

EVIDENCE BRIEF

Alcohol Screening, Brief Intervention and Referral Services in Health Settings

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Key Messages

- Alcohol screening, brief intervention and referral (SBIR) is an effective tool for identifying and reducing high-risk alcohol consumption.
- Alcohol SBIR in a range of healthcare settings, including emergency departments and primary care clinics, can be effective among both adults and adolescents.
- Findings from this evidence brief can help policy makers, primary care providers, hospital administrators and health units decide how to use SBIR to reduce alcohol consumption and associated harms.
- Given the proven link between alcohol and common long-term health harms such as cancer and cardiovascular disease, SBIR may be an effective tool for addressing modifiable causes of chronic diseases. Yet, further research is needed to determine the benefit of SBIR in preventing long-term health harms causally associated with high-risk alcohol consumption.

Issue and Research Question

Alcohol Harms

Alcohol is the most commonly consumed substance in Canada.¹ According to the 2023 Canadian Substance Use Survey, 79% of Canadians aged 15 years and older reported drinking alcohol in the past year.¹ The consumption of alcohol is a causal factor in both short-term and long-term risks.² Short-term risks associated with the consumption of alcohol include violence and unintentional injuries. Chronic consumption of alcohol increases risk for several types of cancers and serious medical conditions such as cirrhosis, pancreatitis, and respiratory disease.²

Canada's Guidance on Alcohol and Health

In 2023, Canada's Guidance on Alcohol and Health was released as an update to the previous 2011 Low-Risk Drinking Guidelines (LRDGs).^{2,3} The 2011 LRDGs specified weekly standardized drink limits to minimize acute and chronic alcohol-related health risks.³ For women, these limits were specified as two standard drinks per day to a maximum of 10 standard drinks per week; for men, the limits were three standard drinks per day to a maximum of 15 standard drinks per week.

Since publication of the LRDGs in 2011, new evidence has emerged necessitating updated alcohol use guidance. Research has demonstrated that people consuming alcohol within the parameters of the Low-Risk Drinking Guidelines were experiencing a high number of alcohol-attributable deaths from chronic disease, including several cancers, and unintentional injury.⁴ Further, previous guidelines have not considered the impacts of alcohol use on social and mental health harms.

The new guidance on alcohol and health has one fundamental recommendation: that people living in Canada consider reducing their alcohol use.² This message is reinforced with four key facts:

1. This guidance establishes a continuum of risk associated with weekly alcohol consumption, where risk is zero for those not using alcohol, lowest for individuals who consume two or less standard drinks per week, moderate for those who consume between three and six standard drinks per week, and increasingly high for those who consume seven or more standard drinks per week.
2. Consuming more than two standard drinks per occasion is associated with increased risk of harm to self and others.
3. There is no known safe amount of alcohol use in pregnancy.
4. It is safest to avoid alcohol when breastfeeding.

Screening, Brief Intervention and Referral

SBIR is one early intervention strategy that has been implemented to reduce high risk drinking among individuals. SBIR was originally developed as a public health tool to provide universal screening for hazardous substance use, and provide secondary prevention by referring individuals to appropriate treatment.^{5,6} The intention of SBIR is to motivate people engaging in high-risk alcohol consumption to reduce their use, and to connect individuals to supportive care.⁷ By identifying high-risk individuals through universal screening, a brief intervention is delivered followed by a referral to treatment, where appropriate.⁶ A brief intervention is a non-confrontational conversation with an individual that identifies health concerns, sets collaborative goals, and develops a tailored treatment plan.^{8,9} It is often conducted using motivational interviewing techniques. SBIR is typically carried out in emergency departments, primary care settings and electronically through web based or computerized interventions by health care professionals.¹⁰

This evidence brief uses the widely accepted definition of screening, brief intervention, and referral to treatment (SBIRT) put forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States.¹¹ SAMHSA asserts that SBIRT is a “comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders”.¹¹

The use of SBIR in clinical practice has been further supported by the Canadian Clinical Guideline for High-Risk Drinking and Alcohol Use Disorder, which recommends screening all adult and youth patients for alcohol use above low risk.⁹ This is the first Canadian guideline to provide formal recommendations on the clinical provision of screening and treatment interventions for high-risk alcohol use. Other approaches to reduce harms associated with alcohol use include alcohol taxation, minimum unit pricing, drinking-driving countermeasures and regulated alcohol.^{7,12,13}

Current Landscape

Mitigating the harms of substance use in Ontario is a public health priority. In 2023, the Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario focused on “an all-of-society approach to substance use and harms”.¹⁴ This report included specific information on alcohol trends and health impacts, as well as changes to the policy environment and recommendations moving forward.

In Ontario, health units are required to deliver programs and services that address alcohol use as mandated by the Ontario Public Health Standards.¹⁵ As such, implementation of universal SBIR has the potential to contribute to a health unit’s effort in addressing alcohol use within their jurisdictions. Additionally, LRDG data are often used as an indicator to determine a health unit’s success in this area.

In 2024, the Canadian Alcohol Policy Evaluation (CAPE) Project released their updated assessment of federal and provincial/territorial alcohol policies, which have been identified as the primary means by which to prevent and reduce alcohol-related harms.^{16,17} Alcohol policies were evaluated across a number of sectors including regulation, distribution, financial supervision, and public health management of alcohol.¹⁷ Overall, the results of CAPE 3.0 demonstrated that there are areas requiring improvement across numerous sectors to reduce alcohol-related harms on a population level. Specifically, the importance of robust screening and treatment interventions was emphasized, with SBIR highlighted as an essential mechanism for intervention at both the federal and provincial/territorial levels.

Research Question

This evidence brief asks: **What is the effectiveness of screening, brief intervention and referral at reducing alcohol consumption and alcohol-related harms in different health system settings?**

Methods

Public Health Ontario (PHO) Library Services searched MEDLINE, Embase, CINAHL, PsychINFO, SOCINDEX and Health Policy Reference Centre on March 14, 2025 for articles published between 2016 and 2025. The search strategy was adapted from MEDLINE for all supplementary databases. The full search strategy can be obtained from PHO upon request.

Articles retrieved during this search were assessed for eligibility by two reviewers. Study design inclusion was limited to reviews, systematic reviews and meta-analyses. Reviews were eligible if published in English, focused on interventions that took place in general health system settings (e.g., primary care, emergency departments, hospital units, health clinics), included both screening and brief intervention components of SBIR, and reported outcomes on the effectiveness of SBIR. Articles were excluded if they focused on substances other than alcohol (e.g., tobacco and cannabis), focused only on populations with co-morbidities, were focused only on low- and middle-income jurisdictions, if the intervention was in a substance use treatment facility, if the brief intervention excluded the screening component of SBIR and if SBIR effectiveness was not the primary outcome. Aligned with recommendations presented at both national and provincial levels that highlight the need for a combined approach to screening and brief intervention,^{18,19} only reviews that evaluated these components together were included.

One reviewer screened all titles and abstracts. Articles meeting the inclusion criteria were retrieved for full text review which were screened in duplicate by two reviewers, with a third reviewer to resolve any conflicts. Two reviewers conducted quality appraisals of the relevant full texts using the *Health Evidence Quality Assessment Tool*.²⁰ Articles rated as weak were excluded from this evidence brief, articles rated moderate or high were included. All relevant information was extracted from each included article using a standardized data extraction form. Additional quality appraisal and data extraction details are available on request.

Main Findings

The literature search identified 863 potentially relevant articles, 14 of which were included in this evidence brief after screening for eligibility.^{10,21-33} One additional review, which provided a clinical distillation of an included Cochrane review, was also included for its relevance to the subject.³⁴ This evidence brief identified seven moderate quality reviews^{21,22,24-27,32} and seven high quality reviews^{10,23,28-31,33} published since 2016. These results build on previous evidence to further clarify the role of healthcare providers in the provision of SBIR and further evaluate its effectiveness in addressing at-risk alcohol drinking behaviours and alcohol-related harms.

Review Characteristics: Components of SBIR

Screening

The goal of screening in SBIR is to assess the severity of substance use.¹¹ Screening should be universal, meaning it is available to all patients.³⁵ A variety of screening tools were implemented in the reviews identified by this evidence brief. Articles that did not specify the approach to screening for alcohol use were excluded. Two main methods of screening for alcohol use were identified in the included studies: self-reported alcohol consumption and validated tools (e.g., Alcohol Use Disorder Identification Test [AUDIT], CAGE questionnaire, Paddington Alcohol Test, Rapid Alcohol Problems Screen, FAST Alcohol Screening Test, Alcohol, Smoking and Substance Involvement Screening Test [ASSIST]).

There was heterogeneity within and between included reviews for the screening processes and thresholds used to consider participants eligible for primary SBIR studies. Additionally, terms used to describe alcohol use based on the screening varied, such as “at risk”, “high risk” or “hazardous use”. These terms or thresholds were not always explicitly defined within the reviews. In practice, thresholds may be adaptable to current guidance.

Brief Intervention

Brief intervention supports individuals on achieving insight and awareness regarding their substance use, motivating them towards behavioural change where needed.¹¹ These interventions should not be time-consuming (e.g., typically 5 to 10 minutes).³⁵ The studies included in this evidence brief implemented a wide range of brief interventions. These were time-limited interventions ranging from one to four sessions and included methods such as feedback tailored to results of the screening process, teaching around “drinking styles”, readiness to change assessments, and brief motivational interviewing.

Referral to Treatment

Referral to treatment should be made when screening and brief intervention identifies individuals as needing more extensive treatment support for their substance use.¹¹ The majority of reviews included in this evidence brief did not include information on referral to treatment. Of the three reviews that included information on referral to specific alcohol use treatment, referrals were made when participants reached a specified risk threshold.^{23,25,30} This process was automated in one review which evaluated an electronic SBIR program.²⁵

Effectiveness of SBIR

Eight reviews (and the clinical distillation) assessed the efficacy of SBIR in a variety of primary healthcare settings, including general practitioners’ offices, emergency departments, and community health centres.^{10,23,25,26,28,30-32,34} Five reviews focused exclusively on the effectiveness of SBIR delivered in emergency departments.^{21,22,24,27,33} One review focused on SBIR provided in a prenatal care setting. Interventions in the reviews targeted a range of populations (e.g., adolescents, adults, pregnant people) and were delivered either in-person or electronically.²⁹

A variety of outcomes were explored in the included reviews. All reviews included measures of alcohol consumption (e.g., reported standard drink consumption, follow-up AUDIT scores). Four reviews included general measures of alcohol-related harms and consequences.^{21,28,30,34}

Reductions in Alcohol Use

Emergency Department Settings

Five reviews focused exclusively on SBIR delivered in emergency departments.^{21,22,24,27,33} The type of providers that delivered SBIR were not consistently reported across reviews, but where reported included a variety of personnel including physicians, residents, physician assistants, nurses, researchers, social workers, community outreach workers or drug and alcohol workers. All of these identified evidence that SBIR can reduce alcohol consumption among people engaging in at-risk drinking, but that this effectiveness tended to weaken over time and can depend on subgroup characteristics. For instance, one umbrella review including meta-analyses identified significantly lower frequency of drinking in groups where motivational interviewing was part of the SBIR intervention.²¹ However, these effects tended to dissipate over time between 3-, 6-, and 12-month follow up assessments. Adolescents and women aged 22 years and younger were found to benefit more from SBIR in the emergency department setting.²²

Two reviews incorporated electronic approaches to SBIR in the emergency department setting.^{27,33} One evaluated the effectiveness of electronic screening and brief intervention (e-SBI) in emergency departments and trauma centres, finding that this method may significantly decrease problematic alcohol consumption up to 6 months post-intervention.³³ Specifically, two randomized controlled trials within this review found that e-SBI significantly influenced the transition from “problematic” to “reduced risk” alcohol drinkers at 6-months post-intervention (effect size $[\mu]$: 1.31; 95% credible interval: 0.18, 1.89). Another review found that customized computer-generated feedback on drinking was associated with a significant reduction in weekly consumption at 6 months (effect size $[d]$: -0.19), which persisted at 12 months ($d = -0.11$).²⁷

Primary Care Settings

Eight reviews (and the clinical distillation) examined SBIR in primary care settings.^{10,23,25,26,28,30-32,34} All reviews found that the implementation of SBIR among people engaging in high-risk drinking behaviours was associated with trends towards reductions in alcohol use, though not all results met statistical significance. This effect was generally strongest over the short term (e.g. 3-6 months). Evidence ranged in quality among included reviews.

One Cochrane review on SBIR in primary care evaluated 69 randomized controlled trials with a total of 33,642 participants.¹⁰ The Cochrane review evaluated the impact of SBIR on both quantity of alcohol consumed per week and the frequency and intensity of consumption. This review found that at 12-months post-intervention, individuals drank a mean of 20 grams per week of alcohol less than those in control groups. Effect size was larger in primary care clinics when compared to emergency departments.¹⁰ An additional review prepared to inform updated recommendations by the United States Preventive Services Task Force (USPSTF) found that among 37 adult trials ($n = 15,974$), adults in intervention groups reduced their weekly number of drinks more than those not receiving intervention (weighted mean difference: -1.59; [95% confidence interval $[CI]$: -2.15, -1.03).²⁸ The proportion of adults reporting a heavy-use episode (six or more drinks) was also reduced among those receiving SBIR (odds ratio $[OR]$: 0.67; 95% CI : 0.58, 0.77). Results from this review suggest that there is some benefit at 2 to 3 years post-intervention; however, several trials in younger adults found that beneficial effects of SBIR appeared at 6 months but were no longer statistically significant at 12 months.

Two systematic reviews explicitly examined the effectiveness of e-SBIR in a number of primary care settings.^{25,32} Screening for high-risk alcohol use was done using either self-report or a validated screening tool (e.g. AUDIT, ASSIST), followed by a brief intervention based on motivational interviewing. Interventions were delivered electronically, with programs incorporating features such as readiness to change assessments and “drinking style” feedback. These reviews found that participants who received e-SBIR significantly reduced the frequency of drinking in a week.

Other Alcohol-Related Harms

A range of other alcohol-related harms were evaluated in reviews included in this evidence brief. Adams et al. (2023) evaluated the effectiveness of SBIR for injury prevention, finding significantly reduced alcohol-related injuries among individuals who participated in brief interventions.²¹ Further, studies in this review found results trending towards reductions in driving offences in brief intervention groups compared to controls, though not all reductions were statistically significant. One review examined the frequency of emergency department re-presentation and found no significant results.²⁷

Reviews identified in this evidence brief identified nuances between outcomes among subgroups (e.g., adolescents versus adults, females versus males). For instance, one systematic review informing the USPSTF identified trials in young adults that demonstrated a reduction in alcohol-related consequences (standardized mean difference: -0.06; 95% CI: -0.11, -0.01).²⁸ Another systematic review and meta-analysis found that at 3 months after brief intervention, there were significant reductions in alcohol-related consequences for females (mean effect size [g]: 0.16; 95% CI 0.08, 0.25), but not for males.³⁰ This review also found that females who engaged with brief intervention were more likely to access substance use treatment at 3-months post-intervention, but the same was not found for males.

Outcomes among pregnant people were explored in one review which was focused on prenatal alcohol exposure.²⁹ This review examined the effectiveness of brief interventions delivered in prenatal care settings (e.g., hospitals, primary care clinics, midwives’ offices). Meta-analyses found that pregnant people who engaged in SBIR were 33% less likely to experience preterm birth compared to control groups (OR: 0.67; 95% CI: 0.46, 0.98). Analyses of low birth weight outcomes did not find a significant difference between SBIR and control groups. O’Connor et al (2018) also included some evidence on the impact of SBIR among pregnant people, finding that interventions doubled the odds that people remained abstinent from alcohol during pregnancy (OR: 2.26; 95% CI: 1.43, 3.56).²⁸

Discussion

This evidence brief identified a number of moderate- to high-quality systematic reviews published since 2016. The landscape of research and practice around alcohol consumption has shifted significantly in recent years. The Canadian Guidance on Alcohol and Health, published in 2023,² offered a fundamental change in thinking around alcohol and harm reduction compared to the previous Low Risk Drinking Guidelines.³ Pursuant to the new guidance, the Canadian Clinical Guideline for High-Risk Drinking and Alcohol Use Disorder provided a framework for clinical providers to screen and treat individuals affected by alcohol use.⁹ This evidence brief identifies that there has been an increase in research in this arena.

The 2023 Canadian Substance Use Survey found that 79% of Canadians have used alcohol over the past 12 months.¹ Of these, 38% reported seven or more drinks in the past seven days, an amount which is now understood to put individuals at increasingly high risk of alcohol-related consequences like heart attack and stroke.^{2,36} Healthcare providers have an opportunity to screen and identify high-risk drinking behaviours.

Emergency department health care providers often attend to patients for alcohol-related issues, and are therefore in the position to identify high-risk drinking behaviours and intervene to prevent future harms.³⁷ This review of the evidence found that SBIR in the emergency department setting can reduce at-risk drinking habits among individuals. This effect tended to weaken over time (e.g., 12 months) and the effect tended to be stronger among certain sub-groups (e.g., adolescents, women). SBIR interventions were conducted by a variety of emergency department providers across the available evidence (e.g., physicians, nurses, social workers, outreach workers, drug and alcohol workers), suggesting some flexibility and sharing of responsibility in a team-based setting such as an emergency department. The use of e-SBI in the emergency department setting was found to be effective at reduction of at-risk drinking and offers a possibly efficient intervention when emergency departments are overburdened and resource constrained.

Primary care is an essential location for SBIR, as this is often the site of first-contact services (e.g., with a family physician) and may occur prior to alcohol-related harms taking place. The evidence from the included reviews found that the implementation of SBIR in primary care settings is effective at reducing at-risk alcohol use behaviours, with potentially a larger effect size when compared to emergency department settings.¹⁰ Electronic SBIR has also been found to be an effective intervention in primary care settings. Implementation of SBIR within the primary care setting could provide an opportunity to identify at risk patients who would otherwise not be recognized as at-risk.³⁸

Implications for Practice

Findings from this evidence brief may assist policy makers, primary care providers, hospital administrators and health units in decision-making regarding the use of SBIR to reduce alcohol consumption and associated harms. Overall, SBIR can be effective at reducing alcohol consumption and its related harms when implemented in certain settings, and potentially when targeted towards specific populations.

In Ontario, the 2023 Annual Report of the Chief Medical Officer of Health focused on an all-of-society approach to substance use and harms.¹⁴ This report highlights the leading role that alcohol plays in preventable harms, and formally recommends enhanced access to screening, brief intervention, and referral. This position was supported by the Association of Local Public Health Agencies, who echoed these statements and called on the provincial government to develop an Alcohol Strategy.³⁹ The Chief Medical Officer of Health report highlighted that this Alcohol Strategy should include support for clinicians to engage in SBIR.¹⁴

Support for clinicians to engage in SBIR could include offering training or educational sessions to increase knowledge about alcohol screening recommendations, validated screening tools for detecting high-risk drinking and alcohol use disorder (AUD), content of brief interventions, motivational interviewing techniques, and decision making and process supports for patients who may require assessments or interventions beyond SBIR (e.g., specialist referrals, medications). A full description of an evidence-informed clinical pathway for AUD and recommendations for improving standards of care for AUD are described in the Canadian Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder.⁹

Under the Ontario Substance Use and Injury Prevention Program Standards, health units are required to work with community partners to develop and implement healthy policies and programs that address alcohol use.¹⁵ As such, health units work to increase capacity to prevent injury and substance misuse through collaboration with community partners. To address issues associated with alcohol consumption, health units may elect to use SBIR.⁷ Health units can support the adoption of SBIR through collaboration with local primary care providers, hospitals and universities thereby contributing to the overall goal of reducing the impact of preventable injury and substance misuse in Ontario.

Recent literature has demonstrated that between 2003 and 2016, emergency department visits attributable to alcohol were more than four times greater than the increase in any other type of visit.⁴⁰ Rates of emergency department visits increased faster among women and young adults. Further, research has demonstrated a high mortality rate among young people who present to the emergency department frequently with alcohol-related harms.⁴¹ It follows that emergency departments are critical locations for SBIR services.

Within primary care settings, this evidence brief identified findings that SBIR is effective at reducing at-risk alcohol consumption. While recent guidelines provide a mechanism to implement SBIR in primary care settings, previous research has demonstrated that the use of validated screening tools among family physicians is limited. Further, rates of screening for substance use disorders among adolescents has previously been much lower than screening among adults.⁴² While family physicians are an essential cornerstone of the healthcare system in Canada, the systemic, financial, and time pressures on providers are currently immense.⁴³ Additional work supporting primary care providers in implementing both screening and brief interventions is needed to assess possible barriers and facilitators.

This evidence brief identified high-quality reviews citing evidence that SBIR can reduce high risk alcohol consumption and mitigate alcohol-related harms. These outcomes are short-term measures. However, the increasing body of evidence linking alcohol consumption to a number of chronic diseases was not captured in this literature. Alcohol is a carcinogen that can cause at least seven types of cancer. It is also a known risk factor for cardiovascular disease, including heart attack, stroke, hypertension, and heart failure. While SBIR has been shown to decrease at-risk alcohol consumption in the short-term, further research is needed to examine the potential long-term benefits of screening and intervention.

Limitations

Due to the rapid nature of this evidence synthesis, we did not check for overlap in primary studies across included reviews or overlap of reviews within the included umbrella reviews. The included reviews were of moderate to high quality. It is important to note that the final quality assessment ratings refer to the methodology of the systematic reviews but do not apply to the quality of the primary studies that were included in each review, nor the strength of the review findings. Most reviews acknowledged various types of bias that should be considered in the interpretation of findings, including publication bias and social desirability bias affecting self-reporting alcohol consumption. These may have influenced the validity of the overall findings of this evidence brief. In addition, some reviews included studies with poor methodological quality, unclear intervention descriptions, and lack of consistent follow-up intervals across studies, making it difficult to compare short- and long-term implications. While all included studies incorporated both screening and brief intervention, the modes by which these interventions were delivered varied. For instance, some studies implemented validated screening tools (e.g. AUDIT, ASSESS), while others relied on self-reporting of alcohol consumption above a specified risk threshold.

While this Evidence Brief did not explicitly investigate the potential harms of SBIR, three reviews explored this outcome.^{10,26,28} No explicit harms of SBIR were identified. However, results were not conclusive, as evidence was generally very low-quality.¹⁰ This is an important area of consideration and potential future research.

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