Mental Health-Substance Use (6 book series)

Book 4: Principles of intervention in mental health-substance use

Chapter 8: Brief intervention: mental health-substance use

Dr Catherine Lock, Lecturer in Public Health Research, BSc, MA, PhD, Institute of Health and Society, The Medical School, Newcastle University, NE2 4HH, UK, Tel: 01912464566, Fax: 01912228211, Email: c.a.lock@newcastle.ac.uk

Professor Eileen Kaner, Professor of Public Health Research, BSc, PhD, MSc, Institute of Health and Society, The Medical School, Newcastle University, NE2 4HH, UK, Tel: 01912227884, Fax: 01912228211, Email: e.f.s.kaner@newcastle.ac.uk

Professor Nick Heather, Emeritus Professor of Alcohol and Other Drug Studies, BA, MSc, PhD, School of Psychology and Sport Sciences, Northumberland Building, Northumbria University, NE1 8ST, UK, Tel: 01912274521, Fax: 0191 2274515, Email: nick.heather@northumbria.ac.uk

(On a separate sheet include a brief biography of up to 100 words for the author text of the book)

Introduction

This chapter will ~~serve to~~ provide a definition of brief intervention and details ~~regarding~~ of its development from humble origins to theory base. Evidence will be set out regarding the effects of brief intervention on substance use, including~~:~~ alcohol, tobacco, cannabis, stimulants, benzodiazepines, opiates and multiple substance use. For each of these substances the evidence for brief intervention and mental health substance use will be presented.

Comment [p1]: This sentence seems too vague. I was at first unsure what "mental health-substance use" meant but I see from an email from David Cooper that it means specifically "dual diagnosis, co-existing, co-occurring etc.". So I think the sentence should be something like: "For each of these substances the evidence on the effects of brief intervention on co-occurring mental health issues will be presented."

What is brief intervention?

The term brief intervention refers to a range of clinical activit~~y~~ies ~~which is~~ focused on the use of a talk-based therapeutic approach aimed at changing certain health~~-~~-limiting behaviours (usually alcohol or other drug consumption in those consuming at high risk levels or ~~quitting~~ at smoking) and their associated problems. Fundamental components of brief intervention include simple structured advice, written information and behaviour change counselling and each of these elements can either occur alone or in combination with each other (Babor & Higgins-Biddle 2000). Brief interventions have also been delivered either in a single appointment or a series of related sessions. Sessions can last between 5 and 60 minutes, however brief interventions do not tend to exceed 5 sessions in total (Kaner et al. 2007). Although there is wide variation in brief intervention activity there are a number of essential principles to delivery; brief interventions should obviously be short and should be deliverable by health professionals without specialist training and who are working in busy health care settings. Brief interventions ~~should be~~are often ~~-~~based on a fundamental ~~structure~~ set of ingredients ~~which is~~ summarized by the acronym FRAMES (Miller & Sanchez 1993).

Comment [p2]: I think "should be" is too prescriptive in this context.

FRAMES

Feedback	provides feedback on the client's risk for behaviour
Responsibility	the individual is responsible for change
Advice	advises reduction or gives explicit direction to change

Menu	provides a variety of options for change
Empathy	emphasizes a warm, reflective and understanding approach
Self-efficacy	encourages optimism about changing behaviour

Again, given the variability in activity, it is ~~also~~ important to explain ~~w~~that brief intervention is *not* ~~and that is~~ merely traditional treatment (psychiatric or psychological) carried out in a short time~~ ~~-scale (Babor 1994;)(Miller & Rollnick 1991); it has more specific properties than that. Brief intervention is a technique that a variety of health professionals (GPs, nurses, pharmacists, health workers, drug workers, social workers, etc.) can easily incorporate into their practice in a variety of cultural settings, populations and health care systems (Heather 2007). Brief interventions are supported by a large literature on their efficacy and cost-effectiveness with a wealth of trials and meta-analyses indicating that brief interventions are efficacious as a secondary prevention strategy. Brief interventions are also highly cost-efficient due to the minimal cost of the intervention and the breadth of scope for prevention of more serious and more costly problems. Brief interventions are particularly effective in the field of substance use (Dunn et al 2001).

Origins of brief intervention

Brief intervention was first developed in the United Kingdom ~~with~~in the smoking cessation field. A study carried out by Russell et al (1979) revealed that a small proportion (5.1%) of patients had stopped smoking one year after a simple intervention provided by their general practitioner. This intervention comprised brief advice to quit smoking plus a leaflet with additional information to help patients to achieve their goals (Russell et al. 1979). While the results from this study appear modest the authors ~~hypothesised~~ estimated that such a simple intervention could easily be delivered by GPs to all smokers who consulted; if implemented by all GPs in the UK, this could potentially result in over half a million smokers quitting each year. They claimed that this figure could not even be matched if the number of specialist withdrawal clinics were doubled. A model for brief interventions, derived from this pioneering study, continued to be used within the field of smoking cessation, however it was further applied to other areas of public health. In particular,

Formatted: Font: Italic

Comment [p3]: This may seem a pedantic point but I think it is confusing and illogical to talk simultaneously about "brief intervention" and "brief interventions". I would favour the latter because, as you pint out, there are lots of different kids of brief interventions.

Comment [p4]: I think we need to say more about this, ie, as one of the central aims of BIs.

Comment [p5]: I think we need to be more explicit here about the switch from a clinical perspective to a public health perspective (ie, modest success rates but high impact in population terms) in thinking about individually-based interventions. Also, a growing interest in secondary prevention in the late 70s and early 80s is part of the story. A final part of the picture here is to move towards intervention in the non-treatment-seeking population, perhaps the key principle supporting the development of BIs

Comment [p6]: 1.This is very much my own take on the origins of BI. You could cite here or elsewhere: HEATHER, N. (in press). Development, evaluation and implementation of alcohol brief intervention in Europe. *Drug & Alcohol Review.* Ms attached.

brief intervention for excessive alcohol consumption has proved successful in a wide range of published studies (Kaner et al. 2007).

Brief intervention theory base

Brief interventions are firmly grounded in theory from the field of pPsychology which is concerned with understanding, predicting and changing human behaviour. The Transtheoretical (Stages of Change) Model has been widely used to guide brief intervention strategies. Initially developed to describe the stages people progress through in smoking cessation (Prochaska et al. 1985), this model has since proved influential in guiding treatment for a range of addictive behaviours. Individuals are characterised as belonging to one of six "stages" (precontemplation, contemplation, preparation, action, maintenance, termination) and progress through these stages sequentially; it may take several cycles around the stage of change (ie, relapses) before a sustained recovery is achieved.. The model also proposed that different self-change strategies or "processes of change" are involved in moving between different stages and that different stages are associated with different beliefs. It argued that brief interventions to promote change should be designed so that they are appropriate to an individual's current stage. Although the theory has provided an influential heuristic model,; evaluations to date have not supported its use in improving treatment outcomes (West 2005).

In more general terms, bBrief intervention is based in social cognitive theory which is drawn from the concept of social learning, which was heavily influenced by the work of Albert Bandura (Bandura 1986). Bandura He posited that behaviour occurred as a result of a dynamic and reciprocal interaction between individual, behavioural and environmental factors, the latter including both physical (structural) and social aspects. Thus each individual has personal, cognitive (thinking) and affective (feeling) attributes that affect how they respond to the external world. Individuals also differ in how they construe and are reinforced by a particular behaviour. In addition, individuals also have the capacity to observe and learn from the behaviour of other people around them. Thus behaviour change interventions based on social cognitive theory focus on both personal and contextual factors. Important components include individual's beliefs and attitudes about a behaviour, their self-efficacy or the sense of personal confidence about changing behaviour and a view about how an individual's

Comment [p7]: Despite my comments below, I think this section is excellent. But I would change the order of paragraphs to begin with social cognitive theory and conclude with the TM as "another" influence, albeit related to MI, on the development of BIs.

Comment [p8]: I don't think it's been all that influential in BI research and practice aside from P&C's own work.

Comment [p9]: As I've said before to Eileen, I disagree about this. On a practical level. I don't think many of those developing and testing BIs were, or are, even aware of Bandura's work. But leave that aside.

behaviour sits in relation to the way that other people behave (normative comparison). All these factors influence an individual's motivation for and ability to change their behaviour. Consequently, brief intervention addresses, in a structured format, an individual's knowledge, attitudes and skills in relation to behaviour so as to encourage behaviour change for subsequent health benefit.

In terms of therapeutic application, brief interventions in pioneering research (Heather et al 1986) were based on principles of cognitive-behavioural therapy (CBT) which was itself close linked to the social learning perspective. This tradition was continued in the Drink-Less pack (McAvoy et al. 1997), a brief intervention developed for the WHO Collaborative Project, *The Identification and Management of Alcohol-related Problems in Primary Care* (Heather 2007). This was based on a six-step plan consisting of (i) examining reasons for drinking; (ii) selecting and endorsing good reasons for cutting down; (iii) identifying personal high-risk situations for excessive drinking; (iv) choosing and practicing coping skills in preparation for the high-risk situations; (v) eliciting social support for a change in drinking; (vi) planning for relapse prevention. These elements represent a condensed version of the treatment modality known as *behavioural self-control training* (Hester 1995).

Recently in brief intervention research and practice there has been a move away from condensed CBT towards adaptations of motivational interviewing (MI) (Miller & Rollnick 2002). MI is a patient-centred interviewing style with the goal of resolving conflicts regarding the pros and cons of change, enhancing motivation and encouraging positive changes in behaviour. The interviewer style is characterised by empathy and acceptance, with an avoidance of direct confrontation. Any statements associated with positive behaviour change that the patient brings up in the discussion are encouraged so as to support self-efficacy and a commitment to take action. Although within the time constraints for brief interventions, particularly in general health and social care settings, it is not possible to carry out MI, the general ethos and some of the techniques of MI can be adapted for this purpose (Rollnick et al 1999). Adapted or condensed versions of MI are often referred to as Behaviour Change Counselling (BCC).

Brief intervention and alcohol

There is now a very strong evidence-base supporting the effectiveness of brief alcohol intervention at reducing alcohol-related problems in non-treatment seeking adults. More than a hundred clinical trials have been conducted to evaluate the efficacy and cost–effectiveness of alcohol screening and brief intervention in primary care, emergency departments and trauma centres (Babor et al 2007). Many systematic reviews and meta-analyses have reported beneficial outcomes of brief intervention, compared to control conditions, in terms of reductions in hazardous and harmful drinking (Freemantle et al. 1993)(Bien at al. 1993) (Agosti 1995)(Kahan et al. 1995)(Wilk et al. 1997)(Poikolainen 1999)(Moyer et al. 2002) (Ballesteros et al 2004)(Whitlock et al. 2004)(Bertholet et al. 2005)(Kaner et al. 2007). Most of this research evidence has focused on primary health care and has reported consistent beneficial effects of brief alcohol intervention in terms of reduced alcohol consumption and alcohol-related problems. A recent review of the impact of brief interventions on substance use and co-morbid mental health conditions identified two studies which related specifically to alcohol misuse. Both studies found a positive impact of brief intervention on alcohol reporting positive drinking outcomes at 6 months in terms of abstinence rates and reduced weekly drinking (Kaner et al. 2009).

Comment [p10]: A bit repetitive.

Comment [p11]: Actually, not all that much direct evidence of this.

Brief intervention and tobacco

Comment [p12]: I guess we have to include this but, as implied above, I think the remit is a bit confused, ie the topic of comorbidity. I'm not sure what to do about this? Just ignore it?.

There have also been numerous studies of brief interventions for smoking cessation Reviews of the evidence have shown that brief advice results in significant increases in smoking cessation among patients when compared to no advice or usual care. It has been concluded that when health practitioners provide brief interventions for smoking it increases the likelihood that the patient will successfully quit and remain a non-smoker 12 months later (NICE 2006) (Stead et al 2008). National surveys have demonstrated that smoking is 2-3 times more common in people with mental health problems than in the general population. A recent review of the impact of brief interventions on substance use and co-morbid mental health conditions identified two studies which related specifically to tobacco use, however only one study found a positive impact of brief intervention on smoking. This study reported a significant reduction in cigarette use at three months in patients with a range of psychiatric disorders but this effect disappeared at one year. However, substance misusers with

Comment [p13]: I thought the evidence showed that BIs for smoking cessation were even more effective if combined with NRT and that this was a conclusion of a Cochrane review. If this is still the consensus, it is important to say it..

psychiatric co-morbidity were more likely to attempt to quit smoking compared to those with substance disorders alone (Kaner et al 2009).

~~In contrast to the alcohol and tobacco literature much less research has been conducted on the efficacy of brief interventions for illicit drug use.~~

Brief intervention and cannabis

In contrast to the alcohol and tobacco literature much less research has been conducted on the efficacy of brief interventions for illicit drug use.

Formatted: Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers

Cannabis abuse or dependence appears to be responsive to the same types of treatment as other substance dependencies. Although research is limited and of ~~reduced~~ lower quality a systematic review of randomised controlled trials involving self-identified problem cannabis users in the community has show brief interventions (including cognitive behavioural, motivational enhancement and contingency management therapies) to be efficacious for reducing cannabis use and associated consequences in adult populations (McRae et al. 2003). A year later another review concluded that, while there was a general lack of research into brief interventions for cannabis use disorders, with few good quality randomised controlled trials mainly carried out in America and Australia, brief cognitive-behavioural therapy had the strongest evidence of success for adults with cannabis dependence. However, among adolescents involved in the juvenile justice system and those with severe, persistent mental illness, longer and more intensive therapies provided by interdisciplinary teams may be required (Copeland 2004).#

~~-~~Brief interventions appear to be generalisable to adolescent populations, with a recent randomised controlled trial of brief interventions consisting of a single session of motivational interviewing for young (non-treatment seeking) cannabis users (aged 14-19 years) in Australia resulting in greater reductions in cannabis use for the brief intervention group compared to a delayed treatment control condition at 3 month follow up (Martin et al. 2005) (Martin & Copeland 2008). When considering brief interventions for mental health and cannabis use, ~~again~~ research evidence is again extremely limited. An Australian randomised controlled trial compared a cannabis-focused intervention for young people with first-episode psychosis to a clinical

control condition which involved psycho-education. Although no significant differences were found between the groups, both the specific cannabis-focused intervention and the brief psycho-education were associated with reduced cannabis use in young people with first-episode psychosis. As neither intervention was found to be superior, relatively simple, brief interventions may be worth implementing in the first instance to reduce cannabis use in this population (Edwards et al. 2006).

Brief intervention and stimulants

Again, evidence for brief interventions and stimulant use is relatively limited in the number of well--conducted controlled studies. Hhowever, a review of the literature on psychosocial interventions for amphetamine use concluded that brief (cognitive behavioural) intervention was feasible and moderately effective among users of amphetamine but that more research was needed (Baker & Lee 2003). Brief (cognitive-behavioural) interventions have shown their effectiveness in two six-month randomised controlled trials in regular users of amphetamine in Australia (Baker et al 2001) (Baker et al. 2005). However Wwith psychiatric inpatients the brief intervention showed a lack of effectiveness, so that the authors concluded ing that people with moderate to severe levels of depression may best be offered more intensive interventions for amphetamine use from the outset, with further treatment for amphetamine use and/or depression depending on response (Baker et al. 2005). A more recent randomised controlled trial of brief intervention for students (14-19 year old) with methamphetamine use disorders in Thailand found short--term (8 week) benefits of brief intervention in terms of a decrease in the number of days that methamphetamine was used (Srisurapanont 2007).

Comment [p14]: Too many "howevers".

Brief (motivational)motivationally-based intervention may also help patients achieve abstinence with from cocaine. A randomised controlled trial of peer--delivered brief intervention for non--treatment--seeking cocaine users in the USA found the intervention group was more likely to be abstinent for cocaine than the control group (Bernstein 2005). However, a randomised controlled trial of a brief (motivational) intervention among young (16-22 years old) ecstasy and cocaine users found positive reactive effects on stimulant use for both the brief intervention and control group who received written health risk information materials (Marsden et al 2006).

Brief interventions and benzodiazepines

Only three randomised controlled trials have been identified which have evaluated brief interventions to reduce benzodiazepine use. However all three studies produced positive effects of brief intervention (a GP letter, simple advice and/or self help booklet) significantly reducing benzodiazepine use compared to control groups (Cormack et al. 1994)(Bashir et al. 1994)(Heather et al. 2004). There is currently a need for research to determine the efficacy of brief intervention for mental health benzodiazepine use.

Comment [p15]: There have been two meta-analyses here that are relevant. I attach copies. There are statement in the abstracts on the effectiveness of BIs relative to other kinds of interventions that can be paraphrased here.

Brief intervention and opiates

There is even less research into brief intervention and opiate use, however brief (motivational) intervention does show promise for opiate users. Opiate users attending a methadone programme who received a brief motivational intervention were more committed to abstaining from their drug use, reported fewer drug related problems, were more compliant with treatment and were slower to relapse (Saunders et al 1995). ~~While A~~a randomised controlled trial of peer- delivered brief intervention for non - treatment seeking heroin users in the USA found the intervention group was more likely to be abstinent than the control group for heroin (Bernstein 2005). Again, there is a need for research to determine the efficacy of brief intervention for mental health opiate use, particularly for those with less severe dependence who are not actively seeking help..

Brief intervention and multiple substances

Most brief interventions focus on a single behaviour however health professionals often manage patients who concurrently drink and smoke or use a combination of other substances. Thus it is important to determine if brief intervention can be successfully used across different areas of behaviour. Much of the evidence regarding brief interventions for multiple substance use focuses on adolescents and young people. A systematic review of brief interventions for adolescents in reducing alcohol, tobacco and other drugs concluded that across a diverse range of settings and therefore probably diverse clients, brief interventions conferred benefits to adolescent substance users (Tait & Hulse 2003). In addition a single session of motivational

interviewing (for alcohol, tobacco, and illicit drug use) resulted in a reduction in use of these drugs at 3 month follow up among 200 young people in a randomised controlled trial in the United Kingdom (McCambridge & Strang 2004), however the beneficial effects were not maintained at 12 months (McCambridge & Strang 2005). An over-review of systematic reviews looking at interventions to reduce harm associated with adolescent substance use (including alcohol, tobacco, non-medical use of prescribed medications, cannabis, heroin, cocaine, amphetamine-type substances and hallucinogens) concluded that there was review--level evidence of efficacy of screening and brief interventions but still a need to evaluate ~~screening and brief interventions~~ them in real-world settings to establish effectiveness (Tambourou et al. 2007). ~~However~~At the same time, a Cochrane review based on findings from 25 randomised controlled trials which assessed the effectiveness of psychosocial interventions (including brief interventions) to reduce substance use by people with a severe mental illness found no compelling evidence to support any one psychosocial treatment over treatment as usual and concluded the need for more research (Cleary et al 2008). A more recent systematic review of the impact of brief interventions on substance use and co-morbid mental health conditions found the evidence of positive brief intervention effects in patients with dual substance use and mental health problems was unconvincing. Brief intervention trials which targeted more than one type of substance use, of which 4 were identified, generally reported null findings or a change in just one behaviour (Kaner et al 2009). Thus further research is needed on interventions to promote positive change across mental health and multiple substance use domains.

Comment [p16]: Just an example of an alternative to the ubiquitous "however".

Conclusion

Research on brief interventions for alcohol and tobacco has accumulated rapidly during the past two decades. Not only are the procedures generally effective with a variety of population groups, they can be delivered with equal effect by a variety of health care providers. Less evidence is available regarding brief interventions for other drug users, but several studies show positive effects. Research indicates the global efficacy of brief intervention for illicit and licit drugs in the general population and there is a growing but diverse evidence-base covering brief interventions for mental health substance use. H~~h~~owever, research findings on brief intervention for substance use and mental health problems are currently inconclusive. Nevertheless,

the recognition of psychiatric comorbidity by patients may be a good platform for behaviour change intervention. Thus further research is needed on interventions to promote positive change across mental health and substance use domains (Kaner et al. 2009).

Comment [p17]: "in", "among"? I'm not sure what is meant here.

Comment [p18]: 2.This conclusion seems a bit tame and predictable to me. Couldn't we say something about the difference between licit and illicit substance that might make BI with the latter less effective? There are a couple of point in the following that could be used: HEATHER, N. (2001). Brief interventions for substance use disorders other than alcohol (Letter). *Addiction*, **96,** 1511-1512.
And maybe some general statement about the added barriers to effectiveness associated with comorbidity?

References

Agosti, V. (1995). The efficacy of treatments in reducing alcohol consumption: a meta-analysis. *International Journal of the Addictions*, *30*(8), 1067-1077.

Babor, T. F., McRee, B. G., Kassebaum, P. A., Grimaldi, P. L., Ahmed, K. & Bray, J. (2007). Screening, Brief Intervention, and Referral to Treatment (SBIRT). *Substance Abuse*,*28*, 7-30.

Babor, T. F. (1994). Avoiding the horrid and beastly sin of drunkenness: does dissuasion make a difference? *Journal of Consulting and Clinical Psychology*, *62*(6), 1127-1140.

Babor, T. F., & Higgins-Biddle, J. (2000). Alcohol screening and brief intervention: dissemination strategies for medical practice and public health. *Addiction*, *95*(5), 677-686.

Baker, A., Lee, N. K., Claire, M., Lewin, T. J., Grant, T., Pohlman, S., Saunders, J. B., Kay-Lambkin, F., Constable, P., Jenner, L., & Carr, V. J. (2005). Brief cognitive behavioural interventions for regular amphetamine users: a step in the right direction. *Addiction, 100*, 367-378.

Baker, A., & Lee, N. K. (2003). A review of psychosocial interventions for amphetamine use. *Drug and Alcohol Review*, *22*, 323-335.

Baker, A., Boggs, T. G., & Lewin, T.J. (2001). Randomised controlled trial of brief cognitive-behavioural interventions among regular users of amphetamine. *Addiction*, *96*, 1279-1287.

Ballesteros, J. A., Duffy, J. C., Querejeta, I., Arino, J., & Gonzalez-Pinto, A. (2004). Efficacy of brief interventions for hazardous drinkers in primary care: systematic review and meta-analysis. *Alcoholism, Clinical & Experimental Research*, *28*(4), 608-618.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, New Jersey: Prentice Hall.

Bashir, K., King, M., & Ashworth, M. (1994). Controlled evaluation of brief intervention by general practitioners to reduce chronic use of benzodiazepines. *British Journal of General Practice, 44*, 408-412.

Bernstein, J., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence, 77*, 49-59.

Bertholet, N., Daeppen, J.-B., Wietlisbach, V., Fleming, M., & Burnand, B. (2005). Brief alcohol intervention in primary care: systematic review and meta-analysis. *Archives of Internal Medicine, 165*, 986-995.

Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief interventions for alcohol problems: a review. *Addiction, 88*(3), 315-335.

Cleary, M., Hunt, G. E., Matheson, S. L., Siegfried, N., & Walter G. (2008). Psychosocial interventions for people with both severe mental illness and substance misuse. *Cochrane Database of Systematic Reviews, Issue 1,* Art. No.: CD001088. DOI: 10.1002/14651858.CD001088.pub2.

Copeland, J. (2004). Developments in the treatment of cannabis use disorder. *Current Opinion in Psychiatry, 17*, 161-167.

Cormack, M. A., Sweeney, K. G., Hughes-Jones, H. & Foot, G.A. (1994). Evaluation of an easy, cost effective strategy for cutting benzodiazepine use in general practice. *British Journal of General Practice, 44*, 5–8.

Dunn, C., Deroo, J., & Rivara, F.P. (2001). The use of brief interventions adapted from mmotivational interviewing across bahvioural domains: a systematic review. *Addiction, 96*, 1725-1742.

Edwards, J., Elkins, K., Hinton, M. Harrigan, S. M., Donovan, K., Athanasopoulos, O., McGorry, P.D. (2006). Randomized controlled trial of a cannabis-focused intervention for young people with first-episode psychosis. *Acta Psychiatrica Scandinavia 114*, 109-117.

Freemantle, N., Gill, P., Godfrey, C., Long, A., Richards, C., Sheldon, T., et al. (1993). Brief Interventions and Alcohol Use. *Effective Health Care Bulletin, 7*, 1-13.

Heather, N. (2007). A long-standing WHO Collaborative Project on early identification and brief alcohol intervention in primary care comes to an end (editorial). *Addiction, 38*, 1004-1031.

Heather, N., Bowie, A., Ashton, H., McAvoy, B., Spencer, I., Brodie, J., & Giddings D. (2004). Randomised controlled trial of two brief interventions against long-term

benzodiazepine use: outcome of intervention. *Addiction Research and Theory, 12*, 141-154.

Heather, N., Whitton, B., & Robertson, I. (1986). Evaluation of a self-help manual for media recruited problem drinkers: six month follow-up results. *British Journal of Clinical Psychology, 25*, 19-34.

Hester, R. (1995). Behavioural self-control training. In R. Hester & W. Miller (Eds.), *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* (2nd Edition ed., pp. 148-159). Massachusetts: Needham Heights.

Kahan, M., Wilson, L., & Becker, L. (1995). Effectiveness of physician-based interventions with problem drinkers: A review. *Canadian Medical Association Journal,152*, 851-859.

Kaner, E., Brown, N., & Jackson, K. (2009) A systematic review of the impact of brief interventions on substance use and co-morbid physical and mental health conditions. *Journal of Psychosomatic Research, in press.*

Kaner, E., Beyer, F., Dickinson, H., Pienaar, E., Campbell, F., Schlesinger, C., Heather, N., Saunders, J. B., Burnand, B., & Pienaar, E. D. (2007). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews, Issue 2*, Art. No.: CD004148. DOI: 004110.001002/14651858.CD14654148.pub14651853.

Marsden, J., Stillwell, G., Barlow, H., Boys, A., Taylor, C., Hunt, N., & Farrell, M. (2006). An evaluation of a brief motivational intervention among young ecstasy and cocaine users: no effect on substance and alcohol use outcomes. *Addiction, 101*, 1014-1026.

Martin, G., & Copeland, J. (2008). The adolescent cannabis check-up: Randomized trial of a brief intervention for young cannabis users. *Journal of Substance Abuse Treatment, 34*, 407-414.

Martin, G., Copeland, J., & Swift, W. (2005). The Adolescent Cannabis Check-Up: Feasibility of a brief intervention for young cannabis users. *Journal of Substance Abuse Treatment, 29*, 207-213.

McAvoy, B., Kaner, E., Haighton, K., Heather, N., & Gilvarry, E. (1997). 'Drink-Less' - Marketing a brief intervention package in UK general practice. *Family Practice, 14*(5), 427-428.

McCambridge, J., & Strang, J. (2004). The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug related risk and

harm among young people: results from a multi-site cluster randomized trial. *Addiction, 99*, 39-52.

McCambridge, J., & Strang, J. (2005). Deterioration over time in effect of Motivational Interviewing in reducing drug consumption and related risk among young people. *Addiction, 100(4)*, 470-478.

McRae, A. L., Budney, A. J., Brady K. T. (2003). Treatment of marijuana dependence: a review of the literature. *Journal of Substance Abuse Treatment, 24*, 369-376.

Miller, W., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*. New York: Guilford.

Miller, W., & Rollnick, S. (1991). *Motivational interviewing; preparing people to change addictive behavior*. New York: Guildford Press.

Miller, W., & Sanchez, V. (1993). *Motivating young adults for treatment and lifestyle change*. Notre Dame, IN: University of Notre Dame Press.

Moyer, A., Finney, J. W., Swearingen, C. E., & Vergun, P. (2002). Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction, 97*(3), 279-292.

National Institute for Health and Clinical Excellence. (2006) *Brief interventions and referral for smoking cessation in primary care and other settings.* ISBN 1-84629-186-0.

Poikolainen, K. (1999). Effectiveness of brief interventions to reduce alcohol intake in primary health care populations: a meta-analysis. *Preventive Medicine, 28*, 503-509.

Prochaska, J. O., DiClemente, C.O., Vlicer, W. F., Ginpil, S., & Norcross J. C. (1985). Predicting change in smoking status for sefl-changers. *Addictive behaviours, 10*, 395-406.

Rollnick, S., Mason, P., & Butler, C. (1999). *Health Behaviour Change: A guide for practitioners*. Edinburgh: Churchill Livingstone.

Russell, M. A. H., Wilson, C., Taylor, C., & Baker, C. (1979). Effect of general practitioners' advice against smoking. *British Medical Journal, 283*, 231-234.

Saunders, B., Wilinson, C., Phillips, M. (1995). The impact of brief motivational intervention with opiate users attending methadone programme. *Addiction, 90*, 415-424.

Stead, L., Bergson, G., & Lancaster, T. (2008) Physician advice for smoking cessation (Review). *Cochrane Database of Systematic Reviews. Issue 2.* Art. No.: CD000165.

Srirurapanont, M., Sombatmai, S., & Boripuntakul, T. (2007). Brief intervention for students with methamphetamine use disorders: a randomised controlled trial. *The American Journal on Addictions, 16*, 111-116.

Tait, R. J., & Hulse, G. K. (2003). A systematic review of the effectiveness of brief interventions with substance using adolescents by type of drug. *Drug and Alcohol Review, 22*, 337-346.

Tambourou, J.W., Stockwell T., Neighbors, C., Marlatt, G. A., Sturge, J., & Rehm, J. (2007). Interventions to reduce harm associated with adolescent substance use. *Lancet, 369*, 1391-1401.

West, R. (2005). Time for a change: putting the Transtheoretical (Stages of Change) Model to rest. *Addiction, 100*, 1036-1039).

Whitlock, E. P., Polen, M. R., Green, C. A., Orleans, T., & Klein, J. (2004). Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: a summary of the evidence for the US Preventive Services Task Force. *Annals of Internal Medicine, 140*, 557-568.

Wilk, A. I., Jensen, N. M., & Havinghurst, T. C. (1997). Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers. *Journal of General Internal Medicine, 12*, 274-283.

To learn more

- Peter Miller. 2009. Evidence-based Addiction Treatment, Elsevier, California, USA.
- Screening and brief alcohol intervention materials available at http://www.ncl.ac.uk/ihs/enterprise/

Useful contacts

Alcohol Concern, 64 Leman Street, London, E1 8EU, Tel: 020 7264 0510, Fax: 020 7488 9213**,** E-mail: contact@alcoholconcern.org.uk,
http://www.alcoholconcern.org.uk/

International Network on Brief Interventions for Alcohol Problems (INEBRIA)
http://www.inebria.net/

Add NIDA, NIAAA?