SMAD, Rev. Eletrônica Saúde Mental Álcool Drog.
2018 Jul.-Sep.;14(3):125-127
DOI: 10.11606/issn.1806-6976.smad.2018.152064
https://www.revistas.usp.br/smad

What have we learned about the implementation of Brief Interventions in Latin America?

Since the 1980s, Brief Interventions (BIs) for alcohol and drug abuse began to be developed, implemented and evaluated in the United States and in some countries in Europe[1]. With the support of the World Health Organization (WHO), researches with different methodological designs and approaches were conducted to analyze whether such actions were effective compared to longer and more expensive interventions.

After obtaining some initial evidence, dissemination actions began to be implemented in several countries to promote the use of the method as a preventive action, based on the concept of risky or harmful use, which can transcend the curative and nosological approach and the focus on dependence[2].

Therefore, going beyond the focus on mental health or specializations in addictions, BIs are prevention sciences and, especially in the context of public health, they are, above all, a health education action[3]. From this perspective, Primary Health Care (PHC) is considered a strategic level. The central idea is that, along with the dissemination of screening instruments, BIs would be routinely incorporated into health prevention and education actions in different services, such as those focused on other chronic health conditions[4]. However, in the initial studies conducted in Northern countries, some barriers were already found, especially negative attitudes from professionals and managers to deal with the matter and issues of organization and rationality of services during the insertion of these topics[1,5].

Despite the initial difficulties, mainly from the year 2000 onwards and with the influence of the WHO, Latin American countries launched projects to implement BIs in PHC services, especially in Brazil[3], Chile[6] and Mexico[7]. Some results regarding barriers to implementation were similar to other countries, such as negative attitudes, lack of time and lack of knowledge of professionals to deal with the issue. However, some specificities of the regions were found, such as the low reach of public services, lack of coordination in the health care network, poor physical infrastructure of services[8] and, due to the greater social vulnerability and inequality in Latin American countries, the need and the challenge of incorporating BI actions in other sectors such as social assistance, education and public security[9]. In addition to these factors, another problem is that these countries incorporated BI procedures based on the reality of other countries, which have epidemiological, cultural, structural and organizational characteristics different from the Southern countries.

Regarding the evidence on BIs, data from a systematic review, with or without meta-analysis, showed that this intervention was not different in efficacy and effectiveness from other longer approaches, and it still presented a better cost-effectiveness ratio[10-11]. Despite these initial results, data shows that BIs have a limitation of effects, with loss of results after a few months of its implementation[12].

Based on these results and after great investment in research/training and inclusion of BIs in other levels of care and sectors, more recently, some criticisms to BIs and the necessity to rethink its implementation began to gain strength. Initially, there is criticism about considering this action as a magic solution to drug problems. Secondly, there is the need to rethink these actions beyond a purely procedural approach, in a way that it can be effectively incorporated into health actions, in a more comprehensive manner, adapted to the different contexts and realities, and with an effective coordination with the care network[13]. Finally, the production of evidence is also questioned, due to methodological problems or outcomes measures that lead to limited conclusions about the effectiveness of BIs for different substances and different contexts. In this sense, the recent review by McCambridge and Saitz[14] questions the generalizability of the evidence on BIs for different drugs and contexts, discussing the lack of evidence, the scarcity of more conclusive studies and the great variation in the definition of BIs regarding content, frequency and intensity of the interventions, generating a gap that makes it harder to define the evidence in the area. In Latin America, the characterization of evidence is similar, since the studies are concentrated in Brazil and Mexico, there is a greater emphasis on process evaluation than on efficacy and effectiveness studies, most studies are carried out in PHC with small samples, there is a predominance of studies on alcohol abuse and there is also a great variation in definition or in practices which are called BIs[15].

Therefore, the current perspective regarding BIs encourages greater caution in its implementation, due to the lack of evidence for certain populations and substances and the need for greater conceptual consistency. In addition, there is the need for a more comprehensive and culturally adaptable implementation[15].

Specifically, for Latin America, in addition to the difficulties in its implementation and the lack of evidence in the area, it is possible to highlight a possible perspective. A current discussion proposes that it is necessary to think of BIs not merely as a technique, going beyond overly structured actions and questionnaires and readapting the method based on the greatest potential in our countries, which is community-based work[13]. In this sense, there are several experiences developed in different countries in the area of community health that could incorporate some principles and actions based on BIs that would improve the work regarding alcohol and other drugs[13]. In this regard, it is important to think about actions and methodologies of action and research that are more coherent with our health practices and with the socio-cultural reality of the countries. Obviously, this will promote a new challenge and new ways of producing evidence and knowledge that are also in line with these actions.

Finally, after a few years of research, training and implementation of BIs, we are in a critical phase, in which we must evaluate what we do and what we research and pay attention to the need to adapt this action. While BIs seem important to us, they also have limits of action and need to be rethought, with more and diversified evidence, considering our social contexts and going beyond a mere technology transfer from other countries with other realities.

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