Main findings

Two of the studies (2,3;5) recorded significantly greater decreases in drinking among young people allocated to the brief intervention than comparison patients, an effect which appeared to last up to a year. Both these successful interventions involved a component delivered many days after emergency attendance. The remaining two studies found no significant reductions in drinking due to the interventions.

In three studies the interventions led to significant reductions in alcohol-related problems relative to control groups offered usual care or very brief personalised feedback on an assessment of their drinking (1,2;5). One study (2) suggested a brief intervention encouraged patients to seek alcohol-related treatment. Finally, one study (5) recorded an improvement in AUDIT questionnaire screening scores indicative of risky drinking as well as in one item measuring satisfaction with close relationships.

The authors’ conclusions

The four reviewed studies assessed a variety of brief interventions and were methodologically very different. The small number of studies and their lack of comparability limit the implications that can be drawn. However, findings seem in line with another similar review – but concerning adolescents, and which included studies of patients whose risky drinking was identified through screening – which also found that interventions which reduced drinking occurred several days after attendance or featured booster sessions after initial intervention.

Although caution is required in this interpretation, the findings suggest that an intervention delivered partly or entirely at a distance from the event may be more effective than one delivered only within the emergency department.
emergency service in the hours following admission. However, management in the emergency ward is usually not supplemented by booster follow-up calls several months after the event, and how best to organise this in normal practice is unclear.

With or without booster sessions, in three of the four studies, face-to-face interventions based on the empathic and non-confrontational style of motivational interviewing appeared to sustainably reduce alcohol-related problems (1 2 5).

The extent to which the findings from this review can be generalised to other contexts is uncertain. In the two US studies a third of the patients declined participation, and three of four studies were conducted in English-speaking countries. Language and cultural barriers could potentially threaten implementation of similar approaches in other countries. All the studies involved therapists specifically trained by the study to deliver the interventions. Whether their impacts will be duplicated when interventions are delivered routinely by emergency staff is unknown.

**FINDINGS**

The most promising finding of this review is that alcohol-related problems were reduced by brief interventions in three of four studies, outcomes which are perhaps the prime target for emergency department interventions with young ‘binge’ drinkers. However, rather than three, just one of the four studies actually seems to have recorded problem reductions attributable to the brief interventions they tested, and this was after an intervention divorced from normal practice; details below. A Welsh study was most convincing in its finding of drinking reductions from a practical intervention, but was not conducted in an emergency department; details below.

Apart from questionable evidence of efficacy among young adults in conditions approximating normal practice, emergency department alcohol interventions are difficult to implement in the department, and appointments made for later intervention are often not kept. Together these limitations raise doubts over whether emergency department brief interventions – though they can work – actually will work in normal practice and be implemented widely enough to appreciably improve public health.

**Did three of the four studies find problems reduced?**

One of the studies (2) cited as suggesting a brief intervention encouraged patients to seek alcohol-related treatment and reduced alcohol-related problems did not find either to be the case compared to a control group offered only brief feedback of assessment results. Treatment-seeking and reduced problems were seen in both groups, but without a no-intervention control group, whether they were due to intervention is unclear. Another study (5) said to have found reduced alcohol-related problems did not report such a finding in the account cited in the review. Again the problem scores of both intervention and control patients changed over the follow-up period, but there was no statistically significant difference between them; in this case the control group received usual care only.

That leaves a single US study (1) which over the six months following a brief motivational intervention, and relative to just being given a handout on drink-driving plus a list of local alcohol treatment agencies, did find significantly greater reductions in drink-related risks and problems. It did so as a result of procedures unlikely to be replicated in normal practice. Motivational intervention practitioners were the same research staff who immediately before the 35–40 minute intervention had conducted research assessments, feedback from which was used in the following session. Patients may have reacted to this as one continuous intervention, which would have extended beyond what is conventionally considered ‘brief’. Therapists were specially recruited, extensively trained, and supervised weekly. The control handout focused on drink-driving, so may have seemed irrelevant to the three-quarters of the sample not attending after a motor vehicle accident. In contrast, the focus for the motivational intervention was not tied down in advance, potentially giving it an advantage over and above any advantage gained by the motivational approach. When later the same lead author tested a brief motivational intervention against individualised assessment feedback, no differential effect was found on alcohol-related problems (2).

**Welsh study most convincing and practice-relevant but not in emergency unit**

As in the study described above, the US study (2 3) which found drinking reductions also deployed well trained and supervised research staff for the interventions, and intervention followed what seemed quite lengthy assessments for research purposes conducted by the same staff, procedures divorced from normal practice. In this study, of the 627 patients who might have joined it, just 198 ended up being allocated to the interventions and 161 completed the final follow-up assessment, raising doubts over the applicability of the results to the trauma centre’s entire caseload of young people attending after having drunk alcohol. It may also be relevant that many if not most would have been below the legal drinking age in the USA, perhaps making the results less applicable to countries like the UK with a lower drinking age.

Most convincing in its findings on drinking reductions and possible applicability to normal practice was a UK study conducted in Cardiff (5). However, the intervention was not implemented in an emergency department, but in a jaw and face clinic to which patients were referred from a local emergency department. The distinctive set of patients were mainly young men facially injured in assaults. The study seems to suggest that when the setting is relatively conducive (a clinic insulated from the department, but in a jaw and face clinic to which patients were referred from a local emergency department). The distinctive set of patients were mainly young men facially injured in assaults. The study seems to suggest that when the setting is relatively conducive (a clinic insulated from the department, but in a jaw and face clinic to which patients were referred from a local emergency department) and whose patients attend for lengthy periods) and the patients relative receptive (recently reminded that drinking can result in serious injury, but not distracted by the immediate aftermath of that injury), intervention is not just effective but also practical, being in this study conducted by the clinic’s own nurses after training and while they treated the patient’s injuries.

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Last revised 24 September 2015. First uploaded 24 September 2015

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STUDY 2010 Screening, Brief Intervention, and Referral to Treatment (SBIRT): 12-month outcomes of a randomized controlled clinical trial in a Polish emergency department

STUDY 2009 Counselor skill influences outcomes of brief motivational interventions