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Wolters Kluwer

# Brief intervention for unhealthy alcohol and other drug use: Efficacy, adverse effects, and administration

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## INTRODUCTION

Unhealthy alcohol and other drug use are among the most common causes of preventable death [1]. "Unhealthy use" describes use of amounts that risk adverse consequences, have resulted in consequences, or meet the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria for a substance use disorder [2]. Despite their frequent presentation in primary care, unhealthy alcohol and other drug use often go unrecognized. Findings from clinical trials support screening of adult primary care patients followed by a brief counseling intervention for unhealthy alcohol use, but not for drug use [3].

The diagnoses substance abuse and substance dependence have previously been replaced by a single diagnosis, substance use disorder. Although the crosswalk between these disorders is imprecise, substance dependence is approximately comparable to substance use disorder, moderate to severe subtype, while substance abuse is similar to the mild subtype.

This topic reviews treatment with brief intervention of adult primary care patients identified by screening to have unhealthy alcohol or other drug use. Screening for unhealthy alcohol and other drug use is described separately. The epidemiology, clinical manifestations, and diagnosis of substance use disorder are described separately as are pharmacotherapy and psychosocial interventions for the disorders.

- (See ["Screening for unhealthy use of alcohol and other drugs in primary care"](#).)
  - (See ["Risky drinking and alcohol use disorder: Epidemiology, clinical features, adverse consequences, screening, and assessment"](#).)
  - (See ["Alcohol use disorder: Pharmacologic management"](#).)
  - (See ["Alcohol use disorder: Psychosocial management"](#).)
  - (See ["Cocaine use disorder: Epidemiology, clinical features, and diagnosis"](#).)
  - (See ["Opioid use disorder: Epidemiology, clinical features, health consequences, screening, and assessment"](#).)
  - (See ["Opioid use disorder: Pharmacologic management"](#).)
  - (See ["Cannabis use disorder: Clinical features, screening, diagnosis, and treatment"](#).)
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## OVERVIEW

Based on results from clinical trials, the United States Preventive Services Task Force has recommended that all adults in primary care who screen positive for unhealthy alcohol use and have risky drinking receive a brief counseling intervention, which has shown efficacy in this group. The panel did not recommend brief intervention among adolescents identified by screening for unhealthy alcohol use, or for drugs (adolescents, adults, pregnant women), or for people with alcohol or other drug use disorder in primary care settings. (See ['Panel recommendations'](#) below.)

In our clinical experience, unhealthy use of alcohol or other drugs is identified in a number of ways other than screening (eg, from patient report, suggested by physical examination and/or laboratory test, or as a factor in patient accident/injury). Once unhealthy alcohol or other drug use is known, the clinician cannot remain silent and brief intervention is the only reasonable path. Done respectfully, it can communicate risks, potentially influence behavior in the long term, and leave the door open for patients to ask for help. For patients with substance use disorder, although referral of those identified by screening has not been widely successful, patients may be interested in treatment in the primary care setting or may eventually conclude that specialty treatment is of interest after brief intervention. All of these benefits seem more likely with repeated discussions over time in a therapeutic relationship.

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## EFFICACY

The efficacy of screening and brief intervention (also known as Screening, Brief Intervention, and Referral to Treatment [SBIRT]) is well established for patients in primary care who are identified by screening who have unhealthy alcohol use but not a moderate to severe alcohol

use disorder [4,5]. SBIRT does not appear to be efficacious for drugs other than alcohol, and it has not been sufficiently studied to determine efficacy for individuals with a moderate to severe alcohol use disorder. Results of clinical trials of SBIRT in settings other than primary care are mixed.

The brief intervention reviewed here is for patients identified by screening, excluding patients identified through their request for help from the primary care clinician [6]. People seeking help have a higher level of readiness and severity when compared with populations identified by screening. Screening for unhealthy use is reviewed separately. (See "[Screening for unhealthy use of alcohol and other drugs in primary care](#)".)

## Treating unhealthy alcohol use

**Primary care** — Several systematic reviews and meta-analyses confirm the efficacy of brief intervention for unhealthy alcohol use in primary care patients identified by screening for reducing self-reported drinking [4,5,7-11]. As an example, a meta-analysis of eight trials of 2784 patients found that brief intervention decreased the proportion of patients drinking risky amounts one year later compared with patients who did not receive brief intervention (57 versus 69 percent; absolute risk reduction of 12 percent) [9]. A meta-analysis of 14 trials reported consumption outcomes for intention-to-treat participants at 12 months [10]. Receiving brief intervention decreased patients' drinking by an additional 3.6 standard drinks per week compared with patients not receiving brief intervention and found a similar risk difference for risky amounts (11 percent).

A clinical trial that has been used as the main basis for simulation modeling found brief intervention in this population to reduce health care utilization and result in cost savings [12,13]. In that trial, 774 patients with unhealthy alcohol use identified by screening for risky drinking amounts were randomized to brief intervention or usual care in 17 primary care practices with a total of 64 clinicians [12]. The intervention, consisting of two 10- to 15-minute clinician discussions and a nurse follow-up phone call, decreased consumption more than usual care, an effect that persisted at 36 months. Hospital use was lower over a four-year period in patients assigned to the intervention compared with patients receiving usual care (420 versus 664 days). The intervention was estimated to have saved \$546 per patient in medical costs and \$7780 per patient in total (including societal) costs (primarily due to a reduction in motor vehicle crashes).

**Inpatient care** — Systematic reviews of randomized trials of brief intervention for alcohol use in hospitals, including trauma services, did not find that brief intervention following screening of inpatients reduced consumption [14,15]. Mixed results have been found for alcohol-related

consequences in clinical trials, with a decrease in alcohol-related problems in three of five studies, and decreased serum gamma-glutamyl transferase in two of three studies [14,16-19].

Examples of studies that did find effects on consumption:

- A trial randomly assigned 596 patients at one of three Level I trauma centers with injury and unhealthy alcohol use to brief advice, brief motivational counseling, or the latter plus a follow-up telephone call [20]. The last group had lower alcohol consumption during the 12-month follow-up period compared with the advice-only group. Average consumption was approximately four drinks in the advice group versus two drinks per week in the phone call group at six months. There were no differences in alcohol consequences.
- A cluster randomized implementation trial that enrolled 878 injured patients with detectable blood alcohol levels assigned 10 of 20 Level I trauma centers with a screening and intervention mandate to receive a one-day workshop and four 30-minute coaching sessions on the practice. At 12 months, 60 percent of patients at sites with no training versus 57 percent of patients at intervention sites (a significant difference) reported unhealthy alcohol use on the Alcohol Use Disorders Identification Test (AUDIT); there were no differences in alcohol consequences [21].

One reason that brief intervention may have less efficacy in hospitalized patients compared with outpatient primary care may be that inpatients identified by screening have more severe unhealthy alcohol use compared with outpatients [16,18,22-24]. As a result, some studies have examined brief intervention with referral and subsequent treatment entry as a goal.

**Emergency departments** — In patients treated in an emergency department, brief intervention for alcohol use has statistically significant but small effects of uncertain clinical significance.

A systematic review and meta-analysis of 28 randomized clinical trials including 14,456 injured and/or intoxicated patients treated in an emergency department found that brief intervention for alcohol use was associated with statistically significant but extremely small effects on consumption (standardized mean difference = 0.09 for drinks per week or month at 12 months, 0.09 to 0.19 at 3, 6, and 12 months for drinks per drinking day/occasion, and 0.07 to 0.13 at 4 to 6 and 12 months for heavy drinking episodes) [25]. In the three trials that reported the outcome, brief intervention led to decreased alcohol-related injury. Other trials, limited to patients with unhealthy use treated for traumatic injury, had mixed findings [26].

Examples of trials conducted in emergency care settings include:

- A trial randomly assigned 899 people with unhealthy alcohol use but who did not have AUDIT scores consistent with alcohol dependence (ie, >19) to brief intervention or screening-only control [27]. Brief intervention was associated with reduced drinking compared with the control group and with reduced driving after drinking (29 versus 42 percent) at 12 months. This trial enrolled people with heavier drinking compared with a prior, negative trial (20 to 21 versus 12 to 14 drinks per week) at the same site [28], suggesting that there may be a narrow band of severity associated with response to brief intervention.
- A clinical trial in nine emergency departments randomly assigned 1204 patients with unhealthy alcohol use to receive an educational pamphlet, brief advice, or longer counseling [29]. There were no differences in unhealthy alcohol use, drinks per day, alcohol-related problems, readiness to change, or patient satisfaction at 6 or 12 months. These results suggest that the very small benefits seen in some individual efficacy trials can be lost in implementation even when done in the context of a trial.

More research is needed into whether brief intervention is effective for specific subpopulations in hospital and emergency settings. Reasons why widespread efficacy may be lacking in these settings for the broader population identified through screening include:

- Not only are patients in such settings often not seeking help for their drinking, patients may not be expecting attention to preventive care.
- Patients do not typically have longitudinal relationships with the clinicians.
- Patients under treatment for a traumatic injury or other consequence of alcohol use may have already made the connection between their drinking and a health consequence, and thus may change their drinking behavior without the need for a brief intervention.
- Severity of unhealthy alcohol use is often greater in these settings and may not be responsive to brief intervention.

**Other settings** — Brief intervention has been tested in a variety of other settings:

- **Mental health treatment settings** – In a randomized trial in a mental health setting, 718 patients with unhealthy alcohol use or other drug use (ie, cannabis or stimulants) were identified by screening or self-referral. The effects of brief intervention with referral versus control (health education) for those likely to have moderate to severe disorder were examined [30]. Participants assigned to brief intervention had fewer heavy drinking days (adjusted mean 3.6 days in the past 90) than those in the control group (7.5 days) at three-

month follow-up. The brief intervention group also reported fewer days of stimulant use in the past 90 days (adjusted mean 5.8 versus 9.8 days). There were no significant differences in cannabis use days.

- **City-wide** – A city-wide public health intervention trial in Sweden enrolled a population-based cohort of 585 middle-aged men with a screening serum gamma-glutamyl transferase (GGT) value in the top decile as an isolated abnormality and self-report of at least 20 grams of alcohol consumption daily [6,31]. Participants were randomized to frequent checks of GGT and repeated nurse and clinician brief interventions or to a one-time letter informing them of the results. After 16 years, no difference was seen in total mortality, but alcohol-related mortality was lower in the intervention group compared with the control group (4 versus 7 percent). Of all deaths in the cohort, 48 percent were alcohol-related.
- **Pharmacies** – Two randomized trials tested alcohol brief interventions in a total of 36 community-based pharmacies with a total of 476 patients. Neither trial found brief intervention to reduce alcohol consumption compared with controls [32,33].
- **Perioperative** – There do not appear to be any randomized clinical trials of brief intervention to reduce alcohol use perioperatively. However, a systematic review identified two briefer behavioral interventions to reduce preoperative unhealthy alcohol use, both among patients undergoing coronary artery bypass surgery, finding some efficacy for reducing self-reported alcohol consumption, with mixed findings for other outcomes. There were, however, multiple methodologic limitations: interventions were wide ranging, methods were poor, samples were not generalizable, and sample sizes were small [34].

As an example, a trial randomly assigned 173 adults age 65 and older undergoing coronary artery bypass to a usual care control group or to receive five sessions of group counseling (education, guidance, and discussion) before and after their operation over 12 months [35]. Among multiple outcomes, patients in the intervention group were more likely to report reduced alcohol use compared with the control group.

Two small randomized trials suggested promise for combined treatment with behavioral and pharmacologic interventions for alcohol cessation perioperatively [36].

**Treating alcohol use disorder** — Fewer randomized trials of brief intervention for alcohol dependence have been conducted compared with trials for unhealthy alcohol use [37]. Findings have been mostly null [17,20,37-39]. (See "[Brief intervention for unhealthy alcohol and other drug use: Goals and components](#)", section on 'Moderate to severe substance use disorder' and

"Screening for unhealthy use of alcohol and other drugs in primary care", section on 'Substance use disorder'.)

- A systematic review of clinical trials found no evidence that brief intervention increased receipt of treatment among patients with alcohol dependence [40].
- In a clinical trial of hospital inpatients identified by screening, with 77 percent meeting criteria for alcohol dependence, brief intervention did not reduce drinking or alcohol consequences compared with usual care [17].
- In a clinical trial of 1336 patients who screened positive for unhealthy alcohol use while receiving treatment for injury at a trauma center, brief intervention decreased use and consequences among patients with alcohol dependence, but not among those without dependence, an unexpected subgroup finding that should be confirmed [38].

**Treating unhealthy use of other drugs** — Although clinicians often provide brief interventions to patients who have unhealthy use of drugs, the overall impact is likely minimal. Results of several studies evaluating brief interventions in primary care and emergency settings to address unhealthy drug use have largely shown no effect on substance use or other psychosocial outcomes among those identified by screening [41-51]. Among those who have a disorder and are seeking help, a range of psychosocial interventions, primarily cognitive-behavioral therapy and motivational interventions, is associated with small, short-term reductions in drug use in select patients.

As an example, a systematic review examined the effect of psychosocial interventions in 52 eligible studies of patients with unhealthy drug use; most of the studies ( $n = 37$ ) evaluated brief interventions such as counseling or advice, and most ( $n = 29$ ) evaluated patients with cannabis use [52,53]. Overall, psychosocial interventions were associated with increased likelihood of abstinence at 3 to 4 months (15 trials,  $n = 3636$ ) and 6 to 12 months (14 trials,  $n = 4031$ ) as well as decreased number of days of drug use (19 trials,  $n = 5085$ ) and drug use severity (17 trials,  $n = 4437$ ) at 3 to 4 months. There were significantly greater effects on outcomes with more intensive compared with brief interventions among patients who sought treatment compared with those identified by screening, and there was a nonsignificant trend towards greater effects for cannabis use compared with other types of drugs.

The limited benefit of brief interventions was further illustrated by a multisite randomized trial in emergency departments that included 1285 patients with drug use; there were no differences in days of drug use with brief intervention versus assessment and referral versus neither [43]. Drug use was corroborated by hair laboratory testing.



It is possible that brief interventions for unhealthy drug use may be useful for certain patients in other settings. As an example, in a trial of 718 patients with unhealthy alcohol use or other drug use (ie, cannabis or stimulants) in a mental health treatment setting, brief intervention resulted in fewer days of stimulant use (odds ratio 0.58, 95% CI 0.5-0.66), but not fewer days of cannabis use (odds ratio 0.93, 95% CI 0.85-1.01) [30].

## Treating population subgroups

**Pregnant women** — Most, but not all [54], randomized trials of positively screened patients in primary care have found brief intervention to reduce alcohol-exposed pregnancy (eg, by reducing exposure to alcohol or by preventing pregnancy) [55-58]. As examples:

- A clinical trial in an obstetrics clinic randomly assigned 330 pregnant women who reported alcohol use before and after recognition of their pregnancy to receive five sessions of an adaptation of motivational interviewing to receive warnings about alcohol use by clinic staff [59]. No difference in alcohol consumption was seen between groups.
- In a randomized trial of information plus four brief motivational counseling sessions and one contraception session versus information alone among 830 nonpregnant, sexually active women of childbearing age who were drinking at-risk amounts, those assigned to intervention had a 15 percent lower risk of an alcohol-exposed pregnancy [57]. Participants had been enrolled from jails, drug and alcohol treatment centers, and clinical settings.

In a randomized trial of clinician brief intervention versus computerized intervention versus usual care in 439 women (18 percent pregnant) at two reproductive health centers, the frequency of the primary substance used (alcohol, tobacco, or other drug) declined from 24 to 16 days per month in the clinician group, 23 to 16 in the computer group and 24 to 18 in the usual care group, significantly greater declines in the intervention groups though of questionable clinical significance [60].

**College students** — Randomized trials of brief intervention for college students have found modest efficacy for reducing self-reported alcohol consumption among those reporting heavy drinking [61-63].

**Adolescents** — Brief intervention for unhealthy alcohol use (but not unhealthy drug use) in adolescents has been found to lead to small reductions of alcohol use in clinical trials [64]. The efficacy of brief intervention for substance use in adolescents is reviewed in greater detail separately. (See "[Substance use disorder in adolescents: Psychosocial management](#)", section on '[Screening and brief intervention](#)'.)



## ADVERSE EFFECTS

Adverse effects of screening and brief intervention are not well studied, are likely few, and do not likely outweigh benefits where established. Although evidence for efficacy from individual randomized trials suggests either benefit or no benefit, but not harm, the confidence intervals from at least five alcohol screening and brief intervention trials include the possibility of harm [9]. At least one study of children found increases in drinking after intervention [65]. A brief intervention, particularly if done poorly, could lead to increased substance use. Training necessary for clinicians to do brief intervention properly is often more extensive than can be disseminated easily [66,67].

It is possible that stigma related to substance use documented in the medical record could lead to lower quality care. Breach of the confidentiality of that information could have social consequences. Depending on local law, for example, a pregnant woman identified as using drugs could be jailed for harming the child when born, or a patient injured while drinking may be denied health insurance benefits [68-73].

Screening and brief intervention could theoretically harm the clinician-patient relationship. In several alcohol brief intervention randomized trials, attrition has been higher in intervention groups than in control groups [5]. However, patients counseled for unhealthy alcohol use in an observational study perceived their quality of care to be better than those not counseled [74-77].

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## ADMINISTRATION

Although brief intervention can be delivered by different types of clinicians and nonclinicians who have been trained to do it, the best evidence for efficacy among patients identified by screening is for brief intervention done by the patient's primary care clinician [4,5,7-9]. However, there are other options for implementing screening and brief intervention with specialized staff and/or electronic support.

**Clinician-delivered** — Whether efficacy of brief intervention for alcohol use depends on the clinician type who administers it or its content has not been well established. For example, a meta-analysis of 52 randomized trials of brief intervention involving 29,891 patients with unhealthy alcohol use found limited evidence informing differences in efficacy between clinician type or content of the brief intervention [78].

The time required to complete screening and brief intervention has limited their use by primary care clinicians and led to considerations of alternative delivery models. Responsibilities can be split where a medical assistant screens patients prior to their visit with the clinician, who interprets the results and does the brief intervention.

Evidence is accumulating that brief intervention done at least in part by nonphysicians in primary care has similar efficacy to those done by physicians [79]. Nurses, nurse practitioners, physician assistants, and other health professionals can be trained to incorporate screening and brief intervention into their roles in primary care [80]. This model has been used by large screening, brief intervention referral and treatment programs funded by federal grants to many states in the United States.

Employment of behavioral health specialists (eg, psychologists, social workers) in primary care settings has been advocated as a means of improving access to mental health and substance-related care. Screening and brief intervention could be part of this role, though research is needed on the efficacy of such an approach. (See ["Overview of psychotherapies", section on 'Primary care'.](#))

Traditional addiction counselors may not be well suited to screening and brief intervention, at least not without additional training. In general, addiction counselors have little familiarity with patients who use alcohol and other drugs but do not have a relatively severe substance use disorder. Since the majority of patients identified by screening in primary care settings will not have a severe disorder, and since mutual help groups and other abstinence-based approaches are inappropriate and may even be counter-productive for such patients, counselors need training to reorient their approach and become familiar with a new condition. Some may find the reorientation difficult or impossible.

**Other modalities** — Bibliotherapy and digital (computer, online) brief interventions have shown convincing effects in clinical trials with patients with unhealthy alcohol use [81]. Online brief interventions for other drug use is less well studied. These modalities are best suited as an adjunct to in person brief intervention (eg, they could be offered to patients as part of a menu of options) or incorporated into primary care brief interventions by recommending them to individuals who screen positive.

**Bibliotherapy** — “Bibliotherapy” refers to an individual’s use of a book as self-help for reducing substance use. A clinical trial compared two individual counseling approaches and a group therapy approach to provision of a self-help manual in 41 patients with “problem” drinking [81]. All groups (38 of 41 completed follow-up at 12 months) decreased their alcohol consumption from approximately 14 to 8 ounces of absolute alcohol per week, with no

difference between bibliotherapy and counseling. A revised version of the book used in the trial, with materials to support self-change, is available for use [82].

**Digital interventions and resources** — Screening, assessment, and counseling interventions are available online for patients to use and for clinicians to recommend.

- **For online screening and initial feedback:**

- Alcohol – [Alcohol Screening](#), [CheckUp & Choices](#)
- Other drugs – [Tobacco, Alcohol, Prescription medication, and other Substance use Tool](#), the National Institute on Drug Abuse (NIDA)'s [Drug Screening Tool](#)

- **Online interventions and resources:**

- The National Institute on Alcohol Abuse and Alcoholism (NIAAA)'s [Rethinking Drinking website](#) has resources addressing alcohol use. These include:
  - Drinking diary – This can help patients see how much they are drinking
  - Drinking worksheets – These help to create a structured accounting of the pros and cons of drinking and facilitate the development of a plan for change
- [CheckUp & Choices](#) is an intervention site for those whose goal is to stop drinking or using drugs [83].
- [CheckUp & Choice's moderate drinking program](#) is a fee-based site providing evaluation, feedback, and training to lower risk, plus access to informational resources, for those whose goal is to reduce drinking. The intervention is intended for those with unhealthy alcohol use that is short of a diagnosis of alcohol dependence.

In a clinical trial of this intervention, 80 adults reporting heavy drinking were randomly assigned to receive the online intervention or to receive access to the informational resources alone [84]. Results across outcomes were mixed, and a primary outcome was not specified. Both groups decreased their drinking over 12 months, with the group assigned to the intervention reporting a greater percentage of days abstinent (43 versus 29 percent). There were no differences between groups in drinks per drinking day or in alcohol problems or consequences.

- The NIDA makes available [an online assessment tool](#) based on the Alcohol, Smoking, and Substance Involvement Screening Test for clinicians to identify unhealthy drug use

and determine level of risk. The levels suggest whether brief intervention alone is likely sufficient or whether referral or specialized treatment might be indicated.

- Watching examples of brief intervention can help clinicians learn how to do the intervention. Video of brief intervention for alcohol use is available at the NIAAA's [Health Professionals and Communities website](#) and the [Moderation Management website](#).

A systematic review that included 25 clinical trials of online brief intervention for those drinking risky amounts found that online interventions reduced alcohol consumption by approximately one drink per week compared with control conditions [85]. Two other systematic reviews reported similar findings [86,87].

As an example, a clinical trial compared an online screening plus brief intervention with screening only in a university health service primary care clinic among students aged 17 to 29 years [88]. After six months, self-reported drinking was lower in the brief intervention group compared with the screening-only group (relative risk = 0.77, median 21 versus 29 drinks in a two-week period).

- **Text messaging interventions** – Text messaging interventions may reduce alcohol consumption among people who drink risky amounts, although the evidence is uncertain. In a meta-analysis, text messaging (a minimum of two messages per week, focused solely on behavior change) resulted in nonstatistically significant reductions in self-reported episodes of heavy drinking per month and weekly alcohol consumption versus control conditions (wait list, basic health information provided once per week, referral to other information sources such as websites) [89].

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## PANEL RECOMMENDATIONS

Based on its review of the effectiveness of the interventions, the United States Preventive Services Task Force has recommended that all adults in primary care who screen positive for unhealthy alcohol use and have risky drinking receive a brief counseling intervention [3]. Screening for unhealthy alcohol use is described separately. (See "[Screening for unhealthy use of alcohol and other drugs in primary care](#)", section on 'Screening tests' and 'Efficacy' above.)

The panel did not find the evidence to be sufficient to recommend brief intervention among adolescents identified by screening for unhealthy alcohol use, and for drugs (adolescents, adults, pregnant women) [3,90], or for people with alcohol or other drug use disorder in primary care settings.

## SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See ["Society guideline links: Insomnia in adults"](#) and ["Society guideline links: Opioid use disorder and withdrawal"](#) and ["Society guideline links: Benzodiazepine use disorder and withdrawal"](#) and ["Society guideline links: Alcohol use disorders and withdrawal"](#) and ["Society guideline links: Stimulant use disorder and withdrawal"](#) and ["Society guideline links: Cannabis use disorder and withdrawal"](#).)

## SUMMARY AND RECOMMENDATIONS

- Brief intervention is often coupled with screening patients or other populations for unhealthy alcohol use. Screening for unhealthy alcohol and other drug use is reviewed separately. (See ["Screening for unhealthy use of alcohol and other drugs in primary care"](#).)
- Once unhealthy alcohol or other drug use is known, a brief intervention should be done to communicate risks, potentially influence behavior in the long term, and leave the door open for patients to ask for help. (See ['Overview'](#) above.)
- For adults who have unhealthy alcohol use, brief interventions in the primary care setting can reduce self-reported drinking. Brief interventions do not appear to be consistently efficacious in other settings (eg, emergency departments or hospitals). However, some subsets of patients with unhealthy alcohol use (eg, those without alcohol use disorder) may still benefit from a brief intervention in emergency and hospital settings. (See ['Treating unhealthy alcohol use'](#) above.)
- Brief intervention also does not appear to be consistently efficacious for drugs other than alcohol. For those with unhealthy drug use, we do not expect a brief intervention to reduce drug use or its consequences. However, we nevertheless provide feedback and advice to open conversations about reducing risk, to inform patients that help is available, to prescribe medications more safely, and to properly diagnose and treat other medical and psychiatric conditions. More intensive brief interventions (eg, motivational interventions, cognitive-behavioral therapy) may have efficacy for those with cannabis use and those with drug use disorder seeking treatment. (See ['Treating unhealthy use of other drugs'](#) above.)
- Clinical trials of screen-positive patients in primary and specialty care have found brief intervention to reduce alcohol-exposed pregnancy (eg, by reducing exposure to alcohol or

by preventing pregnancy). (See ['Pregnant women'](#) above.)

- Clinical trials of brief intervention in college students have found modest efficacy for reducing self-reported alcohol consumption among those reporting heavy drinking. (See ['College students'](#) above.)
- Evidence is accumulating that brief intervention done at least in part by nonphysicians in primary care has similar efficacy to those done by physicians. Nurses, nurse practitioners, physician assistants, and other health professionals can be trained to incorporate screening and brief intervention into their roles in primary care. (See ['Clinician-delivered'](#) above.)
- Screening, assessment, and counseling interventions are available online for patients to use and for clinicians to recommend. Clinical trials have found that computerized screening and brief interventions have reduced alcohol use in subjects with risky drinking. (See ['Digital interventions and resources'](#) above.)
- The United States Preventive Services Task Force has recommended that all adults in primary care who screen positive for unhealthy alcohol use and have risky drinking receive a brief counseling intervention. The panel did not recommend brief intervention among adolescents identified by screening for unhealthy alcohol use, or for drugs (adolescents, adults, pregnant women), or for people with alcohol or other drug use disorder in primary care settings. (See ['Panel recommendations'](#) above.)

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