



European Monitoring Centre
for Drugs and Drug Addiction

TECHNICAL REPORT

Implementation of drug-, alcohol- and tobacco-related brief interventions in the European Union Member States, Norway and Turkey

EMCDDA

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Executive Summary

The review exercise

This report provides a snapshot of the range of different types of intervention that can be described as brief interventions (BIs), and that are currently used in European countries in the field of substance use and, in particular, concerning illicit drugs. This overview is intended to be of interest to policymakers and practitioners who are considering the potential role of BIs in addressing substance use issues in their area. It also represents a first step in developing a clearer definition of BIs in the field of substance use, by describing how BIs are currently defined in practice.

The information presented in the report was extracted from a range of sources: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) National reports on drug situations and the responses to the EMCDDA provided by European countries (28 European Union (EU) Member States, Norway and Turkey) between 2010 and 2014, supplemented by a literature review and internet searches covering the same period.

Based on what was reported by the EU Member States and at a meeting of European experts held at the EMCDDA in January 2013, a BI was defined for the purposes of this exercise as an intervention that:

- is delivered to individuals or small groups, with aims that may include preventing substance use, delaying the initiation of substance use, and reducing the risk of escalation into problem use or more harmful patterns of use;
- may include advice or motivational interviewing (MI) and/or other therapeutic approaches, but does not provide a formally structured long-term treatment programme for substance use (although one aim may be to act as a conduit to more structured treatment options);
- does not by default target substance-dependent people but may be used when it is still unclear whether or not an addiction exists, especially in the case of intensive alcohol, cannabis or ecstasy use;
- may be delivered as a preliminary step prior to treatment ('early interventions').

Limitations to the review exercise

There are a number of limitations to the data reported here. Only information in English, or material available as English translations, was included in the literature review for this study. National reports collected as part of the EMCDDA's annual monitoring exercise provide a summary of the programmes active in Member States, but are not always comprehensive in their coverage and do not directly report on interventions that are not relevant to the field of drugs (such as alcohol and tobacco). In addition, the available information on the reported interventions was not standardised.

Conclusion

Despite these limitations, the information presented in this report is informative, as it covers more than 30 BIs addressing substance use across a range of European countries. The interventions reported are a diverse group, which includes face-to-face BIs, BIs with a combination of face-to-face and online/app elements, publicly available self-help online BIs, other online BIs and telephone-based BIs.

The research and inclusion strategy used influenced the type of interventions reviewed for this study. The reported BIs most often target young people, and illicit drugs were the most common target substances. The objectives for the BIs identified vary, but there are some commonalities: they

address groups at increased risk (defined by age or behaviour) and they aim to intervene at an early stage of use to avoid further harms.

Information on the delivery factors was often missing in the data sources identified. For example, there was no information on who delivered almost half of the reported BIs. Of the remaining BIs, around half were self-administered online or by app, while the remainder were delivered by a variety of professionals, including health and social care staff, youth workers and police officers. Settings for interventions that were not delivered online or by telephone were equally diverse and included a variety of healthcare contexts, along with schools, a bus and in homes.

The BIs included in this report also showed some common features with respect to evaluation. They are:

- unlikely to have been evaluated, and even more unlikely to have been rigorously evaluated;
- highly unlikely to have been conducted as randomised controlled trials, or to have incorporated any element of randomisation of participants;
- unlikely to have been formally evaluated with the results published in the scientific literature.

Although this study does add to the knowledge base on the existence of BIs within European countries, it must be recognised as a preliminary exercise, and the need remains to improve the reporting and sharing of experiences across European countries in this area. One clear limitation to any analysis of what constitutes good practice in this area is the absence of high-quality evaluations of the impact of interventions. The current scarcity of rigorous evaluations and randomised controlled trials for BIs, other than those targeting alcohol, make it difficult to assess 'what works' based on European experiences. Outside Europe, work has been done to determine what works and to identify best practices for BIs, for example in relation to the SBIRT (Screening, Brief Intervention, Referral and Treatment) approach in the US; however, overall, the evidence on the effectiveness of BIs for illicit drug use remains uncertain (Roy-Byrne et al., 2014; Saitz et al., 2014; Saitz, 2015).

Despite the need for better evidence on the effectiveness of BIs in the area of drugs, there are still many reasons to be interested in this approach given its limited costs and broad area of use, the lack of findings on iatrogenic effects and the possible transferability from a growing evidence base in other areas.

Recommendations for improving the evidence base for the future

Based on this review, a number of concrete proposals can be made for improving the evidence base on BIs relevant to drug use. These are listed below. With respect to drug monitoring, a key finding of this exercise is that the lack of a clear conceptual framework, and supporting categories and common definitions, inhibits both data collection and analysis. A consensus on issues of definition would therefore support the ongoing collection and sharing of examples of BI development across Europe. Such a database would facilitate assessment of the feasibility of introducing BIs into existing prevention, primary care and treatment systems, and also promote the development of the evidence base in this area.

The recommendations for improving the evidence base are that:

- a clearer conceptual framework and a basis for the categorisation of BIs is needed to facilitate analysis and the collection of more harmonised and comparable information in this area;
- improved monitoring and sharing of experiences of issues relevant to the successful implementation of BIs would facilitate knowledge transfer;
- robust evaluations and, where possible, randomised controlled trials of BIs are needed;
- it is important to recognise the importance of staff training for the successful design, targeting and implementation of programmes in this area, and to recognise that, in programme

development, it cannot be assumed that the success of alcohol-related BIs is necessarily directly transferable to BIs targeting drugs and tobacco;

- the development of a database of European BIs would facilitate monitoring, and best practice exchange and networking between those working in this area.

1. Introduction

As discussed in a previous paper reviewing the effectiveness of brief interventions (BIs) in emergency departments (EMCDDA, 2016), there is no agreed definition of BIs and the term may be used to describe a wide variety of very different approaches. In the field of alcohol, BIs have been used for many years, and standards recognised by the World Health Organization (WHO) (WHO, 2010) are implemented at national and local levels. In the field of drugs, there is still no standard definition.

This report provides a snapshot of the range of different types of intervention that can be described as BIs and that are currently used in European countries in the field of substance use, particularly with regard to illicit drugs. This overview will be of interest to policymakers and practitioners who are considering the potential role of BIs in addressing substance use issues in their area. It also represents a first step in developing a clearer definition of BIs in the substance use field by describing how BIs are currently defined in practice.

There is considerable interest in BIs because they are quick, there is some research supporting their effectiveness, they can be delivered in a variety of settings and by a variety of workers after brief training, and they are relatively low cost. As cost is currently an especially significant issue for health and social services across Europe, BIs may appeal because, when they are effective, they can yield savings in the longer term by preventing the escalation of substance use problems in return for relatively limited expenditure. However, at the present time little is known about the extent and nature of the use of BIs in the substance use field in Europe. This overview starts to address this gap.

The report begins with a description of the methods used to identify the BIs implemented in Europe and a discussion of the limitations that this imposes on the findings. This is then followed by a description of the main features of BIs reported by European countries from 2010 to 2014, including information on the main characteristics of the BIs (objectives, target population and substances, modes of delivery, intensity and duration), how they were delivered (coverage, staff and training, sites, number of recipients), their evaluation and effectiveness, and the barriers to their implementation. Finally, some conclusions are drawn concerning the implementation of BIs in European countries and future information collection at the European level.

2. Methods

Operational definition of brief interventions

Based on what was reported by EU countries and during the meeting of European experts held at the EMCDDA in January 2013 ⁽¹⁾, a BI was defined in practical terms as an intervention that:

- is delivered to individuals or small groups and aims not solely to prevent substance use, but also to delay initiation, reduce its intensification or prevent escalation into problem use;
- does not provide treatment for substance use (opiate substitution or maintenance treatment, detoxification or psychosocial counselling), although one of the aims may be to encourage recipients to consider treatment;
- includes advice and elements of motivational interviewing (MI) such as empathy, open-ended questions, a non-directive approach and reflective listening in an attempt to reduce ambivalence about substance use and possible treatment;
- does not usually target those who are substance dependent but may be used when it is still unclear whether or not an addiction exists, especially in the case of intensive alcohol, cannabis or ecstasy use;
- may be delivered as a preliminary step prior to treatment (an 'early intervention').

The terms 'brief intervention', 'early intervention' and 'motivational interviewing' are often used in practice as synonyms for the same type of activity. However, at the 2013 expert meeting mentioned above it was agreed that 'early intervention' is a term that should be treated with caution (e.g. in quotation marks), as the term was originally used to refer not to intervening early in drug use trajectories, but to intervening early in the lifecourse, and is not necessarily related to substance use; the term 'brief interventions' was therefore considered more useful.

These interventions have been applied in a number of settings, often with an MI element. Other common features of BIs are the relatively short time spent on the activity; the intervention's objective to delay the development of possible substance use problems; and the technique used to carry out the intervention, which should not rely solely on information provision (i.e. warnings, awareness raising or informing about risk) but also encourage reflection on the individual's own values, motivations and substance use behaviour.

Search criteria and methods

For the purposes of this report, a wide definition of BIs based on the above definition was used to identify interventions for inclusion in this study, especially with respect to intervention length. Otherwise the study would have been very exclusive, particularly as the available data on BIs in the EU, Norway and Turkey are currently limited. This also reflects the objective of this overview, which is to begin to establish how BIs are defined in practice and to test the concept of BIs for the field of illicit drugs.

The search was conducted using the methods described in the sections below.

EMCDDA National reports

Data on prevention interventions are provided annually to the EMCDDA by the national focal points of the 28 EU countries, Norway and Turkey, in English, in their National reports on the drug situation ⁽²⁾. The reports for 2010 to 2014, mainly containing data from 2009 to 2012, were searched and provided

⁽¹⁾ <http://www.emcdda.europa.eu/html.cfm/index197136EN.html>

⁽²⁾ <http://www.emcdda.europa.eu/about/partners/reitox-network>

the starting point for information collection. However, the EMCDDA's National report guidelines at the time did not specifically ask for details of BIs, and in 2013, for example, the term was used in only a few reports (from Belgium, the Czech Republic, Ireland, Greece, France, Croatia, Slovakia and Sweden); instead, some interventions that fitted the BI inclusion criteria for this report were termed 'short', 'short-term' or 'early' interventions. In some cases, it was possible to supplement the sparse details given on BIs in the National reports with information gleaned from the literature and the internet.

In addition, a direct request for information was made to the national focal points, most of which replied and provided additional input on the BIs implemented in their countries. However, feedback was not provided by all countries and the information provided may not be exhaustive.

Literature

A literature search for papers published between 2010 and 2014 on BIs in the EU, Norway and Turkey was conducted using a variety of search terms, including 'Brief Intervention', 'drug', 'alcohol', 'tobacco' and 'substance', using the academic databases available via EBSCO (e.g. MEDLINE and PsycINFO). This search produced only a few relevant results. In some cases, a published evaluation led to grey literature (such as unpublished reports) that gave details of a relevant intervention.

Searches of the Cochrane Library, the website Drug and Alcohol Findings, the EMCDDA website and Medscape were also conducted and covered the same period. Reference lists from relevant published studies and review articles were also used to find information about BIs that fitted the criteria for inclusion.

The internet

The internet was searched to identify BIs implemented in each of the 30 countries, using search terms that included the name of a country and words such as 'brief/short intervention', 'drugs', 'alcohol', 'tobacco', 'substance' and 'motivational interviewing'. Results included conference papers and minutes of meetings, which were followed up to ascertain whether or not the BIs cited fitted the criteria for inclusion. Internet searches were also conducted to provide more detail (if available in English) on some of the BIs reported in the National reports.

In order to present a reasonably up-to-date picture, only BIs that were used at some stage in the period 2010-2014 were included in this investigation, and only information published in English was accessed. Some interventions reported in the second round of data collection from Member States were not included, either because they were generic (strategies instead of interventions), they were simply websites or because they were harm reduction interventions.

The information collected using the methods described above was collated according to country (areas), dates delivered, delivery site, objectives, delivery staff, target population, target substances, number of recipients, tools/methods, sessions/duration and evaluation/quality of the intervention.

Search limitations

As indicated above, for practical reasons information in only English was sought. The picture provided here is therefore likely to be incomplete and to underestimate the number of BIs implemented in the 30 countries. This may be the case particularly for BIs concerned solely with alcohol and/or tobacco; although alcohol and tobacco are included in the EMCDDA's National report guidelines, the main focus of the reports is illicit drugs, and not all countries report existing alcohol and tobacco interventions. In addition, counselling interventions in party settings could be considered BIs if users receive MI-based interventions by trained outreach workers, for instance while they wait for their pill-testing results, but often these may not be reported. One such intervention was reported in Portugal,

but more of them might be available in other parts of Europe. It is also the case that the dividing line between BIs and short courses of treatment may not always be entirely clear, and this may have affected the identification of BIs in some countries. Other interventions might have been reported in earlier National reports not included in this study; for example, the MOVE intervention reported by Croatia, which consists of brief motivational interventions aimed at young people demonstrating risky behaviours, has been in existence for longer in Germany and might not have not been reported in the latter's more recent National reports. Nevertheless, the data collected provide an insight into the range of BIs available across Europe.

Outcomes of the search strategy

No BIs that fitted the criteria for selection were identified in 12 countries: Bulgaria, Estonia, Spain, Italy, Latvia, Lithuania, Malta, Austria, Slovakia and Finland. Where BIs were identified, the information obtained on the interventions was not always complete. The gaps in the information on the BIs that were identified are summarised in Table 1.

Information on target populations and target substances was available for nearly all of the BIs identified. For some of the reported BIs, information on the objectives of the interventions was not provided, but it is likely that they were similar to those of the remaining interventions, which generally focused on selective and indicated prevention. Details on dissemination, duration and delivery site were available for more than half of the BIs presented here. For all other categories, information was not provided in the majority of cases.

Table 1: Available information on BIs

Category of information	Information available (out of 29)	Information unavailable (out of 29)
Target substances	28	1
Target population	25	4
Objectives	22	7
Tools/methods	22	7
Dissemination	19	10
Sessions/duration	19	10
Delivery site	19	10
Delivery staff	15	14
Dates delivered	11	18
Number of recipients	6	23
Evaluation/quality of intervention (with reference)	5	24

The largest information gaps were found for evaluations. Although this might be the result of incomplete reporting in some cases, as with the other categories, it seems likely that this extremely low number of BIs without information on their evaluation is due to a lack of evaluations being undertaken for BIs. It is therefore difficult to assess the overall quality and effectiveness of the BIs reported here.

Similar challenges for data collection on BIs in the EU have been reported in the past. The project BISTAIRS⁽³⁾, which, in 2012, aimed to provide an overview on the then current implementation status of alcohol-related BIs in a range of different settings (primary healthcare, workplace health services, emergency care and social services) by conducting a survey of experts across 27 countries (Schmidt et al., 2014), received input from only 17 countries.

⁽³⁾ Brief interventions in the treatment of alcohol use disorders in relevant settings (<http://www.bistairs.eu/>).

Table 2 presents the BIs reported as being delivered and includes information from more than half of the European countries included in this study. More detail with web links can also be found in the Annex 1 to this report. The funding and management of these BIs involved a variety of local/national health (including drug and alcohol) services, education and social services, charities and the criminal justice system.

Table 2: BIs across the EU, Norway and Turkey, 2010-2014

Country	Name and/or focus
Face-to-face BIs	
Belgium	Binge drinking and cannabis
Czech Republic	Preventure: school-based programme for adolescents
Denmark	The Danish Health Authority is developing a course on BIs
Germany	FreD (Frühintervention bei erstaußälligen Drogenkonsumenten): 14- to 25-year-olds who have come to the attention of the police because of drug use
Ireland (Dublin)	Hazardous alcohol use by drug users receiving methadone treatment
Greece (national)	PEGASUS Mobile Information Unit
France	Youth Addiction Outpatient Clinics (CJCs) established throughout French territory by the government in 2004 to prevent problematic drug use (540 teams)
France	BI in emergency hospital for heavy adolescent drinkers aged 16-25
Croatia	MOVE (Motivierende Kurzintervention bei Konsumierende): at-risk young people
Cyprus	FreD Goes to School: school students who smoke tobacco in the school environment and who use alcohol
Luxembourg (Luxembourg City)	CHOICE: 12-17 year-olds who have come to the attention of law enforcement agencies because of drug use
Netherlands	Preventure: school-based programme for adolescents
Poland	FreD Goes Net: young drug users
Portugal	Não te queimes: BI in party settings
Romania	FreD Goes Net: school students who are first-time drug law offenders
Slovenia	FreD Goes Net: alcohol and illicit drug users aged 13-25
Sweden (Stockholm, Gothenburg, Malmö)	Project Trestad 2: young cannabis users aged under 25
Sweden	Linköping Model: young drug users
Sweden (national)	MUMIN (Maria Ungdom Motiverande Intervention): young drug users
United Kingdom (Scotland)	Excessive alcohol users
Face-to-face and phone app	
United Kingdom (England: Brent, Bournemouth, Cornwall, Hatton, Lancashire)	Street Talk: young people aged 10-19
Online self-help websites (publicly available)	
Belgium	The DrugLijn contains a section with online assessment-tests and self-help programmes (http://www.druglijn.be/aan-de-slag.aspx) Centres for alcohol and drug problems Drug Aid Limburg (http://www.drughulp.be/ and http://www.cannabishulp.be/) run an online treatment programme specifically for cannabis, ecstasy, speed, cocaine and GHB (gamma-hydroxybutyrate)
Germany	Quit the Shit: cannabis and alcohol users aged 15-25
Ireland	Alcohol use

France	Addict'prev: alcohol, tobacco and cannabis use by school students
Netherlands	Wiet-Check: cannabis users aged 14-21
United Kingdom	Drugs Meter, Alcohol Meter
Norway	Balance: alcohol
Norway	Alcohol, cannabis and cocaine use
Online self-help (access for BI participants only)	
Belgium	De Druglijn and Infor-drogues (2012, 2013 and 2014 National reports)
Multi-country (Belgium: Duffel, Kortrijk; Hungary: Budapest, Kaposvár)	eSBIRTes: drug use among young adults presenting to emergency departments (not necessarily for substance-related problems)
Telephone helplines	
Greece	Open Line: drug use
Greece	ITHAKI Psychological Support Help Line: drug use
Greece	SOS Drugs Help Line
Portugal	Linha Vida SOS Droga

3. Results

Characteristics of the brief interventions

Objectives of the interventions

Most BIs were concerned with selective and indicated prevention and, in various ways, aimed 'not solely to prevent substance use, but also to delay initiation, reduce its intensification or prevent escalation into problem use'.

The objectives for of the BIs, based on what countries reported, are shown in the list below. Although they differed in details, there are some commonalities: they address groups exposed to increased risk (defined by age or behaviour); provide information on drug risks; help individuals to make good/better personal judgements on the basis of this information; and intervene in early use to avoid further harms.

Stated objectives of reported BIs

- To deliver a BI rather than instigate criminal proceedings
- To prevent drug-related crime
- To control drug use among young people
- To reduce harmful substance use
- To prevent further development of drug misuse and addiction
- To reduce cannabis use in under-25-year-olds
- To stop young people beginning to smoke tobacco, reduce the numbers of young people who smoke and provide information about alcohol
- To engage young people who would not otherwise seek counselling and who prefer brief meetings
- To identify and engage young people who may be at risk of problem drug use and its associated antisocial behaviour and social vulnerability, but who have not yet met the threshold for, or come into contact with, treatment services (online)
- To target personality risk factors for early-onset substance use disorder and other risky behaviours (2 BIs)
- To make participants more reflective, improve their knowledge about drug use, motivate them to assess risk and act responsibly, change attitudes and behaviours related to drug use, and to provide an insight into local drug services
- To teach young drug users to face the risk factors leading to drug use and take responsibility for their actions, thus preventing addiction (two BIs)
- To communicate health-related knowledge, promote health-related attitudes and behaviour, and support behavioural change (online)
- To allow participants to think about their drug and alcohol use, and to compare themselves with others who have completed the questionnaire (online), help them assess the risks, encourage them to be safer and wiser, provide them with harm reduction tools and point out when their use might be causing them problems (online)
- To deliver an early intervention for those suspected of drug use
- To provide information and advice about cannabis use (online)
- To reduce alcohol-related harm and embed BIs into national health service practice
- To deliver a BI that will identify and develop successful, feasible and acceptable e-health tools for staff in emergency departments (online)
- To provide self-help for those wishing to change their use of, or addiction to, alcohol, cannabis or cocaine (online)
- To provide self-help for those wishing to change their use of, or addiction to, alcohol (online).

Target population

The target population for most of the reported BIs (see list below) was either young people, with an overall age range (where it was given) of between 10 and 25 years, or a subgroup of this age group considered at increased risk of developing problematic patterns of use. Only one BI targeted drug users who were receiving treatment.

Target populations

- School students who smoke tobacco in the school environment
- Binge drinkers
- Excessive alcohol users
- Alcohol users
- Hazardous alcohol users receiving drug treatment with methadone
- Drug, alcohol and tobacco users
- Alcohol and illicit drug users aged 13-25
- People with mild to moderate drug or alcohol problems, who live in stable housing and have contact with friends, relatives or colleagues (two BIs)
- 11- to 16-year-olds at risk
- 13- to 15-year-olds at risk
- At-risk young people
- 14- to 25-year-olds who have come to the attention of the police because of drug use
- 12- to 17-year-olds who have come to the attention of law enforcement agencies because of drug use
- School students who are first-time drug law offenders
- Young adults presenting to emergency departments (not necessarily for substance-related problems)
- School students
- Young people aged 10-19
- Young people aged under 25
- Young people
- Occasional or problem drug users aged 14-21, excluding those who are drug dependent
- Cannabis users aged 14-21
- Drug users aged 15-25
- Young drug users (two BIs).

Target substances

The target substances of the reported BIs were:

- drugs (in general)
- alcohol
- drugs and alcohol
- cannabis
- cannabis and alcohol
- alcohol, tobacco and cannabis
- alcohol, cocaine and cannabis
- tobacco and alcohol
- tobacco, drugs and alcohol.

Of the 28 BIs for which information was provided, drugs were reported as target substances for 21, alcohol was a target substance for 14 and tobacco was a target substance for three. However, as highlighted earlier, this relatively high number of BIs identified with a focus on illicit substances is likely to be a reflection of the search strategy.

Modes of delivery and intervention approaches

The interventions identified used a variety of modes of delivery:

- face-to-face BIs;
- one BI combined face-to-face techniques and online/app elements;
- some were publicly available self-help online BIs;
- one was a multi-country online BI in Belgium and Hungary that is accessible only by those who have been selected as participants (available in Dutch, English and Hungarian);
- three were telephone BIs.

Around half of the BIs were based on face-to-face interactions with the users, one combined face-to-face and online/app methods and the few remaining were either delivered online or by telephone.

The internet and/or apps were utilised to deliver BIs in almost half of the countries for which information on BIs was obtained (Belgium, Germany, Ireland, France, Hungary, the Netherlands, Portugal, the United Kingdom (England) and Norway). The methods and tools used by BIs that are publicly available online vary: some simply automatically compare visitors' drug and/or alcohol use with that of others who complete the assessment, and give brief advice based on the result. Some websites offer a chat facility through which a visitor is advised by a 'real' person. In addition, the Quit the Shit website (Germany) offers visitors the opportunity to pursue a 50-day online programme that includes individualised feedback from a counsellor.

As Moyer and Finney (2004, p. 44) concluded a decade ago, in a paper on factors that facilitate the implementation of BIs, 'New modes of delivery, such as via computers, the Internet, and interactive multimedia presentations, may help to surmount some of the challenges of wide dissemination, such as strains on expertise, time, and resources'. Research on these methods has cautiously reached positive conclusions, as the following studies identified in the literature review show:

- Bonar et al. (2014) reported on a randomised controlled trial (RCT) focusing on drug use and HIV (human immunodeficiency virus) risk, in which emergency department patients were randomised to an intervener-delivered BI assisted by computer, a computerised BI and enhanced usual care. They found that technology-enhanced computerised BIs for the emergency department setting, in particular, are promising and well-received by patients.
- Khadjesari et al. (2011) conducted a meta-analysis of 24 studies that measured the effect of computer-based interventions on total alcohol consumption and the frequency of binge drinking episodes. They concluded that these interventions may reduce alcohol consumption compared with assessment-only interventions. The conclusion remained tentative, however, because of methodological weaknesses in the pertinent studies.
- After conducting a systematic review of the research evidence on online interventions from 17 RCTs, predominantly involving brief personalised feedback interventions for at-risk, heavy or binge drinkers, White et al. (2010) concluded that users can benefit from such interventions and that this approach could be particularly useful for groups unlikely to access traditional alcohol-related services, including women, young people and at-risk users. They found that caution was needed because of the limited number of studies allowing the extraction of effect sizes, the heterogeneity of outcome measures and follow-up periods, and the large proportion of student-based studies.
- A report on the project BISTAIRS, which aimed to provide an overview of alcohol interventions in the EU, stated that BIs via computer or mobile phone seem to be a good way of engaging young adults who might otherwise not be reached (Schmidt et al., 2014).

Most of the BIs contained elements of MI (although this method was not named as such in every case), confirming that there is a close relationship between BIs and elements of MI. It was not possible to ascertain which elements of MI were used, but they mainly aimed to motivate participants to change their behaviour using empathetic, non-judgemental MI techniques. In one case, cognitive behavioural therapy was used.

Although it is highly probable that all the BIs involved an element of screening, the standard screening tools applied were named for only seven: ASSIST (one); AUDIT (two); AUDIT and AUDIT-C (one); CRAFFT (one); and SURPS (two) ⁽⁴⁾. The information provided for a further three BIs mentioned screening, but did not identify the tool used.

Intensity and duration of sessions

In the BIs identified in this study, the number and duration of sessions ranged from just one short conversation to up to four sessions totalling 8 hours. Screening was usually part of the first session or was conducted beforehand.

The different patterns of sessions reported for the BIs included in the study are outlined in the following sections.

Face-to face brief interventions

- One session and one follow-up session
- One short conversation
- One session of 15-20 minutes
- One session of 30 minutes minimum
- Two 90-minute sessions
- Four sessions
- Four 2-hour sessions
- Four sessions (two 90-minute sessions, two 45-minute sessions)
- Twelve short modules.

Face-to-face and online/app brief interventions

- One session and one follow-up questionnaire.

Online and telephone brief interventions

- It is likely that the seven online self-help BIs and three telephone helpline BIs reported consisted of one session each, of variable length. In the case of the German Quit the Shit website, this can be extended through additional elements to a 50-day programme.

Delivery features

This section presents findings concerning the time periods during which the BIs were delivered; how widely the interventions were made available; who delivered the interventions and what training they had; and the overall numbers of participants.

Time period over which the interventions were delivered

Information on the dates between which the reported BIs were delivered was frequently unclear or missing, and precise dates were available for only very few interventions. Some of the interventions had been operational for several years, while others had been delivered for a much shorter period. Only a few BIs (including four online BIs) were known to be being delivered at the time of writing.

⁽⁴⁾ ASSIST, Alcohol, Smoking and Substance Involvement Screening Test; AUDIT, Alcohol Use Disorders Identification Test; AUDIT-C, a shorter version of AUDIT, concerned with alcohol consumption only; SURPS, Substance Use Risk Profile Scale.

Geographic coverage

Most BI were delivered nationally (assuming that the telephone helplines and the self-help online BIs were available across the countries where they were based), but four face-to-face BIs were delivered in only certain cities or regions of the relevant countries.

Delivery staff and their training

There was no information on who delivered almost half of the reported BIs. Of the others, around half were self-administered online or by app, while the remainder were delivered in a variety of ways:

- self-administered after encouragement by a youth worker in one case, and administered by staff in emergency departments in the other;
- delivered by a variety of health and social care professionals who had been trained to deliver the BI;
- delivered by a qualified counsellor and a co-facilitator;
- delivered by police officers;
- delivered by staff in primary care, accident and emergency departments, and antenatal care.

The list above gives some indication of the diversity of professionals that delivered the interventions. An expert meeting held at the EMCDDA in January 2013 considered training to be essential for successful implementation and that it should focus on communication skills and prejudices, as well as on providing information on addiction. It was agreed that staff need to be trained in person-centred communication skills, taking time to listen carefully and being prepared to make a lot of effort to help people think through their situation. In addition, professionals must be supported by and connected with a referral system for specialised treatment. One day of training could be sufficient for most professions ⁽⁵⁾.

The 2012 and 2013 National reports provided information on training programmes as follows:

- Bulgaria reported two training courses, one that targeted general practitioners and the other targeted a wide variety of healthcare, social care and educational workers;
- Ireland provided training courses for nurses and midwives;
- Spain provided training for primary healthcare professionals;
- Poland reported the provision of training for those delivering the FReD Goes Net programme;
- in Slovakia, employees of educational counselling institutions and special educational facilities were trained in BIs;
- Denmark reported that its health authorities are developing a course on BIs.

Delivery sites

The BIs were delivered in a variety of settings:

- online (public access)
- online and/or app (private access)
- via telephone
- schools
- methadone clinics
- a travelling bus
- young drug users' homes
- primary care, emergency department and antenatal settings.

⁽⁵⁾ See minutes at <http://www.emcdda.europa.eu/html.cfm/index222964EN.html>

Almost half of the settings comprised publicly available websites (seven) and websites and/or apps (two) that could be accessed only by participants in the BI. A further three were delivered by telephone. The remainder used one of the wide variety of other delivery sites shown above.

Number of recipients

Face-to-face BIs can be delivered to individuals or small groups. Of the reported face-to-face BIs (including one that combined face-to-face contact with an app), most had information on the number of recipients. The five FreD programmes, the two Preventure programmes and one other BI were delivered to groups, while four were delivered to individuals. The remaining BIs (a combined face-to-face and online/app BI, the publicly available self-help online BIs, the online BI that is accessible only by those who have been selected as participants and three telephone BIs) were all delivered to individuals.

Information on the overall number of recipients was found for only six of the BIs. Obviously, the numbers vary according to the length of time for which a BI was delivered, and also the resources invested in it. In the case of these six BIs, the total number of recipients ranged from 160 to more than 210 000. A detailed breakdown of these recipients is provided below:

- During the eSBIRTes BI in Belgium and Hungary:
 - 449 emergency department patients were selected for screening;
 - 236 completed the online screening while in hospital;
 - 213 were asked to complete the screening at home, but only five (2.3 %) did so; and only 11 (5.2 %) completed the follow-up questionnaire ⁽⁶⁾.
- In 2013, Tossman ⁽⁷⁾ reported that on the Germany-based Quit the Shit website, 5 000 visitors a month complete the cannabis questionnaire and 12 000 visitors a month complete the alcohol questionnaire. Around 600 of the website users (aged 15-30) per year go on to follow a 50-day internet-based programme.
- The BI in Ireland, which targeted hazardous alcohol users receiving drug treatment with methadone, reported that 710 were screened, 160 received the BI and 91 % of these were rescreened after 3 months (Darker et al., 2012).
- In Romania in 2011, there were 129 FReD Goes Net courses, with 1 045 participants. In 2012, there were 103 courses, with 987 participants ⁽⁸⁾.
- During the Street Talk project in England (United Kingdom), 2 196 10- to 19-year-olds were screened for substance misuse and 807 were assessed as requiring the BI (Hart et al., 2012).
- In Scotland (United Kingdom), more than 174 205 alcohol-related BIs were delivered during the 2008-2011 period, exceeding the target of 149 449. A 1-year extension had a target of 61 081, which was achieved (Beeston et al., 2012).

Evaluation and effectiveness

Evaluations were found for a third of the reported BIs (10), with outcomes being measured in only five cases. Evaluations can give an indication of the quality of a BI. Process evaluations can provide useful information, including whether or not the interventions are acceptable to both those receiving and those delivering the intervention, the ease of delivery, and barriers to and facilitators of delivery. Outcome evaluations, to provide strong evidence of causality, should ideally be conducted as RCTs or other experimental designs with controls. However, these designs were rare: only two of the 29 BIs detailed in this report conducted RCTs, and both were delivered in the Netherlands (the online Wiet-Check pilot and a Preventure project). However, no details of the former were found. Outcome

⁽⁶⁾ <http://www.irefrea.eu/>

⁽⁷⁾ See presentation at <http://www.emcdda.europa.eu/activities/expert-meetings/2013/brief-interventions>

⁽⁸⁾ <http://www.emcdda.europa.eu/html.cfm/index228495EN.html>

evaluations based on less robust designs should be viewed with caution. This limits the extent to which an assessment of the quality of the BIs reported here can be made.

The reported evaluations targeted a number of different aspects of BIs:

- Preventure ⁽⁹⁾ — an established, evaluated model — was developed in Canada and has been delivered, with cultural adaptations, in several countries across the EU (those delivered before 2010 are not included in this report). One Preventure programme implemented in the Czech Republic was reported in the 2013 National report, but the source of the evaluation results quoted may have been taken from other evaluations of the programme (see, for example, those cited in EMCDDA, 2013, pp. 10-12).
- An RCT reported by Lammers et al. (2015) found that the Preventure BI had little or no effect on the overall prevalence of binge drinking in adolescents in the Netherlands, but may reduce the development of binge drinking over time.
- One external evaluation (Parkes et al., 2011) was concerned with issues surrounding the target of embedding an alcohol-related BI into the National Health Service (NHS) across Scotland. The focus of the evaluation was on the processes of implementation. The evaluation report on the first phase stated that the 3-year target was reached nationally, ahead of schedule, and included the delivery of 174 205 alcohol-related BIs. The authors added that staff found the delivery of these activities worthwhile, and the vast majority of primary care patients accept BIs as part of the general practitioner or healthcare worker's role. The patients appear to have no problem with being offered alcohol screening or BIs. Gaps in coverage were noted, however, especially in rural and remote areas, and in relation to age and gender.
- An outcomes and process evaluation of the Street Talk programme (Hart et al., 2012), which addressed drug and alcohol use among young people in several areas of England, concluded that it had had positive results, including improving their knowledge and confidence in accessing support and making informed decisions around substance use. The majority of the young people agreed that the role of significant others, personal responsibility for behaviour and a greater understanding of the interplay between past and future use, and of the challenge in changing the levels, methods and social behaviour around substance use, were prevalent. The management and coordination structures worked well and most people felt well supported and that relationships were good. The high quality and consistency of the training element appears to have contributed significantly to the effectiveness of the project.
- An internal evaluation of eSBIRTes (Brief interventions for drugs in emergency services) ⁽¹⁰⁾ in Belgium and Hungary concluded that the programme was able to identify clients at high or moderate risk of developing problems related to their alcohol or other drug use. However, only a few clients used the suggested BIs (self-help or self-referral to treatment) that were provided online. It is very likely that the type of drug users reached by this project — young polydrug users — have a limited awareness of the problems associated with substance use. Ending up in an emergency department on a particular night out is considered just an isolated and unrelated episode (EMCDDA, 2016). The evaluation concludes that it is difficult to motivate recreational drug users to change their drug use habits, at least in the opportunistic way attempted by this project.
- In Dublin (Ireland), an implementation study was designed to assess whether or not BIs are effective at reducing harmful or hazardous alcohol use by patients receiving methadone treatment. It addressed two specific questions: how feasible it is for professionals working in methadone clinics to screen patients and deliver BIs to them; and how feasible it is for these professionals to incorporate screening patients and delivering BIs into their typical clinical

⁽⁹⁾ For a description of Preventure, see http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=10UK01&tab=overview
⁽¹⁰⁾ <http://www.irefrea.eu/>⁽¹¹⁾ <http://www.emcdda.europa.eu/html.cfm/index228421EN.html>

workload. Ireland's 2013 National report ⁽¹¹⁾ cites findings from an evaluation by Darker et al. (2012) that AUDIT-C scores were significantly reduced after a BI was delivered. The proportion of men who had a positive AUDIT-C score at the rescreening decreased significantly following delivery of the BI, but this was not the case for women. The authors stated that this could have been the result of the study being underpowered, as only 46 women received the BI after the baseline screening. The only factors used to predict alcohol consumption at baseline screening were gender and length of time of treatment. The only factor used to predict AUDIT-C scores at rescreening was AUDIT-C scores at baseline screening.

- The 2013 National report from Poland ⁽¹²⁾ gives some details of the evaluation of a FreD Goes Net programme conducted in 27 Polish cities. The National Bureau of Drug Prevention evaluated the programme, based on the data from a 2011 finding that, for 87 % of the participants, this was their first drug prevention programme. The referring institutions included schools (30 % of participants), families (25 %), toxicology wards (21 %), courts and prosecutor's offices (10 %), police (6 %), and other institutions. Most participants stated that the programme had improved their knowledge of the risks related to substance use; 44 % of the participants stated that they changed their views on drug use; 43 % were going to cut down on psychoactive substances and 38 % wanted to quit drugs altogether. Among participants 87 % were satisfied or greatly satisfied with the programme and 97 % would recommend it to others. It should be noted that in 2007-2010 (and therefore not included in this report), FreD Goes Net, an established, evaluated model that uses manuals, was delivered across 17 EU countries ⁽¹³⁾ and reported and evaluated by Görden et al. (2010). The 29 BIs reported here include five versions of FreD (e.g. FreD, FreD Goes Net and FreD Goes to School), which were reported in the National reports.

The lack of reported evaluations and RCTs may be the result of a failure to identify them through the research strategies adopted, or because the findings have not been published. However, it may also be because such evaluations have not (yet) been conducted, which in turn may be because there was no funding to do so, especially in the case of the shorter-duration BIs.

Barriers to implementation

An expert meeting on BIs and MI held at the EMCDDA in January 2013 ⁽¹⁴⁾ discussed the issue of barriers to implementation. The debate centred around the inability of primary care and emergency department staff to implement BIs because of a lack of training and resistance to taking on more work (especially because of the sensitive nature of approaching patients to ask about their substance use, even more so in the case of illicit drugs). The importance of training and the provision of appropriate screening tools is also noted in the relevant literature (Klimas et al., 2012).

The United Kingdom programme to embed alcohol BIs into the NHS (Parkes et al., 2011) highlighted the importance of 'high quality training', as did the evaluation of the eSBIRTes project in Belgium and Hungary ⁽¹⁵⁾, which was conducted in emergency departments. However, even after training, staff were unable to see the value or applicability of the intervention in terms of the potential impact on longer-term health service engagement and demand, resulting in a negative impact on the perceived acceptability and usability of the intervention.

⁽¹¹⁾ <http://www.emcdda.europa.eu/html.cfm/index228421EN.html>

⁽¹²⁾ <http://www.emcdda.europa.eu/html.cfm/index228479EN.html>

⁽¹³⁾ For a description of Fred Goes Net, see

http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=01DE11&tab=overview

⁽¹⁴⁾ See minutes at <http://www.emcdda.europa.eu/html.cfm/index222964EN.html>

⁽¹⁵⁾ <http://www.irefrea.eu/>

The lack of (or sparse) detail on the outcomes and evaluations of the majority of the BIs reported here means that there was little information about barriers to implementation. Of the five BIs for which evaluations were found, three addressed implementation as an issue:

- The eSBIRTes evaluation points out that, because of data protection issues, ethical approval for interventions involving NHS patients in the United Kingdom could not be obtained in time to implement the BI there. The same issue arises with regard to the Preventure programme, which was developed in Canada. In an EMCDDA Thematic Paper examining the programme's transferability to Europe, medical ethical procedures had to be followed in the Netherlands to prevent stigmatisation of those selected for the programme (EMCDDA, 2013). However, the paper also noted that the largest barrier was 'the structural and organisational environment of schools', where resistance 'to a sophisticated and resource-intensive intervention' was encountered.
- The programme that delivered alcohol-related BIs in Scotland was designed as an implementation study and was evaluated by Parkes et al. (2011). The evaluation gave many details of barriers to implementation, such as time constraints, problems with remembering to deliver and record delivery, computer interface issues, interpersonal dimensions of the encounter and under-reporting.
- The evaluation of Street Talk in England (Hart et al., 2012) revealed that the barriers most consistently cited by the project's stakeholders (¹⁶) were the 'linked factors of short timescale and funding delays' (p. 40), which negatively affected both the planning and implementation stages.

Other barriers include attrition and the potential refusal of participants to take part in the screening and/or the BI and/or any follow-up assessments. Three of the 29 BIs had some details of this, showing a wide range of attrition rates:

- In the eSBIRTes project (¹⁷) in Belgium and Hungary, 236 participants completed the online screening and assessment immediately after recruitment, of whom 231 were asked to log on to the assessment at home. Of the latter group, only five did so: an attrition rate of 97.8 %. In addition, only 11 (4.6 %) of the 241 who completed screening responded to the follow-up questionnaire 8 weeks after the BI.
- The Street Talk project in England found an attrition rate of 3 % from before the intervention to the after-intervention questionnaire completion, and a rate of 62 % from after the intervention to the follow-up period of questionnaire completion (Hart et al., 2012, p. 27).
- The project in Dublin (Ireland) that addressed alcohol use among methadone patients reported a 9 % attrition rate at follow-up.

(¹⁶) Identified in this instance as 'National Project Manager, the National Lead and, by area, the Addaction Manager, Addaction Co-ordinator, local Commissioner, representatives (usually managers) from the local delivery partners and young people' (p. 34). The charities Addaction and Mentor UK managed the project.

(¹⁷) <http://www.irefreea.eu/>

4. Discussion and conclusions

BIs are appealing because they are brief; some (but not all) research supports their effectiveness; they can be delivered in a variety of settings and by a variety of workers after brief training; and they are relatively low cost. Cost is a significant issue as health and social services across the EU, Norway and Turkey are frequently being directed to cut their budgets. BIs can also be implemented in a vast range of settings beyond primary healthcare or emergency department settings, for example in party environments, on the internet, in streets and in schools.

The limitations of this investigation are that information in only English could be sought and that the countries' annual National reports to the EMCDDA report mainly on illicit drug BIs rather than those primarily targeting only alcohol and/or tobacco. There is also no specified format for reporting on these interventions, so the level of detail available was variable. No information could be found for more than one third of the BIs on the level of dissemination, number of sessions and duration of the intervention, delivery site, tools and methods, and delivery staff. With regard to the dates between which the BIs were delivered, there was no information for more than half of the BIs, and information on the number of recipients and evaluations was particularly sparse.

Because of the gaps in the information collected during this investigation, a reliable assessment of the quality and effectiveness of the reported BIs cannot be attempted. Five evaluations were found, but their reports of success should be viewed with caution.

Despite these limitations, the results illustrate the appeal and feasibility of this type of intervention. In addition to the BIs identified during this investigation, two reports of drug- and alcohol-related BI protocol development were included in 2013 National reports, one a multi-country project (a two-arm RCT in Belgium, the Czech Republic, Germany and Sweden) and the other in Ireland. The 2012 and 2013 National reports also describe six training programmes for those delivering BIs in Bulgaria (two), Ireland, Spain, Poland and Slovakia; and one incipient training programme in Denmark was later reported.

The limitations of this investigation mean that caution must be exercised when making any generalisations about alcohol-, tobacco- and drug-related BIs across the 28 EU Member States, Norway and Turkey. Nevertheless it is possible to identify some common characteristics of the BIs included in this study, namely that they:

- are labelled as 'brief', 'short' or 'early' interventions;
- are funded and managed by a variety of local/national health (including drug and alcohol) services, education and social services, charities and the criminal justice system;
- are mostly likely to be delivered as face-to-face BIs, followed by self-administration online or by app, rather than by telephone;
- are delivered in a variety of settings where the target group can be accessed (schools, drug services, travelling buses, homes, hospitals or wherever the target group uses the internet, telephone or apps);
- are concerned with selective and indicated prevention;
- aim to prevent substance use, delay initiation, reduce its intensification and/or prevent escalation into problem use;
- are delivered by a variety of health and social care professionals (including general practitioners and other primary care staff, counsellors, youth workers and police officers) who have been trained to deliver the intervention, or self-administered online or by app;
- most often target young people, but also others at risk of problem substance use;
- incorporate elements of MI;
- usually consist of one to four sessions of varying length;

- are unlikely to have been evaluated and even more unlikely to have been rigorously evaluated;
- have not been the subject of a paper in an academic journal, meaning that their operation and results are not disseminated via the international literature.

The current scarcity of rigorous evaluations and RCTs makes it difficult to assess and endorse 'what works' in the case of BIs. Although, among BIs, the effectiveness of alcohol-related BIs has been researched the most thoroughly, they are not yet supported by the evidence from all sample populations and settings, or in the long term. For BIs for substances other than alcohol, the level of evidence is even less convincing. Nevertheless, low cost, easy delivery, a wide range of possible applications and some positive evidence still make BIs an interesting and attractive approach.

Therefore, it is desirable to monitor the implementation of BIs within Europe, and consideration should be given to establishing a network of experts representing each country who could access information from the wide variety of funders and deliverers and conduct searches for information in their own language(s). This is particularly important, as this investigation found that detailed information about most of the reported BIs was not disseminated via the international literature or the internet and is therefore inaccessible via searches.

Almost one third of the reported BIs were delivered using the internet and/or a phone app, and these methods were considered to be particularly appealing to young people. However, again, the lack of evaluations and RCTs means that their effectiveness and quality is unknown. It is recommended that more evaluations and RCTs are conducted for BIs that use these technologies.

As discussed in the introduction to this report, there is no standard definition of 'brief intervention' and one of the aims of this overview was to begin to establish how BIs are defined in practice. The heterogeneity of the elements of the reported BIs demonstrates the complexity of formulating a definition that fits all BIs. It is also apparent that the dividing line between BIs and treatment can sometimes be blurred. It is therefore recommended that any future data collection considers refining the definition of a BI, which should lead to more harmonised information collection.

This report has highlighted some other key criteria that might be useful in defining BIs and might be incorporated into future information collection in Europe. Defining features of BIs might be that:

- they include elements of MI, and not solely information provision or counselling (otherwise, any short talk by an outreach worker on the risks of substance use would have to be considered a BI);
- they operate in the transitional field between prevention and treatment, and aim to avoid the development of a substance use pattern that would need treatment (otherwise, many harm reduction interventions with motivational elements or smoking cessation interventions would have to be considered BIs);
- they are interactive and client centred (if not, a number of websites with targeted information could be seen as BIs).

Many of the barriers to the implementation of BIs centre around staffing, especially the lack of adequate training and commitment to delivering the intervention. Therefore, support for the implementation of BIs should stress that, although the intervention is relatively low cost, it is essential that staff training — not only on how to implement a BI but also why it is necessary — and time for staff to deliver the intervention are provided.

In summary, based on this review, recommendations for those interested in exploring the potential for the use of BIs in Europe are:

- A standard definition of BIs should be established to facilitate the collection of more harmonised information.
- The collection of input from experts in each country should be considered, in order to improve the monitoring of BI implementation.
- More evaluations and RCTs for BIs need to be conducted.
- The importance of staff training (on not only how to implement a BI but also why it is necessary) should be highlighted.
- Those designing BIs should not assume that success in alcohol-related BIs will transfer automatically to BIs that target drugs and tobacco.
- The establishment of a comprehensive database of BIs in the EU, Norway and Turkey should be considered.

Following the above recommendations should result in a more comprehensive description of BIs in the EU, Norway and Turkey, and their effectiveness, than has been possible to present in this report. This information could then be used by those wishing to implement BIs to assess the feasibility and likely effectiveness of introducing BIs into existing prevention, primary care and treatment systems.

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Annex 1: Brief interventions identified in the study for substance use in the European Union Member States, Norway and Turkey, 2010-2014

Country	Name of BI	Method of administration	Description	References/ links
Belgium	<i>Me-assist</i>	Face-to-face	Early detection of substance use; the BI assesses the seriousness and need for treatment. It uses a short intervention for information provision, MI or referral to treatment. Interview about the use of, and problems related to, alcohol, cannabis, cocaine, amphetamine-type stimulants, hypnotics and sedatives, hallucinogens, opiates, volatile inhalants and tobacco. The duration is around 10 minutes.	http://www.vad.be/sectoren/assist.aspx
	<i>Everyone drinks, everyone smokes cannabis</i>	Face-to-face	Individual counselling about alcohol and/or cannabis for CLB (Centre for Pupil Counselling), youth care or other help for young people. The BI focuses on binge drinking and cannabis use. Brief advice based on normative feedback; conversation guide feedback sheets.	http://www.vad.be/sectoren/onderwijs/secundair-onderwijs/in-de-kijker.aspx
	<i>Druglijn</i>	Online	The tests can be used to: verify the risks of use, and to encourage reduced use or cessation of use. The Druglijn contains a section with online assessment tests and online self-help programmes. The Centres for Alcohol and Drug Problems (CADs) and Drug Aid Limburg run an online assessment test, and online treatment programme. Participants are asked 10 questions. The online self-help programmes have a duration of 4 to 6 weeks.	http://www.druglijn.be/aan-de-slag.aspx http://www.drughulp.be/
	<i>eSBIRTes (Brief interventions for drugs in emergency services)</i>	Online	Based on SBIRT (Screening, Brief Intervention, Referral and Treatment), the eSBIRTes project aimed to identify and develop successful, feasible and acceptable e-health tools for staff in emergency departments. After being treated for their acute health problem, all clients meeting the inclusion criteria are screened using the ASSIST questionnaire (Alcohol, Smoking and Substance Involvement Screening Test). The screening can result in three different outcomes: low, moderate or high risk. Clients who scored in the low-risk range received brief motivational advice and a link to local/national drug information websites. Moderate-risk clients were referred to an online self-help module (piloted at festivals). Clients in the high-risk range received brief motivational advice to find professional help. Those who were not motivated to accept a referral to treatment were directed to the self-help module. The intervention consists of one online screening session and a follow-up questionnaire.	https://www.esbirt.org/
Croatia	<i>MOVE</i>	Face-to-face	Motivational BI for young consumers; it has been adapted from a German project and modified in accordance with Croatian needs. It consists of counselling, based on MI, a client-oriented approach and social and psychological theories on attitude and behaviour adjustment. The objective is to engage with young people who would not seek counselling on their own and who prefer brief meetings. The intervention consists of 12 modules/units.	http://www.gruene-liste-praevention.de/nano.cms/datenbank/programm/85

Country	Name of BI	Method of administration	Description	References/links
Cyprus	<i>FreD Goes to School</i>	Face-to-face	Based on the principles of MI and psycho-educational methods, the intervention aims to prevent young people from starting to smoke tobacco and to reduce the number of young smokers in schools. It covers the following contents: knowledge of the effects and risks of alcohol and smoking, and the legal aspects; reflecting on personal patterns of, and motives for consumption; and practical tips for limiting consumption or quitting. It targets young smokers who smoke on school premises or at school events, and who are referred by the principal to FreD Goes to School rather than subjected to disciplinary measures. The programme also gives participants information about alcohol. The intervention consists of four 2-hour small group sessions.	http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=CY2010&tab=overview
Czech Republic	<i>Preventure</i>	Face-to-face	Brief, indicated school-based programme for adolescents. The intervention uses cognitive behavioural therapy to deal with 'hot thoughts', impulsivity and negative automatic thoughts. It aims to target personality risk factors for early-onset substance use disorder and other risky behaviours. It uses SURPS (Substance Use Risk Profile Scale) and ESPAD questionnaires (European School Survey Project on Alcohol and Other Drugs) for screening. The intervention consists of 4 sessions with small groups, lasting 45, 90, 90 and 45 minutes (extended from the original Preventure programme, which has only two 90-minute sessions).	http://www.adiktologie.cz/cz/articles/detail/218/1681/
Denmark		Online	Eleven health promotion packages including prevention of alcohol, tobacco and drug use. Materials for general practitioners and hospitals in Denmark with a focus on BIs and the detection of risk factors.	http://sundhedsstyrelsen.dk/~media/F62F9FBE45034981829DB633AE88AF18.ashx
France	<i>Counselling clinics (CJCs)</i>	Face-to-face	National programme established by the government in 2004, to prevent drug-related problems. It is currently implemented throughout French territory. It delivers the BI using motivational counselling. Approximately 30 000 people have been admitted to CJCs in 2014.	http://www.drogues-info-service.fr/Tout-savoir-sur-les-drogues/Se-faire-aider/Les-Consultations-jeunes-consommateurs-CJC-une-aide-aux-jeunes-et-a-leur-entourage#.WA9n4kZffl4
	<i>Alcohol prevention</i>	Face-to-face and telephone	BI in an emergency hospital setting for heavy-drinking adolescents aged 16-25. It has been accompanied by an RCT.	http://en.ofdt.fr/
	<i>Addict'prev</i>	Online	Website based on BI principles and a motivational approach, targeting young drug users, many of them	http://www.ad

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			(around 50 %) referred by the criminal justice system. Offers general information on substance use, addictive behaviours, prevention measures and support initiatives, and resources for self-assessing use of alcohol, tobacco and cannabis. People demonstrating harmful use behaviour are referred to the university healthcare system. The intervention consists of one session.	dictprev.fr/
Germany	FreD Strafverfolgung	Face-to-face	FreD stands for <i>Frühintervention bei erstauffälligen Drogenkonsumenten</i> . It is a model-project, early intervention among first-time drug offenders, with the objective of intervening without initiating criminal proceedings. FreD aims to motivate participants to change their behaviour with a target of reducing consumption and changing attitudes towards drug use. Initial interviews and group sessions are based on MI techniques. The intervention consists of one interview followed by a total of 8 hours of small group sessions.	www.fred-goes-net.org www.lwl-fred.de
	Quit the Shit	Online	Internet-based, short-term intervention programme for young cannabis and alcohol users intended to communicate health-related knowledge, to promote health-related attitudes and to support behavioural change (BZgA). The tools are questionnaires on cannabis and alcohol use ('cannabis check' and 'check-your-drinking'), which check consumption compared with reference populations (age, gender, etc.). The programme involves keeping a diary, discussion, exercises and weekly individualised feedback from a counsellor: a systemic, solution-focused approach, with MI elements The intervention consists of one session for completing the online questionnaire and a 50-day internet-based programme.	https://www.quit-the-shit.net/qts
Ireland	Hazardous alcohol use by drug users receiving methadone treatment	Face-to-face and online	Self-assessment and BI tool. Designed as an implementation study in order to assess whether BIs were effective in reducing harmful or hazardous alcohol use by patients on methadone treatment. Screening with AUDIT (Alcohol Use Disorders Identification Test) and AUDIT-C (a shorter version of AUDIT, concerned with alcohol consumption only), with a 3-month follow-up. The BI used a World Health Organization protocol for a clinician-delivered single BI to reduce alcohol consumption. The intervention consists of one session and one follow-up session after 3 months.	Darker, C. D. et al. (2012)
Greece	PEGASUS	Face-to-face	Mobile Information Unit (KETHEA), suspended in 2012. The intervention was national and conducted in a specially adapted bus	http://www.ekt.epn.gr/
	SOS Drugs Help Line ITHAKI Open Line	Telephone	Three telephone BIs: Open Line (18 ANO Dependence Treatment Unit, Attica Psychiatric Hospital); ITHAKI Psychological Support Help Line (KETHEA); and SOS Drugs Help Line (OKANA). Information about drugs and the available demand reduction structures in the country, brief individualised counselling, motivation for seeking help, direct aid and psychological support for prompt crisis management (e.g. drug-related suicidal behaviour, relapse prevention) and/or referral.	www.hellasnet.gr/tendetox http://www.ekt.epn.gr/
Hungary	eSBIRTes	Online	BIs for drugs in emergency services. Based on SBIRT (Screening, Brief Intervention, Referral and Treatment), the eSBIRTes project aimed to identify and develop successful, feasible and acceptable e-health tools for staff in emergency departments. After being treated for their acute health problem, all clients meeting the inclusion criteria are screened using the ASSIST questionnaire (Alcohol, Smoking and Substance Involvement Screening Test). The screening can result in three different outcomes: low, moderate or high risk. Clients who scored in the low-risk range received brief motivational advice and a	www.integration.samhsa.gov/clinical-practice/SBIRT

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			link to local/national drug information websites. Moderate-risk clients were referred to an online self-help module (piloted at festivals). Clients in the high-risk range received brief motivational advice to find professional help. Those who were not motivated to accept a referral to treatment were directed to the self-help module. The intervention consists of one online screening and one follow-up questionnaire after 8 weeks.	
Luxembourg	Choice	Face-to-face	Launched by Médecins Sans Frontières, Youth Solidarity (currently Solidarité-Jeunes asbl) in collaboration with the Public Prosecutor's Department of Youth Protection, the Ministry of Health and the Judicial Police Drugs Unit, and based upon a pilot project of early intervention for first-time drug offenders (FreD), it aims to offer young people an early and short-term intervention in order to prevent further development of drug misuse and addicts. An intake interview allows an assessment of whether a participation in the CHOICE project or an individual psychological follow-up is indicated. In the CHOICE group, information is provided about drugs, legislation and treatment services. Police officers hand out CHOICE leaflets, which include all the information on the intervention, to young people in breach of the drug law. The officers also inform the Public Prosecutor's Department of Youth Protection. CHOICE consists of four interactive sessions with six to eight participants.	http://www.gouvernement.lu/3379505/Rapport-national-sur-l-Etat-du-Phenomene-de-la-Drogue-et-des-Toxicomanies-Edition-2013.pdf
	ProST	Face-to-face	In 2015, the Youth Solidarity service, financed by the Ministry of Health, launched a new intervention programme (programme for self-responsible drinking), similar to CHOICE, but specifically designed for alcohol misuse.	http://www.relis.lu/
Netherlands	Preventure	Face-to-face	A brief, indicated school-based programme. It is a tailored intervention based on cognitive behavioural therapy and MI specifically to prevent binge drinking. The aim of Preventure is to target personality risk factors for early-onset substance use disorder and other risky behaviours (hopelessness, depression, anxiety-sensitivity, impulsivity, sensation-seeking, desire for intense and novel experiences, etc.). Substance use can be a self-medication response to these personality traits. The intervention consists of two 90-minute small group sessions.	http://www.kcl.ac.uk/ioppn/depts/addictions/research/legacyprojects/PreVenture.aspx
	Wiet-Check	Online	BI aiming to provide information and advice about cannabis use to young users aged 14-21. Self-administered and based on ACCU (Australian Adolescent Cannabis Check-up), which is delivered in a motivational style The intervention consists of one session.	http://www.trimbos.nl/onderwerpen/prev
Poland	FreD Goes Net	Face-to-face	Early intervention for young drug users aged 14-21, excluding drug-dependent individuals. Sessions are held in small groups. The programme uses the MI method. The objective is to make participants more reflective, improve their knowledge of drug use, motivate them to assess risk and act responsibly, change their attitude and behaviour related to drug use, and obtain insight into local drug services.	http://www.kbpn.gov.pl/portals?id=106315 http://fredwploc.ku.tumblr.com/
Portugal	Before you get burned (Antes que te Queimes)	Face-to-face	A peer-led outreach project in recreational settings that promotes critical literacy among partygoers using peer-to peer counselling to promote self-reflection and facilitate behavioural change based on the message 'Act responsibly before you get burnt'. It also delivers first aid. Since 2007, the process has been repeated twice a year during the local academic festivities (May and October), which involve around 15 000 people per night. The duration of the training for peer educators is 30 hours. Each peer-to peer counselling session in	http://www.sicad.pt/PT/Intervencao/PrevencaoMais/SitePages/Home%20Page.asp

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			recreational settings lasts around 30 minutes.	x
	Linha Vida SOS Droga 1414	Telephone	It is an anonymous and confidential service providing counselling, information and referral in the field of addictive behaviours, dependence and associated topics (adolescence, sexuality, AIDS, among others); online service. It is open 10.00-18.00 Monday to Friday.	http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=1340&tab=overview
Romania	FreD Goes Net	Face-to-face	Early intervention for young drug users. It aims to prevent addiction and reduce harm that occurs as a result of drug or alcohol use, particularly among young people. The basic message of FreD Goes Net is that it is possible to achieve effective prevention at a very early stage, more specifically at the stage when the user has not yet developed an interest in receiving help and advice. The basic purpose is to teach young users to face the risk factors leading to drug use and take responsibility for their actions, thus preventing drug addiction. It targets school students who are first-time drug law offenders. FreD Goes Net courses are conducted with small groups and use elements of MI techniques.	https://www.euronetprev.org/projects/fred-goes-net/
Slovenia	FreD Goes Net	Face-to-face	Early intervention for young drug users. It aims to prevent addiction and reduce harm that occurs as a result of drug or alcohol use, particularly among young people. The basic message of FreD Goes Net is that it is possible to achieve effective prevention at a very early stage, more specifically at the stage when the user has not yet developed an interest in receiving help and advice. The basic purpose is to teach young users to face the risk factors leading to drug use and take responsibility for their actions, thus preventing drug addiction. The course uses Motivational Interviewing aimed at resolving or regulating ambivalence about behavioural change. After completing the course, participants receive a certificate of attendance, which they can submit to the referring institution. The intervention consists of an 8-hour course (four 2-hour sessions).	https://www.euronetprev.org/projects/fred-goes-net/
Sweden	Project Trestad 2	Face-to-face	The project aims at supporting and strengthening different categories of professionals working with adolescents, to enhance their ability to identify and support youth at risk. A project carried out in the three largest cities, Stockholm, Gothenburg and Malmö, with the objective of reducing the use of cannabis among young people under the age of 25. At the slightest suspicion that a young person using drugs, the parents are contacted and the district-level narcotics police make a visit to the young person's home (usually together with a representative from the social services). 'Almost every Swedish municipality was cooperating with the police in matters of illicit drugs in 2012 and nearly 70 % of the municipalities implemented measures related to early detection of drug use among adolescents that are based on cooperation between the police, primary care, social services and parents'.	http://prevention-standards.eu/
	Linköping Model	Face-to-face	The Linköping Model is intended not to prosecute young people, but to draw attention to the problem and possibly motivate contact with healthcare services. If there is the slightest suspicion that a young person is using drugs, the parents are contacted and the district-level narcotics police make a visit to the young person's home (usually together with a representative from the social services).	Wilhelmsson et al. (2009)
	Maria Ungdom	Face-to-face	MUMIN is a project based on collaboration between the Youth Section of the Criminal Police and the Social Services. The aim is to give adolescents and their families quick access to adequate care and	http://www.stockholm.se/Fris

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	Motiverande Intervention (MUMIN)		treatment in conjunction with police action concerning drug-related crime. The outreach social workers at MUMIN strive to participate in the entire process from planning, via operation in the field with the police, to police interrogation and the continued linking to local social services and treatment. The work is mainly focused on crisis support and motivation, in cooperation with relevant social services.	taende-webbplatser/Fackforvaltningssajter/Socialtjanstforvaltningen/Utvecklingensheten/Prevention/Trestad2/Stockholms-delprojekt/
United Kingdom	Alcohol BI	Face-to-face	The Alcohol Brief Interventions aim to reduce alcohol-related harm and to embed alcohol-related BIs into National Health Service (NHS) practice. After screening, using a setting-appropriate screening tool, the BI draws on the ethos of MI and uses a FRAMES approach (Feedback, Responsibility, Advice, Menu, Empathic, Self-efficacy). The intervention consists of a short, structured conversation.	http://www.nhs.uk/focalpoint.aspx
	Street Talk	Face-to-face and online/app interventions	The intervention aims to identify and engage young people who may be at risk of problematic drug use and associated antisocial behaviour and social vulnerability, but have not met the threshold for, nor come into contact with, treatment services. It uses CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) for screening and comprises training for youth workers aiming to deliver MI. Young people are encouraged by youth workers to participate, and participants were given a financial incentive. The intervention consists of one session lasting 15-20 minutes.	http://www.emcdda.europa.eu/html.cfm/index222964EN.html
	Drugs Meter and Drinks Meter	Online	Drugs Meter and Drinks Meter are online interventions designed to allow visitors to think about their substance use and compare themselves with other people (by gender and age) who have completed the questionnaires online, to help them assess the risks they are taking. The aim is to encourage them to be safer and wiser, and to provide them with some simple tools to reduce the risk of harm related to their substance use and point out when their use might be causing them problems. The websites stress that the meters do not tell a person what to do, but reflect back to them what they have shared. The websites say the meters are 'not a doctor. It is not an exact science. Put simply, it is a community of users, aiming to make more informed decisions.' The intervention consists of one session.	http://www.drinksmeter.com/alcohol/DM_Disclaimer.php
Norway	AKAN / Arbeidslivets Komit Mot Alkoholisme Og Narkomani	Online	These BIs are self-help programmes focusing on alcohol, cannabis and cocaine use, and targeting those wishing to change their use of, or addiction to, alcohol, cocaine or cannabis.	http://www.bergenklinikken.no/index.asp?strUrl=1001996i&topExpand=&subExpand