FINDINGS Your selected document

This entry is our account of a study selected by Drug and Alcohol Findings as particularly relevant to improving outcomes from drug or alcohol interventions in the UK. Unless indicated otherwise, permission is given to distribute this entry or incorporate passages in other documents as long as the source is acknowledged including the web address http://findings.org.uk. The original study was not published by Findings; click on the Title to obtain copies. Free reprints may also be available from the authors – click Request reprint to send or adapt the pre-prepared e-mail message. Links to source documents are in blue. Hover mouse over orange text for explanatory notes. The Summary is intended to convey the findings and views expressed in the study. Below are some comments from Drug and Alcohol Findings.

Click HERE and enter e-mail address to be alerted to new studies and reviews

---

▶ Efficacy of physician-delivered brief counseling intervention for binge drinkers.

Rubio G., Jiménez-Arriero M.A., Martínez I. et al. Request reprint

American Journal of Medicine: 2010, 123, p. 72–78.

In Madrid, unusually a primary care brief alcohol intervention targeted heavy episodic or 'binge' drinking. The result was drinking reductions which probably saved lives due to less drunkenness and less drinking overall – and both screening and intervention were done by the doctors themselves, not specialist staff.

Summary Generally the concern in primary care alcohol interventions is to reduce the numbers drinking at levels which risk their health, commonly defined in terms of consumption exceeding safer drinking limits on average per week or on a single occasion. For what seems the first time, this Spanish study focused on the latter pattern, commonly termed 'binge' drinking, defined for this study as men who on a single occasion had drunk at least 64gm alcohol (eight UK units) or women 51gm (six to seven UK units) once or more in the previous month.

Twenty primary care surgeries in Madrid joined the study. Over a 35-month period, doctors at the surgeries asked all patients aged 18 to 65 to undertake screening for risky drinking using the AUDIT questionnaire. Few refused and 15,325 were screened. Of these, the scores of 2433 exceeded the study's binge drinking cut-offs but were not so high as to be indicative of dependence on alcohol. After being asked by their doctors, 1729 patients completed a survey including questions about their drinking over the past four weeks. This revealed that 624 patients had been dependent on alcohol in the past and another 102 had stopped drinking after first being screened. These and other patients who did not meet the study's criteria were excluded, leaving 752 who joined the study. Typically they were in their 30s, employed and married or cohabiting.

A randomly allocated 371 were given an appointment to return to their doctors for the study's brief intervention, while the remainder (the control group) were told to address any health concerns (all the patients had been given a health advice booklet) in the usual

manner.

The brief intervention began with two 10–15-minute counselling sessions four weeks apart in the context of routine patient care. Following a scripted workbook, doctors led patients through a review of alcohol-related health effects, a pie chart showing what proportions of the population were at different levels of risk from drinking, a menu of methods for cutting down, a treatment contract committing the patient to certain goals or actions, and cognitive-behavioural exercises to help them meet those goals. A few weeks later a nurse from the surgery contacted the patients to reinforce the doctor's advice.

Six and 12 months later (when 90% of the patients were re-assessed), researchers unaware of which patients had been allocated to intervention and control groups reassessed their drinking, and at 12 months sought corroboration of their replies from family members.

Main findings

The study's primary yardsticks of the intervention's impact were whether compared to the control group's usual care, 12 months later it meant fewer patients still met criteria for binge drinking, and led to greater reductions in the number of days on which they drank to these levels. On both counts it had, and the differences were statistically significant. Among those who could be reassessed, from 'bingeing' nearly three times (2.95) in the past month, the intervention group had on average cut down to barely over once (1.14 times) but the control group to nearer twice (1.56) a month. Nearly half (48%) the intervention group no longer drank to these levels at all, but just a third of the control group. Drinking overall had also fallen by an extra 46g a week or nearly six UK units and 52% of the intervention group no longer exceeded weekly safer drinking limits but just 33% of the control group.

However, around half the intervention group were still drinking excessively per occasion or over a week and on average they were still drinking 246g a week. The extra reductions due to intervention were most evident among the women. For example, without intervention around nine in ten continued to drink excessively per occasion or over a week but only around half after intervention. Though smaller, the extra reductions were still statistically significant among the men.

The authors' conclusions

This study demonstrated that significant and durable reductions in binge drinking to safer levels can be achieved with screening and brief physician-delivered counselling in men and women who binge, with accompanying reductions in overall drinking. The study also showed that showed that screening and brief intervention for binge drinkers could be conducted in a regular primary care visit without involving either visits scheduled specifically to address alcohol intervention or additional service providers. However, even with screening and brief intervention, a substantial proportion of binge drinkers remained, raising the issue of whether intervention tailored to particular types of patients (such as those with a family history of alcohol dependence, smokers, young adults, or heavy bingers) would be yet more effective.

FINDINGS The featured trial's distinguishing features were its focus on heavy single

occasion drinking, the fact that screening and intervention were done by normal primary care staff, and the relatively extended nature of the intended brief intervention. Spread over screening plus three contacts and two months or more, the study provides strong evidence for what in Britain would be called an 'extended brief intervention' – one in which the nurse's follow-up may have been as critical as the "physician-delivered" initial session. The study usefully extends the general finding that compared (usually) to screening alone, offering brief advice to risky drinking primary care patients leads to extra reductions in their drinking. In particular it helps confirm that such reductions will be seen in normal practice – and that when asked by their doctors and without the extra hurdle of a research process, patients will generally accept screening for alcohol problems. The whole package of screening plus intervention can be expected to have slightly reduced the number of times patients put themselves and others at risk by getting drunk, and made a contribution to extending their lives, slight among the men, but more substantial among the women. Whether this study is seen as one of binge drinking as opposed to heavy regular drinking seems largely arbitrary; its participants did both, and the findings are not relevant to episodic drunkenness among young people, the major 'binge' drinking concern in the UK. Details below.

There is no universally accepted definition of what counts as 'bingeing', and often the category overlaps with heavy regular drinking to the point where it is a matter of choice which term is used to characterise the drinking pattern. As well as by definition all being binge drinkers, the featured study's participants also all exceeded weekly drinking limits, and their drinking reductions were as apparent on the per-week as on the per-drinking day measures. Just 3% were aged 30 or younger. The degree to which the intervention focused on heavy single occasion drinking is unclear.

In a meta-analysis synthesising the results of 22 trials, the reduction in weekly drinking averaged 38g or nearly five UK units, very close to the 46g or nearly six UK units recorded in the featured study. Among the 10 relatively 'real-world' trials in the analysis, the reduction was almost exactly the same as in the featured study. Compared to some of these more realistic trials, the featured study was even closer to how brief interventions would be implemented in routine practice, because researchers were not involved in screening or intervention. Perhaps for this reason, it also managed to get an unusually high proportion of patients to accept screening. Also a high proportion asked to join the study did so and were followed up, heightening confidence that the findings would apply to non-dependent heavy drinkers in general at these and similar practices. The main concern over the generalisability of the findings is the selection of practices, about which no information is given. As in other studies, they may have been unusually keen on and/or equipped to undertake screening and intervention.

The same meta-analysis and a US review offer some evidence that multi-contact or relatively long brief interventions in primary care are more effective than short single sessions. As in the featured study, typically multi-contact interventions have involved personnel other than or as well the doctor. Their relative contributions are unclear, but the intervention in the featured trial would more accurately be described as physician/nurse-delivered rather than "physician-delivered".

Partly but not largely due to restrictions set by the research process, the 15,325 patients screened were whittled down to 752 who joined the study. Among these, adding intervention to screening meant that a year later 112 patients were no longer binge drinking who (accepting the study's results) would have been continuing to binge after screening alone – under 1% of the total screened, but one in seven of the patients offered advice. The typically low return on screening may be one reason why recommended practice in the UK now de-emphasises universal screening in favour of screening limited to situations where it would seem more natural and more needed to both patients and doctors, such as new patient registrations and as part of the

management of chronic diseases. Even in these situations, it is accepted that doctors and nurses may find it more feasible to focus on groups clearly at an increased risk of harm from alcohol or who already show signs of alcohol-related ill-health.

Beyond their statistical significance, there remains the issue of the clinical significance of the featured study's findings. Per person in the study, intervention led to the equivalent of one fewer binge drinking episodes every two months. The whole package of screening plus intervention may have led to the equivalent of one fewer binge drinking episode every fortnight.

Though slight, intervention's contribution to cutting weekly consumption among men averaging 33g can be expected to make a small contribution to reducing their death rate. At up to 90g or 11 UK units, the whole package will have made a bigger contribution. Among women, the corresponding figures of 66g per week due to intervention and up to 132g due to the whole package would make a substantial contribution to reducing mortality. Complicating this picture are the different health implications of further cutbacks in what is already only occasional heavy drinking – the typical pattern in the featured study – versus cutbacks in regular heavy drinking.

The featured study may have been the first and so far only primary care study to focus on binge drinking, but a Swiss study of young army conscripts shared that focus. The age of the recruits meant that occasional heavy drinking was the dominant pattern. This study too found that intervention led to reductions in alcohol consumption and (non-significantly but still appreciably) in the frequency of binge drinking.

Run this search for other Findings analyses of brief alcohol interventions in primary care.

Thanks for their comments on this entry in draft to Nick Heather of Northumbria University. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 02 August 2011

▶ Comment on this entry•▶ Give us your feedback on the site (one-minute survey)

Unable to obtain the document from the suggested source? Here's an alternative.

Top 10 most closely related documents on this site. For more try a subject or free text search

The impact of screening, brief intervention and referral for treatment in emergency department patients' alcohol use: a 3-, 6- and 12-month follow-up STUDY 2010

Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: comparison at intake and 6 months later STUDY 2008

Counselor skill influences outcomes of brief motivational interventions STUDY 2009

The effectiveness of brief intervention among injured patients with alcohol dependence: who benefits from brief interventions? STUDY 2010

The effectiveness of brief alcohol interventions in primary care settings: a systematic review REVIEW 2009

Alcohol screening, brief intervention, and referral to treatment conducted by emergency nurses: an impact evaluation ABSTRACT 2010

Universal screening for alcohol problems in primary care fails in Denmark and no longer on UK agenda STUDY 2008

Randomized controlled trial of cognitive-behavioural therapy for coexisting depression and alcohol problems:

short-term outcome STUDY 2009

The role of ethnic matching between patient and provider on the effectiveness of brief alcohol interventions with Hispanics STUDY 2010

Alcohol-use disorders: Preventing the development of hazardous and harmful drinking REVIEW 2010