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► [A systematic review of emergency care brief alcohol interventions for injury patients.](#)




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Nilsen P., Baird J., Mello M.J. et al. [Request reprint](#)

Journal of Substance Abuse Treatment: 2008, 35, p. 184–201.

Confirmation that brief advice to risky drinkers identified in accident and emergency departments can cut drinking and reduce the chance of further injuries and readmissions; the issue now is why this happens sometimes but not always.

Abstract The authors searched for English-language reports of studies which randomly allocated injured emergency department patients to normal care plus a brief alcohol intervention or to normal care without the intervention or with an alternative. Usually the intervention consisted of a single session of advice lasting up to an hour in the department itself or during later care, but some studies used computerised interventions or arranged 'booster' contacts. Studies aimed to test whether these reduced drinking, alcohol-related consequences, or injuries measured up to a year later. 14 reports were found based on 13 studies from the USA and Europe. Generally they targeted patients identified by screening procedures as risky or hazardous drinkers. Of the 12 which reported before and after measures, 11 found significant effects of the intervention on at least some of the outcomes: alcohol intake; risky drinking; alcohol-related negative consequences; and injury frequency. Five studies found no significant differences between outcomes for patients allocated to different interventions or to a control group. More intensive interventions tended to yield more favourable results. Intervention patients achieved greater reductions than control group patients, although there was a tendency for control groups also to show improvements. Variations in study protocols, alcohol-related recruitment criteria, screening and assessment methods, and injury severities limit the conclusions that can be drawn.



Drug and Alcohol FINDINGS The authors felt differences between the studies were so great as to preclude an attempt to [meta-analytically](#) combine the outcomes, leaving the less satisfactory method of counting which studies did and did not find an effect. Of greatest current interest are the studies which compared an intervention against a no-intervention

control group rather than against another intervention. Of such studies which looked for this outcome, four found the intervention further reduced drinking and four did not. Of the similar studies which measured negative consequences of drinking, four found intervention further reduced these, and two did not. Concerning injuries in particular, these were further reduced by intervention in two studies, but not in another. Combining these categories, six studies found that intervention further reduced drinking and/or drink related consequences, but four did not.

Unlike the featured analysis, another [recent review](#) of brief emergency department alcohol interventions did not confine itself to injured patients, but excluded studies where the intervention was conducted during follow-on inpatient care. The result was an overlapping but different set of 13 studies. Combining findings from some of the studies revealed that overall the interventions did not significantly reduce subsequent alcohol consumption and that impacts on alcohol-related problems were variable. However, six to 12 months later, interventions patients were approximately half as likely as comparison patients to have suffered an alcohol-related injury. The three studies on which this estimate was based were all from the USA; two involved only teenage patients whose drinking would have been illegal in that country.

An [earlier analysis](#) investigated injury reductions after interventions targeting problem drinking, regardless of where these took place. As in the featured analysis, the studies were considered too diverse to combine their findings. Reviewers concluded that such interventions reduce injuries and incidents actually or potentially leading to injury, such as falls, motor vehicle crashes, and suicide attempts. When the analysis narrowed in on brief interventions, five of the seven relevant trials found fewer injuries after intervention than in a control group, and in two the differences were statistically significant. Interestingly, these two trials did not find reductions in drinking; across all the studies, injury reductions often did not parallel drinking reductions and vice versa.

This accumulation of evidence is enough to show that brief intervention during or after emergency department admission *can* work, and work against the most stringent and (for the departments themselves) relevant criterion – reducing injuries. It also shows that positive impacts are by no means inevitable. What accounts for why sometimes intervention works, and sometimes does not, [remains unclear](#). Possibly what the researcher sees as the 'intervention' may be overwhelmed by patients' reactions to injury, admission, screening and research assessments, potentially powerful interventions in their own right. Beyond such methodological issues, it could be that interventions work (or work best) only with the heaviest drinkers, or when some kind of [follow-up](#) is factored in, [even if](#) a minority of patients actually attend.

A major limitation of the evidence base is that nearly all emergency department studies used specialist staff 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. A [recent US study](#) went part way to testing a more real-world scenario by training hospital emergency staff to conduct the intervention. It did lead to drinking reductions over and above those resulting from screening, assessment, an alcohol advice handout, and research follow-up. However, the study leaves a question mark over the feasibility of routine screening. Without dedicated staff, screening rates are often very low unless staff are highly motivated or robustly required to comply with screening requirements.

With varying degrees of specificity and enthusiasm, national strategies across the UK recognise the potential value of brief alcohol interventions in accident and emergency departments, but only in Scotland is there a specific requirement in the form of a brief intervention target for the health service, with emergency departments seen as a priority. Research is best developed in England, where a London hospital has shown such interventions can reduce later drinking and re-admissions, possibly an attractive finding for commissioners seeking to meet national targets to reduce alcohol-related hospital admissions. Further pilot studies are planned at nine departments. Details in [background notes](#).

Given this context, commissioners and emergency department managements may not feel alcohol screening and intervention initiatives are mandated either by the evidence or by national policy. However, neither should they ignore the possibility that patients' health can be improved, and department workloads relieved, by brief advice to risky drinkers identified through a rapid screening procedure and/or through **indications** that the attendance was alcohol-related. If procedures permit, screening questions should be built in to routine assessment/triage procedures. Unless actively and continuously monitored and encouraged, screening may be applied haphazardly and to only a small proportion of the patients who could benefit. If possible the intervention should be conducted while the patient is waiting in the department or on the ward if admitted as an inpatient. If a follow-up reminder and progress check (in person or by telephone or letter) can be factored in, outcomes can be monitored and are likely also to be improved. More severely dependent patients require referral to treatment, preferably actively pursued then and there by hospital staff. A letter to the GPs of positive-screen patients would alert them to the need to pay attention to the patient's drinking, and offer a second chance of intervention if counselling in the hospital proved impractical or was refused.

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