

This is the abstract of a study selected by Drug and Alcohol Findings as particularly relevant to improving outcomes from drug or alcohol interventions in the United Kingdom. It was not published by Drug and Alcohol Findings. Unless permission has been granted, we are unable to supply full text. Click on the [Title](#) to visit the publisher's or other document supplier's web site. Other links to source documents also in blue. Hover mouse over orange text for explanatory notes. The abstract is intended to summarise the findings and views expressed in the study. Below are some comments from Drug and Alcohol Findings.

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► [The impact of screening, brief intervention, and referral for treatment on emergency department patients' alcohol use.](#)

Academic ED SBIRT Research Collaborative.

Annals of Emergency Medicine: 2007, 50(6), p. 699–710.

Just a few minutes with specially hired screening and intervention staff can make a difference to emergency patients' drinking, but in the real world the hospital's own staff will usually do this work. A US study tested this real-world scenario and still found (modest) drinking reductions.

Abstract The study set out to determine the impact of a screening, brief intervention, and referral for treatment (SBIRT) programme in reducing alcohol consumption among emergency department patients. Patients drinking above US National Institute of Alcohol Abuse and Alcoholism low-risk guidelines (men, more than 7 UK units in a day and no more than 24.5 in a week; women, no more than 5.25 UK units in a day and no more than 12.25 in a week) were recruited from 14 sites nationwide from April to August 2004. A quasi-experimental comparison group design was used in which control and intervention patients were recruited sequentially at each site. Control patients received a written handout. The intervention group received the handout plus a brief intervention (the Brief Negotiated Interview) to reduce unhealthy alcohol use. Follow-up surveys were conducted three months later by telephone using an interactive voice response system. Of 7751 screened patients, 2051 (26%) exceeded low-risk limits. Of these, 1132 (55%) agreed to join the study and were enrolled (581 control, 551 intervention). Of these, 699 (62%) completed the three-month follow-up survey. At follow-up, patients receiving a Brief Negotiated Interview reported consuming 3.25 fewer US standard drinks (45.5gm alcohol or nearly 6 UK units) per week than controls, and the maximum number of drinks per occasion was almost three quarters of a drink (10gm alcohol or just over one UK unit) less than controls. At-risk drinkers (CAGE score less than 2) appeared to benefit more from a Brief Negotiated Interview than dependent drinkers (CAGE score greater than 2). At three-month follow-up, 37% of patients with CAGE less than 2 in the intervention group no longer exceeded low-risk limits compared to 19% in the control group. The authors concluded that screening, brief intervention, and referral for treatment appears effective in the emergency department setting for reducing unhealthy drinking three months after intervention.

Previous studies have shown that just a few minutes spent addressing the drinking of at-risk drinkers among emergency patients can reduce consumption and alcohol-related injuries, improve welfare, promote treatment uptake, and cut the future workload of emergency services. But in all the studies of non-admitted emergency patients, specialist staff were used to intervene with patients and generally also to screen them, yet in the real world usually the hospital's own staff will do this work. This US study went part way to testing a more real-world scenario by training hospitals' own emergency staff to conduct the intervention. In [England](#) and in [Scotland](#), national policy promotes such initiatives as a key way to reduce alcohol-related harm.

The featured study was carefully designed and eliminated major threats to the validity of its findings, except for the third of patients who could not be followed up, a testament to the [transient nature](#) of US heavy drinking emergency patients. The main question is not over the validity of the findings, but over whether these mean (as the authors believed) that such programmes should be considered for routine implementation. Screening was done by dedicated research staff; experience is that when hospital staff are relied on, unless they are motivated and committed, few people who might benefit from intervention are identified. Despite research-aided screening, on average each interventionist counselled just one patient every 19 days, a figure which might have risen to one every 10–11 without the encumbrance of research procedures. In the absence of dedicated screening personnel, throughput would probably have been much less. Along with the small size of the [extra](#) drinking reductions attributable to the interview, and their concentration among the least problematic drinkers, such considerations raise doubts over the cost-effectiveness of training emergency department staff in alcohol interventions. It may also be relevant that the sites in the trial were the 14 US *academic* departments, whose commitment to implementing evidence-based practice is unlikely to be matched across the board. Elsewhere the extra drinking reductions might have been smaller.

Another way to view the results is to look not at the *extra* impact of the interview, but at the *total* impact of the entire intervention package. In UK units, patients' typical drinking per week fell from on average just over 39 units to just under 25, a drop of nearly 15 units or over two units a day. The interview led an extra 9% of patients to dip below US risky drinking limits, but after the entire package nearly 28% did so. Such figures look more worthwhile, but are vulnerable to the possibility that some of these improvements would have occurred anyway in the natural course of events, or as a result of the incident which precipitated the emergency visit.

US guidance is available on the [specific intervention](#) used in this study and on emergency department alcohol screening and intervention [in general](#).

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