Brief intervention for unhealthy alcohol and other drug use: Goals and components

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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 (DSM-5) 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 [3,4]. However, screening for drug use is recommended by the United States Preventive Services Task Force based on evidence for validity of screening tests and the availability of efficacious treatment for those who seek help [3].

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnoses, substance abuse and substance dependence, were replaced by one diagnosis, substance use disorder, in DSM-5 [2]. Although the crosswalk between DSM-IV and DSM-5 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 the goals and components of brief intervention for adult primary care patients identified by screening to have unhealthy alcohol or other drug use. Screening for unhealthy alcohol and other drug use is reviewed separately. The efficacy, adverse effects, and

administration of brief intervention for adult primary care patients identified by screening to have unhealthy alcohol or other drug use is reviewed separately. The epidemiology, clinical manifestations, diagnosis, pharmacology and psychosocial interventions for substance use disorder are also reviewed separately.

- (See "Brief intervention for unhealthy alcohol and other drug use: Efficacy, adverse effects, and administration".)
- (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".)

GOALS

The goals of a brief intervention for individuals with unhealthy alcohol and other drug use depend on patient readiness, the severity of unhealthy alcohol or drug use, and often include negotiation. A reduction in use, abstinence, or a change in related behaviors (eg, avoiding bars) are reasonable goals in individuals without moderate to severe disorder. However, in individuals with moderate to severe use disorder, the optimal goal is abstinence and reduction in consequences. These are discussed further below. (See 'Unhealthy alcohol and other drug use' below and 'Moderate to severe substance use disorder' below.)

Unhealthy alcohol and other drug use — “Unhealthy use” refers to the spectrum of use that can result in health consequences. It includes use of amounts that risk consequences (ie, risky use) and use that has already resulted in consequences but is not yet a diagnosable disorder. Additionally, it refers to use that meets DSM-5 criteria for substance use disorder. (See "Screening for unhealthy use of alcohol and other drugs in primary care", section on 'Unhealthy alcohol or drug use'.)

Abstinence is generally the best option for patients with unhealthy alcohol or other drug use who meet one of the following criteria:

- Under age 21, for legal reasons related to alcohol use and because of possible detrimental effects on the developing brain
- A diagnosis of a moderate to severe substance use disorder (see 'Moderate to severe substance use disorder' below)
- Failed prior attempts to cut down
- Pregnant or planning to conceive
- A physical or mental health condition secondary to use
- Use of a medication that contraindicates any alcohol or other drug use
- Drugs that are known to have serious consequences even with low-level use (eg, methamphetamine, cocaine)
- Desire/choice to abstain for any reason

Prior consequences (eg, substance-related injury) or family history of a substance use disorder suggest abstinence may be the best option. Cutting down to levels below unhealthy use is a reasonable option for others using risky amounts or who have had some consequences but not for patients who meet DSM criteria for a moderate to severe substance use disorder. However, even when abstinence is the best option, cutting down on alcohol use can be beneficial when abstinence is not the patient's goal or the achieved goal; while evidence for other drugs in this regard is limited, it is likely also the case [5]. (See "Screening for unhealthy use of alcohol and other drugs in primary care", section on 'Definitions'.)

Moderate to severe substance use disorder — For individuals with unhealthy alcohol or other drug use who meet criteria for a moderate to severe disorder (approximately equivalent to alcohol or drug dependence in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition [DSM-IV]), the optimal clinical goal of brief intervention is abstinence and reduction in consequences. However, even when abstinence is the optimal goal, simply reducing use can lead to clinical benefit [5].

Because these goals may be unrealistic to expect after a brief intervention, an intermediate goal would be engagement in treatment for the disorder. This may include receipt of specialized treatments, some of which can be provided in primary care settings and others through referral to specialty care. (See "Alcohol withdrawal: Ambulatory management" and "Management of moderate and severe alcohol withdrawal syndromes" and "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder" and "Alcohol use disorder:

Psychosocial management" and "Alcohol use disorder: Pharmacologic management" and "Cocaine use disorder: Epidemiology, clinical features, and diagnosis" and "Opioid use disorder: Pharmacologic management" and "Opioid use disorder: Psychosocial management".)

IMPLEMENTATION OF THE INTERVENTION

Structure — Many different models for brief interventions have been tested, more for unhealthy alcohol use than for other drug use. Some are adaptations of motivational interviewing, which is relatively unstructured. Others are highly structured, with the clinician undertaking successive actions.

A structured brief intervention generally begins with personalized feedback regarding the patient's substance use, followed by a discussion of possible goals, along with provision of information. The clinician should provide an explicit recommendation for behavior change. The session ends with negotiation and confirmation of goals and arrangement of follow-up.

A brief intervention involves counseling the patient at least once; some definitions include up to four 30-minute visits. Most brief interventions with proven efficacy are for alcohol and include more than one 10- to 15-minute contact, although duration of the intervention has not been an important determinant of brief intervention effectiveness [4,6,7]. (See "Brief intervention for unhealthy alcohol and other drug use: Efficacy, adverse effects, and administration".)

Treatment in primary care setting — Many patients in primary care with a substance use disorder are not ready for a referral and do not follow through when one is provided. Nonetheless, such referrals should be part of the menu of options discussed (presented as the clinician's "best medical advice"). A referral would be prescribed in a brief intervention as part of a negotiated plan for those with a moderate to severe disorder or those with any disorder who have not improved.

When patients with more severe disorders remain in primary care, the best approach to maintaining treatment engagement is repeated brief intervention; for example, at routine follow-up visits at one- to three-month intervals, the clinician can inquire about use, attempts to cut down or quit, pros and cons of use, readiness to change, and interest in treatment options. The goals remain the same as above.

If the clinician has the ability, and the patient is willing, medications can be prescribed for some substance use disorders, with the patient continuing in primary care to be monitored for side effects, adherence, and treatment response. Other specialized methods can be used, including motivational interviewing or referral for cognitive-behavioral therapies, and/or a mutual help

group [8]. (See "Brief intervention for unhealthy alcohol and other drug use: Efficacy, adverse effects, and administration" and "Alcohol use disorder: Pharmacologic management" and "Opioid use disorder: Pharmacologic management" and "Substance use disorders: Motivational interviewing" and "Alcohol use disorder: Psychosocial management" and "Opioid use disorder: Psychosocial management" and "Primary care management of adults with opioid use disorder".)

Elements of the brief intervention — The active elements of brief intervention are believed to be a repeated, consistent message from a clinician with whom the patient has a relationship.

Key elements of successful brief interventions are described below [9].

- Feedback on the patient's personal risk or impairment.
  - Results of the patient's screening or assessment, including physical or laboratory findings showing current adverse consequences or suggesting potential consequences of continued use.
  - Feedback should usually be accompanied by an expression of concern.
  - Feedback is best followed by an open-ended question asking what the patient thinks of the feedback and of their substance use.
- Emphasis that the patient has the responsibility for changing their use; they have to decide how.
- Providing clear advice to change:
  - Identifying the risks or consequences of use, explaining why change is important, advocating specific changes.
  - Advice is best provided after asking the patient for permission.
  - Advise abstinence or cutting down or drinking or taking other drugs in less risky situations (eg, not before driving). (See 'Goals' above.)
- Presenting and discussing a menu of options and goals.
  - Elicit what the patient thinks of the clinician's advice and recommendations regarding goals.
  - Goals should optimally be generated at least in part by the patient (these goals may be more specific than drinking or other drug use changes and may include strategies to

achieve goals, eg, avoiding friends who drink too much or who use other drugs, not having alcohol in the home, or spacing out drinks).

- Discussion can be directed toward options in which the patient shows interest.

- Once the ideal goal is identified, and the patient responds to it, discussion should lead to next steps that balance what might be ideal for health with what the patient is willing to try.

- Use of an empathic counseling style, which involves listening, understanding, and reflecting that understanding. (See 'Other components' below.)

- Reinforcing the patient's self-efficacy or belief in their competence to change behavior. The clinician should state her or his belief that the patient can make a change.

Other components

Reflective listening — Reflective listening is a useful clinical skill for addressing behavior change. It can improve rapport, help the patient to feel understood, and encourage them to say more. A simple reflection involves repeating or rephrasing what the patient said. Paraphrasing and inferring some meaning, or reflecting feelings, are more complex forms of reflective listening.

As an example, if a patient says, "I really should cut down on my drinking because I am always late to work," the clinician might say one of the following:

- "It sounds like you really want to cut down on your drinking" (a simple reflection).

- "You want to cut down and doing so might help you at work" (paraphrase).

- "Your drinking causes you stress" (reflects feeling).

A reflection is always a statement and not a question.

Readiness to change — Patients who screen positive for unhealthy alcohol or other drug use vary widely in their readiness for change. Some patients may have no idea that their substance use is unhealthy and no intent to seek advice or counsel about it, while others may recognize harmful consequences and seek help. Awareness of readiness can be used to provide an appropriate brief intervention. Although readiness to change is on a continuum, it can be useful to consider stages of readiness when thinking about how best to customize a brief intervention to an individual patient [10]. The content and goal of brief intervention can be tailored to these stages [11].

- **Assessment of readiness to change** – Clinicians can often recognize the patient's stage of readiness to change. Simple questions can be used to elicit information about readiness [12]:

  - How important is it for you right now to cut down on your drinking?
  - If you did decide to stop using drugs, how confident are you that you would succeed?
  - You've decided to quit, you think it is important, and you believe you can do it; how ready are you to do it now?

  Obtaining responses in the form of a score (eg, 1 through 10) can provide language with which to discuss change with the patient and assess changes in readiness over time.

  Another way to determine and discuss readiness is to find out the patient's perception of their use and their need and perceived ability to change behavior [11]. One example is to ask, "Do you think your drug use is causing you harm?"

- **Stages of readiness to change** – Once the patient's stage of readiness is established, the information can inform the clinician's approach.

  - **Precontemplation** – For those who do not recognize risks or harms, the goal of the brief intervention is to increase the patient's perception that there is a concern. The clinician should express concern about the patient's use, state the concern nonjudgmentally (avoiding the word "problem"), agree to disagree about the importance of the concern, and emphasize the importance of follow-up even if the patient does not change behavior.

    Advice can still be given (eg, "My best medical advice is to stop drinking, but I understand that may not work for you now"). A trial of abstinence or cutting down may be a useful learning experience for patients who express the belief that they can do it. A follow-up visit can be scheduled to discuss the experience.

  - **Contemplation** – For those who have considered change or the possibility that their use may not be best for them, the goal is to tip the balance between pros and cons of the behavior towards greater concern and behavior change. It is useful at this stage for the clinician to ask the patient to discuss pros and cons of alcohol or other drug use. Examples include: "What do you like about drinking?" and "Does drinking ever cause you any trouble?" or "What is not so good about drinking?"

Elicit positive and negative aspects of not drinking (eg, "What would happen if you didn't drink for a week?"). Summarize these for the patient; the information can demonstrate a discrepancy between their behavior and their values and goals. As an example, when asked, the patient may report missing a child's weekend soccer game because of a hangover. They may immediately recognize the discrepancy between highly valuing attendance and drinking too much leading to missing the event. For the contemplation stage, advising a trial of cutting down or abstinence is reasonable.

- **Determination** – When the patient has decided to make a change, it is not useful, and possibly counterproductive, to work on motivation to change. Even at this stage, however, patients will likely be ambivalent about change, so reminding them of their reasons to change can still have a role in the brief intervention.

  The goal at this stage is to determine the best course of action. The clinician should help the patient decide on achievable goals. This conversation should be a negotiation, with the clinician providing a menu of options and eliciting what the patient feels ready to do. The approach most likely to be successful is one the patient comes up with or chooses. The conversation should remind patients of their strengths (eg, a prior change they made successfully or the fact they are present discussing the issue), caution patients that change may not be easy, and reassure that drinking or taking other drugs or not achieving the agreed-upon goals will not disrupt the patient's relationship with the clinician.

- **Action** – Once the patient is making a change, the goal is to help them take steps that continue that change. Brief counseling should provide support and encouragement, elicit the positive results of the behavior changes made, reinforce the importance of change (summarize the patient's own reasons), and acknowledge discomfort or difficulty that can arise (eg, withdrawal symptoms, losses including of social connections).

- **Maintenance** – When patients have made a change and are maintaining it, the goal is to help prevent return to alcohol or other drug use. Brief counseling should provide recognition when this stage represents an ongoing challenge for the patient, support and praise the patient's decision and ongoing efforts, reiterate that returning to drink alcohol or take other drugs will not disrupt the relationship with the clinician, and anticipate difficult situations or triggers to return to use.

- **"Relapse"** – In the event of a return to use or use with consequences ("relapse"), the goal is to renew the process of contemplation. Brief intervention should begin with

expression of concern (though it is likely that the patient will already be aware of it), emphasize the positive aspects of prior change and of current efforts to seek help, explore what can be learned from the return to use.

Change talk — The discussion should aim to elicit "change talk" or statements from the patient that are in the direction of change. Means for eliciting such statements include simply asking patients what concerns them about their current behavior, discussing the patient's readiness to change, and asking how the patient's current behavior relates to their personal goals. Elements of change talk can be abbreviated with the acronym DARN-C (ie, when the patient expresses):

- **D**esire to change
- **A**bility to change
- **R**easons for change
- **N**eed to change
- Ultimately, **c**ommitment to change

The patient's ratings of readiness to change can be used to elicit change talk. As an example, if a patient rates the importance of change as a 3 on a scale of 1 to 10, the clinician can recognize that the score was not zero and ask why. This may lead the patient to identify their concerns about substance use. The clinician can ask the patient what it would take for the score (importance) to increase. The patient's response will likely be about change.

When the patient expresses such talk, the clinician should use reflective listening. With that approach, the patient then hears their own words from the clinician, a very effective approach that facilitates actual behavior change.

Motivational interviewing — Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change in which patients explore and resolve ambivalence [13-15]. Motivational interviewing is less structured than the brief intervention described here, but effective brief interventions have been developed that are adaptations of motivational interviewing or involve similar skills. (See "Substance use disorders: Motivational interviewing".)

In motivational interviewing, patients are helped to recognize a discrepancy between their values and goals and their current actions which can lead them to consider change. Motivational interviewing involves collaboration with the patient, eliciting the patient's thoughts and listening to them, and making it clear that the patient has choices and the autonomy and ability to make them.

Follow-up — Clinical trials most strongly support brief intervention delivered over a series of contacts rather than in a single encounter [7]. The clinician should make clear that follow-up is desired and important and that the patient is welcome regardless of whether or not they change their alcohol or other drug use. Follow-up can be in person or by telephone. Steps at follow-up include:

- Reassessment of use and consequences
- Review of the patient's goals, experiences, and progress
- Reassessment of readiness to change
- Feedback and reinforcement of any positive changes
- Advice and discussion of options
- Repeated laboratory tests (if part of the patient's plan)
- Plan for further follow-up

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

- "Unhealthy use" refers to the spectrum of use that can result in health consequences. It includes use of amounts that risk consequences (ie, risky use) and use that has already resulted in consequences but is not yet a diagnosable disorder. Additionally, it refers to use that meets the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for substance use disorder. (See 'Unhealthy alcohol and other drug use' above.)
- Brief intervention is often coupled with screening patients or other populations for unhealthy alcohol and other drug 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".)

- The goals of a brief intervention for individuals with unhealthy alcohol and other drug use depend on the patient readiness, the severity of use, and often include negotiation. (See 'Goals' above.)

  - For individuals with unhealthy alcohol or other drug use who do not meet criteria for a moderate to severe disorder, a reduction in use, abstinence, or a change in related behaviors (eg, avoiding bars) are reasonable goals. (See 'Unhealthy alcohol and other drug use' above.)

  - For individuals with unhealthy alcohol or other drug use who meet criteria for a moderate to severe disorder (approximately equivalent to alcohol or drug dependence in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition [DSM-IV]), the optimal clinical goal of brief intervention is abstinence and reduction in consequences. However, even when abstinence is the optimal goal, simply reducing use can also lead to clinical benefit. (See 'Moderate to severe substance use disorder' above.)

- Many patients in primary care with a substance use disorder are not ready for a referral and do not follow through when one is provided. Nonetheless, such referrals should be part of the menu of options discussed (presented as the clinician's "best medical advice"). A referral would be prescribed in a brief intervention as part of a negotiated plan for those with a moderate to severe disorder or those with any disorder who have not improved. (See 'Treatment in primary care setting' above.)

- The active elements of brief intervention include a repeated, consistent message from a clinician with whom the patient has a relationship. The key elements include personalized feedback regarding the patient's substance use and risks, emphasis on patient autonomy, a menu of options, clear advice, support of self-efficacy, and a nonjudgmental empathic approach. (See 'Elements of the brief intervention' above.)

- Other important components of the brief intervention include reflective listening, assessment of readiness to change, motivational interviewing, and close follow-up. (See 'Other components' above.)

  - Readiness to change is categorized by stages of thinking about reducing or stopping substance use: precontemplation, contemplation, determination, action, maintenance, and "relapse."

- The principal objective of motivational interviewing is to help patients to recognize and resolve a discrepancy between their values and goals, on one hand, and their current actions, which can lead them to consider change.

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