How **brief** can you get?

Three pioneering studies which have stood the test of time. All British, they proved that alcohol problems could be reduced without intensive (and expensive) treatments. The implications are immense, the controversy fierce.

by **Colin Drummond** and **Mike Ashton**

Colin Drummond was an author of the research paper which found that the three studies highlighted in this article were the world's most cited alcohol treatment trials. He is a psychiatrist specialising in alcohol treatment at St George's Hospital in London. Mike Ashton is the editor of FINDINGS

In 1995 three British studies[1, 2, 3] monopolised the medal places in a competitive international league – the world's most cited alcohol treatment trials. They had logged the greatest number of such references in a citation index, reflecting their scientific standing, influence on researchers, and social/political relevance.[4] Among studies of psychosocial interventions, they had also logged the highest *annual* citation rate. Each would have warranted its own *Old Gold* stamp. We decided to treat them as a unit because all three tackled how to do as much as possible with as little as was needed. Together they seeded the 'brief interventions'[5] debate which has grown into such a major issue – perhaps *the* major issue – in alcohol treatment.

KEY SOURCE

Moncrieff J., Drummond D. C. "The quality of alcohol treatment research: an examination of influential controlled trials and development of a quality rating system." *Addiction*: 1998, 93(6), p. 811–823. Found that the most cited alcohol treatment evaluations were all UK studies of brief interventions.

Not only did they seed this debate, they remain central to it. If brief primary care interventions really are now "all the rage",[6] these studies above all created the scientific justification. Together they supported the argument that alcohol interventions could expand beyond the expensive regimes prominent in the '60s and '70s to embrace more drinkers and more settings, promising to help reduce alcohol related problems in the population as a whole.

We'll describe the studies in order of publication – logical in another way, as it takes us from the specialist alcohol clinic through the general hospital and out into the GP's surgery, reflecting the shift since the '70s towards community-based interventions. Finally, we'll briefly assess where the work these researchers pioneered has brought us to today. Along the way readers will find the characteristically modest reflections of the original researchers.

The alcohol clinic

Headed by Griffith Edwards, researchers at London's Maudsley Hospital did most to challenge the '60s orthodoxy that intensive inpatient treatment was required to heal the alcoholic. To caricature, first they showed that the inpatient element could be dispensed with,[7] then 10 years later that the same applied to the treatment.[8] What was left was little more (but the little was probably vital) than a single session of expert advice, yet in some circumstances it could work just as well.

Published in 1977 and titled a test of "advice" versus "treatment", the subjects of the second study were 100 male problem drinkers referred to the Maudsley's outpatient Alcoholism Family Clinic. All were in stable relationships. The couples received a three-hour assessment and an initial counselling session. During this a psychiatrist flanked by a psychologist and a social worker confirmed the man was an alcoholic, advised abstinence, and counselled work and efforts to sustain the couple's relationship. Then the couples were randomised into one of two conditions and reassessed 12 months later.

The control condition was 'treatment as usual': for the men, drug and psychosocial therapies plus specialist inpatient treatment for those who needed it; social work support for their partners. Two-thirds of the men attended at least seven treatment sessions and on average their partners received 18 hours social work contact.

The other half of the draw – the 'advice' group – might well have felt abandoned. After the initial session they were told that "responsibility for attainment of the stated goals lay in their own hands", that there would be no more appointments, and that if the man suffered withdrawal he should contact his GP, not the clinic. A social worker would contact the woman every month, but just to check progress.

After 12 months some measures favoured extended treatment but on none was this statistically superior to advice. Edwards's team, sceptical of the contemporary "tide" of specialised treatments, had found a typical programme no better than a much more modest response.

Those uncomfortable with the findings had straws to clutch at. Strongest were the limited range of clients (men in stable relationships and mostly in work) and of treatments tested. Ten years later Jonanathan Chick and colleagues repeated the essentials of Edwards's experiment with a cohort which included women and single men. After two years the study recorded an advantage for treatment over advice in terms of improved family harmony but not in terms of drinking.[9]

It's true that many of Edwards's advice group received help from elsewhere, while a minority of the treatment group received little treatment, narrowing the gap between the amount of services each experienced. However, this gap remained substantial and there was even greater disparity in the *types* of services received. Certainly the study undermined assumptions about the intensity of specialist input required to stimulate recovery from alcohol dependence, even if that recovery involves help from other sources. In particular, the advice group saw more of their GPs,[10] edging the study into territory later probed by a team including Edwards and the first author of the current article. They found that after assessment and advice at a specialist clinic, patients returned to the care of their GPs did as well as those cared for by the clinic.[11]

While the potential impact of a single intervention session may have been a surprise in the '70s, it should not be now. Today we not only have further demonstrations of the value of brief interventions, but also evidence that longer treatments

KEY SOURCE

Edwards G., Orford J., Egbert S., *et al.* "Alcoholism: a controlled trial of 'treatment' and 'advice'." *Journal of Studies on Alcohol*: 1977, 38, p. 1004–1031. Started the search for quicker and cheaper alternatives to intensive treatment for alcohol dependent patients.

often impact so early that the patients have effectively only received a brief intervention. Seen most recently in Project MATCH,[12] this was also evident in earlier studies,[13] sometimes before formal treatment had started.[14]

For Griffith Edwards (below) the findings redirected attention away from specific specialised therapies towards the basic features which many effective approaches share. What he called his "plain treatment" relied on comprehensive assessment, sympathetically and persuasively communicated advice, optimistic goal setting, an emphasis on the patient's own responsibility for their progress, and external monitoring of this progress[15] – features common to many psychosocial therapies.

How could the benefits of this single advice session match those of extended therapy? One theory is that the impact of the patient's life *outside* the consulting room may overshadow the few hours spent within it, explaining why variation in the number and type of those hours can make so little difference. Ten years later two of the research team re-interviewed many of the former patients from the 1977 study. Compared to the rest of their lives, treatment and formal self-help through AA did not seem major factors in their success or failure.[16] The same trend was seen 12 months after treatment intake, when many of the men spotlighted life changes or changes in relationships and how they felt or thought as the factors which had led to any improvements. Even in the treatment group, relatively few spotlighted treatment.

The general hospital

Edwards's subjects were seeking treatment for their alcohol problem. In next two studies patients attending a medical service for an entirely different reason were identified through a screening process as excessive drinkers and offered an intervention intended to forestall (further) harm. At issue here is whether this results in worthwhile benefits compared – not to more expensive regimes – but to doing nothing.[17]

The general hospital offers a 'captive audience' consisting of a high proportion of heavy drinkers, many painfully reminded of alcohol's physical dangers.[18, 19] But how would they react to an uninvited inquiry into their drinking? First to put it to the test were Jonathan Chick and colleagues in Edinburgh, in a study published in 1985.[20] Outcomes were mixed, but good enough to show that such interventions were feasible and of potential value.

Out of 731 consecutive patients admitted to male medical wards for at least 48 hours, 161 met the study's criteria. All but five agreed to take part. The criteria embraced people whose alcohol problems may have dated back two years, but an average consumption of 10 units a day in the past week suggests current heavy drinking was common. Other criteria would have tended to exclude isolated patients, the least socially stable, and those so obviously in need of psychiatric help that a referral had already been made.

Participating wards fed control and intervention groups in turn, accumulating two fairly evenly matched samples. Screening was followed by nothing at all, or by one hour of counselling aimed at achieving problem-free drinking by leading the patient to reflect on the drawbacks of his current intake. One of the study's strengths was the low attrition rate, raising confidence that any benefits would generalise to male hospital patients as a whole. Low drop out was achieved partly by the seamless provision of screening, assessment and intervention by the same experienced nurse.

When a year later 133 patients were re-interviewed, *both* groups had halved their past-week alcohol consumption, statistically highly significant. Counselling had led to further benefits, but the first question is, why such a dramatic fall after just a brief assessment?

Perhaps before entering hospital these men were at a peak in their alcohol consumption and later simply resumed more normal drinking. Maybe too the focus on drinking in the assessment and their entering a study about "health and drinking habits" provoked some salutary reflections.[21] A further explanation is the very human tendency to behave differently under observation: Chick's patients knew there would be a follow-up interview and roughly when. If so, the (perhaps considerable) costs of monitoring and follow up must be weighed in the cost-benefits balance.

What of the added value of the counselling? Though not apparent in quantities consumed, this *was* seen in greater reductions in alcohol related problems and in levels of a chemical in the blood indicative of excessive drinking, as well as in a composite measure of the proportion "definitely improved".[22] Dr Chick suspects these outcomes had much to do with the 'empathic' character of the nurse involved (p. 26)

A later study also found at least short-term improvements in alcohol-related

KEY SOURCE

Chick J., Lloyd G., Crombie E. "Counselling problem drinkers in medical wards: a controlled study." *British Medical Journal*: 1985, 290, p. 965–967. For the first time showed that screening general hospital inpatients for problem alcohol use and delivering a brief intervention can reduce alcohol-related problems.

HINDSIGHT the alcohol clinic

Reflections on his seminal study which showed that less treatment doesn't have to mean less benefit.

Mundane matters at the core of the change process

by **Griffith Edwards**

Consultant psychiatrist and Professor Emeritus at the National Addiction Centre in London; editor of *Addiction*

Looking back at a paper which one published more than 20 years ago is likely in any reasonably insightful researcher to bring on feelings of discomfort. This study can in retrospect be seen as beset by numerous technical shortcomings: for instance, the outcome measures were primitive, raters were not blind, and no power calculations were made.

The second response is likely to be fond memories for the team with whom one was privileged to work and of the patients. The investigative group was part of the first major alcohol research team to have been assembled in this country and I suspect that Jim Orford was the first psychologist in Britain to have held a full-time research post in this field. So under this second reflective heading I would conclude that team building does matter.

Thirdly, I'm inclined to argue that although our methodology was imperfect, the essential question we asked remains of large present importance. We must continue to study the general factors which can contribute to patient improvement, the words said, the goals suggested, the hope given, the non-specifics, the mundane, rather than focusing only on comparisons of the latest specific treatments. Good luck to specific therapies, psychological or pharmacological, let's not put them down, but at the centre is still the workaday but little understood core of the change process.

problems (and in time abstinent) a year after hospital patients were referred for help with their alcohol problems, though again reductions in consumption did not reach statistical significance.[23] Not until 1996 did a similar study report a statistically significant drop in alcohol use six months after counselling.[24] Its subjects were not severely dependent, the attrition rate was high, and whether the added value of counselling would have persisted is unknown. But at last the full promise of the intervention – reduced problems *and* reduced consumption – had been realised, with a further twist. Those not yet ready to change their drinking (the majority) did better after motivational than skills-based counselling, a clue that the motivational approach is best suited to this environment.

Golden Bullets

Essential practice points from this article

- **More treatment input does not always equate to better treatment outcomes.**
- **Many excessive drinkers seeking treatment will respond adequately to expert assessment and advice which falls short of intensive treatment, enabling limited funds to benefit more people.**
- **But there is no research justification for denying intensive support to drinkers with severe alcohol and/or other problems.**
- **Primary care and general hospitals can make a worthwhile contribution to public health by screening patients for excessive drinking and providing brief interventions.**
- **Realising this potential will require investment in training early in medical careers and (especially in hospitals) in specialist staff. It will be neither easy nor cheap.**
- **Convincing evidence of cost effectiveness in everyday practice will be needed before purchasers will fund, and medical staff embrace, wholesale implementation of such interventions.**

The GP's surgery

When in 1993 the Effective Health Care Team supported brief interventions in the GP's surgery,[25] their primary evidence came from a study published in 1988.[26] Paul Wallace's "carefully executed design"[27] (see his account on p. 28) means his study remains the most convincing demonstration of the potential role of GPs. Effectively his team tested whether primary care interventions *could* work given relatively ideal conditions with pre-selected patients.[28] The answer was a clear 'Yes', but there remained the issue of whether the benefits would survive more routine implementation.

Conducted in 47 group practices across Britain, the results could not be attributed either to individual doctors or to an atypical local population.[29] The randomised and controlled methodology lent confidence to the findings, but also incorporated departures from the conditions in which primary care interventions would normally occur.

Such departures were most evident in pre-intervention recruitment and screening. Researchers first distributed questionnaires to practice patients, then sought to interview the 4203 whose drinking had been excessive or had worried them. The interviews were used to identify patients who in the past week had met the study's criteria for excessive drinking, of whom 909 entered the trial. Despite questionnaire evidence of risky drinking, the remaining 3294 did not participate. Younger and heavier drinkers and men were disproportionately lost to the study, perhaps leaving a sample specially susceptible to intervention.[30]

The GPs had been trained in an intervention which consisted of an assessment of the patient's alcohol use and problems, comparison with drinking norms, information about potential harm, and advice to restrain drinking to safe levels or (if dependent) to abstain. Patients were then asked to monitor their intake via a drink diary and to return at least once to discuss the diary and the results of blood tests.

Half the sample were asked in for this intervention (over 8 in 10 attended), the other half (the controls) received advice only if requested or if blood tests indicated liver damage. Over 80% of both groups were reassessed by research staff six months and a year later. Whether the measure was past-week consumption or the proportion drinking excessively, and in both men and women, the doctor's advice had reduced drinking – modestly, but by enough to create a worthwhile shift to safer levels. By definition, all the patients had been drinking excessively at intake; a year later 45% of the advice group were no longer doing so compared to 27% of controls. Men in the advice group evidenced a small but statistically significant improvement in blood markers indicative of excessive drinking.

Later studies have generally also produced positive if not conclusive results, including one in Sydney which trialed a similar intervention.[31] Though screening was shared by research and practice staff, in other respects the process approximated everyday practice. Patients screened in the waiting room as potentially drinking excessively were allocated to non-intervention groups or to one of two interventions. For the intervention groups, GPs were alerted to the screening results and either immediately delivered five minutes of advice, or asked patients to return for multi-session counselling. Six months later alcohol-related problems had fallen significantly among patients allocated the longer intervention[32] but consumption had not, perhaps because just half the patients returned even for a single session. Factoring in this degree of non compliance would reduce the potentially impressive health gains extrapolated from Wallace's study.

Impact on policy and practice

How are these three studies assessed today, and how far have their findings been translated into policy and practice? The short answer is that they have been fundamental in placing brief interventions firmly on research and policy agendas, but that changes in practice have been disappointing. This is partly because research to date has not demonstrated sufficiently convincing and substantial real-world benefits, and partly because such evidence as there is has been subject to confusing and sometimes contradictory interpretations (*Evidence incomplete and confusing*, p. 27). Purchasers will need to be convinced that brief interventions provide value for money before funding their roll out across the entirety of primary care or general hospitals.

Each study's impact relates mainly to its own setting. We'll address each in turn.

Specialist treatment: pendulum swings

The Maudsley study (still "probably the most influential" of its kind[33]) sent enduring shock waves through the treatment system. Those with a vested interest in specialist treatment countered with charges of therapeutic nihilism and methodological weakness; others, critical of treatment resources being absorbed by the minority of severe cases, mocked the emperor's state of undress. This debate has only recently begun to settle as moderating voices have argued that it's not a case of intensive *or* brief, but of which intervention is best for whom

KEY SOURCE

Wallace P., Cutler S. and Haines A. "Randomised controlled trial of general practitioner intervention in patients with excessive alcohol consumption." *British Medical Journal*: 1988, 297, p. 663–668. First convincing demonstration that a brief GP intervention can lead to persisting falls in consumption among patients screened for excessive drinking.

and in what kind of setting.

Edwards's study challenged the assumption that specialist treatment was better than a briefer and simpler intervention. On its back grew an opposing assumption: that specialist treatments could be replaced by brief interventions across the spectrum of alcohol problems. In the early '90s two influential reviews were seen as supporting this radical step.[34, 35]

Such conclusions were immediately attacked as stretching the evidence beyond what it could safely support.[36, 37] Brief interventions had, it was emphasised, not been tested with the more difficult cases who today would be typical candidates for intensive treatment. Furthermore, patients in clinical trials are generally highly selected in terms of the severity of their problems and their willingness to be researched and randomly allocated. Worse, studies of heavy drinkers identified by screening had been conflated with studies of those seeking treatment – groups likely to differ so much that evidence for brief interventions in one cannot be taken as evidence for the other. Finally, some studies *had* found added benefits from more intensive treatment.[38]

British and Australian commentators cautioned against abandoning intensive regimes, especially for the more severely dependent. [39, 40, 41] A few years later, when it seemed that UK purchasers were indeed diverting resources from specialist treatment, Colin Drummond cautioned that broadening the base of services for problem drinkers in the wider population should not entail narrowing the apex.[42]

An unmitigated benefit of Edwards's study was that it encouraged a new rigour in treatment evaluation to replace conjecture and received wisdom. It also redirected attention towards the commonalities between treatments which might account for positive outcomes, fundamentals which Edwards did much to elucidate by stripping treatment down to its effective essentials. The latest British review has described the Maudsley's advice regime as "still highly relevant to modern practice".[43] Recommended practice today is more theoretically based, but major elements were already there in 1977.[44]

The last word should go to Professor Edwards. While maintaining that after "full assessment and careful and agreed goal setting, much may then often be left to the patient and family", he argues for a flexible commitment of time and therapies responsive to the patient's needs and progress.[45]

Hospitals: resistance and progress

Jonathan Chick's study was a landmark in a different continent – the general hospital, then the fiefdom of men in white coats often critical of their patients' drinking. Probably many physicians were surprised that the unassuming figure of nurse Crombie (below) could have had such a significant and lasting impact: then, as now, the order of the day with excessive drinkers on medical wards tended towards therapeutic nihilism and negative attitudes.

No surprise, then, that implementation of alcohol interventions in hospitals has been achingly slow. Chick's study did stimulate addiction liaison services, but these are patchy and concentrated in teaching hospitals. It can take protracted negotiations to overcome the typical objections: there's no time, patients will feel embarrassed and insulted and lie about their drinking.[46] Detection rates are often low if screening relies on regular ward staff.[47] As with GPs, but even more so, the rewards which might sustain enthusiasm for brief interventions are weakened by the high failure rate.[48] Nurses delivering these interventions will rarely even witness the gains made by the minority who do respond.

Practicality is not the main impediment, rather resources and attitudes. Even in the daunting atmosphere and with the transient population of an accident and emergency department, intervention is possible with suitable resources and specialists to deliver the intervention.[49] But just 1 in 10 departments undertake screening of any kind[50] and staff tend to see the patient's drinking

HINDSIGHT **the general hospital**

With a little help from the "empathic" Evelyn Crombie, Dr Jonathan Chick pioneered brief interventions with hospital patients.

Relationships (with staff and patients) are the key

by **Jonathan Chick**
Consultant psychiatrist at the Alcohol Problems Clinic in Edinburgh

Our study grew partly out of my first foray into alcohol research which involved interviewing 500 healthy working men sampled from institutions where we knew we would find heavy drinkers, namely the Institute of Directors, Chamber of Commerce, and workers in breweries and distilleries. Many told of developing difficulties and evidenced abnormal blood tests.

What could be done to intercept the development of such problems? Michael Russell had shown that some smokers would respond to brief advice from their GPs.[77] With my colleague Geoff Lloyd, a liaison psychiatrist in a general hospital, we decided to see if heavy but non-dependent drinkers, without serious psychiatric problems, could be identified in the hospital and would reduce their drinking after discussing it with a specially trained nurse. The interview instruments were ready from my previous study.

Mrs Evelyn Crombie did most of the interviewing and intervention. Having worked in our alcohol service, she was used to talking to drinkers and made good links with the ward nurses. She had (and has) a relaxed yet firm manner, and is good at getting on the other person's wavelength – 'empathic'. The characteristics of the 'change agent'[78] were then much discussed; some centres with strong treatment effects employed other 'Mrs Crombies'.

Low drop out between screening and intervention made it possible to extrapolate to actual clinical settings. Then and now the evidence supports a very clear role in the general hospital for nurses specialised in alcohol problems. Ability to form good relations with ward staff is critical, otherwise the only referrals are seriously dependent, revolving door patients. (Though for these patients, advice on identifying and managing alcohol withdrawal is also something specialist nurses can very usefully provide.[79, 80])

However, brief interventions have their cons as well as their pros[81, 82, 83, 84] and can be misapplied. Though the studies they reviewed had mostly excluded dependent drinkers, the Effective Health Care Team[85] made it too easy for purchasers to mistakenly conclude that brief intervention was appropriate for alcohol dependence. As the main text explains, commentators quickly sought to set the research record straight.[86, 87, 88]

Evidence incomplete and confusing

The research initiated by these pioneering studies has accumulated good evidence that brief interventions *can* work in relatively ideal conditions. The main impediment to implementation is that there remains practically no evidence of effectiveness – in particular, *cost*-effectiveness – in everyday settings.

Primary care gains unconvincing

Nick Heather – a leading provider of evidence on brief interventions and a cogent critic of how that evidence has been interpreted – has described a trial organised by WHO in eight nations and in a variety of settings[64] as "perhaps the most powerful evidence yet"[65] for brief interventions in primary care. If this really is the case, it suggests that such interventions will be wasted on all female drinkers, lead just 1 in 10 men to cut their alcohol consumption (compared to screening), and produce an across the board reduction in male drinking of about a unit a day[66] – not enough in this study to significantly curtail alcohol-related problems.

Public health analysts might prefer the 'half full' end of the findings, and pessimism must be tempered by the study's limitations, but such evidence may never be enough to convince Britain's 35,000 GPs and several hundred hospital trusts to delve uninvited into their patients' drinking habits.

When is brief too brief?

Currently the evidence for brief(er) interventions among treatment seeking populations is too weak and contradictory to justify withdrawal of intensive treatments, at least for the most severely affected. But until planners know just *how* severe, the implications for practice are unclear.[67]

Some commentators hoped that Project MATCH would clarify this issue.[68] This $28 million US alcohol treatment trial found that a four-session motivational intervention was as effective as (and more *cost* effective than[69]) 12 sessions of cognitive-behavioural or twelve-step therapy, even for heavy and dependent drinkers. The restricted range of patients and treatments, and the exhaustive assessment and follow-up procedures, may have prevented the more intensive treatments revealing their worth. Still, MATCH provides the most convincing demonstration yet that a briefer intervention can be just as good as longer therapies.

In Britain a new four-year trial will test a motivational intervention similar to MATCH's against a more intensive intervention based on social behaviour and network therapy. Unlike MATCH, the United Kingdom Alcohol Treatment Trial (UKATT) will include both abstinence and moderate drinking among its treatment goals and will also test a form of pharmacotherapy.[70]

Confusion over value for money

Most of all planners would like a clear-cut pointer to where they can achieve the greatest health gain for the least outlay. Unfortunately they will find the three most recent reviews of cost effectiveness more confusing than enlightening. All three were meta analyses, combining results from relevant studies to rate the cost-effectiveness of different types of interventions.

In a "first approximation", low-cost brief motivational counselling came third in the league table of effectiveness, behind two higher cost options, but soundly beating most familiar high-cost treatments.[71] A later analysis gave greater weight to more rigorous studies, returning an even more convincing victory for brief interventions.[72] But a reworking of the first study recorded a *negative* score for brief motivational counselling (indicative of poor outcomes relative to other treatments) and placed it *tenth* instead of third in the table.[73]

Why the discrepancy? Part of the answer is that all three analyses had confounded studies of *non*-treatment seeking populations with those of treatment seekers,[74] but in different ways. In the first the criterion of effectiveness was neutrally based on the preponderance of positive versus negative findings. The second gave greater weight to studies comparing an intervention to *no* treatment (appropriate for non-treatment seeking populations), while the third did the opposite, giving most weight to studies comparing an intervention to a strong alternative treatment (appropriate for treatment seeking populations).

In any event, such secondary analyses are far less convincing than research which actually sets out to compare the cost-effectiveness of different interventions in the one study. To guide rational health care purchasing, calculations should also to take account of the wider costs and savings to the individual and to society.[75, 76]

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as irrelevant to the main business of tackling the presenting condition.[51]

Calls to extend interventions in hospitals and primary care often neglect an important feature of the approach trialed by Jonathan Chick. His model places a specialist nurse within the general medical setting rather than asking physicians or ward/practice nurses trained in the intervention to do the work themselves. This approach carries major resource implications if it is to be applied across the board. It also takes a special kind of specialist nurse to work in what can feel like a hostile and alien setting; recruitment could be a problem.

Studies like Dr Chick's show what *can* be done, opening up possibilities which need to be tested in the complex world of clinical practice. It will take very convincing evidence of effectiveness, particularly cost effectiveness, to persuade the average busy nurse or hospital doctor to spend a few extra minutes to enquire about a patient's drinking and to provide even a brief intervention to those drinking too much.

GPs: response disappointing

Paul Wallace's study did for the GP's surgery what Jonathan Chick's did for the general hospital: it demonstrated the *potential* benefits of brief interventions, posing the challenge of how to realise these in practice. Many similar studies followed; few achieved the same methodological rigour. The policy impact was substantial, but on the ground change has been disappointing.

Despite calls from government and from the Royal Colleges, a recent survey found that few GPs in England and Wales had embraced brief interventions.[52] When heavy drinkers *were* identified, interventions were often less than optimal.[53] Though nearly 90% of respondents saw primary care as an appropriate setting in which to address alcohol problems, and most thought this could be effective, most also felt they lacked sufficient training, support and confidence. Paul Wallace (his assessment overleaf) has himself judged the primary care response to alcohol as "frequently disappointing", recommending more support in terms of materials and staff.[54] One way the latter is happening is by addiction prevention counsellors from specialist drug and alcohol services visiting GP practices[55] – the shared care model which has encouraged some GPs to take on problem drug users.

Some British commentators have tried to see the issues from the GP's perspective.[56] With little concrete evidence of health gain, and no way to target those who *will* benefit, GPs are understandably wary about wholesale implementation of an approach which might alienate patients. As in the USA,[57] GPs equipped with motivational interviewing skills might find it easier to

explore drinking, and the potential for provocation can be reduced by focusing on the patient and their perception of their lifestyle rather than on alcohol.

Perhaps the fundamental barrier to progress is the disjunction between the public health perspective – which values change at a population level even if many individuals fail to respond – and that of primary care, which values changes in individuals.[58] Such considerations undermine extrapolations of health gain based on blanket implementation of GP brief interventions; the blanket may always be patchy.

Out of the dark ages

Like all *Old Gold* originals, these three studies have withstood the test of time, their landmark status sealed by the fact that each was the first to ask a fundamental and difficult question about alcohol treatment, and that the answers contributed to a paradigm shift in the field. They remain very much in the consciousness of the alcohol treatment sector, as well as having had a considerable impact on policy in the UK and internationally.

By highlighting the potential value of well directed assessment, guided reflection, and simple advice, Griffith Edwards's work paved the way for study of briefer interventions, including the work of Jonathan Chick and Paul Wallace. This and later work raised the possibility of worthwhile gains in public health by addressing excessive drinking in the wider community, influencing the development of official safe drinking guidelines[59, 60] and the introduction of alcohol as a target for intervention in the 1990 GP contract. Recent proposals for a national alcohol strategy argued that brief interventions in hospitals and surgeries should feature among England's core alcohol services.[61] Further afield this research has influenced strategies in the USA,[62] Europe and Australasia.[63]

Perhaps it is too much to expect a few studies, no matter how eminent, to have had a major impact on practice. Alcohol treatment specialists are bound to find it difficult to accept that their favourite therapeutic approach has little or no substance, and it would take a great deal to turn around the negative attitudes towards problem drinkers and towards alcohol interventions held by many general physicians and GPs.

Fortunately, the survey which found a lack of confidence among GPs also found this was age-related: recently qualified GPs were more confident and positive about screening and intervention. So a key implementation objective must be to train health professionals early, giving them the tools to achieve change in their patients before nihilism has set in. If such training happens it will owe much to the vision of the authors of the studies reviewed here, and to their fortitude in the face of scepticism. Without them we might still be in the dark ages, seeing the only problem with alcohol as 'alcoholism the disease', and the only response as costly intensive treatment.

HINDSIGHT the GP's surgery

Paul Wallace: first to test whether advice from a GP could curb risky drinking. His work led to the inclusion of alcohol targets in GPs' contracts.

Findings consistent, impact uncertain

by **Paul Wallace**

Professor at the Department of Primary Care and Population Sciences of the Royal Free Hospital School of Medicine in London

In 1985 when we began the pilot work for our study there was much excitement about the potential for general practice to modify lifestyle. Studies had shown that GP advice about smoking led a small but (in public health as well as statistical terms) significant proportion of patients to quit.[89] We were stimulated to explore a similar approach for alcohol consumption. First we had to develop a screening technique to identify at-risk drinkers and a suitable intervention package.

Support from the Medical Research Council's General Practice Research Framework gave us access to practices willing to act as research sites. We hoped the trial would indicate whether intervention could be effective, with what proportion of patients, and how to distinguish those from patients the intervention failed to benefit. In the latter objective we were not very successful, but the trial did show that GP advice in this population was effective. Of this we felt fairly certain because questionnaire responses were backed by biochemical markers related to drinking. With the Health Education Authority and Alcohol Concern we went on to develop packages to support intervention in general practice, hoping this approach would be adopted widely.

How big an impact has the trial had on practice? In research terms certainly it is frequently cited and has been replicated in a number of countries where, independent of the setting, findings have been remarkably consistent. In practice terms too there have been some successes, notably when health promotion of this kind was recognised in the 1990 GP contract. However, the degree of impact on everyday practice is difficult to ascertain.

On a personal note, it certainly changed the way I approach my patients. I have retained an active interest in the early detection of patients at risk because of their alcohol consumption and use many of the trial's intervention components in my practice.

1 Edwards G., Orford J., Egert S., *et al.* "Alcoholism: a controlled trial of 'treatment' and 'advice'." *Journal of Studies on Alcohol*: 1977, 38, p. 1004–1031.

2 Wallace P., Cutler S., Haines A. "Randomised controlled trial of general practitioner intervention in patients with excessive alcohol consumption." *British Medical Journal*: 1988, 297, p. 663–668.

3 Chick J., Lloyd G., Crombie E. "Counselling problem drinkers in medical wards: a controlled study." *British Medical Journal*: 1985, 290, p. 965–967.

4 Moncrieff J., Drummond D. C. "The quality of alcohol treatment research: an examination of influential controlled trials and development of a quality rating system." *Addiction*: 1998, 93(6), p. 811–823. Analysis included citations up to the end of 1995.

5 Alcohol Concern. *Brief interventions guidelines*. 1997. As opposed to 'minimal interventions' (such as five minutes of advice or just handing out a self-help manual), brief interventions are typically one or two sessions each lasting 30 minutes to an hour.

6 Cameron D. "Keeping the customer satisfied: harm minimisation and clinical practice." In: Plant M., Single E., Stockwell T. *Alcohol: minimising the harm. What works?* Free Association Books, 1997, p. 233–247.

7 Edwards G., Guthrie S. "A controlled trial of in-patient and out-patient treatment of alcohol dependency." *Lancet*: 1967, 1, p. 555–559.

8 Edwards G., Orford J., Egert S., *et al*, 1977, op cit.

9 Chick J., Ritson B., Connaughton J., *et al*. "Advice versus extended treatment for alcoholism *treatment*: a controlled study." *British Journal of Addiction*: 1988, 83, p. 159–170.

10 Mattick R.P., Jarvis T. "Brief or minimal interventions for 'alcoholics'? The evidence suggests otherwise." *Drug and Alcohol Review*: 1994, 13, p. 137–144.

11 Drummond D.C., Thom B., Brown C., *et al*. "Specialist versus general practitioner treatment of problem drinkers." *Lancet*: 1990, 336, p. 915–918.

12 Project MATCH Research Group. "Matching alcoholism treatments to client heterogeneity: treatment main effects and matching effects on drinking during treatment." *J. Studies on Alcohol*: 1998, 59, p. 631–639.

13 Babor T.F. "Avoiding the horrid and beastly sin of drunkenness: does dissuasion make a difference?" *J. Consulting & Clinical Psych.*: 1994, 62(6), p. 1127–1140.

14 Berg G., Skutle A. "Early intervention with problem drinkers." In Miller W.R., Heather N., *eds*. *Treating addictive behaviors: processes of change*. Plenum Press, 1986, p. 205–220.

15 Edwards G., Orford J. "A plain treatment for alcoholism." *Proceedings of the Royal Society of Medicine*: 1977, 70, p. 344–348.

16 Edwards G., Oppenheimer E. Taylor C. "Hearing the noise in the system. Exploration of textual analysis as a method for studying change in drinking behaviour."

Major reviews of the evidence

The current article is not intended to be a comprehensive review of the evidence but has instead drawn on the reviews below.

Bien T.H, Miller W.R, Tonigan J.S. "Brief interventions for alcohol problems: a review." *Addiction*: 1993, 88, p. 315–336. Seminal review supporting brief interventions for a broad range of clients and settings.

Effective Health Care Team. "Brief interventions and alcohol use." *Effective Health Care*: 1993, no. 7. UK expert consensus and meta analysis emphasising the cost-effectiveness of brief interventions and suggesting routine implementation in primary care settings and hospitals.

Babor T.F. "Avoiding the horrid and beastly sin of drunkenness: does dissuasion make a difference?" *Journal of Consulting and Clinical Psychology*: 1994, 62(6), p. 1127–1140. Argued that the answer to its title question is 'Yes' for those not severely dependent, but also that we have little idea how and why.

Mattick R.P., Jarvis T. "Brief or minimal interventions for 'alcoholics'? The evidence suggests otherwise." *Drug and Alcohol Review*: 1994, 13, p. 137–144. Based on a review and meta-analysis for the Australian Quality Assurance Project. Focuses on whether briefer interventions really are as good as intensive options for treatment seeking alcoholics.

Heather N. "Interpreting the evidence on brief interventions for excessive drinkers: the need for caution." *Alcohol and Alcoholism*: 1995, 3, p. 287–296. Emphasises the distinction between interventions for treatment and non-treatment seeking groups and argues that the evidence is strongest (though far from conclusive) for the latter.

Miller W.R, Brown J.M., Simpson T.L., *et al*. "What works? A methodological analysis of the alcohol treatment outcome literature." In: Hester R.K., Miller W.R., *eds. Handbook of alcoholism treatment approaches*. 2nd edition. Allyn and Bacon, 1995, p. 12–44. Known as the *Mesa Grande* study, this incorporated methodological quality weightings into its assessments of the relative effectiveness of different treatments.

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British Journal of Addiction: 87, p. 73–81.

17 Heather N. "Interpreting the evidence on brief interventions for excessive drinkers: the need for caution." *Alcohol and Alcoholism*: 1995, 3, p. 287–296.

18 Chick J. "Alcohol problems in the general hospital." In: Edwards G., Peters T., *eds*. *Alcohol and alcohol problems*. British Medical Bulletin 50(1). Churchill Livingstone, 1994, p. 200-210.

19 Waller S., Thom B., Harris S., *et al*. "Perceptions of alcohol-related attendances in accident and emergency departments in England: a national survey." *Alcohol and Alcoholism*: 1998, 33(4), p. 354–361.

20 Chick J., Lloyd G., Crombie E., 1985, op cit.

21 Babor T.F., 1994, op cit.

22 However, changes in the blood level of the chemical do not necessarily reflect equivalent changes in drinking (Edwards G., Marshall E.J., Cook C.C.H. *The treatment of drinking problems. A guide for helping professions*. 3rd edition. Cambridge University Press, 1997, p. 195) and, given that self-reported drinking levels were so similar in the two groups, the greater remission of problems after counselling has been queried (Heather N., 1995, op cit, p. 292).

23 Elvy G.A., Wells J.E., Baird K.A. "Attempted referral as intervention for problem drinking in the general hospital." *British Journal of Addiction*: 1988, 83, p. 83–89. These New Zealand patients (even taking into account that some were women) were drinking at far lower levels than the men in Chick's study, so a statistically significant reduction in consumption may have been hard to detect.

24 Heather N., Rollnick S., Bell A., *et al*. "Effects of brief counselling among male heavy drinkers identified on general hospital wards." *Drug and Alcohol Review*: 1996, 15, p. 29–38.

25 Effective Health Care Team. "Brief interventions and alcohol use." *Effective Health Care*: 1993, no. 7.

26 Wallace P., Cutler S., Haines A., 1988, op cit.

27 Babor T.F., 1994, op cit, p. 1134.

28 Heather N, 1995, op cit, p 292–293.

29 However, all the practices had agreed to participate in the MRC's research network, raising a query over how representative they were of all GP practice, and urban practices were under-represented.

30 Edwards A.G.K., Rollnick S. "Outcome studies of brief alcohol interventions: the problem of lost subjects." *Addiction*: 1997, 92(12), p. 1699–1704.

31 Richmond R., Heather N., Wodak A., *et al*. "Controlled evaluation of a general practice-based brief intervention for excessive drinking." *Addiction*: 1995, 90, p. 119-132.

32 But only at six months. The trend at 12 months was in the same direction but not significant.

33 Mattick R.P., Jarvis T. "Brief or minimal...", 1994, op cit, p. 138.

34 Bien T.H., Miller W.R, Tonigan J.S. "Brief interventions for alcohol problems: a review." *Addiction*: 1993, 88, p. 315–336. This review strongly recommended brief interventions for non-treatment seeking populations but was actually more circumspect about replacing intensive with briefer interventions for treatment populations. Here its most confident recommendation was that brief interventions should be provided to those on the waiting list for treatment as an alternative to merely waiting.

35 Effective Health Care Team, op cit, p. 1

36 Heather N, 1995, op cit.

37 Mattick R.P., Jarvis T. "Brief or minimal...", 1994, op cit.

38 Babor T.F., 1994, op cit.

39 Heather N., 1995, op cit.

40 Mattick R.P., Jarvis T. "A summary of recommendations for the management of alcohol problems: the quality assurance in the treatment of drug dependence project." *Drug and Alcohol Rev.*: 1994, 13, p. 145–155.

41 Chick J. "Brief interventions for alcohol misuse." *British Medical Journal*: 1993, 307, p. 1374

42 Drummond D.C. "Alcohol interventions: do the best things come in small packages?" *Addiction*: 1997, 92(4), p. 375–379.

43 Raistrick D., Heather N. *Review of the effectiveness of treatment for alcohol problems*. Final draft. Mimeo: June 1998.

44 Barnes H.N, Samet J.H. "Brief interventions with substance abusing patients." *Medical Clinics of North America*: 1997, 81(4), p. 867–879.

45 Edwards G., Marshall E.J., Cook C.C.H, 1997, op cit, chapter 15.

46 Perry M. "Alcohol screening and early interventions in the medical setting." *Alcoholism*: 1999, 18(2), p. 3–4.

47 Chick J., 1994, op cit, p. 204.

48 Chick J., 1993, op cit.

49 Smith S.G.T., Touquet R., Wright S., *et al*. "Detection of alcohol misusing patients in accident and emergency departments: the Paddington alcohol test (PAT).". *Journal of Accident and Emergency Medicine*: 1996, 13.

50 Waller S., *et al*, 1998, p. 355.

51 Herring R., Thom B. "Resisting the gaze? Nurses' perceptions of the role of accident and emergency departments in responding to alcohol-related attendances." *Critical Public Health*: 1999, 9(2), p. 135–148.

52 Deehan A., Templeton L., Taylor C., *et al*. "Low detection rates, negative attitudes and the failure to meet the 'Health of the Nation' alcohol targets: findings from a national survey of GPs in England and Wales." *Drug and Alcohol Review*: 1998, 17, 249–258.

53 Deehan A., Templeton L., Taylor C., *et al*. "How do general practitioners manage alcohol-misusing patients? Results from a national survey of GPs in England and Wales." *Drug and Alcohol Review*: 1998, 17, p. 259–266.

54 Wallace P, Jarman B. "Alcohol: strengthening the primary care response." In: Edwards G., Peters T., *eds*. *Alcohol and alcohol problems*. British Medical Bulletin 50(1). Churchill Livingstone, 1994, p. 211-220.

55 Henricson C. *Proposals for a national alcohol strategy for England*. Alcohol Concern, 1999. See p. 87.

56 Rollnick S., Butler C., Hodgson R. "Brief alcohol interventions in medical settings. Concerns from the consulting room." *Addiction Res.*: 1997, 5(4), p. 331–342.

57 eg, Barnes H.N, Samet J.H., 1997, op cit.

58 Heather N. "Using brief opportunities for change in medical settings." In Miller W.R., Heather N., *eds*. *Treating addictive behaviors*. 2nd edition. Plenum Press, 1998, p. 133–147.

59 Royal College of Psychiatrists. *Alcohol: our favourite drug*. Tavistock, 1986.

60 Department of Health. *The health of the nation: a strategy for health in England*. HMSO, 1992.

61 Henricson C., 1999, op cit,

62 Barnes H.N, Samet J.H., op cit.

63 Mattick R.P., Jarvis T. "Brief or minimal...", 1994, op cit.

64 WHO Brief Intervention Study Group. "A cross-national trial of brief interventions with heavy drinkers." *American J. Public Health*: 1996, 86(7), p. 948–955.

65 Heather N., 1995, op cit, p. 293.

66 WHO Brief Intervention Study Group, op cit, 1996, p. 953.

67 Heather N., 1995, op cit, p. 295.

68 Mattick R.P., Jarvis T. "Brief or minimal..." 1994, op cit, p. 143.

69 Cisler R., Holder H., Longabaugh R., *et al*. "Actual and estimated replication costs for alcohol treatment modalities: case study from Project MATCH." *Journal of Studies on Alcohol*: 1998, 59, p. 503–512.

70 *British Scientific and Medical News*: 1998, 87. http://www.london.press.net/issues/8/87/pagefive.htm

71 Holder H. Longabaugh R., Miller W.R., *et al*. The cost effectiveness of treatment for alcoholism: a first approximation." *Journal of Studies in Alcohol*: 1991, 52, p. 517–540.

72 Miller W.R, Brown J.M., Simpson T.L., *et al*. "What works? A methodological analysis of the alcohol treatment outcome literature." In: Hester R.K., Miller W.R., *eds*. *Handbook of alcoholism treatment approaches*. 2nd edition. Allyn and Bacon, 1995, p. 12–44.

73 Finney J.W., Monahan S. "The cost effectiveness of treatment for alcoholism: a second approximation." *Journal of Studies in Alcohol*: 1996, 57, p. 229–243.

74 Heather N., 1995, op cit, p. 287–289. This refers only to the Holder study but the later two are no different in this respect.

75 Drummond D.C., 1997, op cit.

76 Heather N., 1998, op cit.

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78 WHO Brief Intervention Study Group, 1996, op cit.

79 Chick J., 1994, op cit.

80 Chick J. "Policies in general hospitals for alcohol use disorders." In: *Hospital Management International*. Sterling Publications, 1997, p. 172–173.

81 Chick J. "Emergent treatment concepts." *Annual Rev. Addiction Research and Treatment*: 1992, 2, p. 297–312.

82 Bien T.H., *et al*, 1993, op cit.

83 Heather N., 1995, op cit.

84 Heather N. "The public health and brief interventions for excessive alcohol consumption: the British experience." *Addictive Behaviors*: 1996, 21, p. 857–868.

85 Effective Health Care Team, 1993, op cit.

86 Chick J., 1993, op cit.

87 Heather N., 1995, op cit.

88 Heather N., 1996, op cit.

89 Russell M.A.H., *et al*, 1979, op cit. Interestingly, the same studies inspired Jonathan Chick.