive manner is useful.)

If no agreement was reached, review the positive action the client took during the session. At this point, it is important to schedule a followup visit to talk about how the client is progressing. The followup could be another face-to-face meeting, a telephone call, or even a voice mail message. The goals of closing on good terms are to arrange another session, to leave the client feeling successful, and to instill confidence that will enable the client to follow through on what was agreed upon

Counseling tips: Tailor your closure to the client and the particular circumstance of this brief intervention; interpret any client resistance in a positive light leading to progress. Thus, if a client has been unwilling to commit to changes, thank her for her willingness to consider the issues and express the hope that she will continue to consider committing to changes.

Brief Intervention Workbooks

Brief intervention protocols often involve using a workbook that is based on the steps listed below. A workbook provides the client and clinician with opportunities to discuss the client’s cues for using substances, reasons for using substances, and reasons for cutting down or quitting. It also usually provides a substance abuse agreement in the form of a prescription and substance abuse diary cards for self-reporting. These techniques, which often target reduction in substance abuse rather than abstinence, are similar to homework techniques used in substance abuse treatment programs. A sample of a workbook used to address drinking problems is provided in Appendix D. The steps

in the workbook follow a script and may focus on the following:

- Identification of future goals for health, activities, hobbies, relationships, and financial stability
- Customized feedback on screening questions relating to substance abuse patterns and other health habits (also may include smoking, nutrition, etc.)
- Discussion of where the client's substance abuse patterns fit into the population norms for his age group
- Identification of the pros and cons of substance abuse—this is particularly important because the clinician must understand the role of substance abuse in the context of the client's life (given the opportunity to discuss the positive aspects of her substance abuse, the client may talk about her concerns honestly instead of feeling she should say what she thinks the clinician wants to hear; this builds a better working relationship)
- Consequences of continued substance use to encourage the client to decrease or stop abusing substances and avoid longer term effects of continued substance abuse
- Reasons to cut down or quit using (maintaining family, work, independence, and physical health all may be important motivators)
- Sensible use limits and strategies for cutting down or quitting—useful strategies include developing social opportunities that do not involve abusing substances and becoming reacquainted with hobbies and interests
- A substance abuse agreement—agreed-upon use limits (or abstinence) signed by the client and the clinician—can often be an effective way to alter use patterns
- Coping with risky situations (e.g., socializing with substance users, isolation, boredom, and negative family interactions)
- Summary of the session

Essential Knowledge and Skills for Brief Interventions

Providing effective brief interventions requires knowledge, skills, and abilities. Studies have shown that applying the clinician's skills listed below produces good outcomes, including getting clients to enter treatment, work harder in treatment, stay longer in treatment, and have better outcomes after treatment such as higher participation in aftercare and better sobriety rates (Brown and Miller, 1993; Miller et al., 1993).

- Overall attitude of understanding and acceptance
- Counseling skills such as active listening and helping clients explore and resolve ambivalence
- A focus on intermediate goals (see discussion earlier in this chapter)
- Working knowledge of the stages-of-change model (see discussion earlier in this chapter)

Attitude of Understanding And Acceptance

Clinicians must assure their clients that they will listen carefully and make every effort to understand the client's point of view during a brief intervention. Brief interventions are by definition time limited, which increases the difficulty of adopting such an attitude. However, when clients experience this nonjudgmental, respectful interest and understanding from the clinician, they feel safe to openly discuss their ambivalence about change—rather than resist pressure from the clinician to change before they are ready to do so. The sooner they address their ambivalence, the sooner they progress toward lasting change (see also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c]).

When clients feel they are being pushed toward change—even if the clinician is not pushing—they are likely to resist. Clients must summon all of their attention and strength to resolve their ambivalence, and resisting the clinician may cause them to lose track and argue against change. If the client and clinician begin arguing or debating, the clinician should immediately shift to a new strategy, otherwise the brief intervention will fail. In other words, resistance is a signal for the clinician to change strategies and defuse the resistance.

Counseling Skills

Active listening

One of the most important skills for brief interventionists is “active listening” (see Figure 2-9). Active listening is the ability to accurately restate the content, feeling, and meaning of the client’s statements. This is also called “reflective listening,” “reflecting,” or sometimes “paraphrasing.” Active listening is one of the most direct ways to rapidly form a therapeutic alliance. When done well, it is a powerful technique for understanding and facilitating change in clients. Active listening goes beyond nonverbal listening skills or responses such as, “Hmmm,” “Uh-huh,” “I see,” “I hear you,” or “I understand where you’re coming from.” None of these short statements demonstrates that the clinician understands. Counselors should also

ask open-ended questions to which the client must respond with a statement, rather than a simple yes or no. Instead of summarizing a situation and then asking, “Is this correct?” ask the client, “What do you think? How do you feel about the situation?” Open-ended questions are invitations to share and provide a means to probe for important information that emerges in the interview.

Exploring and resolving ambivalence

Another important skill is the ability to help clients explore and resolve ambivalence.

Ambivalence is the hallmark of a person in the contemplation stage of readiness. It is one of the most prevalent clinical challenges encountered in brief interventions. Whether it takes 1 minute or 40 minutes, the goal is to help clients become more aware of their position and the discomfort that accompanies their ambivalence. Increasing awareness of this discomfort within an understanding and supporting relationship can inspire the client to progress to a stage of preparation or action. For example, a client might be willing to go to counseling but not an AA meeting; in that case, the clinician should work with the client’s motivation and focus on the positive step the client is willing to make.

One way to help a client recognize his ambivalence is to ask him to identify the benefits and costs of the targeted behavior (e.g., using alcohol) and the benefits and costs of changing

Figure 2-9
Steps in Active Listening

1. *Listen* to what the client says.
2. *Form a reflective statement.* To reflect your understanding, repeat in your own words what the client said.
3. *Test the accuracy of your reflective statement.* Watch, listen, and/or ask the client to verify the accuracy of the content, feeling, and/or meaning of the statement.

Skilled active listeners perform these three steps automatically, naturally, smoothly, and quickly. Active listening saves time by reducing or preventing resistance, focusing the client, focusing the clinician, encouraging self-disclosure, and helping the client remember what was said during the intervention.

the behavior. The clinician listens and summarizes these benefits and costs, then asks the client if any of them is more important than the others. This helps identify values that are important to the client and can therefore increase or decrease the chance of changing. Clinicians might also ask if any of the pros and cons is more or less accurate than others. This provides an opportunity for irrational thoughts to be refuted, which can help remove barriers to change (see example in the text box below).

Another approach to raising awareness of ambivalence is to explore the client's experience of feeling caught between opposing desires. For more specific techniques for resolving ambivalence, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999c).

Brief Interventions in Substance Abuse Treatment Programs

Substance abuse treatment programs frequently use brief interventions, although they might not be called by that name. Brief interventions can be effectively integrated into more comprehensive treatment plans for clients with substance abuse disorders. These approaches can be particularly useful in treatment settings when they are used to address specific targeted client behaviors and issues in the treatment process that can be difficult to change using standard treatment approaches. Brief

interventions can be used with clients before, during, and after substance abuse treatment.

To integrate the use of brief interventions into specialized treatment, counselors and providers should be trained to provide this service. The Consensus Panel recommends that agencies consider allocating counselor training time and resources to these modalities. The Panel anticipates that brief interventions will help agencies meet the increasing demands of the managed care industry and fill the gaps that have been left in client care. It is also extremely important for substance abuse treatment personnel to collaborate with primary care providers, employee assistance program (EAP) personnel, wellness clinic staff, and other community-based service providers in developing plans that include both brief interventions and more intensive care to help keep the client focused on treatment and recovery. The following is a list of the potential benefits of using brief interventions in substance abuse treatment settings:

- Reduce no-show rates for the start of treatment
- Reduce dropout rates after the first session of treatment
- Increase treatment engagement after intake assessment
- Increase compliance for doing homework
- Increase group participation
- Address noncompliance with treatment rules (e.g., smoking in undesignated places, unauthorized visits, or phone calls)

Removing a Barrier to Change

Your client, Mary, is hospitalized because of an alcohol-related injury. You conduct a brief intervention in the hospital. During the session, she says that one of the good things about her drinking is that she “always had fun when she was drinking.” In that case, you can ask her what her perspective is on the situation and whether she sees a connection between her drinking and her current behavior. This could lead to her challenging one of her reasons for drinking. By systematically exploring the reasons for and against drinking, you can help her tip the scale in favor of change.

- Reduce aggression and violence (e.g., verbal hostility toward staff and other clients)
- Reduce isolation from other clients
- Reduce no-show rates for continuing care
- Increase mutual-help group attendance
- Obtain a sponsor, if involved with a 12-Step program
- Increase compliance with psychotropic medication therapies
- Increase compliance with outpatient mental health referrals
- Serve as interim intervention for clients on treatment program waiting lists

Brief Interventions Outside Substance Abuse Treatment Settings

Brief interventions are commonly administered in nonsubstance abuse treatment settings, often referred to as opportunistic settings, where clients are not seeking help for a substance abuse disorder but have come to receive medical treatment, to meet with an EAP counselor, or to respond to a court summons (see Figure 2-10 for a list of health care and other professionals who often conduct brief substance use interventions). These settings and many others provide a multitude of opportunities to help people change their substance abuse patterns. It is unrealistic and unnecessary for providers in opportunistic settings to avoid working with people with a range of substance abuse

problems including substance abuse disorders and merely to refer them for specialty care (Miller et al., 1994). Many clients do not use alcohol, for example, at a level that requires specialized treatment. Others who use at moderate or severe levels may be unwilling or unable to participate in specialized, mainstream substance abuse treatment programs. Moreover, some individuals may attach a stigma to attending treatment versus general health care services. Older adults and women often do not seek or engage in treatment because of stigma.

An individual's level of substance use is detected through screening instruments, medical tests (e.g., urine testing), observation, or simply asking about consumption patterns. Those considered to have risky or excessive patterns of substance abuse or related problems can receive a brief intervention that rarely requires more than several sessions, each lasting only 5 minutes to 1 hour (average = 15 minutes).

The goal of a brief intervention is to raise the recipient's awareness of the association between the expressed problem and substance abuse and to recommend change, either by natural, client-directed means or by seeking additional substance abuse treatment. Because the recipient usually does not expect to have a substance abuse problem identified, he may or may not be motivated to apply any recommendations. The brief intervention is highly structured and focuses on delivering a message about the individual's substance abuse

Figure 2-10
Professionals Outside of Substance Abuse Treatment Who Can Administer Brief Interventions

- | | |
|--|--|
| <ul style="list-style-type: none"> ■ Primary care physicians ■ Substance abuse treatment providers ■ Emergency department staff members ■ Nurses ■ Social workers ■ Health educators | <ul style="list-style-type: none"> ■ Lawyers ■ Mental health workers ■ Teachers ■ EAP counselors ■ Crisis hotline workers, student counselors ■ Clergy |
|--|--|

and advice to reduce or stop it. If the initial intervention does not result in substantial improvement, the professional may refer the individual for additional specialized substance abuse treatment.

Treatment providers who work in settings other than substance abuse treatment must be flexible when assessing, planning, and carrying out brief interventions. For example, they will likely encounter more risky drinkers than alcohol-dependent individuals (in the United States there are four times as many risky drinkers as dependent drinkers [Mangione et al., 1999]). Some research indicates that the potential for brief interventions to reduce the harm, problems, and costs associated with moderate to heavy alcohol use by risky drinkers significantly surpasses the effectiveness from applications of brief interventions on substance-dependent individuals (Higgins-Biddle et al., 1997). Other research on brief interventions, as presented below, highlights some of the more rigorous studies with positive outcomes. The costs of alcohol abuse to society, as interpreted by health care costs, lost productivity, and criminal activity, are enormous, and brief interventions are a cost-effective technique to address such abuse. Typically these brief interventions act as an early intervention before or close to the development of alcohol-related problems and primarily entail instructional and motivational components addressing drinking behavior. In substance abuse treatment, brief interventions are used to assist in the treatment engagement process and to deal with specific individual, family, or treatment-related issues.

When delivering a brief intervention in any treatment setting, the provider should be mindful of room conditions and interruptions because client confidentiality is of utmost importance. Federal law requires that chart notes or other records on substance abuse be kept apart from the rest of the client's main

chart. For example, if a medical client in a primary care clinic is also seen by an alcohol and drug counselor for treatment of a substance abuse disorder, those medical records are strictly protected by Federal law and may not be put in the client's chart. (For more information on these Federal laws, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT, 1997].)

Heather makes an important distinction between brief interventions that are delivered in opportunistic settings where patients are not directly seeking help for a substance abuse disorder and those conducted in treatment environments where patients are seeking the help of specialists (Heather, 1995). Brief interventions conducted in opportunistic settings tend to be shorter, rely less on theory and more on an existing clinician-client relationship, and are less expensive because they are offered as part of an existing service.

Conducting Brief Interventions With Older Adults

Older adults present unique challenges in applying brief intervention strategies for reducing alcohol consumption. The level of drinking necessary to be considered risky behavior is lower than for younger individuals (Chermack et al., 1996). Intervention strategies should be nonconfrontational and supportive due to increased shame and guilt experienced by many older problem drinkers. As a result, older adult problem drinkers find it particularly difficult to identify their own risky drinking. In addition, chronic medical conditions may make it more difficult for clinicians to recognize the role of alcohol in decreased functioning and quality of life. These issues present barriers to conducting effective brief interventions for this vulnerable population. For more on this topic, refer to TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998b).

Research Findings

Brief interventions for substance abuse have been implemented since the 1960s. The literature in this area includes theoretical articles, clinical case studies and recommendations, quasi-experimental studies, and randomized controlled experimental research trials. Many of the brief intervention clinical trials have been conducted in the United States and Europe since the early 1980s, and most have focused on alcohol use. There is some experimental research on brief interventions for drug use but very little has been published to date. This is an area of ongoing and future work.

Reviews of Brief Intervention Studies

A 1995 review article (Kahan et al., 1995) sorted through 43 relevant articles found in MEDLINE published from 1966 to 1985 and 112 in EMBASE published from 1972 to 1994. Another, more recent review (Wilk et al., 1997) culled nearly 6,000 articles from MEDLINE and PsychLIT searches from 1966 to 1995 to find 99 that met criteria for closer inspection. A total of 11 of the articles found by Kahan and colleagues and 12 of those reviewed by Wilk and associates had control groups, adequate sample sizes, and specified criteria for brief interventions.

The most recent reviews of brief intervention studies concluded that brief interventions have merit, especially for carefully selected clients and can be applied successfully in several settings for different purposes (Bien et al., 1993; Kahan et al., 1995; Mattick and Jarvis, 1994; Wilk et al., 1997). The review by Bien and colleagues was one of the first to categorize brief interventions and evaluate their effectiveness according to the stated goals and settings in which they were conducted. After examining 12 controlled studies of strategies to improve clients' acceptance of referrals for additional

specialist treatment or return to the clinic for additional treatment following an initial visit, Bien and colleagues concluded that relatively simple strategies and specific aspects of counselors' styles can increase rates of followthrough on referrals as well as improve initial engagement and participation in treatment (Bien et al., 1993). Only one unsuccessful trial of referral procedures is described, and the failure is attributed to the fact that all subjects had previously failed to respond to brief advice about getting into treatment for alcoholism.

Bien and colleagues also examined 11 well-conducted trials of brief interventions for excessive drinkers identified in health care settings (including the large-scale, 10-nation World Health Organization [WHO] study) (Bien et al., 1993). They found that eight of the studies showed significant reductions in alcohol consumption levels and/or associated problems for the subjects receiving brief, drinking-focused interventions in comparison with those receiving no counseling. Three other studies found no significant differences between experimental and control groups at followup, although drinking levels and other problem measures were reduced in both groups. Bien and colleagues concluded that it is better for health care providers in opportunistic settings such as primary care to intervene in a nonjudgmental motivational format than it is to provide no intervention to patients who did not expect to have their drinking patterns evaluated.

In addition, these authors also reviewed 13 randomized clinical trials comparing brief interventions to a range of more extensive therapies in specialized alcohol treatment settings and found that shorter counseling was, with remarkable consistency, comparable in impact to more traditional approaches in yielding specified outcomes (Bien et al., 1993). Only two studies reported an advantage of more extensive treatment over brief interventions on

some outcome measures. They concluded that no evidence supports the inferiority of brief interventions in comparison with more extensive treatment offered by treatment specialists to patients who are seeking help for their alcohol-related problems. Heather argues, however, that the findings do not support the statement that the effectiveness of brief interventions is equal to that of other studied treatments for alcohol abuse (Heather, 1995).

Finally, Bien and colleagues concluded from an analysis of three other studies that brief interventions enhanced the motivation of treatment-seeking problem drinkers to enter and remain in outpatient or residential alcohol treatment compared with clients not receiving such attention (Bien et al., 1993).

Although other reviewers of brief interventions have reported more qualified reactions, all seem to agree that strong research evidence supports the use of brief interventions for heavy or excessive, nondependent drinkers, particularly those identified in general medical practice settings (Heather, 1995; Kahan et al., 1995; Mattick and Jarvis, 1994; Wilk et al., 1997). Wilk and colleagues examined evidence from 12 controlled clinical trials that randomized nearly 4,000 heavy drinkers to brief intervention or no intervention (Wilk et al., 1997). They concluded that heavy drinkers who received interventions in a primary care setting were almost twice as likely to moderate drinking than those who did not receive an intervention. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has also presented data on the efficacy and uses of brief interventions for dependent drinkers (NIAAA, 1999).

This TIP reviews the most methodologically sound brief intervention studies and discusses methodological limitations of previous and current research in this area. The research is presented in two sections: (1) brief interventions for at-risk and problem use and (2) brief interventions for substance abuse.

Brief Interventions for At-Risk And Problem Use

A study conducted in 1983 focused on males in Malmo, Sweden, in the late 1970s (Kristenson et al., 1983). The subjects, advised to reduce their alcohol use in a series of health education visits, subsequently demonstrated significant reductions in gamma-glutamyl transferase levels and health care utilization up to 5 years after the brief interventions. The Medical Research Council (MRC) trial, conducted in 47 general practitioners' offices in Great Britain (Wallace et al., 1988), found significant reductions in alcohol use by the intervention group compared to the control group 12 months following the intervention.

Anderson and Scott identified men and women from eight general practices in England who consumed more than 15 standard drinks (for men) or 9 standard drinks (for women) of alcohol per week (Anderson and Scott, 1992). These individuals were randomly assigned to receive either no intervention or feedback about the findings from the screening and 10 minutes of advice from the physician to reduce their consumption levels, accompanied by a pamphlet of self-help information. After 1 year, the males in the advice group had significantly reduced their mean weekly alcohol consumption by 2.8 ounces more than those who received no intervention. The females in both groups, however, showed significant reductions in alcohol consumption at the same followup point, with no between-group differences.

In a widely publicized evaluation of brief interventions conducted in health care settings in 10 nations sponsored by WHO, the investigators identified 1,490 nonalcoholic heavy drinkers from eight core sites through a 20-minute health interview (Babor and Grant, 1991; Babor et al., 1994). These participants were randomly assigned to one of four groups: (1) no further intervention, (2) 5 minutes of simple

advice about the importance of sensible drinking or abstinence, (3) simple advice plus 15 minutes of brief counseling and a self-help manual that encouraged the development of a habit-breaking-plan, or (4) at five of the sites, extended supportive counseling delivered in three extra sessions following the initial advice and 15-minute session. After 9 months, males who received any intervention, including the 5 minutes of advice, reported approximately 25 percent less daily alcohol consumption—a greater change than was observed in the no-intervention control group. Significantly, the men who showed the greatest response to simple advice had more severe alcohol problems and higher consumption patterns.

Another interesting finding from the WHO study was that female participants in all groups had reduced their drinking at 9 months, regardless of whether they received any intervention. One explanation may be that the female participants were only recruited from two relatively affluent countries—Australia and the United States—thus, the results cannot be generalized to all women (Sanchez-Craig, 1994). Furthermore, the 20-minute comprehensive assessment was sufficiently intensive that some women may have responded to implicit messages of cutting down on consumption without further overt advice, especially considering that only 10 minutes of simple advice or 15 minutes of counseling were additionally provided (Kristenson and Osterling, 1994).

One successful study demonstrated the efficacy of a brief alcohol intervention in a community-based primary care setting (Fleming et al., 1997). Project TrEAT (Trial for Early Alcohol Treatment) identified 723 men and women as problem drinkers from 17,695 patients who were screened in 17 community-based primary care practices. The outcomes studied were reductions in alcohol consumption and health resource utilization. In comparison

with a no-intervention control group, the patients who received two 10- to 15-minute sessions of scripted advice (using a workbook that focused on advice, education, and contracting information) showed significantly greater reductions in alcohol consumption at a 12-month followup based on drinking levels during the previous week, episodes of binge drinking over the past month, and frequency of excessive drinking in the previous 7 days. Males in the study also had significantly fewer days of hospitalization than counterparts in the control group. Females in the experimental groups reduced their consumption significantly more than males in the experimental group. This research group (Fleming et al., 1999) also conducted a similar trial with primary care patients over 65 and found significant differences in drinking after 12 months for the experimental group compared to the control group.

Miller and colleagues have developed a special form of a brief intervention known as the Drinker's Check-Up (Miller and Sovereign, 1989), designed to evaluate whether alcohol is harming an individual in any way. In the 1989 study, participants were recruited through media advertisements and were asked to come into a neutral setting for the assessment. As reported by Bien and colleagues, several trials of this approach have demonstrated encouraging results from providing systematic feedback about assessment results and some self-help options (Bien et al., 1993). Compared with a no-intervention group of respondents who had to wait 6 weeks for assessment, the recipients of immediate feedback and brief, empathic assistance showed prompt and persistent reductions (of 29 to 57 percent) in consumption patterns. More empathic counseling, an important component of brief interventions (see discussion on FRAMES earlier in this chapter), is also associated with larger reductions than the

use of the more traditional confrontational styles (Miller et al., 1993).

While the types of brief interventions vary, the basic design of most studies is a randomized controlled trial that assigns clients with hazardous drinking patterns either to a brief intervention (ranging from one to ten sessions) or to one or more control conditions (Anderson and Scott, 1992; Babor, 1992; Babor and Grant, 1991; Chick et al., 1985; Fleming et al., 1997; Harris and Miller, 1990; Heather et al., 1987; Kristenson et al., 1983; Persson and Magnusson, 1989; Wallace et al., 1988). Overall, the majority of brief alcohol intervention studies have found significantly greater improvements in drinking outcomes for the experimental group compared to the control group; however, most also found significant changes in drinking over time for both the control and brief intervention conditions. Meta-analyses found an effect size of 20 to 30 percent in studies conducted in health care settings (Bien et al., 1993; Kahan, 1985). Trials conducted since 1995 have garnered similar effect sizes with one trial finding a greater effect size for women (35 percent) (Fleming et al., 1997). Women were not always included in earlier trials, but later trials that did include women found that they were more likely than men to decrease their drinking based on brief targeted advice.

Because of the success of brief alcohol interventions with adults in opportunistic settings, new trials with special populations (e.g., older adults, injured patients in emergency departments, pregnant women) are now being proposed and conducted. In addition, new technologies are being studied, including computerized real-time tailored booklets for at-risk drinkers, and the use of Interactive Voice Recognition (IVR) for interventions and followup. These and other technologies, if efficacious and effective, will provide clinicians with new tools to assist them in working with a

difficult and important clinical and public health issue.

Brief Interventions for Dependent Use

Most studies of brief interventions for alcohol use that had the goal of changing drinking behavior have included only subjects who did not meet criteria for alcohol dependence and explicitly excluded dependent drinkers with significant withdrawal symptoms. The rationale for this practice was that alcohol-dependent individuals or those affected most severely by alcohol should be referred to formal specialized alcoholism treatment programs because their conditions are not likely to be affected by low intensity interventions (Babor et al, 1986; Institute of Medicine [IOM], 1990). However, there have been positive trials that address this issue specifically.

NIAAA reviewed the studies focused on alcohol-dependent drinkers (NIAAA, 1999). Some of these studies focused on the effectiveness of motivating alcohol-dependent patients to enter specialized alcohol treatment. As long ago as 1962, a nonrandomized study was conducted of alcohol-dependent patients, identified in the emergency department (Chafetz et al., 1962). Of those receiving brief counseling, 65 percent followed through in keeping a subsequent appointment in a specialized alcohol treatment setting. Only 5 percent in the control group followed through with an appointment.

Brief interventions have also been compared to more intensive and extensive treatment approaches used in traditional treatment settings with positive results (Edwards et al., 1977; Project MATCH Research Group, 1997, 1998). In a small study, the effectiveness of a one-session brief advice protocol plus monthly followup telephone calls, focused on the patient's personal responsibility to stop

drinking, was compared to standard alcohol treatment for 100 men who were alcohol dependent (Edwards and Orford, 1977). At 1-year followup both groups reported a 40 percent decrease in alcohol-related problems. The study found, at 2-year followup, that the patients with the less severe alcohol problems did best in the brief intervention group. The patients with more serious alcohol-related problems did best in intensive alcohol treatment (Orford et al., 1976).

Several similar studies conducted in New Zealand (Chapman and Huygens, 1988), London (Drummond et al., 1990), the United States (Miller et al., 1980, 1981; Miller and Munoz, 1982), and Norway (Skutle and Berg, 1987) essentially replicated the results of previous positive trials, comparing brief interventions favorably with a variety of extended treatments for problem drinking (including cognitive-behavior therapies, marital therapy, confrontational counseling, and standard inpatient and outpatient treatment).

Sanchez-Craig and colleagues found that when comparing the 12-month treatment outcomes of severely dependent and nonseverely dependent men receiving brief treatment in Toronto and Brazil, there were no significant differences in "successful" outcomes as measured by rates of abstinence or moderate drinking (Sanchez-Craig et al., 1991). The IOM also noted that rates of spontaneous remission of alcoholism suggest that some portion of the most severe alcoholic population will reduce or discontinue their drinking without formal intervention (IOM, 1990).

The largest multisite NIAAA-sponsored study of treatment matching and outcomes, Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity), compared the effects of treatment type on outcomes for more than 1,500 alcohol-dependent patients (Project MATCH Research Group, 1997, 1998). Treatment types included (1) four 1-hour

sessions of motivational enhancement therapy, which is often considered a brief intervention even though it is more intensive than most brief interventions (NIAAA, 1995), (2) 12 sessions of 12-Step facilitation, and (3) 12 sessions of cognitive-behavioral coping skills therapy. At 1- and 3-years postintervention, all three groups reported improvements including drinking less often and drinking fewer drinks per day.

A small successful application of a brief motivational intervention within a substance abuse treatment setting administered approximately 1 hour of motivational interviewing for problem drinkers (adapted from Miller and Sovereign, 1989) to seriously opiate-dependent clients recently admitted to a methadone maintenance clinic (Saunders et al., 1995). Fifty-seven clients were randomized to the experimental group and were asked to identify positive and negative aspects of their opiate use and to project the consequences into the future. These clients were then asked to think about their use and discuss it at the 1-week followup session. The 65 subjects in the control group received a 1-hour educational intervention covering six substance-related issues such as overdose responses, legal aspects, and referral sources. Followup sessions were held with both groups at 1 week, 3 months, and 6 months. Significantly fewer clients receiving the motivational intervention dropped out of the study at each of the followup points compared with those receiving the educational component. By the 6-month point, the motivational subjects had significantly fewer opiate-related problems than the others. In comparison with the educational group, the clients receiving the motivational intervention were also more likely to make a positive initial shift on a stage-of-change measure (see the discussion of stages-of-change earlier in this chapter), express a stronger commitment to abstinence, remain in treatment longer, and relapse less quickly if they did drop out. The study concluded that brief

motivational interventions strengthened recipients' resolution to abstain from opiate use and participate fully in treatment, and were therefore useful in improving performance and program compliance among clients attending a methadone clinic (Saunders, 1995). This and other studies have found that compliance with a treatment plan, rather than simply length of treatment, is one of the important factors influencing positive outcomes for clients receiving treatment.

In a study looking at the costs of brief interventions, Holder and colleagues evaluated the evidence of clinical effectiveness and the typical costs of various alcoholism treatment modalities and found brief motivational counseling among the most effective in terms of a combination of clinical and cost effectiveness (Holder et al., 1991). It ranked third among the six highest ranking approaches in terms of weighted effectiveness (based on a total of nine studies conducted between 1983 and 1990). Brief motivational counseling was also rated the least costly of the six most effective modalities – or most cost-effective of 33 evaluated modalities. The authors of this study specifically stated that treatment planning and funding decisions should not be based on this initial effort to make “first level approximations” of cost-effectiveness.

Critics have raised concerns that brief interventions could be construed as a treatment panacea for all patients with varying levels of alcohol-related problems and different consumption patterns (Drummond, 1997; Heather, 1995; Mattick and Jarvis, 1994). Although most researchers acknowledge that many clients do not need a protracted and expensive course of individual or group treatment, the literature advocating brief interventions as a treatment for all substance abuse is overstated (Heather, 1995; Mattick and Jarvis, 1994). Caution always needs to be employed in evaluating study

recommendations. The clinical trials in this TIP on the use of brief interventions have been specific regarding the targeted population tested and the level of generalizability possible.

Methodological Issues

Issues are frequently raised regarding specific methodological concerns of studies on brief interventions. First, many of the brief intervention studies, particularly those focused on alcohol, rely on self-report data to determine outcomes. The validity of measuring alcohol and other use by self-report is routinely questioned; however, reviewers of relevant literature have concluded that these data are generally valid and reliable (Midanik, 1982; Sobell and Sobell, 1990). Reports from collaterals, such as family members, are not as reliable except for highly visible events, such as drinking-related arrests (Midanik, 1982). Persons with hazardous drinking patterns will provide accurate information about their use, particularly under the following conditions: (1) the setting is a research or clinical one, (2) confidentiality is assured, and (3) the interview is administered when the respondent is sober (Sobell and Sobell, 1990). Techniques to increase the accuracy of self-reports have been employed in recent studies (Fleming et al., 1997, 1999). These studies use interviewers who fully understand drinking-related questions and can explain confusion about common terms (e.g., “blackouts,” “high”).

Concerns about the methodological limitations of some trials have included sample sizes that were too small and a statistical power insufficient to reliably detect differences between effects in the groups compared (Bien et al., 1993; Mattick and Jarvis, 1994). There may be differential attrition in groups at followup, and these dropouts can be ignored or excluded from analyses (Bien et al., 1993; Drummond, 1997; Kahan et al., 1995), or there could be contamination because the comparison group

could be seeking additional treatment during the course of the research (Bien et al., 1993; Kahan et al., 1995; Mattick and Jarvis, 1994). Also, randomization of samples has not always been conducted (Wilk et al., 1997), and some early studies did not have control groups or did not have an adequate comparison group (Bien et al., 1993). Some of the newer brief intervention studies have addressed many of these concerns (Fleming et al., 1997, 1999). These, however, remain issues that must be addressed by new studies of brief intervention techniques with special populations and with new technology.

Future Issues in Research and Practice

The background research in this TIP is based on the most rigorous trials from the 1960s through the 1990s. As study designs have become more sophisticated, many of the earlier methodological issues are being addressed. Questions remain regarding specific levels of abuse and dependence after which brief intervention approaches are less effective and more intensive treatment is required. It is possible that factors such as social stability and support (as indicated in Edwards and Orford, 1977) play a role in improved responses to briefer treatments and that these factors may be more important than the level of substance abuse or dependence.

As secondary analyses are conducted from more recent clinical trials, some of the strongest covariates will emerge. Further research focused specifically on the myriad of issues that could affect outcomes is needed to determine whether brief interventions can be useful for clients with dual diagnoses or whether they always require more intensive treatments because of the complexity of their illnesses. Although there is ongoing research testing the effectiveness of brief interventions with patients who have serious psychiatric illnesses and coexisting substance abuse disorders, there are

no published studies that definitively address this issue.

There is strong evidence supporting the efficacy of alcohol screening and brief interventions, in particular (Fleming et al., 1997). However, few studies to date have tested the implementation of brief intervention strategies in community-based medical and treatment settings. Several new initiatives address this critical next step in the process. Higgins-Biddle and colleagues identified the research base and current applications of screening and brief interventions (Higgins-Biddle et al., 1997). The findings on the effectiveness from clinical trials on screening and brief interventions were found to be encouraging, with risky drinkers reducing their alcohol consumption by 20 percent, on average. Individual study results varied from 15 to 40 percent depending on the population and methodology used. In the next few years, focused work in these areas will inform clinicians regarding optimal brief intervention implementation strategies and provide a bridge from research efficacy to practical application in real world clinical settings.

There is evidence that a variety of brief interventions are effective with at-risk and hazardous substance users, and emerging evidence suggests that brief interventions can be used to motivate patients to seek specialized substance abuse treatment and to treat some alcohol-dependent persons. Clinical evidence also suggests that brief interventions can be used in specialized treatment programs to address specific targeted issues.

In sum, the Consensus Panel believes it is critical for policymakers and providers of managed care to understand that brief interventions should never be thought of as the only treatment option for persons with substance abuse problems but as one of a continuum of techniques for use with a population of clients with substance abuse problems ranging from at-risk to dependent use.

Appendix A

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